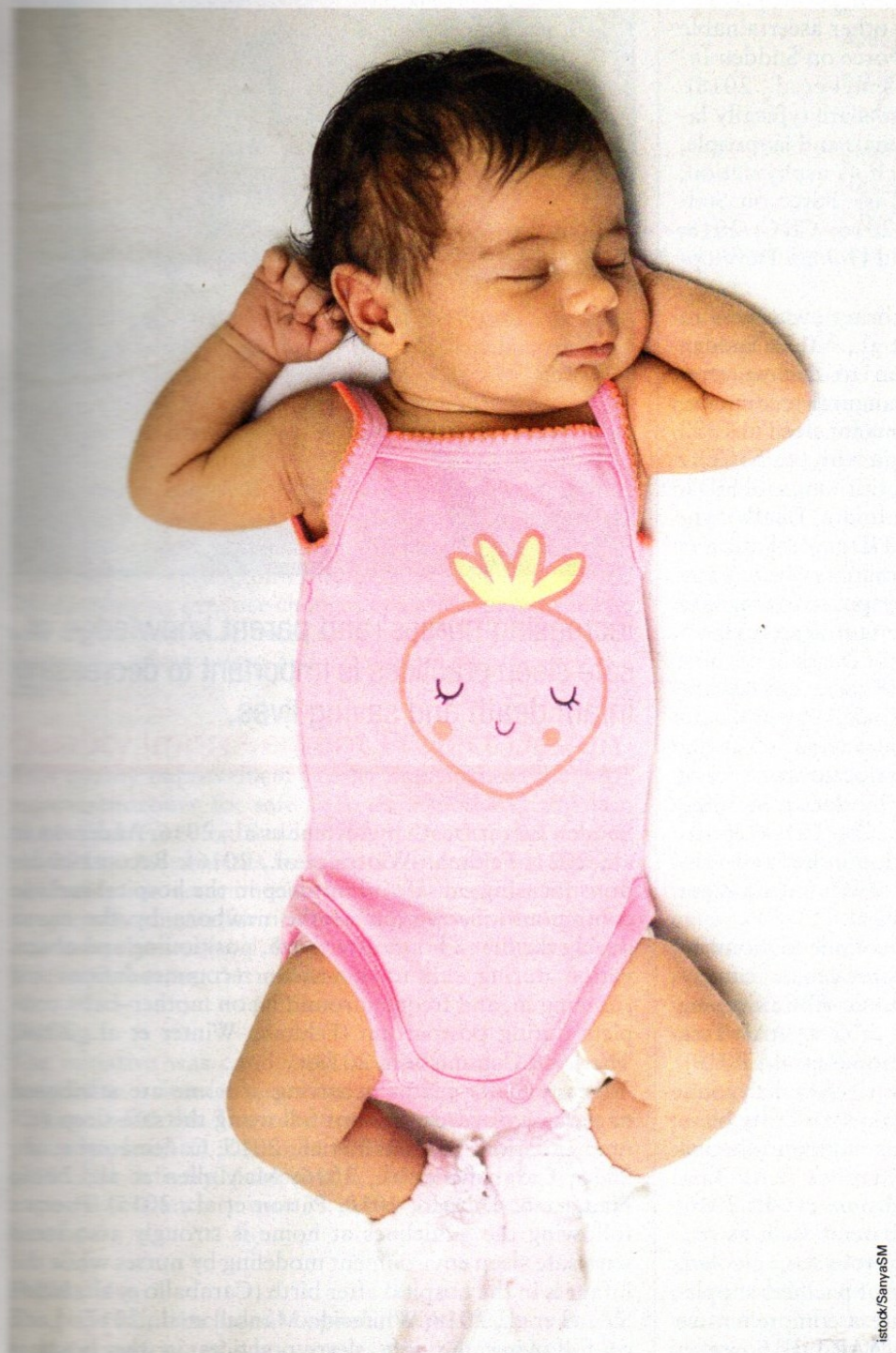


INFANT SAFE SLEEP INITIATIVE IN A SMALL VOLUME MATERNITY SERVICE

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Abstract

Purpose: Despite the 2016 American Academy of Pediatrics recommendations for preventing sudden unexpected infant death, there are approximately 3,400 sudden unexpected infant deaths annually in the United States. Modeling of safe sleep practices by nurses in the hospital influences parents' practice at home; however, safe sleep practices are not consistently modeled during the childbirth hospitalization.

Methods: A quality improvement project was conducted to implement a safe sleep initiative based on the 2016 American Academy of Pediatrics recommendations for nurses caring for hospitalized infants after birth. Evaluation included testing of nurses' knowledge, infant crib audits, and nurses' evaluation of the intervention.

Results: A significant improvement was found in overall nurse education scores. Crib audits demonstrated a significant improvement in the following elements: use of multiple blankets, swaddling of the infant, and parent teaching. Nursing surveys reported an increase in confidence to practice safe sleep recommendations and educate and redirect parents.

Clinical Implications: Implementing a safe sleep initiative can increase nurses' knowledge, improve adherence to recommendations with modeling safe sleep practices, and increase parent awareness of safe sleep recommendations, potentially positively affecting adherence after discharge.

Key words: Infant; Parents; Quality of health care; Sleep; Sudden infant death.

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Sudden unexpected infant death (SUID) is an umbrella diagnosis defined as any infant death that is unexpected and occurs within the first year of life, despite a known or unknown etiology (American Academy of Pediatrics [AAP] Task Force on Sudden Infant Death Syndrome et al., 2016; Anderson et al., 2021; Caraballo et al., 2016; Sleutel et al., 2018). Sudden infant death syndrome (SIDS) falls under the SUID umbrella, defined as unexplained, unexpected infant death occurring in infants less than 1 year of age (Centers for Disease Control and Prevention [CDC], 2018). It is a diagnosis of exclusion occurring only after a thorough medical and environmental investigation when no other ascertainable cause can be determined (AAP Task Force on Sudden Infant Death Syndrome et al., 2016; Sleutel et al., 2018). Though most infant sleep-related deaths are typically labeled as SIDS by health care professionals and laypeople, most occur from known sources, such as asphyxiation, suffocation, and entrapment (AAP Task Force on Sudden Infant Death Syndrome et al., 2016; CDC, 2018; National Institute of Child Health and Human Development [NICHD], 2014).

There have been many efforts to bring awareness to SUID and SIDS prevention (Patton et al., 2015). Sudden unexpected infant death rates began to decline after 1990, directly related to the AAP inaugural recommendations for supine positioning of infants for sleep in 1992 and the joint “Back to Sleep” campaign with the NICHD in 1994 (AAP Task Force on Infant Positioning and SIDS, 1992; AAP Task Force on Sudden Infant Death Syndrome et al., 2016; CDC, 2021; NICHD, n.d.; Patton et al., 2015). American Academy of Pediatrics created recommendations in 2011 and 2016 in response to stagnant rates, focusing on establishing a safe infant sleep environment (AAP Task Force on Sudden Infant Death Syndrome et al., 2016; NICHD, 2014). Despite these efforts, the decline in rates of SUID have lagged since 1999 and continue to affect infants and families (Cadematori et al., 2016; CDC, 2021). Recent SUID rates occur at a rate of 90.1 deaths per 100,000 live births, translating to 3,400 infant deaths in 2019 (CDC, 2021). The CDC reports accidental suffocation and strangulation in bed rates rising in 1997, with the highest rate of 25.5 deaths per 100,000 live births in 2019 (CDC, 2021).

The most recent AAP Safe Sleep recommendations include items that primarily fall under three general categories, easily identifiable by the mnemonic ABC; sleeping Alone on their Back, and in a Crib (Table 1; AAP Task Force on Sudden Infant Death Syndrome et al., 2016). Items such as using wearable blankets (sleep sacks), room sharing without cosleeping, avoiding thick or fluffy blankets, and placing infant on a firm, flat mattress all comprise the backbone of the recommendations (AAP Task Force on Sudden Infant Death Syndrome et al., 2016; Feldman-Winter et al., 2016). Other items such as recommending breastfeeding; avoiding tobacco, alcohol, and drug use in the home; and the use of pacifiers supplement the ABCs of safe sleep to ensure a comprehensive safe sleeping environment for infants (AAP Task Force on



Increasing nurses' and parent knowledge of safe sleep practices is important to decreasing infant death and saving lives.

Sudden Infant Death Syndrome et al., 2016; Anderson et al., 2021; Feldman-Winter et al., 2016). Recommendations focusing on safe infant sleep in the hospital include continuous observation of the newborn by the nurse during the first 2 hours after birth, positioning and observation during skin-to-skin care, recommendations for rooming in, and frequent rounding on mother-baby couplets during postpartum (Feldman-Winter et al., 2016; The Joint Commission, 2018).

Many SUID deaths occurring at home are attributed to parents or caregivers not following the safe sleep recommendations (Barsman et al., 2015; Cadematori et al., 2016; Caraballo et al., 2016; McMullen et al., 2016; Naugler & Dicarlo, 2018; Patton et al., 2015). Parents following the guidelines at home is strongly associated with safe sleep environment modeling by nurses while the infant is in the hospital after birth (Caraballo et al., 2016; Sleutel et al., 2018; Whiteside-Mansell et al., 2017). Lack of following the safe sleep practices in the hospital

TABLE 1. SUMMARY OF AMERICAN ACADEMY OF PEDIATRICS 2016 SAFE SLEEP RECOMMENDATIONS

ALONE	BACK	CRIB	OTHER
Avoiding cosleeping	Back to sleep for every sleep	Firm sleep surface	Breastfeeding
No soft objects, loose bedding	Lay flat, avoid positioning aids, reflux wedges	Separate sleep surface in room with parents	Pacifier at naptime/bedtime
Avoid overheating		Avoid sleeping in swings, bounce chairs	Avoid alcohol, tobacco, illicit substances
Use of wearable blankets (sleep sacks)			Recommended immunizations on schedule
			Avoid use of unsafe commercial items
			No home cardiorespiratory monitors
			Obtain prenatal care
			Regular tummy time
			Health care professionals should model and endorse safe sleep

Note. Adapted from American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome et al. (2016).

prompted the AAP to cite the need for consistent, safe sleep environment modeling by nurses in the hospital setting (AAP Task Force on Sudden Infant Death Syndrome et al., 2016).

The purpose of this quality improvement project was to implement a safe sleep initiative in a hospital setting. The primary goals of the initiative were to improve nurses' adherence to safe sleep recommendations and to increase role modeling of a safe infant sleep environment (Addison & Ludington-Hoe, 2020; Anderson et al., 2021). Nursing practice changes can affect parents using safe sleep practices at home after hospital discharge and, therefore, infant safety and prevention of sleep-related death.

Quality Improvement Project Design

This quality improvement project implemented the AAP recommendations for safe sleep on a mother-baby unit (AAP Task Force on Sudden Infant Death Syndrome et al., 2016). Assessments were made to determine nurses' adherence to recommendations and improvement of sleep environments for newborns. Approval through the university Institutional Review Board was obtained before implementing the initiative.

Setting

The initiative was conducted in a 109-bed community hospital in a women's services unit with an average of 720 annual births. The initiative started in July 2020 and was completed in December 2020. The unit included labor and delivery, postpartum, a level 1 nursery, and a special care nursery with 31 nurses and three care technicians.

Population

The population included hospitalized infants born at ≥ 35 weeks gestation and who were less than 2 months of age

in the newborn and special care nurseries. Infants requiring respiratory support, or central intravenous (IV) access were not included in this population as modifications to create a safe sleep environment may be medically contraindicated. Twenty-nine nurses and two care technicians currently employed full-time in the unit were included. Only full-time nurses and care technicians were included to ensure full participation in the initiative. Enrollment was through convenience sampling with permission from the facility via an affiliation agreement. All participants were given a choice to participate in the initiative and those who chose to participate signed a written consent form.

Procedure

Education. An educational session was provided to participating nurses and included a face-to-face, 1 hour slide presentation discussing background information and statistics involving SUID, the AAP Task Force on Sudden Infant Death Syndrome et al. (2016) recommendations for infant safe sleep, rationale behind the recommendations, and common barriers to following the safe sleep guidance. Ten face-to-face presentations and one virtual presentation were offered on all shifts to ensure all participants were able to attend. Time was allotted after the presentation for questions and the airing of concerns or misconceptions.

Crib Audits. Sixty pre- and postintervention crib audits were performed by the first author over a 45-day period for each cycle and evaluated the categories of the AAP safe sleep recommended using the crib audit tool from Cribs for Kids (Cribs for Kids, 2022). The number of audits were determined based on the average monthly census. Crib audit data were not linked to specific nurses responsible for each patient. The tool contains nine items that evaluated the infant's sleeping environment. Permission to use and modify the instrument was granted from Cribs for Kids which is part of the organization's Safe Sleep Hospital

Certification Toolkit (Cribs for Kids, 2022). This tool is recommended by organizations such as the Tennessee Department of Health and Team for West Virginia Children (Team for West Virginia Children, 2018; Tennessee Department of Health, n.d.-a; n.d.-b). The final instrument used in this project was 10 items. The item “patient in nest” was removed due to similarity with the “positioning device used” item. An item evaluating a hat’s presence was added as hats are loose objects and can contribute to overheating (AAP Task Force on Sudden Infant Death Syndrome et al., 2016). Because many parents room-in, an item to evaluate parental receipt of safe sleep information was added to connect parents’ assimilation of the teaching with the infant’s sleep environment. The revised audit tool can be found in Figure 1.

Safe Sleep Initiative Postintervention Nursing Survey. A survey was administered to participants 1 month after the education sessions were completed. The survey was given to evaluate the intervention and identify barriers to the initiative. Six Likert-type items and four open-ended questions were included.

Data Analysis

Twenty-seven nurses and two scrub technicians participated in this initiative. Descriptive analysis was used to describe the project’s population and outcomes of the surveys. Paired-samples *t*-tests were used to evaluate the impact of the implementation of the AAP Task Force on Sudden Infant Death Syndrome et al. (2016) recommendations for safe sleep on posteducation testing scores among staff and improvement in postintervention crib audit scores. Open-ended responses were listed with common ideas identified.

Results

Demographic Information

Twenty-six of the 29 participants provided demographic information. All participants were female ($n = 26$) with the majority 26 to 35 years old ($n = 10$, 38.5%) and 18 to 25 years old ($n = 7$, 26.9%). They were mostly nurses ($n = 24$, 92.3%) with two scrub technicians (7.7%). Most of the nurse participants have a bachelor’s degree ($n = 17$,

65.4%). Participant experience was 5 to 10 ($n = 7$, 26.9%), 10-plus ($n = 7$, 26.9%), 1 to 3 ($n = 6$, 23.1%), and <1 ($n = 4$, 15.4%) year of experience.

Pre- and Posteducation Testing

Twenty-seven nurses and two scrub technicians completed pre- and posteducation testing. There was a significant improvement in the total correct items from preeducation testing ($M = 12.14$, $SD = 1.597$) to posteducation testing ($M = 14.28$, $SD = .841$), $t(28) = -6.591$, $p = .000$ (two-tailed).

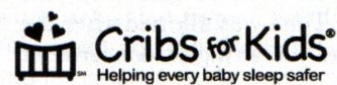
Crib Audits

Three items showed significant improvement after the intervention: use of multiple blankets, swaddled infant, and caregiver receiving information. Seven items showed no significant improvement including infant wearing hat and the use of large, fluffy blankets. See Table 2.

Safe Sleep Initiative Postintervention Nursing Survey

Twenty-six participants (90%) completed the nursing survey. Most ($n = 14$, 53.8%) reported having a moderate familiarity with the AAP Task Force on Sudden Infant Death Syndrome et al. (2016) safe sleep recommendations before the initiative and ($n = 17$, 65.4%), following safe sleep recommendations all the time. All but one ($n = 25$, 96.2%) found the sessions very informative and inspired confidence with adhering to safe sleep recommendations. Participants identified several benefits of the intervention including the convenience of the education and the inclusion of relative information and examples. New information identified by nurses included not using hats, avoidance of multiple blankets, and the overall importance of modeling and educating families about safe sleep recommendations. Commonly identified barriers were cultural beliefs (i.e., infants needing to be over bundled or they will get sick, placing infants prone to help with digestion, etc.), language barriers, and the influence of family members. Identifying cultural beliefs and language barriers is particularly notable due to the large Hispanic patient population at that hospital and the community.

FIGURE 1. CRIB AUDIT TOOL



Safe Sleep Audit Tool		Date: _____								
Auditor: _____		Time of Audit: _____								
Patient #	Head of Bed Flat? Y or N Degree of Elevation	Patient Asleep Supine? Y or N	Multiple Blankets to Crib? Y or N	Stuffed Animals in Crib? Y or N	Large or Fluffy Blankets Around Pt.? Y or N	Patient Wearing Hat? Y or N	Patient Swaddled? Y or N	Caregiver Asleep with Patient? Y or N	Positioning Device Used? Y or N	Caregiver Received Information? Y or N

Note. Y = Yes; N = No.

Adapted with permission from Cribs for Kids, Inc.®, 2022 (<https://cribsforkids.org/wp-content/uploads/Audit-Form.pdf>).

TABLE 2. PRE- AND POSTINTERVENTION CRIB AUDITS COMPARISON BY ITEM (N = 60)

Items	Pre		Post		P
	No./% Correct	M (SD)	No./% Correct	M (SD)	
Head of bed elevated	57 95%	1.05 (.220)	58 96.7%	1.03 (.181)	.659
Supine position	58 96.7%	1.03 (.181)	60 100%	1.00 (.000)	.159
Multiple blankets	40 66.7%	1.33 (.475)	52 86.7%	1.13 (.343)	.009*
Stuffed animals in crib	56 93.3%	1.07 (.252)	59 98.3%	1.02 (.129)	.182
Large or fluffy blankets around infant	52 86.7%	1.13 (.343)	52 86.7%	1.13 (.343)	1.000
Infant wearing hat	28 46.7%	1.53 (.503)	28 46.7%	1.53 (.503)	1.000
Swaddled infant	4 6.7%	1.93 (.252)	14 23.3%	1.77 (.427)	.011*
Caregiver asleep with infant	59 98.3%	1.02 (.129)	60 100%	1.00 (.000)	.321
Positioning device used	53 88.3%	1.12 (.324)	56 93.3%	1.07 (.252)	.321
Caregiver teaching	21 35%	1.65 (.481)	39 65%	1.35 (.481)	.000*

Key: M = mean; SD = standard deviation.

* $p < .05$

Discussion

Three items, use of multiple blankets, swaddled infants, and parents receiving teaching, showed a significant improvement on postintervention crib audits. This finding supports this initiative's goal: more parents received education and essential recommendations. One area that still needs improvement is infants wearing hats, which did not change during the initiative, although a policy was introduced during the education period requiring nurses to remove hats after 24 hours of life. Similarly, the cosleeping, supine positioning, and head of bed flat items had high preintervention audit scores and showed no improvement in the postintervention period, indicating prior adaptation into practice.

Nurses found benefit with the initiative, expressing an increase in knowledge and confidence to adapt safe sleep recommendations to daily practice and provide education and redirection with infants' families. Multiple barriers included cultural beliefs and language barriers due to the large Hispanic population in that community. One recommendation is to provide visual prompts (posters, crib cards, pamphlets) in Spanish where safe sleep recommendations are easily visualized. Most importantly, the improvement in nursing knowledge, adherence to recommendations, and increase in parent education is crucial to decreasing infant death and saving lives. These findings support those of previous quality improvement projects addressing safe sleep in the hospital setting (McMullen et al., 2016; Sleutel et al., 2018).

Limitations

The hospital and community where the initiative took place support a large Hispanic patient population. Hispanic infants have the fourth highest death rates from SIDS and sleep-related death (CDC, 2021). Language barriers limited the success of a safe sleep initiative as many families reported not receiving any safe sleep education, despite the availability of interpreter services at the hospital. Though posters demonstrating a safe sleep environment were placed in patient rooms, all were in English. COVID-19 also affected access to some patients, as restrictions were in place to avoid these patients. Data collection was affected because hospital entrances were restricted on weekends.

Clinical Implications

The initiative was successful in a small community hospital with nurses from labor and delivery, postpartum, and nursery. One recommendation for implementation is to begin safe sleep discussions and education with parents when they are admitted for labor and birth, then continue the education through their postpartum stay. Hospitals should include languages that reflect the patient population and provide signage and education materials in the appropriate native language (e.g., Spanish at our hospital). There are many resources available at no cost to improve or write a safe sleep policy, provide parent education, perform regular crib audits and toolkits to implement or continue a safe sleep initiative. Cribs for Kids provides

CLINICAL IMPLICATIONS

- Knowledge of safe sleep practices is important to decreasing infant death and saving lives.
- Implementing a safe sleep initiative with nurses that includes education on AAP safe sleep recommendations with associated rationale, testing of knowledge. Before and after education, and evaluating the infant sleep environment via crib audits improves nurses' knowledge and parent education.
- Implementing a safe sleep initiative increases nurses' confidence to adapt safe sleep recommendations to daily practice.
- Needs of the population served must be considered and educational materials provided to parents in the language they can understand, e.g., a hospital serving Hispanic patients should have materials in Spanish for parents.
- Resources for safe sleep are often available at no cost for nurses and nurse leaders to create safe sleep policies, provide parent education formally or informally, and perform regular crib audits.
- Implementing a safe sleep initiative can be done in small facilities with positive results in safe sleep adherence.

a comprehensive toolkit that includes PowerPoint presentations for Safe Sleep Hospital certification (Cribs for Kids, 2022). Caregiver information is available in Spanish in the Cribs for Kids Hospital Certification Toolkit (Cribs for Kids, n.d.). In our hospital, after the safe sleep initiative, there was a demonstration of increased knowledge of safe sleep recommendations by nurses, improved overall adherence and critical elements of a safe sleep environment, and a perception of improved confidence in knowledge and ability to implement and educate families about safe sleep recommendations. ✚

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The authors declare no conflicts of interest.

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