Background

In 2016, approximately 28% of the 3600 sudden unexpected infant deaths (SUID), were due to accidental suffocation and strangulation in bed. To think that 900 infants died because of an unsafe sleep environment is more than a tragedy; this is a call to action! A nurse-led multidisciplinary team of physicians, nurses, lactation consultants, and birth certificate clerks collaborated on this project to provide parents with the education, tools, and examples necessary to follow safe sleep practices for the health and well-being of their newborn.

Purpose

To determine if consistency amongst practitioners would lead parents to a higher rate of compliance with safe sleep environment practices.

Design & Methods

A Plan, Do, Study, Act (PDSA) model was used for this project. A variety of educational interventions were deployed to the interdisciplinary team. Successful delivery of this content was confirmed with a post-implementation chart audits of parent education documentation were performed to assess consistency of education.

Education and Tools

Written, verbal and video education was provided to parents. Halo Sleep Sacks were added to the Safe Sleep Project for newborns to wear during hospitalization. Parents were also provided a take-home sleep sack.

Post education, parents were asked to verbalize in a teach-back method to state the tenets of safe sleep practices. A play pen/crib was given to parents who were unable to provide a safe sleep environment at home.

Discussion

Studies show that parents are more likely to follow practices that are modeled by their care providers. Inconsistent messages and unsafe sleep environment practices on the unit was found to be an area that needed significant improvement. Hospitals that provide care to infants should implement an evidence-based Safe Sleep Policy that begins with an audit of the maternal/newborn unit to discover the typical state of the sleep environment when entering the room.

References


Performance Data

Conclusions

Post-implementation audit results demonstrate a significant decrease in unsafe sleep environments (83% to 4%), and a substantial increase in documented parental education (42% to 100%). This data reinforce the value of consistent education and modeling of safe sleep practices to parents. The results support literature indicating parents are more likely to follow safe sleep practices if they have observed nurses model them during their hospitalization.

Hospitals that provide care to infants should implement an evidence-based Safe Sleep Policy that begins with an audit of the maternal/newborn unit to discover the typical state of the sleep environment when entering the room.

Limitations & Further Study

Limitations of this project included: post-implementation follow-up restricted to hospital setting; absence of long-term follow up.

Further studies should be designed to include post-discharge follow up with parents to identify if safe sleep practices continue at home.

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Nurses Make a Difference: Modeling Safe Sleep in the Hospital

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