



The Royal College of Midwives

## Bed Sharing and Co-sleeping

# Guidance Paper

### Introduction

This guidance paper builds on the good practice recommendations on Babies and infants bed sharing published by the RCM in 2000 and more recently on advice issued by UNICEF UK Baby Friendly Initiative. This guidance paper should be read in conjunction with RCM Position Statement Number 8, Bed sharing and Co-sleeping (RCM 2004) where the RCM recommendations in relation to this topic are outlined.

### Guidance

There should be locally developed guidance for mother-baby bed sharing and co-sleeping. The guidance should state the NHS Trusts position on bed sharing and co-sleeping in hospital and at home. Excellent resources such as the BFI sample policy: <http://www.babyfriendly.org.uk/pdfs/bedsharingpolicy.pdf> and sample information leaflet <http://www.babyfriendly.org.uk/parents/sharingbed.asp> are available to inform local guidance.

To minimise the risk of accidents associated with unintentional or uninformed co-sleeping in hospital, a risk assessment should be carried out by a midwife for all women who wish to bed-share with their babies and the level of supervision required communicated to the woman and relevant staff. The risk assessment should not be delegated to unqualified staff (see Appendix 1 for "sample risk assessment").

The use of cot sides or clip on cots can be useful in protecting against the baby falling out of bed. However, cot sides should be used with caution, as babies can become trapped between the mattress and cot side.

Staff should ensure maximum visibility of mother and baby whilst maintaining their privacy.

Hand-over of care in hospital should include information on which women are bed sharing or co-sleeping with their babies, and the level of supervision agreed after individual risk assessment.

- Parents should be informed of the benefits of:
  - bed sharing and co-sleeping including successful breastfeeding and better sleep;
  - skin-to-skin contact and assistance given.
- Parents should be discouraged from:
  - co-sleeping on sofas and armchairs;

- bed-sharing and co-sleeping at home if either parent is a smoker, has recently had alcohol, is on sleep inducing medication or illicit drugs, is unwell, excessively tired or unaware of body periphery;
- co-sleeping if the baby is bottle feeding, is bed sharing or co-sleeping with father only or if the father comes to bed later;
- leaving the baby unattended in bed;
- allowing the baby to bed share or co-sleep with children, or bed share with unwell or restless children;
- allowing pets in the bedroom;
- using heavy quilts duvets, electric blankets or pillows;
- sleeping on waterbeds, feather, soft or sagging mattress, beanbags and V shaped pillows.
- Midwives should ensure that accurate information is given to parents on bed-sharing and co-sleeping including:
  - appropriate sleeping positions;
  - ensuring that there are no gaps between the mattress, furniture and wall.

Information given should be recorded in the woman's notes. If risk factors have been identified, a record of what information and advice has been given on bed sharing and co-sleeping should be recorded. Staff should seek feedback from women to ensure that they have understood the information given.

- Women should have easy access to the call bell system, be shown how to use it and it should be checked to ensure it is working.
- Hand-over of care in hospital should include information on which women are bed sharing or co-sleeping with their babies and the level of supervision agreed on individual risk assessment.
- Information on bed sharing and co-sleeping should be reiterated to women at transfer from hospital, including advise about ideal temperatures for the bedroom (16 – 18 degrees C), appropriate amounts of clothing and the risks associated with over heating.
- Midwife and health visitor liaison should incorporate information exchange for the initial visit, to determine parents understanding of the advantages and disadvantages of bed sharing and co-sleeping.
- Multi-disciplinary training should be provided to staff on bed sharing and co sleeping.

As with other incidents, cases of babies being harmed due to falls from or being trapped in beds, chairs, cot sides or cots should be reported through risk management routes.

## Appendix 1 - Sample Risk Assessment by Midwife

The level of risk depends on factors at the time of bed sharing. For some mothers, the use of clip-on cot or cot-sides will reduce the level of supervision required. Also, for some mothers, suitable family members can be asked to supervise the mother to ensure the baby's safety. The midwife must use her/his professional judgement to assess the family member's willingness and suitability and give basic instruction. The presence of a family member or suitable equipment does not negate professional accountability.

Unless constant supervision can be provided, bed sharing or co-sleeping is not advisable if:

- the woman is still experiencing the effects of a general anaesthetic;
- she is immobile following spinal anaesthesia;
- she has been given drugs which cause drowsiness;
- she is ill to the point of affecting her level of consciousness or ability to respond normally to the baby, e.g. pyrexia, pre-eclampsia, or following severe haemorrhage;
- she is excessively tired, affecting her ability to respond to the baby;
- she suffers from a condition that would affect spatial awareness, such as sight impairment, or that would severely affect mobility and sensory awareness e.g. multiple sclerosis or paralysis;
- she is very obese;
- she is likely to lose consciousness temporarily, e.g. because of insulin-dependent diabetes or epilepsy.

Bed sharing and co-sleeping under the following circumstances may increase the risk of sudden infant death or accident, so an increased level of supervision is required:

- where the mother is a smoker;
- where the baby is premature or ill (an ill or premature baby may require professional supervision over and above that outlined here);
- if a bottle-fed baby is taken into mother's bed for comforting, it is advisable that the baby is put back in the cot before mother goes to sleep.

Mothers who fall into this category should be advised to avoid co-sleeping and should be asked to inform staff when taking their baby into bed if there is a possibility that they may fall asleep. Supervision will be required until the baby is put back in the cot.

Bed sharing and co-sleeping for breastfeeding mothers with none of the above risk factors require the least level of supervision

When the mother is asleep, regular checks are required to ensure that the baby's head remains uncovered and when not feeding, that the baby is in the supine position and that no other risk factors are present.

## Level of supervision required

The level of supervision required for mothers when bed sharing will vary depending on the above factors. Categories of supervision would include:

- constant supervision for mothers whose clinical condition means that they cannot take any responsibility for their baby;
- frequent supervision for mothers who can be left for short intervals only;
- intermittent checks if the mother is bed-sharing when co-sleeping is contra-indicated, to ensure that the mother has not fallen asleep;
- intermittent checks for breastfeeding mothers with none of the contra-indications listed who are sleeping, to exclude risks.

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