

**A Report of the findings of the
Royal College of Midwives (RCM)
United Kingdom (UK)
National Bed Sharing Audit**

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February 2005**

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Executive Summary

The issue of mothers co-sleeping and bed sharing¹ with their babies has been an area of controversy in terms of potential benefits, and of the risks to the infant.

In the autumn of 2004 a multi-disciplinary group, including key stakeholders, was convened to explore the existing guidelines and information available to women, and to practitioners providing care. The resulting activities from this meeting included reviewing the wording of the Department of Health leaflet, the updating of the UNICEF BFI guidance and the development of an RCM position statement and best practice guidance.

A key task identified was the need to undertake an audit into midwives awareness of the practices of co-sleeping, and on existing information available both to practitioners and to women. This was the first such United Kingdom (UK) wide audit. This report focuses mainly on this RCM audit, which was undertaken by the RCM Quality and Audit Development Co-ordinator

Aims and Objectives of the Audit

- To assess the extent of implementation of the use and value to practice, of the “*Babies and infants bed sharing*” chapter of *Midwifery Practice in the Postnatal Period: Recommendations for Practice*²;
- To gauge a national picture of:
 - the implementation of bed sharing guidelines in the UK;
 - the policy and position of NHS maternity services regarding bed sharing i.e. whether the unit is supportive of bed sharing in hospital and at home, at home only, or in neither place;
 - the range of information provided to women;
 - staff training;
 - aids used to support bed sharing;
 - the incidence of incidents related to bed sharing and to non-bed sharing e.g. falls of babies from chairs.

Audit methodology

An audit questionnaire was sent electronically to all Head of Midwifery Services (HOMS) on the RCM email distribution list and checked against

¹ The practical definitions used in this summary and report are Bed sharing - babies sharing a bed with their mother either to breastfeed or to receive comfort; and Co-sleeping - is defined in the context where the mother and baby share a bed and either mother or baby or both are asleep.

² RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period. Recommendations for practice*. RCM. London.

maternity units listed on the *BirthChoiceUK* website³ in April 2004. Analysis of the data was done using *Minitab: version 11*. A 5% significance level ($p < 0.05$) was used to assess statistical significance using ANOVA (One-Way Analysis of Variance).

The results from the audit will be available to maternity services through access to the RCM website⁴.

Audit results

- **Response rate** - (n=100), using the maternity units listed on *BirthChoiceUK* is 31%, ranging from, 15.4% from Wales, 18.6% from Scotland and 35% from England.
- **Unit size** - 45.7% (37) units were categorised as medium, 25.9% (n=21) as large, 19.8% (n=16) as very large, 7.4% (n=6) had no category of size (Midwife-led units), and 1.2% (n=1) were classed as small.
- **BFI Status** 59.3% (n=48) units did not have any BFI status, 27.2% (n=22) had a BFI Certificate of Commitment (BFI C of C), 11.1% (n=9) of units had the BFI Standard Award (BFI S A), and 2.5% (n=2) had the BFI Global Award (BFI G A).
- **Use of the *RCM Midwifery Practice in the Postnatal Period: Recommendations for Practice*⁵** - Eighty of the eighty-one units responded to this question and reported that; 12.5% (n=10) had used all of it, 23.8% (n=19) had used some sections of it, and 63.8% (n=51) had used none of it
- **Extent of implementation of *Babies and Infants bed sharing recommendations*⁶** - (n = 29), 31% (n=9) had implemented all, 62.1% (18) some and 6.9% (n=2) reported none of them.
- **Locally developed bed sharing guidance** - 65.4% (n=53) of units reported that they had locally developed bed sharing guidance, 29.6% (n=24) had guidance in draft and 4.9% (n=4) said they had none. Some of these guidelines were based on BFI recommendations or 'other'. There was strong statistical significance between units having locally developed guidance, and midwives ensuring that comprehensive bed sharing information is given to parents.

³ BirthChoiceUK (2004). Maternity Unit Details List. www.birthchoicework.com

⁴ RCM Web-site: www.rcm.org.uk

⁵ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period: Recommendations for Practice*. RCM. London.

⁶ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period: Recommendations for Practice*. RCM. London.

- **Units with locally developed bed sharing guidance** - 72.2% (n=39) discussed these during pregnancy (n=54), 85.7% (n=48) provided the information in leaflet form (n=56) and 44.4% (n=24) displayed the information in poster form (n=54).
- **Availability of local guidance** - 87.3% (48) units responded that the guidance was available to all staff including ancillary staff and ward clerks (n=55). 94.6% (n=52) of units stated that the guidance was supported by all midwives, 92% (46) said it was supported by all ancillary staff (n=50), 72.7% (32) by ward clerks (n=44), 81.1% (n=30) by Paediatricians (n=37) and 70.1% (26) by Health Visitors (n=37).
- **Units with no locally developed bed sharing guidance** - 55% (n=11) reported that they discussed general bed sharing advice with women during pregnancy (n=20), 76.2% (n=16) provided the information in leaflet form (n=21), with only 20% (4) displaying the information to women in poster form (n=20).
- **Whether parents informed of the risks of bed sharing** - Most units highlighted that parents were informed of the key risks, which included parents who smoke, drink alcohol or who are on medication, but also included issues around risks to the baby of rolling off the bed. The issues least likely to be discussed were electric blankets, unwell, restless children and father only. 73% of units were able to support this information to women with specific language needs.
- **Recording of bed sharing information and advice** – though 92% of units stated that information is given, this was not reflected in the degree to which it was recorded in women's notes.
- **Co-ordinated response** – only 46.1% stated that this is a co-ordinated process across midwives, health visitors and general practitioners.
- **Bed sharing equipment** – A variety of resources was in use, both singly: and together including clip-on cots, chairs or lockers positioned against the bed; lowering beds and tucking in blankets, and cot-sides. 1.6% used nothing.
- **Training** – 69.6% had training on bed sharing for midwives, maternity care assistants and nursery nurses, sometimes on orientation programmes and sometimes as part of the continuing professional development programme.
- **Bed sharing incidents** – 73 units responded that there had been an incident through unintentional bed sharing, and this included 2 deaths due to anomalies; 2 SIDS deaths; 1 sofa sharing death (SIDS) 1 death through suffocation; 1 death through pneumonia, and 2 injuries including a fractured skull.

- **Non-bed sharing incidents** – 20 units reported an incident, and this included 34 incidents – including one baby with a fractured skull.

Limitations

This audit represented information from 100 units across England, Scotland and Wales, and is reliant on the knowledge of the person/s who completed the form. Therefore the results are indicative rather than generalisable. Distinction between bed sharing and co-sleeping was not made in the design of the audit form, and this may have affected the results.

Conclusion

This audit was the first such project to identify the use of guidelines matched against the incidence of bed sharing and non-bed sharing incidents. The audit indicated that there is still a lack of information regarding the degree to which bed sharing and co-sleeping occurs. It also indicates that there is a variable degree to which maternity units are ensuring women and their families are informed and supported in this area. It would appear that parents deemed at higher risk (those who smoke, drink alcohol or are on medication) are more likely to have discussions with a professional concerning potential risks. Some initiatives during 2004 have impacted on the use of local guidance. A key finding was the lack of a multidisciplinary approach in terms of training and information provided to parents.

Key Recommendations

- The need to raise awareness through having locally developed guidance in place
- The utilisation of guidance to ensure comprehensive, evidence based information for women in a variety of formats
- Share best practice in relation to the recording of risks factors discussed and the information given to parents
- Promote truly multi-disciplinary training across primary and secondary care
- Raise awareness that bed sharing and non-bed sharing incidents are likely to occur, regardless of the stance that trusts take on bed sharing; so risk assessments of all women is desirable
- Consider providing multi-disciplinary training on bed sharing to work towards women having access to consistent, high quality, evidence based advice and information

1. Introduction

There is a need to provide clear, unbiased and non conflicting information to women and their families on the issue on co-sleeping and bed sharing⁷. Midwives and other practitioners therefore need to be provided with training and education, and have access to appropriate information and guidelines in order to provide contemporary information.

This report describes a project that emerged from a growing research base - and awareness by stakeholders of the need to update information - and the need for a baseline audit on bed sharing and co-sleeping practices within United Kingdom maternity units. This report will present the background to the RCM bed sharing audit, the development and operation of the audit, and the audit results. The implications for midwifery practice are discussed and some recommendations for midwives and those developing maternity services made.

2. Definitions

This report will use the practical definitions of bed sharing and co-sleeping agreed in the RCM position statement (See Appendix 1). It should be noted that these are different to the ones used by researchers in the field of bed sharing and co-sleeping.

Bed sharing is defined in this context as babies sharing a bed with their mother either to breastfeed or to receive comfort.

Co-sleeping is defined in the context where the mother and baby share a bed and either mother or baby or both are asleep.

3. Background

Traditionally many mothers have chosen to bring their babies into their own beds and, this has been seen positively in terms of maternal infant interaction and as an aid to successful breastfeeding. Professional groups such as midwives, and support groups and charities, have supported this practice as being beneficial. As knowledge has increased however, there has been an increase in concern over the infant's well-being. Some research and evidence has suggested that there may be increased risks of e.g. sudden infant death^{8 9 10}, or infant injury¹¹; though

⁸ Flick L, White DK, Vemulapalli C, Stulac BB, Kemp JS. 2001 Sleep position and the use of soft bedding during bed sharing among African American infants at increased risk for sudden infant death syndrome. *J Pediatr.* Mar;138(3):338-43.

other research suggests confounding variables such as smoking^{12 13 14}. One study suggested that though there were some risks associated with bed sharing, risks to babies left alone on adult beds, or couches was even higher¹⁵.

Therefore there is a need to clarify information regarding potential benefits and risks to the infant, for practitioners, women and families. This will ensure that mothers are able to make an informed choice, develop their relationship with their baby, whilst minimising any potential risks to the baby, and also, assist in successful breastfeeding.

In autumn 2003, a meeting was convened between the Royal College of Midwives (RCM), representatives from the UNICEF UK Baby Friendly Initiative (UNICEF UK BFI), the Foundation for the Study of Infant Deaths (FSID) and the Community Practitioner and Health Visitors Association (CPHVA). The objective of the meeting was to discuss the way forward in light of the research findings that were due to be published in the *Lancet* in January 2004¹⁶. It was expected that these research findings had the potential to be interpreted in different ways, including potentially that clinicians might not support women's choice to bed share with their babies of less than eight weeks old. The group were committed to working proactively to anticipate and manage the consequences of the publication.

The group discussed concerns that advising women not to bed share or co-sleep might limit opportunities for clinicians providing advice on the risks and benefits of co-sleeping; particularly recognising that women do co-sleep, both intentionally and unintentionally and need to be informed as to the safest ways to co-sleep.

As a result of the meeting, the RCM decided to raise awareness of best practice in relation to bed sharing and co-sleeping amongst midwives, by

⁹ Mitchell EA, Tuohy PG, Brunt JM, Thompson JM, Clements MS, Stewart AW, Ford RP, Taylor BJ. 1997 Risk factors for sudden infant death syndrome following the prevention campaign in New Zealand: a prospective study. *Pediatrics*. Nov;100(5):835-40.

¹⁰ Nakamura SW. 2001 Are cribs the safest place for infants to sleep? Yes: bed sharing is too hazardous. *West J Med*. 2001 May;174(5):300.

¹¹ Nakamura S, Wind M, Danello MA. 1999 Review of hazards associated with children placed in adult beds. *Arch Pediatr Adolesc Med*. Oct;153(10):1019-23.

¹² James C, Klenka H, Manning D. 2003 Sudden infant death syndrome: bed sharing with mothers who smoke. *Arch Dis Child*. Feb;88(2):112-3

¹³ Blair PS, Fleming PJ, Smith IJ, Platt MW, Young J, Nadin P, Berry PJ, Golding J. 1999 Babies sleeping with parents: case-control study of factors influencing the risk of the sudden infant death syndrome. CESDI SUDI research group. *BMJ*. Dec 4;319(7223):1457-61.

¹⁴ Fleming PJ, Blair PS, Bacon C, Bensley D, Smith I, Taylor E, Berry J, Golding J, Tripp J. 1996 Environment of infants during sleep and risk of the sudden infant death syndrome: results of 1993-5 case-control study for confidential inquiry into stillbirths and deaths in infancy. Confidential Enquiry into Stillbirths and Deaths Regional Coordinators and Researchers. *BMJ*. Jul 27;313(7051):191-5.

¹⁵ Beal SM, Byard RW. Sudden infant death syndrome in South Australia 1968-97. Part 3: is bed sharing safe for infants? 2000 *J Paediatr Child Health*. Dec;36(6):552-4..

¹⁶ Carpenter RG, Irgens LM, Blair PS, England PD, Fleming P, Huber J, Jorch G, Schreuder P. (2004). Sudden unexplained infant death in 20 regions in Europe: case control study. *The Lancet*. Vol 363. January 17, 2004: 185-191

publishing separately, the recommendations from the “Babies and infants bed sharing” section of *Midwifery Practice in the Postnatal Period: Recommendations for Practice*¹⁷. The whole publication was available for sale, but it was agreed that dissemination of the specific recommendations could be achieved by developing a RCM Position Statement (see Appendix 1) and Practice Guidelines (see Appendix 2)¹⁸. This was considered to be an effective means of providing concise information to practitioners, thereby ensuring that clear and accessible information and support would be available to women and their families.

The RCM also decided to undertake a national audit of implementation of the recommendations in the “*Babies and infants bed sharing*” section of the main document¹⁹, assess its use and value to practice, as well as a national profile of bed sharing and co-sleeping.

In January 2004, following the high profile media reporting of the death of a baby in hospital, linked with bed sharing, and of awareness of other incidents, the National Patient Safety Agency (NPSA) gained approval to lead a project on the profile of baby deaths related to bed sharing, within its maternity programme of work.

In February 2004, the NPSA then hosted a meeting for this project, with parties including UNICEF UK, BFI, FSID, the Department of Health (DoH), the Scottish Cot Death Trust, the CPHVA, a Head of Midwifery Services (HOM), a number of lead midwives for breastfeeding, a professor of paediatrics and the RCM. The outcomes of this meeting were:

- agreement that a meeting of statisticians involved in and out-with the Carpenter et al study²⁰, would be facilitated, with the aim of reaching consensus on how robust the study data was and what implications it might have for practice;
- rewording of a new DH leaflet, to include the statement that the safest place for a baby to sleep is in a cot in the mother’s bedroom, but not that there is an increased risk to babies under eight weeks of age bed sharing;
- group members commented on and amended the draft of the RCM position statement and best practice guidance, including a risk assessment
- group members commented on the draft RCM bed sharing audit tool for national use and that;

¹⁷ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

¹⁸ RCM (2004) *Bed sharing and co-sleeping: position statement*. RCM. London

¹⁹ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

²⁰ Carpenter RG, Irgens LM, Blair PS, England PD, Fleming P, Huber J, Jorch G, Schreuder P. (2004). Sudden unexplained infant death in 20 regions in Europe: case control study. *The Lancet*. Vol 363. January 17, 2004: 185-191

- the RCM would consider potential education and training needs in relation to bed sharing; and that
- an audit would be carried out by the RCM Quality and Audit Development Co-ordinator.

UNICEF UK BFI reviewed and updated the bed sharing policy, first published in 2001, and the updated policy was published in May 2004²¹. This is available on the BFI web-site along with research and other supporting resources in relation to breastfeeding²².

4. Objectives of the audit

The objectives of the national audit were discussed and agreed as:

- to assess the extent of implementation of the use and value to practice, of the “*Babies and infants bed sharing*” section of *Midwifery Practice in the Postnatal Period: Recommendations for Practice*²³;
- to gauge a national picture of:
 - the implementation of bed sharing guidelines across the UK;
 - the policy and position of NHS maternity units regarding bed sharing and co-sleeping i.e. whether the unit is supportive of bed sharing in hospital and at home, at home only, or in neither place;
 - the range of information provided to women;
 - staff training;
 - aids used to support bed sharing;
 - the incidence of incidents related to bed sharing and to non-bed sharing e.g. falls of babies from chairs.

5. Audit method

In April 2004 the *RCM Bed sharing audit questionnaire* (see Appendix 3) was sent electronically to all HOMS on the RCM email distribution list - a community of approximately 165 HOMS - that covered the majority of maternity units. Respondents were asked to return their questionnaire, preferably by email, to the RCM by May 2004. The return of audit forms was then cross-checked against maternity units listed on the *BirthChoiceUK* website²⁴.

As only 34 responses were received by May 2004, the original deadline was extended to the end of June 2004. In this report, the response rates

²¹ UNICEF UK Baby Friendly Initiative (2004). *Babies sharing their mothers’ bed while in hospital. A sample policy*. www.babyfriendly.org.uk/pdfs/bedsharingpolicy.pdf

²² <http://www.babyfriendly.org.uk/pdfs/sharingbedleaflet.pdf>

²³ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

²⁴ BirthChoiceUK (2004). *Maternity Unit Details List*. www.birthchoiceuk.com

for specific questions are noted in brackets. Analysis of the data was done using *Minitab: version 11*.

A 5% significance level ($p < 0.05$) was used to assess statistical significance; using ANOVA (One-Way Analysis of Variance). Percentages were rounded up or down to one decimal point.

6. Results

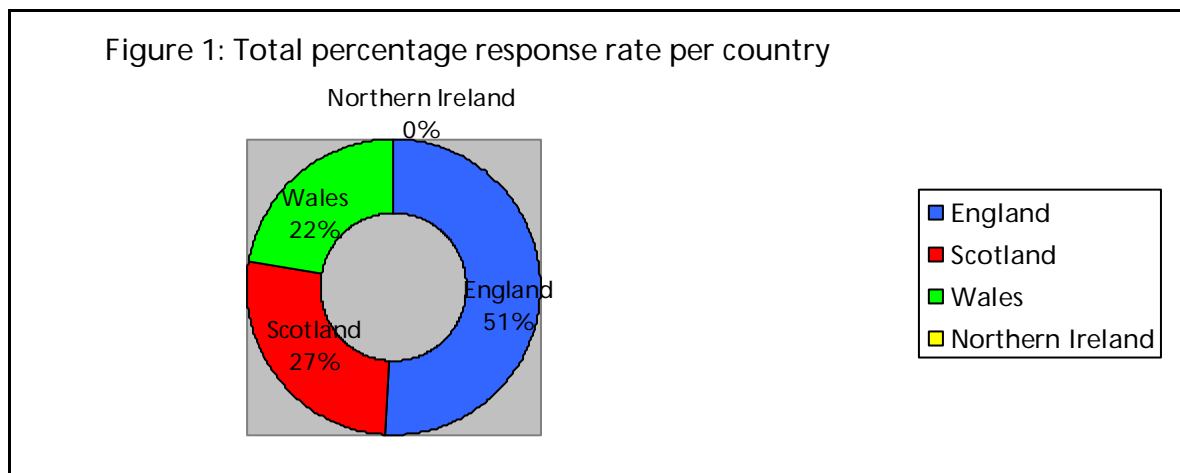
Eighty-one audit forms were returned from maternity units in England, Scotland and Wales, none were received from Northern Ireland. Some responses related to practice at one unit and others to practice at more than one site. It is calculated that practice in at least one hundred maternity units was included within the audit.

Although the audit questionnaire requested both the service and hospital name, the hospital name was omitted from several forms; therefore the exact number of maternity units participating could not be confirmed. Five further audit forms were received after analysis was completed, so therefore are not included in the analysis.

The results and some descriptions of the results follow.

6.1 Overall response rates

The overall response rate ($n=100$) was achieved using the maternity units listed on *BirthChoiceUK* was 31%, ranging from, 15.4% from Wales, 18.6% from Scotland and 35% from England.

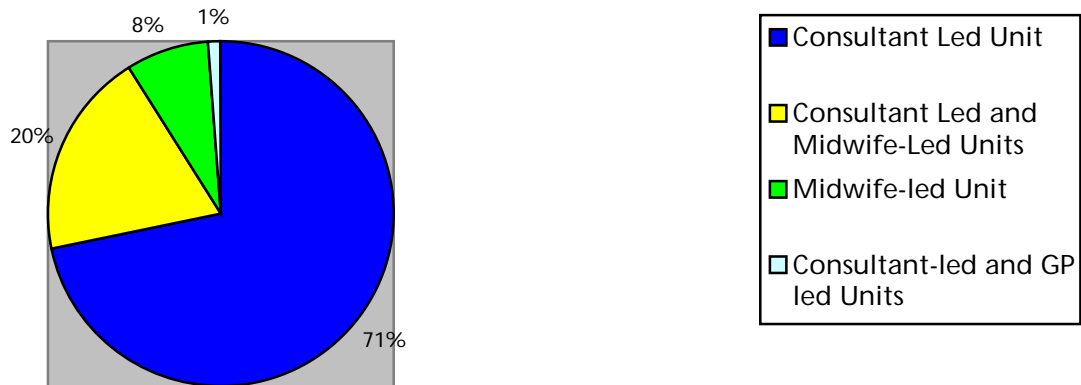


6.2: Profile of maternity units responding

Figure 2 indicates the size and type of maternity service providers responding ($n=81$). This was analysed using *BirthChoiceUK* categories.

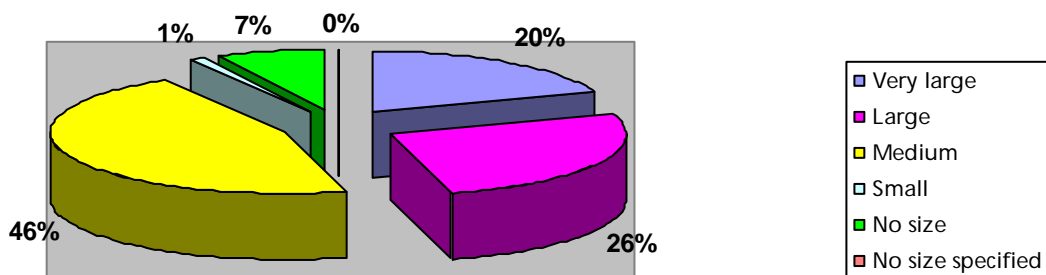
71.6% (n=58) maternity units were Consultant-led units (CLU); 19.6% (n=16) had Consultant-led and Midwife-led units (CLU & MLU); 7.6% (n=6) were Midwife-led (MLU); and 1.2% (n=1) had Consultant-led and GP-led units (CLU & GPU).

Figure 2: Different Types of Maternity Units responding



If the maternity service providers had more than one size of unit, then the larger size was used. Please note that size is not designated on *BirthChoiceUK* for Midwife-led units. 45.7% (37) units were categorised as medium, 25.9% (n=21) as large, 19.8% (n=16) as very large, 7.4% (n=6) had no category of size (Midwife-led units), and 1.2% (n=1) were classed as small.

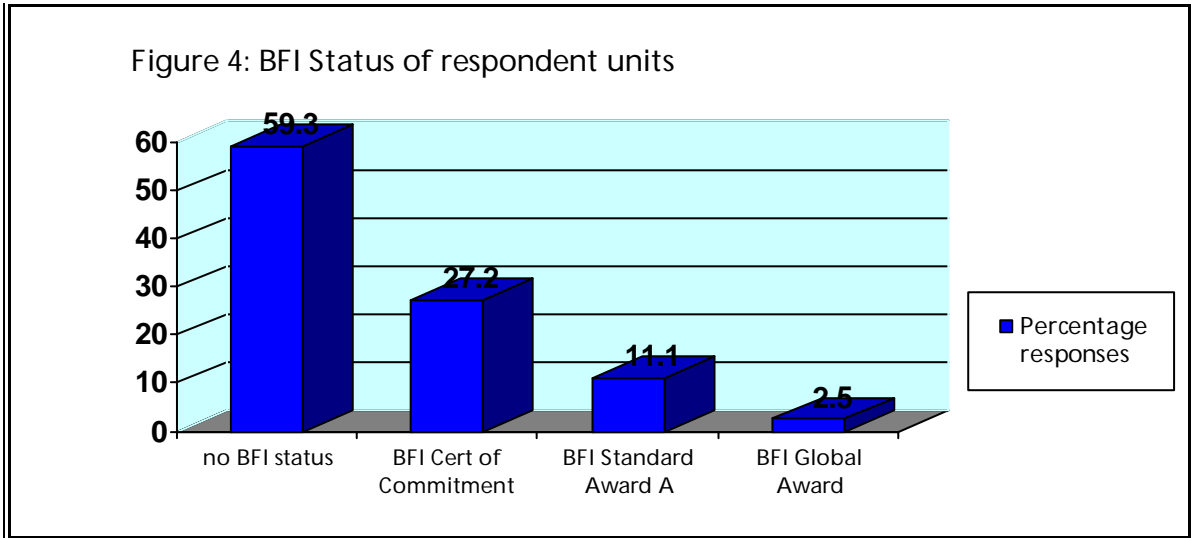
Figure 3: Percentage of different sizes of units responding.



Services were then profiled against BFI status, using the list of trusts on the UNICEF UK BFI website²⁵ (www.babyfriendly.org.uk) and cross-checking this with the BFI Programme Director, Andrew Radford (see Figure 4). 59.3% (n=48) units did not have any BFI status, 27.2% (n=22) had a BFI Certificate of Commitment (BFI C of C), 11.1% (n=9) of units

²⁵ UNICEF UK Baby Friendly Initiative: www.babyfriendly.org.uk

had the BFI Standard Award (BFI S A), and 2.5% (n=2) had the BFI Global Award (BFI G A).

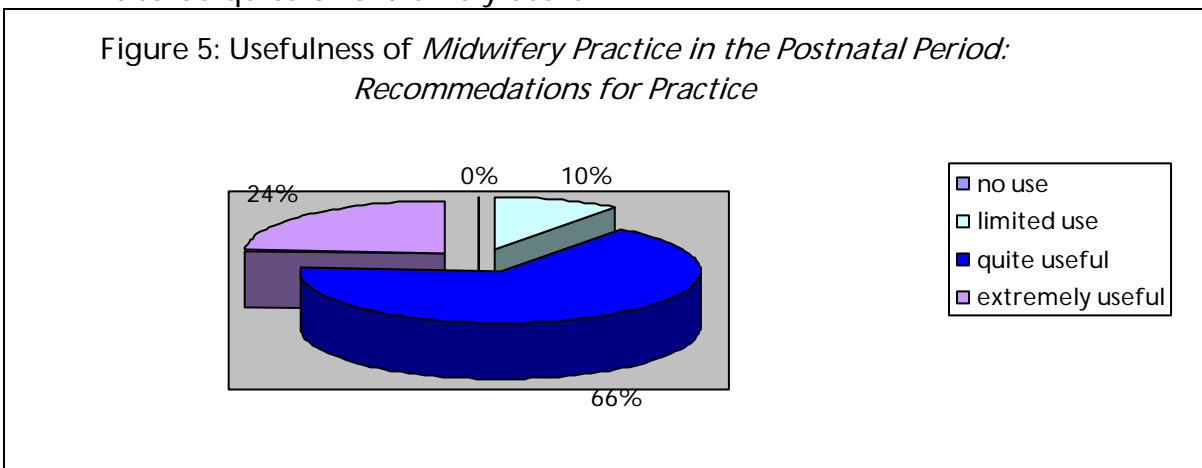


6.3 Use of the *RCM Midwifery Practice in the Postnatal Period: Recommendations for Practice guidelines*

Eighty of the eighty-one maternity service providers responded to this question and reported that; 12.5% (n=10) had used all of it, 23.8% (n=19) had used some sections of it, and 63.8% (n=51) had used none if it.

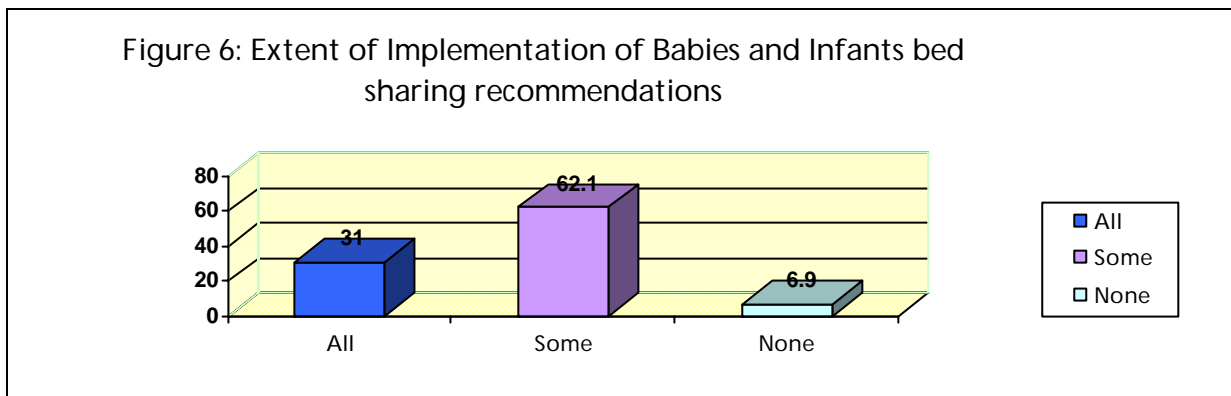
When asked **why** units had not used the document, the reasons given (n=49) were, 71.4% (n=43) were unaware of its' existence, 20.4% (n=10) said other e.g. "used BFI and or other research, 8.2% (n=4) stated "other priorities" and none said, "Not user friendly".

In response to a question as to its usefulness (n=29); from those who responded, no units reported it to be of no use, 10.3% (n=3) said it was of limited use, 65.5% (n=19) said it was quite useful and 24.1% (n=7) said it was extremely useful. Therefore 89.7% of the units that used it, found it to be quite or extremely useful.



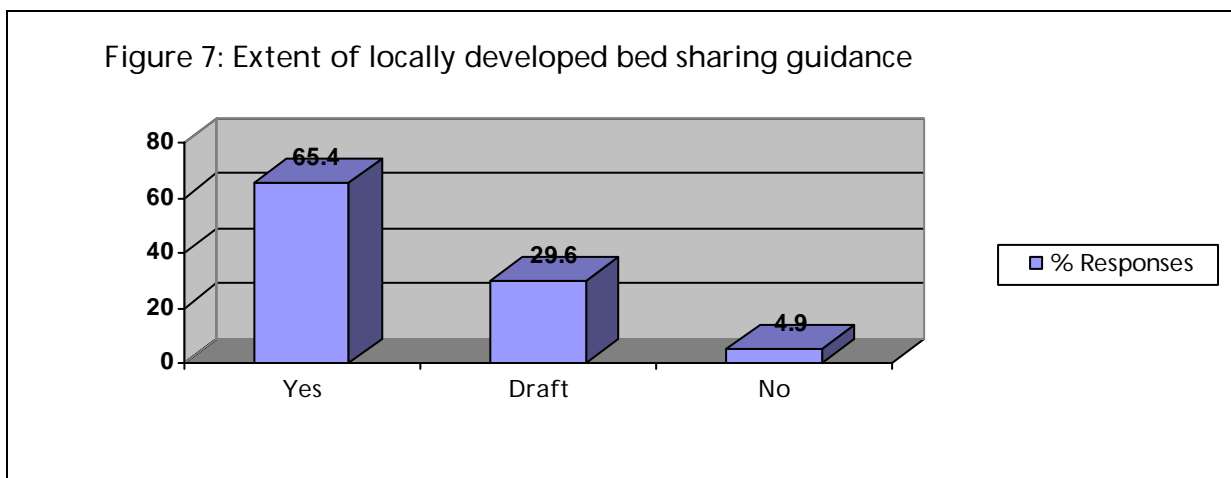
When asked with whom they had used the document (n = 20), 10% (n=2) of respondents reported that they used it with medical staff, 20% (n=4) with educational colleagues, 20% (n=4) with educational and medical staff, 10% (n=2) with commissioners and medical staff, 20% (n=4) with medical and other colleagues, 5% (n=1) with educationalists and others, 5% (n=1) with medical, educational and other staff and 10% (n=2) with others.

When asked if units had implemented the RCM recommendations²⁶, (n = 29), 31% (n=9) responded that they had implemented all of them, 62.1% (18) that they had implemented some of them and 6.9% (n=2) reported none of them.



6.4 Locally developed bed sharing guidelines

Figure 7 illustrates the extent of locally developed guidance, from the respondents (n=81). 65.4% (n=53) of units reported that they had locally developed bed sharing guidance, 29.6% (n=24) had guidance in draft and 4.9% (n=4) said they had none.

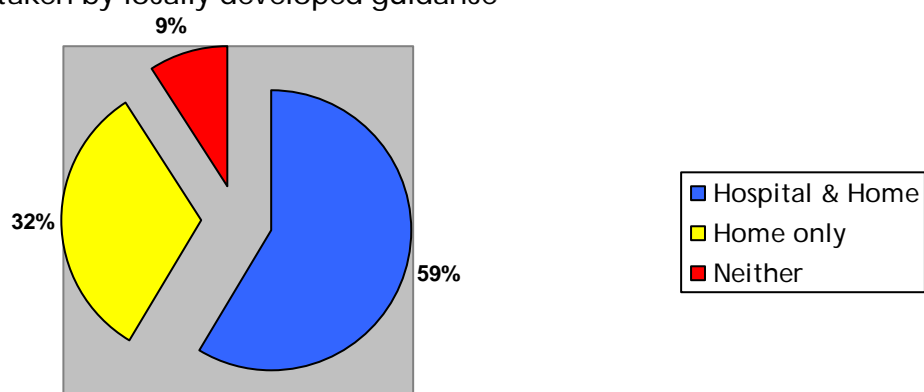


²⁶ RCM (2000) Babies and infants bed sharing in *Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

When units were asked if their local bed sharing guidance was either based on the BFI policy, or "other" (n=77); 62.3% (n=48) of units stated that their local bed sharing guidance was either the BFI policy or based on it, and 10.4% (8) stated "other".

In exploring what area the advice covered, and whether this included hospital and community, 58.8% (n=40) of units stated that they supported bed sharing in hospital and at home, whilst 32.3% (n=22) only supported bed sharing at home and 9.2% (n=6) were unsupportive of bed sharing in either hospital or home.

Figure 8: Stance taken by locally developed guidance



There was no statistical significance between units having locally developed bed sharing guidance in place, in relation to:

- ❖ the type of unit (p=0.252);
- ❖ the size of the unit (p=0.570);
- ❖ the use of "Midwifery Practice in the Postnatal Period: Recommendations for Practice"²⁷ (p=0.259);
- ❖ having implemented the recommendations within the RCM document (p=0.808)²⁸;
- ❖ having or not having BFI status (p=0.121)²⁹.

6.4.1 Units with locally developed bed sharing guidance

Of the units who had locally developed bed sharing guidance, 72.2% (n=39) reported that they discussed the bed sharing guidance with women during pregnancy (n=54), 85.7% (n=48) provided the information

²⁷ RCM (2000) Babies and infants bed sharing in *Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

²⁸ RCM (2000) Babies and infants bed sharing in *Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London

²⁹ Having BFI status ranged from having a Certificate of Commitment to having the Global Award

in leaflet form (n=56) and 44.4% (n=24) displayed the information to women in poster form (n=54).

87.3% (48) units responded that the guidance was available to all staff including ancillary staff and ward clerks (n=55). 94.6% (n=52) of units stated that the guidance was supported by all midwives, 92% (46) said it was supported by all ancillary staff (n=50), 72.7% (32) by ward clerks (n=44), 81.1% (n=30) by Paediatricians (n=37) and 70.1% (26) by Health Visitors (n=37).

There was **no statistical significance** when examining a correlation between an overall compliance with discussing the guidance with women during pregnancy, providing it in leaflet form, displaying it in poster form, having it available to all staff, and it being supported by all groups of staff, in relation to:

- ❖ the size of the unit (p=0.179);
- ❖ the type of unit (p=0.437);
- ❖ the use of "*Babies and infants bed sharing*"³⁰ (p=0.292);
- ❖ whether local guidance was the BFI or based on the BFI policy (p=0.447) or local guidance based on "other" (p=0.173);
- ❖ having or not having BFI status (p=0.157).

6.4.2 Units with no locally developed bed sharing guidance

55% (n=11) of units without locally developed bed sharing guidance or guidance in draft, reported that they discussed the bed sharing advice with women during pregnancy (n=20), 76.2% (n=16) provided the information in leaflet form (n=21), with only 20% (4) displaying the information to women in poster form (n=20).

70% (14) of units reported bed sharing advice was available to all staff including ancillary staff and ward clerks (n=20). 89.5% (17) of units stated that bed sharing advice was supported by all midwives (n=19), 73.7% (14) said it was supported by all ancillary staff (n=19), 44.4% (8) by ward clerks (n=18), 60% (6) by paediatricians (n=10) and 61.5% (8) by health visitors (n=13).

There was **no statistical significance** when examining any correlation between an overall compliance with discussing bed-sharing advice with women during pregnancy, providing advice in leaflet form, displaying it in poster form, having advice available to all staff, and the advice being supported by all groups of staff, in relation to:

- ❖ the size of the unit (p=0.926);

³⁰ RCM (2000) *Babies and infants bed sharing in Midwifery Practice in the Postnatal Period. Recommendations for Practice*. RCM. London.

- ❖ the type of unit (p=0.744);
- ❖ having or not having BFI status (p=0.151);
- ❖ the use of *Midwifery Practice in the Postnatal Period: Recommendations for Practice* document (p=0.054* - but it may be indicative of a correlation).

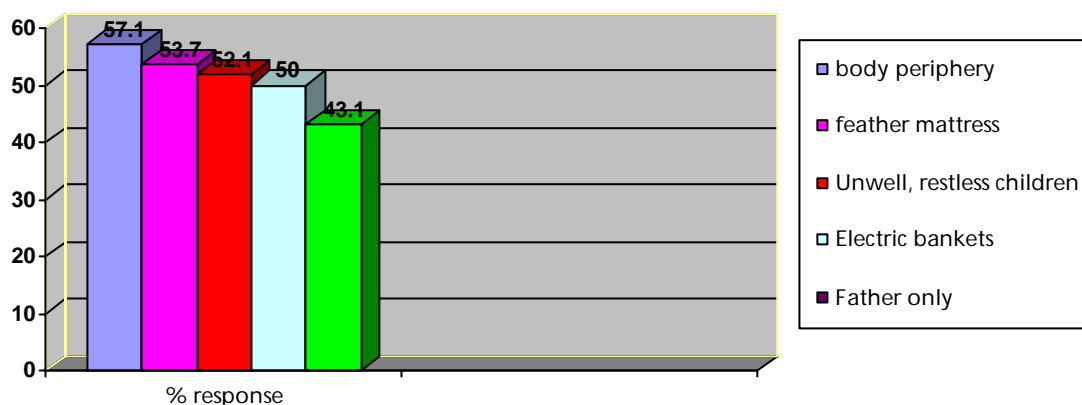
6.5 Whether parents informed of the risks of bed sharing

The responses from units stating the advice provided on specific risks are listed below. The list of responses is in the order they appeared in the audit form.

Figure 9: Advice provided on specific risks

If parents smoke	100%	(n=74)
If parents have had alcohol	100%	(n=74)
If parents are on medication	100%	(n=74)
If parents are unwell	97.3%	(n=74)
If unusually tired	98.7%	(n=74)
If grossly obese	76.1%	(n=71)
If unaware of body periphery	57.1%	(n=70)
If bottle feeding	81.7%	(n=71)
If bed sharing with father only	43.1%	(n=65)
If father comes to bed later	57.4%	(n=68)
Of leaving baby bed sharing with children	60.6%	(n=71)
Of baby bed sharing with unwell or restless children	52.1%	(n=71)
Due to pets	78.9%	(n=71)
Of sleeping on sofa	98.6%	(n=72)
Of over-heating bedroom	94.4%	(n=72)
If on water bed	78.6%	(n=70)
If feather mattress	53.7%	(n=67)
If mattress soft or sagging	92.7%	(n=68)
If gaps between mattress, furniture and wall	89.6%	(n=67)
Of heavy quilts	97.3%	(n=73)
Of electric blankets	50%	(n=70)
Of pillows	90.1%	(n=71)
Of swaddling baby	97.1%	(n= 70)
Of heavy baby clothing	85.7%	(n=70)
Of baby at edge of bed	88.7%	(n=71)
Of leaving baby unattended	92.4%	(n=66).

Figure 10: Risk factors least often discussed



There was **no statistical significance** when examining the correlation between overall compliance with discussing all the afore-mentioned risks of bed sharing with women, in relation to:

- ❖ the size of the unit (p=0.532);
- ❖ the type of unit (p=0.895);
- ❖ the local bed sharing guidance being the BFI policy or based on the BFI policy (p=0.360), or based on "other" (p=0.931);
- ❖ the use of *Midwifery practice in the postnatal period: recommendations for practice*³¹) (p=0.226);
- ❖ having or not having BFI status (p=0.516).

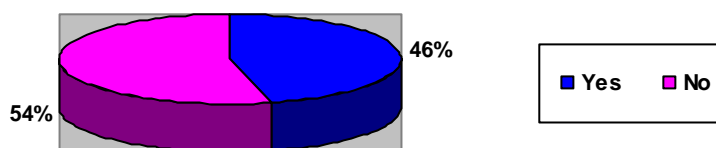
6.6 Giving and recording bed sharing information and advice

92.4% (n=79) of units stated that their midwives ensure that information is given to parents on bed sharing (n=79), but only 47.4% (n=36) reported that this is recorded in the woman's notes. Also, only 43.5% (n=30) stated that a record of information and advice given would be recorded (n=69) if risk factors had been identified. Some units stated that they were addressing the recording of information and advice given, with the introduction of new documentation, including care pathways.

In response to being asked whether the information given to women and their families is a co-ordinated response by all health professionals responsible for care, including midwives, health visitors, GPs and specialist services (n=76), only 46.1% (35) stated that it was.

³¹ RCM (2000) Babies and infants bed sharing in *Midwifery Practice in the Postnatal Period. Recommendations for practice*. RCM. London.

Figure 11: Co-ordinated response across health professionals



73% (n=46) of units reported that they had provision to support women with language needs. Those who reported that they had no provision stated that it was not required by their client group (n=63).

There was **no statistical significance** when examining any correlation between units having or not having BFI status, in relation to:

- ❖ information given being recorded in women's notes (p=0.503);
- ❖ identified risk factors and advice given in relation to them, being recorded (p=0.526);
- ❖ information-giving being a co-ordinated response by all health professionals (p=0.164).

There was however, **strong statistical significance**, when examining any correlation between units having locally developed guidance, in relation to:

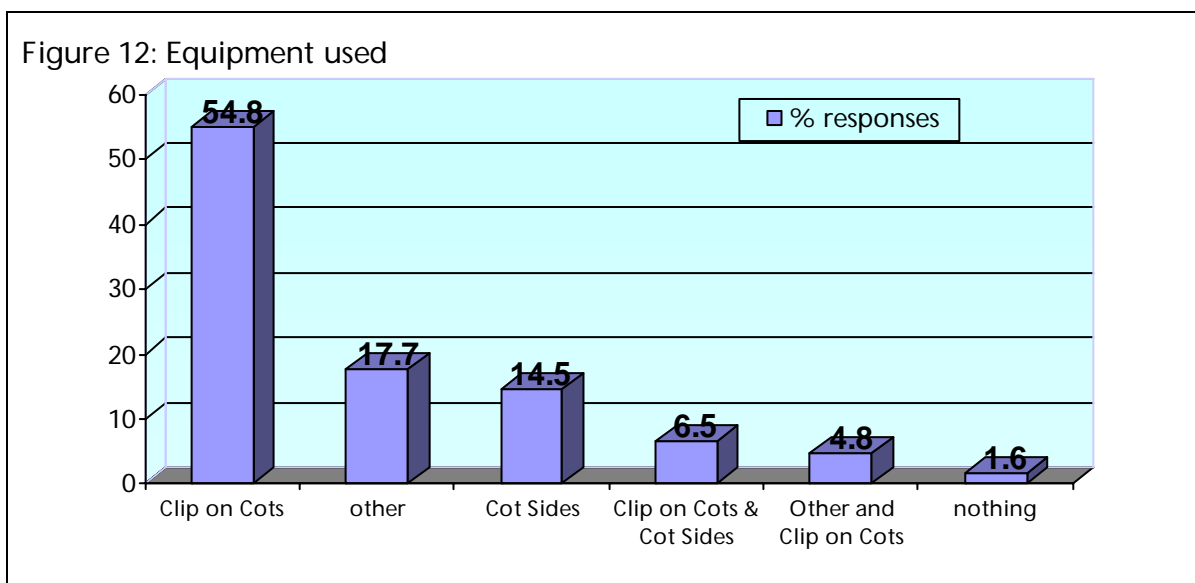
- ❖ midwives ensuring that information is given to parents on bed sharing (p=0.004); but no correlation, between units having locally developed guidance, in relation to:
- ❖ information given being recorded in women's notes (p=0.160);
- ❖ identified risk factors and related advice given, being recorded (p=0.580);
- ❖ information-giving being a co-ordinated response by all health professionals (p=0.023 * but it may be indicative of a correlation)

6.7 Bed sharing equipment used

The reported use of equipment (n=62), in descending order was:

- clip-on cots 54.8% (n=34);
- other - which included chairs or lockers positioned against the bed; lowering beds and tucking the bed clothes in, 17.7% (n=11);
- cot sides 14.5% (n=9)
- clip-on cots and cot sides 6.5% (n=4);
- other and clip-on cots 4.8% (n=3)
- nothing 1.6% (n=1).

The majority of units stated that they only had limited numbers of clip-on cots or cot sides, and a few reported problems associated with the compatibility of clip-on cots with newer designs of beds.



6.8 Provision of training

69.6% (55) of units reported that they provided training on bed sharing (n=79). This was commonly described as being part of other training activities, such as breastfeeding training, or part of the orientation to the clinical areas.

The majority of the training was provided only to midwives and maternity care assistants 32.6% (15), though some was provided to a broader range of staff e.g. midwives, maternity care assistants, health visitors, children's nurses, neonatal nurses, nursery nurses and community workers, including *Surestart* 13% (n=6).

6.9 Incidents related to bed sharing and non-bed sharing incidents

6.9.1 Bed sharing incidents

Seventy-three units gave a response when asked about the occurrence of bed sharing incidents between January and December 2003; 32.9% (n=24) gave details of at least one incident, some through intentional bed sharing, but others from mothers falling asleep and babies falling from the bed.

The results from such incidents ranged from no injuries to fatalities. Thirty-five incidents in total were reported in 2003 and five out-with the requested timescale. Of the thirty-five incidents, there were:

- 2 deaths – due to anomalies discovered at post mortem
- 2 bed sharing deaths - Sudden Infant Death Syndrome (SIDS) (one documented with risk factors)
- 1 sofa sharing death - SIDS
- 1 death – suffocation diagnosed
- 1 death – pneumonia diagnosed
- 2 injuries – fractured skull
- No other injuries reported

There was **no statistical significance** when examining any correlation between bed sharing incidents, in relation to:

- ❖ Having a locally produced bed sharing policy in place (p=0.245);
- ❖ A policy supportive of bed sharing in the hospital and home (p=0.698);
- ❖ A policy supportive of bed sharing in the home only (p=0.386);
- ❖ A policy unsupportive of bed sharing in both the hospital and home (p=0.407);
- ❖ Having or not having BFI status (p=0.966).

6.9.2 Non-bed sharing incidents

When asked about the occurrence of non-bed sharing incidents between January and December 2003; out of the 72 units that responded 29.8% (n=20) gave details of at least one incident.

A total of thirty-four non bed sharing incidents were reported in 2003, with a further five reported out-with the requested timescale. Of the thirty-four, there were two injuries – fractured skull, but no other injuries reported.

There was **no statistical significance** when examining any correlation between non-bed sharing incidents, in relation to:

- ❖ having a locally produced bed sharing policy in place (p=0.208);
- ❖ a policy supportive of bed sharing in the hospital and home (p=0.125);
- ❖ a policy supportive of bed sharing in the home only (p=0.177);
- ❖ a policy unsupportive of bed sharing in both the hospital and home (p=0.543);
- ❖ having or not having *BFI* status (p=0.888).

7. Limitations

The audit findings only represent the views of 100 units across England, Scotland and Wales and rely on the knowledge of the person or persons who completed the audit form; therefore the findings are not generalisable and only relate to those units who responded.

Though the form was reviewed by the audit team, a pilot survey was not done, which may have compromised the completeness and accuracy of the audit data.

Distinctions between bed sharing and co-sleeping were not made in the design of the audit form, which could affect the results.

8. Discussion

It is difficult to have clear evidence as to actual numbers of parents who co-sleep with their babies, and this has not necessarily been an issue that midwives have asked women and their partners about, or discussed. It is acknowledged in the published literature, that a substantial proportion of parents co-sleep with their babies, either intentionally, or unintentionally and for a variety of reasons.^{32 33 34}

All women and their partners must therefore be informed of the benefits and contra-indications of co-sleeping and bed sharing to enable them to make an informed choice about co-sleeping and to minimise the risk of accidents associated with unintentional or uninformed co-sleeping.

The audit results demonstrated that of the units that responded, there was a high compliance with discussing some risks with the parents e.g. smoking; having had alcohol; or being on medication. However, compliance with discussing other risks could be improved e.g. the baby bed sharing with the father only.

It should also be acknowledged that information from professionals to women on some risk factors such as alcohol and drug consumption may be reliant upon their own assumptions, and what personal information the woman chooses to share with them. Midwives need therefore to provide the same level of information to all women, in a non-judgemental and sensitive manner.

The audit indicated that the documentation of such discussions was variable.

³² Ball HL (2003). Breastfeeding, Bed-Sharing, and Infant Sleep. *Birth*. 30(3), September 2003. 181-188.

³³ Ball HL (2002). Reasons to bed-share: why parents sleep with their infants. *Journal of Reproductive Psychology*. Vol 20(4). 2002: 207-221.

³⁴ Hooker E, Ball HL, Kelly PJ (2001). Sleeping like a baby: attitudes and experiences of bedsharing in northeast England. *Med Anthropol* 19: 203-222.

It is also crucial that any discussion which takes place regarding co-sleeping, advice given and risk factors that the woman needs to be aware of, are recorded clearly in the woman's notes, in order that she, and her carers, are aware of the implications and has a source of information to refer to.

Some free-text comments on the audit forms demonstrated that some of the significant events that have occurred in 2004, have affected the status of local guidance (i.e. final or re-drafts), the stance that the guidance takes and potential confusion of staff on what best to inform women. These are:

- publication of the Carpenter et al (2004³⁵) study in the Lancet;
- media reports of the Lancet article;
- media reports of a coroners inquest findings of a fatal bed sharing incident in a large teaching trust;
- statements from the BFI in January and February about the ECAS study;
- re-draft of the Department of Health "Reduce the risk of cot death" leaflet;
- a review of the BFI bed sharing policy, launched in May.

The audit also demonstrates that in the units that responded, a truly multi-disciplinary approach to bed sharing is not yet being achieved in either training or in the co-ordination of information given to parents on bed sharing.

9. Recommendations

- 9.1: Bed sharing is an important issue and women will continue to wish to do this, but require information and support to ensure that they are aware of the risks and benefits of this practice. Midwives are in a key position to provide this information they therefore need to be aware of the issues involved and be able to work in partnership with women and families.

The audit provides important information for midwives, for Heads of Midwifery, in the planning and provision of care, and Lead Midwives for Education (LMEs) for developing appropriate education. The results of this audit will therefore be disseminated to key colleagues within maternity units, specifically to:

³⁵ Carpenter RG, Irgens LM, Blair PS, England PD, Fleming P, Huber J, Jorch G, Schreuder P. (2004). Sudden unexplained infant death in 20 regions in Europe: case control study. *The Lancet*. Vol 363. January 17, 2004: 185-191.

- raise awareness that having locally developed guidance in place, is strongly associated with midwives ensuring that comprehensive information is given to parents on bed sharing;
- share best practice in relation to the recording of risks factors discussed and the information given to parents;
- promote truly multi-disciplinary training across primary and secondary care;
- raise awareness that bed sharing and non-bed sharing incidents are likely to occur, regardless of the stance that trusts take on bed sharing, so risk assessments of all women is desirable;
- consider providing multi-disciplinary training on bed sharing to work towards women having access to consistent, high quality, evidence based advice and information;
- carry out further audits into protocols, guidance papers and real life practice.

9.2 Following dissemination to midwives, the findings and recommendations from this audit will also be shared with colleagues in the following organisations:

- The NPSA;
- UNICEF BFI;
- The CPHVA;
- FSID.

This will further facilitate cross professional working and expansion of the knowledge base within this area:

10. Acknowledgements

The support of the following people, assisted in performing and analysing this audit. Thanks are extended to:

- The NPSA Bed sharing project group for commenting on the audit form;
- RCM staff for commenting on the audit form and distributing it to Heads of Midwifery Services;
- Heads of Midwifery Services, for ensuring audit forms were completed and returned;
- Andrew Radford, for cross-checking the BFI status of units;
- Stephen Blakelock, Patient and Public Liaison Manager, Airedale NHS Trust statistician
- Sue Macdonald, for editing this report.

Appendix 1



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Position Statement No. 8 – Bed sharing and Co-sleeping

Introduction

It is acknowledged in the published literature, that a substantial proportion of parents co-sleep with their babies, either intentionally, or unintentionally and for a variety of reasons (Ball 2003, Ball 2002, Hooker et al 2001). Successful breastfeeding and better sleep patterns are more common among mothers and babies who sleep in the same bed (Ball 2003, McKenna et al 1997). However, it has been suggested by Carpenter et al 2004, Blair et al 1999 that there is a link between sudden infant death and bed-sharing if parents are smokers or if other risk factors are present.

This position statement 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 the UNICEF UK Baby Friendly Initiative (BFI). It is intended to be used in conjunction with Guidance Paper No. 8a "Bed sharing and co-sleeping (RCM 2004).

Definitions

The practical definitions of bed sharing and co-sleeping used in this position statement, are different to the ones used by researchers in the field of bed sharing and co-sleeping.

Bed sharing is defined in this context as babies sharing a bed with their mother either to breastfeed or to receive comfort.

Co-sleeping is defined in the context where the mother and baby share a bed and either mother or baby or both are asleep.

RCM Position

The RCM position remains one of facilitating women's informed choices in maternity and child care and believes that all women and their partners should be informed of the benefits and contra-indications of bed sharing to enable them to make informed choices and decisions about co-sleeping or bed sharing with their babies. Further, the RCM believes that in ensuring the safety of babies, it is crucial to respect and support cultural norms and practices.

RCM recommendations

- The RCM recommends the development of local guidance for mother-baby bed sharing and co-sleeping. This should state the NHS Trust's position on bed sharing and co-sleeping in hospital and at home.

- All guidance should be developed in conjunction/consultation with “mother support” groups and communicated to all staff including midwives, ancillary staff, nursery nurses, ward clerks, paediatricians, health visitors and GPs, so that women receive consistent evidence based information.

The bed-sharing and co-sleeping guidance should be discussed with women during pregnancy and again postnatally and the information provided to women in a format appropriate to their language needs.

The RCM recommends that midwives familiarise themselves with the evidence to enable them to discuss the issues objectively with women to enable them to make an informed decision

References and related documents

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UNICEF UK BFI sample policy (October 2003)

www.babyfriendly.org.uk/pdfs/bedsharingpolicy.pdf

www.babyfriendly.org.uk/parents/sharingbed.asp.

Appendix 2



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Guidance Paper No. 8a: Bed Sharing and Co-sleeping

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: www.babyfriendly.org.uk/pdfs/bedsharingpolicy.pdf and sample information leaflet 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 bed alone 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
 - Ensure 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 - 18C), 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 probably safest to advise 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 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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Appendix 3: A UK-wide audit of bed sharing practices

From key criteria in: RCM (2000) "Babies and Infants Bed Sharing" from *Midwifery Practice in the Postnatal Period: Recommendations for Practice*, RCM London.

Unit and Trust name:

Completed by (name)

Post

Contact details.....

1. Have you used the document as a working guide?

All of it Sections of it None of it

Comments.....

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2. If you answered yes to Q1, how would you rate the usefulness of the document?

Of no use Of limited use Quite useful Extremely useful

Comments

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3. If you answered yes to Q1, did you use the document in conjunction with any of the following colleagues?

Medical staff Educational staff Commissioners

Other

4. Did you use implement the recommendations in the "Babies and infants bed sharing" section of the document?

All of them Some of them None of them

Comments

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5. If you answered no to Q1, why did you not use the document:

Unaware of it Not user friendly Other priorities

Other

Recommendation	Implemented	Please provide comments including year and extent of implementation, barriers to implementation or other drivers Please provide examples of best practice
1. There is locally developed guidance for infant-mother bed sharing whilst in the maternity unit.	Yes No	
2. If you answered yes to 1, is the guidance: supportive of bed sharing in hospital and at home only supportive of bed sharing at home unsupportive of bed sharing in hospital and at home the BFI sample policy Other	Yes No Yes No Yes No Yes No Yes No	
3. If you answered yes to 1, is the bed-sharing guidance: discussed with women during pregnancy provided to women in leaflet form displayed to women in poster form available to all staff, including ancillary staff and ward clerks supported by all staff: midwives ancillary staff ward clerks Paediatricians	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	

Health Visitors	Yes	No	
4. If you answered no to 1, is bed-sharing advice:			
discussed with women during pregnancy	Yes	No	
provided to women in leaflet form	Yes	No	
displayed to women in poster form	Yes	No	
available to all staff, including ancillary staff and ward clerks	Yes	No	
supported by all staff: midwives	Yes	No	
ancillary staff	Yes	No	
ward clerks	Yes	No	
Paediatricians	Yes	No	
Health Visitors	Yes	No	
5. Are parents informed of the benefits and risks associated with bed-sharing at home, including:			
Risks if parents smoke	Yes	No	
Risks if parents have had alcohol	Yes	No	
Risks if parents are on medication	Yes	No	
Risks if parents are unwell	Yes	No	
Risks if unusually tired	Yes	No	
Risks if grossly obese	Yes	No	
Risks if unaware of body periphery	Yes	No	
Risks if bottle feeding	Yes	No	
Risks if bed sharing with father only	Yes	No	

Risks if father comes to bed later	Yes	No	
Risks of leaving baby bed sharing alone with children	Yes	No	
Risks of baby bed sharing with unwell or restless children	Yes	No	
Risks due to pets	Yes	No	
Risks of sleeping on sofa	Yes	No	
Risks of over-heating the bedroom	Yes	No	
Condition of mattress			
Not water bed	Yes	No	
Not feather	Yes	No	
Not soft/sagging	Yes	No	
No gaps between mattress, furniture and wall	Yes	No	
Risks of heavy quilts / duvets	Yes	No	
Risks of electric blankets	Yes	No	
Risks of pillows	Yes	No	
Risks of swaddling baby	Yes	No	
Risks of heavy baby clothing	Yes	No	
Risks of baby at edge of bed	Yes	No	
Risks of leaving baby unattended	Yes	No	
6. Do midwives ensure that information is given to parents on bed-sharing.	Yes	No	
7. Is the information given recorded in the woman's notes.	Yes	No	
8. If risk factors have been identified, is a record of what information and	Yes	No	

advice has been given on bed-sharing recorded.		
9. Is information given to women and their families a co-ordinated response by all health professionals responsible for care i.e. Midwives, Health Visitors, GPs and specialist services involved	Yes No	
10. Please state how the information is provided for women with language difficulties		
11. Please name and describe adaptations to beds, if any are used, to prevent babies falling beds them and any difficulties with them e.g. clip-on cots, cot sides etc.		
12a. Please state what training is provided to staff on bed sharing 12b. If you answered yes to 12a, which staff groups attend the training		
13. Please summarise any safety incidents / baby deaths that occurred from January – December 2003 in hospital linked with: a bed sharing (including entrapments in cot sides etc.) b non bed sharing e.g. baby falls from mums in chairs etc.		

Please return your completed audit form by Sunday 16th May 2004 to: Carol Paeglis, RCM Quality and Audit Development Co-ordinator, preferably by email to: carol.paeglis@rcm.org.uk or by post to: The RCM, 15 Mansfield Street, London, W1G 9NH. Thank you