**OBSERVATIONAL ASSESSMENT:**

**INFANT SLEEP POSITION AND ENVIRONMENT**

**1. Infant Details**

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| *1.1 Date of audit (day/month/year):*  / /2017 |
| *1.2 Infant Hospital Number:* |
| *1.3 Infant’s Date of Birth*  / /2017 |
| *1.4 Birth Weight* (grams) |
| *1.5 Age at time of audit* days |
| *1.6 Gestational Age at Birth* weeks + days (if known) |
| *1.7 Sex* Male Female |
| *1.8 Infant Location* Postnatal Unit Other: |
| *1.9 Date of Admission* / /2017 |
| *1.10 If admitted to Special Care Nursery, reason for admission:*  *eg. Prematurity, Respiratory distress, seizures for investigation*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  or NA |
| *1.11 Mode of delivery:*  SVD LSCS Instrumental VB: Forceps Instrumental VB: Vacuum  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical History relevant to infant positioning 1.12 Acute Respiratory Distress Yes No  1.13 Seizures Yes No  1.14 Upper Airway Malformations, eg. Pierre Robin Syndrome Yes No    1.15 Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  1.16 Severe gastro-oesophageal reflux Yes No  1.17 If severe gastro-oesophageal reflux, did diagnosis include pH monitoring?  Yes No Date of pH monitoring \_\_\_\_\_\_\_ |
| Observed Sleep Period 1.17 Has the infant been placed to sleep or rest at time of audit? Yes No  1.18 Who placed the infant to sleep or rest at time of audit? Nurse /Midwife /Parent  1.19 Does infant usually have periods allocated to tummy time (prone)? Yes No  Comment, if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

2. Observed Infant Sleep Position

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| *2.1 What best describes the infant’s observed sleeping / resting position:*  a) Lying on front with face down  b) Lying on front with face to side  c) Lying on back  d) Lying on side |

3. Infant Sleep Location

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| *3.1 Where is the baby located?*  a) In the standard newborn cot (go to question 3.2.)  b) In the mother’s bed (go to question 3.3)  c) In the MaBim cot (go to question 3.4)  d) In the First Days Pēpi-Pod (go to question 3.5)  e) Not in the ward at time of audit (complete again at a later time)  f) In a chair, with an adult?  *3.2.1 If the baby is in the standard newborn cot, where is the baby positioned?*  a) Head to top of cot  b) In the middle of the cot  c) Feet to foot of cot  3.2.2 *If the baby is in the standard newborn cot:*  a) Are all of the brakes on? Yes No  b) Is the cot in the neutral / flat position? Yes No  c) Is the cot positioned within arm’s reach of the mother? Yes No  d) Is the bedding tucked in firmly and securely? Yes No  e) Is the baby’s head and face uncovered? Yes No  f) Is anything else present in the cot (i.e. soft toy, comfort blanket, pillow) Yes No  *3.3 If the baby is in the mother’s bed, where is the baby positioned?*  a) Under the same covers as the mother with no divider  b) On top of mother’s bed covers/bedding  b) Raised on a pillow or bedding next to the mother  c) In a basket / carrycot in the mother’s bed (other than First Day’s Pēpi-Pod)  d) On the mother’s chest: Baby on tummy / Baby on side / Baby on back  e) In the mother’s arms  f) Are the bed rails: Up / Down on side baby is on  f) On father’s chest / father’s arms  *3.4.1 If the baby is in the MaBim cot, where is the baby positioned?*  a) Head to top of cot  b) In the middle of the cot  c) Feet to foot of cot  3.4.2 *If the baby is in the MaBim cot;*  a) Are all of the brakes on Yes No  b) Is the baby clear of the cot door Yes No  c) Is the cot positioned adjacent to, and overlapping the  mother’s bed Yes No  d) Is the cot side down Yes No  e) Is the cot side open to the mother’s bed Yes No  f) Is the mother in physical contact with her baby Yes No  g) Are there any loose maternal sheets /covers over or  around the baby Yes No  h) Is the bedding tucked in firmly and securely Yes No  i) Is the baby’s head and face uncovered Yes No  j) Is anything else present in the cot (i.e. comfort blanket / pillow) Yes No  k) Is the mother in physical contact with her baby  with the cot side down Yes No  *3.5.1 If the baby is in the First Days Pēpi-Pod, where is the baby positioned?*  a) Head to top of Pēpi-Pod  b) In the middle of the Pēpi-Pod  c) Feet to foot of Pēpi-Pod  *3.5.2 If the baby is in the First Days Pēpi-Pod:*  a) Are the mother’s bed rails up on the same side as the  First Days Pēpi-Pod Yes No  b) Is the pod in the top half of the bed Yes No  c) Is the pod at least 20cm away from the mother’s pillows Yes No  d) Is the pod flat on the mother’s bed (not in the groove of the bed head) Yes No  e) Are there any loose baby sheets/covers over or around  the baby Yes No  f) Are there any loose maternal sheets/covers over or  around the baby Yes No  g) Is the bedding tucked in firmly and securely Yes No  h) Is the baby’s head and face uncovered Yes No  i) Is anything else present in the pod (i.e. toy/comfort blanket / pillow) Yes No  j) If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**4. Other Sleep Location**

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| *4.1 If sleep location is other than the allocated cot/sleep space or mother’s bed, describe:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *4.2 Sketch infant’s position in relation to the sleeping environment:* |

# **5. Baby's Bed and Bedding Environment**

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| *5.1 Did the baby sleep on a pillow*? Yes No |
| *If* ***YES, please circle***  • *was it:* a baby's pillow or an adult's pillow |
| • *was**it:*  for baby’s head or for baby’s whole body |
| *5.2 What bedding was used to* ***cover*** *baby (circle all that apply)?* |
| Sheet Blanket – air cell Towel |
| Plastic sheet Duvet/Doona Draw sheet |
| Blanket – flannelette/cotton baby wrap Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| *5.3 Did baby sleep with soft toys?* Yes No |
| *5.4 Did baby sleep with a sleep positioner (e.g. rolled up towel)*  Yes No |
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| *5.5 Additional Comments relating to infant sleeping environment and bedding:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**6. Chart Audit**

*6.1 Has the safe sleeping section of the pathway been completed/signed?*

Yes No

**7. Discharge Education**

*7.1 Has the mother watched the discharge video which includes safe sleep information?*

Yes No

*7.2 When is discharge planned? \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_*