**INFANT SAFE SLEEP POLICIES**

**AT MASSACHUSETTS MATERNITY FACILITIES**

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A Report of Survey Findings

February 2014

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The Infant Safe Sleep Survey was sponsored by the Massachusetts Department of Public Health’s **Division of Violence and Injury Prevention** and the **Massachusetts Perinatal Team.** This report was prepared by **Catherine Barber** of the Harvard Injury Control Research Center (HICRC, **David Hemenway**, Director) under contract with the Massachusetts Department of Public Health’s Bureau of Community Health and Prevention (**Carlene Pavlos**, Director). Funding was provided by the Centers for Disease Control and Prevention’s National Center for Injury Prevention and Control (Grant #U17 CE002009). The contents of the report are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Members of the team that developed the survey were **Ruth Aga, Lisa Alee, Catherine Barber, Deborah Clapp, Holly Hackman, Jeanne Hathaway, David Hemenway, Ruth Karacek, Lisa McCarthy, Paul Muzhuthett, Carlene Pavlos,** and **Lauren Smith** (see Appendix 3 for affiliations).

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**INTRODUCTION**

The leading cause of death among Massachu­setts infants ages one month to twelve months is sudden unexpected infant death. Multi­disciplinary reviews by Massachusetts Child Fatality Review Teams have found that many of these deaths are associated with unsafe infant sleep positions and environments. The Massachusetts Department of Public Health has set a goal of reducing these deaths by increasing the proportion of families of new­borns who follow safe sleep habits such as placing infants on their backs to sleep.

Maternity hospitals and birthing centers play a unique role in this effort by educating pa­tients and by modeling safe practices by their own staff. After the American Academy of Pediatrics (AAP) released its updated recommenda­tions for safe sleep practices in 2011, the Massachusetts Department of Public Health (DPH) sought to learn how it could best assist Massachusetts maternity facilities in imple­menting these recommendations and dissemi­nating them to their patients. As a result, DPH and the Massachusetts Perinatal Team—an association of providers in mater­nity hospitals and birth centers—jointly spon­sored a survey to document current practices and to request input on ways that DPH could assist maternity facilities.

**METHODOLOGY**

*Collaborators and Survey Items*

DPH contracted with the Harvard School of Public Health’s Injury Control Research Center (HICRC) to develop the instrument and administer the survey to Massachusetts maternity facilities. An ad hoc committee (see Appendix 3) provided advice in developing the survey items, and staff from HICRC and DPH sought feedback on the survey items at meetings with the Massachusetts Perinatal Team, the Massachusetts Perinatal Advisory Committee, and with neonatologists Dr. Munish Gupta and Dr. Susan Hwang.

*Ensuring High Participation Rate*

HICRC developed an online survey using Qualtrics software. Interim Commissioner of Public Health Lauren Smith sent letters to hospital CEOs advising them of the project in April 2013. The Massachusetts Perinatal Team provided a list of contact people at each of the 47 mater­nity hospitals (see Appendix 2). Contact people were typically nurse managers or directors of nursing in hospital maternity departments. The administrator of the MA Perinatal Team sent an email to the contact list inviting recipients to complete the survey and sent reminder emails at intervals over the next few months. July through September, HICRC personnel sent personal emails, wrote letters, and telephoned the remaining non-responders to urge their participation. Invitations were also sent to the state’s two birth centers in September.

***100% Response Rate***

*All Massachusetts maternity hospitals and both birth centers completed the online survey.*

**

By September 2013 all maternity hospitals and both birth centers had responded to the survey, for a 100% response rate.

*Data Analysis*

We created a variable to indicate whether facilities had a “model” written policy for staff practices, that is, one that included each of six AAP recommendations relevant to hospital care (back sleep only, no co-sleeping with adults, no soft items in the crib, no co-sleeping multiple birth siblings, avoid overheating infant, and encourage co-rooming with parents). Similarly, we created a variable to indi­cate whether facilities had a “model” dis­charge document that educates newborn mothers on each of seven AAP recom­mendations (back sleep only, no co-sleeping with adults, no soft items in crib, no co-sleeping with babies/children/pets, avoid overheating infant, encourage co-rooming, inform other caretakers like babysitters and grandparents about safe sleep practices).

*94% of facilities report training all nursing staff on safe sleep.*

*73% report that all nurses were trained within the past 3 years.*

We tested the association between having a model policy and certain outcomes using chi square analy­sis. To improve statistical power, for key variables we collapsed responses into two categories: yes and all others (no, unknown, missing).

**RESULTS**

Results on each survey item are included in Appendix 1 and summarized here.

*Hospital Policies and Staff Practices*

Among the 49 facilities, all but 3 (94%) report training all nursing staff on how to sleep healthy infants. For nearly three quarters of the facilities, all nursing staff were trained within the past three years, but for 12 facilities, at least some staff were trained over three years ago. The most recent release of the AAP safe sleep guidelines was in 2011. A quarter of facilities report that placing “spitty” or “mucous-y” infants on their side is a somewhat or very common practice among nursing staff at their hospital; 27% report that it is never done. The 2011 AAP guidelines advise against side-sleeping infants (with the rare exception of infants for whom the risk of death from gastroesophageal reflux is greater than the risk of SIDS).

Nearly half (46%) of the facilities had a written policy or guideline governing safe sleep procedures. Information was pro­vided on the content of these policies. Among the 22 with written policies, all but one (95%) call for back sleep only (no side sleep), 82% instruct that soft items be kept out of the crib/isolette, and 82% rec­ommend against co-sleeping. Lower proportions recommend encouraging co-rooming with parents/caregivers (68%), avoid­ing infant over-heating (77%), and avoiding co-sleeping multiple-birth siblings (68%). Eleven of the written policies were last revised in 2012 or 2013 and ten were last revised in 2011 or before.

Seventy-eight percent of the respondents report that their department has educated staff about the 2011 AAP recommenda­tions, and many of the remainder plan to do so.

*27% of facilities report that nurses never side-sleep otherwise healthy “spitty” or “mucous-y” babies. 25% report that nurses somewhat or very commonly do. The AAP does not recommend side-sleeping these infants.*

*46% of the facilities have a written safe sleep policy.**26% have a policy that covers each of these AAP guidelines:*

* *back sleep only*
* *no soft items in crib/ isolette*
* *no co-sleeping with adults*
* *no co-sleeping with siblings*
* *encourage co-rooming*
* *avoid overheating.*

*Patient Education*

All of the respondents (except one miss­ing response) report that staff verbally review a discharge checklist or other doc­ument with each newborn’s mother before the mother can be discharged. Safe sleep practices are recommended in that document for all but one of the facilities. Among the 43 facilities that provided in­formation about the contents of the safe sleep recommendations in the document, 100% report recommending back sleep only, 93% recommend keeping soft items out of the crib, and 89% advise against co-sleeping. Somewhat lower proportions recommend co-rooming with a parent/caretaker (76%), discourage over-heating the infant (80%), discourage co-sleeping with another baby/child/pet (74%), or telling others responsible for newborn care (like babysitters and grandparents) about safe sleep guidelines (74%).

Facilities use a variety of educational materials on safe sleep. 93% use bro­chures or other written materials, 46% use newborn classes in the hospital, and 28% use posters. One hospital volunteered the information that they attach a sim­ple laminated diagram about safe sleep to every infant crib.

The most common (81%) barrier to im­proving safe sleep practices that was en­dorsed by respondents was patients’, or their family members’, beliefs about how to sleep a baby. The second most com­mon was language barriers (33%). None of the facilities reported that low aware­ness of safe sleep practices among pro­viders was a barrier, but 23% report that nursing staff do not always follow these practices.

*Advising the Massachusetts Department of Public Health*

A surprising 57% of respondents volun­teered to join a working group to advise DPH and Massachusetts facilities on ways to improve safe sleep practices among staff and patients.

Nearly three-quarters (72%) of the re­spondents recommended that DPH assist facilities’ safe sleep efforts by providing patient education materials (or advice on the best source of free or low cost materi­als). 62% endorsed DPH providing prod­ucts to give to patients, like mugs or t-shirts, that reinforce safe sleep messages (like infant t-shirts that say “This Side Up” on the front). Over half (57%) recommended that DPH share a model hospital safe sleep policy. Other suggestions endorsed by nearly half of respondents were that DPH provide staff education materials to facilities and share tips about successful safe sleep cam­paigns from other facilities.

Additional suggestions volunteered by re­spondents moved beyond the hospital walls, calling for DPH or others to de­velop media campaigns; discourage re­tailers from promoting bump­ers, blankets, or stuffed animals in cribs; train daycare providers; provide more educa­tion in outpatient settings, and better co­ordinate messaging with breastfeeding advocates.

*Analysis*

Facilities with model safe sleep policies were more likely than other facilities to have educated staff on the 2011 AAP recommendations (100% vs. 69%, p=.02) and to use a patient discharge document that covers key AAP recommendations (77% vs. 44%, p=.04). However, side-sleeping a spitty or mucous-y baby was about as common in facilities with model policies as in other facilities. Nurses were reported never to side-sleep these infants in 31% of facilities with a model policy vs. 25% in other facilities, a difference that was not statistically significant (p=.69).

DISCUSSION

*Limitations*

The survey has important limitations. Information about providers’ be­havior is based only on self-report by a manager and not on direct observation by an outside observer. The actual content of hospital written policies and patient edu­cation materials was not reviewed. In an attempt to keep the survey short, important issues, like whether the hall­ways or patient education materials in­clude art depicting babies in unsafe sleep environments (e.g., sleeping in cribs with bumpers or stuffed animals, or sleeping with a sleeping adult) were not asked.

*Facilities say DPH can help most by:*

* *Providing patient education materials*
* *Providing educational products like infant t-shirts to give families*
* *Sharing model safe sleep policies that hospitals can adopt. .* 

*57% of the survey respondents volunteered to join a work group to advise DPH.*

*Next Steps*

Over half of the facilities (57%) indicated that DPH could promote safe sleep practices by sharing a model written policy with maternity facilities. Because this is low-cost and easy to accomplish, and because having a model written policy was associated with facilities giving patient education materials that cover key provisions of the new AAP recommendations, DPH plans to move forward on this. Because there is considerable heterogeneity across hospitals with respect to side-sleeping spitty or mucous-y infants who are not on a monitor, the policy should clarify that this practice is not advised.

*Facilities with model written policies were significantly more likely to use patient education materials that covered key AAP guidelines.*

THIS SIDE UP

For Safe Sleep

One note regarding dissemination of a model policy: at a meeting with the Massachusetts Perinatal Team, members expressed their preference for use of the term “standard of care” over “policy.” The former was perceived as directly relevant to patient health while the latter sounded administrative and remote from actual care.

Finally, hospitals and birth centers are logical distribution points for education materials geared to newborns’ families. To the extent that DPH can provide patient education materials and products for these facilities to give to their patients—or point them to a source of free or low-cost—survey results indicate that respondents at most of the facilities will welcome them.

APPENDIX

1. Survey responses
2. List of Massachusetts maternity hospitals
3. Ad hoc Hospital Infant Safe Sleep Survey Committee members

APPENDIX 1. Survey Responses

STAFF TRAINING

1. Does your maternity department, normal newborn nursery, or birthing center (hereafter called “department”) train all nursing staff on how to “sleep” healthy infants while they are cared for at your facility?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 46 | 94% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 3 | 6% |
| Unknown |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Total |  | 49 | 100% |

2. Approximately how many of the nurses in your department have been trained in safe sleep practices in the past three years (either by your department or elsewhere)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| All |

|  |  |
| --- | --- |
|  |  |

 | 36 | 73% |
| Most |

|  |  |
| --- | --- |
|  |  |

 | 7 | 14% |
| Some |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Few |

|  |  |
| --- | --- |
|  |  |

 | 2 | 4% |
| None |

|  |  |
| --- | --- |
|  |  |

 | 3 | 6% |
| Unknown |

|  |  |
| --- | --- |
|  |  |

 | 1 | 2% |
| Total |  | 49 | 100% |

SIDE SLEEPING

3. Setting aside infants who are on monitors, how common is it for nursing staff in your department to put “mucous-y” or “spitty” infants on their side for sleep? (Missing= 1)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Very common |

|  |  |
| --- | --- |
|  |  |

 | 3 | 6% |
| Somewhat common |

|  |  |
| --- | --- |
|  |  |

 | 9 | 19% |
| Uncommon |

|  |  |
| --- | --- |
|  |  |

 | 23 | 48% |
| Never done |

|  |  |
| --- | --- |
|  |  |

 | 13 | 27% |
| Unknown |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Total |  | 48 | 100% |

WRITTEN POLICY

4. Does your department have a written "safe sleep" policy or guideline on how to place healthy infants (i.e., those not on a monitor) for sleep while they are cared for at your facility? (Missing= 1)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| # | Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| 1 | Yes |

|  |  |
| --- | --- |
|  |  |

 | 22 | 46% |
| 2 | No |

|  |  |
| --- | --- |
|  |  |

 | 22 | 46% |
| 3 | Unknown |

|  |  |
| --- | --- |
|  |  |

 | 4 | 8% |
|  | Total |  | 48 | 100% |

5. Please identify which items are explicitly included in your department’s safe sleep policy/guideline. (Please check all that apply.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Back sleep only for infants (i.e., no side sleep) |

|  |  |
| --- | --- |
|  |  |

 | 21 | 95% |
| Keep soft items out of the crib/isolette (e.g., stuffed animals, pillows, rolled blankets) |

|  |  |
| --- | --- |
|  |  |

 | 18 | 82% |
| Avoid co-sleeping (i.e., babies do not sleep on the same surface with another sleeping person) |

|  |  |
| --- | --- |
|  |  |

 | 18 | 82% |
| Avoid co-sleeping of multiple-birth siblings (twins, triplets, etc.) |

|  |  |
| --- | --- |
|  |  |

 | 15 | 68% |
| Avoid infant overheating |

|  |  |
| --- | --- |
|  |  |

 | 17 | 77% |
| Encourage co-rooming (infants sleep in the same room, but not same bed, as caregiver) |

|  |  |
| --- | --- |
|  |  |

 | 15 | 68% |
| Other (please describe: e.g., "Back sleep or side sleep only") |

|  |  |
| --- | --- |
|  |  |

 | 3 | 14% |

|  |
| --- |
| Other (please describe: e.g., "Back sleep or side sleep only") |
| Encourage no blankets |
| Not a separate policy, just mentioned in Mother/Infant Teaching prior to discharge |
| We use the NICHD December 2012 Guidelines |

6. In what year was the safe sleep policy or guideline at your department last revised?

|  |  |
| --- | --- |
| Year | Response |
| 2013 | 3 |
| 2012 | 8 |
| 2011 | 6 |
| 2010 | 3 |
| 2009 | 1 |

AAP GUIDELINES

7. Has your department educated your staff about the 2011 safe sleep recommendations from the American Academy of Pediatrics?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 38 | 78% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 6 | 12% |
| Unknown |

|  |  |
| --- | --- |
|  |  |

 | 5 | 10% |
| Total |  | 49 | 100% |

8. If "No," is your department planning to? (Missing= 1)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 4 | 80% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Unknown |

|  |  |
| --- | --- |
|  |  |

 | 1 | 20% |
| Total |  | 5 | 100% |

PATIENT EDUCATION

9. Do nursing staff in your department verbally go over an educational document (like a discharge checklist or flyer) with each newborn’s mother before they can be discharged? (Missing= 1)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 48 | 100% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Total |  | 48 | 100% |

10. Are safe sleep practices recommended in that document? (Missing= 1)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 47 | 98% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 1 | 2% |
| Total |  | 48 | 100% |

11. Which safe sleep practices are recommended in that document? (Please check all that apply.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Place infants only on their back for sleep |

|  |  |
| --- | --- |
|  |  |

 | 46 | 100% |
| Keep soft items out of the crib (such as stuffed animals, pillows, bumpers, positioners, etc.) |

|  |  |
| --- | --- |
|  |  |

 | 43 | 93% |
| Avoid co-sleeping on the same surface with a sleeping adult (to avoid suffocation and falls) |

|  |  |
| --- | --- |
|  |  |

 | 41 | 89% |
| Avoid co-sleeping on the same surface with another baby, child, or pet |

|  |  |
| --- | --- |
|  |  |

 | 34 | 74% |
| Encourage co-rooming (but not co-sleeping) with parents/caregivers |

|  |  |
| --- | --- |
|  |  |

 | 35 | 76% |
| Avoid overheating the infant |

|  |  |
| --- | --- |
|  |  |

 | 37 | 80% |
| Tell others responsible for newborn care (e.g., babysitters, grandparents) about safe sleep guidelines |

|  |  |
| --- | --- |
|  |  |

 | 34 | 74% |

12. What parent educational materials devoted solely or primarily to safe sleep practices are available at your department? (Please check all that apply.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| DVDs |

|  |  |
| --- | --- |
|  |  |

 | 5 | 11% |
| Brochures and other written materials |

|  |  |
| --- | --- |
|  |  |

 | 43 | 93% |
| Posters |

|  |  |
| --- | --- |
|  |  |

 | 13 | 28% |
| Educational messages on products such as infant t-shirts, mugs, etc. |

|  |  |
| --- | --- |
|  |  |

 | 2 | 4% |
| Newborn classes |

|  |  |
| --- | --- |
|  |  |

 | 21 | 46% |
| Other (please describe) |

|  |  |
| --- | --- |
|  |  |

 | 6 | 13% |

|  |
| --- |
| Other (please describe) |
| Prenatal education classes |
| One on one discussion |
| We have a laminated picture of an infant in a "safe sleep" environment with bullet points about safe sleep attached to every infant crib. |
| Newborn Channel |
| We are presently out of "Back to Sleep", and ordering more |
| Beautiful Beginnings (postpartum/newborn) Guidelines given to all patients on discharge/ A section in booklet on Safe Sleep |

BARRIERS TO SAFE SLEEP

13. What do you think are strong barriers to improving safe sleep practices in your Department? (Please check all that apply.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Medical (MD) staff don’t always follow safe sleep practices |

|  |  |
| --- | --- |
|  |  |

 | 3 | 6% |
| Nursing staff don't always follow safe sleep practices |

|  |  |
| --- | --- |
|  |  |

 | 11 | 23% |
| Low awareness of safe sleep practices among nursing or medical staff |

|  |  |
| --- | --- |
|  |  |

 | 0 | 0% |
| Staff members’ beliefs that co-sleeping improves bonding and breast-feeding |

|  |  |
| --- | --- |
|  |  |

 | 9 | 19% |
| Patients' or their family members' beliefs |

|  |  |
| --- | --- |
|  |  |

 | 39 | 81% |
| Lack of appropriate educational materials |

|  |  |
| --- | --- |
|  |  |

 | 3 | 6% |
| Language barriers |

|  |  |
| --- | --- |
|  |  |

 | 16 | 33% |
| Other competing priorities |

|  |  |
| --- | --- |
|  |  |

 | 4 | 8% |
| Too little time to educate parents about safe sleep during their stay |

|  |  |
| --- | --- |
|  |  |

 | 1 | 2% |
| Other (please describe) |

|  |  |
| --- | --- |
|  |  |

 | 4 | 8% |
| No barriers |

|  |  |
| --- | --- |
|  |  |

 | 5 | 10% |

|  |
| --- |
| Other (please describe) |
| Products sold for beds or sleeping. |
| We are all in agreement about safe sleep practices. |
| Most information is important but time is short. Maybe more information and teaching prior to hospitalization might help. |
| Most of our patients have early D/C to the hospital for 48 hours stay. They are with us for 3-4 hours. Or 6 -12 if they go home form here. |

ADVICE FOR DPH

14. In what ways do you think the Massachusetts Department of Public Health could help hospitals encourage safe sleep practices? (Please check all that apply.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Share a model hospital safe sleep policy we could use within our hospital |

|  |  |
| --- | --- |
|  |  |

 | 27 | 57% |
| Provide on-site, in-service trainings to hospital staff |

|  |  |
| --- | --- |
|  |  |

 | 14 | 30% |
| Provide staff education materials on safe sleep |

|  |  |
| --- | --- |
|  |  |

 | 22 | 47% |
| Provide patient education materials on safe sleep (or advice on the best source of free/low cost materials) |

|  |  |
| --- | --- |
|  |  |

 | 34 | 72% |
| Share successful safe sleep campaigns and efforts from other hospitals |

|  |  |
| --- | --- |
|  |  |

 | 23 | 49% |
| Provide products to give to new families that reinforce safe sleep messages (e.g. onesies that say “This Side Up” on the front) |

|  |  |
| --- | --- |
|  |  |

 | 29 | 62% |
| Train visiting nurses and pediatricians on safe sleep practices |

|  |  |
| --- | --- |
|  |  |

 | 21 | 45% |
| Other (please describe) |

|  |  |
| --- | --- |
|  |  |

 | 6 | 13% |

|  |
| --- |
| Other (please describe) |
| PSA's. |
| Media campaign aimed at parents and family. |
| Marketing campaign to get the message out. |
| Training Daycare Providers; Mandates for Retailers Restricting Crib Bumpers, etc. |
| Media. |
| Provide more coordination with breastfeeding advocates on the best message. |

VOLUNTEER

15. Would you like to join a working group that will meet by telephone 3-4 times in the next year to advise DPH and Massachusetts hospitals on ways MA maternity hospitals can improve safe sleep practices among staff and patients? (Missing= 2)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Answer |

|  |  |
| --- | --- |
|  |  |

 | Response | % |
| Yes |

|  |  |
| --- | --- |
|  |  |

 | 27 | 57% |
| No |

|  |  |
| --- | --- |
|  |  |

 | 20 | 43% |
| Total |  | 47 | 100% |

16. Space is provided here for your suggestions or comments on improving infant safe sleep.

|  |
| --- |
| Text Response |
| Safe sleep media campaign |
| Educate all (parents, grandparents, care providers) through PSA's. Show them what a safe sleep environment looks like. |
| While there is no formal staff training, safe sleep is covered during new staff orientation. |
| We held a safety fair for all hospital employees teaching safe sleep recommendations, many grandparents informed. |
| We are strong advocates of safe sleep practices in our unit. |
| I have a great interest in the topic & the challenges involved with educating parents, families, health care professionals and Lactation professionals. |
| Public education not just birthing families. |
| Continual, consistent message to all patients. |
| Start a campaign on the social media sites to assist with safe sleeping, Encourage stores to stop all the "pretty" crib accessories. |
| Increased patient education in the outpatient setting so the information is reinforced in the inpatient setting. |
| We have been struggling with balancing the care of the NAS infant with the new AAP guidelines for safe sleeping. We had inconsistencies between units (SCN, PP and pedi) so have a task force to develop policy and consistent education/messaging for staff. |
| We have linked our safe sleep education with infant drop prevention. |
| Our patients are going to do what they want. |

**APPENDIX 2.** Massachusetts Maternity Facilities

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| ANNA JAQUES HOSPITAL |
| BAYSTATE FRANKLIN MEDICAL CENTER |
| BAYSTATE MEDICAL CENTER |
| BERKSHIRE MEDICAL CENTER INC/BERKSHIRE CAMPUS |
| BETH ISRAEL DEACONESS MEDICAL CENTER/EAST CAMPUS |
| BEVERLY HOSPITAL/BEVERLY CAMPUS |
| BOSTON MEDICAL CENTER CORP MENINO PAVILION |
| BRIGHAM & WOMEN'S HOSPITAL |
| CAMBRIDGE HEALTH ALLIANCE/CAMBRIDGE |
| CAPE COD HOSPITAL |
| COOLEY DICKINSON HOSPITAL, INC. |
| EMERSON HOSPITAL |
| FAIRVIEW HOSPITAL |
| FALMOUTH HOSPITAL |
| GOOD SAMARITAN MEDICAL CENTER |
| HALLMARK HEALTH SYSTEM MELROSE-WAKEFIELD |
| HARRINGTON MEMORIAL HOSPITAL |
| HEALTHALLIANCE HOSPITAL-LEOMINSTER CAMPUS |
| HEYWOOD HOSPITAL |
| HOLY FAMILY HOSPITAL |
| HOLYOKE MEDICAL CENTER |
| JORDAN HOSPITAL |
| LAWRENCE GENERAL HOSPITAL |
| LOWELL GENERAL HOSPITAL |
| MARTHA'S VINEYARD HOSPITAL |
| MASS GENERAL HOSPITAL |
| MERCY MEDICAL CENTER CAMPUS |
| METROWEST MED CTR/FRAM UNION CAMPUS  |
| MILFORD REGIONAL MEDICAL CENTER |
| MORTON HOSPITAL |
| MOUNT AUBURN HOSPITAL |
| NANTUCKET COTTAGE HOSPITAL |
| NEWTON-WELLESLEY HOSPITAL |
| NORTH ADAMS REGIONAL HOSPITAL |
| NORTH SHORE MED CTR/SALEM HOSPITAL |
| NORWOOD HOSPITAL |
| SIGNATURE HEALTHCARE BROCKTON HOSPITAL |
| SOUTH SHORE HOSPITAL |
| SOUTHCOAST HOSPITALS GROUP INC/CHARLTON |
| SOUTHCOAST HOSPITALS GROUP INC/ST LUKES |
| SOUTHCOAST HOSPITALS GROUP INC/TOBEY |
| ST ELIZABETH'S MEDICAL CENTER |
| ST VINCENT HOSPITAL  |
| STURDY MEMORIAL HOSPITAL |
| TUFTS MEDICAL CENTER |
| UMASS MEMORIAL MED CTR/MEM CAMPUS |
| WINCHESTER HOSPITALCAMBRIDGE BIRTH CENTERNORTH SHORE BIRTH CENTER |

APPENDIX 3. Ad hoc Hospital Infant Safe Sleep Survey Committee members

1. Massachusetts Department of Public Health

Deborah Clapp, Program Manager, Emergency Medical Services for Children

Justin Egan, Epidemiologist, Division of Violence and Injury Prevention & Office of Adolescent Heath and Youth Development

Holly Hackman, Epidemiologist, Division of Violence and Injury Prevention

Jeanne Hathaway, Epidemiologist, Injury Surveillance Program

Ruth Karacek, Public Health Nurse Advisor (former), Division of Perinatal, Early Childhood and Special Health Needs

Lisa McCarthy, State Child Fatality Review Coordinator, Division of Violence and Injury Prevention

Paul Muzhuthett, Regional Director, Northeast Regional Health Office; Administrator, Massachusetts Perinatal Team

Carlene Pavlos, Director, Bureau of Community Health and Prevention

Lauren Smith, Interim Commissioner (former), Department of Public Health

1. Harvard School of Public Health

Ruth Aga, MPH student, Senior Doctor, Oslo University Hospital Injury Department

Catherine Barber, Senior Researcher, Harvard Injury Control Research Center

David Hemenway, Director, Harvard Injury Control Research Center

Christelle Salomon, Intern, Harvard Injury Control Research Center

1. Hospital

Lisa Allee, **Injury Prevention Coordinator, BMC Injury Prevention Center**