document 5

Resources and Supplemental Materials

Our Babies: safe&sound

Resources and Supplemental Materials – April 2018

1. Say YES Program Model Consistency (New)
2. Say YES Program Overview: Phases and Schedule (Updated)
3. Participation Agreements (Updated)
4. Roles and Responsibilities of Partner Organizations' Key Contact Persons
5. American Academy of Pediatrics Infant Safe Sleep Recommendations
6. Samples of Infant Safe Sleep Policies/Standards of Care (Updated)
7. Samples of Infant Safe Sleep Practice Audit/Assessment Tools (Updated)
8. Online Training Module for Staff of Partner Organizations (Updated)
9. Overview of In-Home Family Education/Home Visitation Program Partners (Updated)
10. Discussion Points for Providers of Prenatal and Initial Education for Parents/Caregivers (Updated)
11. Discussion Points for Providers of Reinforcement Education for Parents/Caregivers (Updated)
12. Cribs For Kids®
13. First Candle Safe Sleep Media Guidelines (New)
14. Cribs For Kids Guidelines for Photography in Certified Safe Sleep Hospitals (New)

For information about additional infant safe sleep resources, see www.safesoundbabies.com/resources.html.

SAY YES TO SAFE SLEEP FOR BABIES

The Importance of Consistency in Delivering the *Say YES To Safe Sleep For Babies* Program through Multiple Organizations in West Virginia

In order to maximize the potential to achieve our mutual goal in West Virginia of preventing infant deaths due to unsafe sleeping practices and environments, it is essential to consider consistency across programs, or as evaluators emphasize, program fidelity.

Program consistency or program fidelity is the degree to which implementation of Say YES To Safe Sleep for Babies initiatives within multiple partner organizations aligns with the intended design of the model. Simply stated, is the program delivered as it was supposed to have been?

There are several key factors that make up the design of Say YES To Safe Sleep for Babies. To be successful as a group, all partners should pay special attention to adhering to the model.

- Has the sponsoring partner organization identified one or two key contact persons who will be responsible for providing oversight of program planning and implementation, internal communication and communication with Our Babies: Safe and Sound staff?

- Does the sponsoring partner organization have a written, approved policy or standards of care in place that follows the latest infant safe sleep recommendations of the American Academy of Pediatrics? Are staff educators familiar with the policy? Is it reviewed at specified intervals and updated as necessary?

- Does the sponsoring partner organization have an audit or assessment practice and tool in place to periodically monitor adherence to its policy/standards of care?

- Does the sponsoring organization have a written participation agreement established with TEAM for WV Children?

- Has the sponsoring organization provided orientation to staff educators to gain buy-in about the internal operation and expectations of providing safe sleep education to families?

- Has all staff who will educate expectant parents, new parents and other caregivers of infants under age one completed the Say YES online training module prior to commencing the education? Do they feel comfortable providing the education?

- Is newly employed staff trained promptly? Is continuing education / refresher education provided or made available?

- Does at least one staff representative participate in Our Babies: Safe and Sound annual competency training? Is the sponsoring agency routinely represented on quarterly peer sharing calls sponsored by Our Babies: Safe and Sound?

- Are Say YES materials used for parent/caregiver education? Is an adequate supply of materials available at all times?

- Does the messaging adhere to recommendations of the American Academy of Pediatrics? Do the educators provide the recommendations even in cases where the staff person educating does not agree with the AAP recommendations? What process is used to address questions and challenges when staff disagrees with the messaging?

- Is the education provided verbally and face-to-face in a nonjudgmental way along with opportunities to ask questions and materials given to the family to keep? Is guidance offered to correct practices that are unsafe? Is staff aware of the availability of discussion points?

- Does staff model safe sleep practices at all times?

- Are data related to safe sleep education documented and reported as requested?

- Does linkage exist with other organizations providing safe sleep education in the region?

Assistance to partner organizations is available from Our Babies: Safe and Sound staff to support consistency with the design of the model. Additionally, the online *Say YES To Safe Sleep For Babies Guide and Toolkit* contains numerous examples, resource materials and other guidance that may be beneficial.

SAY YES TO SAFE SLEEP FOR BABIES
PROGRAM OVERVIEW OF PHASES AND SCHEDULE

GOAL: ZERO DEATHS OF INFANTS IN WEST VIRGINIA DUE TO UNSAFE SLEEP

Phases apply to new and continuing sites.

PHASE I READINESS: Months 1-4*

Prepare to implement and model infant safe sleep practices

- Orientation calls for new hospital sites and home visitation programs
- Recruit your infant safe sleep team and other champions and link to corresponding Dose I/II providers
- Complete and return Participation Agreement
- Conduct online and in-house staff training and engagement activities to ensure consistent messaging and use of materials
- Develop your organization's safe sleep policy/standards of care (Examples provided)
- Develop tool and conduct baseline audit of newborn units (tool example provided) and pre-test staff knowledge (hospitals)
- Develop tool and process to conduct home assessments (home visitation tool example provided). Pre-test staff knowledge
- Determine "Go Live" date and goal
- Participate in bi-monthly peer-to-peer calls
- Participate in Annual Competency Training (March 17, 2016)
- Prepare for post-implementation benchmark data collection

PHASE II IMPLEMENTATION: Months 3-5*

Begin to provide consistent, accurate, safe sleep messages to expectant parents, parents, and caregivers of infants under one year of age, ideally prenatally, near the time of birth before hospital discharge and/or within the first weeks of baby's life

- Order parent education materials and begin marketing and visibility
- Face-to-face discussion for initial or reinforcement education and distribution of materials prenatal or postnatal
- Dose II: Face-to-face reinforcement by home visitation program partners
- Public and community awareness (PSAs, community events, etc.)
- Continue to conduct follow-up audits in hospital newborn units and assessments in homes re: infant sleep practices
- Peer sharing and support
- Continue to train new staff
- Collect and report post-implementation benchmark data, as required

- **Phase III MEASURING SUCCESS AND PLANNING FOR SUSTAINABILITY: July - December 2016***
  Lessons learned will be shared and success will be celebrated!
  - Continue to implement and train new staff (Regional Training Forums for Home Visitation Staff to be planned)
    Continue peer sharing and support
    Continue quarterly benchmark data reporting and conduct periodic nursery audits/home assessments
    Participate in Infant Safe Sleep Month (September)
    Explore national safe sleep hospital certification through Cribs for Kids® (hospital sites)
    Plan for sustainability and expansion

*Time frames are flexible

Participation Agreements

Partners providing education to expectant parents, parents and other caregivers through Say YES To Safe Sleep For Babies must develop an agreement with TEAM for WV Children.

Agreement forms for hospitals and home visitation programs are provided on the following pages. Home visitation programs submit agreements annually. Hospitals submit agreements prior to implementation of the program and when significant changes occur.

The agreement may be revised to adapt it to the needs of the partner organization. For other types of partner organizations, staff of Our Babies: Safe and Sound are happy to help you develop a tool appropriate for your use.

Say Yes To Safe Sleep For Babies Program
Hospital Participation Agreement

The purpose of this agreement is to clearly identify the collaborative relationship and define individual roles and responsibilities of TEAM for WV Children and _____ _____ (hospital) in facilitating the *Our Babies: Safe and Sound - Say Yes to Safe Sleep for Babies* program. This agreement will be updated in writing as any relevant significant change occurs on the part of TEAM for WV Children/Say YES To Safe Sleep For Babies program or the hospital.

For this understanding, TEAM for WV Children agrees to:

1. Provide copies of the *Say YES To Safe Sleep For Babies Parent/Caregiver Education Kit* and other materials, as available, at no charge for the hospital's use in parent/caregiver education.

2. Provide access to required training and related materials to ensure new and existing hospital staff members are knowledgeable in providing education to parents/caregivers. Materials and resources include the following:
    A. An online Guide and Toolkit with specific information about program readiness, implementation and ongoing continuance tasks along with sample tools and resource information, such as an infant safe sleep hospital policy example and sample tools for use in periodic audits of appropriate units of the hospital to assess if internal infant safe sleep policies are practiced
    B. Web-based information and resources at www.safesoundbabies.com
    C. Discussion points and messages to use when presenting the program education and materials to parents/caregivers
    D. A 75-minute on-line training module with CEs provided, as available
    E. An annual statewide competency training forum for representatives of all partner organizations
    F. A tool for reporting benchmark data and publication of a composite report of annual data

3. Provide consultation and technical assistance through peer-to-peer conference calls, regular communications, and staff availability to share updates and resolve issues as program readiness, implementation and continuance occur.

For this understanding, _____ Hospital agrees to:

1. Assign a designated contact person(s) within the hospital who will be responsible for providing oversight of program readiness, implementation and continuance, including serving as the primary point of contact for ongoing communications, assuring participation in quarterly peer sharing calls, and participating in the statewide annual competency training provided by TEAM for WV Children/Our Babies: Safe and Sound.

2. Adopt a hospital-approved infant safe sleep policy/standards of care and corresponding procedures. Design an audit tool and process to periodically assess adherence to the policy/standards of care and define staff procedures for situations where parents/caregivers or staff are non-compliant.

3. Training:
    - Assure all staff have completed training before educating families including (1) completion of the 75 minute online training module developed by TEAM for WV Children and CHERI and (2) participation in internal face-to-face training about the hospital's safe sleep policies and practices. Assure all staff are familiar with the latest infant safe sleep recommendations of the American Academy of Pedicatrics.

- Assure prompt training for new staff and continuing education for existing staff. Assure staff receive information about training topics provided at the annual statewide competency training sponsored by TEAM for WV Children/Our Babies: Safe and Sound.
- Document dates and topics of all infant safe sleep training received by staff.

4. Order and ensure supplies of the *Say YES To Safe Sleep For Babies* parent/caregiver education materials are adequate.

5. Review the contents of the *Say YES To Safe Sleep For Babies* Parent/Caregiver Education Kit with parents/caregivers before discharge, using a multi-modal approach, including verbal discussion of infant safe sleep reccommendations, providing copies of materials, providing an opportunithy for parents/caregivers to review and/or sign the pledge card, assuring opportunities for parents/caregivers to view the DVD, and having any questions answered. Include education about *Keep Your Cool* when baby cries.

6. Collect basic benchmark data in the format designed by TEAM for WV Children/Our Babies: Safe and Sound and submit quarterly.

7. Participate in September infant safe sleep month community outreach/education activities, as possible

8. Serve as an ambassador for the program and work with corresponding home visitation program contact(s) and other partners providing infant safe sleep education in the hospital's area.

9. In partnership with Cribs for Kids®, explore achieving/continuing/upgrading National Safe Sleep Hospital Certification.

The person designated as the point of contact is _____. He/She may be reached at (email & phone) _____.

Signatures:

_____ _____

Hospital Administrator/Hospital **Date**

_____ _____

TEAM for WV Children **Date**

Please return one signed copy electronically or by mail to Laurie McKeown at laurie@teamwv.org or P.O. Box 1653, Huntington, WV 25717.

Revised December 2017

Say Yes To Safe Sleep For Babies Program
2018 Home Visitation Program Participation Agreement

The purpose of this agreement is to clearly identify the collaborative relationship and define individual roles and responsibilities of TEAM for WV Children and _____ (home visitation program) in facilitating the *Our Babies: Safe and Sound - Say Yes to Safe Sleep for Babies* program during 2018. This agreement will be updated annually in writing or as any relevant significant change occurs on the part of TEAM for WV Children/Say YES To Safe Sleep For Babies program or the home visitation program.

For this understanding, TEAM for WV Children agrees to:

4. Provide copies of the *Say YES To Safe Sleep For Babies* materials for parent/caregiver education, as available, at no charge for the home visitation program's use in parent/caregiver education.

5. Provide access to required training and related materials to ensure new and existing home visitation staff members are knowledgeable in providing education to parents/caregivers. Materials and resources include the following:
   G. An online Guide and Toolkit with specific information about program readiness, ~~and~~ implementation and ongoing continuance tasks along with sample tools and resource information
   H. Web-based information and resources at www.safesoundbabies.com
   I. Discussion points to use when presenting the program education and materials to parents/caregivers
   J. A 75-minute on-line training module with CEs provided, as available
   K. A one-day annual statewide competency training forum for representatives of all partner organizations
   L. Infant safe sleep home visitation program policy examples
   M. Examples of tools for use in periodic in-home assessments to assess if infant safe sleep practices are being followed

6. Provide consultation and technical assistance through quarterly peer-to-peer conference calls, regular communications, and staff availability to share updates and resolve issues as program readiness and implementation occur.

For this understanding, _____(home visitation program) agrees to:

10. Assign a designated contact person(s) who will be responsible for providing oversight of program readiness,implementation and ongoing continuance, including serving as the primary point of contact for ongoing communications, assuring at least one representative's participation in quarterly peer-to-peer calls, participating in the statewide annual competency training provided by TEAM for WV Children/Our Babies: Safe and Sound, and assuring staff may participate in infant safety trainings sponsored by TEAM for WV Children/Our Babies: Safe and Sound.

11. Adopt a home visitation program-approved infant safe sleep policy and corresponding procedures. Utilize an assessment tool and process to periodically monitor adherence to the policy and define procedures for situations where parents/caregivers or staff are non-compliant.

12. Training:
    - Assure all staff have completed training before educating families including (1) completion of the 1.5 hour on-line training module developed by TEAM for WV Children and CHERI and (2)

participation in internal face-to-face training about the home visitation program's safe sleep policies and practices. Assure all staff are familiar with the latest infant safe sleep recommendations of the American Academy of Pedicatrics.

- Assure prompt training for new staff and continuing education for existing staff. Assure staff receive information about training topics provided at the annual statewide competency training sponsored by TEAM for WV Children/Our Babies: Safe and Sound.
- Document dates and topics of all infant safe sleep training received by staff.

13. Place orders online and ensure supplies of *Say YES To Safe Sleep For Babies* materials are adequate.

14. Provide timely infant safe sleep education to parents/caregivers.
    a. Prenatal or Initial Education (first exposure) - For parents/caregivers who did not receive safe sleep education prenatally or prior to discharge from the hospital, provide education including a review of the contents of the *Say YES To Safe Sleep For Babies Parent/Caregiver Education Kit*, using a multi-modal approach, including verbal discussion of infant safe sleep practices; providing copies of materials; giving the parents/caregivers an opportunity to sign the pledge card; providing a copy of the *Sleep Baby – Safe and Snug* book; assuring opportunities for parents/caregivers to view the DVD; and assuring an opportunity to ask questions. Include education about *Keep Your Cool* when baby cries.
    b. Reinforcement Education (follow-up exposure) - For parents/caregivers who did receive safe sleep education prenatally or prior to discharge from the hospital, provide follow-up reinforcement of *Say YES To Safe Sleep For Babies* messages. The reinforcement education uses any Say YES materials that may be helpful, through a multi-modal approach with verbal face-to-face discussion and provision of materials at home visits and/or group educational settings. Continue the education at subsequent visits.
    c. In any educational environment, assure parents/caregivers have opportunities to ask questions.

15. Collect and submit data as requested.

16. Participate in September infant safe sleep month community outreach/education activities, as possible.

17. Serve as an ambassador for the program and work with corresponding hospital contact(s) and other partners providing infant safe sleep education in the area.

The person designated as the point of contact is _____

He/She may be reached at (email/phone) _____

Signatures:

_____ _____
Home Visitation Program Administrator **Date**

_____ _____
TEAM for WV Children **Date**

Please return one signed copy electronically or by mail to Laurie McKeown at laurie@teamwv.org or PO Box 1653, Huntington, WV 25717.

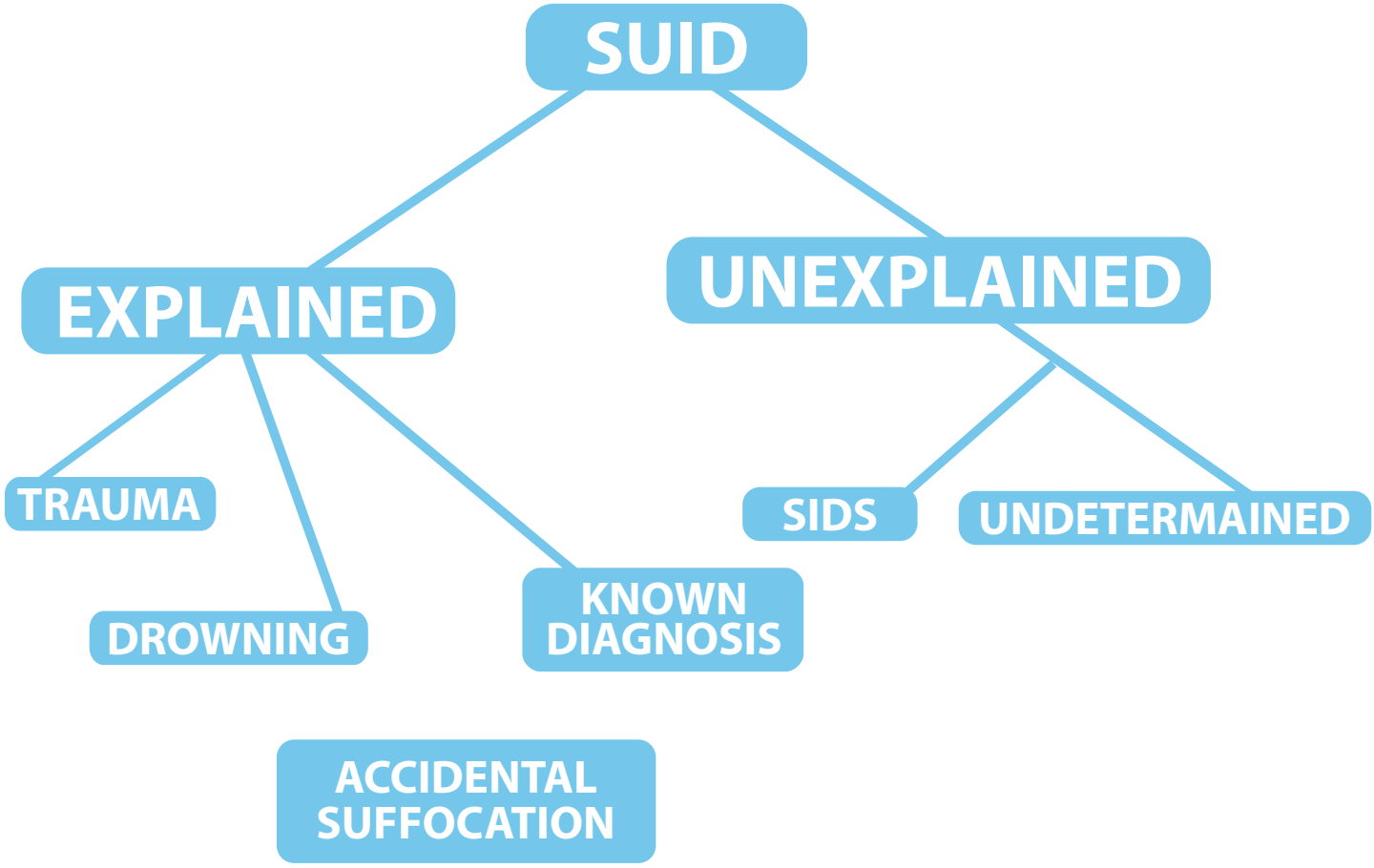
Revised 12-2017

Roles and Responsibilities of Partner Organizations' Key Contact Persons

Each organization participating in Say YES To Safe Sleep For Babies is required to designate a primary contact person(s) / safe sleep champion to ensure:

- Linkage with the *Our Babies: Safe and Sound* staff
- Oversight of program readiness, implementation and ongoing continuation tasks
- Participation in quarterly peer sharing conference calls/webinars
- Good communication with local staff and the community
- Sharing information received from the *Our Babies Safe and Sound* with relevant staff
- Policy development
- Staff completion of training
- Positive modeling practices are in place and monitored
- Consistent data collection
- Linkage with Say YES partners and other relevant entities in the region
- Making adjustments for changes resulting from staff turnover

Categories of Sudden Unexpected Infant Death (SUID)



University of Virginia Health System

American Academy of Pediatrics Infant Safe Sleep Recommendations

SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment

To view or download the 2016 (most recent) report of recommendations see http://pediatrics.aappublications.org/content/early/2016/10/20/peds.2016-2938.full.pdf

Say YES To Safe Sleep For Babies' materials and educational messaging are consistent with AAP guidelines.

Sample Infant Safe Sleep Policies / Standards of Care

All programs participating in Say YES To Safe Sleep For Babies are required to develop and implement an internal operating policy / standards of care about infant safe sleep.

All existing partner organizations are asked to annually review, and where necessary, update their existing policies / standards of care. New sites are asked to create policies. All policies/standards of care should ensure consistency with the participation agreement, learnings from the previous years' experiences, findings from data collection and evaluations and the most recent recommendations of the American Academy of Pediatrics (AAP).

Sample policies / standards of care are described on the following pages as examples that may be adapted to the partner organization's needs.

Samples may be created for other types of organizations that are not currently partners.

Policies/standards of care should cover topics such as staff training, safe sleep practices to be used, process for educating expectant parents and parents/caregivers of infants under the age of 1, materials and messaging, and documentation.

WELLSPAN HEALTH- YORK HOSPITAL NURSING POLICY AND PROCEDURE

DATES: **Original Issue:** **August, 1995**
Annual Review: **August, 2016**
Revised: **August, 2017**

Owner: **M. Goodstein**
Approved by: **WCSL Council**

TITLE: INFANT POSITIONING / SAFE SLEEP PRACTICE POLICY

I. Purpose

A. Establish guidelines and parameters for infant positioning.
B. Establish appropriate and consistent parental education on safe sleep positions and environment.
C. Establish consistent safe sleep practices by healthcare professionals for infants prior to discharge.
D. To comply with Pennsylvania ACT 73 which mandates that provision of education for parents relating to sudden infant death syndrome and sudden unexpected death of infants.

II. Definitions

Infant Mortality Rate: Number of deaths in infants aged under 1 year of life per 1,000 live births in a given geographic location.

Neonatal Mortality Rate: Number of deaths in infants aged under 29 days of life per 1,000 live births in a given geographic location.

Post-neonatal Mortality Rate: Number of deaths in infants aged 29 to 364 days of life per 1,000 live births in a given geographic location.

SIDS (Sudden Infant Death Syndrome): The sudden death of an infant younger than one year of age that remains unexplained after a complete investigation.

SUID (Sudden Unexpected Infant Death): The death of an infant less than one year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before the investigation. Most SUIDs are reported as one of three types:

- SIDS

- Accidental suffocation or strangulation in bed
- Unknown Cause

SUPC (Sudden Unexpected Postnatal Collapse) Any condition resulting in temporary or permanent cessation of breathing or cardiorespiratory failure in a well-appearing, full-term newborn with Apgar scores of eight or more, occurring during the first week of life. Many, but not all, of these events are related to suffocation or entrapment.

NAS (Neonatal Abstinence Syndrome): Is a constellation of symptoms that occur in a **newborn** who has been exposed to addictive opiate drugs. This is most commonly due to prenatal or maternal use of substances that result in withdrawal symptoms in the newborn. It may also be due to discontinuation of medications such as fentanyl or morphine used for pain therapy in the newborn (postnatal NAS).

III. Policy Statement

The infant mortality rate is a widely-used indicator of the nation's health. In 2010, the United States (U.S.) ranked 26th in infant mortality among industrialized nations, with an overall infant mortality rate of 6.1 deaths per 1,000 live births. [1] The leading causes of infant mortality in the U.S. are a) congenital malformations, b) short gestation/low birth weight, c) sudden infant death syndrome (SIDS), d) maternal complications, and e) unintentional injuries (mostly suffocations)[2]. Although the infant mortality rate in the U.S. decreased to 5.96 deaths per 1,000 live births in 2015, this still represents approximately 24,000 deaths per year, of which, **about 3,500 are sudden unexpected infant deaths (SUID).**

In 1992 the American Academy of Pediatrics (AAP) recommended that infants no longer sleep in the prone position. By 1994, the National Institutes of Health, introduced the Back to Sleep campaign. Over the next 10 years, the sudden infant death syndrome (SIDS) rate in the U.S. fell 53%, correlating with an increase in exclusive supine sleep.

Despite these advances, approximately 1,500 infant deaths occur due to SIDS each year. SIDS is the third-leading cause of infant mortality overall, and it is the leading cause of post-neonatal mortality. And although the incidence of SIDS continues to decline, other deaths (including accidental suffocation and strangulation in bed and undetermined deaths) have increased, suggesting a possible "diagnostic coding shift," resulting in little change in the incidence of SUID in recent years.

The AAP recommends "Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk reduction recommendations from birth. All physicians, nurses, and other health care providers should receive education on safe infant sleep. Hospitals should ensure that hospital policies are consistent with updated safe sleep recommendations and that infant sleep spaces (bassinets, cribs) meet safe sleep standards."

However, studies show that many hospitals do not currently provide consistent and accurate information or model appropriate behavior in the hospital. In one study, parents reported receiving instruction on sleep position from either nurses and doctors less than 50% of the time and only 37% of parents reported seeing their infant placed exclusively in the supine position in the nursery. Yet parents who reported both receiving instruction and observing their infant put to sleep in the supine position were most likely to keep their babies in the supine position for sleep at home (70%), while parents who received no instruction and did not see their babies' supine in the nursery were least likely to report using the supine position at home (22%). Parents are less likely to believe that infant safe sleep practices are important when the hospital staff is inconsistent with their message and behavior.

[1] (MacDorman, Matthews, Mohangoo, & Zeitlin, 2014).

[2] (MacDorman, Hoyert, & Matthews, 2013).

Healthcare professionals play a vital role by showing mothers/caregivers a positive model for safe sleep practices in the hospitals or office settings, and educating parents and caregivers on the importance of infant sleep safety**.** The challenge for hospitals is to provide education about reducing the potential for accidental injury or death while still promoting methods for mothers/caregivers to bond with their newborns**.** Healthcare providers should have open, frank, nonjudgmental conversations with families about their sleep practices. Healthcare facilities can make a difference by providing education for staff and families, and promoting and monitoring safe sleep behaviors that can reduce the risk of injury or infant death.

IV. Equipment

Open cribs/bassinets, isolettes or infant warmers

V. Procedure

A. Infants in the Newborn Nursery:

1. Place all infants on their backs to sleep and the head of the bed flat. Infants with a medical contraindication to supine sleep position -- i.e. congenital malformations, upper airway compromise, severe symptomatic gastroesophageal reflux -- should have a physician's order along with an explanation documented.

2. A firm sleep surface should be used (firm mattress with a thin covering). Use of soft bedding such as pillows, quilts, blanket rolls, and stuffed animals should not be used.

3. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet and can be returned to the newborn nursery at the discretion of the nurse. The mother/parent should then be re-educated on safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous with the most serious consequence being death.

4. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "wearable blanket" may be used. If temperature instability occurs, an additional layer of clothing can be used. Swaddling the baby with an additional blanket or wearable blanket is also acceptable.

The following measures are to be discouraged, since they are not consistent with the AAP Guidelines:

i. Use of extra blankets should be discouraged. If a baby cannot maintain temperature with normal clothing and swaddling materials, it is preferable to place the infant in an incubator or under a radiant warmer. Alternatively, the baby may be covered transiently with an extra blanket tucked in under the mattress. If this is required, please remove prior to discharge and re-educate the mother/caregiver on the importance of "no loose" or "bulky blankets" in the crib or bassinet.

ii. If a hat is still needed for thermoregulation at discharge, educate the parents/caregivers to monitor baby's temperature, and to attempt to discontinue using the hat after 2-3 days of stable temperatures at home. If the baby maintains a normal temperature without the hat, then it can be permanently discontinued. Generally, a hat should not be needed after a few days in home environment.

5. Environmental temperature should be maintained at 72-78 degrees Fahrenheit.

6. The following recommendations for **skin to skin** bonding, when the mother is awake and fully alert, will decrease the risks of **SUPC** (see page 1 for definition.)

- Infant's face can be seen
- Infant's head is in "sniffing" position
- Infant's nose and mouth is not covered

- Infant's head is turned to one side
- Infant's neck is straight, not bent
- Infant's shoulders and chest face mother's
- Infant's legs are flexed
- Infant's back is covered with blanket
- Mother-infant dyad is monitored continuously by the staff in the delivery environment and regularly on the postpartum unit
- When mother want to sleep, infant is placed in bassinet or with another support person who is awake and alert.

B. Infants in the Neonatal Intensive Care Nursery (NICU):
Please see home safe sleep environment algorithm

1. Infants who are ill and do not meet the criteria for the home safe sleep environment should have the Therapeutic Positioning Card at their bedside stating: "Infant is not ready for the Home Sleep Environment (HSE)"

2. Place all infants on their backs to sleep and the head of the bed flat, using the Home Sleep Environment guidelines (HSE). NICU infants should be placed exclusively on their backs to sleep when stable and in the convalescent stage of their development (see #5 for guidelines). The placement of NICU infants on their back to sleep should be done well before discharge, to model safe sleep practices to their families.

The following exceptions should be noted:

i. Infants with upper airway compromise, life-threatening GE reflux (not mild to moderate apnea/bradycardia), respiratory distress, or a greater degree of prematurity may be placed prone or side lying until resolution of symptoms.

ii. Preterm infants and ill newborns may benefit developmentally and physiologically from prone or side lying positioning and may be positioned in this manner when continuously monitored and observed.
iii. Infants with Neonatal Abstinence Syndrome (NAS) with difficult to control symptoms may be placed in a prone position for brief periods of time (see addendum for guidelines).

3. The following recommendations for skin to skin when mother is fully awake and alert will decrease the risks of SUPC (see page 1 for definition):

- Infant's face can be seen
- Infant's head is in "sniffing" position
- Infant's nose and mouth is not covered
- Infant's head is turned to one side
- Infant's neck is straight, not bent
- Infant's shoulders and chest face parent's
- Infant's legs are flexed
- Infant's back is covered with blanket
- Parent-infant dyad is monitored continuously by the staff in the NICU
- If the parent becomes drowsy, infant is placed back in the incubator, warmer or bassinet, or with another support person who is awake and alert.

iv. A firm sleep surface should be used (firm mattress with a thin covering). Soft bedding and objects such

as pillows, quilts, blanket rolls, bumpers and stuffed animals should not be present. Positioning devices (such as snugglies) may be used for developmentally sensitive care of any infant in the NICU (premature infant, infant with neurologic or orthopedic abnormalities) as determined by the team (including occupational and physical therapy).

v. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "wearable blanket" may be used. If temperature instability occurs, an additional layer of clothing can be used. Swaddling the baby with an additional blanket or wearable blanket is also acceptable.

The following measures are to be discouraged, since they are not consistent with the AAP Guidelines:

i. **Use of extra blankets should be discouraged. If a baby cannot maintain temperature with normal clothing and swaddling materials, it is preferable to place the infant in an incubator or under a radiant warmer. Alternatively, the baby may be covered transiently with an extra blanket tucked in under the mattress. If this is required, please remove prior to discharge and re-educate the mother/caregiver on the importance of "no loose" or "bulky blankets" in the crib or bassinet.**

ii. **If a hat is still needed for thermoregulation at discharge, educate the parents/caregivers to monitor baby's temperature, and to attempt to discontinue using the hat after 2-3 days of stable temperatures at home. If the baby maintains a normal temperature without the hat, then it can be permanently discontinued. Generally, a hat should not be needed after a few days in home environment.**

4. Environmental temperature should be maintained at 72-78 degrees Fahrenheit.

5. The following guidelines should be used to transition NICU patients to the Home Sleep Environment (HSE):

   i. Babies with a gestational age of 33 weeks and beyond AND greater than 1500 grams without respiratory distress should be placed in HSE.

   ii. Babies with gestational age 34 weeks and beyond with respiratory distress may be positioned prone until respiratory symptoms are resolving.

   iii. Babies with gestational age under 34 weeks should be assessed when reaching a post-conceptional age of 33 weeks and weight greater than 1500 grams:

   iv. If the baby has respiratory distress, staff may continue with prone positioning until respiratory symptoms are resolving. Safe sleep modeling can be performed with an infant on Low flow nasal cannula or High Flow Nasal Cannula <2. LPM.

   v. If the baby has no respiratory symptoms, then the primary nursing team should discuss the infant's neuromuscular status with Occupational Therapy. Once the baby no longer requires positioning devices, begin HSE protocol.

6. Once it is determined that an infant is ready for home sleep environment, the following actions should be completed:

   i. Apply the HSE card/safe sleep ticket to the baby's bedside.
   ii. Fill out the graduation certificate with the baby's name.
   iii. At the parent's next visit, have them watch the safe sleep DVD and then provide modeling and review of the appropriate home sleep environment.
   iv. After completion of the training, present the family with the graduation certificate.

Also educate the mother/caregiver on the following:

i. No burp cloth under infant.
ii. No sleeping in swing or car seats. It is acceptable to place a fussy baby in a swing to calm down, then transfer to the bassinet for sleeping.
iii. Prior to discharge the MD/NNP to give the "Sleep Baby Safe and Snug" book to family and review education.

C. Infants in the Pediatric Unit (Infants less than 1 year of age):

1. Follow the guidelines for the Newborn Nursery
2. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet or crib. The mother/parent should then be re- educated on safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous, with the most serious consequence being death.

VI. Documentation

A. Document the infant's position on the Newborn Nursery, or Pediatric Flow sheets.

B. Family/Parental teaching: All parents and caregivers (daycare workers, grandparents, and babysitters) will be educated on SIDS and safe sleep environments and positioning.

1. All healthy infants should be placed on their backs to sleep.
2. All infants should be placed in a separate but proximate sleeping environment (in a safety approved crib, infant bassinet, or Pack 'n Play/play yard).
3. All infants should be placed on a firm sleep surface. Remove all soft-loose bedding, quilts, comforters, bumper pads, pillows, stuffed animals and soft toys from the sleeping area.
4. Never place a sleeping infant on a couch, sofa, recliner, cushioned chair, waterbed, beanbag, soft mattress, air mattress, pillow, synthetic/natural animal skin, or memory foam mattress.
5. Avoid bed sharing with the infant.

   Note the risk of bed sharing:

   - Adult beds do not meet federal standards for infants. Infants have suffocated by becoming trapped or wedged between the bed and the wall/bed frame, injured by rolling of the bed, and infants have suffocated in bedding.
   - Infants have died from suffocation due to adults rolling over on them.
   - Sleeping with an infant when fatigued, obese, a smoker, or impaired by alcohol or drugs (legal or illegal) is extremely dangerous and may lead to the death of an infant.
6. If a blanket must be used, the preferred method is to swaddle/bundle the infant no higher than the axillary or shoulder level.
   - **Swaddling should be discontinued when the infant shows signs of rolling over.**
7. The use of a "wearable blanket" may be used in place of a blanket.
8. Avoid the use of commercial devices marketed to reduce the risk of SIDS.
9. Avoid overheating. Do not over swaddle/bundle, overdress the infant, or over heat the infant's sleeping environment.
10. Consider the use of a pacifier (after breastfeeding has been well established) at sleep times during the first

year of life. Do not force an infant to take a pacifier if he/she refuses.

11. Avoid maternal and environmental smoking.
12. Avoid alcohol and drug use.
13. Breastfeeding is beneficial for infants.
14. Home monitors are not a strategy to reduce the risk of SIDS, this includes both Medical grade and direct to consumer devices/monitors.
15. Encourage tummy time when the infant is awake, to decrease positional plagiocephaly.

C. Document all parental teaching (note if the contract was signed and whether the Safe Sleep DVD was viewed) related to sleep safe practices on the parental teaching portion of the plan of care.

D. For additional information please refer to the Cribs for Kids® tool kit on Safe Sleep Practices.

NAS & Prone Positioning

Infant Irritable

Comfort Measures

- Rocking (including use of swings/Mamaroo)
- Holding (volunteers)
- Swaddling
- White noise
- Appropriate Skin-to-skin care
- Infant massage

Irritability continues > 12 hours that necessitates prone positioning at times

Consult with MD/NNP to review scores and meds

Re-assess need for prone positioning and ALWAYS use comfort measures BEFORE placing an infant prone!

Getting ready for home--

- Discontinue prone positioning if used.
- Discuss with primary nursing team, PT/OT, MD/NNP

Begin Home Sleep Environment (if not done earlier) when-

- Morphine dose 0.16mg every 3 hours
- Average abstinence scores of < 6 over 24 hours
- No scores > 10 in the last 24 hours
- No prn doses needed in the previous 24 hours

Implement the "home sleep environment" at least 1 week before discharge if not sooner.
KEY POINT -implement when infant is ready for "home sleep" and not earlier in the hospitalization

- View video
- Post Safe sleep ticket
- Post-Graduation card - make this a "special" day for parents!
- Review information and safe sleep DVD with parents
- Swing time limited to awake/fussy times.
- Safe Sleep baby book given to parents by MD, NNP

Family Education

- Need extra education when prone

- **DO NOT say**, "I couldn't get him to sleep so I put him on his belly". "She was very fussy last night and slept better being on her belly", "belly sleeping is okay here in the NICU because our babies are monitored – don't do this at home"
- **DO say**, "to help her calm I put her on her belly for a brief time. This special therapy is sometimes needed to help with withdrawal symptoms".
- **Be consistent** with messages.

Considerations

- Staffing – try to avoid clustering NAS babies in 1 area
- Avoid triage assignments if possible
- Consistent care givers are important
- Maintain positivity
- Communicate with charge nurse any concerns with assignments
- Safe Sleep Notes
- May begin in isolette, bassinet, or open crib
- No washcloths under infant

References: *"Portions of the following resources may have been consulted as part of the development of this policy. These resources are not authoritative."*

Moon RY and AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment. *Pediatrics.* 2016;138(5): e20162940

AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics.* 2016;138(5): e20162938

Feldman-Winter L, Goldsmith JP, AAP COMMITTEE ON FETUS AND NEWBORN, AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. *Pediatrics.*2016;138(3): e20161889

SAMPLE

INFANT SAFE SLEEP POLICY
XXX HOME VISITATION PROGRAM
DATE

Please feel free to use this example and to make modifications that are beneficial to the understanding of how your infant safe sleep education program works.

Purpose: To ensure consistent, accurate information about infant safe sleep practices and environments is (1) provided to expectant parents and parents/caregivers of infants under the age of one enrolled in the XXX program and (2) understood and modeled by staff of XXX program, based upon the latest recommendations of the American Academy of Pediatrics (AAP)

Education to Parents/Caregivers:

1. Every expectant parent and parent/caregiver of an infant under the age of one in the XXX program will receive the following one-on-one consistent education about Infant Safe Sleep for every naptime and night sleep time:

    - ABC: Baby always sleeps **a**lone, placed on her/his **b**ack and in a safe **c**rib, basinet or portable crib, nearby.
    - Room sharing – yes. Bed sharing – no. People who sleep with baby could easily accidentally roll over and suffocate the baby.
    - It is safest for baby to sleep in the room where the parent/caregiver sleeps, but not in your bed. Place the baby's bed near your bed – within arm's reach. That makes it easier to breastfeed, which is recommended.
    - Crib is clear of toys, heavy or loose blankets, unfitted sheets, bumper pads and pillows.
    - Baby should never be placed to sleep on an adult bed, couch, waterbed, cushion or other soft surface because of the risk of accidental suffocation and should not sleep with anyone on these kinds of surfaces.
    - Baby sleeps in a smoke-free environment. Caregivers' use of alcohol and drugs should be avoided.
    - The crib mattress is firm and fits close to the sides.
    - Dress baby in light sleep clothing and keep the room at a comfortable temperature. Sleep sacks or wearable blankets are recommended in place of blankets.
    - Consider using a pacifier if baby is receptive. If breastfeeding, begin use of the pacifier after breastfeeding is established.
    - If pregnant, attend all prenatal visits.
    - Tell everyone else who cares for baby how to use safe sleep practices.

2. Staff will provide the initial education format for expectant parents/caregivers (prenatal) and for those who did not receive the education while in the hospital near the time of the birth of the baby (postnatal). Staff will provide the reinforcement education format to those who have received safe sleep education previously and remember the recommendations. In subsequent contacts, the home visitor will continue to reinforce the recommendations.

3. The education will be provided through a mufti-modal approach, using verbal face-to-face discussion, provision of Say YES To Safe Sleep For Babies program materials for the parent/caregiver to keep, and opportunities to ask questions.

4. When the home visitor is aware the parent/caregiver is not practicing a safe sleep recommendation(s), the staff will provide nonjudgmental guidance about making the sleep environment safe.

5. Program staff will model safe sleep practice at all times.

Preparation and Training for Staff Educators
Staff in the XXX program will participate in and document training on Infant Safe Sleep using the following training materials and opportunities:

- Orientation from XXX program about internal policies and practices related to infant safe sleep (required prior to educating parents/caregiver)
- The 75-minute *Say YES To Safe Sleep For Babies* online training module via www.safesoundbabies.com (required prior to educating parents/caregivers)
- *Say YES To Safe Sleep For Babies Guide and Toolkit* at www.safesoundbabies.com
- (to be used as an ongoing resource)
- Cribs for Kids® Safe Sleep Educational Flipchart (if desired)
- Relevant trainings presented by TEAM for WV Children /Our Babies: Safe and Sound
- Quarterly peer sharing calls/webinars sponsored by Our Babies: Safe and Sound
- New staff will be trained promptly.
- Other:

Documentation by Staff
- Staff will document and submit reports following each visit, using the required format.
- Staff will document date, topic and duration of any relevant training received.

This policy will be reviewed annually and revised as needed.

I acknowledge that I have been given the opportunity to read this policy, ask questions about the policy, and understand the contents.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Sample Infant Safe Sleep Audit/Assessments

Cribs for Kids®
Helping every baby sleep safer

Safe Sleep Audit Tool

Date: _____

Auditor: _____

Time of Audit: _____

Patient #	*Head of bed Flat?* *Y or Degree of elevation*	*Patient Asleep Supine?* *Y or N*	*Multiple Blankets to Crib?* *Y or N*	*Stuffed Animals in Crib?* *Y or N*	*Large or Fluffy Blankets Around Pt.?* *Y or N*	*Patient in Nest* *Y or N*	*Patient Swaddled?* *Y or N*	*Care giver asleep with baby?* *Y or N*	*Positioning Device used?* *Y or N*
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Y – Yes N- No

HOME VISITING SAFE SLEEP ASSESSMENT TOOL

Client Name:_____ Client I.D.#_____

1. **What safe sleep surface is available?**	□ Crib □ Bassinet □ Pack 'n Play ¨Other_____ ¨ None		□ Observed □ Parent reported	□ Education Provided
2. **Are there stuffed animals, toys, pillows, quilts, blankets, wedges, positioners, other loose bedding or bumpers in the infant's sleep environment?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
3. **Where does baby usually sleep?** Sleep environment should be placed away from: drapes or curtains, window blinds or shutters, electric cords, furnace vent or radiator, space heater or other heat sources, baby monitor, any other item that could burn, cut or become wrapped around your baby.	**For Naps:** □ Crib □ Bassinette □ Pack 'n Play □ Couch □ Recliner □ Swing □ Car Seat □ Bouncy Seat □ Floor □ With an adult, child or pet □ Other_____	**At Night:** □ Crib □ Bassinette □ Pack 'n Play □ Couch □ Recliner □ Swing □ Car Seat □ Bouncy Seat □ Floor □ With an adult, child or pet □ Other_____	□ Observed □ Parent reported	□ Education Provided
4. **Does baby ever share a sleep surface with a sibling, adult or pet?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
5. **Does baby ever share a sleep surface in a bed, couch, recliner or other?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
6. **What position do you place baby to sleep?**	**For Naps:** □ Back □ Side □ Stomach	**At Night:** □ Back □ Side □ Stomach	□ Observed □ Parent reported	□ Education Provided
7. **Are you and/or other caregivers smoking inside or outside the baby's home?**	□ Yes: ¨ Inside □ Outside □ No smoking ***(skip to #9)***		□ Observed □ Parent reported	□ Education Provided
8. **If you smoke outside, do you change your clothes before holding your baby?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
9. **Is the infant dressed appropriately for the temperature of the home?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
10. **Is the infant breast feeding?**	□ Yes: ¨ Exclusively breastfeeding □ Formula and breast milk □ No		□ Observed □ Parent reported	□ Education Provided
11. **Do you use a clean dry pacifier that is not attached to a string or stuffed animal?**	□ Yes ¨ n/a □ No		□ Observed □ Parent reported	□ Education Provided
12. **Do you provide supervised tummy time while the baby is awake?**	□ Yes □ No		□ Observed □ Parent reported	□ Education Provided
13. **Staff presented and reviewed NICHD "What does a safe sleep environment look like?" handout.**	□ Yes □ No □ parent declined		Others educated: □ Father of baby □ Grandparent □ Other_____	

Home Visitor Signature: _____ Date: _____

9/2014

THE CITY OF COLUMBUS
MICHAEL B. COLEMAN, MAYOR
COLUMBUS PUBLIC HEALTH

Ohio Better Birth Outcomes

Staff Orientation Training PowerPoint Presentation

Each participating program is required to conduct orientation training for all staff early in the readiness phase and on an ongoing basis as reinforcement training or for training new staff.

A PowerPoint presentation with notes is provided and can be adapted to the site.

To download the PowerPoint, go to the Downloads section of http://www.safesoundbabies.com/resources.html.

An outline about conducting the orientation workshop may be found on the next page.

CONDUCTING THE *SAY YES TO SAFE SLEEP FOR BABIES* STAFF ORIENTATION WORKSHOP

January 2016

Introduction

The following workshop overview and materials were developed for use by hospital and home visitation program providers and other partners to initiate or continue the *Say YES To Safe Sleep For Babies* initiative in their respective programs. This orientation session may be adapted to meet the needs of the organization, but should include all key concepts and align with the PowerPoint presentation.

The workshop objectives are to:

- Increase awareness of issues surrounding infant safe sleep nationally and in WV
- Explain the rationale and model components of the *Say YES To Safe Sleep For Babies* infant safe sleep educational program
- Promote and create an organizational culture of prevention through policies, modeling, and messaging

Workshop Outline and Timing

This workshop is designed to be conducted in approximately one hour. The following table outlines the sections and indicates the estimated teaching time. The *Say Yes to Safe Sleep* on-line training module is designed to provide most of the instructional context. The instructor-led components provide customization of the training to your facility/program.

	TOPIC	KEY POINTS	TIME
1.	Course Overview	Introduce yourself and explain why your program is participating and who supports it. Hand out materials.	5 min
2.	Orientation Power Point	Review the slides, which provide national and WV statistics, readiness and implementation phases, messaging and materials. Emphasize the importance of modeling safe sleep practices.	25 min
3.	Review parent/caregiver and provider teaching materials related to education in the ofollowing envirinments: prenatal, in-hospital near the time of birth, and after hospital discharge.	The parent DVD may be shown in its entirety. Review the discussion points, brochure, pledge form, and the Cribs for Kids flipchart tool. If available, discuss any organizational policies and the readiness phase components.	15 min
4.	Briefly describe the on-line training workshop	Ask each participant to view the online *Say YES To Safe Sleep For Babies* training course and review how to access it.	5 min
5.	Answer questions and wrap-up	Address questions from participants. Ask participants to complete an evaluation form.	5 min
	Total estimated time		55-60 min

Online Training Module for Staff of Partner Organizations

All partner organizations must ensure their staff completes a 75-minute online training on infant safe sleep recommendations and practices prior to commencing delivery of parent/caregiver education, as described on the following page.

ONLINE TRAINING MODULE DESCRIPTION

Say YES To Safe Sleep For Babies
Web-based Training Module for Parent Educators

Jointly Sponsored by CAMC Health Education and Research Institute and TEAM For West Virginia Children

The *Say YES To Safe Sleep For Babies* training module is a tool for all partners who educate new and expectant parents and caregivers about infant safe sleep recommendations. This web-based module was updated in June 2016, and is jointly sponsored by CAMC Health Education and Research Institute and TEAM for West Virginia Children. Staff of all *Say YES* partner organizations should complete the module prior to educating parents and other caregivers.

The course lasts 75 minutes and may be used for both staff orientation and continuing education training in individual or group settings. It may be reviewed in whole or in incremental parts from any device with Internet connection. As available, continuing education credit may be requested by physicians, nurses and social workers, and by early childhood professionals through West Virginia STARS.

There are 2 parts to the module:

Part 1 is *What You Need to Know About Sleep Related Infant Deaths*, and covers definitions, research, data and recommendations from the American Academy of Pediatrics. Dr. Rachel Moon, Chair of the American Academy of Pediatrics' Task Force on SIDS and associate editor for the journal *Pediatrics*, presents this section.

Part 2 provides an overview of West Virginia's model, S*ay Yes To Safe Sleep For Babies*, and reviews tools and messages providers can use to educate new and expectant parents and caregivers about keeping their babies safe while sleeping. This section is co-presented by Lee Ann Romeo, a registered nurse and childbirth educator at United Hospital Center, and Stephanie Barnett, a licensed social worker with the Ohio County Maternal Infant Health Outreach Worker Program.

Visit: www.safesoundbabies.com. Click on *Say YES Educator Training Module* link.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

ACCREDITATION STATEMENT

In support of improving patient care, this activity has been planned and implemented by TEAM for West Virginia Children and CAMC Health Education and Research Institute. CAMC Health Education and Research Institute is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

CREDIT HOUR STATEMENT

Physicians- CAMC Health Education and Research Institute is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The CAMC Institute will designate this live activity for a maximum number of hours for AMA PRA Category I Credit(s)TM. Certification for the offerings will be issued upon review and approval by CAMC Health Education and Research Institute.

Nurses – The CAMC Health Education and Research Institute is an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Certification numbers for the offerings will be issued upon approval by CAMC Health Education and Research Institute

Social Workers - CAMC Health Education and Research Institute is an approved provider of continuing education by the West Virginia Board of Social Work Examiners. Certification numbers for the offerings will be issued upon approval by the West Virginia Board of Social Work Examiners.

Overview of In-Home Family Education / Home Visitation Program Partners

Five models of in-home family education / home visitation programs are active partners with Say YES To Safe Sleep For Babies, including:

- Early Head Start
- Healthy Families America (HFA),
- Maternal Infant Health Outreach Workers (MIHOW)
- Parents As Teachers (PAT)
- Right from the Start (RFTS)

In combination, these programs serve all 55 counties in West Virginia at no cost to the families served. A description of the models is provided below followed by links for specific contact information for each local organization offering the models in West Virginia.

Program Models

Early Head Start/Head Start Programs
Early Head Start serves pregnant women, infants, and toddlers, prenatally up to age 5 with no insurance/income requirements. Early Head Start programs are available to the family until the child turns three years old and is ready to transition into Head Start or another pre-K program. Early Head Start helps families care for their infants and toddlers through early, continuous, intensive, and comprehensive services. In addition to education services, programs provide children and their families with health, nutrition, social, and other services. Early Head Start services are responsive to each child and family's ethnic, cultural, and linguistic heritage. Additional information about Head Start and Early Head Start can be found at wvheadstart.org.

Healthy Families America
www.healthyfamilies.org

Healthy Families America is a nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. The HFA model, developed in 1992 by Prevent Child Abuse America, is based upon 12 Critical Elements derived from more than 30 years of research to ensure programs are effective in working with families. **In West Virginia, Healthy Families America is available in Cabell, Logan, Mason, Wayne and parts of Lincoln Counties through Mountain State Healthy Families.**

www.mihow.org

Maternal Infant Health Outreach Workers Program is a parent-to-parent intervention that targets families from pregnancy through the child's third year of life. The program employs and trains parents to serve families in their own communities to encourage and support healthy lifestyles, positive parenting practices, and to help families understand and promote healthy child development. **In West Virginia, the MIHOW program is available in Fayette, Mingo, Monongalia, Ohio and Raleigh Counties and bordering communities of Greenbrier and Nicholas Counties. Enrolls families prenatally and shortly after birth and serves the families up to the child's third birthday.**

Parents as Teachers™

www.parentsasteachers.org

Parents as Teachers is the overarching program philosophy of providing parents with child development knowledge and parenting support. The Parents as Teachers National Center drives the philosophy through four components (personal visits, group connections, screening and resource network) and three key areas of emphasis (parent-child interaction, development-centered parenting and family well-being). **In West Virginia, PAT is available in Barbour, Berkeley, Boone, Brooke, Calhoun, Clay, Doddridge, Fayette, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jefferson, Kanawha, Lincoln, Marshall, McDowell, Mercer, Mineral, Monongalia, Monroe, Morgan, Nicholas, Pleasants, Pocahontas, Preston, Randolph, Ritchie, Summers, Taylor, Tucker, Tyler, Webster, Wetzel, Wirt and Wood Counties. Enrolls families prenatally through the child's fifth birthday.**

http://www.wvdhhr.org/rfts/

The Right From The Start (RFTS) Program provides home visitation services to Medicaid eligible pregnant women and infants up to one year of age. RFTS home visitors, Designated Care Coordinators (DCCs), are registered nurses or licensed social workers and use evidence-based curriculum to provide education on a range of topics pertinent to mothers and infants, including what happens during pregnancy, nutrition, the importance of prenatal care, infant care, safe sleep, postpartum depression, and more. RFTS offers a smoking cessation program for women who are interested in quitting and/or reducing tobacco use during pregnancy. Our goal is to provide a support system for mom and baby by being in the home as an educational resource, assisting in access to care, and linking mom to other needed community resources. DCCs are employed by agencies within the communities where they work, giving them unique knowledge of the availability of other services in the area. Visits are tailored according to the information and support the family may request. Participants must be eligible for WV Medicaid. **RFTS serves all 55 West Virginia Counties.**

Local Contact Information

For specific details about counties served, local contact information and enrollment, see the links below.
For Early Head Start Home-based Options see http://www.wvdhhr.org/wvhomevisitation/
For Healthy Families America (HFA), Parents as Teachers (PAT) and Maternal Health Outreach Workers (MIHOW) see http://www.wvpartners.org/documents/CURRENTListofIHFEprograms.pdf
For Right From The Start (RFTS) see http://www.wvdhhr.org/rft

Discussion Points for Providers of Prenatal or Initial Education for Parents / Caregivers

Introductory remarks:

- I know you want your baby to be happy and healthy.
- There is new information to help you keep your baby safe while she/he is sleeping – at every nap time and night sleep time during the first year. I'd like to share some very important information with you.
- The reason this information is so important is because babies can accidentally suffocate while sleeping. And these kinds of infant deaths are preventable.
- You will get lots of information and advice from many sources. Some of that advice will be wrong or outdated. It's essential to have accurate information.
- You can trust this information since it is recommended by the American Academy of Pediatrics.

  [*Hand parent(s) the pre-packaged parent education kit in the blue envelope: This Kit which includes a letter from the former WV First Lady – Joanne Jaeger Tomblin, brochure, DVD, pledge card, pen and 2 brochures about keeping cool when baby cries. The Sleep Baby Safe and Snug book may be given as well. Option: At a minimum, provide the safe sleep brochure.]*
- Every 10 days a WV baby dies form unsafe safe sleep practices or conditions.
- Do you know how to make sure your baby sleeps in a safe way? Do you know where your baby will sleep? *(Be prepared to give parents information on crib resources/options if they need it).*
- Let's look at the infant safe sleep brochure and we can review how to safely lay your baby down to sleep.

Review Key Teaching Points:

1. An easy thing to remember is **ABC** – baby sleeps **Alone**, placed on her/his **Back**, in a safe **Crib**, bassinet or portable crib.

   - **A - ALONE**:
     Baby should always sleep **alone** in a crib, portable crib, or bassinet. Not with any adults, children or pets.

     The safest place for your baby to sleep is in the room where you sleep, but not in your bed. **Room sharing – Yes. Bed sharing – No**

It's very dangerous to sleep with your baby, even in cold weather, because you could **accidentally roll over** on her/him. Or baby's **nose or mouth could be blocked** by your arm or a blanket or other item in your bed.

You'll be as tired as you have ever been and could accidentally suffocate your baby without knowing it.

Place the baby's crib, portable crib, or bassinet **near your bed** – within arm's reach. That makes it easier to breastfeed your baby. *If the Mother is breastfeeding or plans to, encourage her with additional information as follows*:

Breastfeeding is best for both you and your baby's health. Breastfeeding your baby provides protection from many illnesses and diseases. Remember – to keep baby safe, put baby alone in crib **when you finish** breastfeeding.

[For questions or more information, you may visit the WV Breastfeeding Alliance at www.wvbfa.com or you may contact the National Breastfeeding Helpline from the Office on Women's Health. The number is: 800-994-9662. M-F 9am-6pm.]

If the Mother is practicing skin-to-skin, emphasize the importance of mother staying awake and what do to if drowsy and the importance of mother being able to respond to the baby.

Twins should sleep separately.

- **B - BACK**
  Baby should always be placed to sleep on her/his **back** until one year of age.

  Many people mistakenly think babies will choke if they sleep on their backs, but actually they are **more** likely to choke if they spit up while sleeping on the stomach.

  Tummy time is important while the baby is awake and supervised.

  Once baby can intentionally roll over from back to stomach and from stomach to back, you can allow baby to stay in the position he/she prefers. But you should always start baby to sleep on the back.

- **C - CRIB**
  Always use a safe crib, bassinet or portable crib for **every** nap time and night time sleep.

Always avoid laying your baby on a **couch or arm chair** to sleep - or allowing your baby to **sleep with anyone on that kind of furniture.** Babies should also never be laid to sleep on an **adult bed, waterbed, cushion or any other soft surface** because of the risk of accidental suffocation. Babies' neck and shoulder muscles are not developed enough to enable then to move their head if their nose or mouth becomes covered and prevents their ability to breathe.

The crib should be clear of any kind of toys, stuffed animals, heavy blankets, loose blankets, unfitted sheets, bumper pads and pillows.

There should be **no loose covers or blankets** in the crib. Infant sleep clothing or a wearable blanket should be used instead of blanket or covers since these can block their air passages.

Make sure your baby is **comfortable** but doesn't become **overheated,** which is dangerous. The baby should be dressed is no more than one layer more than an adult would wear in the same circumstances.

The crib should be in good shape and meet Consumer Product Safety Commission Guidelines. **Drop-down side cribs** are banned because they are too dangerous. The **space between the crib's slats** on all 4 sides should be narrow enough so an upright soda can does not fit through the opening.

The **mattress** should be firm (not soft) and fit close to the sides, and the **sheet** should fit tightly.

Bumper pads of all kinds are very dangerous and there is no longer any reason to use them.

*[**If you are in the home at the time of this education**, ask to see the baby's sleep area. Give the parent/caregiver positive reinforcement about appropriate sleep conditions you observe. Offer nonjudgmental guidance to help the parent make corrections as needed to create a safe environment.]*

2. **Other Recommendations**

   Sitting devices such as car seats, strollers, swings, infant carriers and slings are not recommended for routine sleep.

   Consider offering a **pacifier** at naptime and night bed time while starting to sleep if the baby is receptive to it, as a protective factor. (If breastfeeding, you may start using a pacifier after the breastfeeding has been well established.)

   Prevent baby's exposure to **tobacco smoke** at home and away from home.

   Caregivers should avoid **alcohol use as well as drug use**.

   Remember, a baby's neck and shoulder muscles are not well developed, so the baby cannot turn her/his head to get out of a situation where the nose or mouth are covered or blocked. Also overheating and is dangerous.
   So… Nothing in the crib, bassinet or portable crib but your baby wearing comfortable sleep clothing on a tightly fitted sheet.

   VERY IMPORTANT DISCUSSION POINT: Who else will be with your baby at nap times and night sleep time? Make sure to tell **everybody** who will be around your baby about the safe sleep practices and show the brochure to them.

3. Here is a **7 minute DVD.** [View together with the family depending on family and situation or give to the parent for later viewing or ask that the parent reviews it on the hospital closed circuit TV.]

The DVD shows the ending of a baby shower with expectant parents, new parents, baby, grandmother and a nurse friend present. They are discussing want's safe for baby's sleep times, even if it means doing things differently than we used to.

4. **Review Additional Teaching Points:**
   - If you have any questions, I will try to answer them for you. What questions do you have?

   - Here is a **safe sleep pledge card** that you can read and sign – and keep. It includes what we just discussed. [*Hand parent pledge card and pen].* You may not have known that unsafe sleep conditions are the leading cause of injury-related deaths for WV babies. You are making great choices to keep your baby safe!!

     You can keep all of these materials. The information will be valuable to you and any others who take care of your baby. There is also a website if you want more information. (www.safesoundbabies.com.)

5. ***Keep Your Cool* brochure/messages**
   [Give the parent/caregiver the *Meet Kate* and *Meet Sean* brochures.]

   One more important infant safety precaution for anyone who is around the baby - to always keep their cool when baby cries – even if it's **for hours and hours**.

   All babies cry. It's normal.

   Sometimes they don't stop **no matter what you do**. This kind of inconsolable crying usually starts at 2 months of age and continues till around 5 months – but it WILL end.

   Have a plan in advance in case this happens and you feel like you'll lose your mind. First, make sure baby is safe in the crib, bassinet or portable crib. Then take a break and count to a hundred or listen to music or call a relative or friend or shoot some hoops for a few minutes. Call your doctor if you need advice or reassurance.

   Never, ever shake a baby. And **tell anyone** who is around your baby to never shake the baby.

6. **Closing Remarks:**
   I know you want to keep your baby safe and happy – this information will help you do that. It will also help others caring for your baby to know what to do. Please never be reluctant to ask questions. Lots of people will give you advice and you want to be sure you use accurate information.

Discussion Points for Providers of Reinforcement Education for Parents / Caregivers

For use in situations where the parent/caregiver has previously received detailed infant safe sleep education and recalls the recommendations:

1. Did you get information from a nurse while you were in the hospital or from some other source about ways to keep your baby safe while sleeping till he/she is 1 year old?

   If no, provide thorough education, using *Discussion Points for Providers of Prenatal or Initial Education of Parents/Caregivers*

   .

   If yes, provide education such as follows:

2. You will get lots of different information and advice from many sources. Some of that advice will be wrong or outdated. It's essential to have accurate information. *[Provide the safe sleep brochure and/or postcards.]*

   Do you have any questions? May we talk about recommendations to keep your baby safe while sleeping? I am happy to help. [Pause]

   Examples are:

   - **ABC** – **A**lone, placed on **B**ack, in a safe **C**rib, bassinet or portable crib – for **every night sleep time and every nap time**
   - Baby should always sleep **alone**, even in cold weather. No adults, children, pets.
   - The safest place is the room where you sleep. Place the baby's bed **near your bed** – within arm's reach. That makes it easier to **breastfeed**.
   - **Room sharing – Yes. Bed sharing – No.** People who sleep with baby could easily accidentally roll over on him/her.
   - Place baby to sleep on **back**. Even if others have told you to put babies on their stomach. There is less risk of choking if baby is on the back instead of the stomach. Tummy time is good while baby is awake and supervised.
   - Using a **couch or arm chair** for baby's sleep is dangerous. So is allowing your baby to sleep with anyone on a couch or arm chair. Same with baby sleeping on an **adult bed, waterbed, cushion or other soft surface** because of the risk of accidental suffocation.
   - **The crib should be clear of** any kind of toys, stuffed animals, heavy blankets, loose blankets, bumper pads and pillows. There should be **no loose covers or blankets** in the crib. **Sleep clothing and wearable blankets are recommended** to replace blankets.

- The space between the **crib slats** should be narrow enough so an upright soda can does not fit through.
- Firm **mattress**. **Sheet** fits tightly.
- Make sure your baby is **comfortable** and doesn't become **overheated,** which is dangerous. Appropriate sleep clothing or wearable blankets are recommended as a way to avoid using covers and blankets so your baby doesn't get **overheated** or **tangled up** in a loose cover and not be able to **breathe**.
- **Bumper pads** of all kinds are very dangerous and there is no longer any reason to use them.
- **Sitting devices** such as car seats, strollers, swings, infant carriers and slings are not recommended for routine sleep.
- Consider offering a **pacifier** at naptimes and night bedtimes while starting to sleep if the baby is receptive to it, as a protective factor. (If you are breastfeeding, you may start using a pacifier after breastfeeding has been well established.)
- Prevent baby's exposure to **tobacco smoke** at home and away from home.
- Caregivers should avoid **alcohol use as well as drug use**.
- **Remember, a baby's neck and shoulder muscles are not well developed, so the baby cannot turn her/his head to get out of a situation where the nose or mouth are covered or blocked. Also overheating is dangerous.**
  So… Nothing in the crib, bassinet or portable crib but your baby wearing comfortable sleep clothing on a tightly fitted sheet.
- **VERY IMPORTANT DISCUSSION POINT**: Who else will be with your baby at nap times and night sleep time? Make sure to tell **everybody** who will be around your baby about the safe sleep practices and show the brochure to them.

3. ***If in the home at the time of the education, observe*** *baby's sleep environment and practices. Offer reassurance and positive reinforcement for safe measures. Offer nonjudgmental guidance to help parent make corrections as needed so baby is safe.*

4. If appropriate, show the **7-minute DVD** for reinforcing your education. Or encourage viewing it when convenient.

5. **Ask who else is or will be around the baby** – regularly or from time to time. Recommend they be informed about the importance of infant safe sleep practices and conditions.

6. Give *Sleep Baby: Safe and Snug* **book** to the family

7. One more important infant safety precaution -**always keep your cool when baby cries** – even if it's **for hours and hours**. **All babies cry. It's normal**. Sometimes they don't stop no **matter what you do**.

   Have a plan in advance in case this happens and you feel like you'll lose your mind. First, make sure baby is safe in the crib. Then take a break and count to a hundred or listen to music or call a relative or friend or shoot some hoops for a few minutes. If helpful, call your doctor for reassurance and guidance.
   Never, ever shake a baby. And **tell anyone** who is around your baby to never shake the baby.

8. **Ask** if there are questions.

9. **Closing Remarks**

I know you want to keep your baby safe and happy – this information will help you do that. It will also help others caring for your baby to know what to do. Please never be reluctant to ask questions. Note website: www.safesoundbabies.com.

Cribs for Kids®

Since 1998, Cribs for Kids® National Infant Safe Sleep Initiative has been making an impact on the rate of babies dying of sleep-related death in unsafe sleeping environments. The mission of Cribs for Kids® is to prevent these deaths by educating parents and caregivers on the importance of practicing safe sleep for their babies and by providing portable cribs to families who, otherwise, cannot afford a safe place for their babies to sleep.

Also, The Cribs for Kids® National Safe Sleep Hospital Certification program awards recognition to hospitals that demonstrate a commitment to reducing infant sleep-related deaths by promoting best safe sleep practices and by educating on infant sleep safety.

For more information see: http://www.cribsforkids.org/

Guidelines for Depicting Infant Safe Sleep Images Appropriately

Correctly modeling infant safe sleep is a powerful teaching tool, as is depicting safe practices and environments in any images. Too often infants are depicted sleeping in unsafe sleep conditions, thereby sending an erroneous and harmful message to parents and caregivers.

Examples of guidelines from CJ First Candle and Cribs for Kids® about depicting infants sleeping safely are provided on the following pages.

First Candle

SAFE SLEEP

MEDIA STARS CAMPAIGN




SAFE SLEEP IMAGE GUIDELINES

FIRST CANDLE IS CALLING ON EVERYONE who creates or uses photos of babies, or products intended for sleeping babies, to pledge adherence to the following lifesaving safe sleep image guidelines:

Always Show:

- Babies being placed to sleep or sleeping on their backs.
- Cribs, portable play yards and bassinets that meet current safety standards and are free from any soft bedding items, i.e., blankets, quilts, bumper pads and stuffed animals or toys. Bassinets should not have padded sides.
- Babies sleeping ALONE; not with a parent, other adult, child or pet.
- Mattresses that fit snugly in the crib, play yard or bassinet, covered with only a fitted sheet.
- Crib mattresses at the lowest level for babies old enough to pull up or stand.

Never Show:

- Babies sleeping in positioners or on wedges.
- Babies sleeping on any surface other than a firm mattress, including a parent's chest, adult bed, sofa, chair, pillow or other unsafe place.
- Babies sleeping in car seats, swings, bouncy seats or similar products.
- Cribs, play yards and bassinets near windows, draperies or blind/shade cords.
- Crib gyms or mobiles in photos of babies who appear to be older than five months.

When Possible Show:

- Room sharing for babies younger than six months, showing the baby's separate, safe, sleep space in the room with or alongside the adult bed.
- A pacifier with a sleeping baby older than one month.
- Sleeping babies dressed in a wearable blanket or other sleeper clothing for warmth, without the use of blankets.

WHAT'S WRONG WITH THESE PHOTOS?

Bumpers, blanket, pillow

Sleeping in a car seat

Stuffed animal, blanket, soft surface

Tummy sleeping, not in a crib

First Candle
Helping Babies Survive & Thrive
2105 Laurel Bush Road Suite 201 | Bel Air, MD 21015
443.640.1049 | www.firstcandle.org

Funded by our friends at All Baby & Child, Inc.

Guidelines for Photography in Certified Safe Sleep Hospitals on their Websites or Walls

Unacceptable pictures on the websites or walls of certified safe sleep hospitals (any level) include, but are not limited to:

- photos of babies sleeping on their sides,
- photos of babies sleeping on their tummies,
- photos of babies on their tummies under fur, faux fur, pillows, hanging from a hammock, the edge of a bed, or under fluffy loose blankets,
- photos of baby with draping blanket over head of baby (peek-a-boo),
- photos of babies sharing cribs or bassinets,
- photos of babies with sleeping adults,
- photos of babies sleeping in an adult bed,
- photos of babies sleeping on a couch,
- photos of babies sleeping on chairs, or bean bags,
- photos of babies sleeping with animals,
- photos of babies sleeping on the chest of a sleeping adult,
- photos of babies in baskets,
- photos of babies sleeping in positioners or on nursing pillows,
- photos of sleeping baby with headbands or hats on,
- photos of sleeping babies with stuffed animals, and
- photos of babies in a crib/bassinet with loose blankets, pillows, stuffed animals, bumper pads, bulb syringes, extra diapers, bottles or toys.

Acceptable pictures on the websites or wall of certified safe sleep hospitals (any level) include, but are not limited to:

- photos of babies on their tummy while baby is awake (considered supervised tummy time),
- photos of babies on their side while clearly awake,
- photos of babies skin to skin while adult is awake or standing,
- photos of babies awake and bundled (no higher than the shoulder level),
- photos of babies on their backs in crib/bassinet,
- photos of babies sleeping in the arms of adult, while adult is clearly awake,
- photos of babies getting a bath,
- photos of babies with headbands or hats on while baby is clearly awake,
- photos of babies with siblings as long as they are all awake and not crib/bassinet sharing,
- photo of babies in bare crib/bassinet with no blankets, toys, pillows or stuffed animals

Rule of thumb; if it is questionable, please call Tiffany A. Price at 412-322-5680 xt.112.

Say YES To Safe Sleep For Babies Process Evaluation – Report of Findings and Recommendations

January 2015

The report that follows reflects the process evaluation conducted during the pilot phase of Say YES To Safe Sleep For Babies.

SAY YES TO SAFE SLEEP FOR BABIES

Process Evaluation

REPORT OF FINDINGS AND RECOMMENDATIONS

January, 2015

Report Prepared by:
Steven Heasley, MA
Independent Evaluator

Contents

Introduction

In 2010 TEAM for WV Children established a statewide infant safety educational campaign called Our Babies: Safe and Sound. Based on guidelines of the American Academy of Pediatrics, the campaign focuses on two areas: (1) ways to keep babies safe while sleeping, in order to prevent or reduce unintended injury or death, primarily from accidental suffocation and (2) ways to cope with frustrations resulting from frequent, constant or inconsolable baby crying. Over 240 local organizations partner with the campaign to educate families with whom they work.

In response to the increasing number of infant deaths in 2013, a task team was established to design a more intensive hospital-home visitation initiative, *Say YES to Safe Sleep for Babies*, to promote safe sleep practices with parents and caregivers of newborns. The hospital component was closely integrated with home visiting services provided to families through West Virginia's *Right From the Start Program*, as well as other evidence-based home visitation programs including *Healthy Families America* (HFA), *Maternal Infant Health Outreach Worker* (MIHOW), and *Parents As Teachers* (PAT) that are available in some parts of the state, in order to provide multiple doses of safe sleep instruction to families.

West Virginia's hospital-home visitation Safe Sleep initiative was modeled on the program at WellSpan York Hospital in York, Pa. that was implemented under the leadership of Dr. Michael Goodstein. This program has been evaluated and shown to result in a statistically significant increase in intention to follow through with supine sleep and the use of a crib. The WellSpan York Hospital program includes several key process components including:

- Education of labor and delivery staff about safe sleep practices.
- Development of educational materials and curriculum for providing safe sleep information to parents and caregivers.
- Presentation of safe sleep information and education to all parents and caregivers prior to discharge from the hospital.
- A voluntary acknowledgement statement signed by parents confirming receipt of information on infant sleep safety and acknowledging that the safest position for an infant to sleep is on the back and that sleeping with an infant increases the risk that the baby can die of SIDS.
- Public awareness and community-wide education about safe sleep practices.
- Limited follow-up with some families to reinforce the information provided during the hospital stay.

The key process components of the West Virginia program generally mirror those of the WellSpan York Hospital program with some additional elements. The pilot hospital-home visitation program in West Virginia - *Say YES to Safe Sleep for Babies* – has the following critical process components:

1. Completion of readiness activities including participation agreement, development of internal policies, and compliance with procedures related to infant safe sleep.

2. Education of labor and delivery staff at participating birthing hospitals and home visitation staff through:
    a. Face-to-face "train the trainer" regional sessions,
    b. On-line and web-based training module, and
    c. Local in-service training.
3. Development and provision of educational tools and resources to all participating hospitals and home visitation programs including:
    a. Brochure
    b. Pledge card
    c. DVD
    d. Letter from First Lady Joanne Tomblin
    e. *Sleep Baby: Safe and Snug* book
4. An ongoing public awareness campaign promoting key safe sleep messages.
5. Delivery of safe sleep education and resources to all parents or caregivers of newborns prior to discharge. (Dose I)
6. Follow-up with parents or caregivers served through home visiting programs to reinforce safe sleep practices in the home. (Dose II)
7. Regular (usually monthly) peer-to-peer conference calls with local safe sleep partners based at participating hospitals and home visiting programs to discuss implementation issues, problem solve, and share strategies.

The pilot phase of the *Say YES to Safe Sleep for Babies* initiative included twelve hospitals and twenty–two home visitation programs (see appendix for list of all participating programs). These hospitals and home visitation programs are located in geographically diverse areas throughout West Virginia. Six of the initial pilot hospitals were included in the evaluation of the pilot phase of the initiative. These six birthing hospitals are:

- Cabell Huntington Hospital,
- Greenbrier Valley Medical Center,
- Ohio Valley Medical Center,
- Princeton Community Hospital,
- Stonewall Jackson Memorial Hospital, and
- United Hospital Center.

Process Evaluation Methodology

A process evaluation focuses on program implementation. This type of evaluation is designed to examine how well program activities are carried out and the extent to which program services and content are delivered as planned. Some of the issues examined through a process evaluation include:

- Were the critical program components implemented in the intended manner?
- How was the program received by both those persons delivering the program and the intended target population?
- What barriers were encountered in delivering the program?
- How many people were reached through the program?

- Were those persons delivering the program knowledgeable and comfortable in their role?
- The extent to which various program components work well together in a manner consistent with program design.
- What changes may be needed in the way the program is being implemented to improve results?

The process evaluation for the *Say YES to Safe Sleep for Babies* pilot phase is based on multiple sources of information and includes both quantitative data collected through surveys and qualitative data from an independent review of program documents and interviews conducted by the evaluator with the state co-coordinators and other key informants.

Local labor and delivery supervisors within the six pilot hospitals participating in the evaluation and Regional Care Coordinators (RCCs) for the *Right From the Start* program completed a survey in order to capture information about their practice and experiences during the pilot phase of the initiative. This survey also provided an opportunity for these key implementers of the initiative to offer suggestions and recommendations about how program implementation might be improved. Survey responses were also collected from new parents discharged at each of the six birthing hospitals during a two week period (September 22nd through October 5th, 2014) about their experience while in the birthing hospital related to the *Say YES to Safe Sleep for Babies* initiative. Parent survey responses about how the safe sleep teachings were delivered to them provide additional process related information for evaluation purposes.

In addition to analyzing data collected through surveys of key implementers and a sample of the target population of new parents, the evaluator reviewed hospital policies, descriptions of processes used to educate parents in the six hospitals participating in the evaluation, program materials made available by the initiative, summaries of planning sessions, training content, notes from monthly conference calls, and other documents related to program design and delivery. The six hospital contacts provided additional information to the evaluator about the local process for safe sleep education at each of these hospitals during one of the monthly conference calls. A conference call was also held with HFA, MIHOW and PAT contacts and the statewide initiative co-coordinators to gain additional information about process issues related to implementation within the those home visitation programs, which were not part of the evaluation.

Specific questions addressed through the process evaluation for the pilot phase of the *Say YES to Safe Sleep for Babies* initiative include:

Is training sufficient to assure consistent and accurate safe sleep education?

- Are hospital labor and maternity staff and *Right From the Start* staff adequately trained in program content?

Are the safe sleep teachings delivered to the target population in an effective manner?

- Is the program content delivered to the target population?
- Is the program content delivered in a manner consistent with the program design?
- Is the program content delivered to the target population in an effective manner?
- Does the target population receive both dose 1 and dose 2 of the safe sleep information?

Does the target population understand and agree with the program teachings?

- Is the information provided through the program well received by the target population?
- Does the target population (parents and caregivers) understand the information provided?
- Do local and regional staff providing safe sleep instruction to the target population agree with all safe sleep practices?

Is delivery of program content supported through materials, resources, and statewide coordination and support?

- Are materials and resources to support the instruction made available as needed?
- Are local and regional programs delivering the *Say YES to Safe Sleep for Babies* program content adequately supported by the statewide program infrastructure?
- Are peer-to-peer conference calls useful and valued by local and regional programs participating in the initiative?

Do birthing hospitals and local home visitation programs work together well to deliver dose 1 and dose 2 education?

- Do participating hospitals and home visitation programs work together well in delivering the program content to the target population?

The overall evaluation design of the *Say YES to Safe Sleep for Babies* pilot phase also includes an outcomes evaluation component which will address the degree to which parents and caregivers exposed to the pilot hospital-home visitation program report knowledge of safe sleep practices prior to discharge from the hospital and actually employ safe sleep practices in the home two months after discharge. Over the longer term, a review of any available data related to reduced incidence of unintended injury and death that may be attributable to increased prevalence of safe sleep practices with infants will also be examined. These outcomes will be discussed in a separate report.

The process evaluation summarized in this report is useful in order to provide information about why the *Say YES to Safe Sleep for Babies* initiative was or was not effective and to examine issues related to implementation during the pilot phase of the initiative that can be used to improve program design, sustainability and outcomes in the future.

Evaluation Findings

Is Training Sufficient to Assure Consistent and Accurate Safe Sleep Education?

Two regional "train the trainers" sessions were provided in November of 2013 for key contacts of hospitals and home visitation programs prior to implementation of the *Say YES to Safe Sleep for Babies* pilot phase. The train the trainer sessions appear to be effective in preparing local program participants to deliver the *Say YES to Safe Sleep for Babies* program content to the target audience. Evaluation forms completed by training participants following the training indicate that a very high percentage of all participants found the training session to be useful and informative and participants reported

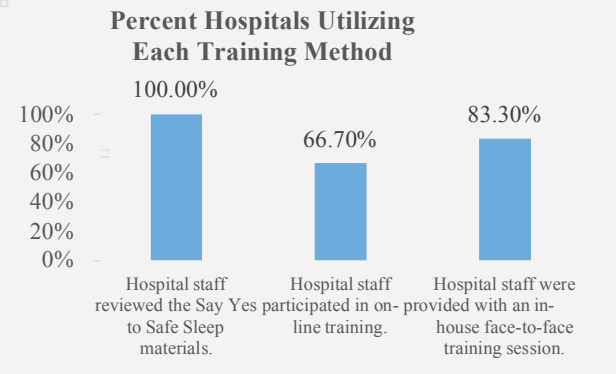
> *"The leadership and commitment of the local partners during the pilot phase will have a lasting impact on the safety of our babies in West Virginia."*
>
> - Initiative Statewide Co-Coordinators

they had "a good working knowledge about elements of infant safe sleep" and were "comfortable using the safe sleep messages and tools with parents".

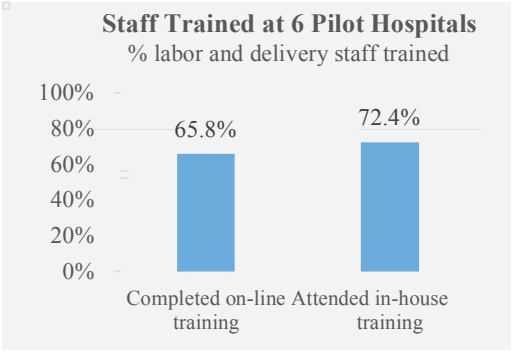
An on-line training module (webinar) was also developed and made available in 2013. Completion of the on-line training was required for those hospitals and home visiting programs participating in the *Say YES to Safe Sleep for Babies* pilot project. A scan of the evaluations completed by those persons completing the on-line training during calendar year 2013 indicate the on-line training session is also an effective means of preparing hospital and home visiting staff delivering the safe sleep messages to parents and caregivers.

Training in Pilot Hospitals

The local key contacts at the six pilot hospitals participating in the evaluation reported training labor and delivery staff in the safe sleep program content prior to implementing the program within each of the hospitals. 100% of the hospitals reviewed the *Say YES to Safe Sleep for Babies* materials with staff and five of the six hospitals (83.3%) provided staff with a local in-house face-to-face training session. Four of the six hospitals (66.7%) required staff to complete the web-based one-hour on-line training.



A total of 142 nursing staff employed by the six birthing hospitals participated in an in-house training session. This was 72.4% of all labor and delivery nursing staff employed at these hospitals.

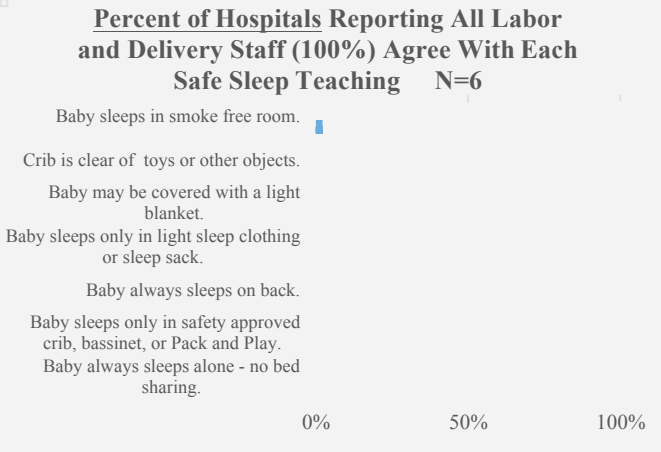


129 labor and delivery nursing staff completed the on-line training module - 65.8% of the total labor and delivery nursing staff employed at the six hospitals. One of the hospital contacts completing the survey said they would like to see a more condensed version of the on-line training developed and the length of the training module may be a factor as to why some staff do not complete the on-line training.

Additional steps taken by some pilot hospitals prior to launching the initiative included developing a hospital policy and training labor and delivery staff on hospital policy and procedure related to safe sleep practices. Five of the six hospitals included in the evaluation developed a local safe sleep policy and trained staff on in-house policy and procedures. Four of the six hospitals also developed an audit process to assure safe sleep practices were adhered to within the labor and delivery unit. Two of the hospitals developed additional parent education materials to supplement the materials and resources provided by the statewide program.

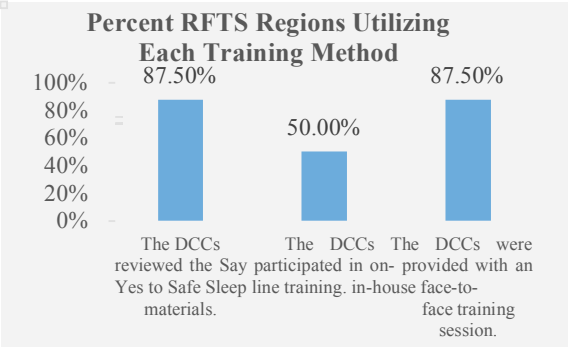
The hospital contacts in each of the six hospitals participating in the evaluation were also asked about the level of agreement among the hospital labor and delivery staff related to each of the

safe sleep practices. Practices that are fully agreed with are likely to be more effectively conveyed to parents than those that may be less fully accepted by hospital staff.

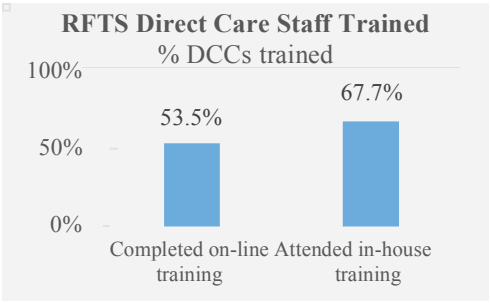


The only "specific teaching" that all six hospital contacts believe all labor and delivery staff (100% agreement) fully agree upon is "baby sleeps in smoke free room". Five of the six hospitals reported a high level of agreement that the crib should be clear of any toys, heavy or loose blankets, bumper pads, pillows, or other objects. Other teachings appear to be somewhat less fully accepted by hospital staff; however, the evaluation design does not allow for specific conclusions to be reached about the level of overall staff agreement with each of the safe sleep teachings.

Training by *Right From the Start*



Each of the eight Regional Care Coordinators reported training direct care staff (DCCs) in their region after attending the "train the trainers" session. Seven of the eight regions (87.5%) reviewed the *Say YES to Safe Sleep for Babies* materials with staff, seven regions also reported providing a face-to-face regional training session for direct care staff. Four of the eight regions (50%) had their direct care staff complete the on-line training module.



Across all eight RFTS regions, eighty-six (86) direct care staff have attended a face-to-face training session about the *Say YES to Safe Sleep for Babies* initiative representing 67.7% of all staff involved in providing the safe sleep teachings. A total of 68 RFTS direct care staff have completed the on-line training module representing just over half (53.5%) of the total direct care staff.

Comments provided by RFTS regional coordinators (RCCs) on the process survey indicate all newly hired direct care staff are now required to complete the on-line safe sleep training module.

Six of the eight Regional Care Coordinators reported they had completed the on-line training module through the Our Babies Safe and **S**ound website.

Based on the survey responses from the RFTS Regional Care Coordinators, there is a high degree of agreement with all safe sleep teachings among the direct care RFTS staff. Seven of the

eight regional coordinators reported 100% agreement of direct care staff with all safe sleep teachings and the remaining coordinator indicated 100% agreement with all teachings other than "baby may be covered with a light blanket".

Are Safe Sleep Teachings Delivered to the Target Population in an Effective Manner?

Dose 1 Delivery in Hospitals

Research indicates learning is most effective when program content is delivered in a multi-modal manner. Discussing the safe sleep information with the parent and demonstrating (modeling) safe sleep practices for the parent are teaching strategies more likely to result in retention of the information than simply having the parent read the information or view the video.

All hospitals included in the evaluation reported they provide safe sleep information to parents through one or more modalities prior to discharge from the hospital. All six hospitals (100%) said "a nurse or other trained staff person discusses the information about *Say YES to Safe Sleep for Babies* with the parent". Five of the six hospitals also provide the safe sleep information for the parent(s) to review on their own and four play the video presentation for parents to view in their rooms.

When asked how safe sleep practices are modeled in the hospital if labor and delivery staff observe parents engaging in non-recommended practice, all six hospital contacts reported "staff correct the situation and remind the parent about the recommended safe sleep practice".

A sampling of new parents discharged at the six hospitals included in the evaluation were asked: "How did you receive information about Infant Safe Sleep while in the hospital?" Eighty-two parents responded to this question representing 41.4% of the total number of births over the two week period when parent surveys were collected (September 22nd through October 4th of 2014).

829 % of the parents completing the survey indicated they received the "packet of information" however, only 51.2% of the parents completing the survey prior to discharge said "a nurse discussed the information about *Say Yes to Safe Sleep for Babies* with me". 40.2% said they watched the video about Say Yes to Safe Sleep for Babies during their hospital stay; 3 of the 82 parents completing the survey (3.7%) indicated they did not receive any information about *Say YES to Safe Sleep for Babies* while in the hospital.

Dose 1 and/or 2 Delivery by RFTS

In addition to providing dose 2 education after birth, all eight of the RFTS regions reported they provide dose 1 during the pre-natal period to families they serve. All eight RFTS Regional Care Coordinators indicated in their survey responses that RFTS enrolled families are exposed to the safe sleep materials and teachings prior to entering a birthing hospital. The *Say YES to Safe Sleep*

for Babies information is provided to parents and caregivers in seven of the eight RFTS regions through a multi-modal approach. Survey responses indicate the video presentation is used to educate the parent or caregiver in all eight RFTS regions and direct care staff in at least seven of the eight regions also discuss the dose 2 information directly with the parent or caregiver during face-to-face educational sessions in the home.

> *"DCC's determine on a case by case basis how to best present information. Materials are minimally reviewed during 3rd trimester and during visit postpartum. Material may also be reviewed 2nd trimester or when discussing preparation for baby earlier in pregnancy. Safe sleep and tummy time are reviewed as needed in all visits."*
>
> - RFTS Regional Care Coordinator

Does the Target Population Understand and Agree with the Program Teachings?

When hospital safe sleep coordinators and RFTS regional coordinators were asked if they think parents understand the information provided, four of the six hospital contacts (66.7%) and five of the eight RFTS coordinators (62.5%) indicated they thought "parents fully understand all of the information". The remaining hospital contacts and RFTS regional supervisors believe parents "understand some of the information".

> *"We receive a lot of feedback stating other family members etc. are instructing clients on unsafe practices (giving bad advice)".*
>
> - RFTS Regional

Five of the six hospital contacts and five of the eight RFTS regional coordinators also indicated they thought the level of information provided to parents about safe sleep for babies was "just right". Remaining hospital contacts and RFTS coordinators indicated they thought there was "not enough" information provided.

Parent understanding of the safe sleep teachings was also assessed through the survey completed by eighty-one new parents and one grandparent prior to discharge at the six hospitals over a two week period. Parents were asked if they understood the information provided to them about infant safe sleep and 96.3% of all parents completing the survey indicated they "fully understand the information". Only one parent said they did not understand a lot of the information. Thus, it appears that the vast majority of parents feel confident that they fully understand the safe sleep teachings.

> *"I think parents fully understand what they are being taught but some choose to practice otherwise despite the education provided."*
>
> - Hospital Safe Sleep Contact

When asked if they agree with the information about safe sleep provided to them in the hospital, 85.2% of the parents said they "fully agree with everything they learned about safe sleep for babies". The remaining 14.8% of parents indicated they "agree with most of the information but not everything". Almost all (97.5%) of the parents surveyed also reported the information provided to them about safe sleep for babies was "just right". Only one parent felt the information was too much and only one felt it was not enough.

Is Program Delivery Supported through Materials, Resources, and Statewide Coordination?

Birthing hospitals and RFTS staff appear to have access to all *Say YES to Safe Sleep for Babies* resources and materials as needed. All hospital contacts and RFTS regional coordinators said they had access to all materials in a timely fashion. The *Sleep Baby: Safe and Snug* book has been cited by several local providers as a particularly useful resource.

All (100%) of the hospital contacts and RFTS regional coordinators also reported that the *Say YES to Safe Sleep for Babies* statewide coordinators have provided them with "all necessary support and assistance". The monthly peer-to peer conference calls hosted by the statewide coordinators is also generally found to be useful by all six of the birthing hospitals. Four of the six (66.7%) hospital contacts find the calls to be "extremely useful" and the remaining two indicate the calls are "somewhat useful". Comments about the conference calls from the pilot hospitals indicate the calls are good way to share safe sleep education strategies – *"We have exchanged many good ideas with other hospital contacts".*

RFTS Regional Care Coordinators (RCCs) are less enthusiastic about the peer-to-peer conference calls – two of the eight RCCs think the calls are "extremely useful" and four find the calls to be "somewhat useful". One coordinator responded that the calls were "not very useful", and one said the calls were "not useful at all". RFTS RCCs commented that the calls could be every two months and one RCC respondent said they did not always have information to review prior to the call.

Interviews with the statewide co-coordinators of the initiative provide anecdotal information about the value of First Lady Joanne Tomblin's involvement and support for the *Say YES to Safe Sleep for Babies* initiative. Hospitals and home visitation programs have responded quite favorably to the First Lady's appeals to participate in the program and her involvement has also increased public awareness and attention to the safe sleep messages through public appearances and resulting media coverage.

Do Birthing Hospitals and Local Home Visiting Programs Work Together Well?

Regional Care Coordinators report working with all twelve pilot hospitals during 2014. Two different RFTS regions worked with Cabell-Huntington Hospital and CAMC and one RFTS region worked with each of the remaining ten hospitals.

The type of working relationship between birthing hospitals and the *Right From the Start* program appears to vary from region to region. When asked to specify the type of working relationship with birthing hospitals in the region, one RFTS Regional Care Coordinator said they were based at a birthing hospital and had a "close working relationship" with hospital labor and maternity staff. Four of the seven regional coordinators responding to this question indicated they were not based at a hospital but "worked with labor and delivery staff". Two of the RCCs said they receive information and referrals from birthing hospitals but "do not work closely with hospital staff". One respondent skipped over the question. When asked how the RFTS program works with hospital staff to "reinforce safe sleep practices for clients or families eligible for RFTS, the RCCs report different levels of coordination across the eight regions. Two regions

report communication with hospital staff prior to admission and RFTS staff in four of the regions regularly meet with hospital labor and delivery staff to coordinate services. In four of the eight regions, the RCC also indicates the hospital makes referrals for follow-up after discharge. Based on the survey responses, RFTS staff in three regions participate in joint training sessions with hospital labor and delivery staff about safe sleep for infants.

Feedback received from the six birthing hospitals included in the process evaluation of the *Say YES to Safe Sleep for Babies* pilot reflects a less formal and less intense working relationship between these hospitals and the RFTS program. Five of the six hospitals report they "are aware of the RFTS program but do not work closely with RFTS staff". Also, when asked how they work with RFTS to reinforce the safe sleep practices, three of the six pilot hospitals (50%) that are included in the evaluation indicate "hospital staff have little planned contact or communication with RFTS staff". One of the hospitals does report they have participated in joint training sessions with RFTS staff about safe sleep.

Regarding linkage with HFA, PAT and MIHOW, Five of the eight RFTS regions "work closely with other home visiting programs serving the area to assure the *Say YES to Safe Sleep* practices are reinforced" after discharge from a birthing hospital. An additional two regions "are aware of other home visiting programs but do not have a close working relationship with them, and one RFTS region reports they are not aware of any other home visiting programs serving the region. In the seven regions where other home visiting services are available, RFTS Regional Care Coordinators report that staff refer families to other home visiting programs for continued follow-up and support after RFTS services end. Estimated referral rates range from a high of 90% of RFTS families being referred for continued home visiting services in one region to a low of 10% in some other regions.

None of the six birthing hospitals included in the evaluation appear to have a working relationship with other home visiting programs such as Parents As Teachers, MIHOW, or Healthy Families America. Half of these pilot hospitals (3 of 6) indicate in survey responses that they are not aware of any other home visiting programs serving their area and the other three hospitals are aware of other programs but do not have a close working relationship with them. One of the birthing hospitals does report that hospital staff have made referrals to a home visiting program (other than RFTS) for follow-up after discharge.

Conclusions and Recommendations

General Conclusions and Recommendations

The *Say YES to Safe Sleep for Babies* initiative in West Virginia appears to have been successfully implemented during the hospital-home visitation pilot phase. Generally speaking, the basic parameters of the program model were carried out by all participants.

> *The pilot phase has resulted in a firm foundation for sustaining and expanding the program to reach all births in the state.*
>
> - Statewide Co-coordinators

Although the pilot phase was reasonably well defined in terms of the expectations of local providers, there was a considerable degree of variation in how the pilot hospitals and home visitation programs trained staff,

delivered the safe sleep teachings, and otherwise implemented the initiative. Flexibility was permitted during the pilot phase as to specific procedures and standards that would be adhered to at each local site.

As the initiative moves beyond the pilot phase to include more local providers, it is recommended that program guidelines or standards be more explicitly defined and adhered to in order to assure that the safe sleep teachings are delivered in a consistent manner at all locations. A number of specific conclusions and recommendations are listed in the following section to improve the fidelity of the *Say YES to Safe Sleep for Babies* program statewide.

Specific Conclusions and Recommendations

Conclusion 1: Regional train-the-trainers sessions are an effective way to provide an orientation to the program requirements and train key local contacts to implement the *Say YES to Safe Sleep for Babies* initiative through birthing hospitals and home visitation programs.

Recommendation 1: Additional train-the-trainers orientation sessions should be held as needed for new hospitals and home visitation programs joining the initiative.

Conclusion 2: All hospitals included in the evaluation trained labor and delivery staff in safe sleep practices and use of the "*Say YES to Safe Sleep for Babies*" materials.

Conclusion 3: Not all hospitals provided labor and delivery staff with an in-house training session and not all required completion of the on-line training module.

Recommendation 2: In order to improve fidelity to the program model, local birthing hospitals participating in the Say YES to Safe Sleep for Babies initiative should be required to train all labor and maternity staff through both (1) an in-house training session and (2) the on-line webinar.

Recommendation 3: As the on-line training module is revised and updated, feedback from training participants as to length and content should be considered.

Conclusion 4: Not all hospitals developed a specific policy related to safe sleep practices and auditing procedures to verify compliance with policy.

Recommendation 4: In order to improve fidelity to the program model, all participating hospitals should be required to adopt formal policy and procedures consistent with safe sleep practices.

Conclusion 5: All RFTS direct care staff have received some training in safe sleep practices and use of the "*Say YES to Safe Sleep for Babies*" materials.

Conclusion 6: Not all RFTS direct care staff have completed the on-line training module.

Recommendation 5: The program may wish to require that all staff providing home visiting services complete the on-line module in order to establish a uniform training requirement related to safe sleep education with families.

Conclusion 7: All six hospitals included in the evaluation reported providing safe sleep education by discussing the information with the parent; however, only about half of the parents surveyed reported that the information was discussed with them by nursing staff.

Recommendation 6: The Say YES to Safe Sleep for Babies initiative should take steps to assure that the dose 1 information is provided to all new parents through a dialogue with labor and maternity staff since this is a more effective way to provide the teachings than having parents read the materials or view the video alone.

Conclusion 8: Hospital staff report effective modeling of safe sleep practices and correction of unsafe practices while the baby is in the hospital.

Recommendation 7: Hospital staff should continue to model safe sleep practices and correct any unsafe practices by parents that may be observed while in the hospital.

Conclusion 9: Although safe sleep education is provided to parents by the birthing hospitals through several different modalities, not all hospitals appear to utilize a multi-modal learning approach.

Recommendation 8: The Say YES to Safe Sleep for Babies program may wish to further clarify how the materials and instruction should be provided to parents and caregivers prior to discharge in order to provide more consistency related to content delivery.

Conclusion 10: Education about safe sleep practices is provided by RFTS staff to all families served through the RFTS program.

Conclusion 11: Seven of the eight RFTS regions report providing additional instruction through discussion of the materials with the parent.

Recommendation 9: The Say YES to Safe Sleep for Babies program may wish to provide further guidance as to how the materials and instruction should be provided through discussion with parents and caregivers during home visits in order to improve consistency of content delivery.

Conclusion 12: The target population understands the information provided about safe sleep for babies; however, there are indications that advice from family members and other influences affect actual practice in the home.

Recommendation 10: Efforts to educate the general public about infant safe sleep should be continued and enhanced to the degree possible.

Recommendation 11: The dose 1 and 2 messaging related to "tell others about safe sleep" should be emphasized.

Conclusion 13: There is general agreement among both professionals delivering program content and parents receiving the information that the amount of information provided is appropriate.

Recommendation 12: Content dosage should continue to be provided at the current level.

Conclusion 14: The involvement and support of First Lady Joanne Tomblin has been extremely helpful in bringing public attention to the *Say YES to Safe Sleep for Babies* campaign.

Recommendation 13: Continue involvement of the First Lady in order to recruit more Dose I and II providers, promote the "Say YES" teachings, and increase public awareness.

Conclusion 15: Local safe sleep educators report a generally high level of support from the statewide *Say YES to Safe Sleep for Babies* initiative and have access to materials, resources, and the statewide coordinators as needed.

Recommendation 14: Statewide coordination and support should continue to be provided in order to assure local programs have access to needed resources and to monitor compliance with necessary requirements and standards.

Conclusion 16: Monthly peer-to-peer calls appear to be more useful to hospital contacts than they are to RFTS coordinators.

Conclusion 17: Few home-based family education programs (other than RFTS) participate in the monthly peer-to-peer calls.

Recommendation 15: Topics for discussion on peer-to-peer calls should be of interest to both hospitals and home visiting programs.

Recommendation 16: Peer-to peer calls with established programs should be held only as necessary and useful.

Conclusion 18: The RFTS program maintains a working relationship with at least some of the birthing hospitals serving each of the eight regions; however, the type and intensity of the relationship varies from one region to another.

Conclusion 19: None of the six birthing hospitals participating in the process evaluation report a sufficiently well-developed working relationship with either the RFTS program or with other home visiting programs to assure families served by these programs receive dose 2 follow-up and reinforcement of the safe sleep practices after babies are discharged from the hospital.

Conclusion 20: Working relationships related to continued follow-up and promotion of safe sleep practices appear to be reasonably good between the RFTS program and other home visiting programs in regions where other home visiting programs are available.

Recommendation 17: Adoption of formal standards or guidelines related to procedures for dose 2 follow-up after birth may be necessary to assure safe sleep practices are reinforced after discharge from the birthing hospital.

Recommendation 18: Local face-to-face joint training opportunities that include RFTS, staff of other home visiting programs, and hospital labor and delivery staff may be an effective way to promote closer working relationships between hospitals providing dose 1 and programs providing dose 2 after the birth.

Recommended Next Steps

- Based on the findings from the process evaluation, the hospital-home visitation *Say YES to Safe Sleep for Babies* initiative should be expanded to include all birthing hospitals and home visitation programs in West Virginia.

- The planned outcomes evaluation should be conducted as soon as possible in order to determine the extent to which parents and caregivers of infants are adhering to safe sleep practices in their homes after discharge from the hospital.

- Sudden Unexpected Infant Death (SUID) data should be analyzed to the extent possible in order to determine what factors influence the prevalence of infant death and how those factors might be addressed through the *Say YES to Safe Sleep for Babies* initiative in future years.

- Basic process data should be routinely collected by all participating hospitals and home visitation programs and reported to a statewide coordinating entity on a regular basis. The monitoring of basic process indicators can provide for an acceptable degree of assurance that the dose 1 and dose 2 program content is being delivered in a manner consistent with participation requirements.

- Ongoing reporting of process data should include but not necessarily be limited to:
    - Number of hospital labor and delivery staff delivering dose 1 program content.
    - Number of labor and delivery staff completing the on-line training module.
    - Number of births at participating hospitals.
    - Number of families with newborns who receive dose 1 program content prior to discharge from hospital.
    - Percent families with newborns receiving dose 1 program content prior to discharge from birthing hospital.
    - Number of families referred to home visitation program for follow-up after discharge from birthing hospital.
    - Number of home visiting staff delivering dose 2 program content.
    - Number of home visiting staff completing on-line training module.

- Number of families receiving dose 2 program content from home visitation program after discharge from birthing hospital.
- Percent families receiving dose 2 program content after discharge from birthing hospital.

Appendix

List of Participating Hospitals and Home Visitation Programs – Pilot Phase

Pilot Hospitals	**Pilot Home Visitation Programs**
Bluefield Regional Medical Center Cabell Huntington Hospital CAMC Women and Children's Hospital, Neonatal Intensive Care Unit Garrett County Memorial Hospital Greenbrier Valley Medical Center Ohio Valley Medical Center Princeton Community Hospital St. Joseph's Hospital of Buckhannon, Inc. St. Mary's Medical Center Stonewall Jackson Memorial Hospital United Hospital Center Wheeling Hospital	ABLE Families, Inc., MIHOW Children's Home Society of WV, Parents As Teachers Program Cornerstone Family Interventions, Parents As Teachers Program Doddridge County Starting Points Family Resource Center, Parents As Teachers Program Marshall County Starting Points for Family Resource Center, Parents As Teachers Program Monroe County Head Start/Early Head Start, Parents As Teachers Program Mountain State Healthy Families, Healthy Families America Program Northern Panhandle Head Start, MIHOW Preston County Caring Council, Inc./Taylor County Starts Points Family Resource Center, Parents As Teachers Program REACCH Family Resource Center, Parents As Teachers Program Right From The Start, Regions I-VIII The Community Crossing, Parents As Teachers Program Tucker County Family Resource Network, Parents As Teachers Program Upper Kanawha Valley Start Points Family Resource Center, Parents As Teachers Program

Say YES To Safe Sleep For Babies Outcomes Evaluation – Report of Findings and Recommendations

June 2015

The report that follows reflects the outcomes evaluation conducted at the end of the pilot phase of Say YES To Safe Sleep For Babies.

SAY YES TO SAFE SLEEP FOR BABIES

Outcomes Evaluation

REPORT OF FINDINGS AND RECOMMENDATIONS

June, 2015

Report Prepared by:
Steven Heasley, MA
Independent Evaluator

Contents

Introduction

In 2010 TEAM for WV Children established a statewide infant safety educational campaign called Our Babies: Safe and Sound. Based on guidelines of the American Academy of Pediatrics, the campaign focuses on two areas: (1) ways to keep babies safe while sleeping, in order to prevent or reduce unintended injury or death, primarily from accidental suffocation and (2) ways to cope with frustrations resulting from frequent, constant or inconsolable baby crying. Over 240 local organizations partner with the campaign to educate families with whom they work.

In response to the increasing number of infant deaths in 2013, a task team was established to design a more intensive hospital-home visitation initiative, *Say YES to Safe Sleep for Babies*, to promote safe sleep practices with parents and caregivers of newborns. The hospital component was closely integrated with home visiting services provided to families through West Virginia's *Right From the Start Program*, as well as other evidence-based home visitation programs including *Healthy Families America* (HFA), *Maternal Infant Health Outreach Worker* (MIHOW), and *Parents As Teachers* (PAT) that are available in some parts of the state, in order to provide multiple doses of safe sleep instruction to families.

The pilot phase of the *Say YES to Safe Sleep for Babies* initiative included twelve hospitals and twenty–two home visitation programs (see appendix for list of all participating programs). These hospitals and home visitation programs are located in geographically diverse areas throughout West Virginia.

Outcomes data was collected on families who had babies at six of the initial pilot hospitals. These six birthing hospitals participating in the evaluation are:

- Cabell Huntington Hospital, Huntington, WV
- Greenbrier Valley Medical Center, Lewisburg, WV
- Ohio Valley Medical Center, Wheeling, WV
- Princeton Community Hospital, Princeton, WV
- Stonewall Jackson Memorial Hospital, Weston, WV and
- United Hospital Center, Clarksburg, WV.

Outcomes Evaluation Methodology

Outcomes evaluation focuses on the degree to which an intervention results in obtaining desired results.

The outcomes evaluation for the *Say YES to Safe Sleep for Babies* initiative was designed to answer three key questions. These questions were examined through data collected from two separate cohorts of parents who had their babies at one of the six birthing hospitals participating in the evaluation.

1. Do families exposed to the safe sleep program teachings understand and demonstrate knowledge of the *Say YES to Safe Sleep for Babies* program content? (Cohort 1)
2. Do the families exposed to the safe sleep program teachings agree with and intend to adhere to the safe sleep practices when they leave the birthing hospital? (Cohort 1)

3. Do families exposed to the safe sleep program teachings actually adhere to safe sleep practices in the home at approximately two months after birth? (Cohort 2)

Questions 1 & 2, related to the degree to which parents demonstrate knowledge of the safe sleep teachings and intend to apply safe sleep practices in the home with their infants, are examined through analysis of information collected from a survey of 82 parents (cohort 1) who were discharged from one of the six birthing hospitals participating in the evaluation during the two week period September 22nd to October 5th, 2014. Parents discharged during this period completed a survey before leaving the birthing hospital that included a number of questions about how well they understand the safe sleep teachings, their level of agreement with the practices, and their expectations about implementing the practices in the home after discharge. The mother completed the survey 94% of the time (77 of the 82 respondents). Remaining surveys were completed by fathers (4) and a grandmother (1). This cohort of 82 parents or caregivers who completed the survey prior to discharge from the six birthing hospitals were provided with the dose 1 safe sleep education while in the hospital.

It is not known to what extent the parents/caretakers making up cohort 1 were exposed to the dose 1 safe sleep education prior to entering the birthing hospital or to what extent they may have received the dose 2 safe sleep education after leaving the hospital. Tracking this particular cohort after discharge was beyond the scope of the evaluation.

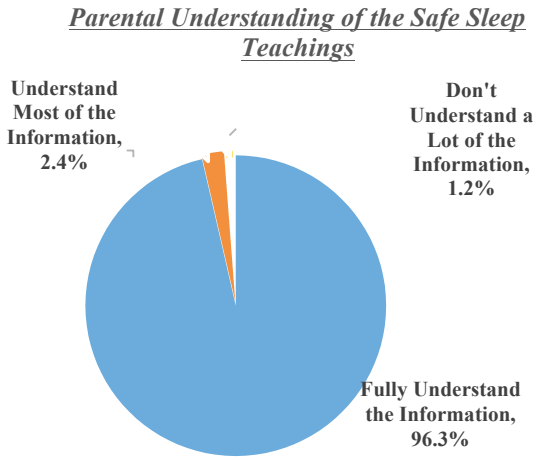
In order to examine question 3 (*Do families exposed to the safe sleep program teachings actually adhere to safe sleep practices in the home at approximately two months after birth?*), a second survey was designed to capture information about post-partum safe sleep practices in the home by families enrolled in the *Right From the Start* (RFTS) program. This survey was completed by Direct Care Coordinators (DCCs) for the RFTS program in order to capture information about safe sleep practices in the home by enrolled families at approximately 2 months post-partum. Information was collected through this survey for families enrolled in the RFTS program who had a birth at one of the six birthing hospitals participating in the evaluation during the months of November, December, and January. RFTS direct care staff were asked a series of questions about their observations of safe sleep practices in the home at the time the case was closed (typically 2 months after the birth of the baby).

Nearly all of the 66 families included in cohort 2 who were served by the RFTS program were provided with dose 1 safe sleep education while in the hospital and also received dose 2 follow-up safe sleep education after returning home with the baby. Only one of the families within this cohort failed to receive both dose 1 and dose 2 safe sleep education. The RFTS home visitors also reported 78.8% of the families within this cohort received dose 1 safe sleep education from RFTS staff prior to entering the birthing hospital.

Evaluation Findings

Parental Knowledge of Safe Sleep Practices

When asked how well they understood the information provided to them about infant safe sleep, 96.3% of the parents and caregivers indicated they "fully understood" the information. An additional 2.4% (2 people) said they understood most of the information. One respondent said they did not understand a lot of the information.



Parents and caregivers were asked to respond to a series of True-False statements in order to assess their knowledge of safe sleep practices. A high percentage of all parents/caregivers selected the correct response for each statement. The statements and percentage of correct responses are summarized in the Table 1 below.

Table 1

Statement	**Percent Correct Responses**
It is safest for my baby to sleep in the same bed with the mother. (F)	98.6%
My baby should sleep on his/her back and in a crib or bassinet. (T)	100%
It is OK to let my baby sleep with a stuffed animal or plush toy since this is comforting for the baby. (F)	98.8%
It is safest for my baby to sleep alone. (T)	92.6%
There should be no bumper pads in the crib with my baby. (T)	88.5%
It is OK if there is a warm quilt or comforter in the crib with my baby. (F)	91.4%
My baby should always sleep in rooms that are smoke free. (T)	97.6%
While sleeping, my baby should only have a diaper, sleeper or sleep sack. (T)	93.8%

Although nearly all parents appear to understand the recommended safe sleep practices, the survey responses indicate some degree of uncertainty about the use of bumper pads and blankets in the crib, and also about appropriate sleep clothing among some (6% to 11%) of the parents/caregivers in the cohort.

Parental Understanding of Safe Sleep Teachings

Questions were also included in the parent survey administered prior to discharge from the birthing hospital that were designed to assess the degree to which parents/caregivers agree with the safe sleep practices.

When asked: "How much do you agree with the information about safe sleep for babies provided to you in the hospital?" 85.2% of the parents/caregivers said they "fully agree with everything I learned about safe sleep for babies". The remaining 14.8% of the parents/caregivers (12 people) said they "agree with most of the information but not everything".

Survey respondents were also presented with several statements related to safe sleep practices and asked to indicate "how much" they agree or disagree with each statement. A five point Likert type scale ranging from "Strongly Agree" to "Strongly Disagree" was used to assess the level of agreement or disagreement with each of the statements. Statements were intentionally designed to require a degree of judgement on the part of the respondent in order to identify safe sleep practices that may not be fully understood. Each statement and the percentage of parents/caregivers responding in agreement or disagreement with the statement is summarized in Table 2.

Table 2

Statement	**Percent Agreement**	**Percent Disagreement**
It is OK for my baby to sleep in the same bed with me if I am breast feeding.	9.0%	91.0%
My baby should only sleep alone in a safety approved crib, bassinet, or pack and play.	97.5%	2.5%
My baby should be bundled in a warm blanket to be sure he or she doesn't get too cold while sleeping.	43.7%	56.4%
Bumper pads help keep my baby from getting stuck in the side of the crib.	39.8%	60.2%
It is OK for my baby to sleep on his or her tummy sometimes.	13.6%	86.4%
It is important for me to talk to anyone caring for my baby about safe sleep.	98.7%	1.3%

Note: "Percent Agreement" in above table reflects the percentage of parents/caregivers who either strongly agree or agree with the statement. "Percent Disagreement" reflects the percentage of parents who strongly disagree or disagree with the statement.

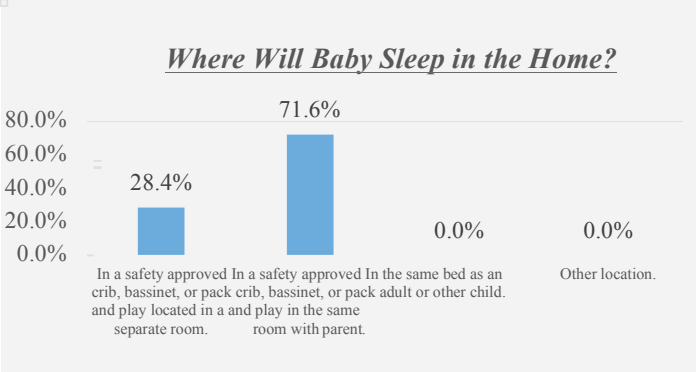
Responses to these statements about safe sleep practices indicate a high percentage of parents/caregivers exposed to dose 1 education have a good understanding of safe sleep teachings related to the baby sleeping alone; sleeping in an approved crib, pack and play, or bassinet; and sleeping on their back. The survey respondents also believe it is important to talk with anyone caring for their baby about safe sleep.

There appears to be far less understanding and/or agreement among these parents/caregivers about the use of blankets and crib bumpers.

Parental Intention Related to Safe Sleep in the Home

A few questions were also included in the pre-discharge parent survey about where baby will be sleeping when baby is taken home. Survey respondents were asked: "When you get home where will your baby be sleeping?"

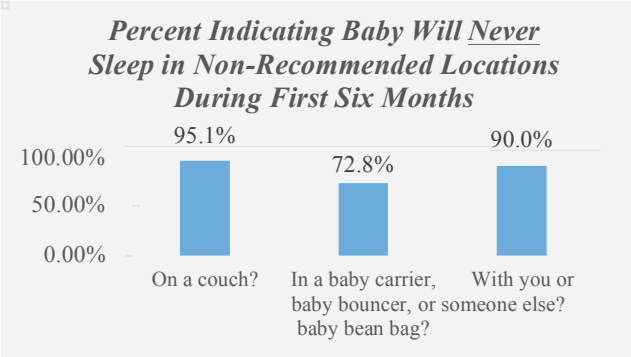
28.4% of the parents/caregivers indicated their baby would sleep in an approved crib, bassinet, or pack and play located in a separate room and the remaining 71.6% said the baby would be sleeping in a safety approved crib, bassinet, or pack and play in the same room with parent(s).



None of the survey respondents indicated the baby would be sleeping with an adult or other child, or in any other location within the home.

Parents/caregivers were also asked how often they thought their baby would sleep in non-recommended locations over the next six months.

Respondents were somewhat less certain about baby sleeping only in approved crib, bassinet, or pack and play when responding to this question.

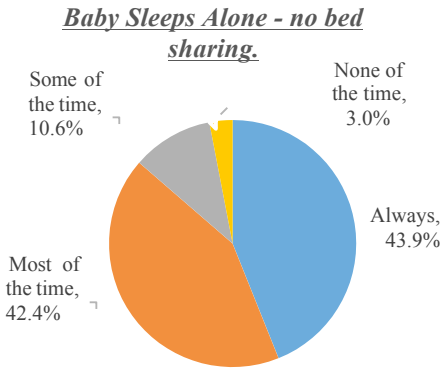


90% of the parents/caregivers said baby would never sleep with them or someone else and 95.1% said baby would never sleep on a couch. However, 27.2% of survey respondents expect that baby may sometimes sleep in a baby carrier, baby bouncer, or baby bean bag.

Safe Sleep Practices in the Home – Two Months Post-Partum

Direct Care staff for the *Right From the Start* (RFTS) program provided information about safe sleep practices in the home at approximately two months after the birth of the baby. The observations of RFTS staff provide for a reasonably objective assessment of safe sleep practices at two months post-partum. RFTS staff were asked to rate the degree to which they believed each safe sleep practice was being implemented by each family on their caseloads where a baby was born during the three month period of November, 2014 through January, 2015. This is a total of 66 families. A four point scale was used ranging from the parent or caregiver is **always** adhering to the practice in the home to the parent or caregiver is adhering to the practice in the home **none of the time**.

Families enrolled in the *Right from the Start* program must be Medicaid eligible; consequently, this cohort of families is not necessarily typical of the general population of families with infants. It is a group, however, that has been repeatedly exposed to the safe sleep teachings both through the RFTS program and at the birthing hospital.

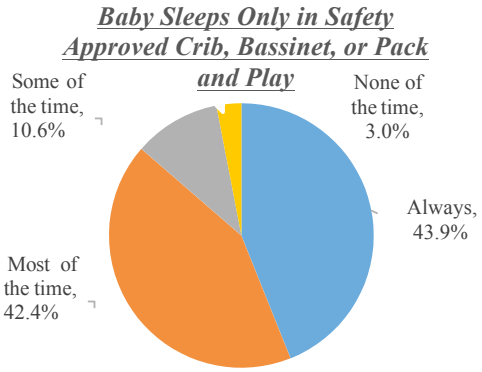


Baby Sleeps Alone

Based on the RFTS staff observations in the home, 43.9% of the infants always sleep alone and an additional 42.4% of infants sleep alone most of the time.

Baby Sleeps Only in Approved Crib, Bassinet, or Pack and Play

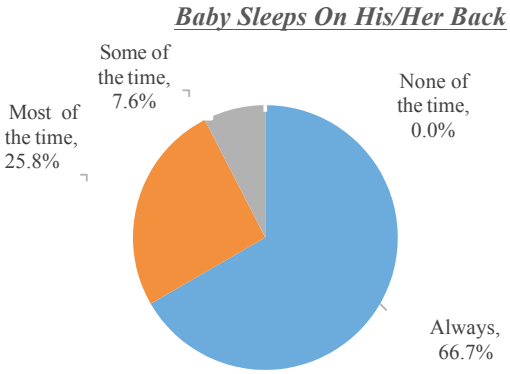
The RFTS home visitors observations about where the infant sleeps mirror their opinions about whether or not the infant sleeps alone. In the opinion of the home visiting staff, 43.9% of the babies always sleep in a safety approved crib, bassinet, or Pack and Play and 42.4% sleep in these recommended locations "most of the time".



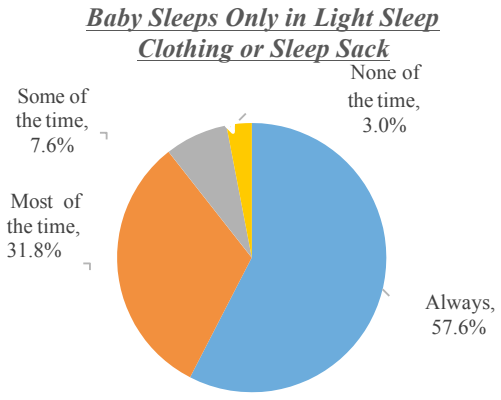
> *"The mother sometimes lets infant sleep on her chest."*

13.6% of this cohort of infants may be considered "at risk" based on observations by home visitors that they sleep alone and in a safety approved environment only some of the time or none of the time.

Baby Sleeps On Back

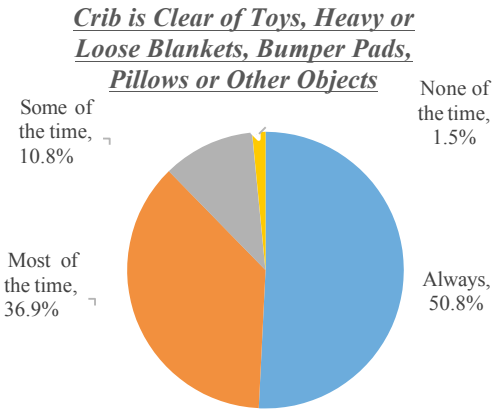


Most infants within this cohort appear to sleep on their back at least most of the time. 66.7% of these infants were reported to always sleep on their back and an additional 25.8% sleep on their back most of the time.



Baby Sleeps in Light Sleep Clothing or Sleep Sack

89.4% of the infants sleep in light sleep clothing or a sleep sack all or most of the time. Based on the observations of the RFTS staff in the home, 10.6% of these infants are dressed in light sleep clothes or use a sleep sack only some of the time they are sleeping or not at all.

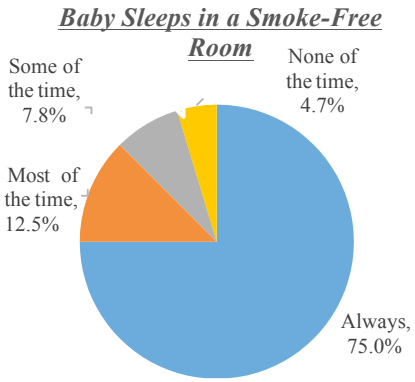


Crib is Clear of Potentially Hazardous Objects

More than half of these infants appear to sleep in cribs that are free of any objects that might be potentially hazardous. The crib is always clear of these objects in 50.8% of the cases and is clear of these objects most of the time in an additional 36.9% of the cases observed. The crib was clear of potentially hazardous objects in one case none of the time.

Baby Sleeps in Smoke Free Environment

875 % of the infants sleep in a smoke free room all or most of the time. A total of 12.5% of these infants sleep in smoke free environments only some of the time or none of the time and these infants may be at risk from exposure to tobacco smoke.



> *"The mother smokes but says she smokes outside. The home smells of smoke and she doesn't feel that it is a problem."*

Conclusions

- The Say YES to Safe Sleep initiative appears to be an effective means to (1) educate parents/caregivers about recommended infant safe sleep practices, and (2) influencing practices related to infant safety in the home.
- The dose 1 and dose 2 Say YES to Safe Sleep for Babies education is effective in conveying safe sleep practices to nearly 100% of parents/caregivers exposed to the teachings.
- A high percentage (over 90%) of parents/caregivers provided with the dose 1 information are able to correctly answer questions about safe sleep practices with infants.
- Not all parents/caregivers agree with all safe sleep teachings. At least 15% do not fully agree with some practices encouraged through the Say YES to Safe Sleep initiative.

- Practices related to the use of blankets and bumper pads are less well understood by parents and caregivers than are the other recommended practices.

- Messages about sleeping in a safety approved crib, bassinet, or Pack and Play are effectively conveyed to all parents/caregivers through the dose 1 education.

- All (100%) of the parents/caregivers making up evaluation cohort 1 intend at the time they leave the hospital to have their infant sleep in a safety approved crib, bassinet, or Pack and Play in the home.

- About 1 in 4 parents/caregivers expect that the infant will occasionally sleep in a baby carrier, baby bouncer, or baby bean bag.

- Safe sleep practices are not adhered to all of the time within approximately half of the families included in the RFTS 2-month follow-up cohort.

- Based on the observations of RFTS staff in client homes at two months post-partum, approximately 10% to 14% of the infants in the evaluation cohort appear to be "at risk" due to a lack of safe sleep practices "most or "all of the time".

Recommendations

- Continue to expand the Say Yes to Safe Sleep initiative throughout West Virginia.

- Further define expected benchmarks of success for the initiative related to both parent/caregiver education and post-partum safe sleep practices in the home.

- Continue to collect outcomes data on a regular basis in order to monitor trends in safe sleep practices over time.

Appendix

List of Participating Hospitals and Home Visitation Programs – Pilot Phase

Pilot Hospitals	**Pilot Home Visitation Programs**
Bluefield Regional Medical Center Cabell Huntington Hospital CAMC Women and Children's Hospital, Neonatal Intensive Care Unit Garrett County Memorial Hospital Greenbrier Valley Medical Center Ohio Valley Medical Center Princeton Community Hospital St. Joseph's Hospital of Buckhannon, Inc. St. Mary's Medical Center Stonewall Jackson Memorial Hospital United Hospital Center Wheeling Hospital	ABLE Families, Inc., MIHOW Children's Home Society of WV, Parents As Teachers Program Cornerstone Family Interventions, Parents As Teachers Program Doddridge County Starting Points Family Resource Center, Parents As Teachers Program Marshall County Starting Points for Family Resource Center, Parents As Teachers Program Monroe County Head Start/Early Head Start, Parents As Teachers Program Mountain State Healthy Families, Healthy Families America Program Northern Panhandle Head Start, MIHOW Preston County Caring Council, Inc./Taylor County Starts Points Family Resource Center, Parents As Teachers Program REACCH Family Resource Center, Parents As Teachers Program Right From The Start, Regions I-VIII The Community Crossing, Parents As Teachers Program Tucker County Family Resource Network, Parents As Teachers Program Upper Kanawha Valley Start Points Family Resource Center, Parents As Teachers Program

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