Improving Safe Sleep Practices in the Special Care and Newborn Nurseries

Rowena Leong Milburn, DNP, RNC-LRN, Danielle Asante, MSN, RN, Irish Anne Cabrera, BSN, RNC-NIC, Lindsay Kirker, MSN, RNC-NIC, Jennifer Merzius, BSN, RN
Women's and Infants' Services (WIS) Department, Sibley Memorial Hospital, Washington D.C.

Introduction

Safe sleep practices (SSP) are not consistently observed in the Special Care and Newborn nurseries, including in patient rooms. Unsafe sleep practices may lead to neonatal injuries and/or death. In the United States annually, about 3,500 infants die of sleep-related infant deaths , including Sudden Infant Death Syndrome (SIDS), ill-defined deaths, and accidental suffocation and strangulation in bed. The American Academy of Pediatrics (AAP) encourages all healthcare providers to model safe sleep practices in the hospital to help promote safe sleep after discharge.

Practice Question

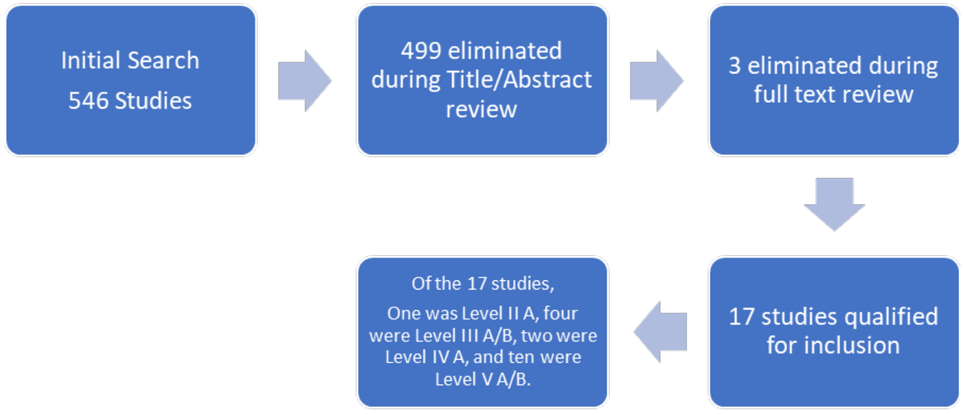
"What are best practices for improving clinical nurses' modeling of Safe Sleep Practices (SSP) for the parents of medically stable infant patients preparing for discharge?"

Search Strategy

Databases used for the initial search include CINAHL Plus, PubMed, Cochrane and JBI. **Inclusion criteria**: November 2017-November 2022, English language, inpatient, medically stable, newborn, maternal-newborn/mother-baby nurses, NICU/SCN nurses
Exclusion criteria: outpatient, nurses who are not working in mother-baby and NICU/ SCN units

Level and Quality of Included Evidence

Level and quality of included evidence:
The initial search returned 546 studies. 499 were eliminated during the title and abstract review, three were eliminated during the full text review. The remaining seventeen studies qualified for inclusion. Of these, one was Level II A, four were Level III A/B, two were Level IV A, and ten were Level V A/B.



Synthesis

The evidence revealed good and consistent evidence. Themes that addressed our EBP question indicate that the following strategies were most often associated with improvement in nurses' modeling of SSP:

- Auditing patient room
- Auditing patient in nursery
- Document of SSP in the patient room by the nurse

The search strategy revealed AAP Clinical Guidelines on SSP. This, as well as other sources that find modeling behavior of nurses in the hospital and providing consistent education to families, increase SSP at home.

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Recommendations for Translation into Practice

The best practice recommendations of audit and education are low risk and aligned with departmental and organizational priorities. FCCU and SCN nurse managers chose Safe Sleep Champions from both units to create an action plan, perform audits and educate nurses and parents. The change is feasible, fit and acceptable. It is suitable and has little to no impact on workflow. It is applicable to our problem of current safe sleep failure rates and answers the formulated PICO question.
The recommendations are currently in progress. An action plan was created by the Safe Sleep Education team and approved by nursing leadership. Audit tools and myLearning Safe Sleep Education for both FCCU and SCN were created. Baseline audits for current compliance with Safe Sleep Practices (SSP) of both staff (FCCU/SCN nurses) and parents (in patient rooms) were collected from August 1, 2022-September 30, 2022 (FY23 Q1). Approximately, 100 audits per month would be performed, which is 30% of newborn patients. The audit results showed a 20% SSP pass rate in Special Care Nursery, and a 74% SSP pass rate in the Newborn Nursery. Nursing staff received Safe Sleep Education in November 2022 (FY23 Q2) before resuming safe sleep audits to ensure staff/parent compliance in January 2023 (FY23 Q3). The goal is to achieve at least 75% pass rate for SSP by FY23 Q4.