Safer Sleeping Guidelines

These guidelines provide evidence based information to enable staff to discuss and promote safer sleeping practices with parents and carers of infants. They describe the main, established, modifiable factors associated with either an increased or a decreased risk of SIDS

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EQUALITY STATEMENT

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.
These guidelines take into account the provisions of the Equality Act 2010 and advances equal opportunities for all.
This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.
In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.
This applies to all the activities for which LPT is responsible, including policy development and review

1.0 INTRODUCTION

Sudden Infant Death Syndrome (SIDS) is the term given to Infant deaths that happen unexpectedly, without warning, and which cannot be explained, even after a detailed post mortem. Since the launch of the Reduce the Risk Campaign in England and Wales in 1991, the number of SIDS has fallen by around 65%. However SIDS continues to be the leading cause of death for infants aged between one month and one year in developed countries

According to the Lullaby Trust (2015): SIDS Facts and Figures for England and Wales 2013

- 249 unexplained infant deaths occurred in England and Wales, a rate of 0.36 deaths per 1,000 live births. **This is the first rise in unexplained infant deaths since 2008**. Before 2013, the rate had fallen steadily from 0.41 in 2008 to 0.32 in 2012

- SIDS accounted for 9% of all infant deaths occurring in 2013.

- Just over half (55%) of all unexplained infant deaths were boys in 2013 (138 deaths) compared with 64% in 2012 (150 deaths)

- The largest monthly rise in unexplained infant deaths was in February 2013. This coincided with a colder than average mean monthly temperature

- The rate of infant deaths rose from 0.92 to 1.27 for mothers aged **under 20**. Although numbers are very small, this was four times greater than the combined categories of babies born to mothers aged 20 and over(0.32)

- In 2013, 87.1% of SIDS occurred in babies under the age of 6 months

Local data for Leicester, Leicestershire and Rutland for the years 2009 to 2014 show the incidence of SIDS to be:

Year	Number of deaths
2009	5
2010	4
2011	3
2012	2
2013	4
2014	4

Source Lisa Hydes: Child Death Review Manager for LPT

Nobody knows why SIDS happens but it is known that several factors are associated with increased risk. One theory called the 'Triple Risk Model' offers an explanation. According to this model first proposed by Filiano and Kinney in 1994, interaction between different risk factors is needed to result in SIDS.

1. A vulnerable infant (e.g. were exposed to smoking during pregnancy, were premature, or have an unknown brain anomaly)
2. A critical developmental period(5-12 weeks old for most babies)
3. Exposed to some sort of challenge(stressor) they are unable to cope with(e.g. sleeping for too long, sleeping face down and getting insufficient oxygen, being under too many covers and becoming over heated)

It is not always possible to know whether a baby is vulnerable and because all babies go through critical developmental periods, guidelines on reducing the risk of SIDS focus on avoiding the third group of factors – the stressors. Many of these factors are modifiable and parents/carers need to be informed about how they can provide the safest sleeping environment for their infant.
Bed sharing between infants and adults is a controversial subject. Taking a simplistic position of whether it is 'safe' or 'unsafe', without considering the particular circumstances in which it happens is unhelpful, may undermine parents/carers and put infants at risk.

2.0 AIMS OF GUIDELINES

The aims are to:

- Reduce the death rate of babies and infants in Leicester, Leicestershire and Rutland Health and Local Authority Services

- Provide staff with research based information and resources to enable them explore and discuss with parents/carers the modifiable factors involved so that the risk of SIDS can be minimised

- Reduce the number of babies and infants who are put to sleep in unsafe conditions.

- Empower parents/carers make a fully informed decision about safer sleeping practices
- Promote breastfeeding for as long as the mother desires whilst ensuring the safety of babies
- Ensure information is provided to all families regardless of the chosen feeding method

3.0 DEFINITIONS OF TERMS

NICE Clinical Guideline 37 on Post-Natal Care Up-dated the recommendations on Co-sleeping and sudden infant death in Dec 2014
The term “association” was used in the recommendations to describe the relationship between factors and outcome. (“Risk” infers a cause and effect relationship)
The term co-sleeping was used to cover “sharing a bed or sofa or chair with an infant”

Recommendations on co-sleeping and SIDS now extend to cover the first year of an Infant’s life.

When discussing parent/carer and infant sleep location it is important to clarify terminology and definitions ,as the terms ‘co-sleeping and bed-sharing ‘ are often used interchangeably by the public, by practitioners and in the research literature.
It is also recognised that parents/carers take their baby into bed to feed and provide comfort and closeness without any intention of sleeping with their baby. While it is acknowledged that no activity is entirely without risk, in the absence of parental/carer sleep there is no evidence that this incurs any greater risk than the mother holding or feeding her baby elsewhere.

However, in certain circumstances mothers who bed-share may fall asleep whether or not they intend to. This would result in **co-sleeping** and there is evidence to indicate that this is associated with a greater incidence of accident or SIDS **where certain risk factors are present**.

For the purpose of this document

Bed-sharing is defined as either the baby and/or the parent/carer sleeping for any period of time, together in the same bed

It does not include sleeping with the baby on another sleep surface such as a sofa, bean bag, mat, etc.

4.0 TARGET AUDIENCE

These guidelines are intended for use by:

- Midwifery Services
- Health Visiting Services
- Children Centre Services

- Voluntary services having contact with families
- G.P services
- Alcohol and Drug services
- Neonatal and Paediatric Services
- Social Workers for Children
- Smoking cessation services
- Family Nurse Partnership Services
- Foster Carers

5.0 BED-SHARING PRACTICES

5.1 It is recognised that parents/carers practice bed-sharing for a variety of reasons and can include the following:

- Lack of awareness of risk factors reducing the ability to make an informed decision
- Parents'/carers' choice
- To breastfeed the baby who feeds frequently or is unsettled
- Necessity due to lack of space/travelling- 'no-where else for baby to sleep'
- Normal cultural practice or ideology

5.2 Although there is an association between bed-sharing and SIDS, increasingly the evidence suggests that it is not bed-sharing per se that is a risk factor, but the additional factors and circumstances in which it occurs (Blair P.S et al 2014)

However no study has ever found bed-sharing to be associated with a **reduced** risk of SIDS (Ball and Klingaman, 2007 and McGarvey et al, 2006 and Mitchell, 2007) and parents/carers need to be made aware of the contra-indications to bed-sharing

The reviewed Nice Guidance (2014) is clear on the need to give parents balanced information to allow informed decision making. In order for this to happen a parent centred discussion on care of their baby when sleeping, tailored to individual circumstances, is required. (UNICEF UK Dec 2014)

5.3 Contra-indications to bed-sharing

Research has shown that the association between co-sleeping and SIDS is likely to be greater when certain factors are present.

Key Messages

- Inform parents and carers that the association between co-sleeping and SIDS is likely to be greater when they or their partner smoke, or did so in pregnancy. They need to be aware of the need to keep a baby out of smoky areas and not to allow people to smoke near their baby. It is now illegal to smoke in a car with a child under the age of 18.

- Inform parents and carers that the association between co-sleeping and SIDS is greater with:
    - Parent or carer recent alcohol consumption
    - Parent or carer drug use, or
    - Low birth weight or preterm infants

Other factors to consider:

- Either parent/carer have taken drugs, medication either illicit or prescribed which could make them less responsive (see Appendix 2 for more information)
- Either parent/carer have any condition which alters levels of consciousness or reduces the ability to respond to baby e.g diabetes, epilepsy
- Parents/carers are formula feeding their baby
- Parents/carers are very obese
- Babies have any other signs of ill health or pyrexia
- There is a family history of SIDS

6.0 BEST PRACTICE GUIDANCE

6.1 Environmental Considerations

- **It is recommended that the safest place for baby to sleep is in a cot or crib in the same room near to the parent/carer regardless of time of day for the first six months.**
- **Parents /carers should never sleep with babies on a sofa, armchair or bean bag. Research has demonstrated that this increases the risk of SIDS (Blair et al 2009).**
- The ideal room temperature is between 16-20 °C (Lullaby Trust 2013)
- The home and car should be kept completely smoke free. Research has shown that living in a household in which one or more people smoke more than doubles the risk of SIDS (Royal College of Physicians 2010).

  Electronic (e) cigarettes are gaining popularity as smoking cessation devices. They are battery-powered gadgets that deliver a smokeless form of nicotine to users, suspended in vapour. The acknowledged advantage of these devices is the absence of tobacco and the harmful toxins produced from its burning. The Lullaby Trust (2014) support the role of e-cigarettes in a harm reduction model but also calls for further research to advance our knowledge of the effect of vapour suspended nicotine on unborn babies and developing infants. The Trust urges e-cigarette users to follow all safer sleep

guidance as it pertains to tobacco cigarette users, such as avoiding co-sleeping with an infant

6.2 Sleeping Position

To reduce the risk of overheating or suffocating

- Babies should always be placed on their back to sleep and never on their tummy or side (unless clinically indicated).
- When placed in a cot/crib/pram babies should always be placed with their feet to the foot of the cot/crib/pram to ensure the bedding does not cover the baby above the shoulders.

To strengthen different muscles, promote gross motor development and to prevent the back of the babies head becoming flat, parents should be encouraged to include “tummy time” as part of the baby’s daily routine. This should take place while the baby is awake and under supervision.

6.3 Equipment

- The mattress ideally should be new. If this is not possible it should be in good condition, waterproof, not torn and thoroughly cleaned.
- The mattress should be firm and fit the base of the cot/crib/pram well without any gaps.
- Baby’s should never sleep using pillows , cot bumpers, wedges ,bedding rolls or anything that would increase the risk of the baby overheating or suffocating(unless clinically indicated for children with complex needs- see document entitled ‘The Provision of night time equipment as part of 24 hr postural management in children, Guidelines for Clinicians’
- Blankets and sheets should be used and duvets should be avoided.

Parents/carers should avoid overheating their babies by not overdressing them or swaddling them, unless this is clinically indicated.

7.0 DUMMY USE

Some research suggests that using a dummy when putting a baby down to sleep might help to reduce the risk of SIDS (Hauck et al 2005).It is not clear exactly why this is.

- If a baby uses a dummy as part of their general routine it should be given for every sleep period, as this is thought to be more protective than occasional use. (Lullaby Trust 2013)

- If Breastfeeding, the baby should not be given a dummy until breastfeeding is well established (around 4-6 weeks). Use of a dummy before this time may affect how

the baby breastfeeds and can potentially increase the risk of stopping (Howard et al, 2003)

- Parents should not force their baby to take a dummy or put it back in if the baby spits it out.
- Parents should be advised not to use a neck cord, apply anything sweet on the dummy or use it during wake times.
- The dummy should gently be withdrawn between the ages of 6-12 months to avoid any potential adverse longer-term effects such as misalignment of teeth (Lullaby Trust 2013)

8.0 FEEDING METHOD

8.1 BREASTFEEDING

- Breastfeeding reduces the risk of SIDS (Venneman et al 2009) and has other well documented health benefits (Ip et al 2007,Smith and Harvey 2010 and Horta et al 2007)
- Evidence suggests that babies who share a bed with their mother tend to feed more frequently and are more likely to be breastfeeding at three months of age (Ball 2003).
- Bed- sharing is associated with longer and more restful infant and maternal sleep (Ball 2003)
- Evidence suggests that breastfeeding mothers sleep facing their babies and adopt a protective position around their baby and video studies in sleep labs and parental homes have shown that mothers frequently touch their babies, even when they are half awake, monitoring the baby's temperature and relationship to the bedding (Ball.2007) .
- Parents/carers should be informed of the benefits of breastfeeding and the association between co-sleeping and SIDS, to ensure they have the knowledge to make an informed decision, and are able to relate the guidance to the reality of their lives.
- It is essential that parents/carers are fully informed of the dangers of falling asleep with their babies on sofa and armchairs etc
- It is important to promote, support and protect breastfeeding. Ensure that key messages related to co-sleeping and SIDS are proportionate and contextualised within a broader discussion on safer sleep practices
- Key message – the safest place for a baby to sleep is on their back in a cot in the same room as the parent/carer. After they have fed they can be returned to the cot/crib/pram

This is particularly important if there are any contraindications to bed-sharing-see section 5.3

8.2 FORMULA FEEDING

Unlike breastfeeding formula feeding does not protect against SIDS and therefore formula feeding may be considered a contraindication to bed sharing.

Parents who are formula feeding need information and advice about the safe preparation of feeds, practical ways to manage night feeds and feeding their baby in a responsive way. (Guide to Bottle Feeding -Start4life)

IF PARENTS MAKE AN INFORMED DECISION TO SHARE A BED:-

It is important to note that Ball et al (2002) found that although prospective parents did not anticipate sleeping with their new-born baby, three months later, the majority of parents had done so. According to the Infant Feeding Survey DH, 2010, around half of all mothers allowed their baby to sleep in the parental bed at least occasionally and bed sharing was associated with breastfeeding mothers.

Whilst it is acknowledged that the safest place for a baby to sleep is in their own cot/crib in the same room as the parent/carer it is **important to ensure parents who choose to bed-share, should do so as safely as possible.**

The following should be discussed to minimise the risks;

To prevent the baby overheating, suffocating or becoming trapped;

- The mattress must be firm and flat; waterbeds,bean bags and sagging mattresses are not suitable
- Ensure there are no gaps for the baby to become trapped and that the baby cannot fall or roll out of the bed
- Make sure the bedclothes cannot cover the baby's face and pillows are kept away
- Sheets and blankets are used instead of a duvet
- The baby is never left alone in the bed.
- Mother's partner should know if the baby is in bed
- Pets should never be allowed to share the bed
- Babies should sleep on their back
- If an older child is also sharing the bed, the mother or partner should sleep between the child and the baby. If partner is under the influence of drugs/alcohol s/he should not co-sleep with the baby

9.0 CAR SEATS

- It has long been acknowledged that using an infant car seat correctly is the safest way to travel with infants in a car (Weber 2000). Car seats are at risk of being misused and parents may leave infants in car seats longer than is necessary. There is evidence to suggest premature infants, those with health problems and even healthy term infants may be at risk of a reduction in oxygen levels and potentially life threatening events. (Cote et al 2008,Kornhauser et al 2009 and Tonkin et al 2006)
- When using a car seat it is recommended that parents should avoid using a car seat with a steeply angled back and that premature infants being discharged from neonatal units should be observed carefully while in the car seat and placed into the crib as soon as possible after the car journey has ended (Elder et al 2007)
- Many car seats come as part of a travel system enabling the car seat to be placed onto a pram/pushchair base. Therefore prolonging the time spent in the car seat. It is suggested that on reaching the destination that baby is lifted from the car seat and placed in an appropriate environment(Kornhauser et al 2009)

9.1 Best practice for car seat use

- Only use the car seat while travelling (Kornhauser et al 2009)
- Avoid using a car seat with a steeply angled back (Elder et al 2007)
- Observe baby while in the car seat (Lullaby Trust 2013 and Elder et al 2007)
- Remove outdoor clothing when in the car to avoid overheating (Lullaby Trust 2013)
- Build time into a long journey for breaks (Lullaby Trust 2013)
- Premature babies or vulnerable babies may require more care and observation when travelling

10.0 KEY RECOMMENDATIONS.

The safest place for a baby to sleep is in their own cot/crib/pram in the same room as their parents/carers whatever the time of day for the first six months

Every parent/carer should have a discussion and be given consistent evidence based information about bed sharing exploring the safety issues and contraindications as well as the benefits

Any information /discussion should be accurately documented in the appropriate records

Remember the risk of SIDS can be managed and reduced but not completely eradicated

11.0 RESPONSIBILITIES

11.1 The guidelines will be made available and accessible via the website of the organisations

11.2 Line managers and clinical leads will be responsible for ensuring staff within midwifery and health visiting teams are orientated to the guidelines and understand their role within it and for supporting and encouraging education for appropriate staff members

11.3 Children Centre Managers will be responsible for dissemination of the guidelines to children centre staff

11.4 Key workers overseeing the Breastfeeding Peer Support Programme will be responsible for dissemination of the guidelines to Breastfeeding Peer Supporters

11.5 The guidelines will be disseminated to General Practitioners via the Practice manager.

12.0 TRAINING REQUIREMENTS

12.1 LPT and UHL will facilitate the provision of appropriate Infant Feeding training and updates. This training will be facilitated by the Infant Feeding Lead for LPT and UHL.

12.2 Information about safer sleep is included in the mandatory Infant Feeding Training. For LPT staff there are Safer Sleep and CONI updates available from October 16. These can be booked via U learn.

12.3 Evaluation of the Guidelines will take place through audit of the Baby Friendly Initiative Standards which involve direct questioning of staff and postnatal mothers (Who are breast and formula feeding).

13.0 RELATED DOCUMENTS

The Guidelines should be read in conjunction with the following document (s) which can be accessed by the organisations website

- Joint Infant Feeding Policy
- Standard Operating Guidance for Health Visiting Teams

14.0 RESOURCES

- Caring for your baby at night- A guide for parents produced by the Baby Friendly Initiative.

  This is available to download from the Baby Friendly Website www.babyfriendly.org.uk and a health professionals guide to this leaflet can be downloaded at www.unicef.org.uk/caringatnight

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2. The Lullaby Trust is a charity previously known as the Foundation for the Study of Infant Death .It provides specialist support for bereaved families, expert advice on safer sleep and raises awareness of sudden infant death. It produces many publications which can be downloaded for free from the following website www.lullabytrust.org.uk .

Resources include:

- Safer sleep for babies – a guide for parents
- Sudden Infant Death Syndrome- a guide for health professionals
- Safer sleep for babies- easy read guide
- Fact sheets aimed at parents to give additional information on specific areas such as bedsharing,smoking, mattresses bedding and cots etc.

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3.

Infant Sleep Information Source

This is an online resource which has information about SIDS and latest research. It has a parent and health professional page. The site is called Infant Sleep Information Source and can be accessed from the following website

www.isisonline.org.uk

ISIS is a resource produced by Durham University Parent- Infant Sleep Lab, in collaboration with La Leche League, N.C.T and UNICEF UK Baby Friendly Initiative

They produce a number of information fact sheets which include the following:

- Sleep training
- Twin Infant Sleep
- Where Babies Sleep
- Bed –sharing and Safety
- Using a sling for Daytime Sleep
- Normal Infant Sleep
- **A free phone app** which provides up to date information about normal infant sleep and sleep safety ,based on the Infant Sleep Information Source

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Appendix 1

Leicestershire Partnership NHS
NHS Trust

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/Not applicable	Comments
	Will any sections of this Policy satisfy one or more criteria of the NHSLA Risk Management Standards?*		
	If Yes – Have you attached the relevant self-assessment(s) for those criteria as an appendix?*		
	* for further guidance consult the Trust Lead for Corporate Risk Assurance: Richard.Apps@leicspart.nhs.uk		
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Key Points / Changes to the Policy**		
	Updated original guidelines formulated in 2010		
3.	**Rationale**		
	Are reasons for development of the document stated?	yes	
4.	**Development Process**		
	Does the front page include a sentence which summarises the contents of the policy?	yes	
	Is the method described in brief?	yes	
	Are people invited in the development identified?	yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	yes	
	Is there evidence of consultation with stakeholders and users? (with representatives from all relevant protected characteristics)	yes	
5.	**Content**		
	Is the objective of the document clear?	yes	
	Is the target population clear and unambiguous?	yes	
	Are the relevant CQC outcomes identified?	yes	
	Are the intended outcomes described?	yes	
	Are the statements clear and unambiguous?	yes	
6.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	yes	
	Are key references cited?	yes	

	Are the references cited in full?	Yes	
	Is there evidence to show that there has been due regard under the Equality Act 2010, and in working towards the Trust's equality objectives? (e.g. attach the equality analysis as summary of evidence)	Yes	
	Are supporting documents referenced?	Yes	
7.	**Approval**		
	Does the document identify with committee/group will approve it?		
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?		
8.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Stated in document	
	Does the plan include the necessary training/support to ensure compliance?	Stated in document	
9.	**Document Control**		
	Does the document identify where it will be held?	Within internet	
	Have archiving arrangements for superseded documents been addressed?	as per procedural protocol	
10.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	n/a	
	Is there a plan to review or audit compliance with the document?	Yes	
11.	**Review Date**		
	Is the review date identified?	TBC	
	Is the frequency of review identified? If so it is acceptable?	TBC	
12.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Carole Fishwick	Date	30.5.16
Signature	*carole fishwick*		
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			

Name		Date	
Signature			

Appendix 2 Parental/Carer drug use and SIDS
Below is a guide to drugs both legal and illicit that may reduce responsiveness or consciousness:

Parental/Carer drug use can cause changes to alertness levels which could affect bed sharing practices involving babies. The main issue would involve a reduced responsiveness and or altered consciousness. **Alcohol** is a clear example of a drug that could lead to this scenario and is a particular risk factor due to its easy availability and common use. Other drugs whether illicit, prescribed or bought "over the counter" from pharmacies may also produce this effect.

All illicit substances can alter thinking and impact on alertness and responsiveness. Parents/Carers taking any illicit substance should not co-sleep/bed share with their infant. Parents should also be advised about the impact of withdrawal from substances and how this can effect alertness and tiredness.

New psychoactive substances will also alter thinking and functioning and their use will be a contraindication for any bed-sharing. Some of these substances can lead to delirium and hallucinations(e.g. black Mamba).Again consideration should be given to the impact of withdrawal. For example, using synthetic stimulants and synthetic cannabinoids can lead to sleeplessness during usage which may result in over tiredness and the need to sleep following usage.
Poly drug use is a particular issue. For example, using any substance with alcohol will heighten the effects

Certain prescribed drugs and over the counter (OTC) drugs may affect responsiveness. Again usage with alcohol will heighten the effect. Some medications which can particularly affect responsiveness are

- Any opioid medication(opiate painkillers, opiate substitute medication)
- Benzodiazepines
- Sleeping tablets including Nytol
- Anti-psychotic drugs
- Anti-depressants
- Some anti-histamines
- Anti-nausea and vertigo drugs
- Anti-migraine drugs
- Some anti-epileptic drugs

This is not an exhaustive list. Further information can be obtained from your local pharmacist.
If there are any concerns about a parent using any substances please refer to LSCB Guidelines: Children of Drug and Alcohol Misusing Parents and further advice can be sought from local drug/alcohol services and safeguarding leads. Additionally , UKMI (UK Medicines Information) services can be contacted for advice on the effects of drugs on the foetus and whilst lactating.

Appendix 3 Version Control

Version	**Date**	**Comment** (description change and amendments)
Version 1	Issued June 2008	Original version by Sharon Robson. Updated by Annette Ogilvie-Forbes.
Version 2	Written August 2011	Update of Version 1 incorporating information on the use of dummies and SIDS and car seats as a sleeping environment. Includes new evidence around bed-sharing.
Version 3	Written September 2012	From feedback received definition of bed-sharing refined and section on formula feeding added.
Version 4	Written September 2012	Following comments on Version 3 alterations made: 'safe' replaced for 'safer'; Alcohol and Drug practitioners added to target audience; statement on dummy use and effect on breastfeeding omitted to avoid confusion.
Version 5	Written October 2012	Appendix 2 added to incorporate information about drugs with potential to cause sedation
Version 6	Written Jan 2013	Additional bullet point added relating to smoking and environmental considerations under 6.1
Version 7	March 2016	Update of version six

All LPT guidelines can be provided in large print or Braille format if requested and interpreting service is available to individuals of different nationalities who require them

The Guidelines will apply equally to full and part time staff.

Appendix 4 Definitions that Apply to these Guidelines

Approved	Formal confirmation by relevant Committee that the document meets the required standards and may be sent to either the Senior Clinical and/or Senior Operational Group for ratification.
Ratification	The document is agreed by either the Senior Clinical and/or Senior Operational Group and signed off
Stakeholder	An individual or organisation with an interest in the subject of the document E.g. staff, staff side representatives, service users, commissioners.
Guideline	An official recommendation, which indicates how something should be done and the action that will be required.
LPT	Leicestershire Partnership Trust
UHL	University Hospitals of Leicester
Parents	Parents in the guidelines include same sex parents
FYPC	Families, Young People and Children Division
Bed-sharing	Defined as the baby /infant sleeping for at least some of the night in the same bed as a parent(s) or carer(s).
Co-sleeping	Parents or carers sleeping on a bed or sofa or chair with an infant
SIDS	Sudden Infant Death Syndrome
Due-regard	Having **due regard** for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics • Taking steps to meet the needs of people form protected groups where these are different form the needs of other people. Encouraging people from protected groups to participate in public life • Or in other activities where their participation is disproportionately low