

Best Practice Indicators for Health,
Families SA and Childcare Staff

South Australian Safe Infant Sleeping Standards



Government
of South Australia

SA Health

Acknowledgements

The Centre for Health Promotion, Children, Youth and Women's Health Service (CYWHS), Department of Health (DoH), acknowledges the valuable work of the South Australian Safe Sleeping Advisory Committee which provided expert advice, support and essential linkages. The Committee included representatives from:

- > The Centre for Health Promotion, CYWHS
- > Health Promotion Branch, DoH
- > SIDS and Kids SA
- > Kidsafe SA
- > Child and Family Health, CYWHS
- > Families SA, Department of Families and Communities (DFC)
- > SA Health Injury Surveillance and Control Unit
- > Child Death and Serious Injury Review Committee
- > SA Maternal, Perinatal and Infant Mortality Committee
- > Aboriginal Health Division, DoH
- > Association of Neonatal Nurses
- > Australian College of Midwives

Most importantly, the Committee wishes to acknowledge the research carried out by Prof (Adj) Jeanine Young and Queensland Health identifying the important role health professionals play in the uptake of safe sleeping messages by parents. The *Safe Infant Care to Reduce the Risk of Sudden Unexpected Deaths in Infancy Policy Statement and Guidelines* developed by Queensland Health set the benchmark in terms of what can be achieved within a practice and policy document.

Special thanks go to SIDS and Kids ACT for their kind agreement to use their images throughout this document and supporting resources.

The expert advice received by the Head of Gastroenterology at the Women's and Children's Hospital South Australia, Dr David Moore and supported by a Cochrane Review, regarding the placement of infants, including those with gastroesophageal reflux, *on their backs to sleep on a firm, flat mattress that is not elevated* (page 13) has provided much needed clarification for both medical and nursing staff.

For more information

To obtain further information or copies of the Standards, please contact the Centre for Health Promotion

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Introduction

The sudden and unexpected death of infants during sleep has reduced significantly since a public health campaign about safe sleeping for infants was conducted in the 1990s. However, the sudden and unexpected death of infants during sleep remains a leading cause of preventable death for infants between one month and one year of age. The Maternal, Perinatal and Infant Mortality Committee (MPIMC) and the Child Death and Serious Injury Review Committee (CDSIRC) are two South Australian committees that investigate and document the circumstances surrounding deaths and serious injuries to children and make recommendations to Government. In 2006, these committees recommended a further public health campaign to highlight the risks within the infant sleeping environment and in 2008 they continued to identify co-sleeping and unsafe sleeping environs as risk factors in the infant deaths they reviewed. They also continued to identify a link between unsafe sleeping environments and socioeconomic disadvantage. Both Committees noted that hospital and community midwives and maternal child health nurses employed in the Universal Home Visiting program in South Australia had pivotal roles in discussing and checking safe sleeping arrangements for infants with families.¹ These findings led to the Coroner, in June 2008, endorsing the recommendations of CDSIRC and further recommending that health professionals and carers be supported to *'properly, accurately and consistently'* promote and model safe sleeping practices to parents and families.²

These South Australian Safe Infant Sleeping Standards respond to the State Coroner's Recommendations made on 25 June 2008 to *'develop a single set of consistent guidelines that define the appropriate strategies to be implemented by parents, carers and health professionals for the reduction of risk factors in sudden unexpected death in infancy (SUDI)'* and to *'enable members of the nursing profession, carers and other health professionals to properly, accurately and consistently impart to parents and families the essentials of safe sleeping practices for infants'*.²

Studies conducted with Queensland health professionals and nursing staff highlighted the importance of staff understanding and modelling of recommended practices to increase the uptake of safe sleeping messages by parents at home.³⁻⁷ Their studies found that improvements could be made to the information provided by staff to parents about modifiable risk factors in the infant's sleeping environment. In South Australia, a consultation with young parents suggests that inconsistencies between the information provided by health professionals and their practice causes confusion and some anxiety for parents.

Queensland Health's Safe Infant Care to Reduce the Risk of Sudden Unexpected Deaths in Infancy Policy Statement and Guidelines note the unique position health professionals hold and the power they have *'to directly influence the behaviour of parents and caregivers, by modelling safe infant sleep practices while the infant is in hospital and by providing parents with information and support strategies, to ensure parent practices used at home are consistent with public health safe sleeping recommendations'*.⁸

The five Standards contained in this document provide clarity and direction for staff and volunteers working with families and caregivers with infants under 12 months of age. This document is intended as a practical resource and outlines essential safe infant sleeping practices and environments alongside the respective challenges they pose for parents and staff. The Standards are informed by the available evidence about risk factors in the infant sleeping environment as well as current professional practice and consumer needs and apply to all families with infants from birth through to 12 months of age.

The SA Safe Infant Sleeping Standards were developed by a core group of experts from Government and non-Government sectors in South Australia under the direction of the *South Australian Safe Sleeping Advisory Committee*. They are the result of extensive consultations and conversations, not only with members of the Committee, but also with local and interstate experts outside the Committee including consumers, retailers, staff within SA Health, Families SA, Disability SA, Department of Education and Children's Services (DECS) Early Childhood, Queensland Health and the Victorian Child Safety Commissioner.

The Standards were written to guide staff and increase family and community awareness of the key infant care practices associated with reducing the risk of infants dying while asleep. This document is informed by current Australian and international research and provides information consistent with the safe sleeping recommendations being promoted in many parts of the world. The decision to adopt a precautionary approach in South Australia, particularly in relation to co-sleeping, was not taken lightly. To the extent possible, the Committee has attempted to take account of all available evidence and arrived at an approach which they believe best supports the interests of public health. The safety of infants has been given the highest priority in formulating these recommendations.

Classifications and explanation of terms

The definition of sudden unexpected death in infancy (SUDI) used in this document is based on the definition proposed by Fleming and others.⁹ This definition includes infants under one year of age whose deaths:

1. were unexpected and unexplained at autopsy;
2. occurred in the course of an acute illness that was not recognised by carers and/or health professionals as potentially life-threatening,
3. arose from a pre-existing condition that had not been previously recognised by health professionals, or
4. resulted from any form of accident, trauma or poisoning.

Sudden unexpected death in infancy could be described as an umbrella term with Sudden Infant Death Syndrome (SIDS) a subset of SUDI. The definition for SIDS currently accepted in Australia and by many experts internationally, is the San Diego definition proposed by Krous and others:¹⁰

'the sudden and unexpected death of an infant under one year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy and review of the circumstances of death and the clinical history'.

The current definition of SIDS has become more stringent, such that some deaths which were attributed to SIDS in earlier years would now be classified as SUDI's in the 'unexplained' group.

SUDIs fall into one of two categories:

- > explained deaths of infants which incorporate criteria 2 to 4 of the above definition, or
- > unexplained deaths of infants accounted for by criteria 1 and incorporating the San Diego definition if SIDS proposed by Krous and others.

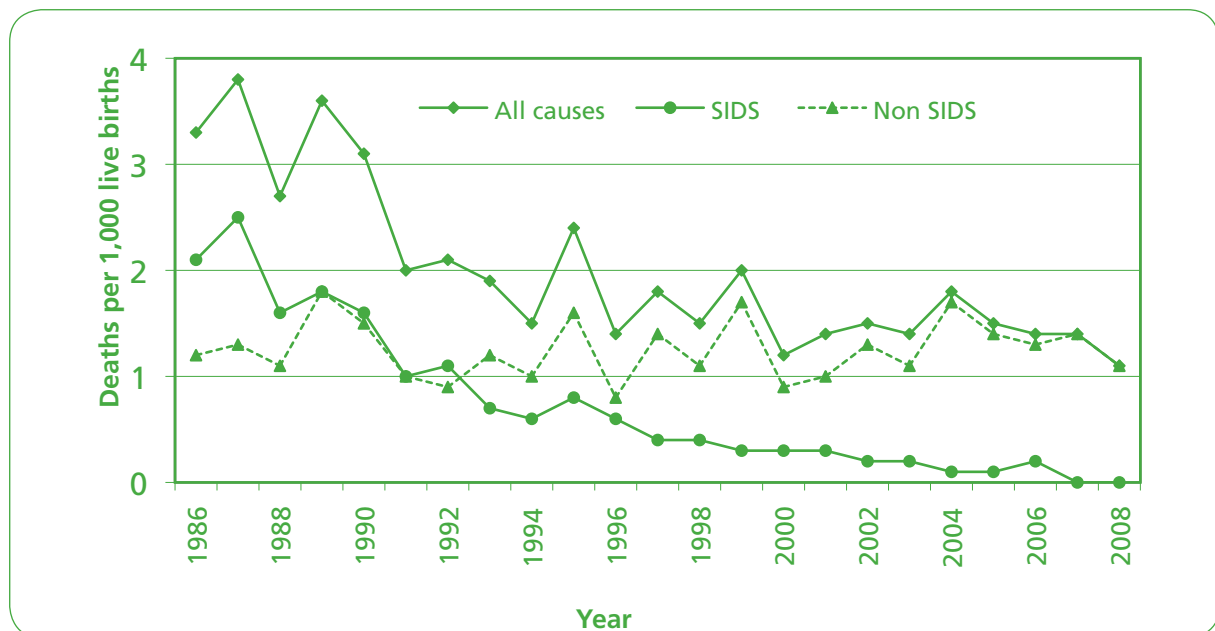
There are a number of known maternal, infant and socio-demographic risk factors which are common to SUDI and fatal sleep incidents. Research has clearly shown that the sleeping environment of infants can increase their risk of SUDI. For example infants who are placed to sleep on their front or side; who are exposed to tobacco smoke, both before and after birth; or who do not have a safe sleeping place are at a greater risk of sudden infant death.¹¹

Incidence

In Australia, infant deaths attributed to SIDS have fallen approximately 83% during the last 20 years.¹² Evidence suggests that the marked reduction in SIDS incidence can be directly associated with Australian public health campaigns which promoted safe sleeping practices, particularly advice to parents to place baby on their back to sleep.¹³

The number of infant deaths attributed to SIDS has also fallen in South Australia during the period 1989–2005, from 2.1 per 1,000 live births in 1989 to 0.2 per 1000 live births in 2006.¹⁴ In 2007 and 2008 in South Australia, no sudden unexplained deaths in infancy have been attributed to SIDS.¹⁵ This is mostly attributed to the success of the SIDS and Kids Reducing the Risk of SIDS Campaign, but also to changing trends in classification. However, annually over the past few years there have been approximately 10 sudden unexpected deaths in infancy associated with unsafe sleeping environments. This represents a significant number of preventable deaths. This incidence can be further reduced by continuing to improve parental practices with regard to sleeping environments.

Figure 1: Post neo-natal death rates, South Australia 1986–2008 as reported in the *Maternal, Perinatal and Infant Mortality in South Australia 2008 Report*¹⁵



Risk factors for SUDI, SIDS and fatal sleeping incidents

There are a number of factors that can increase the risk of an infant dying suddenly and unexpectedly during sleep. The level of risk increases significantly when a number of known factors are clustered in the infant's care or sleep environment.^{6,9,11,16–21}

It is useful to consider risks within the three areas of infant characteristics, parental capacity and environment. Within these three areas, risks can be most easily addressed in the sleep environment although other protective factors can be identified to reduce the level of risk in other areas.

Modifiable risk factors include:

- > infant sleep position and sleep environment,
- > smoking during pregnancy and after birth,
- > alcohol and other drug use (including medications which cause drowsiness),
- > co-sleeping with the infant on the same sleep surface (such as couch, bed or floor).

Potentially protective factors include:

- > sleeping the infant in the same room as the parents,
- > immunisation,
- > use of a pacifier (please note that if a pacifier is to be used it should be introduced after 6 weeks of age to ensure breast feeding is fully established first),
- > breastfeeding.

There may be increased incidence also associated with infants who are:

- > born prematurely (< 37 weeks),
- > of low birth weight (< 2,500 grams),
- > from multiple births,
- > of Aboriginal and/or Torres Strait Islander descent,
- > of young mothers (< 20 years of age),
- > of parents with mental health issues including depression,
- > of parents with intellectual disability,
- > experiencing neonatal health problems, including a history of minor viral respiratory infections and/or gastrointestinal illness in the days leading up to the death,
- > male and first born,
- > born into families experiencing unstable or violent family relationships,
- > born into unstable or transient living situations.

Significantly increased incidence is associated with infants who are born into families of low socio-economic status, disadvantaged by occupational status, low educational level and unemployment.²²

Protective factors for parents and caregivers can include the provision of appropriate support from agencies such as Families SA, Disability SA, mental health services, health or welfare agencies as well as access to extended family support, general practitioners and child and family health nurses.

It is important that workers and volunteers are able to identify risks and take appropriate action to mediate those risks. These Standards will assist workers and volunteers to:

1. Identify the risk factors and talk with families about those risks that can result in infants dying suddenly and unexpectedly whilst sleeping.
2. Promote and model to families evidence-based safe infant care practices and environments.
3. Provide families with relevant information on how to address identified risks and the reasons why safe infant care practices are important (using the *Quick guide for information* and the *Challenges to meeting best practice* sections).
4. Assist families to access relevant services, supports or referrals, or if necessary engage relevant services, supports or referrals on their behalf (using the *Quick guide for help* section).
5. Document discussions and actions taken with the family in the client record.

NOTE: Every agency is likely to have broader assessment frameworks which may include consideration of infant characteristics, parent capacity, environment and protective factors. It is always important to refer to your agency's specific guidelines to assist in the identification of risk factors, particularly where a combination of risks may be present.

About the standards of practice

These Standards apply:

- > To all SA Health, Families SA and Department for Education, Early Childhood Services staff, carers and volunteers whose work brings them in contact with families, parents and caregivers with infants under 12 months of age.
- > To all settings across clinical, acute care and the community.
- > In all circumstances unless medically indicated reasons state otherwise.

These Standards aim:

- > To ensure staff in all facilities (i.e. antenatal, birthing, postnatal, paediatric, child health, childcare, community and general practice settings) promote and model safe infant care practices and environments consistent with the Standards.
- > To ensure staff provide parents and caregivers with consistent and accurate information and the opportunity to observe recommended safe sleeping practices that take into consideration the needs of the baby and the family so that parents can implement these on return to their home environment.
- > To support ongoing training and/or professional development activities that build the capacity of staff to model and promote safe sleeping best-practice.

These Standards ensure all staff are able to effectively promote and model the five safe infant care practices which ensure a safe sleeping environment. It is expected that all staff will comply with these Standards unless medically indicated reasons state otherwise.

Standard 1

All staff will place well infants under 12 months on their back to sleep from birth, never on the front (tummy) or side, unless there are medically indicated reasons.

Standard 2

All staff will be fully informed about the risks of co-sleeping and promote the placing of infants for sleep in a Standards Australia compliant cot (AS/NZS 2172) in the same room as the parents for the first six to 12 months.

Standard 3

All staff will consider the social and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

Standard 4

All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of SIDS and are supported and referred to smoking cessation or reduction programs.

Standard 5

All staff will provide families, parents and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

This document lists Standards common to all workers and volunteers. Additional indicators apply to SA Health, Families SA and Early Child staff. See Appendices 1,2 and 3 for those additional indicators relevant to your organisation.

The five safe infant care practices

The following key infant care practices ensure a safe sleeping environment for babies up to 12 months of age:

1. Sleep infants on their back from birth for every sleep period (night and day), never on their front or side:
 - with feet at the foot of the cot,
 - with appropriate bedclothes or sleeping bag which are the correct weight for the season to provide adequate warmth whilst avoiding overheating,
 - with head and face uncovered,
 - with bedclothes tucked in securely so bedding is not loose or in a sleeping bag that fits the neck firmly,
 - without quilts, doonas, duvets, pillows, cot bumpers, sheep skins, soft toys or any other soft item which could pose an asphyxiation risk.
2. Avoid exposing babies to tobacco smoke before and after birth.
3. Sleep baby in their own cot in the same room as the parents for the first six to 12 months,
4. Provide a safe sleeping place night and day in a cot that is compliant with the Australian Standards for Household Cots (AS/NZS 2172)²³ and positioned away from blind cords and other hazards.

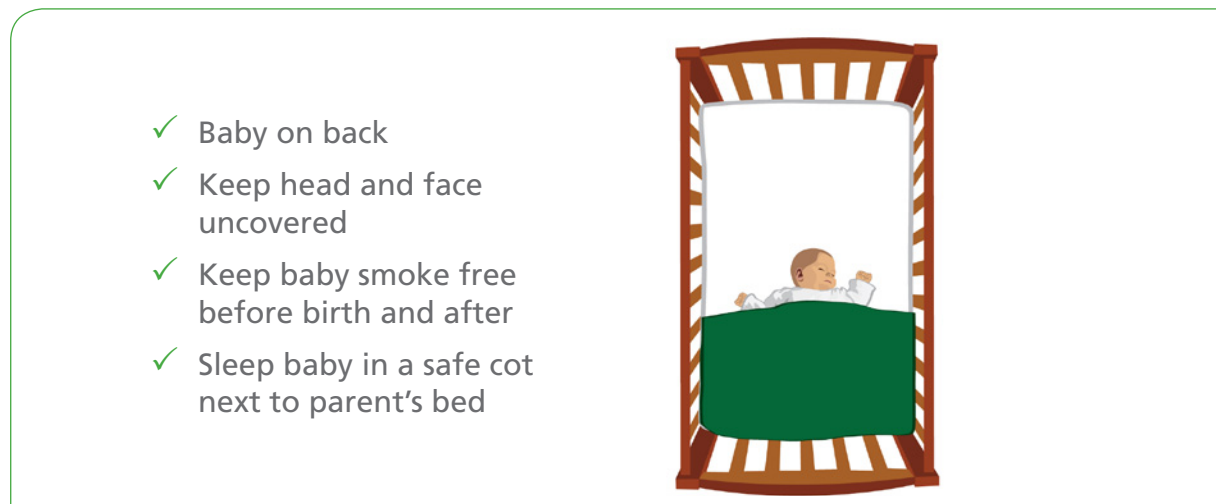


Image courtesy of SIDS and Kids ACT

Although the current definitions and classifications presented in this document refer to an age limit of up to 12 months and relate to the immediate sleeping environment (e.g. sleep positioning, cot), other items in or around the sleeping environment, such as blind cords or electrical cords, can pose a risk of strangulation for children of any age. These and other risks become more evident as infants become more mobile and capable of exploring their environment. For this reason it is important that parents continue to remain alert to risks in the sleeping environment throughout their child's developmental stages.

Parents and carers of children with developmental delay or special needs are encouraged to consult with their child health specialist (ie. doctor, nurse, allied health worker) regarding the safest sleep practices for their child. It is always important to consider a child or infant's ability to move, lift and turn their head to breathe when choosing the most appropriate sleeping situation, cot, bed, bedding and temperature control. Staff should consider referring parents/carers to their child health specialist (i.e. doctor/nurse/allied health worker) for further information regarding infant safety issues as well as information in relation to the infant's overall health, development and wellbeing.

The safe infant care practices referred to in these Standards apply in all circumstances unless medically indicated reasons dictate otherwise. These Standards do not replace specific agency guidelines, protocols or procedures.

The South Australian approach to co-sleeping

Although there may be divided opinions about co-sleeping, in South Australia we have chosen to present an approach that can be applied universally by staff to all parents and families. This approach is one of actively discouraging co-sleeping (sleeping on any surface with a baby). This approach is informed by evidence and ensures all families, regardless of their social and life circumstances, are provided with known best practices in relation to safe infant sleeping, the reasons why these practices are safest and the dangers and risks of practices which differ from those being promoted. Specifically these Standards do not support a harm minimisation approach to co-sleeping as this approach may inadvertently expose infants to unnecessary risks. On the other hand the Standards support room sharing, where infants sleep in a safe cot in the same room as their parents.

The South Australian position is to provide a clear, unambiguous message to parents (i.e. that co-sleeping with an infant increases the risk of infant death). It is based on an understanding that as part of their normal practice, professionals will provide information and education to parents about the behaviours and circumstances that may pose unintentional risks to their infants and the rationale for such advice.

The reasons that South Australia has taken this universal approach to co-sleeping include the following:

- > Co-sleeping with infants increases the risk of infant death, particularly if the baby is of low birthweight or premature, if the mother has smoked during pregnancy or if adults in the household are smokers, if the baby is younger, if the co-sleeping adult has been drinking alcohol, taken medication or drugs or is very tired. Recent research has shown that co-sleeping is an independent risk factor for SUDI.²⁴⁻²⁶ As an example, Tappin et al found the association between co-sleeping and infant death remained even if the mother did not smoke.²⁵
- > A substantial proportion of the Australian population, including parents, use drugs and alcohol. Parents of young infants are often fatigued. There is a high incidence of obesity in both women and men in Australia. Reducing these lifestyle risk factors is difficult as is attempting to individually tailor a message for particular families.

These Standards support a clear, safe, universal message about co-sleeping.

Standards

South Australian Safe
Infant Sleeping Standards

South Australian Safe Infant Sleeping Standards

Standard 1

All staff will place well infants under 12 months on their back to sleep from birth, never on the front or side, unless there are medically indicated reasons.

Indicators of best practice:

To meet this Standard, all workers must be able to:

1. Describe to parents with infants under 12 months of age how to place the infant on their back from birth for every sleep period (night and day):
 - with feet at the foot of the cot,
 - with appropriate bedclothes or sleeping bag which are the correct weight for the season to provide adequate warmth whilst avoiding overheating,
 - with head and face uncovered,
 - with bedclothes tucked in securely so bedding is not loose or in a sleeping bag that fits the neck firmly,
 - without quilts, doonas, duvets, pillows, cot bumpers, sheep skins, soft toys or any other soft item which could pose an asphyxiation risk.
2. Provide parents and caregivers with evidence about the risks associated with side and front sleep positions (illustrated below).
3. Provide parents and caregivers with advice about the importance of a firm sleeping surface (mattress).
4. Recognise when lack of appropriate sleep and settling strategies are contributing to unsafe sleeping practices and make relevant referrals based on the specific needs of the infant and the family circumstances.
5. Explain to parents and caregivers the importance of supervised tummy time when the infant is awake (ie. to strengthen infant neck muscles and prevent a 'flat head').
6. Explain to parents and caregivers the dangers of positional aids, devices and rolls which are marketed to maintain infants in certain sleep positions in the sleep environment (such devices could pose an asphyxiation risk).
7. Recognise when referrals, supports and information are necessary to better support the parent or caregiver to provide a safe sleeping environment for their infant (see pages 27–30).

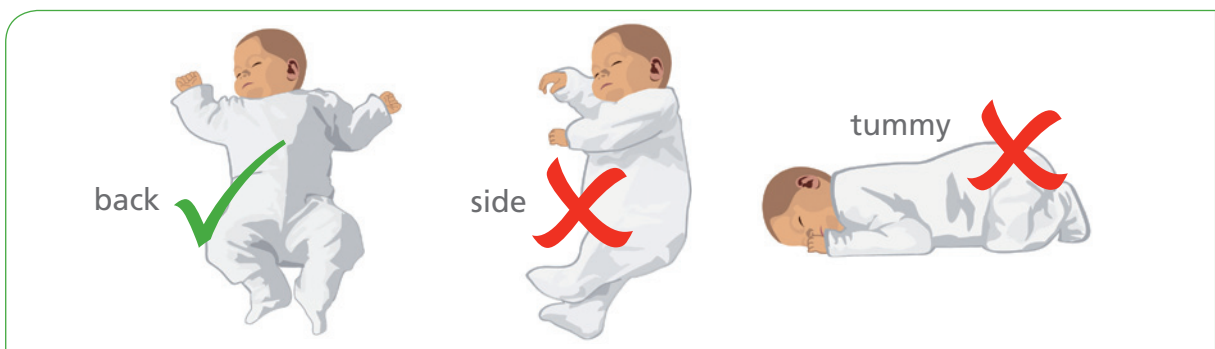


Image courtesy of SIDS and Kids ACT

Standard 2

All staff will be fully informed about the risks of co-sleeping and promote the placing of infants for sleep in a Standards Australia compliant cot in the same room as the parents for the first six to 12 months.

Indicators of best practice:

To meet this Standard, all workers must be able to:

1. Explain the risk factors (see pages 3–4) which contribute to the deaths of infants, particularly the risks of co-sleeping.
2. Describe to parents of infants aged under 12 months the benefits of room sharing and the risks of co-sleeping (see below).
3. Describe to parents the risks of co-sleeping whilst still encouraging breastfeeding, bonding and closeness before returning the infant to its own cot beside the bed.
4. Work in partnership with parents and caregivers to develop settling and sleep strategies which work best for the family or ensure a referral is made to Child and Family Health staff for assistance with this. Suggested strategies must take into account the families' social and life circumstances.
5. Link families with appropriate supports and resources, making referrals as necessary and documenting these in the client record (see page 27–30).

These are definitions of the terms used in this Standard:

Room sharing (RECOMMENDED)

Room sharing is defined as an infant sleeping in a Standards Australia compliant cot (AS/NZS 2172) in the same room as their parents. This is recommended for the first six to 12 months of life. Bed sharing when awake is defined as a parent taking their infant into bed in hospital or at home to feed, provide comfort and closeness and then to return the infant to a safe cot before the parent falls asleep.

Co-sleeping (NOT RECOMMENDED)

The term co-sleeping refers to mothers/partners (or any other person) sleeping on any surface (bed, sofa, couch or mattress) with a baby, whether with the intention to fall asleep or not.



Image courtesy of SIDS and Kids ACT

Please note that these definitions differ slightly from those proposed by UNICEF²⁷ because of the new evidence regarding the protective effect of room sharing and because in the SA context we wish to make clear distinctions between sleeping with a baby (co-sleeping) and sharing the bed when awake with an infant to feed or cuddle (bed sharing).

*'Co-sleeping with infants (whether in a bed or on a sofa, mattress or chair) should be strongly discouraged because it carries with it a clear risk of the infant dying particularly if the baby is of low birth weight or premature, or if adults in the household are smokers, or if the co-sleeping adult has been drinking, has taken medication or drugs or is very tired.'*¹

Standard 3

All staff will consider the social and life circumstances of each family when promoting safe sleeping practices and ensure that information is provided in ways that are culturally accessible and can be easily understood by that family

Indicators of best practice:

To meet this Standard, all workers must be able to:

1. Demonstrate they are able to promote the safe infant care practices recommended by SIDS and Kids in the format most appropriate for the individual family and caregiver.
2. Describe, particularly to 'high needs' and vulnerable clients, including pregnant women, young parents and families from diverse cultural communities, where further evidence-based culturally-appropriate information, services and resources related to safe infant sleeping can be accessed.
3. Work in partnership with families to identify any specific resources, information and services that may be required to meet the unique needs of the infant or the family circumstances.
4. Make referrals as appropriate, particularly where they have reason to believe the parent or caregiver is unable to understand the risks inherent in the sleep environment (e.g. due to language difficulties, intellectual disability or mental health issues).
5. When necessary, engage culturally appropriate supports: such as a person or service that has credibility with the family and is able to translate or convey the evidence-based safe infant care practices in the language or manner that is most suitable for that family (see pages 27–30).
6. Document in the client record any risks identified and referrals made.

The Translating and Interpreting Service provides professional translating services 24 hours a day, 7 days a week – phone 131 450 and quote your service's client number.

See pages 27–30 for services available to Aboriginal families.

Standard 4

All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleeping incidents and that they are supported and referred to smoking cessation or reduction programs.

Indicators of best practice:

To meet this Standard, all workers must be able to:

1. Explain to expectant and new parents the harmful effects to the infant of smoking during pregnancy and second-hand smoke after birth.
2. Describe to families the importance of ensuring a smoke-free zone around pregnant women, infants and children to avoid them being exposed to tobacco smoke before and after birth. This includes the parent's bedroom when room sharing occurs.
3. Work in partnership with individuals to increase smoking disclosure and support them to stop or reduce smoking (e.g. the 5A's approach: Ask, Advise, Assess, Assist, Arrange).
4. Provide pregnant women who smoke with Quit SA resources and referral information as appropriate to assist them to cease or reduce smoking (see page 27–30).

All community facilities will promote smoke-free displays and smoking cessation resources (e.g. antenatal and maternity outpatient clinics, postnatal wards, neonatal units, child care centres, etc).

All agencies will ensure educational messages relating to smoking are available to secondary care providers including day care and child care providers, grandparents, foster parents and babysitters.

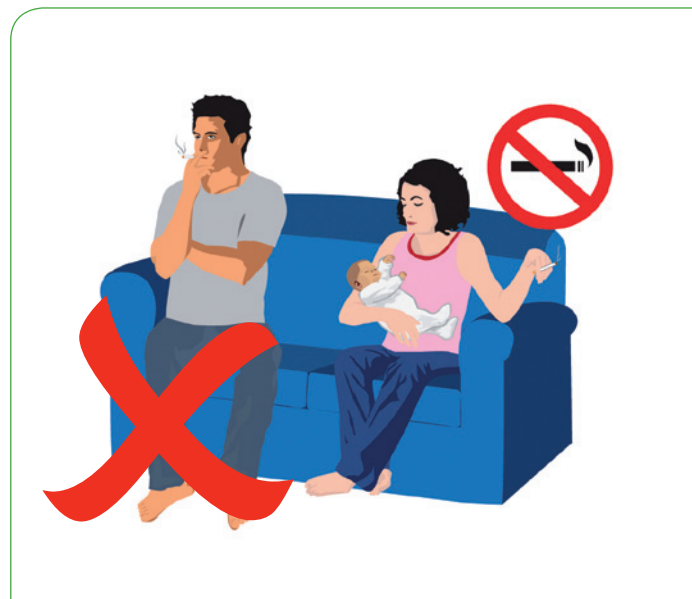


Image courtesy of SIDS and Kids ACT

Standard 5

All staff will provide families and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

Indicators of best practice:

To meet this Standard, all workers must be able to:

1. Describe the dangers associated with a cot that doesn't comply with the Australian Standards for Household Cots (AS/NZS 2172) or is in poor condition, broken or damaged with missing slats. This includes:
 - where the spacing between the bars may be too wide and trap a child's head or too narrow and trap a child's arms or legs,
 - where the corner posts of the cot may be higher than the sides and ends creating a strangulation hazard if clothes get caught on any corner post,
 - when the mattress does not fit snugly to within 20 mm of the sides and ends, and when pillows, toys and other items are not removed to prevent asphyxiation.
2. Explain, particularly to expectant parents and families with young infants, the Australian Standards for Household Cots and the importance of positioning the cot away from blind cords and other hazards.
3. Provide information about safe infant care practices and safe sleeping environments to parents and caregivers of infants under 12 months.
4. Consistently model safe sleeping environments in community settings.
5. Link families with appropriate supports and resources – make referrals as necessary and document this in client records (see page 27–30).

Appendices

Appendix 1:
Additional best practice indicators
specific to SA Health staff and volunteers

Appendix 2:
Additional best practice indicators
specific to Families SA staff and volunteers

Appendix 3:
Additional best practice indicators
specific to Department of Education
and Children's Services – Early Childhood
Services staff and volunteers

Appendix 1: Additional best practice indicators specific to SA Health staff and volunteers

Standard 1: All staff will place well infants under 12 months on their back to sleep from birth, never on the front or side, unless there are medically indicated reasons.

To meet this Standard, all health workers must be able to:

1. Provide parents and caregivers with information on how to position infants safely in the cot and an explanation of the risks associated with side and front positioning.
2. Provide sleep and settling strategies that support parents and caregivers in ways that take into account the specific needs of the infant and the family circumstances.
3. Demonstrate the practice of placing all infants, including those with gastroesophageal reflux, on their back to sleep on a firm, flat mattress that is not elevated.
4. Provide parents and caregivers with strategies to manage gastroesophageal reflux effectively without placing the infant at risk.
5. Demonstrate the practice in neonatal units of placing premature and low birth weight infants on their backs as soon as their oxygen requirements allow and well before discharge.
6. Demonstrate, where a medical directive exists that requires the infant is not placed on their back to sleep in a health facility, that information is provided to parents or caregivers prior to discharge about the importance of placing baby on their back once home.

Standard 2: All staff will be fully informed about the risks of co-sleeping and promote the placing of infants for sleep in a Standards Australia compliant cot in the same room as the parents for the first six to 12 months.

To meet this Standard, all health workers must be able to:

1. Work in partnership with parents and caregivers to identify settling and sleep strategies which take into account the families' social and life circumstances.
2. Demonstrate that the birthing and post-natal facilities where they work model the placing of cots by the mother's bed (away from blind cords) and promote the return of infants to their cot after feeding and before parents fall asleep.
3. Demonstrate that discharge planning, in particular from postnatal or neonatal care units, takes into account risk factors (infant characteristics, parental capacity and environment) and ensures accurate information is provided and appropriate referrals are made in response to these.
4. Demonstrate that discharge planning, in particular from postnatal or neonatal care units, includes information for parents about the risks of co-sleeping and the benefits of room sharing.

Standard 3: All staff will consider the social and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

To meet this Standard, all health workers must be able to:

1. Specifically discuss the five safe infant care practices and intended infant sleeping environment with families prior to discharge.
2. Discuss safe infant care practices and proposed sleeping arrangements with families on their return home and work in partnership with them to address any barriers to implementing safe infant care practices at home through the provision of culturally appropriate referrals, information and services based on the specific needs of the infant and the family.

Standard 4: All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleeping incidents and that they are supported and referred to smoking cessation or reduction programs.

There are no additional indicators of best practice specific to health workers for this Standard.

Standard 5: All staff will provide families and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

To meet this Standard, all health workers must be able to:

1. Provide information and appropriate referrals to parents and caregivers at each point on the care continuum – from the first antenatal contact until the end of infancy.
2. Document information about discharge preparation and referrals to support safe infant sleeping on clinical care pathways and medical and nursing records for both parent and child.
3. Work in partnership with families to identify their reasons for being unable to provide a safe sleeping environment for their infant. These reasons could include cots given as family heirloom, financial constraints, high levels of transience, inadequate housing or other reasons.
4. Engage supports and referrals as appropriate.

Appendix 2: Additional best practice indicators specific to Families SA staff and volunteers

All staff have a duty of care which extends beyond the individual child and includes other family members.

The role of Families SA, as the statutory child protection agency within the Department for Families and Communities, is to provide assessment, education and support to parents and carers aimed at preventing sudden and unexpected infant death. Where the parenting environment has been assessed as being unsafe, Families SA may take action to secure the care and protection of an infant under the Children's Protection Act, 1993. Families SA workers, foster carers and contracted alternative care service provider staff must adhere to the relevant policies, procedures and practices including:

- > Aboriginal Child Placement Principle Policy,
- > Care and Protection Assessment Framework Policy,
- > Care and Protection Assessment Framework Practice Guidelines for Investigation and Assessment,
- > Families SA safe sleeping procedure,
- > Families SA Duty of Care for Children and Young People in Care Policy and Practice Guide,
- > Relative Kinship and Specific Child Only Care Policy,
- > Standards of Alternative Care in South Australia (specifically standard 3.7.1).

Standard 1: All staff will place well infants under 12 months on their back to sleep from birth, never on the front or side, unless there are medically indicated reasons

Best practice indicators

1. Foster carers, relative/kinship carers and contracted alternative care service provider staff who care for infants are informed about, and implement safe sleeping practices for infants under 12 months.
2. Foster carers, relative/kinship carers and contracted alternative care service providers staff who care for infants must seek advice from medical staff about positioning infants safely where a medical directive exists that requires the infant not to be placed on their back to sleep.

Standard 2: All staff will be fully informed about the risks of co-sleeping and promote the placing of infants for sleep in a Standards Australia compliant cot in the same room as the parents for the first six to 12 months.

Best practice indicators

1. When investigating a notification, Families SA staff must sight the infant, view the infants sleeping environment and discuss the sleeping arrangements with the infant's caregivers.
2. This is undertaken as part of the child protection assessment process, or it can be incorporated into an already existing assessment process (e.g. drug and alcohol assessment) which should explore how caregivers who use drugs and/or alcohol will mitigate risks to their infants safe sleeping.
3. It is recommended that Families SA staff demonstrate safe sleeping techniques to support caregivers understanding of the importance of providing safe sleeping environments to their infants.

Standard 3: All staff will consider the social and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

Best practice indicators

1. Families SA recognises that families who are disadvantaged and marginalised may be harder to reach using traditional public health education strategies and therefore require more direct intervention to ensure that safe sleeping strategies are understood and implemented.
2. Families SA staff must promote safe sleeping depending on the family's circumstances (and unless it is not required due to good practices already being in place) including recommending that parents/carers do not sleep with their infant due to risks associated with substance abuse, overlaying by another person and suffocation from pillows and blankets.
3. Families SA staff will consult with the Principal Aboriginal Consultant to ensure engagement with Aboriginal and Torres Strait Islander families/carers/kin/ community is supported in a culturally appropriate manner.
4. Staff must document in the investigation notes on C3MS what safe sleeping promotion was undertaken with the parents/carers, or why safe sleeping promotion was not required (i.e. the parents/carers were already practicing safe sleeping strategies).

Standard 4: All staff will ensure that expectant and new parents are made aware of the strong association between smoking and increased risk of fatal infant sleeping incidents and they are supported and referred to smoking cessation or reduction program.

Best practice indicators

Families SA staff will work in partnership with parents/carers to ensure that they are aware of the increased risk of SIDS associated with smoking and support them to engage with programs to address their smoking behaviour.

Standard 5: All staff will provide families and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and safe environment.

Best practice indicators

1. There may be many reasons why families do not have safe cots or goods to provide a safe sleeping environment for their infants. Staff must work in partnership with families to identify the reasons for this such as financial constraints, high levels of transience, inadequate housing or other reasons.
2. Families who are disadvantaged may also find it harder to adapt their home environment to militate against the risk of SUDI, and therefore may require additional support to do so.
3. Where assessed to be appropriate, Families SA workers should consider integrated practice with Families SA Anti-poverty teams to assess the family's financial difficulties/needs and assist the family to obtain safe cots, baby sleeping bags or appropriate bedding.
4. Staff must document what safe sleeping promotion was undertaken with the caregiver.
5. Staff must document the parents/carers willingness and capacity to meet the needs of the infant as part of the overall assessment of risk to the infant.

Appendix 3: Additional best practice indicators specific to Department of Education and Children's Services – Early Childhood Services staff and volunteers

It is important to acknowledge the critical role early childhood workers play in promoting and modelling safe sleeping practices and environments to families with infants.

The South Australian Safe Sleeping Standards have important implications for both Childcare Centres and Family Day Care workers in relation to the onus they place on staff and family day care providers to model and promote accurate information to parents about:

- > placing infants under 12 months of age in an Australian Standards compliant cot, away from blind cords, with appropriate supervision and lighting,
- > sleeping baby on back, the effects of smoking and the risks of co-sleeping, and
- > conveying this in a way that parents of infants in their care can understand.

NB: It is important to note that a National Standard for Early Childhood Services (covering Family Day Care and Child Care Centres) is currently under development and will include safe sleeping. Once these National Standards have been developed, they will be linked with the accreditation of services from January 2012. All staff and family day care workers will be governed by these National Standards for Early Childhood Services (relevant section) and any other legislation, policies, procedures or guidelines that support the safety of infants particularly in the sleeping environment.



Evidence

Challenges to meeting best
practice, evidence and resources

Challenges to meeting best practice, evidence and resources

Standard 1: All staff will place well infants under 12 months on their back to sleep from birth, never on the front or side, unless there are medically indicated reasons

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Parents and staff may experience many reasons for not placing infants on their back. These may include:</p> <ul style="list-style-type: none"> > Concerns about infants aspirating after feeding and regurgitating. 	<p>All infants should be placed on their back to sleep.</p> <p>Studies have demonstrated that even in healthy infants, respiratory rates, swallowing and arousal are each reduced in the prone (tummy) position compared to the supine (back) position. There is no evidence to support the elevation of the head of the cot for Gastro-oesophageal Reflux Disease (GORD).²⁸</p>	
<ul style="list-style-type: none"> > Belief that baby sleeps and settles better on their front or side.^{29,30} > Difficulty settling and putting infant down to sleep. 	<p>Front and side sleeping positions significantly increase the risk of SIDS, a finding supported by a large body of international studies.^{11,16,28,31,32}</p> <p>All aids and devices intended to keep infants in a certain sleep position are not recommended as they do not prevent infants from rolling on to their tummies and limit the movements of the baby as they get older.</p>	<p>Sleep (Children 0–6 years) Parent Easy Guide www.parenting.sa.gov.au/pegs/PEG34.pdf</p> <p>Parent Helpline can provide advice on settling – avail. 24 hours a day 7 days a week. Ph: 1300 364 100</p> <p>Kidsafe SA and SIDS and Kids can provide advice on sleeping bags and the risks and safety aspects of aids and devices for infants Ph: 8161 6318</p> <p>SIDS and Kids Information Statement ‘Wrapping Infants’ available at www.sidsandkids.org</p> <p>Helping Your Baby to Sleep by Gethin A and McGregor B 2007</p>

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Parents and staff may experience many reasons for not placing infants on their back. These may include:</p> <ul style="list-style-type: none"> > Concerns about misshapen head shape (plagiocephaly). 	<p>All infants should be placed on their back to sleep.</p> <p>Positional plagiocephaly is a flattened spot on the head that can develop if a baby lies with their head in one position for long periods of time.</p> <p>A recent study³³ has shown no significant relationship between sleeping baby on their back and the development of deformational plagiocephaly; positional preference and infant care practices used by parents including the frequency of tummy time, played a greater role.</p> <p>Some of the ways to prevent positional plagiocephaly are:</p> <ul style="list-style-type: none"> > Always place baby to sleep on the back. Alternate baby's head position (left or right) when placed to sleep. > From birth offer baby increasing amounts of time playing on the tummy while awake and watched by an adult. > If bottle feeding, alternate the holding position when feeding baby. <p>There is no evidence to suggest that sleeping baby on their back affects brain development.</p>	<p>SIDS and Kids Information Statement 'Baby's Head Shape' (under Information Statements) for information and strategies to reduce the risk of positional plagiocephaly, available at www.sidsandkids.org</p> <p>Children, Youth and Women's Health Service for information sheet on plagiocephaly visit www.cyh.com</p> <p>Eat well be active – Healthy eating and active play for under 5's DVD provides tips on tummy play time for infants. Go to www.healthpromotion.cyw/hs.sa.gov.au or call 8161 7777 to order your free copy</p> <p>'Tummy time' brochure available from SIDS and Kids SA Ph: 8369 0155</p>
<ul style="list-style-type: none"> > Inconsistent role modelling by staff conflicts with these recommendations. 	<p>Many infants in neonatal special care units are placed on their front or side for medical reasons. However, premature and low birth weight infants are placed on their backs as soon as their oxygen requirements allow and well before discharge, to ensure that the infant and parents are accustomed to the infant being placed on its back to sleep.</p>	
<ul style="list-style-type: none"> > Observation on television or through other media which suggests front or side sleeping of infants is safe. 	<p>It is sometimes implied during advertisements or television programs that it is safe to place baby on the tummy or side to sleep. The side sleeping position is unstable and therefore increases the risk of SIDS by two to four times, attributed mainly to the side position being relatively unstable, resulting in some infants rolling to the tummy position during sleep and asphyxiating. Side sleeping is not recommended as a safe alternative to sleeping on the back. Positioning devices are also not recommended.</p>	

Standard 2: All staff will be fully informed about the risks of co-sleeping and promote the placing of infants for sleep in a Standards Australia compliant cot in the same room as the parents for the first six to 12 months

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Families may site reasons for co-sleeping and not room-sharing. These may include:</p> <ul style="list-style-type: none"> > Being too tired or exhausted to return baby to the cot after breastfeeding. > Having trouble settling their baby. > Falling asleep unintentionally on the couch. 	<p>Infants are more at risk of SUDI and fatal sleeping accidents when co-sleeping occurs</p> <p>It is not safe for anybody to fall asleep with a baby on the same sleep surface.³⁴ Placing a baby to sleep or falling asleep together with a baby on a sofa or couch is extremely hazardous. There is a greatly elevated risk of infant death and sleeping accidents when a baby shares a sofa or couch with an adult during sleep. The risks are increased when the parent or family member is under the influence of alcohol and/or other drugs or under the influence of medication that causes sleepiness and they co-sleep.</p>	<p>See Adelaide Now article on Coroner's Findings 2010 www.adelaidenow.com.au/news/south-australia/parents-warned-on-cot-death-dangers-of-sharing-beds-with-babies/story-e6frea83-1225932207035</p> <p>SIDS and Kids (2007) Information statement on the dangers of co-sleeping: Sleeping with a baby Sept, 2007. Canberra: www.sidsandkids.org</p>
<ul style="list-style-type: none"> > Frequent changes to infant routines and usual sleeping environments lead to difficulty settling. 	<p>When infants become unsettled and have trouble sleeping, parents may be tempted to co-sleep with their infant. Parents will benefit from settling ideas which can be found in the Sleep Parent Easy Guide.</p> <p>A bassinette or travel cot which has been specifically designed as an infant sleeping environment can be used for daytime sleeps and moved from room to room or used when visiting or moving from one house to another. A portacot should only be used with the thin mattress which it comes with. No other mattress or padding should be added to the portacot. The mattress which the portacot comes with is designed to provide adequate comfort for the infant.</p> <p>Car seats, bouncinettes, hammocks, bean bags, pillows and sofas (armchairs, lounges, couches) are not designed as sleeping environments for babies and are not be used for that purpose.</p>	<p>Kidsafe SA can provide advice on the use of portable/travel cots Ph: 8161 6318</p> <p>Parenting SA have information on sleep and settling in their Parent Easy Guide – www.parenting.sa.gov.au/pegs/PEG34.pdf and also www.cyh.com</p> <p>Parent Helpline can provide advice and support 24 hours a day 7 days a week Ph: 1300 364 100</p>

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Families may site reasons for co-sleeping and not room-sharing. These may include:</p> <ul style="list-style-type: none"> > Historically and culturally co-sleeping with infants is considered the norm. > Parents, particularly those for whom English is a second language, may not be aware of the risks of co-sleeping. > Lack of funds to purchase a cot > No room for a cot in the parent's bedroom. > Lack of stable housing. > Overcrowding, with many children sharing the same bed. 	<p>Infants are more at risk of SUDI and fatal sleeping accidents when co-sleeping occurs</p> <p>Despite the practice of sharing a sleep surface with baby being common in culturally diverse communities, Coronial inquests have determined that co-sleeping is a risk to all infants including those from culturally diverse backgrounds.</p> <p>Although it may seem difficult, it is essential that staff provide all families with information about the risks of co-sleeping and the benefits of room-sharing regardless of the family's cultural background.</p> <p>All families, particularly those from diverse backgrounds, need to be aware that the risks of co-sleeping with infants under 12 months are increased when protective factors such as a firm mattress or mat on the floor are substituted with softer sleeping surfaces.</p> <p>All parents also need to be particularly aware of the risks of co-sleeping and smoking.</p> <p>Where possible:</p> <ol style="list-style-type: none"> 1. Ask the parents or caregivers about the baby's sleep environment at home. 2. If the caregiver consents and if home visiting takes place, take a look at the infant's sleeping place. 3. Whether it is obvious that co-sleeping is occurring or not, discuss the risks of co-sleeping and the benefits of room sharing (including breastfeeding). 4. Note the discussion in the case notes and ensure relevant supports and services have been engaged. <p>Maternal awareness of the risk factors associated with SIDS and fatal sleeping incidents is likely to be lower where English is a second language or health literacy is low.</p> <p>If parents use co-sleeping as a means for settling their child before sleep, work in partnership with them to identify other settling strategies which enable them to return baby to his/her own sleep surface or contact the Parent Helpline to get assistance with this.</p>	<p>Aboriginal Maternal Infant Care Workers provide Aboriginal Women with continuity of care for antenatal, birthing and postnatal services. They can be contacted through:</p> <ul style="list-style-type: none"> > Women's and Children's Hospital Ph: 8161 7000 > Lyell McEwin Hospital – Birthing and Assessment Unit Ph: 8182 9326 > Northern Area Midwifery Group Practice Ph: 8252 3711, and Nunkawarrin Yunti Ph: 8406 1600 <p>Australian Refugee Association provide assistance with community and cultural orientation and emergency financial and material assistance Ph: 8354 2951</p> <p>Migrant Resource Centre provide help with settlement, family relationship counseling, financial support and emergency relief, CALD family and children's support service Ph: 8217 9510</p> <p>Translating and Interpreting Service provide professional translating services 24/7 Ph: 131 450</p>

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Families may site reasons for co-sleeping and not room-sharing. These may include:</p> <ul style="list-style-type: none"> > Parents being concerned about not being able to respond to baby quickly enough during the night. 	<p>Infants are more at risk of SUDI and fatal sleeping accidents when co-sleeping occurs</p> <p>Research in New Zealand and the UK has shown that sleeping baby in the same room, but not in the same bed, with the parents for the first 12 months is protective. This is thought to be because parents can see the baby and easily check to see that baby is safe. Recent evidence from the UK indicates that sharing the same room during baby's daytime sleeps is also protective.²⁵</p> <p>Several studies have shown that when a caregiver sleeps in the same room, but not the same bed with their baby, the chance of the baby dying suddenly and unexpectedly is reduced by up to 50% when compared to babies sleeping in a separate bedroom.</p> <p>If baby is sleeping in a separate room, parents are not expected to observe baby constantly but they should check baby regularly to ensure that the infant remains on their back and the head and face remain uncovered (as baby grows beyond 5–6 months they will move around the cot and may roll over).</p> <p>Room-sharing facilitates a rapid response to a baby's needs, more convenient settling and comforting of babies, and closer mother-infant contact and communication.</p> <p>Room sharing is recommended for all babies although the room where baby sleeps must be kept smoke free.</p>	<p>See Adelaide Now article on Coroner's Findings 2010 www.adelaidenow.com.au/news/south-australia/parents-warned-on-cot-death-dangers-of-sharing-beds-with-babies/story-e6frea83-1225932207035</p> <p>SIDS and Kids (2008) Information statement: Room-sharing. May, 2008. Canberra www.sidsandkids.org</p>

Standard 3: All staff will consider the social and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Staff may cite many reasons for not providing information in culturally accessible and appropriate ways including:</p> <ul style="list-style-type: none"> > Assumptions of family literacy levels. > Over reliance on written health information and resources. 	<p>Families need information to be provided in ways that assist them to make decisions and exercise greater control over their health</p> <p>Much of the information provided to families assumes more than a basic level of health literacy. Prior to the birth and after the birth of a baby, families are exposed to an enormous amount of information from a variety of sources including media, marketing, 'bounty bags', nurses, doctors and family members.</p> <p>Unpublished market research conducted in Adelaide, South Australia in 2009, found parents and caregivers more likely to act on and understand information about safe sleeping when this information is provided verbally from a health professional.</p> <p>Parents stressed the importance of the relationship with nurses and health professionals as once at home with baby they are often time poor, tired and stressed. Some parents also reported they relied very little on books, pamphlets and other written information preferring to act on experience.</p> <p>It is essential that staff work in partnership with families and provide information in ways that assist families and caregivers to understand and implement safe infant care practices and that they encourage families to ask questions and critically consider the information available to them. The provision of this essential information to parents should be documented in client records for both mother and baby.</p>	<p>SIDS and Kids provide resources in a number of languages – www.sidsandkids.org/safe_sleeping.html</p> <p>Centre for Health Promotion offer Quality Guidelines for Health Information available on their website www.healthpromotion.cvwhs.sa.gov.au</p> <p>A summary of the Safe Sleeping Program Market Research – Draft Report is available from the Centre for Health Promotion, South Australia.</p>

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Staff may cite many reasons for not providing information in culturally accessible and appropriate ways including:</p> <ul style="list-style-type: none"> > Time taken to communicate effectively. > Lack of knowledge about where to access culturally appropriate information and support. > Difficulties engaging with client relatives and kin. 	<p>Families need information to be provided in ways that assist them to make decisions and exercise greater control over their health</p> <p>The time taken to communicate safe sleeping messages to families can significantly improve parents' capacity to provide a safe sleeping environment for their infant and reduce unnecessary risks. Failure to communicate or the provision of inconsistent, wrong or misleading information, significantly impairs parental capacity to problem solve and make critical decisions around achieving recommended safe sleeping practices.</p> <p>Wherever possible information should be provided in the most appropriate language and format. Approximately 2.7 million Australians (18%) have difficulty understanding and using information relating to health issues.³⁵ Merely translating written health information may exclude those who are illiterate or have exceptionally low literacy levels, regardless of the language used.³⁶</p> <p>Despite the difficulties that communication exchanges might present, it is very important that staff call on people who have credibility with the family or are able to effectively convey the messages and their importance. This may involve seeking people out who are able to help translate the information into the language or in a manner that is suitable and has meaning for the family.</p> <p>By doing this staff can ensure:</p> <ul style="list-style-type: none"> > knowledge and understanding of safe sleeping messages by families is improved, > families have greater commitment and confidence to problem solve and overcome the barriers to implementing the safe infant care practices at home, and > they have a greater awareness of families' needs and preferences. <p>Many agencies now have Culturally and Linguistically Diverse (CALD) workers and Aboriginal Health or Liaison workers. Staff should familiarise themselves with these supports and call on them as needed.</p>	<p>Aboriginal Maternal Infant Care Workers provide Aboriginal Women with continuity of care for antenatal, birthing and postnatal services. They can be contacted through:</p> <ul style="list-style-type: none"> > Women's and Children's Hospital Ph: 8161 7000 > Lyell McEwin Hospital – Birthing and Assessment Unit Ph: 8182 9326 > Northern Area Midwifery Group Practice Ph: 8252 3711, and > Nunkawarrin Yunti Ph: 8406 1600 <p>Australian Refugee Association provide assistance with community and cultural orientation and emergency financial and material assistance Ph: 8354 2951</p> <p>Migrant Resource Centre provide help with settlement, family relationship counselling, financial support and emergency relief, CALD family and children's support service Ph: 8217 9510</p> <p>Translating and Interpreting Service provide professional translating services 24/7 Ph: 131 450</p>

Standard 4: All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of SIDS and supported and referred to smoking cessation or reduction programs.

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Expectant and new parents may not disclose their smoking status for a number of reasons</p> <ul style="list-style-type: none"> > Families and caregivers may underestimate the effects of smoking on infants and children. > Families and caregivers are under-informed about the risks between smoking, infants and fatal sleeping incidents. 	<p>Infants of mothers who smoke or who are exposed to second hand smoke are more likely to be stillborn, born prematurely and of low birth weight and suffer perinatal death.</p> <p>Infants and children are at a higher risk of harm from passive smoking than adults because of their smaller, developing bodies, higher breathing rates and less developed respiratory and immune systems.</p> <p>Infants of mothers who smoke or who are exposed to second hand smoke are more likely to be stillborn, born prematurely and of low birth weight and suffer perinatal death. Specific effects of passive smoking on infants and children include SIDS; respiratory infections and conditions including croup, bronchitis, and pneumonia; ear infections; learning difficulties; behavioural problems; and increased likelihood of childhood asthma.³⁷⁻⁴⁰</p> <p>There is no safe level of passive smoke exposure, and even brief exposures can be harmful. The elimination of smoking in indoor spaces is the only way to fully protect children from exposure to second hand smoke. Primary sources of infants' and children's passive smoke exposure are the home and vehicle. A single cigarette smoked in a room with poor ventilation generates much higher concentrations of toxic substances in the air than normal, everyday activities in a city, while nicotine from second hand smoke is deposited on household surfaces and in dust. Environmental tobacco smoke permeates the entire house and lingers long after the cigarette has been extinguished, so smoking in certain rooms, at certain times, or by a window, fan or door is not safe.³⁷</p>	<p>Smoking and Pregnancy booklet available from Quit SA – www.quitsa.org.au/asp/order_online.aspx</p> <p>Pregnant and Smoking (Aboriginal) booklet available from Quit SA – www.quitsa.org.au/asp/order_online.aspx</p> <p>Quit SA can provide information and advice on how to quit smoking Ph: 137848 www.quitsa.org.au</p>
<ul style="list-style-type: none"> > They are unaware of the opportunities pregnancy presents to quit smoking. 	<p>Pregnancy provides a unique window of opportunity to minimise smoking rates and increase the health of women and children. More women cease smoking in pregnancy than at any other time in life. One quarter of Australian women who are smokers when they become pregnant stop smoking. Most of the women who quit smoking spontaneously upon becoming pregnant have a non-smoking partner, are supported to quit, or have stronger beliefs about the dangers of smoking than do those who do not quit.^{39,40}</p>	<p>Quit SA can provide information and advice on how to quit smoking Ph: 137848 www.quitsa.org.au</p>

Standard 5: All staff will provide families and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

Challenges in meeting best-practice	Evidence supporting best practice	Support and resources
<p>Parents and staff may experience reasons for not implementing safe sleeping environments including:</p> <ul style="list-style-type: none"> > Belief that baby sleeps better with teddy bears and soft toys, a pillow or doona. > Belief that cot bumpers protect baby's head. 	<p>A safe sleeping environment is one where all potential dangers have been removed and the infant is sleeping in a safe place.</p> <p>One of the key barriers to parents and caregivers implementing safe infant care practices is perceptions of infant comfort believing their baby sleeps better with a teddy or a pillow. It is critical that parent's are provided with evidence based health advice about not placing toys and pillows in the cot.²⁰</p> <p>Research has found that parents who have the opportunity to work in partnership with health professionals to problem solve the issues around comfort and protection for their baby are more likely to adopt safe infant care practices.⁴¹</p> <p>Providing information in ways that allow parents to gain an understanding of the evidence which supports safe infant care practices, particularly those relating to the risks of asphyxiation (suffocation) and overheating due to soft toys, bumpers, pillows and doonas is essential.</p>	<p>Sids and Kids SA provide advice on setting up the sleep environment Ph: 8369 0155</p> <p>Sids and Kids also have an easy-to-read brochure with graphics of a safe cot and bedding on their website www.sidsandkids.org</p> <p>Kidsafe SA provide advice on the cot standards and safe sleeping environments Ph: 8161 6318 www.kidsafesa.com.au</p> <p>SIDS and Kids provide an Information statement on Room Temperature www.sidsandkids.org</p> <p>The www.cyh.com website provides a comprehensive explanation with pictures of the ins and outs of wrapping babies</p>
<ul style="list-style-type: none"> > Parental concerns about baby not being warm enough lead to over dressing and overheating. 	<p>Infants regulate their temperature through the head, particularly the face. In a heavily wrapped infant, 85% total heat loss is through the face. If this normal method of heat loss is restricted by bedding covering the face; wearing a bonnet or tummy sleeping (partial face covering by mattress and/or bedding), there is the propensity for thermal stress to occur (overheating).⁴¹</p> <p>A safe cot is one that meets the Australian Standard for cots. All new and second-hand cots sold in Australia must meet the Australian Standard for Household Cots (AS/NZ 2172)²³ and will carry a label verifying this. Portacots sold in Australia must now also meet the Australian Standard AS/NZS 2195 for portable cots.^{42,43}</p> <p>Unsafe cots and bedding, whether given as a well-meaning gift at a baby shower or passed down through the family as an heirloom, pose risks to infants. These are best kept for display only and not used where the infant sleeps.</p> <p>If you or a parent seek information about the safety of a product, contact the Australian Competition and Consumer Commission.</p>	<p>Kidsafe Australia website www.kidsafe.com.au</p> <p>For information on mandatory product safety www.productsafety.gov.au</p>
<ul style="list-style-type: none"> > Lack of knowledge about Australian Standards for cots. > Relatives and friends give bumpers and pillows as gifts or heirlooms. 		



Services and information

Quick guide for help
Quick guide for information
References

Quick guide for help

This list is intended as a guide only and does not in any way intend to be an exhaustive list of all available services in South Australia.

Challenges to Safe Practice	Services	Details	Contact
Sleep positioning Placing baby on back to sleep may raise: <ul style="list-style-type: none"> > concerns about infants aspirating after feeding and regurgitating, > belief that baby sleeps and settles better on the front or side, > difficulty settling and putting infants down to sleep, > concerns about miss-shapen head (plagiocephaly). 	Child and Family Health nurses	Child and Family Health Nurses can provide support and advice to parents.	CaFHs appointment line Ph: 1300 733 606
	Kidsafe SA	Kidsafe SA provide advice on sleeping bags and the risks and safety aspects of aids and devices for infants.	Kidsafe SA Ph: 8161 6318 www.Kidsafesa.com.au
	SIDS and Kids SA	Provide counselling and advice on the reasons for sleeping baby on back.	SIDS and Kids SA Ph: 8369 0155 www.sidsandkids.org
	SA Parent Helpline	Advice on settling babies is available from the Parent Helpline 24/7.	SA Parent Helpline Ph:1300 364 100 www.parenting.sa.gov.au/helpline/
	Health Direct Helpline	24 hour call centre for non urgent health advice.	Health Direct Helpline Ph: 1800 022 222
Cot bedding Removing many forms of bedding and toys from the cot may raise: <ul style="list-style-type: none"> > concerns baby will get cold without a doona, hat, duvet etc, > belief that baby sleeps better with toys, pillow or sheep skin in the cot, > no funds to purchase baby sleeping bag. 	Child and Family Health nurses	CaFHs nurses can demonstrate wrapping techniques and advise on appropriate infant bedding and settling techniques.	CaFHs appointment line Ph: 1300 733 606
	SA Parent Helpline and Kidsafe SA	Can provide advice on setting up a safe sleep environment for babies 24/7.	Parent Helpline Ph:1300 364 100 www.parenting.sa.gov.au/helpline/ Kidsafe SA Ph: 8161 6318
	SIDS and Kids SA	Provide counselling and advice about the sleep environment for babies.	SIDS and Kids SA Ph: 8369 0155 www.sidsandkids.org
	Health Direct Helpline	24 hour call centre for non urgent health advice.	Health Direct Helpline Ph: 1800 022 222
Smoking at home Families and caregivers: <ul style="list-style-type: none"> > underestimate the effects of smoking on infants, > are unaware of the association between smoking and fatal sleeping incidents, > are unaware of the opportunities pregnancy presents to quit smoking. 	Quit SA	Provides state-wide programs to help smokers quit smoking.	Quit SA Ph:137 848

Challenges to Safe Practice	Services	Details	Contact
<p>Room sharing</p> <p>Sleeping baby in their own cot located next to the parent's bed or in the same room as the parents could present difficulties if there is:</p> <ul style="list-style-type: none"> > no access to a cot, > no funds for a cot, > no room for a cot in the parent's bedroom, > cultural practices which support other than safe practice, > no stable housing, > many children sharing the same bed. 	Aboriginal Maternal Infant Care Workers	Aboriginal Maternal Infant Care Workers provide Aboriginal Women and their families with continuity of care for antenatal, birthing and postnatal services.	<p>AMIC workers can be contacted through:</p> <ul style="list-style-type: none"> > Women's and Children's Hospital Ph: 8161 7000 > Lyell McEwin Hospital – Birthing and Assessment Unit, Ph: 8182 9326 > Northern Area Midwifery Group Practice Ph: 8252 3711 > Nunkawarrin Yunti Ph: 8406 1600
	Department for Families and Communities (DFC)	Can provide information and access to financial services, housing services and family support.	The DFC website has location and contact details of services provided http://www.dfc.sa.gov.au/pub/
	Centacare Lutheran Community Care Anglicare Uniting Care Wesley	These 4 agencies can provide emergency financial assistance and housing support in certain circumstances and some provide services in country areas.	<p>Their websites have location and contact details of services available: www.centacare.org.au</p> <p>Lutheran Care Ph: 8269933</p> <p>www.anglicare-sa.org.au</p> <p>Uniting Care Wesley: www.ucwpa.org.au/</p>
	Nunkawarrin Yunti of SA	Provide access to paediatric services for Aboriginal families.	Nunkawarrin Yunti Ph: 8406 1600
	Translating and Interpreting Service (TIS)	Provide professional translating services 24/7.	Translating and Interpreting Service (TIS) Ph: 131 450 and quote your service's client #
	Migrant Health Service	The MHS provides culturally appropriate medical care for migrants, refugees and asylum seekers. Training, advice and information is also provided to individuals and groups.	Migrant Health Service Ph: 8237 3900
	Migrant Resource Centre (MRC)	Can provide help with settlement, financial support and emergency relief, CALD family and children's support service.	Migrant Resource Centre (MRC) Ph: 8217 9510

Challenges to Safe Practice	Services	Details	Contact
<p>Difficult social and life circumstances</p> <p>Difficulty implementing safe infant care practices due to:</p> <ul style="list-style-type: none"> > poor emotional health and wellbeing, anxiety, depression, > recent migration, > cultural and linguistic diversity, > limited mental capacity, > drug/alcohol use, > violence, > young parents. 	Nunkawarrin Yunti of SA	Have access to psychologist and psychiatric services for Aboriginal families.	Nunkawarrin Yunti Ph: 8406 1600
	Alcohol and Drug Information Service helpline	Provide confidential alcohol and drug counselling 24/7. If an interpreter is needed, ring the Translating and Interpreting Service on 13 1450 and ask to be connected to the SA Alcohol and Drug Information Service.	Alcohol and Drug Information Service helpline Ph: 1300 13 1340 South Australian callers – local call fee Or phone TIS on 131450 for an interpreter
	Beyond Blue Info Line	Provides access to information and referral to relevant services for depression and anxiety.	Beyond Blue Info Line Ph: 1300 22 4636
	Department for Families and Communities (DFC)	Can provide access to financial services, housing services and family support. Families SA has a specific role to protect children. Any concerns about the safety and well being of infants and children can be made to the Child Abuse Report Line which operates 24/7.	The DFC website has location and contact details of services provided www.dfc.sa.gov.au/pub/ The Child Abuse Report Line Ph 131 478 is a part of Families SA.
	Louise Place (Centacare)	Louise Place is a 24hour supported accomm. service for young women who are pregnant or parenting and who are homeless or at risk of homelessness, during their pregnancy and in the early months of parenting. They also provide an outreach service.	Louise Place can be contacted directly on Ph: 8272 6811
	Migrant Health Service	The MHS provides culturally appropriate medical care for migrants, refugees and asylum seekers. Training, advice and information is also provided to individuals and groups.	Migrant Health Service Ph: 8237 3900
	Migrant Resource Centre (MRC)	Provide help with settlement, family relationship counselling, financial support and emergency relief, CALD family and children's support service.	Migrant Resource Centre (MRC) Ph: 8217 9510

Continued on page 30...

Challenges to Safe Practice	Services	Details	Contact
<i>Continued from page 29...</i>			
Difficult social and life circumstances <i>Difficulty implementing safe infant care practices due to:</i> <ul style="list-style-type: none"> > poor emotional health and wellbeing, anxiety, depression, > recent migration, > cultural and linguistic diversity, > limited mental capacity, > drug/alcohol use, > violence, > young parents. 	Translating and Interpreting Service (TIS)	Provide professional translating services 24/7.	Translating and Interpreting Service (TIS) Ph: 131 450 and quote your service's client number
	Men's Line	Provides a dedicated service for men with relationship and family concerns 24/7.	Men's Line Ph: 1300 789978 www.menslineaus.org.au/
	Domestic Violence Crisis Service 1300 782 200 Mon–Fri 9am–4pm	These are just a starting place to contact Aboriginal workers located in the Northern and Southern regions of SA providing advice and assistance responding to domestic violence.	> Northern: Muna Paiendi Ph:8182 9206
	Police 131 444		> Southern: ATSI Primary Health Care Team Ph: 8384 9266
Central Eastern Domestic Violence Service (CALD workers may be available) Ph: 8365 5033		> Aboriginal Family Clinic Ph: 8179 5943 > Flinders Medical Centre: Karpa Ngarrattendi Ph: 8204 5012	

Quick guide for information

The Child and Family Health Service website www.cyh.com provides a comprehensive range of up-to-date evidence-based information about safe sleeping for babies. Another useful source of information is the SIDS and Kids website www.sidsandkids.org. Listed below are further information sources available to families seeking evidence-based information about safe infant sleeping environments and care practices.

Safe infant care	Information service	Details	Contact
Sleep and settling	Parenting SA	Parent Easy Guides 'Sleep (Children 0–6 years)'	www.parenting.sa.gov.au/pegs/PEG34.pdf
Head shape (plagiocephaly)	Child and Family Health	'Plagiocephaly' 'Baby's Head Shape'	www.cyh.com www.sidsandkids.org
Wrapping Infants	SIDS and Kids SA	'Wrapping Infants' Info Sheet	www.sidsandkids.org
Tummy time	SIDS and Kids SA	'Tummy time' brochures	SIDS and Kids – Ph: 8369 0155 www.sidsandkids.org
	Centre for Health Promotion	Eat well be active – Healthy eating and active play for under 5's DVD tips on tummy play time for infants	Centre for Health Promotion Ph: 8161 7777 to order a free copy www.healthpromotion.cywhs.sa.gov.au
Post natal depression/anxiety	Beyond Blue	Provide information about mental health, anxiety and depression on their website	Ph: 1300 22 4636 www.beyondblue.org.au www.cyh.com
Culturally and linguistically diverse written information	Sids and Kids	SIDS and Kids provide information sheets in other languages	www.sidsandkids.org
Product Safety, cots and the dangers of positioning cots near blind cords and other hazards	Australian Standards	Australian Standard for Household Cots (AS/NZS 2172)	Tips to keep your baby safe Kidsafe Australia www.kidsafe.com.au
	Australian Competition and Consumer Commission	For information about competition, fair trade and consumer protection laws and benefits for consumers, business and the community	www.productsafety.gov.au www.accc.gov.au/

References

1. Child Death and Serious Injury Review Committee. Annual report 2008–2009. Adelaide: Government of South Australia. 2010 Oct. p. 13.
2. Coroner's Court South Australia. Findings in the matter of Inquest Number 6/2008 (1908/2005, 2061/2005, 2152/2005, 2299/2005, 0953/2006). Adelaide: Courts Administration Authority South Australia; 2008 June. p. 26.
3. Young J, O'Rourke P. Improving attitudes and practice relating to sudden infant death syndrome and the Reduce the Risk messages: The effectiveness of an educational intervention in a group of nurses and midwives. *Neonatal, Paediatric and Child Health Nursing*. 2003 July;6(2):4–14.
4. Douglas TA, Buettner PG, Whitehall J. Maternal awareness of sudden infant death syndrome in North Queensland, Australia: An analysis of infant care practices. *Journal of Paediatrics and Child Health*. 2001;37(5):441–445.
5. Panaretto KS, Smallwood VE, Cole P, Elston J, Whitehall JS. Sudden infant death syndrome risk factors in north Queensland: A survey of infant-care practices in Indigenous and non-Indigenous women. *Journal of Paediatrics and Child Health*, 2002;38(2):129–134.
6. Young J, Schluter PJ. SIDS: What do nurses and midwives know about reducing the risk? *Neonatal, Paediatric and Child Health Nursing*. 2002 Nov; 5(2):19–26.
7. Schluter PJ, Young J. Reducing the risk of SIDS: what infant care practices are being used by primary caregivers in Queensland? *Neonatal, Paediatric and Child Health Nursing*. 2002 Nov;5(2):27–35.
8. Queensland Health. Safe Infant Care to Reduce the Risk of Sudden Unexpected Deaths in Infancy Policy Statement and Guidelines. Queensland: Queensland Health, Queensland Government; 2008 Nov. p. 10.
9. Bacon C, Fleming, PJ. Design of the SUDI study. Chapter 2, p.8. In: Fleming PJ, Blair PS, Bacon C, Berry J, editors. Sudden unexpected deaths in infancy: the CESDI SUDI studies 1993–1996. London: The Stationery Office; 2000.
10. Krous HF, Beckwith JB, Byard RW, Rognum TO, Bajanowsky T, Corey T, Gutz E, Hanzlik R, Keens TG, Mitchell EA. Sudden infant death syndrome and unclassified infant deaths: A definitional and diagnostic approach. *Paediatrics*, 2004;114(1): 234–238.
11. National Institute of Clinical Studies. Evidence-practice gaps report, volume 2. Melbourne: NICS; 2005.
12. Linacre S. Australian social trends 2007: Australia's babies. Catalogue no. 4102.0. Canberra: Australian Bureau of Statistics; 2007.
13. Tursan d'Espaignet E, Bulsara M, Wolfenden L, Byard RW, Stanley FJ. Trends in sudden infant death syndrome in Australia from 1980 to 2002. *Forensic Science Medicine and Pathology*. 2008;4(2):83–90.
14. Chan A, Scott J, Nguyen A-M, Sage L. Pregnancy Outcome in South Australia 2006. Adelaide: Pregnancy Outcome Unit, South Australian Department of Health; 2007.
15. Maternal, Perinatal and Infant Mortality Committee. Maternal, perinatal and post-neonatal deaths in South Australia 2008. Adelaide: SA Health, Government of South Australia; 2009.
16. Mitchell EA. Recommendations for sudden infant death syndrome prevention: a discussion document. *Archives of Disease in Childhood*. 2007;92(2):155–159.
17. Hunt CE, Hauck FR. Sudden infant death syndrome. *Canadian Medical Association Journal*. 2006;174(13):1861–1869.
18. Vennemann MMT, Butterfaß-Bahloul T, Jorch G, Brinkmann B, Findeisen M, Sauerland C, Bajanowski T, Mitchell EA, The GeSID group. Sudden Infant Death Syndrome: No increased risk after immunisation. *Vaccine*. 2007;25(2):336–340.
19. Mitchell EA, Blair, PS, L'Hoir MP. Should pacifiers be recommended to prevent sudden infant death syndrome? *Pediatrics*. 2006;117(5):1755–1758.

20. Moon RY, Horne RS, Hauck FR. Sudden infant death syndrome. *The Lancet*. 2007;370(9598):1578–1587.
21. Blair PS, Sidebotham P, Berry PJ, Evans M, Fleming PJ. Major epidemiological changes in sudden infant death syndrome: a 20 year population-based study in the UK. *The Lancet*. 2006;367(9507):314–319.
22. NSW Child Death Review Team. Sudden Unexpected Deaths in Infancy: the New South Wales Experience. Report written for the NSW Child Death Review Team by the Commission for Children and Young People, Sydney: NSW Commission for Children and Young People, NSW Child Death Review Team; 2005.
23. Joint Technical Committee CS-003. Australia/New Zealand Standard 2172: Cots for household use – Safety requirements. Sydney/Wellington: Standards Australia/Standards New Zealand; 2003 Nov.
24. Carpenter RG, Irgens LM, Blair PS, England PD, Fleming P, Huber J, Jorch G, Schreuder P. Sudden unexplained infant death in 20 regions in Europe: case control study. *The Lancet*. 2004 Jan 17;363:185–191.
25. Tappin D, Ecob R, Brooke H. Bedsharing, roomsharing and sudden infant death syndrome in Scotland: a case-control study. *The Journal of Pediatrics*. 2005 July: 147(1):32–37.
26. Escott A, Elder DE, Zuccollo JM. Sudden unexpected infant death and bedsharing: referrals to the Wellington Coroner 1997–2006. *The New Zealand Medical Journal*. 2009 July 3;122(1298):59–68.
27. UNICEF UK Baby Friendly Initiative. Babies sharing their mother’s bed while in hospital: a sample policy. London: UNICEF UK Baby Friendly Initiative; 2004 May.
28. Craig WR, Hanlon-Dearman A, Sinclair C, Taback S, Moffatt M. Metoclopramide, thickened feedings, and positioning for gastro-oesophageal reflux in children under two years. *Cochrane database of systematic reviews*. The Cochrane Collaboration: John Wiley and Sons, Ltd. 2010; Issue 5. Art. No.: CD003502.
29. Boschert S. Mother’s race a factor in infant sleep positioning: expand education efforts. *Family Practice News*. 2004;34(2):57.
30. Colson ER, McCabe LK, Fox K, Levenson S, Colton T, Lister G, Corwin MJ. Barriers to following the back-to-sleep recommendations: Insights from focus groups with inner-city caregivers. *Ambulatory Pediatrics*. 2005;5(6):349–54.
31. Jeffery H, Megevand A. Why the prone position is a risk factor for sudden infant death syndrome. *Pediatrics*. 1999;104(2):263–269.
32. Galland BC, Taylor BJ, Bolton DPG. Prone versus supine sleep position: A review of the physiological studies in SIDS research. *Journal of Paediatrics and Child Health*. 2002;38(4):332–338.
33. Van Vlimmeren LA, van der Graaf Y, Boere-Boonekamp MM, L’Hoir MP, Helders PJM, Engelbert RHH. Risk factors for deformational plagiocephaly at birth and at 7 weeks of age: A prospective cohort study. *Pediatrics*. 2007;119(2):e408–e418.
34. Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EMA, Fleming P. Hazardous co-sleeping environments and risk factors amenable to change: case-control study of SIDS in south west England. *BMJ*. 2009;339(b3666): 1–11.
35. Linacre S. Adult literacy and life skills survey, summary results. Catalogue no. 4228.0. Canberra, Australian Bureau of Statistics; 2006:5.
36. Nutbeam, D. Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies in the 21st Century. *Health Promotion International*. 2000;15(3):259–267.
37. National Health and Medical Research Council. The health effects of passive smoking: A scientific information paper. Canberra: Australian Government Publishing Service; 1997.
38. US Department of Health and Human Services. Children and Secondhand Smoke Exposure. Excerpts from *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta: US Department of Health and Human Services, Centres for Disease Control and Prevention, Coordinating Centre for Health Promotion, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2007.

39. Lumley J, Oliver S, Chamberlin C, Oakley L. Interventions for promoting smoking cessation during pregnancy. The Cochrane Database of Systematic Reviews. The Cochrane Collaboration; John Wiley and Sons, Ltd. 2009; Issue 3. Art No.: CD001055.
40. Centre for Community Child Health. Preventing Smoking During Pregnancy: Practice Resource [Internet]. 2006 [cited 2011 Jan 12]. Available from: http://www.rch.org.au/ccch/profdev.cfm?doc_id=11187
41. Australian Competition and Consumer Commission. Keeping baby safe: a guide to nursery furniture. Canberra: Commonwealth of Australia; 2005.
42. Joint Technical Committee CS-003. Australia/New Zealand Standard 2195: Folding Cots – Safety Requirements. Sydney/Wellington: Standards Australia/Standards New Zealand; 2010 Feb.
43. Kids Health. Safety fact sheets, portable cots [pamphlet]. Sydney: Kids Health, the Children's Hospital at Westmead; 2010.

For more information

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Phone: (08) 8161 7777
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Non-English speaking: for information in languages other than English, call the Interpreting and Translating Centre and ask them to call The Department of Health. This service is available at no cost to you, contact (08) 8226 1990.

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