

# A Statewide Safe Sleep Survey of Massachusetts Birthing Hospitals



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# What we know....

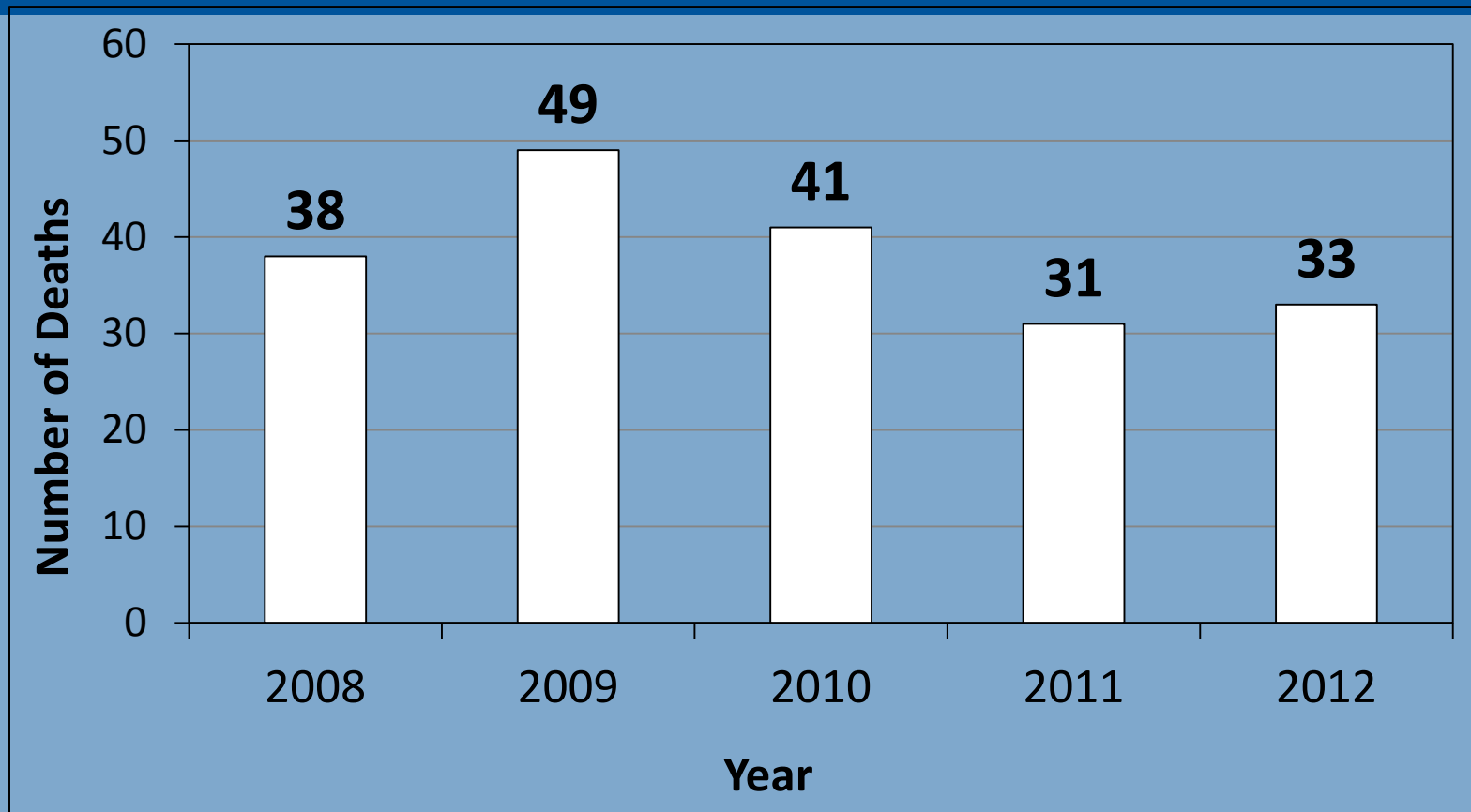
SUID is the leading cause of death among infants 1-11 months of age.

- In 2012, 30% (N=28) of all MA deaths in this age group were due to SUID

Source: Registry of Vital Records and Statistics, MDPH



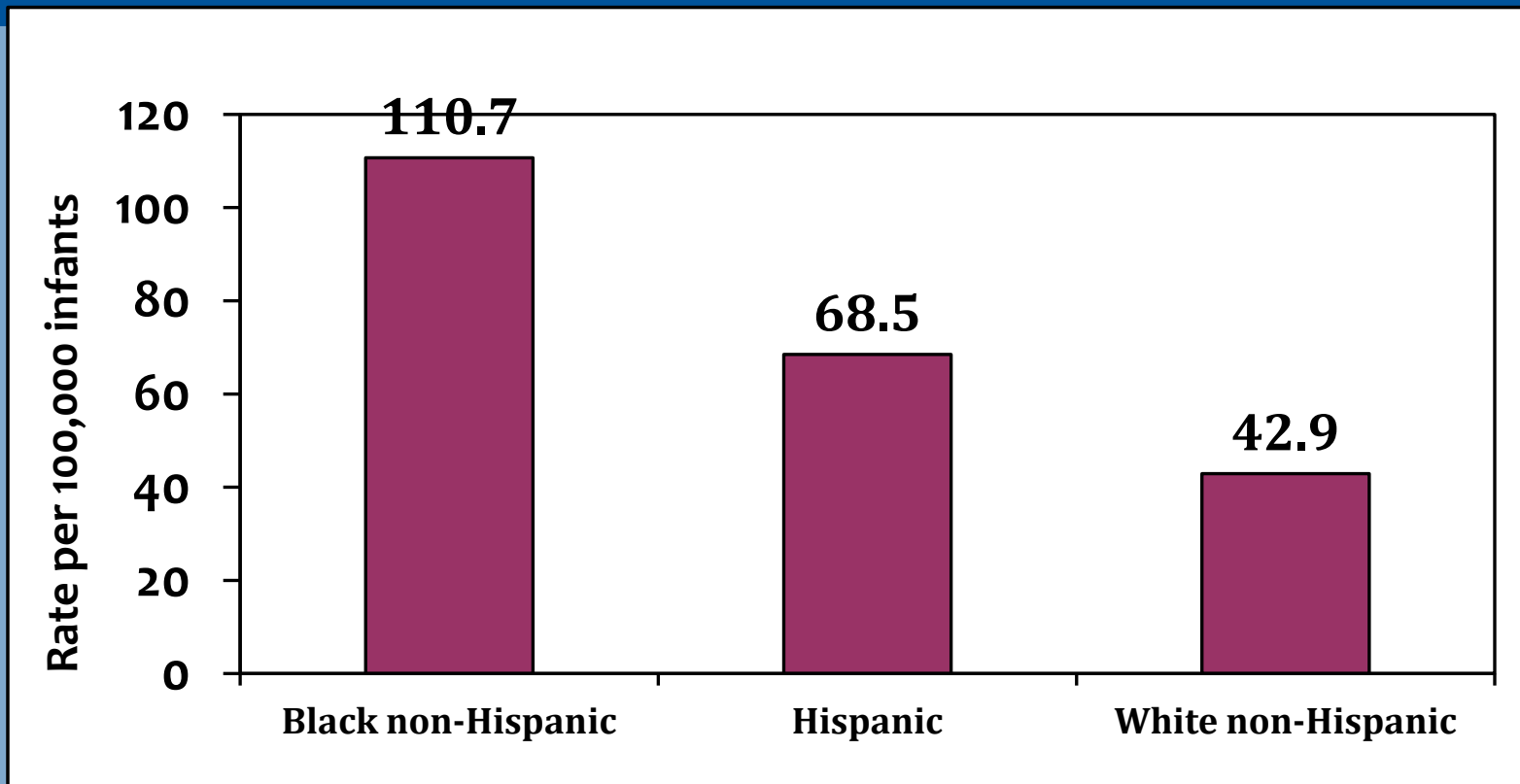
# Sudden Unexpected Infant Deaths, MA Infants 2008-2012



Source: Registry of Vital Records and Statistics, MDPH



# Average Annual Rate of Sudden Unexpected Infant Death\* by Selected Race/Ethnicity, MA Residents <1 Year, 2008-2012



Source: Registry of Vital Statistics, MDPH.

\*SUID includes: SIDS, unintentional suffocation in bed, and undetermined causes

Rates not displayed for racial and ethnic groups where count <5



# MA Birthing Hospital Survey & Results



# Survey of MA Maternity Facilities

- ★ MDPH and MA Perinatal Team collaboration
- ★ Maternity facilities are natural resource for newborn parent education about safe sleep
- ★ Purpose of survey was to document:
  - Current practices and policies
  - Input on how MDPH can assist facilities



# Methods

- ★ MDPH contracted with Harvard School of Public Health's Injury Control Research Center (HICRC) to survey facilities
- ★ Ad hoc committee and many advisors provided input on items
- ★ MA Perinatal Team provided contact info
- ★ Online survey via Qualtrics software administered April – September 2013



# Participation

- ★ 47 maternity hospitals and 2 birthing centers invited to participate
- ★ Paul Muzhuthett of MA Perinatal Team sent invitation and multiple reminders
- ★ HICRC contacted remaining non-responders personally
- ★ 100% RESPONSE RATE





# Limitations

- ★ Survey was self-report, not based on objective observation
- ★ Actual content of hospital written policies was not reviewed
- ★ Policies do not always reflect practice



# Results: Safe Sleep Policy

- ★ Half of the birthing hospitals had a written infant “safe sleep” policy.
- ★ Within their safe sleep policies:
  - “Back Only” sleep was the most common component (95%)
  - Exclusion of soft crib items (82%)
  - Avoidance of general co-bedding (82%)
  - Co-bedding multiples (68%)
  - Encouraging co-rooming (68%)
  - Avoidance of overheating (77%)
- ★ Twenty-six percent had a written policy with all six components



# Results: Patient Education

- ★ 100% of the nursing staff review a discharge document with each newborn mother
- ★ 98% of the discharge documentation have listed safe sleep recommendations



# Birthing Hospital Safe Sleep Report

★ MDPH's Safe Sleep website:

[www.mass.gov/safesleep](http://www.mass.gov/safesleep)

- Located under "Publications and Reports"



# Where we are today?

## ★ Birthing Hospitals

- Developed safe sleep programs
- NICUs

## ★ Hospital Forum – June, 2014

- 2<sup>nd</sup> Forum - 2015

## ★ Developing a model policy for birthing hospitals

## ★ Training/Presentations



# Ad Hoc Advisory

## ★ MDPH

- Deborah Clapp
- Justine Egan
- Holly Hackman
- Jeanne Hathaway
- Ruth Karacek
- Lisa McCarthy-Licorish
- Paul Muzhuthett
- Carlene Pavlos
- Lauren Smith

## ● HSPH

- Ruth Aga
- Catherine Barber
- David Hemenway
- Christelle Salomon

## ● Hospitals

- MA Perinatal Team
- Lisa Alee



# Thanks Also to

- ★ Respondents at MA maternity facilities
  - ★ Dr. Munish Gupta
  - ★ Dr. Susan Hwang
  - ★ Charlene Torrisi
  - ★ Becky Sarah
  - ★ Mary McClain
- MA Perinatal Advisory Committee
  - Funding by:
    - CDC National Center for Injury Prevention and Control



# Thank You

## Contact Information

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