SLEEP ROOM POLICY

Parents will be consulted respecting their child's sleeping arrangements at the time of enrolment and at any other necessary time and made aware of MLCP's nap time protocols to ensure that the optimum sleep time arrangements are followed.

Infants will never be left alone. As per CCEYA regulations, sleeping **infants** will be monitored at all times. Nap time will be a soothing, peaceful time with music and rubbed backs or rocking as requested by parent or needed by child. They will be monitored for comfort. **Infants** who are unable to roll independently or are under 12 months will be placed on their backs. **Infants** will sleep for approximately two hours and awoken gently and with respect.

Please see the attached Joint Statement on Safe Sleep (ss.33.1[1]) – MLCP shall ensure that that those children **younger than 12 months** will be placed for sleep in a manner consistent with recommendations set out in this document.

Assigned cribs will be labelled and occupants of the sleep room noted at its entrance.

Monitoring sheets will be prepared listing all registered **infants**, who will be checked at 15 minute intervals and initialled by the staff doing the check. Visual checks must include note of comfort, chest movement and healthy colouring.

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(iv) Parents of children who regularly sleep at MLCP will be advised of MLCP's policies and procedures regarding children's sleep {(O. Reg. 137/15, ss. 33.1(2)(c)(iv))}. (iii) Parents of children **younger than 12 months** will be advised of MLCP's obligation under subsection (1), {(O. Reg. 137/15, ss. 33.1(2)(c)(iii))} & (iv) parents of children who regularly sleep at MLCP will be advised of MLCP's policies and procedures regarding children's sleep, {(O. Reg. 137/15, ss. 33.1(2)(c)(iv))}.

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Sheets will be submitted to the office at the end of each month.

Staff monitoring sleeping children are expected to use that time for documentation and planning.

Licenced students and/or their parents may decide whether a child naps or partakes of quiet activity.

A cot or crib will be assigned to each napper and labelled accordingly. Each student shall use their own personal bedding with substitutes available as needed. Bedding will be changed weekly or as needed.

The nap rooms will be arranged to offer dimmed lighting, soothing music and whatever may be needed to assist a child to sleep or quiet play. Children deciding not to nap can use materials or activities of their choosing in a quiet and peaceful manner during rest time.

Should there be significant sleep patterns or behaviour changes noted with any napper, these will be relayed to parents/guardians along with any adjustments made to the regular routine to make the child's sleeping experience as pleasant as possible (raised bed, additional blanket, etc.). As always on-going communication with the parents is of utmost importance especially for our youngest students.

Older nappers will be monitored at all times – with visual checks of each child at 30 minute intervals.

MLCP strives to create a program making all parts of the child's day a positive experience.

Joint Statement on Safe Sleep:

Preventing Sudden Infant Deaths in Canada

Introduction

The Public Health Agency of Canada recognizes Sudden Infant Death Syndrome (SIDS) and other infant deaths that occur during sleep as major public health concerns. The *Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada* is part of the Government of Canada's continuing commitment to raise awareness of sudden infant deaths and safe sleeping environments. The purpose of this statement is to provide health practitioners with current evidence-based information so they may offer parents and caregivers information and support to prevent deaths due to SIDS and unsafe sleeping practices, in Canada.

SIDS is defined as the sudden death of an infant less than one year of age, which remains unexplained after a thorough case investigation, including the performance of a complete autopsy, an examination of the death scene, and a review of the clinical history.[1] Current medical and scientific evidence, explains SIDS as a multifactorial disorder arising from a combination of genetic, metabolic, and environmental factors.[2] Terms such as sudden unexplained infant death (SUID) and sudden unexpected death in infancy (SUDI) have emerged in an attempt to group all infant deaths possibly related to the infant sleeping environment. Definitions of these terms have not been consistent enough to make them universally acceptable.

The actual cause or causes of SIDS is unknown. In 2004, SIDS accounted for 5% of all infant deaths (0 to 1 year of age) and 17.2% of postneonatal deaths (28 days to 1 year of age).[3] SIDS can occur at any time during the first year of life but peaks between 2 and 4 months, with fewer SIDS deaths occurring after 6 months.[4,5] Infants who are male, premature, or of low birth weight, as well infants from socio-economically disadvantaged and Aboriginal populations have a higher incidence of SIDS.[4,5,6] Further research is necessary to increase our understanding of the biological causes and mechanisms that predispose some infants to sudden infant deaths relative to non-affected infants in seemingly comparable circumstances.

Large scale epidemiological studies over the last two decades have increased our understanding of SIDS and identified certain modifiable risk factors. The most important modifiable risk factors for SIDS are infants sleeping in the prone position and maternal smoking during pregnancy [7,8,9,10,11,12,13,14,15,16]

In 1993, the Government of Canada, along with other international organizations, recommended that infants be placed on their backs to sleep and in 1999, reinforced this message by launching the *Back to Sleep* campaign. The rate of SIDS has been declining since the late 1980's, but between 1999 and 2004, Canada observed a 50% decrease in the rate of SIDS.[3] This decline may be attributable, in part, to changes in parental behaviour such as placing infants on their backs to sleep and decreasing maternal smoking during pregnancy.[17]

Other causes of death that occur while an infant is sleeping may be difficult to distinguish from SIDS. While studying SIDS, researchers have identified additional risk factors in the infant sleeping environment that may contribute not only to SIDS, but to deaths from unintentional suffocation due to overlaying or entrapment.[18,19] Factors associated with unsafe sleeping environments include infants sharing a sleeping surface with an adult or another child,[7,15,20] and the presence of soft bedding.[15,21,22,23,24,25,26]

The *Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada* has been developed in collaboration with North American experts in the field of sudden infant deaths, the Canadian Paediatric Society, the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, Health Canada, and the Public Health Agency of Canada, with input from provincial/territorial, national, and regional public health stakeholders from across the country.

Government of Canada / Gouvernement du Canada
Canadian Paediatric Society / Société canadienne de pédiatrie
Canadian Institute of Child Health / Institut canadien de la santé infantile
The Canadian Foundation for the Study of Infant Deaths/ La fondation canadienne pour l'étude de la mortalité infantile

PRINCIPLES OF SAFE SLEEP AND MODIFIABLE RISK FACTORS

Infants placed on their backs to sleep, for every sleep, have a reduced risk of SIDS.

Prone and lateral sleeping positions are linked to increased rates of SIDS, even for infants who regurgitate.[7,9,15,20,27,28,29] Infants who normally sleep on their backs and are then placed to sleep on their stomachs are at a particularly high risk.[27] This reinforces the importance to consistently place infants on their backs to sleep at home, in child care settings, and when travelling. Sleep positioners or any other infant sleep positioning devices should not be used as they pose a risk of suffocation.[30] Once infants are able to roll from their backs to their stomachs or sides, it is not necessary to reposition them onto their backs.

Infants will benefit from supervised *tummy time*, when they are awake, several times every day, to counteract any effects of regular back sleeping on muscle development or the chance of developing plagiocephaly, commonly referred to as *flat head*.[31,32]

Preventing exposure to tobacco smoke, before and after birth, reduces the risk of SIDS.

Maternal smoking during pregnancy is an important risk factor for SIDS.[5,7,12,20,33] The more a woman smokes during pregnancy, the higher the risk of SIDS.[7,34,35] Women who reduce the amount of cigarettes smoked during pregnancy can reduce the risk of SIDS for their infants, and women who stop smoking can further reduce the risk.[7,8,14] It is estimated that one third of all SIDS deaths could be prevented if maternal smoking was eliminated.[36,37]

Infants who are exposed to second-hand smoke after birth are also at a greater risk of SIDS, and the risk increases with the level of exposure.[8,12]

the safest place for an infant to sleep is in a crib, cradle, or bassinet that meets current Canadian regulations.

When infants sleep on surfaces that are not designed for them, such as adult beds, sofas, and armchairs, they are more likely to become trapped and suffocate, in particular when the surface is shared with an adult or another child.[15,20,26,38,39] Other than a firm mattress and a fitted sheet, there is no need for any extra items in a crib, cradle, or bassinet. Soft bedding such as pillows, duvets, quilts and comforters, as well as bumper pads increase the risk of suffocation.[15,21,22 23,24,25,26]

Overheating is a risk factor for SIDS.[40] Infants are safest when placed to sleep in fitted one-piece sleepwear that is comfortable at room temperature and does not cause them to overheat. Infants do not require additional blankets as infants' movements may cause their heads to become completely covered and cause them to overheat.[41] If a blanket is needed, infants are safest with a thin, lightweight, and breathable blanket.

Strollers, swings, bouncers, and car seats are not intended for infant sleep. When sleeping in the sitting position, an infant's head can fall forward and their airway can be constricted.[42] This risk reinforces the importance to move an infant to a crib, cradle, or bassinet to sleep, or when the destination is reached.

Infants who share a room with a parent or caregiver have a lower risk of SIDS.

Room sharing refers to a sleeping arrangement where an infant's crib, cradle, or bassinet is placed in the same room and near the parent or caregiver's bed. Infants who share a room have a lower risk of SIDS and will benefit from room sharing for the first 6 months during the period of time the risk of SIDS is highest.[12,38,43] Room sharing facilitates breastfeeding and frequent contact with infants at night.

Bed sharing describes a sleeping arrangement where an infant shares a sleeping surface such as an adult bed, sofa, or armchair with an adult or another child. Sharing a sleeping surface increases the risk of SIDS and the risk is particularly high for infants less than 4 months of age.[12,20,38,44,45] Sharing a sleeping surface with an infant also increases the risk of entrapment, overheating, overlaying, and suffocation.[44] The risk of SIDS and other unintentional deaths that occur during sleep increase further when an infant shares a sleeping surface with a parent or caregiver who smokes, has consumed alcohol, is under the influence of sedating drugs, or is overly tired.[12,20,43,46]

The term *co-sleeping* can refer to a range of sleeping practices that include both bed sharing and room sharing. Definitions of this term are not consistent enough to make it universally acceptable.

breastfeeding provides a protective effect for SIDS.

Any breastfeeding for any duration provides a protective effect for SIDS, and exclusive breastfeeding offers greater protection.[47,48] It is estimated that exclusive breastfeeding for the first 6 months, during the period of time the risk of SIDS is highest, may reduce the risk SIDS by up to 50%.[47] Successful breastfeeding is not dependent on sharing a sleeping surface.[12,20] However, for women who may bring their infant into bed to breastfeed, the risk of SIDS is not increased when the infant is placed back to sleep in a crib, cradle, or bassinet following the feeding.[20,46]

Pacifiers appear to provide a protective effect for SIDS.[24,49,50,51,52] No solid evidence demonstrates that pacifier use impairs breastfeeding, however delaying the introduction of a pacifier is best left until breastfeeding is well established.[53] Infants who accept a pacifier should have one consistently, for every sleep; however, a pacifier is not required to be reinserted if it is expelled during sleep.

The Public Health Agency of Canada has produced the *Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada* for health practitioners so they may provide parents and caregivers with information and support to prevent deaths due to SIDS and unsafe sleeping practices. Parents and all caregivers are encouraged to practice the principles of safe sleep at home, in child care settings, and when travelling.

For additional information on safe sleep please visit the following websites:

Public Health Agency of Canada:	www.publichealth.gc.ca/safesleep
Health Canada:	www.healthycanadians.gc.ca/kids
Canadian Paediatric Society:	www.cps.ca
Canadian Foundation for the Study of Infant Deaths:	www.sidscanada.org
Canadian Institute of Child Health:	www.cich.ca

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Montessori Learning Centre of Pickering

SLEEP ROOM MONITORING SHEET

(Infants Checked at 15 Minute Intervals / Licensed Children Checked at 30 Minute Intervals)

Class Room: _____	**Date:** _____									**Date:** _____									**Date:** _____									**Date:** _____					
Child's Name: _____	12:30p	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm

Class Room: _____	**Date:** _____									**Date:** _____									**Date:** _____									**Date:** _____					
Child's Name: _____	12:30p	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm	1:45pm	2:00pm	2:15pm	2:30pm	12:30pm	12:45pm	1:00pm	1:15pm	1:30pm

Head Teacher _____ Date _____