**Hospital Safe Sleep Audit Form**

**(this form is to be used internally as a voluntary self-assessment of current safe sleep practices)**

|  |  |  |
| --- | --- | --- |
|  | **Please check the appropriate boxes and enter comments as necessary.** |  |
|  | **1 Name of hospital:** |  |  |  |
|  |  |  |
|  | **2 Location and Time of Audit:** |  |  |  |
|  | Unit Name and Type: |  |  |  |
|  | Room Number: |  |  |  |
|  | Observer Name: |  |  |  |
|  | Date: |  |  |  |
|  | Time: |  |  |  |
|  | **3 Age of Child:** |  |  |  |
|  |  | Under 1 week old |  | 3 month old |  |
|  |  | 1 - 2 weeks old |  | 4 months old |  |
|  |  | 2 - 3 weeks old |  | 5 months old |  |
|  |  | 3 - 4 weeks old |  | 6 months old |  |
|  |  | 1 month old |  | 7 months old |  |
|  |  | 2 months old |  | 8 months old |  |
|  **4**  |  **Is the child asleep during observation?** |  |
|  |  | Yes |  | No |  |
| **5** |  **Location of Baby:** |  |  |  |
|  |  | Bassinet  |  | Parents Arms |  |
|  |  | Couch/Recliner |  | Swing/Bouncy Seat/Car Seat |  |
|  |  | Other (please specify): |  |  |  |
| **6** | **Position of Baby:** |  |  |  |
|  |  | Back |  | Stomach |  |
|  |  | Side |  | Held by Parent |  |
|  |  | Other (please specify): |  |  |  |

 **7 Is there a physician’s order for position other than the back?**

**(If yes please indicate medical concern below):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Yes |  | No |

|  |
| --- |
|  |

Medical indication for order**:**

|  |
| --- |
|  **8 Condition of Crib and Baby (please check all that apply):** |
|  |  | Bassinet is bare |  | Loose blankets in bassinet (e.g. patient not swaddled) |
|  |  | Pillow in bassinet |  | Loose toy in bassinet |
|  |  | Bumpers in bassinet |  |  |
|  |  | Additional Comments: |  |  |
| **9** | **Was a caregiver present and awake during audit?** |
|  |  | Yes |  | No |
| **10** | **Any Additional Comments?** |  |  |  |
|  |  |  |  |  |  |