

SLEEP & REST – HOME CHILD CARE

POLICY

FROM ONTARIO REGULATION 137/15, 33.1 AND 47(2)

It is the policy of Cook's School Day Care Inc to ensure that:

- Infants' sleep and rest periods are based on their own schedules.
- Each toddler and preschool child enrolled is permitted to sleep, rest or engage in quiet activities based on the child's needs.

This policy and its procedures meet the mandatory Ministry of Education requirements regarding sleep and supervision of sleep.

The Sleep & Rest policy will be:

- Implemented and monitored at all times for compliance and contraventions.
- Reviewed with staff annually and any time changes are made.

INTENT

While not all children need a mid-day nap, young children benefit from periods of quiet relaxation to balance their active play. Some children who are tired may take a relatively long time to relax and sleep, while others only require a short rest period. Children's needs may also change from day to day or week to week.

The need for rest and sleep varies greatly at different ages, and even among children of the same age; however, rest is an important part of the day for all children. This provision allows for a period during which quiet activities are encouraged and children can nap if required.

For the Children Who Sleep

Toddlers and preschoolers who regularly sleep have a rest period not exceeding two hours in length.

Monitoring sleeping children reduces the risk of harm/injury as caregivers can look for:

- Signs of distress.
- Behaviours during sleep.
- Changes in sleeping patterns.

SPECIAL INSTRUCTIONS

Sleep and rest time should be of such duration that normal sleep patterns at home are not disrupted.

Programs should take into consideration instructions given from parents regarding their children's sleep and rest period. These instructions should be followed as closely as possible but the licensee also needs to take into consideration the need of the individual child.

If a parent has provided instructions for the child to not sleep during the day but the child is falling asleep at the table, the licensee should provide a rest period for this child. The licensee can explain to the parents that the child required a nap that day because the child was unable to stay awake

PROCEDURE

UPON ENROLLMENT AND AT ANY TIME DURING ENROLLMENT

Parents/guardians of children who regularly sleep at the home setting will:

- Be provided with our current Parent Handbook which gives information on our policies regarding sleep and rest. Parent Handbook's are updated and given out yearly.
- Be provided with a place on the application form and to indicate their child's specific sleeping arrangements or patterns to be implemented. Application forms are reviewed annually.
- Be provided a Bedtime/Rest Time Routine Details form completed by the provider if the child is enrolled in extended / overnight hours care. Once signed off by the provider, the parent/guardian and the CEC consultant/Home Visitor, the provider will receive a copy. Any time a provider makes a change to what has been signed off on the original form, the parent/guardian must sign off confirming acceptance of the change. A new form may need to be completed and signed off by all parties if a number of changes are being indicated.
- Have Child Care Information Change Notices readily available to allow parents to make any changes to their child's sleep and rest arrangements as their child grows or transitions from room to room.
- Be shown each child's personal sleep and rest space and any time there is a change to the arrangement that is agreeable to the parent/guardian.
- Be verbally notified if any significant changes in their child's sleeping patterns or behaviors are observed during sleep to allow adjustments to be made if necessary.
- If using extended / overnight hours, be provided with a Bedtime/Rest Time Routine Details form to review and sign that includes information about:
 - The provider's typical hours of overnight sleeping when the child will not be directly observed 100% of the time.
 - The use of the electronic monitoring device as one method of overnight supervision and its maintenance.
 - Who may be in the home during the extended / overnight period of time and may assist with monitoring sleep disturbances. All sleep disturbances will be directed to the provider.

Providers will be notified when:

- Information is on a child's application form kept in the child's file to read regarding sleep and rest arrangements.
- New information on a Child Care Information Change Notice is provided by the family regarding a child's sleep arrangements in the child's file.
- An observance of a significant change in a child's sleep patterns during a direct visual check resulted in changes being made. The change is documented in the child's file.

SUPERVISION

Daytime Hours

All children that regularly sleep and rest at the home child care setting will:

- Be monitored by the provider, including direct visual checks four times throughout each two-hour sleep and rest period. The number of daytime sleep and rest periods applies to the age and need of the child.

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- Be monitored ensuring sufficient light in the sleep / rest area to conduct direct visual checks.
- Have their direct visual checks documented by initial on the Sleep Monitoring Form. The completed Sleep Monitoring Form is submitted with attendance forms to the agency office each pay period.
- Have any significant change in sleep pattern or behaviour observed while the provider is conducting the direct visual checks documented on the Sleep Monitoring Form and communicated to the parent/guardian. Adjustments, if applicable will be documented on the child's application form and the provider will be notified by the ECE Consultant/Home Visitor.

Extended / Overnight Hours

Families of children who sleep at the home during the extended / overnight hours must review and sign the Bedtime/Rest Time Routine Details form when initiated and any time a change is made.

When children sleep at the home during extended / overnight hours, it is understood that the provider must also acquire sufficient rest and sleep. To that end, electronic sleep monitoring devices will be used to monitor sleeping children during that period. Electronic sleep monitoring devices must be checked before each sleep period to make sure they work and replaced immediately if they do not. The equipment checks are noted on the Sleep Monitoring Form provided for extended / overnight hours.

Any significant change in sleep patterns or behaviour experienced during the extended / overnight hours is documented on the Sleep Monitoring Form and communicated to the parent/guardian at the earliest convenience.

Adjustments, if applicable will be documented on a Child Care Information Change Notice and attached to the child's application form. The provider will be notified of changes by the ECE Consultant/Home Visitor.

Important

Electronic sleep monitors cannot be used in place of direct visual checks of sleeping children during daytime sleep and rest periods.

DIRECT VISUAL CHECKS

Steps when conducting direct visual checks:

- Fill out the names of the children who are sleeping on the Sleep Monitoring Form along with the date.
- Look at each child closely for a rise and fall of the chest and/or stomach and document the time.
- Document when any significant changes are observed and communicate the observations to the parent/guardian.
- Daytime Hours: conduct and document direct visual checks four times throughout each two-hour sleep and rest period.
- Extended / Overnight Hours: conduct and document direct visual checks:
 - Before going to bed.
 - Upon awaking during the night.
 - Anytime a disturbance is heard over the electronic sleep monitoring device.
 - When another person in the home notes a disturbance has occurred.
 - When rising for the day.

POTENTIAL INDICATORS OF DISTRESS

- Change in skin colour
- Change in breathing
- Wheezing
- Grunting
- Nose flaring
- Signs of overheating – sweating

SAFE SLEEP

Children age 0-12 months of age are placed for sleep in a manner consistent with recommendations set out in the most current version of the **Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada** (attached), a document endorsed by Health Canada.

Requirements relating to sleep positions may only be waived if a medical doctor advises a different position in writing. The recommendation must be submitted to Cook's School Day Care Inc.

ADDITIONAL INFORMATION

As discussed in **How Does Learning Happen**, children's well-being is supported when adults respect and find ways to support each child's varied physiological and biological rhythms and needs for active play, rest and quiet time.

Finding ways to reduce stress through providing space and time for rest and quiet play based on individual differences helps children become increasingly aware of their own basic needs and supports their developing self-regulation skills.

Our program makes every effort to organize time, space and materials to support the children's varied needs for sleep, rest and quiet time.

MODIFICATIONS TO THIS OR OTHER POLICIES

Any policy that does not respect and promote the dignity, independence, integration and equal opportunity of people with disabilities will be modified or removed. Our policies are maintained and updated regularly to reflect our practices, employees and best serve our customers.

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.⁷ 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.^{5,7,12,20,35} 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.^{1,5,7,22,23,24,25,26}

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.^{12,70,38,44,45} Sharing a sleeping surface with an infant also increases the risk of entrapment, overheating, overlying, 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.^{12,29} 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

Joint Statement on Safe Sleep: Preventing Sudden Infant Deaths in Canada

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