

**Continuing Education (CE) Activity on Risk Reduction for Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death: Curriculum for Nurses.  
Customer Satisfaction Survey OMB Number: 0925-0643 Expiration Date: 10/31/17**

1.

You are receiving this survey because you completed the online or live version of NICHD'S Continuing Education (CE) Activity on Risk Reduction for Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Death: Curriculum for Nurses. We are assessing your satisfaction with the program and your satisfaction with the activity and your experience with using information and materials.

We would appreciate your input to help guide future enhancements and inform the best use of our resources. Participating in this survey is completely voluntary. You may choose to skip a question or stop the survey at any time.

\*Public reporting burden for this collection of information is estimated to average 15 minutes, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, PRA (0925-0643). Do not return the completed form to this address.

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2.

Informed Consent Form: Identification of Project *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). Continuing Education (CE) Activity on Risk Reduction for Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death: Curriculum for Nurses.

**Statement of Age of Subject**

I state that I am at least 18 years of age, in good physical health, and wish to participate in research being conducted by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, Bethesda, MD.

**Purpose**

The purpose of this survey is to assess participants' overall satisfaction with the Continuing Education Activity on Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death: Curriculum for Nurses and obtain information regarding key aspects of the activity that were particularly helpful or challenging.

**Procedures**

Participants will be asked to access a web-based questionnaire and complete the questionnaire by a specific date. The total time involved, including instructions, will be no more than 15 minutes.

**Confidentiality**

All information collected in this study will be kept secure to the extent permitted by law. I understand that the data I provide will be grouped with data that others provide for the purpose of reporting and presentation, and that my name will not be used.

**Risks**

I understand that the risks of my participation are expected to be minimal in nature.

**Benefits, Freedom to Withdraw, & Ability to Ask Questions**

I understand that this study is not designed to help me personally but that the investigators hope to learn about the participants' overall satisfaction with the Continuing Education (CE) Activity on Sudden Infant Death Syndrome (SIDS) and other Sleep-Related Causes of Infant Death: Curriculum for Nurses. The survey population will include nurses who attended an in-person workshop on NICHD's Continuing Education (CE) Activity on Sudden Infant Death (SIDS) and Other Causes of Sleep-Related Infant Death: Curriculum for Nurses or the online version. I am free to ask questions or withdraw from participation at any time and without penalty.

**Contact Information of Investigators**

Name: Lorena Kaplan, MPH, CHES; Telephone: 301-496-6670; Email: lorena.kaplan@nih.gov

**Agreement to Consent**

- I have read the information about this study, and I agree to participate in this survey.
- I have read the information about this study and I do not wish to participate in this survey at this time.

### 3. RESPONDENT INFORMATION

1. What is your highest level of education?

- Associate's
- Bachelor's
- Master's degree
- Doctorate
- Other

Other (please specify)

2. How many years have you been a practicing nurse?

- 0-2
- 3-5
- 6-10
- 11-15
- More than 15

3. In what type (s) of setting (s) do you currently work?

- Labor and Delivery
- Neonatal Intensive Care Unit (NICU)
- Well Baby Nursery
- Public Health Department
- Community Clinic
- Child Care Setting
- Social Work Organization
- Other

Other (please specify)

4. When did you complete the CE Activity?

Month

Year

5. Why did you complete the CE Activity? (Please check all that apply)

- Required by your organization
- Needed continuing education hours
- Interested in the topic
- It was free
- Other

Other (please specify)

**4. SATISFACTION WITH CURRICULUM STRUCTURE AND CONTENT**

6. Did you complete the CE Activity in person, or online? (Please check only one).

- In person: At a national conference
- In person: At a university sponsored session
- In person: At a hospital sponsored session
- Online

7. Please rate your level of agreement with the following statements regarding the CE Activity. (Please fill in one response for each row).

	Strongly Agree	Agree	Disagree	Strongly Disagree
Session met your expectations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Length of time was appropriate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Instructions were appropriate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Materials were appropriate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. How would you rate your overall satisfaction with the following aspects of the CE Activity? (Please fill in one response for each row).

	Excellent	Above Average	Average	Below Average	N/A
Registration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trainer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Curriculum Content	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Course Materials	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Receiving Your Certificate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. How would you rate your level of SIDS risk reduction knowledge prior to completing the CE Activity?  
(Please check only one).

- Excellent
- Good
- Average
- Fair
- Poor

10. Was there a topic (or topics) not covered in the CE Activity that you would like to have included?

- Yes
- No

If yes, please explain

11. In general what is your preferred method for completing training and continuing education sessions?  
Please rank them 1-4 with 1 being your top choice and 4 your last.

	1	2	3	4
Online Modules	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In-Person (in-service, seminars, conferences)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5. SATISFACTION WITH USING THE SIDS RISK REDUCTION TRAINING IN YOUR PRACTICE**

12. Have you used the training and knowledge you received through the CE Activity?

Yes

No

If yes, please give an example.

13. Do you feel that the CE Activity provided you with information to enhance your organization's practice and patient education?

Yes

No

If no please explain

14. After completing the CE Activity, did you do any of the following? (Please check all that apply).

Do nothing further

Share the curriculum with colleagues

Set up a training for faculty

Request additional materials

Review your organization's existing policy addressing SIDS/SUID risk reduction

Revise your organization's existing policy addressing SIDS/SUID risk reduction

Create a policy for your organization addressing SIDS/SUID risk reduction

Other (please specify)

15. Does your organization advocate for a preferred sleep position for infants?

- Yes
- No
- N/A, if No or N/A, skip to Q18

16. What is your organization's preferred sleep position for infants? (Please check only one)

- Supine (Back)
- Side
- Prone (Stomach)

17. Does your organization have policies/competencies regarding SIDS/SUID risk reduction?

- Yes
- No
- N/A

18. Are you planning any educational interventions for staff or clients in the near future related to SIDS/SUID risk reduction and safe infant sleep?

- Yes
- No

19. How do you place infants to sleep?

- Supine (Back)
- Side
- Prone (Stomach)

20. Do you routinely discuss with parents the sleep position for their baby once he/she is born, including where the baby will sleep (room sharing vs bed sharing, crib, bassinet, etc) and the importance of keeping the baby's sleep environment clear of bedding, crib bumpers, and other objects?

- Yes
- No



## 6. ADDITIONAL RESOURCES

21. Did the CE Activity identify new resource(s) you were not aware of before completing the activity?

- Yes  
 No

If yes, identify the new resource(s)

22. Are there additional SIDS/SUID educational materials you would like to receive? (Please check all that apply).

- PowerPoint Slides  
 Public Service Announcements  
 DVDs  
 Brochures  
 Presentations  
 Posters  
 Nothing at this time

Other (please specify)

**7. FINAL COMMENTS AND SUGGESTIONS**

23. Would you recommend the CE Activity to other healthcare professionals?

Yes

No

If no, why not?

24. Do you have any final suggestions for improving the CE Activity?

8.

Thank you for completing this survey. We would like to invite you to visit NICHD's new Safe to Sleep® website, <http://safetosleep.nichd.nih.gov>, to access new campaign materials, including the "Safe Sleep for Your Baby" video that is now available on YouTube and on DVD.