Newborn Positioning, Plagiocephaly Screening and Parent Education
Preventative Health Information for Pediatric Clinicians

By Laura C Steinmann, RN

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Disclosure:
Author evaluates children ages 3-18 months for plagiocephaly at Steinmann Prosthetics & Orthotics, Las Cruces NM
Learning objectives

• overview of safe sleep, positioning, plagiocephaly
• screening for plagiocephaly, torticollis, craniosynostosis
• intervention strategies
• teaching strategies

Goals: Increase awareness, screening and intervention of plagiocephaly, torticollis and craniosynostosis, using current research and information consistent with recommendations; improve children’s related health outcomes.
Provide advice that is Consistent with Recommendations

Maternal Report of Advice Received for Infant Care Eisenberg 2015

- measured advice received by new mothers (n=1031)
- 4 sources (doctors, nurses, family, media)
- 5 infant care practices
  (breastfeeding, sleep position, sleep location, immunization, pacifier use)

<table>
<thead>
<tr>
<th>Sleep Position Advice</th>
<th>Consistent with Recommendations</th>
<th>Not Consistent with Recommendations</th>
<th>No Advice</th>
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</thead>
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A consistent message is needed to create a culture of safe sleep practices and minimize bias.
Safe sleep

**What is Safe Sleep?**AAP, CDC, NIH

- safe sleep position, supine position only, no side or prone position
  “back/safe to sleep” NIH “con la boca arriba”
- safe sleep environment (smoke-free, avoid overheating, safe crib, no sleeping in car seats or carriers, room-sharing but not bed-sharing)
- other recommendations for maternal and infant health practices: diet, breastfeeding, immunizations, pacifier use, tummy time

**Why is safe sleep important?**Sudden Infant Death Syndrome (SIDS) CDC

- #1 cause of Sudden Unexpected Infant Death (SUID)
- #3 cause of overall Infant Mortality

**Why is the supine position important?**

- a primary factor in reducing SIDS by ~50% AAP
- a factor in ~600% coincident increase in plagiocephaly multiple
Safe sleep

What is positioning? AAP

- **supine** position at birth or within a few hours, up to age 1 year
- **rotate** head side-to-side while supine to avoid or improve plagiocephaly
- **rotate** position in the crib
- provide **exercises, tummy time**

Teach both supine positioning AND head positioning.

What are sleep recommendations? AASM, AAP 2016

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>&lt; 4 months</td>
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<td>4 mo – 1 yr</td>
<td>12-16 hrs/day, including naps</td>
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<tr>
<td>1 yr – 2 yr</td>
<td>11-14 hrs/day</td>
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- Become Certified in Safe Sleep at “Cribs for Kids”
Safe sleep

Positioning biases: Risk of Choking myth

<table>
<thead>
<tr>
<th>SUPINE = TRACHEA ON TOP</th>
<th>PRONE = ESOPHAGUS ON TOP</th>
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<tbody>
<tr>
<td>(easier to swallow regurgitate)</td>
<td>(aspiration more likely)</td>
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</table>

Image courtesy of the Safe to Sleep® campaign for educational purposes only
Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).
Safe sleep
Positioning biases: prone position

Effects of prone position in stable neonates after 10 minutes

Physiologic responses consistent with adult responses in prone position.

- Intrathoracic Pressure
  - Venous Return
  - Stroke Volume
  - Cardiac Output
  - Cerebral O2
  - Skin blood flow
  - Vascular Tone*
  - Blood Pressure

* Heart rate did not increase (compensate) until age 2-3 months; lack of HR response to vascular changes in this study may be due to immature regulatory response.
Plagiocephaly

What is plagiocephaly?
Because the infant skull is moldable, plagiocephaly is a relatively common issue faced by pediatric providers. Serious causative factors such as cranial suture stenosis (craniosynostosis) must be ruled out.

Non-synostotic plagiocephaly
- skull flattening in one area
- compensatory bulge in another area(s)
- may involve 1, 2, 3, or 4 skull quadrant(s)
- often involves facial bones
- often involves neck muscle disorders

ICD 10: Q67.1-4

Investigate all head, face, and neck asymmetry.
Plagiocephaly

Risk factors

Intrinsic = not modifiable, congenital, or genetic, such as
- craniosynostosis, torticollis
- male gender
- varying maturation rates of sutures

Extrinsic = modifiable, acquired, or environmental, such as
- mechanical pressure on moldable skulls for prolonged periods
- improper positioning, misuse of sitting devices
- swaddling, cultural practices (cradleboard)

Intrinsic and extrinsic factors affect skull growth and development.

Plagiocephaly may be multifactorial
Plagiocephaly

More risk factor examples (modifiable and not modifiable)

• low birth weight, age at gestation, family history
• maternal meds, Prenatal Alcohol Exposure (PAE)\textsuperscript{Clarren,Graham}
• insufficient Vitamin D levels that reduce bone mineralization\textsuperscript{Misra}
• neck/spine/hip problems
• developmental delay
• lack of awareness, poor advice

Correlated obstetric risk factors

• primiparity, plural births
• restricted uterine environment
• assisted delivery
• NICU\textsuperscript{Hummel}
Plagiocephaly

**The asymmetry of plagiocephaly** AAP

- may be apparent at birth, or develop within weeks
- may persist in some children into adolescence
- can be detected in a significant number of adults
Skull anatomy overview

Infant skull structures

- large bone plates
- facial bones
- fibrous sutures
- fontanels
- septums, sinuses

- cranial/neck muscles
- ligaments, tendons
- connective tissues
- fascia
- synovial joints

Individualistic factors (intrinsic, extrinsic) affect size, width, weight, shape, patency, and ability to accommodate movement
Skull anatomy overview

- Frontal
- Parietal
- Anterolateral fontanel
- Posterior fontanel
- Posterolateral fontanel
- Sphenoid
- Temporal
- Zygoma
- Maxilla
- Mandible
- Sagittal suture
- Coronal suture
- Squamosal suture
- Lambdoid suture
- Occiput
- Metopic suture
Skull anatomy overview

**Brain and cranial growth factoids**

**Brain growth**

- from age 2 days to 90 days, the brain grows 1%/day, then slows
- the male brain grows faster than female
- brain growth over the 20 wk period from gestational age 30 wks (165g) to postpartum age 10 wks (528g), is 220% or 6%/week

**Brain size**

- larger brain size is associated with normal gestation (39-40 wks)
- smaller brain size is associated with early gestation (≤38 wks), is 5% smaller at birth, and 2% smaller at age 90 days

**Cranial growth**

- cranial growth slows after age 32 weeks (7.2 months)
- cranial sutures are generally interlocked at age 24 months
# AAP Bright Futures Periodicity Chart

**Recommendations for Preventive Pediatric Health Care**

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary if circumstances suggest variations from normal.**

**Developmental, psychosocial, and chronic disease issues for children and adolescents require frequent counseling and treatment visits separate from preventive care visits.** These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

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**KEY**
- "1" to be performed
- "2" risk assessment to be performed, with appropriate action to follow, if positive
- "3" range during which a service may be provided, with the symbol indicating the preferred age
# AAP Bright Futures Periodicity Chart

## Screening

### AGE

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Screening

How to determine plagiocephaly

1. Visual assessment

2. Measurements

   a) Head Circumference *(does not indicate head shape deformity)*

   b) Width and Length

   c) Cranial Index (CI) \[\text{Width} \div \text{Length} \times 100\]

<table>
<thead>
<tr>
<th>Head Shape</th>
<th>Cranial Index</th>
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<tr>
<td>Normocephaly</td>
<td>76% - 90%</td>
</tr>
<tr>
<td></td>
<td><em>Graham</em></td>
</tr>
<tr>
<td>Plagiocephaly</td>
<td>76% - 90%</td>
</tr>
<tr>
<td></td>
<td><em>Graham</em></td>
</tr>
<tr>
<td>Brachycephaly</td>
<td>&gt; 90%</td>
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<td></td>
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<tr>
<td>Dolichocephaly</td>
<td>&lt; 76%</td>
</tr>
</tbody>
</table>

   d) Cranial Vault Asymmetry (CVA); *also called Diagonal Difference*
Screening

CVA = diagonal difference

**Symmetric**

fz = frontozygomaticus  eu = eurion

**Asymmetric**

fz = frontozygomaticus  eu = eurion

<table>
<thead>
<tr>
<th>Mild</th>
<th>5mm $^{\text{Steinberg}}$</th>
<th>3-10mm $^{\text{Hutchinson}}$</th>
<th>6-10mm $^{\text{Yoo}}$</th>
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<tr>
<td>Moderate</td>
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<td>11-15mm $^{\text{Yoo}}$</td>
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</tr>
<tr>
<td>Severe</td>
<td>10mm $^{\text{Loveday, Graham}}$</td>
<td>10-12mm $^{\text{Mulliken}}$</td>
<td>16mm $^{\text{Yoo}}$</td>
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</tbody>
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Screening

**Normocephaly**

- CI >76% to <90-92% (*same for plagiocephaly*)
- skull and facial landmarks are relatively even, aligned
- skull quadrants are relatively proportional
Screening

Plagiocephaly

- CI 76% to 90% - 92% (*same for normocephaly*)
- primary asymmetry may be *anterior* or *posterior*
- may be due to craniosynostosis, torticollis
- may combine with brachycephaly or dolichocephaly
Screening

**Brachycephaly**

- CI > 90% - 92%; short wide skull
- may be due to coronal or lambdoid suture synostosis

**Symmetric**
- CI not WNL, CVA WNL
- central flattening
- little/no ear shift

**Asymmetric**
- combined w/plagiocephaly
- CVA >6mm
- ear shift
Screening

**Dolichocephaly**
- CI < 76%; long narrow skull
- may be familial; seen in premature infants and NICU
  - may be due to sagittal suture stenosis

**Symmetric**
- CI not WNL, CVA WNL
- little/no ear shift

**Asymmetric**
- combined w/plagiocephaly
- CVA and CI not WNL
Torticollis is an independent factor in the failure of conservative treatment for plagiocephaly. Steinberg

**What is torticollis?**

- may be due to injury (nerve, vascular, muscular)
- usually affects sternocleidomastoid (SCM), less often trapezius muscle
- may be Congenital or Acquired, Temporary or Fixed

![Diagram of torticollis symptoms](image)

- head tilt
- neck twist
- shoulder hike
- face rotation
- inability to turn head 90°

Torticollis is an independent factor in the failure of conservative treatment for plagiocephaly. Steinberg
How can asymmetry screening be easily incorporated into practice?

- When measuring head circumference, screen head, face and neck
- When palpating fontanelles, palpate sutures for ridging or closure

Quick screen for head/face/neck asymmetry

1. **Visualize alignment**
   - imagine lines (anterior/posterior, and horizontal/vertical)
   - connect landmarks (features)

2. **Visualize proportion**
   - divide skull into 4 quadrants, should be relatively equal

3. **Document asymmetry**
   - skull: bossed (prominent), flat, misaligned, uneven features
   - neck: neck twist, head tilt, shoulder hike, face rotation
Screening

Quick screen for infant head/face/neck asymmetry

**SYMMETRY**

<table>
<thead>
<tr>
<th>Anterior</th>
<th>Posterior</th>
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<tbody>
<tr>
<td>• fontanel</td>
<td>• vertex</td>
</tr>
<tr>
<td>• nose</td>
<td>• fontanel</td>
</tr>
<tr>
<td>• chin</td>
<td>• occiput</td>
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<tr>
<td>• neck</td>
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</tbody>
</table>

**Landmarks**:

Anterior: fontanel, nose, chin, neck

Posterior: vertex, forehead, eyebrows, eyes, ears, cheeks, chin, neck

**ASYMMETRY**

**Not aligned or proportional:**
- uneven landmarks
- uneven vertex
- uneven facial feature(s)
- ear shift
- uneven neck

- flattened, less volume
- temporal bulge
- parietal widening

- symmetrical, not proportional
- central occipital flattening
- decreased posterior volumes

- flattened, less volume
- bosshed forehead, orbit, cheek
- anterior shift temporal, parietal
- flattened, less volume

- flattening may cross occipital midline

**Neck muscle disorder, torticollis**: look for head tilt, neck twist, shoulder hike, face rotation
How is plagiocephaly classified?

No standardized system; may use validated severity assessment scales:

- observational severity (Argenta Scales) Argenta, Branch, Couture
- asymmetry severity (Level 1-5 plus CVAI) Children's Healthcare of Atlanta
- proportion severity (based on cranial index) Dekaben 1977, Hutchinson 2009

How is plagiocephaly documented?

- clinical impression, evaluation
- measurements (CI, CVA, CVAI, scales, etc.)
- photos with consent
- interventions, referral
- parent/caregiver teaching
Why is it important to recognize plagiocephaly early?
Craniosynostosis

- life-threatening birth defect (1:2000 US live births)
- requires immediate intervention, possible surgery
- majority of cases are male, sporadic, no associated syndrome, and no family history

Risk factors

gene expression, syndrome, prenatal diet/environment, maternal meds (clomiphene citrate, fluoxetine, levothyroxine, valporic acid)\(^\text{CDC}\)

Signs

- asymmetry of the head, face, neck
- premature closure or bulging of fontanels, proptosis
- prominent scalp vein, ridging along suture line(s)
- increased intracranial pressure (crying, emesis, apnea, seizures)
Craniosynostosis

**Could that plagiocephaly really be craniosynostosis?**

Nonsynostotic plagiocephaly and craniosynostosis have similar signs and symptoms.

Knowing when to **monitor** and when to **refer** for management requires an ability to recognize early plagiocephaly, distinguish plagiocephaly from craniosynostosis, and recognize improvement or worsening of head asymmetry. Looman

**Differential Diagnosis** examples:
- dolichocephaly due to prematurity *vs* sagittal synostosis
- brachycephaly due to lambdoid synostosis *vs* positional molding or developmental delay

**Diagnostic imaging tests:** usually Radiography, Computed Tomography, Magnetic Resonance Imaging, less often Ultrasound
Craniosynostosis

Suture synostosis overview

1. **Metopic**: trigonocephaly

2. **Sagittal**: most common 1:5000; dolichocephaly

3. **Coronal**: anterior plagiocephaly, brachycephaly

4. **Lambdoid**: plagiocephaly, brachycephaly

5. **Squamosal**: separates temporal, sphenoid, parietal, occiput bones; atypical asymmetry

6. **Sphenoidal**: borders frontal, parietal, temporal, orbit bones; atypical asymmetry, 1:10,000
## Craniosynostosis

### Texas Birth Defects Registry, Epidemiology and Surveillance Branch

<table>
<thead>
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<th>Craniosynostosis</th>
<th>Cases</th>
<th>Prevalence</th>
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<tr>
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<td>Black non-Hispanic</td>
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<td>Hispanic</td>
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<td>Female</td>
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Craniosynostosis

Centers for Disease Control and Prevention

All states report to CDC, Centers for Birth Defects Research and Prevention (CBDRP). CDC keeps data for National Birth Defects Prevention Study (NBDPS).

Texas

Center for Birth Defects Research and Prevention

Report to: Birth Defects Epidemiology and Surveillance (BDES)

TX Dept State Health Services (DHSH), Mail Code 1964

P.O. Box 149347, Austin TX 78714

Phone 512-776-7232, 1-888-963-7111

New Mexico

All birth defects diagnosed before age 4 years are notifiable.

Report to: Epidemiology and Response Division, NM DOH

PO Box 26110, Santa Fe, NM 87502-6110

Phone 505-827-0006
Craniosynostosis

**Regional craniosynostosis surgeons**

**NM UNM:** Kimberly A. Foster, MD, Pediatric Neurosurgery
Jeremy Lewis MD, Neurosurgery
Anil Shetty MD, Pediatric Plastic Surgery

**TX El Paso:** David Yates, MD, Cleft and Craniofacial Surgery
Providence Specialty Clinic (UTHSC-SA rotates through monthly)
- Peter Wang MD, DMD, Plastic Surgery, UTHSC-SA
- Cecilia Alejandra Garcia de Mitchell MD, Plastic Surgery, UTHSC-SA

**TX Lubbock:** Laszlo Nagy MD, Pediatric Neurosurgery
Muhittin Belirgen MD, Pediatric Neurosurgery
Joshua Demke MD, Plastic/Reconstructive Surgery

**TX San Antonio, Dallas, Houston:** multiple

**AZ Phoenix:** David Shafron MD, Pediatric Neurosurgery, Children’s
Ruth Bristol MD, Pediatric Neurosurgery, Children’s
Plastic Surgery: Davinder Singh MD, Stephen Beals MD, Ed Joganic MD
Intervention

**Does plagiocephaly affect growth and development?**

Research (international, evidence-based, peer-reviewed) correlates plagiocephaly with risks to developmental, sensory and oral health.

- **Developmental** Collett, Kordestani, Miller, Clarren, Knight, Shamji
- **Sensory – Vision** Siatkowski
- **Sensory – Hearing** Harlor, Balan, Fellman
- **Oral Health** van Vlimmerman, St. John, Mulliken, Netherway, Kane

**AAP:** No causal links between vision problems, mandibular asymmetry

**Insurance policies:** Plagiocephaly may be associated with future ocular and/or oral abnormalities

**Clinical significance:** Federal law mandates early identification of children at-risk for developmental disabilities
Conservative Treatment guidelines  

- **Preventive Counseling** (anticipatory guidance)

- **Mechanical Adjustments**
  - 2-3 month trial of positioning, with exercises and tummy time
  - Physical Therapy

- **Referral**
  - for torticollis, teach neck stretching exercises or refer to PT
  - for asymmetry that does not improve, or by age 4-6 months,
    or for any concerns, refer to a craniofacial specialist
Intervention

77.1% of asymmetrical skulls r/t positional deformity (n=4378) normalized with conservative treatment (CVA \leq 5\text{mm}). Steinberg

Risk factors for conservative treatment failure

- craniosynostosis, torticollis, plagiocephaly
- age of child, lack of parent compliance Steinberg
- unknown or unmodifiable factor(s)

American Physical Therapy Association

Any clinician or family member should immediately refer for: positional preference, reduced cervical range of motion, sternocleidomastoid masses, facial asymmetry, and/or plagiocephaly.
Intervention

**Teach neck stretching exercises to parents**

AAP

- do exercises at each diaper change (adds 2 minutes)
- perform exercises slowly, gently, and only as tolerated
- 3 repetitions per exercise, 10 seconds per repetition as tolerated

**Sternocleidomastoid muscle stretch**

Place one hand on baby’s upper chest; use other hand to gently rotate baby’s head $90^\circ$ (so chin touches shoulder); hold position for 10 seconds or as tolerated; rotate baby’s head to the opposite side and repeat.

**Trapezius muscle stretch**

Tilt head so baby’s ear touches the shoulder; hold position for 10 seconds; repeat for the opposite side.
Intervention

Cranial molding orthoses or cranial helmet

- requires prescription; craniosynostosis must be ruled out
- not indicated ages <3 months, >18 months, or with hydrocephalus
- not a protective helmet; channels growth with passive resistance on bossed areas, leaves room for growth in flat areas

Age recommendations:

AAP: 4-12 months
FDA: 3-18 months
Teaching

**Parent/caregiver education**

- Teach safe sleep concepts consistent with recommendations in the prenatal, hospital, clinic and home settings
- Prepare parents to teach family members

Parents are more likely to follow advice when they understand the rationale.

Use a combination of teaching methods to reinforce learning

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<th>Auditory</th>
<th>directions, feedback, questions, discussion</th>
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<td><strong>Kinesthetic</strong></td>
<td>demonstration, hands-on practice</td>
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<tr>
<td><strong>Visual</strong></td>
<td>video; learning materials in parent’s language</td>
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Examples of cognitive biases and assumptions

- **Projection bias**: projecting personal beliefs

- **Status-quo bias**: “it’s always been done this way”

- **Experience bias**: desensitized as a result of experience; the clinician understands and accepts the information but the patient is overwhelmed

- **Generational differences**: different attitudes, beliefs, and ways of learning that may be counterintuitive to other generations

To minimize bias:
- provide advice Consistent with Recommendations
- be cognizant of personal biases
Why don’t parents remember patient teaching instructions?

Postpartum restorative/adaptive phases: Rueben 1967

- **Taking-in phase** – 1-3 days postpartum, or longer Ament, Wrasper
  
  Mother is passive, self-focused; needs to reconcile the birth experience before moving on.

- **Taking-hold phase** – about 10 -14 days postpartum
  
  Ready to learn, not necessarily ready to do.

- **Letting-go phase** – after several weeks
  
  Better able to let go of “expecting” expectations

Parents leave the hospital while in the **taking-in phase**, which will affect their ability to remember patient teaching.
Other considerations when teaching parents:

- may **not be aware** of plagiocephaly, the risk factors or implications
- may have reported a **flat spot** to a clinician but received **poor advice**: “don’t worry,” “wait and see,” “they will grow out of it,” “the hair will cover it,” “it’s only a minor cosmetic problem”
- may have received **advice inconsistent with recommendations**
- may have **misconceptions** or **confusion** about plagiocephaly or be influenced by family, friends
- may have feelings of **guilt** that the plagiocephaly is their fault
- may shun treatment because they **feel judged, blamed, or embarrassed**
- may worry that touching baby’s ‘soft spot’ or turning their head will **hurt**
- may worry about their child’s future **body perception**
Teaching

**Anticipatory Guidance** (preventative counseling)

*Ask questions to determine level of knowledge or concerns:*

What do you know about SIDS?

Do you know why babies have soft spots called fontanelles?

What do you know about tummy time?

*Anticipate concerns that parents may encounter:*

Always place baby to sleep on his back, not tummy or side.

Let’s touch baby’s head, it’s okay to touch the soft spots.

Let’s practice positioning baby’s head while he is asleep.

Show me how you will demonstrate positioning to your family.
Teaching

Encourage Early Movement in Newborns

- Provide clothes that protect but allow freedom to move head, shoulders and arms.
- The skull bones are malleable, so avoid prolonged immobility, be aware of head position, and rotate baby's head side to side at regular intervals.
- Reduce time restricted in seating devices, and the use of swaddles that restrict movement. Swaddle recommendations: monitor closely, supine position only; do not wrap tightly across chest, hips or knees; do not swaddle after age 2 months. AAP
- To encourage head movement, counterposition baby on alternate ends of the crib. During sleep, rotate baby's head side to side. When feeding and holding, alternate right and left sides.
- For playtime and tummy time, a firm surface (play mat, rug) is best for baby to practice movement. Alternate supine and prone positions. Alternate placement of toys at baby’s side to encourage turning and reaching movement. If baby has a preference for one side, attract attention to the other side. Hold baby (cuddle time) as much as possible to facilitate muscle growth (baby sling, front pack).
- Have fun! Try a positioning program to encourage early movement such as Tummy Time Tools, and search for videos and information from experts.
Swaddling

Advantages: may help decrease physiologic distress

Disadvantages: inhibits normal newborn movement; increases risks for plagiocephaly, overheating, hyperthermia, SIDS, suffocation, hip dislocation, hip dysplasia, respiratory infection, delayed postnatal weight gain

Swaddling recommendations: AAP, APHA

- monitor closely
- supine position only
- do not wrap tight across chest, hips or knees
- do not swaddle after age 2 months
Teaching

**Bottom-line teaching strategies to promote safe behaviors** Dias, Goodstein, Voos

For staff:

- promote a top-down culture of safe sleep
- provide advice consistent with recommendations
- incorporate current recommendations, educational updates
- develop information packets, safe sleep observation checklist Voos
- incorporate follow-up survey to determine knowledge retention

For parents:

- watch an effective video on safe sleep
- read written materials on safe sleep and positioning with clinician
- demonstrate how to position baby and rotate head to clinician
- sign an acknowledgement or commitment form
- respond to follow-up survey
- contact clinician for questions or concerns
Summary

**Now that you know....**

you can improve children’s health outcomes.

Screen early and often for head, face and neck asymmetry, and for risk factors related to plagiocephaly, torticollis and craniosynostosis, and intervene quickly and appropriately.

Follow guidelines on positioning newborns. Investigate all asymmetry to rule out serious causative risk factors; for asymmetry that does not improve with conservative treatment, refer to a craniofacial specialist.

Incorporate plagiocephaly risk reduction practices in the prenatal, hospital, clinic and home settings.

Teach parents/caregivers about plagiocephaly and positioning, with demonstration and hands-on practice, and provide advice consistent with recommendations.

Thank you!
As pediatric healthcare providers, we are all on a team. The child is the name of the team, the parent is the team owner, the primary care provider is the team coach, allied providers and specialists are team players, and our team goal is optimal function at each stage of growth. Pediatrics requires team play.

Robert Steinmann, CPO

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575-532-5900; fax 575-532-6008
email: steinmannoandp@comcast.net
web: http://www.SteinmannProsthetics.com
<table>
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<tr>
<td>Infographic “Quick Screen for Head/Face/Neck Asymmetry”</td>
<td>Yes</td>
<td>No</td>
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What information was most interesting to you?

Do you have suggestions to enhance or improve this presentation?
### 6 month follow-up evaluation: Newborn Positioning, Plagiocephaly Screening, and Parent Education

**Date of presentation:**

**Today’s date:**

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<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>No Change</th>
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<td>Providing positioning advice per recommendations</td>
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<td>Providing safe sleep advice per recommendations</td>
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<td>Screening for head/face/neck asymmetry</td>
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<td>Recognizing plagiocephaly and risk factors</td>
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<td>Recognizing torticollis and risk factors</td>
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<td>Teaching positioning and safe sleep to parents/caregivers</td>
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<td>Developing an education program for parents/caregivers</td>
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**What information has been most helpful to you?**

**Based on your experience in the past 6 months, do you have suggestions, advice or lessons learned related to these topics?**