Livewell Southwest

Growth Faltering Management

Version no. 4.1

Review: April 2017

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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	Children's Society 2002 4. Failure to Thrive: A Teaching Pack for Health Professionals. The Parkin Project. Newcastle. Ed. Charlotte Wright 1997 5. Child abuse and neglect: A Clinicians Handbook Hobbs, C., Hanks, H. and Wynne, J. 1993. Edinburgh: Livingstone 6. Health for all Children: 4th Report. David Hall. 7. Freeman, J.V., Cole, T.J., Chin, S., Jones, P.R.M., White, E.M. and Preece, M.A. Cross sectional stature and weight reference curves for the UK. Archives of Disease in Childhood 1995; 73: 17 - 24 8. The Victoria Climbie Inquiry. Report of an Inquiry by Lord Laming 2003
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2.1	August 2008	D.Edgecombe	Review and updating in line with changes in procedures
2.2	Jan 2009	M. Coutts	Formatting of document
2.3	Feb 2009	D. Edgecombe	Impact assessment and completion of front sheet.
2.4	Feb 2009	Sue Baldwin	Minor amendment – ratified Policy ratification group
3	May 2010	D. Edgecombe	Review and updating in line with changes in procedures
3:1	June 2012	PRG	Review date extended, no other changes made.
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3:3	May 2013	PRG	Review date extended, no other changes made
3:4	Nov. 2013	PRG	Review date extended, no other changes made
3.5	December 2013	Clinical Education Lead for Health Visiting	Review and updating, consultation process commenced
4	January 2014	Clinical Education Lead for Health Visiting	Updates in response to consultation

Growth Faltering Management

1. Introduction

1.1 Formerly known as failure to thrive, faltering growth is an observation that a child is growing exceptionally slowly.

1.2 This integrated care pathway has been devised by a multi-professional working party in response to a number of serious case reviews and details the pathway of care from early recognition of faltering growth to dietary, social and medical assessment and management.

1.3 Most children who do not grow well simply do not eat enough food and can be helped by following simple nutritional advice. It is important, however, not to overlook the child who has a serious medical cause for growth faltering or the child who is being neglected where failure of co-operative multi-agency working can place a child at risk of serious harm.

1.4 Children who are severely undernourished from whatever cause may suffer long term growth, developmental, behavioural and emotional problems.

2. Integrated Care Pathway

2.1 Aim

- To ensure that the family of every infant/child whose growth is faltering receives appropriate assessment and where necessary a timely package of care.

- To promote working in partnership with families and between professionals.

2.2 Key Principles

- Growth Faltering is the failure to gain weight and/or height at a satisfactory rate.

- The Health Visitor or School Nurse provides the initial assessment and intervention and is responsible for continued monitoring.

- Growth faltering is due to insufficient calorie intake in approximately 90% of cases with no serious underlying medical or social cause and is likely to respond to dietary and feeding management advice alone.

- In the minority of cases, where the reasons for growth faltering are more complex, the referral route will depend on likely cause but multi-agency involvement should follow if there is no improvement. The

timing of each agencies involvement will depend on the level of concern as guided by the Common Assessment Framework.

- If at any time there is concern about possible abuse or neglect a Child Protection referral should be made to Children's Social Care (Reference 1).

- Admission to hospital is seldom required but is indicated if the child is suffering severe malnutrition or for management of serious organic disease. Rarely hospital is used as a temporary place of safety for a child who is at risk.

2.3 Rationale (Reference 2)

- Faltering growth occurs in about 5% of children. Simple interventions within the community are usually effective. In only approximately 5% of these children is there a primary organic cause for growth faltering and in a further 5% there is a need to invoke child protection procedures.

- Faltering growth occurs in children from all socio-economic groups and cultures. Children with disabilities are at particular risk of growth faltering.

- A fully coordinated approach is required so children with growth faltering are identified and responded to appropriately.

- If growth faltering is not addressed the child's development may be delayed and there may be increasing family stress and poor parent/child interaction. Dysfunctional eating behaviour may develop or become more severe.

3. Abnormal growth patterns (Reference 3)

When is fall in weight centile significant?

3.1 Children whose weight has been between 9th and 90th centile (UK – WHO charts 2009**)**

- 20% of this group of children's weight will fall through 1 - 2 centile channels at some time. The majority will improve spontaneously but will require ongoing monitoring**.**

- 10% of this group will fall through more than 2 channel widths - one weight only. This may be related to short term illness or family upset and will require further monitoring

- 5% of this group will fall through more than 2 channel widths - more than one weight (based on recommended weighing intervals).

This is likely to indicate a problem therefore further investigation is needed.

- Catch up within 1 baseline channel constitutes recovery. Partial recovery has occurred if child catches up to within 2 channel widths. Monitoring should continue with prompt action if a further decline occurs.

3.2 Children: Weight > 90th centile

A fall through 3 or more channel widths – with more than one weight. Indicates a likely problem therefore investigation is needed.

3.3 Children: Weight < 9th centile

A fall through 1 channel width – with more than one weight indicates a likely problem therefore investigation is needed.

N.B **This is for guidance only.** The total picture of the health and welfare of the child needs to be taken into account when action is considered. Young infants are particularly vulnerable. A fall off in weight centile usually exceeds and comes before any fall off in height centile. A fall off in head circumference centile usually only occurs in children with very severe growth faltering. An equivalent fall off in weight and height centile or a fall off in height centile in excess of weight centile may suggest an endocrine (hormonal) cause.

3.4 Other Growth Patterns Which May Indicate Growth Faltering

(Reference 4)

- Weight centile 2 or more centiles below height centile. (More than 1 centile if height below 9th centile). You may wish to refer to a BMI centile chart.
- Height/weight centile below 0.4th centile.
- Height centile below target centile range (based on accurate parental heights).
- A fall in more than 1 channel width in height centile (children over 2 years) with a continuing fall at next measurement.
- Fluctuating centile positions - commonly a reflection of family stress.

3.5 Catch Down Growth

Children less than 2 years may show catch down growth to their genetic centile making interpretation of growth charts more difficult. Infants size at birth is mainly determined by how well nourished (fed) they have been in utero. After about 6 months of age genetic factors become important and the rate of growth of infants who have been well nourished may slow until they have reached the centile where they are genetically ‘destined’ to be (usually by 2 years).

Typically, in catch down growth, both weight and height will fall through the centiles at the same rate or, if the weight centile is more than the height centile, then the weight centile alone may fall to approximately the same centile as the height. Similarly catch-up growth may occur if infants are poorly nourished in utero.

Catch down growth is unlikely to be the cause for a fall in growth through the centiles if:-

- This occurs rapidly
- Fall in height centile is preceded by a significant fall in weight centile
- There is a fall outside the target centile range-based on measured parental heights
- History suggests a possible underlying cause

3.6 Recommended Weighing Intervals

Age Range	**Routine Surveillance (+ opportunistic)**	**Universal plus Service**	**Frequency of weighing if concerns exist**	**If no improvement refer after**
0-1 Month	**Refer to section 2.1**	1 month	weekly	weekly
1-3 months 3-12 months	According to healthy child programme	3 months	2-4 weeks	2-4 weeks
1-2 years 0ver 2 years	Guidelines Ref. 5.	6 months 2 years and at school entry and 10 years	3 months 6 months	3-6 months

This is for guidance only. A high level of concern or rapid fall from original centile line may prompt more frequent weighing.

For children where there are concerns about growth, length / height measurements should usually be taken with each or alternate weights. Head circumference should be measured with each or alternate weights in first year of life. Height measurements should be taken opportunistically in children where there are no concerns about growth and at school entry.

Outline of possible causes of growth faltering

Under nutrition

Inadequate calorie intake(95%) (see over)	**Vomiting**	**Poor absorption**	**Increased demands**
Feeding problem/mismanagement Behavioural problem Physical problems Social • Poverty • parenting ability • neglect	Pyloric stenosis Severe gasto-oesophageal reflux	Coeliac disease Cystic fibrosis Cows milk protein intolerance Lactose intolerance Immune deficiency Chronic infection	Chronic illness incl. lung and heart disease

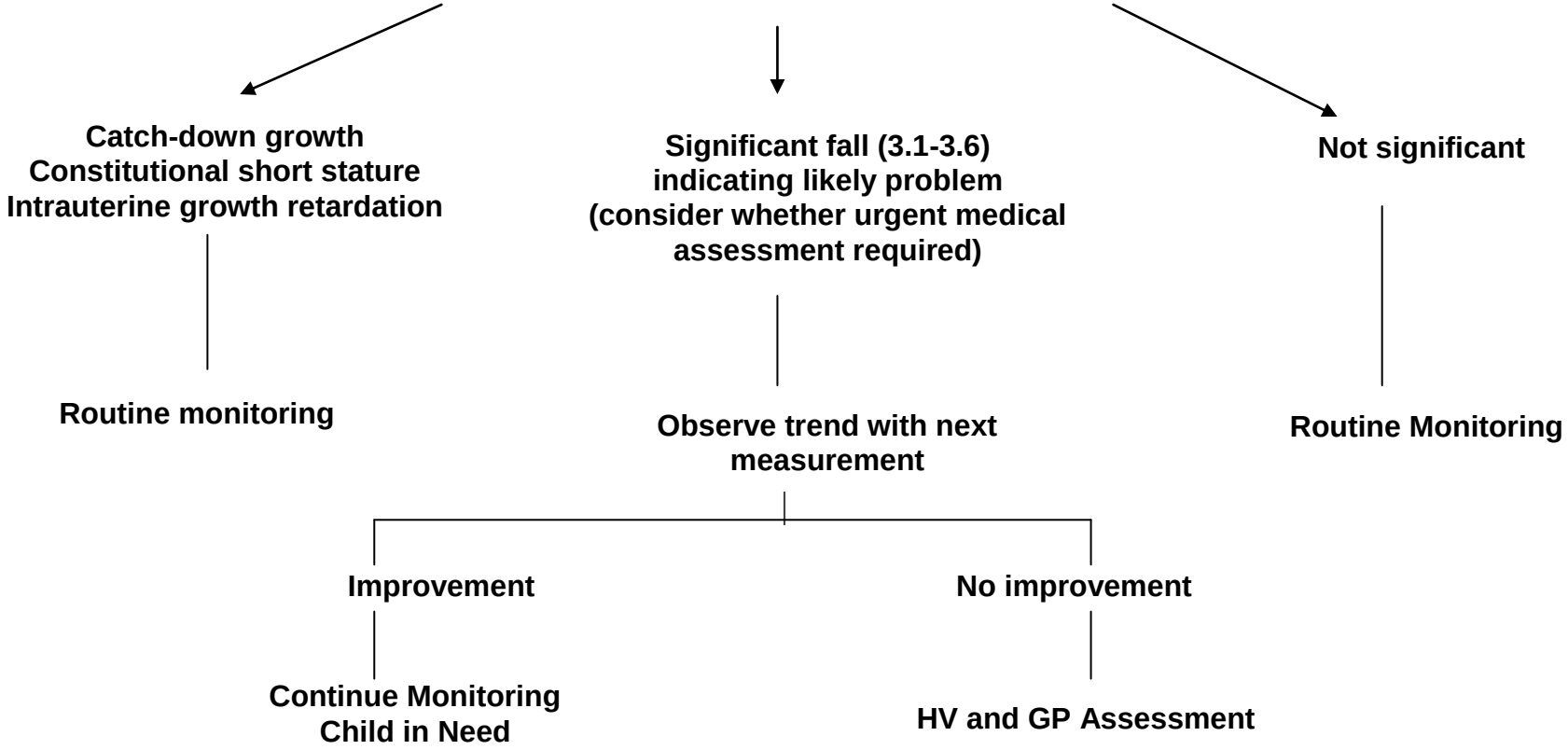
Inability to use nutrients for growth

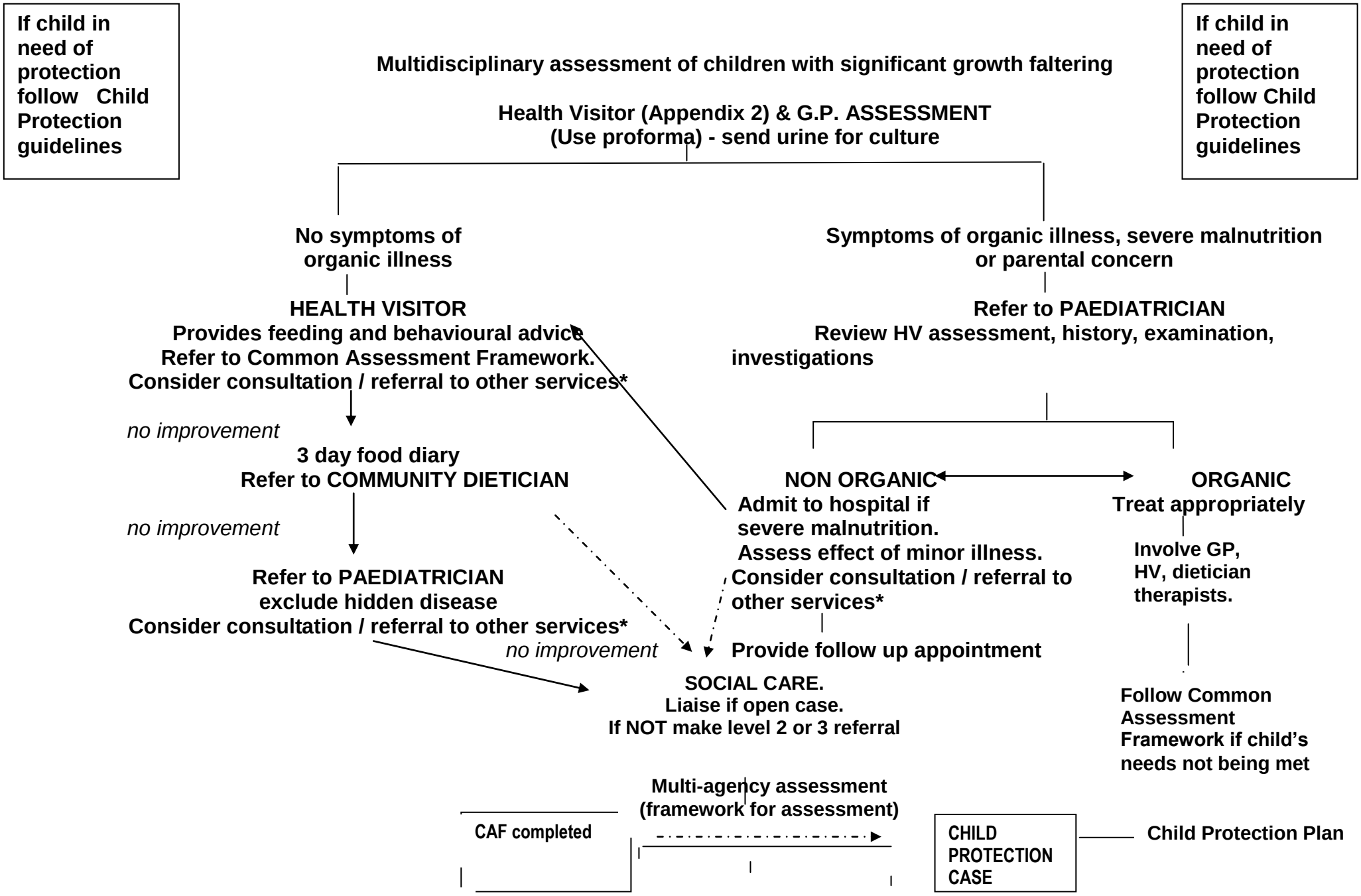
Hormonal }
Biochemical (metabolic) } **abnormalities**
Chromosome }

Growth faltering flow chart

Poor Growth

Assessment of degree of fall off in weight, length and head circumference from original centile





* Other services may include speech therapy, clinical psychology, learning disabilities team.

4. Professional Roles

4.1 The role of the Health Visitor

- Monitor growth of all children less than 5 years based on agreed national and local guidelines, using equipment and techniques specified by the Child Growth Foundation and in compliance with local policies and procedures.

- Take lead responsibility in monitoring children < 5 years with growth faltering.

4.2 Weights (height and head circumference) should be plotted in the parent held child health record (PHCHR) using UK-WHO 2009 centile charts. Where there is concern about growth the HV should keep a separate record on a contemporary growth chart in the health visiting records. For babies born at or after 32 weeks gestation, correction should stop at 1 year and this change should be clearly marked. After the age of 2 years all gestational correction should stop and plotting should be on the UK-WHO 0-4 years chart (UK-WHO low birth weight centile chart).

- The growth faltering protocol should be followed where there is concern about growth. If there is significant growth faltering perform an assessment using the assessment proforma (appendix A or B). Request GP to see child and liaise regarding further management.

4.3 **NB.** GP should be asked to see urgently in cases of severe malnutrition, if rapid fall off from centiles or / and if serious organic disease is suspected. Urgent admission to hospital may be required and can be requested by the health visitor.

- Young infants are more at risk of dehydration and malnutrition (refer to local guidance on management of babies with significant weight loss >10%).

After birth; if an infant loses **8-10%** of birth weight a care plan should be agreed with parents and documented and this should include reweighing within 48hrs.

if an infant loses **10 –12.5%** of birth weight referral to a neonatologist is required to check electrolytes to exclude hypernatraemia. Close monitoring and an agreed care plan is required.

If an infant loses**>12.5%** of birth weight an urgent neonatal referral should be made by contacting the neonatal registrar.

Babies with hypernatraemic dehydration may not exhibit classical signs of dehydration. Weight loss and feeding history are key factors in clinical assessment.

- If a baby has not regained birth weight by 2 weeks or there after loses weight or fails to gain weight urgent assessment and intervention are required.

- For infants being monitored as part of CONI (Care of Next Infant) programme, follow recommended guidelines.

- Inform parents about concerns and recommendations and obtain consent for referral and information sharing as per Common Assessment Framework (CAF) consent procedures.

- Provide dietary and feeding / behavioural management advice. Offer advice booklets i.e. Food for Growth (Parkin Project, Newcastle).

- Design care plan and set objectives and desired outcome according to identified needs (Feeding assessment/ Framework for Assessment).

- Health Visitor to be proactive in facilitating attendance at appointments.

- Take account of cultural differences and use translators/ interpreters where English is not the first language.

- Ensure all carers have received advice.

- Liaise with other agencies working with the family including learning disabilities team, mental health services and drug and alcohol treatment team.

- Contact and initiate information sharing with the liaison Health Visitor if the child has been seen in hospital.

- Consider the possibility of iron deficiency anaemia which may suppress appetite. Assess intake of iron containing foods and provide advice. Discuss with GP.

- Make appropriate referrals according to flow chart in agreement with parents and GP. Enclose copy of growth charts and assessment proforma.

- Collate responses from other professionals to whom the child has been referred. Record in HV records and Personal Child Health Record (LSWR) if available. Ensure parents have understood advice given, and address any inconsistencies in advice offered. Ensure parents are aware and agreeable to recommended management plan.

- Discuss with supervisor under caseload management or child protection supervision arrangements.

- Provide ongoing assessment and management and inform other professionals involved including GP if there is no improvement and agree further action to be taken. This may include arranging a CAF meeting.

Refer urgently to Social Care if child thought to be at risk of significant harm and in need of protection.

- Record all contacts, according to local record keeping policy. Continue to monitor response to interventions following a CAF meeting. If there is no improvement and growth faltering is thought to be due to neglect a child protection referral should be made.

- At school entry; where there are on-going concerns a referral to the School Nurse should be made and records including growth charts should be transferred.

4.4 The role of the school nurse

Growth Monitoring - School Entry

Children commence school between the age of 4 and 5 years.

Systems are currently being put in place to ensure close professional and working links between Health Visitors and the School Health Nurse where health or social concerns have been raised by the following;

- Parents.
- Health visitor at school entry.
- School teachers/Special Educational Needs Co-ordinators (SENCOs).

The school health nurse maintains good communication links with head teacher, class teachers and SENCOs in order for any concerns to be addressed promptly.

4.5 Process

All children will be weighed at Year 1 and Year 6 as part of the National Child Measurement Programme.

Growth charts, will be continued or raised for children;

- Where there are concerns about growth.
- With medical conditions which may affect growth.
- Where there are parental concerns.
- Who are subject to a child protection plan.
- Attending special schools.

4.6 Action

If there is concern about growth on assessment, children should be weighed and height measured at 6 monthly intervals and if there are ongoing concerns about faltering growth the GP should be asked to see the child and referral to other services considered (page10).

All children whose height is less than 0.4th centile at any stage in monitoring should be referred via a GP to a consultant paediatrician unless the child is receiving on-going paediatric follow-up.

Children require further assessment and a referral should be considered if;

- The height is below the 2nd centile and below the target centile range (calculation based on parental heights).

- The height of children between 4 - 10 years has fallen more than 1 channel width and on the next measurement there is a continued fall in height centile.

- The weight centile is 2 or more channel widths below the height centile (>1 channel width if height is <9th centile).

  Assessment (Appendix B) prior to referral may include;

  - Parental concerns.
  - Diet.
  - Acute/chronic illness.
  - Medical/psychological symptoms.
  - School attendance.
  - Teacher's concerns.
  - Parental stature – measured by professional.

4.7 The role of the general practitioner

- To weigh and measure children opportunistically and record in PHCHR.

- To provide initial medical assessment of children where there is significant growth faltering to assess severity of growth faltering and likely cause.

- Arrange admission to hospital if severe malnutrition or / and serious organic disease is suspected.

- Agree initial primary care management with the health visitor and make (or support) secondary referrals as indicated. Continuity of care is important in partnership with the Health Visitor.

- By means of close liaison with HV be informed of child's progress and agree further management / referral as appropriate.

- Ensure that planned action points are carried through.

- Refer urgently if child thought to be at risk of significant harm and in need of protection to Children's Social Care. (Ref. 1) Follow up referral in writing within 48 hours.

- Where there is a disagreement between professionals about concerns for the child disagreement/ dissent must be recorded those holding differing views should meet and if agreement cannot be reached the case should be reviewed by a nominated third party within an agreed time scale. Resolution of professional disagreements in work relating to the safety of children - Escalation Policy. www.swcpp.org.uk

- Contribute to multi-agency assessments and attend CAF / child protection conferences whenever possible.

- Consider and respond to physical / mental health needs of the family member and assess how these may impact on child's well-being.

- All children whose height is less than 0.4th centile should be referred to a paediatrician unless child has been (is being) seen by a paediatrician because of concerns about growth.

4.8 The role of the specialist speech & language therapist

Specialist speech and language therapists accept referrals from any practitioner for children suspected of having a specific feeding problem.

4.9 Reasons for referral may include:

- Structural problems.
- Cleft palate.
- Complex neurological problems affecting feeding.
- Trachea-oesophageal fistula.
- Tracheostomy.

A Consultant Paediatrician will request a Specialist Speech and Language Therapist opinion early in management.

- Suck / swallowing in co-ordination.
- Hypersensitivity to oral stimuli.

These problems are most common in infants who have been born pre-term and / or have required ventilation and / or nasogastric tube feeding.

4.10 Assessment:

- Oral examination.
- Observation of eating and drinking during a meal.
- Cervical auscultation.
- Videofluoroscopy in selected cases.

4.11 Intervention

Recommendation and demonstration of particular feeding techniques to carers and professionals involved.

- For children with oral hypersensitivity advice will be given in techniques to aid desensitisation.
- Advise no oral feeding, where necessary.

4.12 Liaison (with parental consent)

- A report will be sent to the referring professional and a copy sent to other professionals involved. Parents / carers will receive a verbal explanation and option of a written report.
- Liaison, if indicated, may take place with other professionals.

4.13 The role of the dietician (plus health visitor)

This includes:

- Assessing the variety and frequency of food and drinks offered (Review food diary).
- Comparing estimated nutritional intake with requirements.
- Looking at meal pattern; when, where and with whom.
- Assessing interest and knowledge about food and cooking skills.
- Finding out about kitchen and eating facilities.
- Looking at shopping arrangements, money available, budgeting, access to shops.
- Possible video recording of child's meal time.

4.14 Intervention

Qualitative information more informative than quantitative.

- Give advice on diet and feeding pattern as appropriate.
- Discuss:

- The importance of meals as enjoyable social occasion and for development of social skills.
- Normal behavioural expectations according to developmental stage.
- How behavioural problems arise and how they can be managed.

- High-energy supplements are occasionally indicated. Vitamin supplements A, C, D are recommended for all children 1 - 5 years.
- Liaise with Health Visitor and other carers.

4.15 The role of the clinical psychologist

Clinical Psychologists accept referrals from medical staff (e.g. Paediatricians, GPs, Health Visitors) for children with a range of feeding problems, e.g. mealtime difficulties, food fads or more serious eating disorders.

4.16 Assessment of Feeding Problems

From a clinical psychology perspective, this may include:

- Detailed history of feeding behaviour.
- Identification of child and adult characteristics relevant to the eating pattern.
- Analysis of interaction (child and family) patterns at mealtimes.
- Establishing possible links between eating difficulties and other behaviour problems (e.g. oppositional behaviour, anxiety, disturbed sleep patterns).
- Evaluating eating patterns within a developmental perspective and excluding possible developmental delay / disorder.
- Identifying the attributions, belief systems of the child and family in relation to feeding problems and the impact of the child's growth faltering on the family and wider social networks (e.g. Nursery, school).
- Consideration of broader issues (e.g. attachment) within the family system.

4.17 Interventions

- Detailed analysis of the child's eating pattern.
- Working in collaboration with parents to understand and modify the child's behavior.
- The use of a psychological knowledge base to underpin strategies to facilitate change.
- Acknowledging and understanding parental anxiety.
- Advice/information giving about normal eating patterns in children – establishing appropriate expectations.
- Helping parents modify mealtime/feeding parameter.
- Exploring with parents any links between their past experience, beliefs and goals with regard to feeding their children.
- Reinforcement of progress (often small steps) with children who have chronic feeding problems and growth faltering.
- Maintaining a level of psychological support to families – particularly during any crisis periods, e.g. weight loss or illness in their child.

4.18 Liaison

The clinical psychologist liaises with other health professionals involved with the child with feeding problems and with other staff who may observe/manage mealtimes (e.g. in nursery settings).

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All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

Signed: Director of Operations

Date: **9th April 2014**

APPENDIX A

Assessment Proforma

For children with slow growth less than 6 months of age

Name
Dob
NHS number

SEX MALE □ FEMALE □

Date of Birth…….

Address……
……..

Gestation ……
Age Chronological ……..Corrected …….
Birth Wt ……. Centile ……
Length…….. Centile……
HC …….. Centile ……
Current weight ……. Centile ……
Length ……... Centile ……
HC …….. Centile ……
Neonatal Problems Yes/No
Detail
……
……
……

Time to first passage of meconium (hours) …….

Time to regain birth weight (days) ……

Parents concerns

Feeding history

From birth Breast □ Formula Fed □

At assessment Breast □ Formula Fed □

Duration of breast feeding (if discontinued by time of assessment)

Weeks ……..

If breast fed
No. feeds per day ……

Duration of each feed …….

Any problems with feeding …….

Longest interval between feeds ……..

Does he/she wake for feeds Yes □ No □

Amount of time settled after each feeds (Hours) …….

If formula fed
Type of feed ……

Number of feeds ……

Amount of feed in 24 hours mls ……..

Number of mls/kg/24 hours ……

Longest interval between feeds ……

Amount of time settled after feeds …….

Who gives feed? Mother □ Father □ Other □ specify

Weaning
Age of introduction of solid feed …….

Number of meals per day …….

Number of teaspoons/meal ……..

Type of food offered ……

Medical History
Hospital admissions (specify date and reason for admission)

……
……

Other illnesses
……
……

Vomiting Yes □ No □

If yes, number of times per day ……

Time after feeds …….

Nature (effortless/projectile) ……..

Stools

Frequency ……

Colour …….

Consistency ……

Other symptoms
……
……

Immunisations (with dates)
……
……
……

Family History

Family history of illness including feeding problems and growth faltering
……
……
……...

Maternal health problems Yes □ No □

Specify……
……
……

Advice given to parents

Further action taken

Date of next assessment

Signature of person doing assessment…….

Name ……..

Designation……

Date ……

APPENDIX B

Growth Faltering Assessment Proforma
For children with slow growth more than six months of age

Name
Dob
NHS number

SEX MALE □ FEMALE □

Address……
……..

What are the family's worries about the child's growth?

Are there any other concerns about the child? (e.g medical. dietary, social)

Has the child already been referred to a specialist for any reason?

Yes □ No □

If yes, who, when and where?

Feeding History

Do the family have any particular concerns about feeding, now or in the past?

Was the child ever breast fed? Yes □ No □ Until what age?.....

At what age were they given solids…… finger foods……

As a baby did she/he have any trouble with the following:

Sucking Yes □ No □

Swallowing Yes □ No □

Chewing Yes □ No □

Food Preparation

Who acts as the main carer?

Does she/he offer and plan the child's meals Yes □ No □

What sort of food is cooked?

Where, when and how does the family shop for food?

Mealtimes

Where does the child mainly eat? Highchair □ Small table □
Dining table □ Other □ please specify
Does the child usually feed him/herself? Yes □ No □

If so, with what (e.g spoon, fingers)……..

What does he/she drink from during the day?

Bottle □ Feeding beaker □ Cup/glass □

Please tick most applicable answer for each question

	Every day	Most days	Some days	Never
Does mum enjoy child's mealtimes	□	□	□	□
Does child enjoy mealtimes	□	□	□	□
Is child hungry/ready for meals	□	□	□	□
Does the child eat everything on plate	□	□	□	□

What sort of extra foods would you like your child to be eating?.....
.....

Feeding Routines

Does carer have regular routine?
Always □ Mostly □ Rarely □ No □

Run through a typical day with carer.
What time does child normally wake up?.....
What time is breakfast?.....

Eaten with whom? Alone in room □ with sibs □
Carer supervises □ carer eats with child □

What sort of food is eaten?.....
.....

Any mid morning snacks? Yes □ No □ what time? …… No fixed time □

What sort of food or drinks? ……

What time is lunch? …….
Eaten with whom ? Alone in room □ with sibs □

Carer supervises □ carer eats with child □

What sort of food is eaten?……..
…….

Any mid afternoon snacks? Yes □ No □ what time? …… No fixed time □

What sort of food is
eaten?.....
.....

What time is tea?.....

Eaten with whom? Alone in room □ with sibs □
Carer supervises □ carer eats with child □

What sort of food is eaten?
……
……

Any bedtime snacks? Yes □ No □ what time? …… No fixed time □

What sort of food or drinks? ……..

When is bedtime? …….

Does the child sleep at any time in the day? Yes □ No □ If yes when?.....

What drinks does he/she normally have in the day, when and how much?

……
…….

How much does she/he drink overnight?.....

Behavioural and Development

Are there any behavioural problems related to food and eating?

Any others?

Does he/she appear to be developing normally?

Medical History

Was she/he born normally?

Is he/she a healthy child?

Are there any medical worries about him/her?

Are there any illnesses in other family members?

Family History

Any relevant social factors e.g poor housing, benefits, lone parent.

Advice given to parent /carer

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Further action

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……
……
……
……

Date of next assessment

Signature of person doing assessment…….

Name ……..

Designation……

Date ……