

# Guidance for Practitioners responding to Failure to Thrive

# Contents

1	Introduction.....	3
2	Background.....	3
3	Causes.....	3
4	Assessment.....	4
5	Pathways Following Assessment.....	5
6	Effective Information Sharing in Failure to Thrive.....	6
	Appendix 1: Failure to Thrive Pathway.....	8
	Appendix 2: Assessment Framework.....	9
	Appendix 3: Hospital Medical Assessment.....	12
	Appendix 4: References / Further Reading.....	15

## 1. Introduction

- 1.1 This policy has been written in respect of the 0-3 year age group. The principles throughout it can be applied to other age groups, but it is recognised that failure to thrive in the 0-3 age group can place these individuals at extreme risk. The policy seeks to ensure that a consistent pathway is followed, wherever the child presents.

## 2. Background

- 2.1 *'Failure to thrive occurs when an infant or child fails to achieve the expected growth as assessed by measurements of weight and height. The child may also fail to achieve full potential in other parameters of development.'* (Hobbs, Hanks and Wynne, 1999)
- 2.2 Failure to thrive is identified when infants and children are not achieving their expected growth pattern. This is most often initially observed as failing to gain their required weight but also later their height can also be affected. Precise, workable definitions using growth criteria have yet to be defined.
- 2.3 There are several factors which can affect an infant and child's ability to gain weight and thrive such as recent illnesses, genetic predisposition or a physical/organic cause. Both physical and psychosocial factors contribute to this condition and are not mutually exclusive.
- 2.4 Failure to thrive is not exclusive to any one ethnic group, community or social class. It can affect children from any background.

## 3. Causes

- 3.1 The causes of failure to thrive are often divided into 3 categories:
- Organic
  - Non-organic
  - A combination of both organic and non-organic.
- 3.2 Organic failure to thrive can occur when there is an explainable physical reason. These reasons need to be explored, and subsequently refuted before a diagnosis of non-organic failure to thrive can be made. Assessment must include allowance for perinatal factors (e.g. small for dates) and frequent illnesses.
- 3.3 In the first few weeks of life, failure to thrive often reflects poor feeding techniques (e.g. failure to establish breast feeding) and the input of the Infant Feeding Team may be required.
- 3.4 Non-organic failure to thrive is when the infant/child's failure to thrive is due to psychosocial and environmental factors. This diagnosis depends on full assessments of
- The child's developmental and behavioural characteristics

- The parent/carer relationship with the child and attachment of the child to the care giver
- 3.5 It is now recognised that often there can be a combination of factors including both organic and non-organic causes of failure to thrive. Infants and children who fail to thrive may have some organic characteristics for failure to thrive but there can also be socio/environmental factors, which contribute to this condition. This becomes evident as the organic factors alone do not explain the lack of growth and development.

## 4. Assessment

**If at any point in a practitioner's involvement with the child and their family or carers there is a concern about significant harm to the child then the agency Child Protection procedures should be used. This should result in a referral to, or consultation with, Children's Social Work who may decide to carry out an initial assessment leading to a child protection (or s.47) enquiry.**

- 4.1 The initial recognition of concern about failure to thrive is not a simple matter. All aspects of the child's development should be considered and family & environmental factors must also be assessed alongside the parental capacity to care for the child (see appendix 2).
- 4.2 Growth screening methods also vary so it is vital in the assessment of the child's physical development that the use of methods is consistent and standardised across all services that the child comes into contact with.
- 4.3 There will always be a concern about Failure to Thrive if a child is below the 50<sup>th</sup> centile and experiences a fall of 2 or more centiles in weight. **However, failure to thrive can also be diagnosed where this has not happened because the assessment must take into consideration all aspects of the child's growth.**
- 4.4 Infants and children who are failing to thrive often initially come to the attention of a health visitor. Although sometimes other practitioners, particularly the GP, may be concerned about an infants/child's growth these should be directed to the midwife/health visitor. This is to enable the Midwife/Health Visitor to undertake an assessment of the infant/child using the 'Assessment Framework' (DOH 2000) along with the Common Assessment Framework (CAF).

### **Signpost: Tameside Children's Needs Framework (2007)**

- 4.5 This assessment needs to be completed in consultation with other practitioners to decide upon a course of action. The health visitor is generally felt to be the most appropriate person in most cases as they are in receipt of information from the other agencies. At times there may be a direct referral to the Paediatrician due to presentation at other medical venues. Even so the health visitor (and GP) needs to be kept informed at all times.

- 4.6 The Health Visitor (or other practitioner) making an assessment of the social circumstances of the family should check the knowledge of the family by other agencies. This should usually be done with the consent of the child's parents/carers.

## 5. Pathways Following Assessment

- 5.1 It needs to be remembered whenever applying this policy that the way to proceed when uncertain is through competent professional judgements based on sound assessment of the child's needs. This includes the parents' capacity to respond to these needs, including their ability to keep the child safe from harm

After an assessment by the health visitor the following may occur.

### 5.2 Low level concern

The Health visitor will initially discuss weight gain issues with the infant feeding co-ordinator/GP/paediatrician. After this consultation if there is not felt to be the need for referral into any other agencies then a plan to be drawn up for appropriate advice and monitoring with a review date.

If concerns about weight progress are resolved then the child can be returned to the universal services on offer.

If not resolved then there may need to be referral to, or discussion with, a paediatrician. If there are any welfare concerns there must also be a referral to Children's Social Care.

### 5.3 Medium level concerns

If the health visitor assessment indicates that there are somewhat higher levels of concerns due to physical or family/social factors, then there is a need for referral to the Consultant Paediatrician, as well as to Children's Social Care. The Consultant Paediatrician should be contacted to decide on the best course of action.

This can be:

- Seen in the Children's Outpatient Department
- Rapid access clinic
- Observation and Assessment Unit

The child should be seen by an experienced paediatrician of at least middle grade level and discussed in detail with a consultant as would be the case for a child referred for possible non accidental injury.

At this level of concern it is also important that there should be a multi-agency planning meeting. This should be done with the consent of the parent(s) where possible, using the CAF as the basis for the meeting. However if there is no parental consent then there should still be a multi-agency planning meeting if

this is considered to be a 'necessary and proportionate' response to the concerns.

The government has published *Information Sharing Guidance* which is very helpful in setting out when information should be shared. It can be accessed at: <http://www.everychildmatters.gov.uk/deliveringservices/informationsharing>

To aid the assessment by the paediatrician it is essential that the Health Visitor attends the appointment with the infant/child and family to allow for a full detailed assessment to be undertaken and for all concerns to be addressed fully.

#### **5.4 High Level Concerns**

If there are significant safeguarding concerns, even in the absence of specific health concerns, then a referral is to be made to Children's Social Care along with a referral to a consultant paediatrician. The referral to Social Care should be fully documented in the infant/child's records along with a copy of the written referral.

After referral to Children's Social Care an assessment will be made by them as to their course of action.

#### **Signpost: Tameside Safeguarding Children Framework (TSCB 2007)**

- 5.5 There will need to be direct contact between the Health Visitor and the Hot Week Paediatrician with agreement as to how to proceed. The child will normally need to be seen within 24 hours and in many cases admission to hospital will be required.
- 5.6 Once admitted to hospital, a plan of care must be clearly documented with specific outcomes identified. These must include observations of the child whilst in hospital and their interaction with family members.
- 5.7 When the child is an inpatient in the hospital and concerns have been expressed about failure to thrive the child must not be discharged home without the agreement by the Consultant Paediatrician. If this paediatrician has been in post for less than 2 years a more senior colleague should be consulted by the paediatrician. (Inpatient assessment appendix 3)
- 5.8 Prior to discharge, a **discharge planning meeting** should be called to ensure that there is an accepted and agreed plan of follow up after discharge from hospital. This is a multi-agency plan and requires attendance from all agencies involved. This plan should include:
  - A clear feeding plan, including what to be fed, by whom and frequency.
  - When the child is to be weighed, by whom and frequency.
  - A record of the child's weight, height/length and head circumference at discharge. This provides the baseline for subsequent measurements.

- Out patient follow up. To be clear about when and by whom.
- Other agencies involvement needs to be outlined clearly.
- A clear statement of actions with time limits and a named person responsible for that action.
- What will happen if the plan is not adhered to
- A date for a follow up meeting to ensure that progress is being made.

The agreed plan must be distributed to all agencies as soon as possible.

## **6. Effective information sharing in failure to thrive**

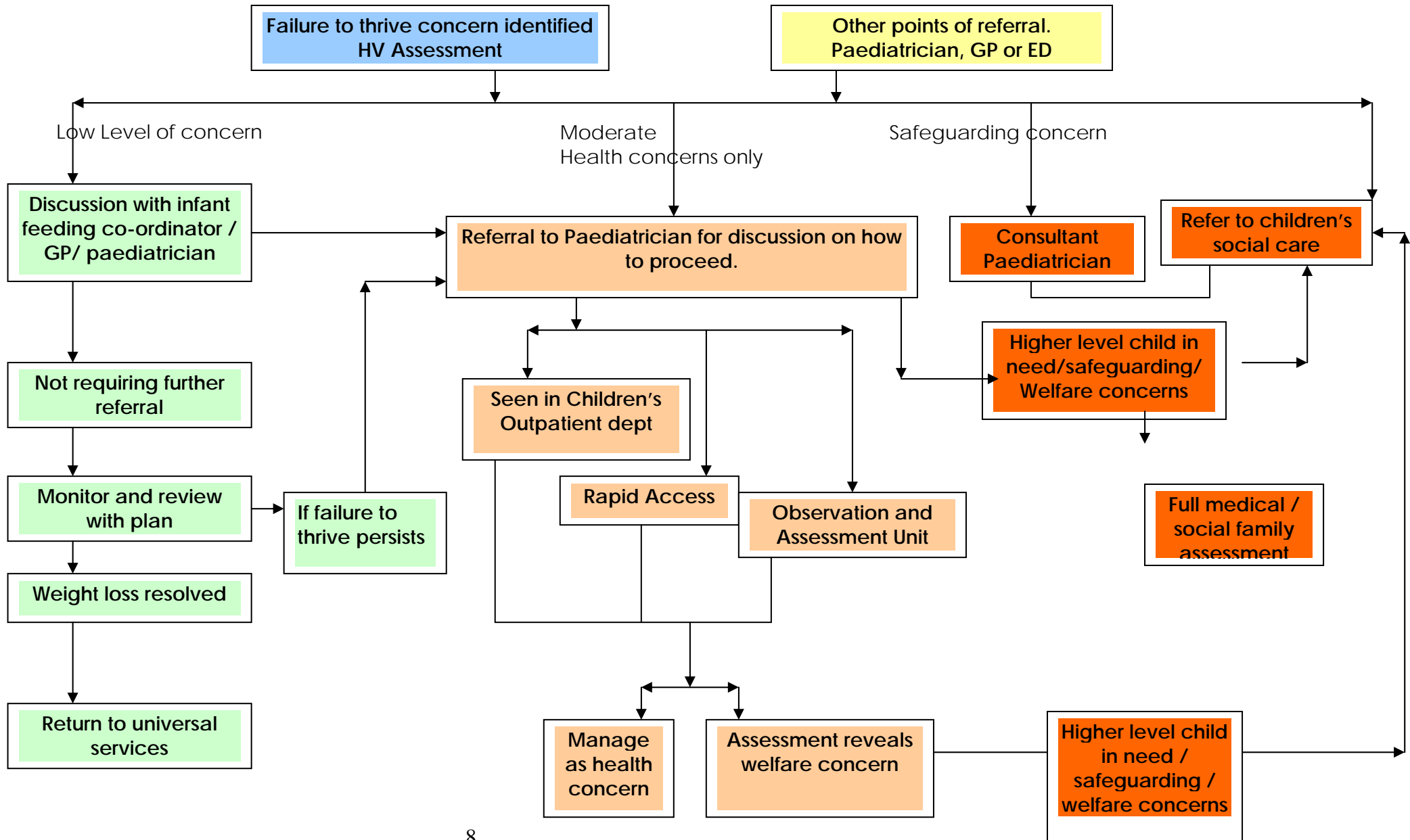
6.1 This is essential to ensure the safety of the child and can be achieved by:

- Accurate and comprehensive record keeping including both physical observations and tests plus information.
- If the level of concern is medium or high then an entry must be made on JASPER/ContactPoint to indicate that there is information to share.
- Information about the interaction between the infant/ child and carer, including the question 'would you expect this behaviour/ reaction from any reasonable parent carer'.
- If there is any action that is out of the normal sphere of expected reactions these need to be recorded clearly and explicitly, then shared with other agencies as appropriate.
- Use of information sharing protocols along with the child in need process.
- Look at JASPER/ContactPoint to find out if a CAF has been completed, who the Lead Professional is, whether action has been taken and if a practitioner has important information to share.

**Signpost: Thameside Children's Needs Framework (TSCB 2007)**

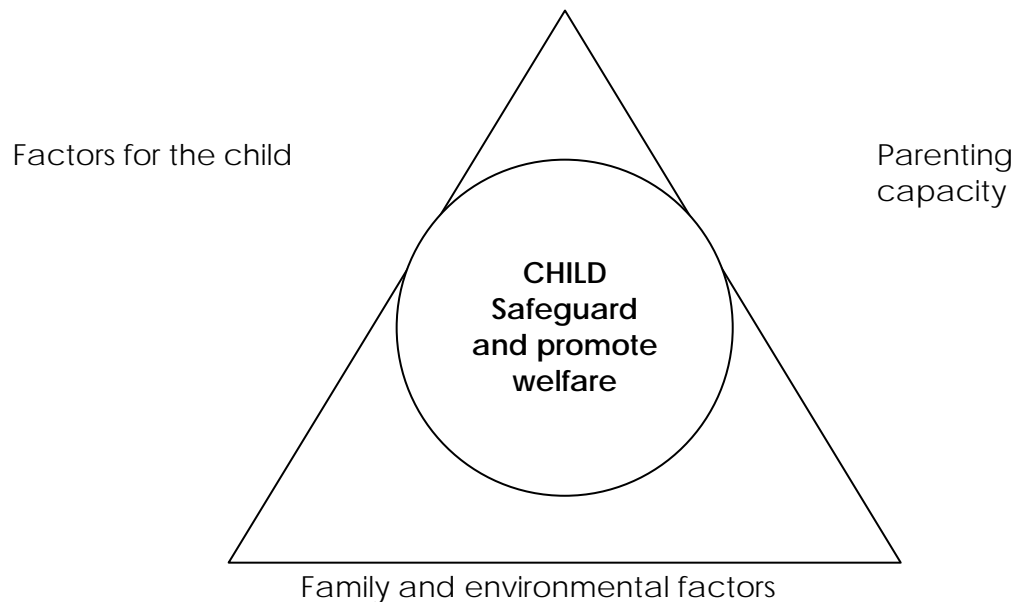
# Appendix 1

# Failure to Thrive Pathway



## Appendix 2

### Adapted from the Assessment Framework (2000)



A number of factors may be identified in the assessment of a child with failure to thrive. Some may relate specifically to the child, others may relate more to parenting capacity or to other family / social factors. These may be included under more than one heading as it is important to remember that the same factor can be identified within many different areas.

The following list covers the main areas and is only to help with considering failure to thrive.

### **Factors for the child**

The needs of the child may be either unmet or unrecognised, by acts of omission or commission.

Insufficient nutrition

Difficulties in feeding? Refusing, spitting?

Do parents give up or force feed? Which parent / carer is more successful?

Interest in food: avoidance or persistent craving / searching

Was this child the wrong child (sex, appearance, personality)?

Is this child an easy child to care for?

Is this child considered to be different to other children in the family?

Child's health: are there any underlying conditions or medical conditions present that make it more difficult to care for this child?  
Frequent illnesses?

Past medical history, such as admissions to hospital, attendances at the Emergency Department and the GP's (incl out of hours).  
Has the child attended routine appointments such as immunisations, developmental checks? Who has brought the infant/child to these?

How does the child behave, eg. Sleeping, tantrums, irritability?  
Appearance of the child and observation of behaviour, for eg. sad face, no smiling, withdrawn, tearful.  
Any signs at all of non-accidental injury?

How does the parent/carer react to the child being distressed?  
Is the child tense when in the parents company?  
How does the child appear and react when in the parents' and siblings' company, or when they leave?

Is there any developmental delay?

## **Parental Factors**

Establish if this child was planned / wanted.  
Did both parents want this child?  
Have there been miscarriages or child deaths in the past?  
Is this a replacement child?

Do you think the parent likes this child?  
Is the parent interested in this child?  
Does the parent feel that this child is small, failing to thrive?  
How does the parent react to this child? (Bonding)  
Does the parent demonstrate an understanding of the child's needs?  
Do the parent(s) play appropriately with the child?

Family structure.  
Have siblings thrived?  
Is there any domestic violence?  
Drug and alcohol misuse.  
Parental mental health issues, incl post natal depression  
Maternal eating disorders  
Parents' experience within their childhood, e.g. have they been in care?  
Is this family hard to engage?

What is the parent's relationship like, are they supportive of each other?  
If single parent, where does the parent get their support from?  
Are the parents' expectations of the child realistic?

## Family and environmental factors

How did this child present to the professional?

Is this a well functioning household?

Current / previous involvement of Social Care or other professionals

Is there any evidence of any dysfunction?

What support systems are available?

Has there been any bereavement or loss?

Assess the environment where the child is living/home circumstances.

Interaction between the child and family members.

Family composition, what is this child's position within this household?

Closure from the family to professionals, lack of engagement.

Cultural reasons being given for lack of engagement.

Having a transient life style.

Economic situation

## Appendix 3 Hospital Medical Assessment

### A – OPD Assessment

1. Background Information

Growth charts – including length and head circumference  
HV present/report – including full family background

Consider structured referral form

2. Assess

Relevant factors in pregnancy/birth incl birth weight  
Detailed feeding history (incl swallowing problems; any force feeding)  
Current intake incl time taken (may need diary)  
GI function  
General health  
Previous interactions with health services (incl immunisations)  
Development  
Behaviour

3. Observe/Examine

Child - detailed examination including development

- signs of wasting; thin arms and legs, distended abdomen, thin wispy hair, dark circles around eyes
- alternatively, does he/she seem just generally small?
- signs of neglect, e.g.- deprivation hands / feet [cold, red, swollen / indurated]
- any injuries (incl torn frenulum)
- any bruising in premobile child highly significant
- any dysmorphic features
- level of alertness
- interaction with parents
- feeding skills

Parents

- interaction with child
- attitude
- response to discussion

4. Differential Diagnosis

Carefully plot and review all growth data (weight, length & head circ)

Need to consider balance of likely causes in the light of information from other professionals, especially health visitor.

## 5. Potential Outcomes

**(always discuss fully with consultant before agreeing a plan)**

1. Investigation (minimal unless history/examination suggests a problem).  
Minimal investigations might include:
  - blood for U&E, LFT, PO4, FBC, ferritin, folate
  - urine culture
  - consider PTH
  - consider CF gene probe / sweat test
2. Input from dietician – likely to need early discussion, not just referral form
3. Input from specialist speech and language therapist (based at CDU at Rowan House, Tel 366 5705) to assess feeding skills
4. Input from Infant Feeding Team
5. Input from Social Care (including eg Child in Need)
6. Agree ongoing assessment/observation
  - eg - admission (with clear plan [see Hobbs et al p46])
  - OPD

## **B – Presentations to A&E**

- (i) If child ill or suggestion of neglect / physical abuse or serious concerns from family/professionals:
  - refer paediatrician
  - consider admission if age below 6 months
- (ii) If not and less serious concerns:
  - age below one month – refer infant feeding team and midwife / HV
  - age one month to 3 years – refer infant feeding team and health visitor

## **C – Presentation to O&A or Rapid Access**

For full assessment (as in OPD assessment – see section A)

Ensure full and documented involvement of consultant (as in a Child Protection medical)

Agree outcome (as in OPD assessment)

## **D – Inpatient Assessment**

Often unnecessary. Consider if:

1. Age less than 8 weeks
2. Significant weight loss/serious failure to thrive
3. Serious concerns from family or professionals
4. Failure of outpatient management
5. Significant Safeguarding concerns

If undertaken, there needs to be clear goals of admission and agreement on:

- role of parents in feeding
- documentation of feeds including volume and duration
- documentation of parental involvement
- investigations
- involvement of other professionals (eg SALT, dietician)

Prior to discharge a clear discharge plan to be formulated, often requiring a formal discharge meeting (see p4)

## Appendix 4

### References / Further Reading

1. Hobbs CJ, Hanks GIH, Wynne JM: Failure to Thrive in: Child Abuse and Neglect 2<sup>nd</sup> Ed. 1999 p23 – 62
2. Raynor P, Rudolf MCJ: Anthropometric indices of failure to thrive. *Arc Dis Child* 2000; 82: 364-5
3. Wilensky DS et al: A community based study of failure to thrive in Israel. *Arch Dis Child* 1996; 75: 145-8
4. Wright CM, Parkinson KN, Drewett RF. The influence of maternal socioeconomic factors on infant weight gain and weight faltering (failure to thrive). *Arch Dis Child* 2006; 91: 312-7
5. Skuse D. Non organic failure to thrive; a reappraisal. *Arch Dis Child* 1985; 60: 173-8
6. O'Callaghan MJ, Hull D. Failure to thrive or failure to rear? *Arch Dis Child* 1978; 53: 788-93.
7. Olsen EM et al. Failure to thrive: prevalence and occurrence of anthropometric criteria in a general infant population. *Arch Dis Child* 2006; 92: 109-114
8. Edmond A et al. Postnatal factors associated with failure to thrive in term infants in the Avon Longitudinal Study. *Arch Dis Child* 2007; 92: 115-9
9. Wright C Birks E. Risk factors for failure to thrive: a population based study. *Child Care Health & Dev* 2000; 26: 5-16
10. Rudolf MCJ Logan S. What is the long term outcome for children who fail to thrive? A systematic review. *Arch Dis Child* 2005; 90: 925-31
11. Lewin D Herron H. Signs, symptoms and risk factors: health visitors' perspectives of child neglect. *Child Abuse Review* 2007; 16: 93-107
12. Dickens J. Child neglect and the law: catapults, thresholds and delay. *Child Abuse Review* 2007; 16: 77-92
13. Iwaniec, D. (2004) *Children Who Fail to Thrive*. John Wiley and Sons Ltd.
14. Iwaniec, D. (1997) *An Overview of Emotional Maltreatment and Failure-to-Thrive*. *Child Abuse Review* Vol. 6: 370-388.
15. Department of Children, Schools and Families (2010) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. The Stationery Office. London.

16. Department of Health, Home Office, Department for Education and Employment (2000) Framework for Assessment of Children in Need and their Families. The Stationary Office. London.
17. Royal College of Paediatrics and Child Health (2006) Child Protection Companion. RCPCH. London.
18. Tameside Safeguarding Children Board (2007) Tameside Safeguarding Children Framework (TSCB).
19. Tameside Safeguarding Children Board (2007) Tameside Children's Needs Framework (TSCB).
20. Infant & Pre School Children Feeding Guidelines 2008. Tameside & Glossop PCT.