

INADEQUATE GROWTH

I. DEFINITION:

Malnutrition resulting in inadequate physical growth as determined by failure to meet the norms established by the National Center for Health Statistics (NCHS). Growth below the 5th percentile, or a change in growth that has crossed two major growth percentiles (i.e., from above the 75th percentile to below the 25th) in a short time are generally accepted criteria for failure-to-thrive (FTT). Growth parameters for premature infants should be corrected for gestational age until the age of 24 months for head circumference, age 24 months for weight, and age 24 months for height.

II. CLINICAL FEATURES:

- A. Growth parameters show a decline in growth velocity, poor growth velocity, or growth below the 5th percentile.
- B. Signs of severe malnutrition may include dehydration, listlessness, thin extremities, prominent ribs, and wasted buttocks.
- C. May have signs of abuse and/or neglect.
 - 1. Diaper rash, unclean skin and nails, or unclean clothing may evidence neglect of hygiene.
 - 2. A flattened occiput with hair loss can be indicative of an infant spending long periods of time unattended.
 - 3. Avoidance of eye contact, apathy or an expressionless face, and the absence of cuddling on the part of the parent or the child warrant further exploration.
 - 4. Suspicious bruising or other trauma may be present.

III. MANAGEMENT PLAN:

- A. Management
 - 1. General Management by the County Health Department Clinic Nurse
 - a. Referral to APRN or private physician for acute illness and/or suspected growth failure.
 - b. Laboratory Studies
 - 1) Hemoglobin (6 months of age or older) if not previously obtained.
 - 2) Lead Screening if not previously obtained.
 - c. Make nutritionist appointment, and if breastfeeding, refer to the breastfeeding coordinator or lactation consultant if available.
 - d. The clinic may adopt the more intense management required of C-1 nurses (see III.A.,2.) or develop and write a standardized plan for use in the specific county. The plan must be signed by the county medical director and a copy sent to Nursing Service. Such a plan may be more intense than the above stated general management for the clinic nurse but less intense than the management required of the C-1 nurse.
 - 2. Specific Management for Children First Infants
 - a. Obtain additional history – unwanted or difficult pregnancy or birth, early separation, feeding difficulties, psychosocial stressors, (i.e., substance abuse, financial, or marital stressors.)
 - b. Obtain and review results of newborn metabolic screening tests.

- c. Ongoing assessment of parent-child interaction (inappropriate, lack of eye contact). Observe feeding of infant whether breast or bottle fed.
- d. Obtain a 24 hour food recall.
- e. Request parent to complete a one week food diary or a three day food record.
- f. Home visit as indicated.
- g. Contact the primary care provider's office to assure the child receives ongoing medical care and to request a copy of the record of the most recent visit.
- h. Children First infants are to be entered on tracking for follow-up.

B. Prevention

- 1. Identify cases early and refer promptly when indicated.
- 2. Build self-esteem of caregiver.
- 3. Role model feeding, nurturing and playful behaviors for caregiver.
- 4. Provide recommendations in non-directive, non-threatening manner.
- 5. Assess sleeping and eating patterns of infant/child.

C. Consultation/Referral

- 1. Refer to DHS if child abuse or neglect is suspected.
- 2. Once APRN or physician establishes formal diagnosis, infants or children with "Failure-to-Thrive" should be referred to the SoonerStart Program.

D. Follow-up

- 1. General: Determine tracking priority using professional judgment.
- 2. Specific for Children First Infants
 - a. Monitor growth parameters, including head circumference, by regular Children First nurse home visits until progress is apparent. If these parameters are not progressing as evidenced by a graphed growth curve, refer the client to the primary care provider and/or the Department of Human Services per assessment of the situation.

Recommendations:

AGE	FREQUENCY
0 up to 4 months	Weekly (Gaining 5-7 oz/week)
5 up to 12 months	1-2 weeks (Gaining 3-4 oz/week)
1 up to 3 years	Monthly

- b. Rule of thumb: 4-6 months – doubled birth weight
1 year – tripled birth weight
1-5 years - 4-6 lbs./year
2 ½ years - quadrupled birth weight
- c. Continue to monitor growth parameters until steady progress is assured.
- d. Assess and support the caregiver's parenting efforts.

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