Regional Paediatric Dietetic Care Pathways

(Dietetic Booked Elective Work)

Revised Edition December 2020

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Introduction

Enclosed within this document are regionally agreed dietetic care pathways for paediatric patients within **dietetic booked elective services**.

Elective patients are monitored under the DHSSPS target that states:

‘no patient will wait longer than 13 weeks from referral to commencement of AHP treatment’.

An **elective** service is where patients require a booked appointment for the dietetic service. It does not include inpatients or patients seen in the Emergency Department.

A **dietetic booked** elective service is where it is the Nutrition and Dietetic service that holds the responsibility for booking and controlling the management of the patients within the Nutrition and Dietetic service.

Whilst there may be Trust variation in operationally how services are delivered (i.e. booked elective, non-booked elective including Consultant led services and via multi-disciplinary teams) the pathways for the clinical management of these patient groups remains largely the same. These booked elective services may be delivered in a variety of settings such as community centres, GP surgeries, out-patient clinics or a domiciliary setting.

Where there are additional specialist services for elective services within Trusts – separate care pathways will be developed.

Guiding principles for use of the care pathways

These care pathways have been developed to ensure a safe standard of clinical care, using the current evidence base. They are to be used as a guide for Dietitians but professional judgement must always determine the content of treatment provided. If there are variances to dietetic care, these should be justified in the patients nutritional care plan.

Pathways should be used in conjunction with other disease specific nutritional care pathways, as appropriate. Clinical priority dictates which pathway the patient will follow.

Before commencement of any care pathway it is essential to confirm whether the patient/client is currently under the care of the dietetic service.

Although dietary treatment commences at the initial appointment it may not be possible to cover all the treatment/education components at initial assessment. Staging this process across visits may be necessary.

For all initial appointments the Dietitian should outline the format of the appointment, length of appointment and, where appropriate, the duration of the treatment. Be careful how this is communicated with the patient so that expectations are not unduly raised, as individuals may not require to follow the full pathway outlined.

These care pathways are primarily designed for the care of patients in the clinic setting. Where care is undertaken in the domiciliary setting, an additional 15 minutes intervention time is required. Travel allocation is as agreed at Trust operational level.

The appropriate UK-WHO growth chart should be used for all children. However children who have been plotted to date using UK 1990 growth charts may remain in use.

Use of interpreters: the clinical time listed does not allow for when interpreters are required for patient consultations. Allow additional time per appointment, as required and agreed at Trust operational level.

Safeguarding Children and Young Adults:
If a patient/client has significant need or is deemed as vulnerable or at risk, the Dietitian should follow up non-attendance or no response to partial booking process with the GP/Referrer/Social Worker/Relevant Key Worker/Health Visitor/carer/patient to determine any issues that may be preventing attendance.

Children who are under Child Protection/Safeguarding Children Services should not be treated any differently to other children referred for clinical care and treatment.

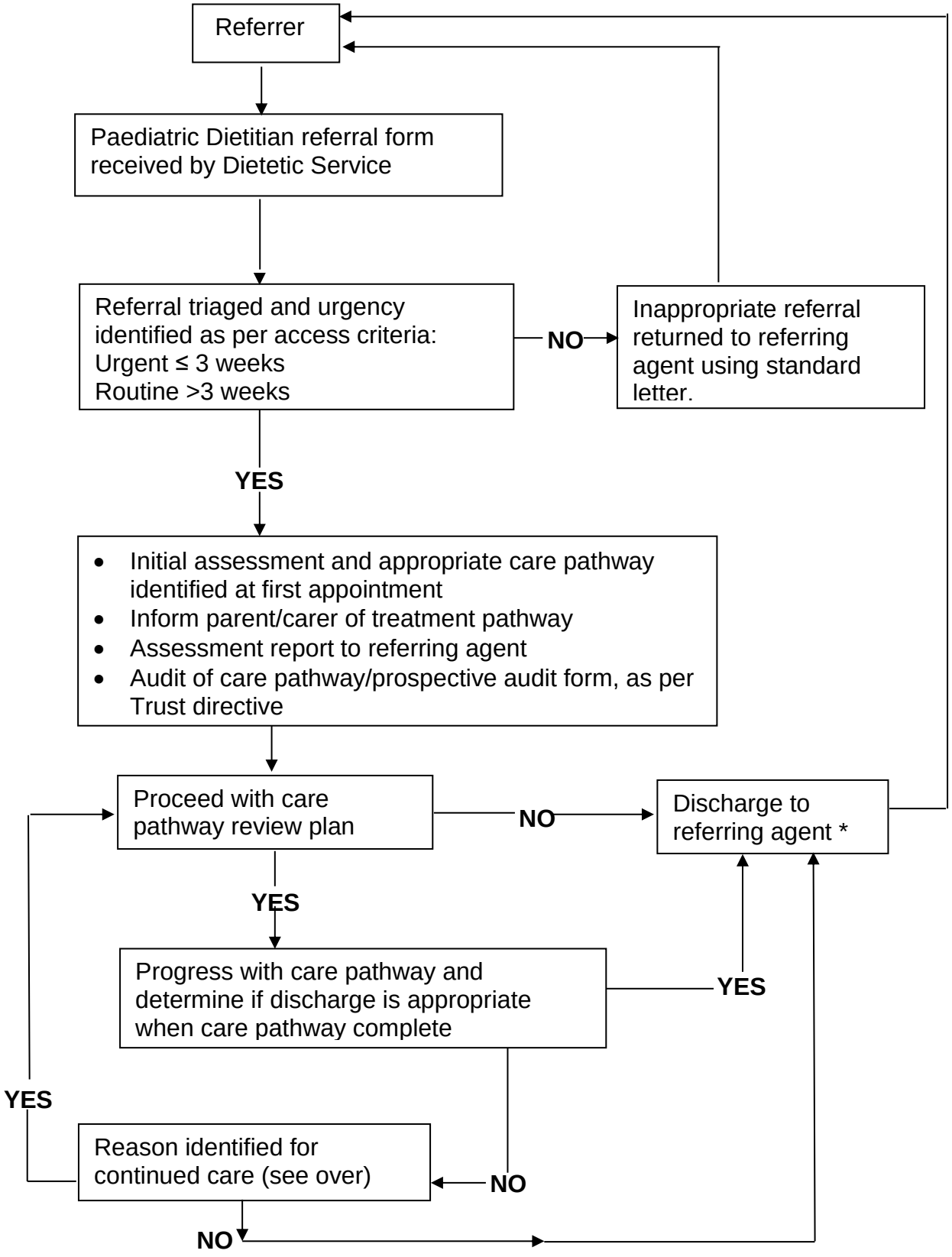
Record keeping
Ensure the nutritional care plan is documented in the patient's dietetic record, as per Trust policies and guidance.
Allocated times for new and review appointments includes all associated clinical administration including write up, letters and phone calls in relation to that specific appointment.

Referral Criteria

URGENT REFERRALS AIM: To be seen within 3 weeks of receipt of referral	ROUTINE REFERRALS AIM: to be seen within 13 weeks of receipt of referral
Faltering growth A fall across; ≥1 centile spaces, if birthweight was < 9th centile ≥2 centile spaces, if birthweight was between the 9th and 91st centiles ≥3 centile spaces, if birthweight was above the 91st centile when current weight is <2nd centile for age, whatever the birthweight (29). Newly diagnosed Coeliac disease Allergy: introduction of milk free solids advice for infants >17 weeks and <52 weeks who have confirmed Cow's Milk allergy (CMA) Maternal dietary exclusion trial for breastfed CMA infant Management of breastfeeding mother on cow's milk free diet IgE mediated reaction to 1 or more foods Non-IgE multiple food exclusion Nutritional support requiring specialised ACBS Borderline products, NG or PEG feeds Inflammatory Bowel Disease Active/symptomatic Crohn's disease requiring dietary management Active/symptomatic Ulcerative Colitis (UC) requiring dietary management	Coeliac disease requiring new dietary assessment and education Allergy: introduction of milk free solids advice for infants <14 weeks who have confirmed CMA Obesity: Defined as BMI >98th centile, using paediatric BMI chart Food allergy/ Food hypersensitivity (Non-IgE) e.g. trial exclusion diet Transfer of nutritional care from UK and/or Ireland Specialist Treatment Centres Dietary assessment to confirm / treat dietary related vitamin and mineral deficiencies Dietary assessment of feeding problems due to sensory, oro-motor or developmental concerns

NOTE: Diabetes is not part of the dietetic booked elective access criteria as these referrals arise via unscheduled care

Algorithm for elective clinical care pathways for children referred to Paediatric Dietetic services



* Referrers, along with other appropriate health care professionals such as GPs/ Paediatricians/ Health visitors should be sent a letter advising them if a patient has declined or not attended an appointment and therefore has been discharged from the service, as per operational procedures. All the aforementioned and appropriate health care professionals should be forwarded a treatment summary letter following initial consultation and any further consultations which result in a significant treatment change or outcome. A copy of the discharge letter (DNA/ CNA) should be sent to the Parents/ Guardians and the referrer.

1. Paediatric care pathway for the dietary management of faltering growth

Referral: Faltering growth – a fall across:

- 1 or more weight centile spaces, if birthweight was below the 9th centile
- 2 or more weight centile spaces, if birthweight was between the 9th and 91st centiles
- 3 or more weight centile spaces, if birthweight was above the 91st centile

or when current weight is below the 2nd centile for age, whatever the birthweight (29).

Infants who lose more than 10% of their birth weight in the early days of life, or they have not returned to their birth weight by 3 weeks of age.

BMI<0.4th centile probably indicates undernutrition that requires assessment and intervention.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment **60 mins**	▪ Assess growth history from available measurements ▪ Measure and record current weight and length/height in PHCHR ▪ Assess relevant biochemistry ▪ Use appropriate centile chart for age, gender and condition (if born premature please indicate number of weeks and use *corrected age in weeks and provide with BLISS Weaning your premature baby (2017) leaflet and recommend/ ensure they are on the appropriate supplementation e.g. Fe, Vit D as per Trust policy); if concerns about infant's length or child's length/height obtain the biological parents' heights if possible and work out the mid-parental height centile; if >2 years of age determine the BMI centile (a BMI below the 2nd centile may reflect either undernutrition or a small build, a BMI below the 0.4th centile suggests probable undernutrition (1). ▪ Assess early feeding history, when solids commenced, transition through textures, if oro-motor assessment completed, meal and fluid intake and routine, assess nutritional intake from reported diet history against EAR/SACN/ESPGHAN (2); consider protein: energy ratio for catch up growth ▪ Identify calorie deficit: fat and protein ▪ Aim to correct nutritional deficit by most appropriate means: food first, food fortification or nutritional supplementation for catch up growth (expressed breastmilk, standard infant formula or ACBS products as appropriate). ▪ Provide parents/ guardians with Dietetic contact details to be used in the event of any concerns arising between initial assessment and 1st review ▪ Arrange prescription ▪ **Breastfed infants and those with significant concerns re: volumes taken or additional losses**	Achieved appropriate growth centiles since point of referral Parent/Carer declines further input

	(generally those aged <1 year) may require weekly review. ▪ Close monitoring with HV/community team with twice weekly weights may be required dependent on growth velocity and clinical judgement.	
1st review *Within 2 weeks if aged under 1year* 45 minutes	▪ Reassess nutritional intake and nutritional deficit when compared with requirements ▪ Reassess growth ▪ Dependent on growth velocity and clinical judgement next review should be no longer than 8 weeks when being actively monitored until adequate growth achieved. *>1 year 1st review dependent on degree of faltering growth 2-8 weeks dependent on clinical judgement*	Appropriate growth centile achieved without the aid of oral nutritional supplements Non-compliant or non-attendance
2nd review *clinic/telephone within 2 weeks aged under 1 year (via HV weight or clinic)* 45 minutes	▪ Reassess nutritional intake and nutritional deficit when compared with requirements ▪ Reassessment of growth ▪ Dependent on growth velocity and clinical judgement reviews should be no longer than 8 weeks when being actively monitored until adequate growth achieved. *>1 year 1st review dependent on degree of faltering growth 2-8 weeks dependent on clinical judgement*	As above
3rd review *via clinic/telephone within 2 weeks aged under 1 year (via HV weight or clinic)* 45 minutes	▪ Reassess nutritional intake and nutritional deficit when compared with requirements ▪ Reassessment of growth ▪ Dependent on growth velocity and clinical judgement reviews should be no longer than 8 weeks when being actively monitored until adequate growth achieved. *>1 year 1st review dependent on degree of faltering growth 2-8 weeks dependent on clinical judgement*	As above
4th *review (depending on need for telephone as above)* *Via clinic/phone within 2 weeks aged under 1 year (via HV weight or clinic)* 45 minutes	▪ Reassess nutritional intake ▪ Discharge or if requiring medium - long term support transfer to nutritional support care pathway *>1 year 1st review dependent on degree of faltering growth 2-8 weeks dependent on clinical judgement*	As above

PHCHR = Parent Held Child Health Record book.

***For infants born between 32 and 36 weeks gestation, correction should stop at 1 year. Preterm infants aged <32 weeks should be corrected until aged 2 years. (SACN/ ESPGHAN guidelines)**

NICE Clinical Guideline NG75 (September 2017), Faltering growth: recognition and management of faltering growth in children http://www.nice.org.uk/guidance/ng75.
Nutritional Requirements for Children in Health and Disease. Great Ormond Street Hospital for Sick Children NHS Trust. 2018. 7th edition.

Introduction of complementary foods for premature babies - links to Bliss website:
https://www.bliss.org.uk/search/results?q=weaning

https://shop.bliss.org.uk/en/products/health-professional-resources/weaning-info-card

https://s3.eu-west-2.amazonaws.com/files.bliss.org.uk/documents/Weaning_2017_v6.pdf?mtime=20180412115133&focal=none

2. Paediatric care pathway for the dietary management of Coeliac disease

Referral: Coeliac Disease – newly diagnosed/requiring new dietary assessment and education.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Educate on appropriate dietary changes to establish gluten free diet ▪ Nutritional and growth assessment (include calcium and vitamin D requirements for age group) ▪ Importance of lifelong dietary compliance and avoiding cross-contamination risk of gluten ▪ Discuss: gluten free prescription products and monthly entitlements; see https://www.coeliac.org.uk/information-and-support/coeliac-disease/once-diagnosed/prescriptions/national-prescribing-guidelines/ ▪ gluten free product sample request forms and resources; non-prescribable products; Coeliac UK and membership application; eating out, school meals/lunches, birthday parties ▪ Examine relevant available biochemistry e.g. haemoglobin and advise ▪ Consider use of a proprietary multivitamin/mineral preparation for the first 3 months on the gluten free diet. If vitamin levels are low discuss with paediatrician	Self-discharge Parent/carer declines further input
1st review **12 weeks** 45 minutes	▪ Nutritional and growth assessment as above ▪ Compliance with gluten exclusion ▪ Discuss gluten free prescription products and monthly entitlements ▪ Check symptoms, growth, micronutrient status and dietary adherence.	As above
2nd review **12 weeks** 45 minutes	▪ Nutritional and growth assessment as above ▪ Compliance with gluten exclusion ▪ Prescription products and monthly entitlements ▪ Check symptoms, growth, micronutrient status and dietary adherence ▪ Consent for patient discharge to group education database for continued review (if available); or one-to-one annual review arrangements as per Trust arrangements.	As above
Annual review (as per Trust arrangements) 45 minutes	▪ Update on new literature and products. ▪ Address other issues e.g. excessive or poor weight gain and advice as per initial assessment ▪ Age appropriate advice would be given ▪ Check symptoms, growth, micronutrient status and dietary adherence ▪ Liaise with adult team at point of adolescent transition phase to adult service.	As above

ESPGHAN recommends – asymptomatic children can also be diagnosed without the need for biopsy, using the same criteria as in pts with symptoms (>10 times normal limit tTGA and EMA positive) – hoping to avoid biopsy in majority of children.
[3] [4] [5] [6]

3. Paediatric care pathway for the dietary management of cow's milk allergy; introduction of milk free solids

Referral: Introduction of solids for infants <1 year old with suspected/confirmed Cow's milk allergy

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Assessment of available growth history (PCHR). ▪ Nutritional assessment to include full diet history and ensuring age appropriate introduction of solids. ▪ Assessment of RNI for all major nutrients with emphasis on calcium, Iron, Iodine and vitamin D (2) ▪ Allergy focused history to include: o Born full term or preterm o Family history of Atopic disease o Presenting symptoms – Reflux, bowel issues, eczema, vomiting, any blood in stools, respiratory, irritability etc o Age of onset, speed of onset, what food and how much? o Details of previous management eg. Medications, thickeners etc. o Infants feeding history- age of weaning, breast or formula fed o Details of any foods that are avoided and why o Any response to the elimination and reintroduction of foods (7,8,11) ▪ Consider home milk challenge to confirm diagnosis for non-IgE CMA if this has not already occurred, as per HSC infant feeding guidance [7] ▪ **IgE mediated reactions should not be home challenged. Refer to or liaise with child's Paediatrician.** ▪ Determine treatment plan: continue on breast milk (mother assessed & advised as per pathway 4) **or** extensively hydrolysed formula or amino acid based formula ▪ Advise on the introduction of age-appropriate foods to ensure cow's milk protein exclusion and educate on reading food labels and diary alternatives that can be used ▪ Advise on the introduction of other allergens ▪ Ensure Calcium requirements are met and advise on additional vitamin supplementation as required. [13] ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	Successful milk challenge and reintroduction. DNA/two consecutive CNA's Patient does not consent to treatment Patient declines further input Patient not ready to commit to treatment programme/non compliance Treatment completed

1st review Infant aged 6-9 months **or** 4-8 weeks if there are concerns with faltering growth 45 minutes	▪ Reassess tolerance of appropriate formula and nutritional adequacy of diet ▪ Assessment of growth ▪ Ensure other allergens have been introduced ▪ Ensure progression with textures ▪ Reassess need for vitamin/mineral supplementation. ▪ Assess if accidental exposure ▪ Discuss home milk challenge for non-IgE patients(7) following 6-9months exclusion. ▪ Discuss step down of prescribable products where appropriate. ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	As above
2nd review Infant aged 12 months 45 minutes	▪ Reassess nutritional adequacy of diet ▪ Reassess growth ▪ Assess progress with home milk challenge ▪ Assess if formula is required and advise on suitable alternatives. ▪ Ensure additional vitamin supplementation. ▪ Assessment of major nutrients such as calcium and advice on appropriate fortified products. ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	As above
3rd review 3-6months after previous review 45 minutes	▪ Reassess nutritional adequacy of diet ▪ Assess progress with home milk challenge ▪ Ensure calcium and vitamin requirements are being met. ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	Discharge

[7] [8] [9] [10] [11] [12] [13]

4. Paediatric care pathway for breast feeding dietary exclusion due to Infant with suspected Cow's Milk Allergy (CMA).

Referral: Maternal dietary exclusion for breastfed CMA infant.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60mins	▪ Refer to care pathway 3 for assessment of the infant ▪ Full nutritional and dietary assessment of the mother ▪ If the breastfed infant only presented after consuming cow's milk formula or milk in their weaning diet; Transfer to Pathway 3 and allow normal maternal diet. ▪ If history supports a 2-4week milk free trial, proceed. ▪ Nutritionally assess the maternal and infant diet if weaned. Note if including calcium rich foods, eggs, fish, nuts, soya. Note specific foods avoided and why. ▪ Compare dietary intake with calculated or reference Nutritional requirements for key nutrients; such as calories, calcium, vitamin D. Check for dietary sources of Iodine and omega-3 fats. Specify any deficit, if indicated, and how to resolve from calcium enriched foods (bread, cereals, milk substitute). ▪ Assess if prescribable or over the counter supplements are indicated to correct or prevent nutrient deficits. Requirements are 1250mg calcium and 10 µg vitamin D daily for women during lactation. Refer to local prescribing guides. e.g NATECAL D3 (600mg calcium, 10 µg Vitamin D) [7]. For Breast fed infants advise a supplement of 8.5-10 µg Vitamin D from birth (HSC, PHA 2017). Seek Pharmacist advice if needed. ▪ Agree the level and duration of dietary restriction. Usually 2-4 weeks milk free trial (iMap 2017). Occasionally, Eggs or Soya products may need restricted. Avoid unnecessary restrictions**.** ▪ Discuss exclusion of cow's milk protein. Provide written dietary information and educate how to avoid agreed allergens, how to read food labels. Identify safe alternative foods, recipe ideas, milk free calcium rich foods. ▪ If the mother wishes to stop breast feeding or would like a formula for use whilst introducing solids consider;	DNA/two consecutive CNA's Patient declines appointment No nutritional concerns in mother and her treatment is complete. Transfer Infant to Pathway 3. Mother ceases breastfeeding. Successful milk challenge and reintroduction. Patient does not consent to treatment

	If Mild-moderate non-IgE milk allergy, use Extensively Hydrolysed products. Amino acid formula is first line for infants with severe reactions to traces of milk protein, infants who have severe gut symptoms with growth faltering. Refer to most recent guidelines (HSC 2014 NI Infant Feeding Guidelines, iMAP 2017). ▪ Assess for Home Challenge to confirm diagnosis. Do not re-challenge Infants with Severe acute IgE symptoms [8, 11]. ▪ Confirm the diagnosis as per protocols (e.g. NI Feeding guidelines or iMAP 2017). Simply introduce cow's milk sources into the mother's diet over a period of 1 week. ▪ **Refer to the care pathway 3 for the dietary management of milk free weaning diets to ensure the child continues to have review.** ▪ If Infant receives prescribable products, ensure proactive to maximise opportunities to "step down" infant prescribable products.	
REVIEW 4-6 weeks	▪ Review outcome of re-challenge to confirm diagnosis and step down prescribable products where appropriate. ▪ Review progress/symptom resolution ▪ Query need for additional dietary exclusions ▪ Ensure calcium and vitamin requirements are being met ▪ Discharge or plan review if necessary. ▪ **If for review refer to the care pathway for the dietary management of introducing milk free solids to ensure the child continues to have review.**	
Review	▪ If multiple foods remain excluded, review nutritional adequacy and plan further re-challenges.	

[7]

5. Paediatric care pathway for the dietary management of IgE and non-IgE mediated food allergies

Referral: IgE and non-IgE mediated reaction to one or more foods.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Assessment of available growth history (PCHR). ▪ Nutritional assessment to include full diet history and ensuring age appropriate introduction of solids. ▪ Allergy focused history to include: o Born full term or preterm o Medical history e.g. asthma, eczema o Family history of Atopic disease o Presenting symptoms –Reflux, bowel issues, eczema, vomiting, any blood in stools, respiratory, irritability etc o Age of onset, speed of onset, what food and how much? o Details of previous management eg. Medications, thickeners etc. o Infants feeding history-age of weaning, breast or formula fed o Details of any foods that are avoided and why o Any response to the elimination and reintroduction of foods(7,8,11, 30, 31) ▪ Assessment of RNI for all major nutrients with emphasis on calcium, Iron and vitamin D (2) ▪ Document skin or blood tests, if available, for identified allergen ▪ Document current medical treatment should an adverse reaction occur ▪ Advice to family/carer regarding appropriate exclusion of identified dietary allergens to include contamination. ▪ Provide dietary advice that is individually tailored taking into account overall requirements, likes and dislikes. Provide advice regarding alternatives that can be sourced locally or online ▪ Details of available support groups eg anaphylaxis UK/allergy UK ▪ **IgE mediated reactions should not be home challenged without recommendation from Paediatrician or under the supervision of allergy specialist dietitian with appropriate competencies.** ▪ Home challenge for Non-IgE food allergies to be discussed and reviewed as appropriate (BDA FASG diet sheets)	DNA/two consecutive CNA's Patient does not consent to treatment Patient declines further input Patient not ready to commit to treatment programme Treatment completed

	▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	
3-6 months (timeframe dependent on specific food allergen(s) and nutritional impact as clinically required or in liaison with MDT team). 45 minutes	▪ Nutritional assessment of the individual's nutritional intake for growth and age ▪ Assess nutritional adequacy of diet ▪ Compliance with exclusion of dietary allergens ▪ Assess for any new food allergy concerns or any accidental exposures ▪ Ensure rescue treatment carried at all times ▪ Discuss food labelling, contamination, support groups ▪ Depending on the clinical allergy history, identify if any foods are safe and suitable for reintroduction at home. Liase with MDT if necessary. Usually this is an option for mild-moderate delayed non-IgE food allergy. ▪ Advise on home challenge/hospital based oral food challenge if indicated. ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	As above
Further reviews 3-6 months until competent to self-manage and as per MDT approach 45 minutes	▪ Nutritional assessment of the individual's nutritional intake for growth and age ▪ Assess nutritional adequacy of diet ▪ Compliance with exclusion of dietary allergen ▪ Assess for any new food allergy concerns or any accidental exposures ▪ Depending on the clinical allergy diagnosis and history, discuss which foods are suitable for re-introduction at home. Liaise with MDT if necessary. ▪ Ensure rescue treatment carried at all times ▪ Discuss food labelling, contamination, support groups ▪ Check if patient has any additional queries ▪ Provide relevant written information with contact details	As above

[11] [12] [14]

6. Paediatric care pathway for nutritional support requiring specialised ACBS borderline products, NG or PEG feeds

Referral: Nutritional support requiring specialised ACBS Borderline products, NG or PEG feeds

60 minutes

Initial assessment to determine level of nutritional support (oral nutritional supplements (ONS) or enteral nutrition):

- Assessment of growth history (PHCHR "Red Book") from available measurements: centile chart for actual age, gender and condition.
- Nutritional assessment from reported diet history in comparison with nutritional requirements for weight and age group [2].
- Children with neurodisabilities should have nutritional requirements determined using height age (if available) [1]. In practice the energy requirement for children with neurodisabilities is often no more than 90% of EAR/SACN for actual age and often may be less. Actual age should be used for micronutrient estimations aiming to achieve LRNI as the minimum.
- Consider dysphagia; aspiration risk; assessment by Speech & Language Therapist
- Identify nutritional deficit and appropriate nutritional support route (oral or enteral).
- Identify projected duration of nutritional support based on category listed
- If applicable, undertake full risk assessment for use of liquidised food via NG/PEG [16].
- Ensure risk assessment for overnight feeding has occurred (GAIN Guidelines) [15]

Review criteria:

- Telephone reviews may be provided rather than face: face, as per clinical judgement
- Some children may be reviewed when attending other medical appointments if unable to review otherwise.
- Review should be required in accordance with changing nutritional requirements for age, growth and tolerance
- Regimen should be monitored and amended accordingly, to ensure optimal nutrition is achieved to support the individual's quality of life
- Agree appropriate timescale for weight checks with parent/carer/ community healthcare professional prior to next planned review
- **N.B.** Dietitian will work closely with other MDT members for enterally fed children
- If child <2yrs: a review at 1-2 weeks until stable and then 1-2 monthly until established and a telephone contact with HV/MDT
- If child >2 yrs and stable: a review at 4-6 months with a telephone contact with health professional.

Short term < 6months e.g. : ▪ NG feeding during acute illness ▪ NG feeding post-operatively ▪ ONS ACBS products or Enteral feeding due to faltering growth ▪ Pre surgical requiring improved nutritional status or weight gain ▪ Diagnosed Infant feeding difficulty resulting in faltering growth.	**Medium term of 6-12 months e.g. :** ▪ Pre-cardiac surgery infant ▪ Feeding problem with associated faltering growth infant or child ▪ Preterm infant.	**Lifelong/long term >1year intervention e.g. :** ▪ Nil orally due to medical condition (physical disability, dysphagia, aspiration risk, genetic condition) ▪ ONS (ACBS) or Enteral nutrition due to inadequate oral nutritional and fluid intake ▪ PEG may be placed due to anticipated need for long term enteral nutrition > 1 year.

Review appointments:	**Methodology/Targets**	**Discharge criteria**
1st review Telephone or face-to-face 1 - 2 weeks (enteral) 4-8 weeks (oral) 45 minutes	▪ Reassess growth on centiles ▪ Reassess nutritional regimen in comparison with weight gain for nutritional requirements and fluid ▪ Nutritional product tolerance and level of oral intake, as appropriate ▪ Establish if nutritional products are required to continue and advise appropriate daily quantity ▪ Consider permitted level of oral nutritional intake, as applicable.	Meeting nutritional requirements orally. Parent/carer declines further input. No nutritional concerns and treatment complete.
On-going reviews either by telephone/ face-to-face 4-8 weeks until stable (enteral)or as clinically indicated 3-6 months (oral) until stable or as clinically indicated 45 minutes	▪ Review depending on weight gain target being achieved ▪ Reassess as per previous review process ▪ Discharge as per algorithm.	Meeting nutritional requirements orally. Self-discharge.

Additional information

1. Use of Liquidised Food with Enteral Feeding Tubes
Option 2 RISK ASSESSMENT

Risk Assessment Template for Enteral Tube Administration of Liquidised Diet.
http://www.peng.org.uk/pdfs/hcp-resources/risk-assessment-template.pdf
[15] [16]
ESPGHAN guides can be accessed at https://espghan.info/advice-guides/

7. Paediatric care pathway for the dietary management of active/symptomatic Crohns Disease

Referral: Inflammatory Bowel Disease:

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Growth history for age – plot on appropriate growth chart and consider weight loss & reduced height velocity. ▪ Nutritional assessment to assess current dietary intake and eating pattern/behaviours. ▪ Symptoms at presentation, including presence of oral disease, bowel habit, anorexia, abdominal pain, site/s of inflammation. ▪ Review patient's investigation results including TPN profile (particularly if risk of refeeding), full blood count, iron profile, upper & lower endoscopy and Small Bowel Series (to assess extent of disease & area/areas of GIT affected), CRP & ESR (raised during active disease), faecal calprotectin and vitamin D. ▪ Estimate nutritional intake from reported diet history compared against estimated average requirements – SACN/Schofield: adjust requirements (120%) to allow for weight gain as required. Consider risk of refeeding syndrome and discuss with parents/carers and patient. ▪ If diagnosis is during puberty it is vital to ensure correct nutrition and treatment to optimise growth. ▪ Exclusive Enteral Nutrition (EEN) is first line treatment in newly diagnosed Crohns Disease (Nice, 2012; BSPGHAN, 2010; ECCO/ESPGHAN, 2014). ▪ EEN is the complete avoidance of food (see below) for a period of 6-8 weeks. All nutritional requirements are provided in "liquid" diet. ▪ There is no consensus on what other fluids are allowed during EEN, examples of foods allowed include 7 Up, Sprite, boiled sweets, ice lollies. ▪ The aim of treatment with EEN is to induce remission, aid mucosal healing, reduce inflammation and provide optimum nutrition to promote growth and development. ▪ A polymeric feed is the feed of choice and is a more palatable option than elemental feeds – the latter only being used with a co-existing CMPA. Choose appropriate feed that is specifically for use in Crohns Disease and contains a natural anti-inflammatory factor. The feed can be concentrated between 1.0 – 1.5 kcal/ml.	Dietary intervention inappropriate Parent/carer declines further input No nutritional concerns and treatment complete – particularly if steroid treatment

	▪ Children < 5 years use age appropriate polymeric feed if required. ▪ The option of an NG tube should be considered if the patient is unable to drink the required volumes of feed. ▪ Introduce feeds (oral/NG/combination) over 3/4 days with a total avoidance of food from day 1/2. Provide recipe, contact details, 3 day feed supply, GP letter & prescription. ▪ Request parent to telephone weekly with weight and tolerance/compliance updates for duration of diet. ▪ Failure in compliance/failure of EEN will require discussion with MDT. ▪ TPN may be required in rare cases of extensive disease/post op/malabsorption.	
1st review Telephone review 1 week 45 minutes	▪ Assess EEN intake, weight, compliance, clinical wellbeing, bowel habit, biochemistry including CRP, ESR, Hb and any other issues identified i.e. mood.	As above
2nd review Face to face 2 - 6 weeks 45 minutes	▪ Assess supplement intake, weight, compliance, clinical wellbeing, any other issues identified i.e. mood. ▪ Repeat biochemical parameters i.e. CRP, ESR, Hb ▪ Discuss food reintroduction as per information below. Introduce low residue, low fat foods over a 3 day period whilst weaning volumes of supplements daily i.e. introduce 1 light meal daily ▪ Recommend continuing supplement at 25% of energy requirement (may prolong remission). ▪ Gradually relax the diet over the next weeks to increase fibre rich foods and normalise the diet – promoting healthy eating. ▪ Consider commencing multivitamin if deemed necessary upon dietary assessment.	As above
3rd review Face to face 2-6 weeks 45 minutes	▪ Check tolerance to oral intake and nutritional requirements and discharge as per criteria.	As above

8. Paediatric care pathway for the dietary management of active/symptomatic Ulcerative Colitis (UC)

Referral: Inflammatory bowel disease:

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Growth history for age – plot on appropriate growth chart and consider weight loss & reduced height velocity. ▪ Nutritional assessment to assess current dietary intake and eating pattern/behaviours. ▪ Symptoms at presentation, including presence of oral disease, bowel habit, anorexia, abdominal pain, site/s of inflammation. ▪ Review investigation and biochemical findings including endoscopy findings to assess extent of disease. ▪ Estimate nutritional intake from reported diet history compared against estimated average requirements – SACN/Schofield, adjust requirements to allow for weight gain as required i.e. 120 %. ▪ Consider risk of refeeding syndrome, particularly with excessive diarrhoea, prolonged reduced intake. ▪ Identify appropriate intervention: o Fibre modification o Food fortification o Oral nutritional supplements o Vitamin and mineral supplements o Probiotic use should be discussed with medical team	Dietary intervention inappropriate Parent/carer declines further input No nutritional concerns and treatment complete
1st review 12 weeks 45 minutes	▪ Reassess nutritional intake, growth and nutritional intervention ▪ Consider clinical wellbeing ▪ Discharge as per algorithm and transfer to nutrition support care pathway, as necessary.	As above

9. Paediatric care pathway for the dietary management of obesity

Referral: Obesity defined as BMI > 98th centile using paediatric BMI chart.

Appointment	Methodology/Targets	Discharge Criteria
Initial appointment 60 minutes	**Opening introduction** ▪ Explain reason for referral and pathway, including number of sessions and attendance/discharge criteria **Classification of clinically obese:** Current weight and height. BMI >98th centile using gender specific paediatric BMI chart **Clinical Assessment** Presenting symptoms, medical history, medication, relevant bloods **Social History** Support networks e.g. family, friends, carers. After schools clubs etc. **Diet History** ▪ Establish current eating habits: o Dietary intake – e.g. 'typical day' approach o Meal / eating patterns – weekdays & weekends, number of meals & snacks, any food swapping/skipping meals, takeaways/eating out o Portion sizes, e.g. 'seconds' at school/after school clubs o Any supplements taken. Check if seasonal or age appropriate o Any cultural influences on diet o Calorie dense liquids **Behaviour Lifestyle Assessment** **Suggested areas to cover may include the following:** ▪ Gain understanding of patient's and parent/guardian thoughts on referral ▪ Explore importance, level of readiness to adopt change ▪ Explore motivation to change, confidence in making changes e.g. willingness & ability to change ▪ Explore patient and parent/guardian understanding of their weight and the diagnosis in more detail e.g. extent to which patients feel weight is under their control and possible reasons for weight gain ▪ Explore any beliefs about eating, physical activity and weight gain that are unhelpful, if the person realises they need to lose weight (helps build confidence and motivation) e.g. what might make losing weight difficult.	DNA/two consecutive CNA's Patient does not consent to treatment Patient declines further input Patient not ready to commit to treatment programme/non compliance

	NB: engage more directly with children depending on capability **<u>Weight Management Dietary Interventions</u>** ▪ Tailor dietary changes to food preferences and allow for a flexible and whole family approach to reducing calorie intake ▪ Do not use unduly restrictive and nutritionally unbalanced diets, because they are ineffective in the long term and can be harmful ▪ Encourage people to improve their diet even if they do not lose weight, because there can be other health benefits ▪ The main requirement of a dietary approach to weight loss is that total energy intake should be less than energy expenditure Consider the following: ▪ Improving eating behaviours e.g. establish structured and regular meal pattern ▪ Nutritionally adequate diet – base intake on the Eatwell guide, as age appropriate. Focus on frequency, amount and type of foods eaten e.g. food proportions as per Eatwell guide, portion sizes, lower calorie alternatives ▪ Food labelling advice **<u>Activity</u>** Establish current level of exercise/activity – type and frequency. **<u>Physical Activity advice;</u>** ▪ Encourage patient to increase their level of physical activity; **Early years (under 5's) – for infants who are not yet walking**; ▪ Physical activity should be encouraged from birth, through floor-based play, including tummy time, reaching for and grasping objects, pulling, pushing and playing with other people and water-based activities, including, baby swimming sessions in safe environments. All under 5's should minimise the amount of time spent being sedentary, including time in infant carriers or seats, in walking aids or baby bouncers and reducing time spent in front of TV or other screens **Early years (under 5's) – for children who are capable of walking;** ▪ Aim to be physically active daily for at least 180 minutes (3 hours), spread throughout the day. All under 5's should minimise the amount of time spent being sedentary for extended times. Activities include;	

	energetic play, chasing games, running, walking to and from school/play park. **Children and young people 5-18 year olds:** ▪ Aim for at least 60 minutes every day, include muscle and bone strengthening activities 3 times/week. Examples include; bike riding, playground activities, fast running, sports such as swimming or basketball. Muscle and bone strengthening activities include; swinging on playground equipment, hopping and skipping, gymnastics or tennis. **All patients:** Aim to reduce the amount of time they spend inactive, such as watching television, using a computer or playing video games. Fact sheets available from: (https://www.gov.uk/government/publications/uk-physical-activity-guidelines) Consider local initiatives including park run, deals from local leisure centre. **Weight Loss Targets** ▪ If appropriate – discuss individual and ***realistic*** weight loss goals and manage expectations ▪ Aim for most children is weight maintenance, with height growth leading to a natural decrease in BMI ▪ For over 7 years slow weight loss may be advised 0.5kg/month (1) ▪ For some older children, and particularly those with very severe and extreme obesity, a weight loss of around 0.5-1kg per month is acceptable (1) **Choose appropriate weight management intervention option(s) and weight loss target** ▪ Agree 2-3 SMART goals/develop a change plan – may include physical activity, portion control etc ▪ Consider reward chart or non-food rewards e.g. magazine, trip to park/ swimming voucher etc ▪ Problem solving (as arises) – to help patients cope with various emotional / social situations (refer to Behaviour change techniques summary) ▪ Encourage family support (where available) ▪ Is vitamin supplementation required ▪ Literature - provide supporting literature ▪ Provide contact details	
1st review 4 -6 weeks 45 minutes	▪ Clinical assessment including weight/BMI ▪ Evaluation of agreed aims/ targets ▪ Review activity – type and frequency of activity/exercise ▪ Consider if vitamin and mineral supplement due to age/winter months	DNA/two consecutive CNA's

2nd review 2-4 weeks 45 mins	▪ Praise successes – however small – at every opportunity to encourage the person through the difficult process of changing established behaviour ▪ If appropriate – reassess readiness to change **Way Forward** ▪ Agree further SMART goals/continue to work on plan of change/ discuss rewards ▪ Continue to explore barriers to change and difficulties with losing weight ▪ Consider local Trust group support ▪ Encourage use of websites and apps as useful tools e.g. NHS Choices, NHS Change4life, choose to live better, Healthy Start (Safe food), to access menus and recipe ideas etc. ▪ Literature - provide supporting literature ▪ For under 5 refer to HENRY programme ▪ Refer to appropriate weight management programme for >5 years if available	Patient does not consent to treatment Patient declines further input Patient not ready to commit to treatment programme/non compliance Treatment completed
3rd review **2-4 weeks** 45 minutes	▪ Clinical Assessment Weight/BMI ▪ Evaluation of agreed aims/ targets ▪ Review activity – type and frequency of activities/exercise **Way Forward** ▪ Agree target of weight loss or weight maintenance ▪ Encourage people to eat a balanced diet in the long term, consistent with other healthy eating advice ▪ Signposting – consider ongoing support via, for example, supermarket tours, weight loss groups, exercise groups, support worker review etc. ▪ Literature - provide supporting literature	As above

[23] [24]

10. Paediatric care pathway for the dietary management of general food allergy / food hypersensititvity (Non-IgE)

Referral: Food allergy/ Food hypersensitivity (Non-IgE) e.g. trial exclusion diet.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Nutritional assessment of the individual's nutritional intake for growth and age ▪ Document symptom details and grade of reaction (gastrointestinal, skin, etc.) from parent/carer: age of onset, speed of reaction and signs, duration and severity, frequency, how much allergen ingested (refer to NICE guidelines 2011; HSC Infant feeding guideline, 2017 [7] & MAP Guideline 2017) [8] BDA position statement: complementary feeding 2020 [30] ▪ Document skin or blood tests, if available, for identified allergen ▪ Document current drug treatment should an adverse reaction occur ▪ Advice to family/carer regarding appropriate exclusion of identified dietary allergens ▪ Educate on reading food labels to identify safe food substitutes ▪ Identification of substitute foods and exclusion of allergens ▪ Agree level of food exclusion and time frame for review based on allergen & when challenge likely to occur ▪ Details of available support groups ▪ NB If a single food allergen such as egg, wheat, soya the patient may be discharged. However if multiple allergens on-going review may be required.	Self-discharge. Dietary exclusion determined inappropriate. Successful self-food challenge and reintroduction If single food allergen and no further review required
1st review 4-8 weeks (dependent on number of allergens excluded and impact on nutritional status) 45 minutes	▪ Reassess nutritional intake, micronutrients and growth ▪ Food challenge as appropriate.	As above
2nd review 4-8 weeks (on-going review as necessary) 45 minutes	▪ Reassess nutritional intake, micronutrients and growth ▪ Food challenge as appropriate.	As above

N.B. Circumstances for food challenge will be dependent on each individual.

BSACI guideline for the diagnosis & management of cow's milk allergy 2014.

BSACI guideline for the diagnosis & management of egg allergy 2014.[7] [8] [11] [12]

11. Paediatric Dietetic care pathway for patients referred from UK and / or Ireland Specialist Treatment Centres

Referral: Transfer of nutritional care from UK and/or Ireland Specialist Treatment Centres.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	NB In advance of initial assessment, liaise with the Dietitian in the Specialist centre to obtain most up-to-date information and proposed treatment plan from specialist unit, as applicable. If no specialist treatment care pathway available follow as below: ▪ Assessment of growth history (PHCHR) from available measurements ▪ Biochemistry if available ▪ Use of appropriate centile chart for actual age, gender and condition ▪ Assessment of nutritional intake from reported diet history against EAR/SACN [2] ▪ Aim to correct nutritional deficit by most appropriate means: food fortification or supplementation for catch up growth ▪ Liaise with MD Team in writing as required.	Appropriate weight gain and growth centiles in proportion and no further nutritional issues
1st review Up to 8 weeks (dependent on age and clinical condition) 45 minutes	▪ Reassess nutritional intake ▪ Assessment of growth as above ▪ Enter appropriate care pathway, as required.	Appropriate weight gain and normal growth centiles achieved No further nutritional issues Self-discharge
On-going reviews, as necessary	▪ As above until optimal nutritional requirements/ status achieved.	As per above Non-compliant

[2]

12. Paediatric care pathway for dietary assessment to confirm / treat dietary related vitamin and mineral deficiencies

Referral: Dietary assessment to confirm / treat dietary related vitamin and mineral deficiencies

Appointment	Methodology/Targets	Discharge criteria
Initial assessment and discharge 60 minutes	▪ Nutritional assessment of the individual's nutritional intake for growth and age [2] ▪ Assess biochemistry and medical condition, as applicable ▪ Depending on nutritional status/ deficiency tailor dietary advice accordingly ▪ If indicated e.g. ASD patients, consider onward referral to other disciplines such as OT (for sensory issues), S&LT (feeding assessment) or clinical psychology (non-dietary behavioural aspects ▪ Consider supplementation and communicate with medical colleagues ▪ NB. If at nutritional risk (due to a highly restricted diet) patients may need to be offered a review appointment and concerns highlighted to medical colleague.	Treatment complete Self- discharge

[25]

13. Paediatric care pathway for the dietary management of selective eaters / ARFID.

Referral: Dietary assessment for feeding difficulties due to sensory issues, developmental delay or oro-motor problems.

Appointment	Methodology/Targets	Discharge criteria
Initial assessment 60 minutes	▪ Nutritional assessment of the individuals nutritional intake for growth and age in comparison to anticipated nutritional requirements for age (GOSH Seventh edition 2018) ▪ Ensure: o a structured routine with meals and snacks at similar times each day. Discourage grazing/irregular snacking o an adequate fluid intake and routine o foods included from each of the four main food groups. ▪ If a food group is lacking, discuss ways to introduce. ▪ Determine if a particular type/texture of food is identified as preferred e.g. crunchy, bland, particular colour etc. and work on expanding this range ▪ Remember the desensitisation hierarchy e.g. seeing–smelling-touching-tasting-eating ▪ Advise ways to achieve a nutritionally balanced diet and expand range of foods taken, as appropriate ▪ Identify if potential for vitamin and mineral deficiency and advise re dietary sources and supplementation, if required (GOSH 2018) ▪ It may be necessary to refer to occupational therapy if sensory issues are causing aversions to certain foods ▪ If a range of textures are not managed SLT assessment may be required	Treatment completed Patient/carer declined further input

	▪ Establish clear treatment goals in agreement with child and parents ▪ Consider providing food diary for completion prior to follow up.	
1st Review 6-8 weeks 45 minutes	▪ Reassess nutritional intake, growth and nutritional intervention ▪ Consider providing food diary for completion prior to follow up.	Treatment completed No recommended changes tried or implemented – no change Self-discharge
2nd Review 6-8 weeks 45 minutes	▪ Reassess nutritional intake, growth and nutritional intervention ▪ Consider providing food diary for completion prior to follow up.	As above

[2] [23]

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