Dietitians Australia

# Paediatric Disability Nutrition Assessment Tool

# Paediatric Disability Nutrition Assessment Tool

**Purpose:**
This tool helps dietitians systematically assess feeding, growth, and nutrition factors for children with disability or complex medical needs. It guides what to ask, what to observe, and who to collaborate with, ensuring care is holistic and coordinated across the multidisciplinary team. By capturing key information and referral needs, it supports consistent, person-centred, and evidence-informed nutrition practice.

**Scope:**
This resource is applicable to Dietitians working in all areas of clinical practice (private practice, public health, private hospitals). In Australia, approximately 4.4 million people (one in six) have a disability. Therefore it is likely that most dietitians will benefit from this resource.

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## Dietetic Referral reasons covered in this resource include:

- Oral motor differences
- Eating and feeding differences
- Positive relationships with food.
- Reduce negative GI symptoms including toileting
- Supplementation
- Seizures
- Tube feeding management
- Medication impacts
- Increased nutrition requirements due to disability
- Growth Assistance

Referral reason

# Oral motor differences

## What do we need to assess/ask?

**MDT Team:**
Does the child have a speech pathologist (SP) currently involved?

**Feeding history:**
- History of choking, gagging, coughing during meals?
- Has the child had previous feeding therapy or swallow assessments?

**Oral motor skills**
- Does the child have difficulties chewing, biting, or swallowing?
- Does the child pocket food in cheeks or spit food out?
- Is there drooling, poor lip closure, or difficulty clearing food from mouth?
- Any tongue thrust, limited jaw movement, or weak bite strength?
- How does fatigue or illness impact their oral motor skills?

**Current feeding practices:**
- How long does a typical meal take?
- Ability to self-feed – fully independent, assisted, or fully dependent?
- Are certain food textures consistently avoided or preferred?

## What can we do to support?

- Supporting texture modified diets and thickened fluids
- MDT feeding therapy
- Mealtime positioning advice with Physio
- Provide energy/protein fortification strategies within safe texture levels.
- Support use of adaptive feeding equipment (in conjunction with OT).
- Educate family/carers on safe feeding practices and mealtime pacing.
- Referral to SP, OT, Physio

## Who might we need to work with?

Speech Pathologist (SP) | Occupational Therapist (OT) | Physiotherapist (PT)

Referral reason

# Eating and feeding differences

## What do we need to assess/ask?

**Anthro data and growth history:**
- Current growth
- Growth history / growth charts

**Medical history:**
Adenoids / Grommets – Ear Nose and Throat (ENT) specialist?

**Feeding History:**
Any history of traumatic feeding events (e.g., choking, force-feeding).

**Current Feeding Practices**
- Is the child able to feed themselves? If partially, what assistance is needed?
- Who is usually feeding the child – parent, sibling, teacher aide?
- Where meals are eaten (home, school, daycare) – environmental differences.
- Who is around?
- Current mealtime positioning – supportive and stable?
- When was the last time a new food was attempted and what was the process?
- Will safe foods be eaten if a new food is on the plate?

**Current Intake:**
Diet history and safe food list:
- What is the child's usual diet?
- What foods are accepted or refused?
- Any sensory triggers – smells, textures, colours of food?

## What can we do to support?

- Create a safe and supportive mealtime environment plan.
- Provide parent/caregiver counselling on responsive feeding.
- Introduce appetite regulation strategies without pressure.
- Support MDT feeding therapy goals.
- Assist with sensory-based food exposure and chaining techniques.
- Coordinate feeding approaches between school, home, respite care.

## Who might we need to work with?

Speech Pathologist | Occupational Therapist | Psychologist | School / Educators | Ear, Nose and Throat specialist (ENT)

Referral reason

# Positive relationships with food

## What do we need to assess/ask?

**Anthro data and growth history:**
- Current growth
- Growth history / growth charts

**Medical history:**
- Adenoids / Grommets – Ear Nose and Throat (ENT) specialist?
- Past medical history – tube feeding, long hospital stays, negative associations.

**NFPF - Oral Motor**
Oral motor function – gagging, choking, spitting food out.

**Feeding History:**
History of forced feeding, bribing, or reward systems.

**Current Feeding Practices**
- Who is usually feeding the child – parent, sibling, teacher aide?
- Who is present at meals – siblings, other carers, educators.
- Family mealtime atmosphere, what is going on during meals – high stress vs relaxed
- Where meals are eaten (home, school, daycare) – environmental differences.
- When was the last time a new food was attempted and what was the process?

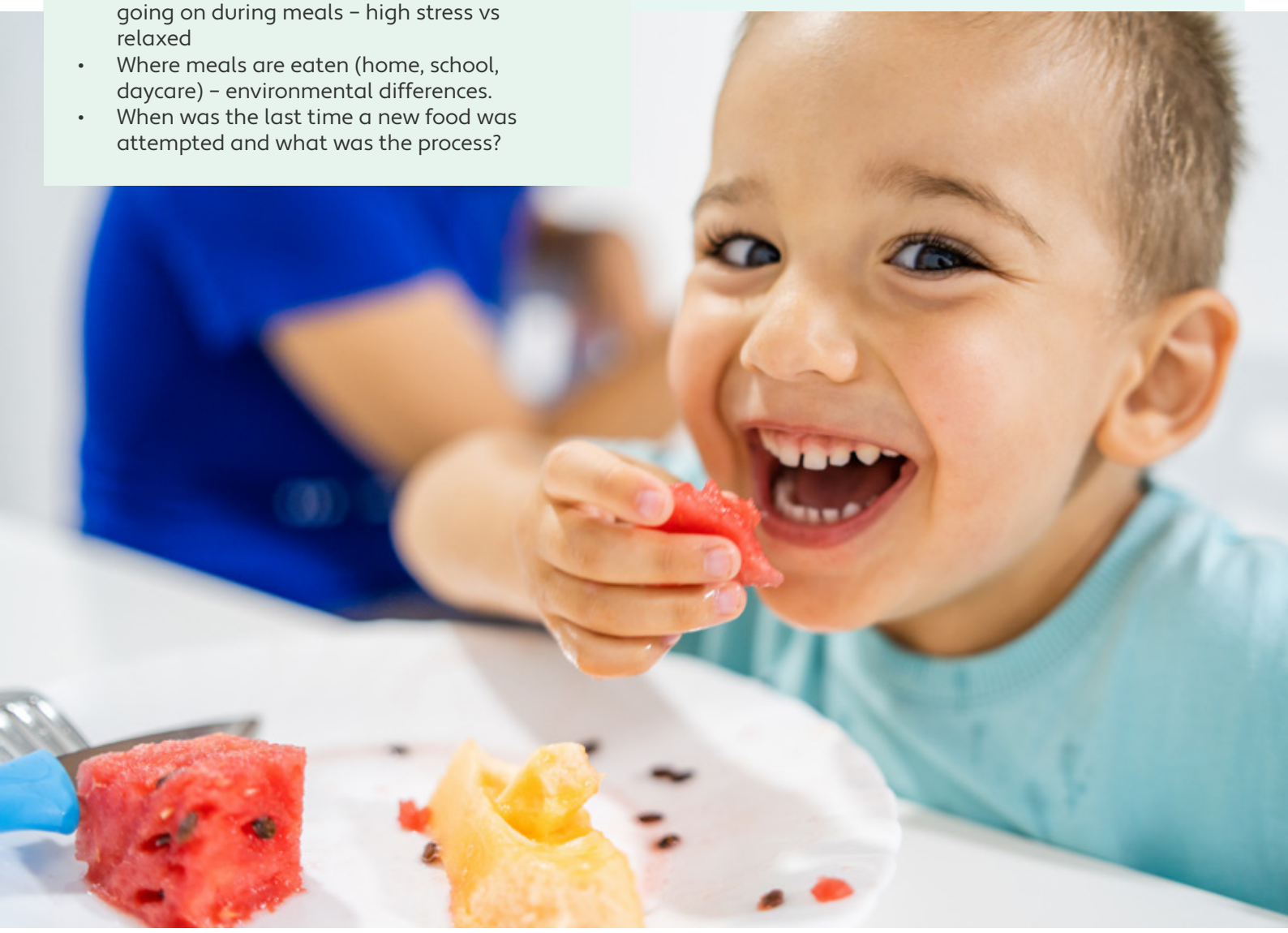
**Current Intake:**
- Diet history and safe food list:
  - What is the child's usual diet?
  - What foods are accepted or refused?
  - Any sensory triggers – smells, textures, colours of food?
- How does the child respond emotionally to mealtimes? excitement, anxiety, avoidance.
- Are there any signs of anxiety or distress related to food? (crying, hiding, aggression)
- Film dinner time

## What can we do to support?

- Trauma-informed feeding approaches.
- Fun, non-pressured food play and desensitisation.
- Coaching parents/caregivers in responsive feeding.
- Cross-environment feeding consistency plans.
- Strategies for gradual, low-stress new food exposure.

## Who might we need to work with?

Speech Pathologist | Occupational Therapist | Psychologist | School



Referral reason

# Reduce negative GI symptoms including toileting

## What do we need to assess/ask?

**Functional Limitations of their disability:**
- Communication
- Mobility
- Continence

**Medications:**
Medications for GI symptoms – effectiveness, side effects.

**Clinical:**
- Constipation, diarrhoea, reflux, vomiting frequency/severity.
- Bowel movement frequency, consistency (Bristol Stool Chart), routine.
- History of abdominal pain, bloating, excessive gas.
- Stress or anxiety level related to bowel symptoms. Child's level of stress or anxiety on scale of 1 to 10?

**Current Daily Routine:**
Child's toileting routine – are they independent, supported, or in nappies?

**Current Diet:**
Adequacy of hydration and fibre intake.
Are probiotics, prebiotics, or herbal products being used?

## What can we do to support?

- Implement bowel management plans – fibre adjustment, fluid goals.
- Provide continence-friendly dietary advice.
- Reduce reflux triggers and improve GI comfort at meals.
- Collaborate with MDT on toileting programs.
- Support gradual reintroduction of fibre after impaction treatment

## Who might we need to work with?

Occupational Therapist | Physiotherapist | GP | Continence Nurse | Gastroenterologist

Referral reason

# Supplementation

## What do we need to assess/ask?

- Current vitamin/mineral/oral nutritional supplement use – dose, timing, duration.
- Reason for starting supplementation – who recommended it?
- Tolerance – GI upset, taste aversion, compliance.
- Are supplements replacing food or complementing it?
- Growth and pathology data to support continued need.

## What can we do to support?

- Assess supplement necessity against RCH and clinical guidelines.
- Educate on safe, evidence-based use of supplements.
- Monitor nutrient status via growth and labs.
- Adjust dosage or discontinue where appropriate.

## Who might we need to work with?

**Nutrient specific**
Royal Childrens Hospital
RCH Clinical Practice Guidelines

**Nutrition**
Supplement reps (for samples/ supply issues etc) | Paediatrician | GP

Referral reason

# Seizures

### What do we need to assess/ask?

- Weight change patterns during periods of increased seizure activity.
- Seizure frequency and severity.
- Impact on eating/drinking during postictal states.
- Temperature or sweating patterns that may influence hydration needs.
- Neurologist recommendations – ketogenic diet consideration.
- Hospital dietitian involvement for specialised diets.

### What can we do to support?

- Support safe fluid and nutrition intake around seizure episodes.
- Provide high-energy snacks/meals if appetite is reduced post-seizure.
- Coordinate with hospital team if on medical ketogenic diet.
- Support hydration strategies.

### Who might we need to work with?

Hospital dietitian | Neurologist | Speech Pathologist

Referral reason

# Tube feeding management

### What do we need to assess/ask?

- What type of feeding tube is used; Nasogastric (NGT), Gastrostomy (G-tube), Jejunostomy (J-tube)?
- What formula and feeding regimen is prescribed?
- Are there any tube feeding complications (blockages, infections)?
- How is tube feeding equipment managed and sourced?
- What is the child's growth and nutritional status on tube feeding?
- How involved are caregivers in tube feeding?
- Have they received training?
- Is there regular communication with hospital and community teams?

### What can we do to support?

- Optimise enteral formula for growth and tolerance.
- Train caregivers in safe administration and troubleshooting.
- Coordinate regular reviews and adjustments.
- Liaise with suppliers for equipment needs.
- Work with MDT on oral stimulation alongside tube feeding.

### Who might we need to work with?

**Hospital / medical team – Community MDT**
Physiotherapist | Speech Pathologist | Occupational Therapist | Community nurse

Referral reason

# Medication impacts

### What do we need to assess/ask?

- Medication list, doses, timing.
- Side effects – nausea, reduced appetite, constipation, reflux.
- Impact on taste perception or oral health.
- Drug–nutrient interactions.
- Lab monitoring for nutrient depletion.

### What can we do to support?

- Timing meals/snacks around medication to reduce side effects.
- Adjust texture/temperature to counter taste changes.
- Monitor growth/nutrient status.
- Collaborate on alternative med formulations if intake is affected.

### Who might we need to work with?

Community nurse | Paediatrician | GP

Referral reason

# Increased nutrition requirements due to disability

### What do we need to assess/ask?

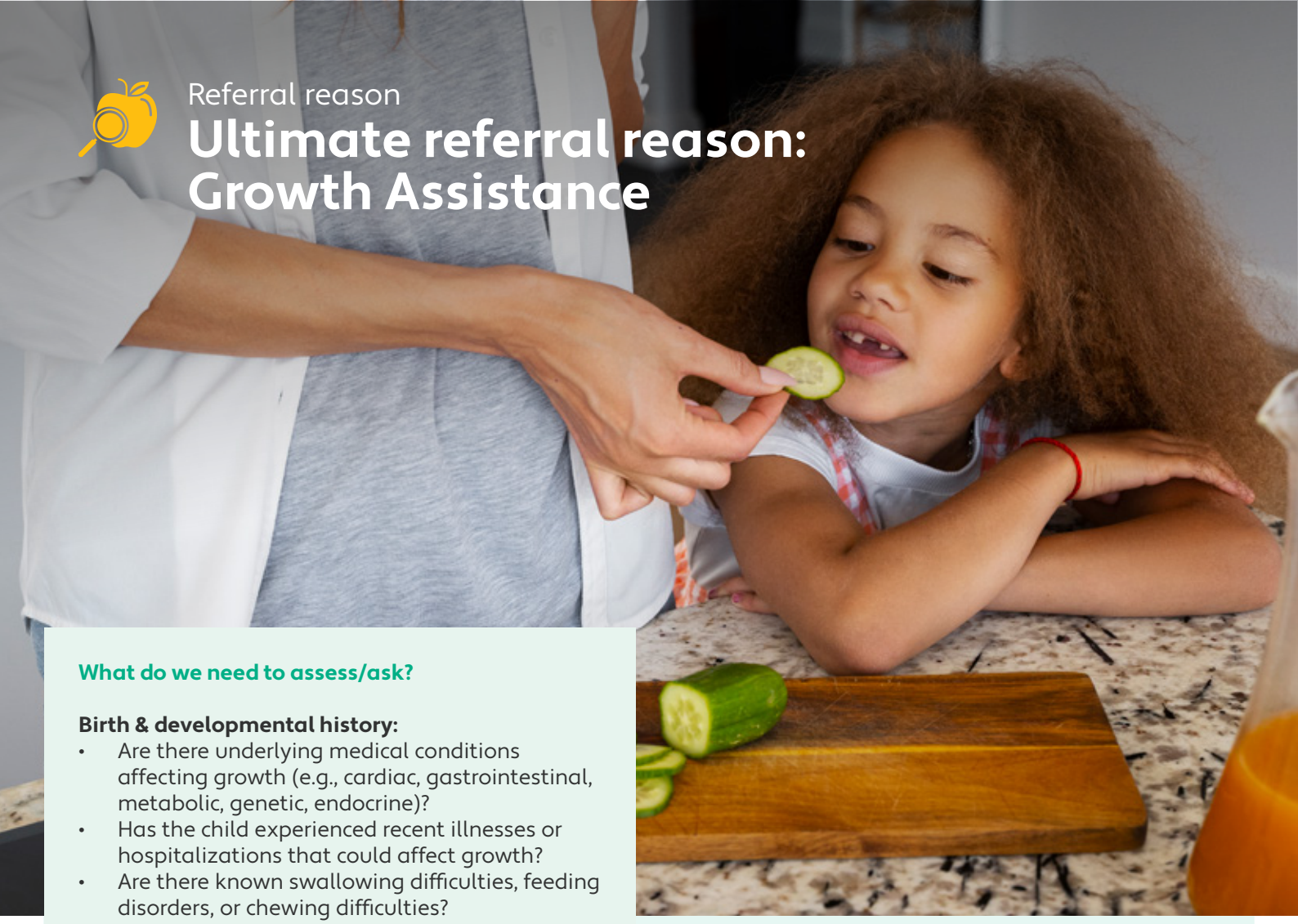
- Anthropometric and growth data.
- Impact of dystonia, spasticity, involuntary movements on energy needs.
- Illness frequency or recent surgery.
- Stress-related catabolism.
- Feeding fatigue limiting intake.

### What can we do to support?

- Fortification of meals and snacks with energy and protein.
- Use of high-energy finger foods for self-feeding.
- Oral nutrition supplements.
- Adjusting portion sizes to match tolerance and needs.
- Coordinate with physio for movement-related energy expenditure estimates.

### Who might we need to work with?

Physiotherapist | Speech Pathologist | Occupational Therapist | Paediatrican



Referral reason

# Ultimate referral reason: Growth Assistance

## What do we need to assess/ask?

**Birth & developmental history:**

- Are there underlying medical conditions affecting growth (e.g., cardiac, gastrointestinal, metabolic, genetic, endocrine)?
- Has the child experienced recent illnesses or hospitalizations that could affect growth?
- Are there known swallowing difficulties, feeding disorders, or chewing difficulties?
- Any diagnosed developmental delays, cognitive impairment, or intellectual impairment?
- Any history of low muscle tone, hypotonia, or mobility limitations?

**Anthropometric Data & Growth History**

- Current weight, height/length, and head circumference:
- Please provide recent growth charts or health records (attach if available).
- Has there been any recent weight loss, plateau, or unexpected gain?
- Any concerns about growth velocity or faltering growth?
- Birth weight and length:
- Was the child premature? If yes, provide gestational age
- Any NICU or special care nursery stay?

**Feeding History**

- Was the child breastfed, formula-fed, or mixed feeding? For how long?
- If formula-fed, what type and how much? Any changes over time?
- How long was bottle feeding continued? Is there any ongoing bottle use?
- When were solids introduced? How was the introduction managed (smooth transition, delayed, feeding aversion)?
- Any feeding difficulties during infancy (e.g., poor latch, reflux, gagging, choking)?

**Diet History**

- Feeding environment & mealtime routine:
- Who usually feeds the child?
- Are meals structured or flexible?
- Typical duration of a meal:
- Any distractions (TV, devices) or stressors (noise, conflict) during meals?
- Any behavioral challenges (refusal, throwing food, leaving table early)?

## What can we do to support?

- Growth monitoring
- Nutrition analysis
- Adapt foods and fluids to meet texture and swallowing safety needs
- Fortification of meals and snacks with energy and protein.
- Use of high-energy, high protein foods
- Oral nutrition supplements.
- Adjusting portion sizes to match tolerance and needs.
- Provide responsive feeding strategies to reduce mealtime stress and improve intake.
- Tube feeding support

## Who might we need to work with?

Paediatrican | GP | Other allied health as indicated.