Nutrition Care Planning

Nutrition care plans communicate what action is to be done to help the resident reach their goals based on their conditions, needs and preferences, or risk for potential conditions. They are person-centered, meaning they empower the resident with control in making their own choices and having control over their daily lives.

Nutrition care plans must include person-specific, measurable objectives, and timeframes to evaluate the resident's progress towards their goal(s). Develop the nutrition care plan based on admission orders, information about the resident available from the transferring provider, and information obtained from the nutrition assessment.

Care Area Assessment (CAA)

The Care Area Assessment (CAA) will trigger for any nutrition problem that requires further assessment. If triggered, determine whether the resident is at risk of developing, or currently has a need associated with that CAA, and how the risk or need affects the resident. Document whether each area triggered needs care planning. There may be times when a resident risk or need is identified but may not cause a CAA to trigger. Address these areas and document whether you need to develop a care plan.

A resident may refuse certain treatments that the interdisciplinary team believes may help the resident reach their highest practicable level of well-being or keep the resident safe. In these situations — particularly those that pose a risk to the resident's health or safety, such as the refusal of thickened liquids — the nutrition care plan should identify the care being declined, the risk associated with that choice, and efforts by the interdisciplinary team to educate the resident and representative, if applicable.

Writing the Nutrition Care Plan

There are three ways or styles of writing nutrition care plans:

- **Resident planned:** This style sounds like the resident wrote the care plan, e.g., due to my recent stroke, I have trouble swallowing safely and need a mechanically altered diet.
- **Problem, etiology, and signs or symptoms (PES):** This style uses a PES statement, e.g., swallowing difficulty related to stroke requiring mechanically altered diet as evidenced by coughing and hoarse voice associated with eating.
- **Resident stated:** This style uses the term resident or their name, e.g., resident has dysphagia secondary to stroke and requires a mechanically altered diet for safe and efficient swallowing.

The style you use will likely depend on which electronic health record (EHR) software your facility uses. In either case, always include the resident in the nutrition care planning process to ensure the care plan reflects the resident's goals and wishes.

As conditions change, goals are met, interventions are determined to be ineffective, or as specific treatable causes of nutrition-related problems — for example, chewing difficulties or poor appetite — are identified, the nutrition care plan needs to be updated. Otherwise, the nutrition care plan needs to be reviewed — and updated if necessary — after each nutrition assessment.