3:4 CARE PLANNING:

Following nutritional assessment and screening of patients admitted to hospital or onto a community caseload or patients who are physically health care screened within community mental health teams it is essential that a multidisciplinary care plan is developed, implemented and evaluated on an ongoing basis with the patient **(Healthcare Improvement Scotland 2014 FFN Standard 2)**

All care plan entries about the patient's nutrition should be documented in the Mental Health in patient Food, Fluid and Nutrition Profile/ nursing notes or the community nutritional profile for mental health services and discussed fully with the patient to include:

- Outcome of initial assessment
- Outcome of screening for the risk of malnutrition
- Frequency and review dates for repeat screening
- Actions taken as a consequence of repeat screenings
- Review of care plan and supporting Food, Fluid and Nutrition documentation e.g. food and fluid charts and relevant nursing and medical notes.
- Follow on nutritional care upon discharge or transition to another service

Screening for malnutrition should be carried out on a weekly basis, or if in community depending on what the MUST score is according to the NHSGGC Community MUST Pathway however individual nutritional care plans should be reviewed on a daily basis and findings documented in nursing progress notes. Forward care planning is essential for effective patient centered nutritional care.