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Interdisciplinary Nutrition Care Plan

Tube Feeding

Client Name: ______________________ **#:** __________ **Initiated by:** ______________ **Date:** ______

Screen
Nutrition Screen diagnosis: Tube Feeding.
Enteral Tube Feeding Continuity of Care from Referring Agency/Facility reviewed ______ (Date).

Signed: ____________________ Date: ______

Goals (check any/all):
- ❑ Maintain or improve mobility in ______ (goal time).
- ❑ Maintain or improve nutritional status in ______ (goal time).
- ❑ Increase strength in______ (goal time).

Weight ❑ maintained, or ❑ loss/❑ gain of _____ lb in _____ (goal time).

Assess *(Check any/all)*
- ❑ **Tube feeding initiated within 5 days**
- ❑ **Change in TF administration/formula**
- ❑ **Change in enteral access**
- ❑ **Aspiration risk**
- ❑ **Dehydration**
- ❑ **Tube site infection**

Weight/BMI
- ❑ Weight loss >3 lb/wk or >5%/mo or >10%/6 mo
- ❑ BMI <20 (High Risk)
- ❑ BMI >27

GI Distress Symptoms
- ❑ Nausea ❑ Vomiting
- ❑ Diarrhea ❑ Constipation

Signed: ____________________ Date: ______

→ None

Moderate Risk Interventions
(Check any/all)
- ❑ **Food Record** provided and explained (if also on PO diet)
- ❑ **Enteral TF prescription/protocol explained**
- ❑ **TF management reinforced**

Obtain Dr. orders as needed:
- ❑ RD chart consult
- ❑ Tube site care

❑ **Other:** ____________________
(See notes for documentation.)

Signed: ____________________ Date: ______

↓ Next visit

↓ 1 or more

High Risk Interventions *(Check any/all)*
❑ **Enteral TF prescription/protocol explained**

Obtain Dr. orders as needed:
- ❑ RD referral for home visits
- ❑ Change in TF administration/formula
- ❑ Tube site care
- ❑ Medication initiation/adjustment
- ❑ Monitor weight q: ______
- ❑ Monitor I & O q: ______

❑ **Other:** ____________________
(See notes for documentation.)

Signed: ____________________ Date: ______

Assess Response *(Check any/all)*
- ❑ Tube site infection
- ❑ Weight change not appropriate per goal
- ❑ Exhibiting GI Distress Symptoms
- ❑ Dehydration
- ❑ Other: ____________________

(See notes for documentation.)

Signed: ____________________ Date: ______

← 1 or more

→ None

Outcomes Achieved
- ❑ Tube site free of infection
- ❑ Weight maintained or gained
- ❑ Hydration status maintained or improved
- ❑ Absence of GI Distress Symptoms
- ❑ Other: ____________________

(See notes for documentation.)

❑ Repeat Nutrition Risk Screen in _____ days

Signed: ____________________ Date: ______

↓ Next visit

Assess Response *(Check any/all)*
- ❑ Tube site infection
- ❑ Weight change not appropriate per goal
- ❑ Continued dehydration
- ❑ Exhibiting GI Distress Symptoms
- ❑ Other: ____________________

(See notes for documentation.)

Signed: ____________________ Date: ______

→ None

Outcomes Achieved
- ❑ Tube site free of infection
- ❑ Weight maintained or gained
- ❑ Hydration status maintained or improved
- ❑ Absence of GI Distress Symptoms
- ❑ Other: ____________________

(See notes for documentation.)

❑ Repeat Nutrition Risk Screen in _____ days

Signed: ____________________ Date: ______

↓ 1 or more

Outcomes Not Achieved
Reassess/evaluate need for additional treatment/parenteral nutrition. Document on Nutrition Variance Tracking form.