Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Food Fortification Action Plan Record (Implement if MNA 8-11points ROP 049MNA	Care site:

Resident Name:_____ **Ward:**_____
DOB: _____ **Bed/Room Number:** _____
Food & Fluid consistency required (check SLT recommendations): _____
Action plan started on: _____ **by:**_____
Discontinued on:_____**by:**_____

Meal	**Food/Drink** **Fortifiers/extra snacks to be added ***	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**
Breakfast																	
Mid-morning																	
Dinner Dessert																	
Mid-afternoon																	
Evening Tea Dessert																	
Supper																	
Total extra Kcals (add up to 600 kcal)																	

* state what fortifier & how much to be added to each food/drink or state what extra snack(s) and when to be given - use laminated sheet of 50kcal exchanges and 200kcal snack list as a guide

Codes if required:
1 = patient away from ward, 2 = patient fasting/vomiting/too unwell to eat,
3 = patient refused meal / food fortifier / snack, 4 = food fortifier not available,
5 = eaten less than half, 6 = other (document in nursing notes)