ENTERAL FEEDING SUPPORT PLAN

Identified need for support	Interventions
Goals ☐ Maintain adequate nutrition and hydration ☐ Maintain healthy body weight ☐ Minimize aspiration, choking, diarrhoea, vomiting or abdominal pain ☐ Maintain skin integrity of stoma site ☐ Other: _____ **Tube feeding secondary to:** ☐ CVA(Stroke) ☐ Complex Physical Disability ☐ Severe Epilepsy ☐ Severe Dysphagia ☐ Inability to feed self ☐ Other: _____ **Potential for:** ☐ Unintentional weight loss/gain ☐ Dehydration ☐ GI disturbances ☐ Aspiration/ Choking ☐ Skin Integrity breakdown ☐ Other:_____ **Evidenced by:** ☐ Nutritional Assessment ☐ Speech Pathology Assessment ☐ Dietician review ☐ Occupational Therapist ☐ Health Care Directive, Date: _____ ☐ Medical Notes ☐ Progress Notes ☐ Weight at care commencement _____ kg/s	☐ **Formula:** _____ **Via:** ☐ PEG ☐ Nasogastric ☐ Pump ☐ Gravity ☐ Bolus **Enteral/NG Feeding Tube:** **Type/Name/Code:** **Size:** _____fg. **Date inserted (approx. if known):** _____ **Change Tube (frequency):** _____ **Medical Practitioner Directive, Date:** _____ **Feeding Schedule/Regime (refer to current plan):** **Date:** _____ ☐ **Continuous** Start Time: _____ Finish Time: _____ Total formula per 24hrs: _____ml/s Give _____ml/s water flushes via tube before and after medication ☐ **Intermittent** Number of feeds per day: _____ Duration of each feed: _____ Total formula each feed: _____ ml/s Time of feeds: _____ Give _____ ml/s water flushes via tube before and after each feed (and medication if given via tube) ☐ Monitor fluid intake and output

☐ Other: _____

NOTE - Replacement of NG Tube to be undertaken by Health Practitioner only.

Weigh participant: ☐ Daily ☐ Weekly

☐ Other: _____

Usual range _____ to _____ (kg)

☐ **Before** feeding make sure tube is positioned correctly
☐ **Check** skin disc is not tight against skin daily. Allow slight in and out movement of tube/observe for blockages
☐ **DO NOT LIE FLAT** during feeding, elevate between 30º to 45º
☐ **Stop** feed if participant has difficulty breathing, coughs or chokes during feed or behaviours where participant dislodges tube
☐ **Wait** 1hr post feed before lying flat

Record input and output ☐ Daily ☐ Weekly

☐ Other: _____

Usual Range:
Input: _____ Output: _____

☐ Daily recording and documentation in participants notes

Stoma Care

☐ Wash under tube disc with warm soapy water using face washer or gauze. Dry well
☐ Inspect stoma site for signs of swelling, redness, or skin breakdown daily
☐ Report any signs of infection or inflammation to health practitioner

Participants with Complex Physical Disability

☐ Positioning and turn to maintain airway safety
☐ Pressure area care

Other specific interventions:
_____

Observe for:

☐ Unexpected weight gain or loss
☐ Allergic reaction
☐ Poor chest health
☐ Accidental dislodgement of tube
☐ A blocked tube or slow flow

	☐ Symptoms of dehydration, such as dark urine, urinating small amounts, or being thirsty Other specific observations: _____

Risk / Response

☐ Blood in or around the feeding tube
☐ Creamy, foul-smelling drainage
☐ Leakage of formula or stomach contents around tube site
☐ Fever
☐ Nausea or upset stomach that lasts for 24 hours
☐ Vomiting
☐ Diarrhoea that lasts for 2 days
☐ Constipation that lasts 4 days

Refer to the Medical Practitioner or transfer to hospital if any of the above risks occur to ensure participant's wellbeing.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Enteral Feeding Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Enteral Feeding Regime

Participants Name: _____ **NDIS No.:** _____

Participants Diagnosis: _____

Type of Feed: ☐ Bolus ☐ Non-Bolus

Feeding via: ☐ Nasogastric Tube ☐ PEG tube

Commenced on (date): _____

Description of Feed:

_____

_____.

Medical Practitioner Name: _____

Medical Practitioner Signature: _____ **Date:** ____/___/____

Dietician Name: _____

Dietician Signature: _____ **Date:** ____/___/____

Review Dates

Dates	Change to Feed Plan	Name/Signature

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

Enteral Feeding Medical Practitioner Directive

Date:	

Diagnosis/Medical History

Specific Care Orders/Treatment Plan
Tube Type: _____ (Name size, change frequency, other) **Feeding Regime:** _____ (Name of formula, amount, frequency, route, technique)

Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Enteral Feeding Speech Pathologist Directive

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Enteral Feeding Dietician Directive

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Enteral Feeding Health Practitioner Directive
Registered Nurse, Physiotherapist, Occupational Therapist

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

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