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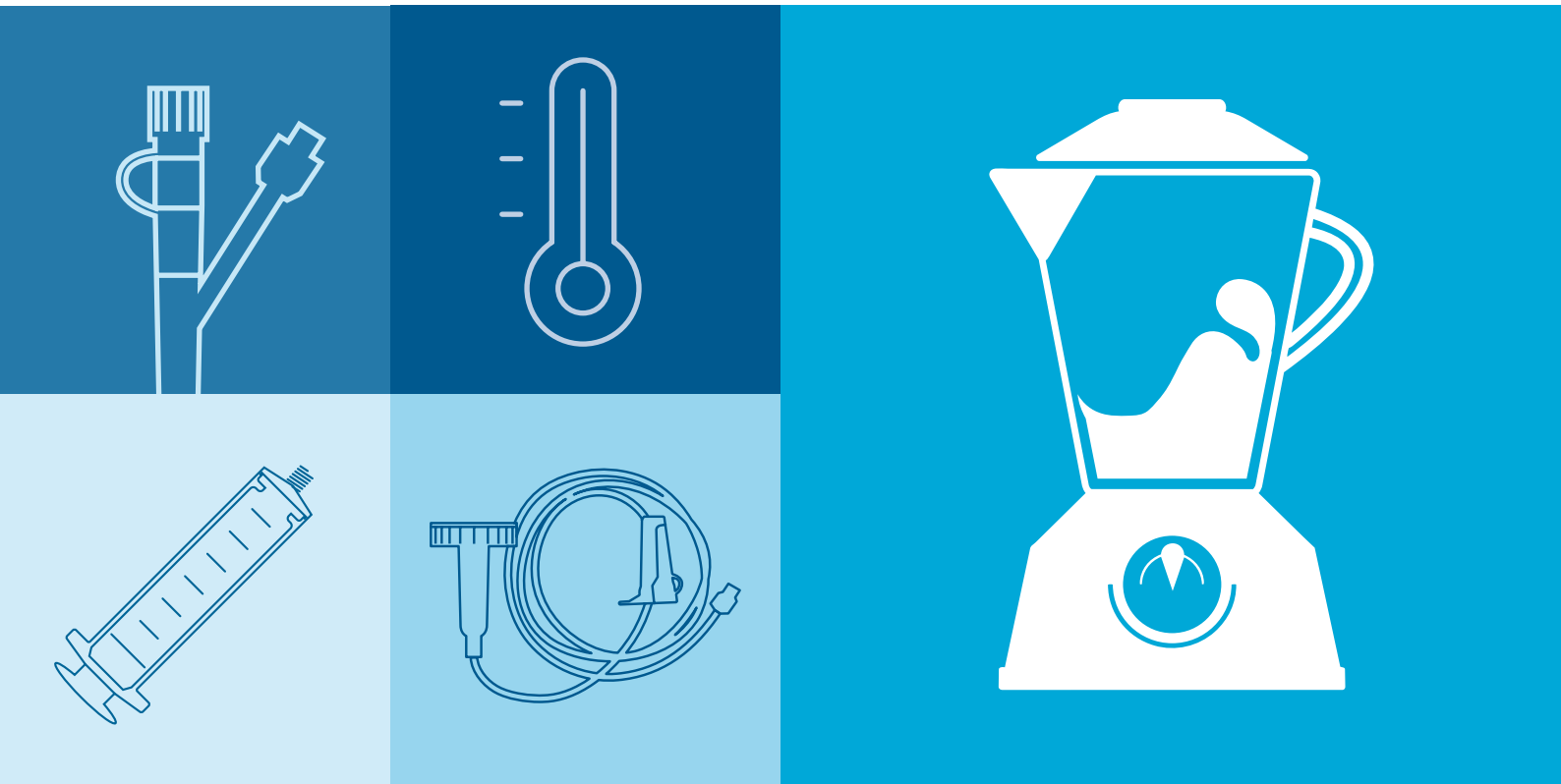
BDA The Association of UK Dietitians

2026 Edition

The use of Blended Diet with Enteral Feeding Tubes

Practice Toolkit

Durnan, Stanley, Kennedy, Kennedy and Daniels



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Foreword

Development of this Practice Toolkit

The updated Blended Diet Practice Toolkit is a great example of collaboration of the BDA and BAPEN. This project, funded jointly by the two organisations, has involved a huge effort by those involved, with a thorough literature review of 49 identified papers which more than doubles the research evidence underpinning the previous version of the Toolkit. A UK survey of professionals and a series of roundtables further identified current knowledge and attitudes, along with barriers to extending best practice. A Position Statement was developed with 22 statements and 14 suggested actions for healthcare professionals. Invited case studies show how blended diets can be used both for children and adults. Importantly, there is a cohort of patients who have incorporated blended diets into their nutrition support as children and are now moving to adult care. The revised Practice Toolkit is the culmination of all those efforts and will help extend practice to those who would like to use blended diets safely and confidently. Congratulations to all who were involved in producing this revised guidance.



Nick Thompson
President of BAPEN, 2023–26

We are delighted, on behalf of the Parenteral and Enteral Nutrition Specialist Group (PENG) and the BDA Paediatric Specialist Group (PSG), to introduce the third edition of The Use of Blended Diet with Enteral Feeding Tubes: Practice Toolkit. This edition has been jointly funded by both groups and BAPEN, reflecting our shared commitment to this important area of practice.

There has been significant progress in blended diet practice since the second edition was published five years ago. Dietitians want to support the patients they care for who choose a blended diet, and to do so with confidence. As its use grows, so does the need for dietitians, alongside the wider multidisciplinary team and multiagency colleagues, to develop the knowledge, confidence and practical skills needed to support informed discussions and deliver personalised care.

Blended diet is now firmly recognised as a legitimate feeding option for tube-fed people. It sits along a continuum of feeding approaches, from commercial enteral formula at one end to home-blended family meals as the sole source of nutrition at the other. Between these is a range of options, including commercial formulas containing food-derived ingredients, shop-bought food pouches, and a combination of home-blended feeds alongside

commercial formula. These approaches are not fixed. Tube-fed people, their families and carers may move along this continuum over time, according to their preferences, circumstances and clinical needs.

At the heart of this Toolkit is a commitment to shared decision-making and personalised care. A particularly important development is the move away from formal risk assessment processes towards collaborative conversations that support informed choice, while ensuring that benefits and challenges are openly discussed. The question is no longer whether blended diet should be considered, but how to ensure that people have access to balanced information, expert guidance and the support they need to make decisions that are right for them.

This edition reflects the growing use of blended diet in adult services and extends into areas where practice continues to evolve, including nasogastric feeding, jejunal feeding, intestinal failure and pump feeding. The case studies support clinical understanding and offer valuable examples for navigating discussions in more complex situations.

A major strength of this edition is its practical focus. The ten appendices provide editable and printable resources for patients, families, carers and multidisciplinary teams. These include patient information leaflets, conversation guides, documentation templates, letters confirming the use of blended diet, and practical guidance on preparation and reheating. Together, they help translate guidance into everyday practice, supporting both experienced dietitians and those new to discussing or establishing blended diet.

This Toolkit will strengthen the confidence and capability not only of dietitians, but of all professionals who provide care and support to tube-fed people, their families and carers.

Finally, we would like to thank the authors and contributors of this edition. This encompasses a range of health professionals and people with lived experience, and their commitment has shaped this comprehensive update.



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November 2026

About this Toolkit

Development of this Practice Toolkit

The BDA first published practice guidance on blended diet in 2013, followed by the first Practice Toolkit in 2015, titled 'Liquidised Food via Gastrostomy Tube'. The guidance was updated in 2019, and the 2021 Practice Toolkit was retitled 'The Use of Blended Diet with Enteral Feeding Tubes'. This third edition, a Position Statement and Practice Toolkit, keeps that title.

The 2026 review began in April 2025, led by Dr Sarah Durnan for the British Dietetic Association (BDA) together with BAPEN, reflecting a recognised need for a multiprofessional approach. The large team of co-authors and collaborators was selected for expertise in blended diet, and includes clinicians, academics and people with lived experience of tube feeding or of caring for a tube-fed person. The 2026 programme of work included a scoping review of the literature published since 2020, a UK survey of professionals, a survey of tube-fed people and their families, four practitioner roundtables, and case studies. An appreciative inquiry approach was used throughout the surveys, the roundtables and the case studies: contributors were invited to describe what worked and how they made it work, so these accounts describe successful practice. Each piece of work is reported separately with its own references.

This Practice Toolkit is the how-to for clinicians. It sets out how to support tube-fed individuals, their families and carers in their choices, with practical advice. The accompanying Position Statement presents the evidence and action points for commissioners, employers and care settings. It is hoped this Practice Toolkit will support equitable, person-centred care across the life course for tube-fed individuals in relation to blended diet.

What has changed since 2021

The new evidence supports the 2021 core principles: blended diet is a real choice option, shared decision-making is the basis for planning, and the risks are largely modifiable. The following has changed since 2021:

- Large comparative cohorts have examined the safety of blended diet in comparison with commercial enteral formula since 2021 (Part 1, scoping review).
- A risk assessment is no longer required for blended diet (Part 2, roundtables).
- The position on nasogastric tube feeding has been updated (Part 3, scoping review and case studies).
- The position on jejunal feeding has been updated (Part 3, scoping review and case studies).
- The position on stoma maturity has been updated (Part 3, roundtables).
- Advice on reuse of ancillaries (Part 4, scoping review).
- Food safety guidance has been strengthened on time and temperature control, ingredient safety and cleaning, and the reheating advice has changed (Part 7, scoping review and correspondence with the Food Standards Agency).
- Caution on over-reliance on food composition tables for calculating nutritional content (Part 6, scoping review).
- Greater detail on developing a monitoring plan, now including patient reported outcome measures (Part 10, scoping review).
- Greater detail on managing transition to adult care (Part 12, scoping review and the adult roundtable).
- This is the first edition to address adults directly (Part 12, scoping review and the adult roundtable).
- Guidance for settings other than the home has been expanded, with governance rather than clinical risk identified as the main barrier (Part 11, scoping review, case studies and roundtables)
- Blended diet may be used to support weaning from parenteral nutrition in intestinal failure (Part 8, scoping review and case studies).
- Pumps designed for blends are now available in the UK market. The 2021 edition recorded that pump manufacturers advised against pump use (Parts 4 and 9).
- The industry position has moved: the Enteral Products Safety Group accepts that some devices may be compatible with blended food under the advice of a healthcare professional (Part 3).

How to use this Toolkit

This Practice Toolkit has been developed to be read either from start to finish as an introduction to blended diet, or part by part, since each part relates to a different area of practice and can be read alone.

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Wider review

The draft Toolkit and Position Statement were read and commented on by twelve reviewers and by the four authors of the scoping review. Reviewers are listed in alphabetical order of surname.

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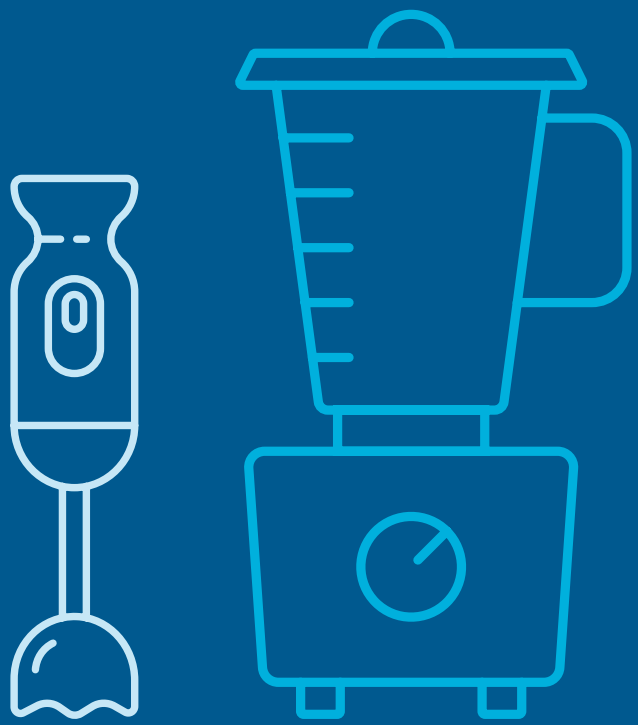
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Funding and declarations of interest

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1

Blended diet today



What is a blended diet?

Blended diet refers to food and drink blended to a consistency that can pass through an enteral feeding tube. It is an umbrella term for a wide variety of practices and is best understood as a continuum. Some people use blended food and drink as the sole source of nutrition, others alongside a commercial enteral formula, in proportions that vary widely: a small amount, an even split, or anywhere between. This is commonly referred to as hybrid use. People move along the continuum in both directions. The balance shifts with circumstances, for example, more home blends in the school holidays or at less busy times, more commercial enteral formula when life is harder to plan around. Some blend meal-by-meal, others batch blend or use ready-to-use shop-bought products such as baby food, and there is now an increasing choice of commercially prepared formulas containing real food ingredients. Appendix 1 sets out the different approaches with the advantages and considerations of each; people may use several in combination.

Who uses it, and where?

Blended diet has been part of children's home enteral feeding practice in the UK for over a decade, and professional attitudes to blended diet have changed considerably from a position of caution to support. Adult home enteral feeding services are now inheriting the long-standing users established by paediatric teams. There is also growing interest among adults who start tube feeding in later life, particularly in motor neurone disease as well as head and neck and upper gastrointestinal cancer. This Practice Toolkit applies across the lifespan.

Blended diet use is no longer confined to the home environment. There are now working examples of blended diet being started, as well as continued, during a hospital admission. There are also examples of it being provided in education, respite, residential and supported living settings (Part 11). Many tube-fed people are well enough to travel and to work away from home, and they blend while they are away.

Reported benefits

Tube-fed people, their families, carers and professionals consistently describe, in the surveys and the roundtables, occasions where starting a blended diet made a substantial difference to the quality of life of the individual and their family.

Improved gastrointestinal tolerance is the most commonly reported benefit in the scoping review, and often the initial reason why blended diet is adopted and continued. Reductions in reflux, retching, vomiting and abnormal stooling are described consistently in both children and adults, though not everyone improves, and it is not yet possible to predict who will. The mechanisms are increasingly understood: blends are measurably more viscous than traditional commercial enteral formula, and the fibre content of a blend is often higher and more diverse. Other physical benefits are recurring themes: brighter skin, glossier hair, stable growth, better sleep, greater alertness and improved energy, along with perceived resistance to common illnesses. There are social and emotional benefits too. People fed exclusively by

tube can otherwise be excluded from social occasions centred on food, and being able to share the same meals as family and friends is described as one of the key benefits. People also describe feeding feeling less medical, and a greater sense of control.

Perceived risks and concerns

The concerns which were most often raised by professionals about blended diet were nutritional inadequacy, tube blockage and microbial contamination. A decade of clinical practice and large prospective cohorts have found no increase in stoma site infection, gut infection, tube blockage, hospital presentation or equipment complications. Reports of serious harm are few, and each has come down to a specific, avoidable failure in food choice, preparation and/or monitoring. Blended diet is sometimes reached for only as a last resort, after several changes of commercial enteral formula have failed to improve gastrointestinal tolerance. It should instead be offered as one of the feed choices when enteral feeding is first planned (Part 2). Blended diet no longer requires a formal risk assessment if the advice here is followed.

Challenges

Blended diet asks more of the person preparing it than commercial enteral formula does. Ingredients and equipment are not funded, and the planning, preparation and storage fall largely on carers. Most people report being self-taught with little professional advice and support. This Toolkit aims to upskill professionals to address that gap. Provision outside the home varies between neighbouring hospitals and between wards of the same hospital. The obstacle is usually a lack of policy, training, staff time or clear accountability. Monitoring can fall between services when it has not been agreed in advance. Each of these challenges is addressed in the parts that follow.

Blended diet is sometimes reached for only as a last resort, after several changes of commercial enteral formula have failed to improve gastrointestinal tolerance. It should instead be offered as one of the feed choices when enteral feeding is first planned (Part 2).

2

Blended diet, the choice



All tube-fed people should be made aware that blended diet is a choice available to them. They need timely information so they can consider blended diet in their own circumstances. This decision should be supported by the healthcare professionals involved in the person's care. This part covers what needs to be discussed as part of that decision-making process, and what a subsequent plan should record. This plan should be revisited as circumstances change.

1 Structure the conversation as a shared discussion.

An individual risk assessment is not required and should not be a precondition. The decision must still be fully informed and documented. The conversation guide in Appendix 3 sets out the topics to cover, and Appendix 2 is written for the person and their family to take away.

2 The person's own preferences, capacity and consent are central.

Adults are presumed able to make their own decisions, including ones others consider unwise. Where an adult cannot, the decision is made under the mental capacity legislation applying in that nation, taking account of their wishes, feelings and beliefs. For children, it rests with those holding parental responsibility, weighting the child's own views by their understanding. The person or people who will plan and prepare the blends should always be part of the discussion.

3 Discuss the different approaches to blended diet available.

There are many ways to incorporate blended diet. The person or people preparing the blends should be aware of the different approaches available and be supported to make decisions about preparation methods. Appendix 1 sets out the approaches as a continuum.

4 Make one decision, shared across the MDT.

A person should not have to remake the decision with each professional they see. Everyone involved should know what has been decided and their own role and responsibilities in relation to it. The feeding plan should be recorded and made available to every setting the person attends (Appendix 7).

5 Consider the type of enteral feeding tube used.

Some tubes are better suited to blended diet than others. Blended diet is more commonly used with balloon retained gastrostomy tubes of 12Fr gauge or above. However, tube type and size alone should not preclude blended diet; there may be circumstances where another tube type is considered (Part 3).

6 Consider if additional ancillaries are required.

Ancillary needs are unlikely to exceed those of the wider tube-fed population, but additional or O-ring syringes and containers can be helpful (Part 4).

7 **Consider the time and cost involved.**

Blended diet takes time and work to plan, shop for, prepare and store. It also shifts the cost from the NHS to the tube-fed person's household, since commercial enteral formula is prescribed. The costs and the support required can be set out in a Continuing Healthcare or Personal Health Budget application, for both children and adults, and the dietetic care plan should be included in it. Disability Living Allowance or its equivalent may be relevant. Some regional or condition-specific charities fund blenders.

8 **Consider the equipment needed.**

The initial outlay on equipment can be a barrier for households on low incomes, so discuss it openly at the outset (Part 5).

9 **Consider the current understanding of the person preparing the blends.**

This covers both nutrition (Part 6) and food safety and hygiene (Part 7). Where knowledge is lacking,scoping what matters is a willingness to learn. Translating nutrition into practical terms is a core dietetic skill, and the dietitian can and should teach and support this.

10 **Consider the person's medical condition and any dietary requirements.**

A therapeutic or modified diet can be blended too, but it affects food choices and takes more planning and preparation, so specialist dietetic support is likely to be needed (Part 6).

11 **Agree how the person will move onto a blended diet.**

Transition onto a blended diet may take several weeks, and it depends on feeding history as much as diagnosis (Part 8).

12 **Agree how blended diet will be administered.**

Method, rate and posture all need to be agreed and recorded in the plan (Part 9).

13 **Agree how blended diet will be monitored and when.**

A monitoring plan should be established, with parameters and review intervals agreed in advance and by whom. Agree with the person what is being monitored and why. Weight is almost always part of the plan, but the goal attached to it differs. The outcomes that matter to the tube-fed person, their family and carers belong in the plan alongside it (Part 10).

14 **Identify where outside the home the person is fed.**

Tube-fed people are cared for in many settings other than their home, and provision outside the home can be a challenge. Consider whether the home or care setting, including paid carers, can support preparation. Settings may require support and training from enteral feeding professionals. Many people also manage to work or travel with a tube and blended diet (Part 11).

15 **Plan ahead for transitions.**

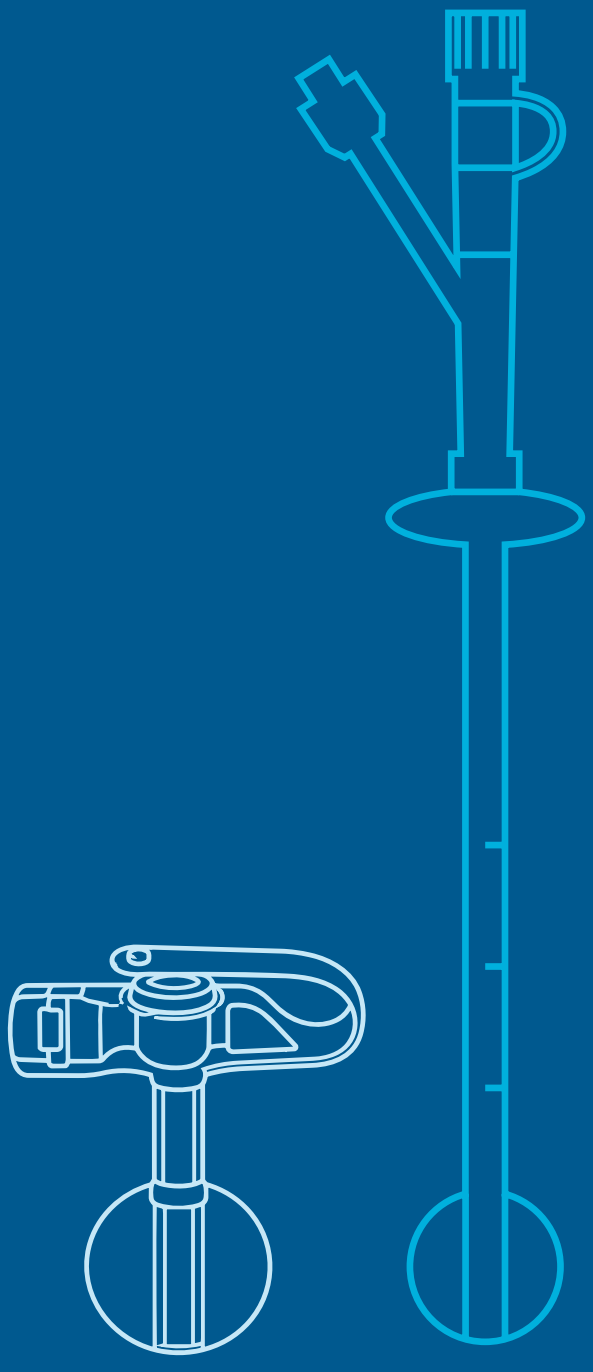
Transition means any change in circumstance, treatment or setting and is applicable to children and adults (Part 12).

16 **Support the decision not to use blended diet, or to stop.**

Some people decide that blended diet is too difficult under their circumstances. The level of work required should not be underestimated. No one should be made to feel guilty for deciding not to try blended diet, or to stop. Some may choose to use blended diet only on special occasions, where sharing food with others matters most to them.

3

Tubes and routes



This part covers the tube type, route, diameter and retention device best suited to blended diet. Where a person or their family is considering blended diet before a tube is placed, tell the team placing it. Retention device and diameter are most easily influenced at that point and are harder to change later.

What tube manufacturers say
The Enteral Products Safety Group, which represents UK suppliers of enteral feeding devices, accepts in its November 2026 position statement that some devices may be compatible with blended food, on the advice of a healthcare professional. For practice recommendations it refers clinicians to this Toolkit.

1 Use blended diet with a balloon retained gastrostomy tube or low profile device (button) where there is a choice.

Gastrostomy provides a direct route to the stomach and is the tube most commonly used with blended diet, in UK practice and in international cohort studies. Balloon retained tubes can easily be changed in the community, whereas disc retained tubes require a hospital admission to replace. A disc retained tube is not a reason to rule blended diet out. Many adults are fed by disc retained tubes for years, often at a wider bore, and blended diet is used successfully with them where there is an agreed plan for how nutrition, fluid and medication would be given if the tube is blocked, and for how the tube would be replaced. Where gastric feeding using commercial enteral formula is poorly tolerated, blended diet given via the gastrostomy should be considered before changing to jejunal feeding.

2 Assess a request for nasogastric use individually.

Where gastrostomy placement is not possible and blended diet could offer benefits, assess case by case. Be aware that nasogastric tubes are both longer and narrower, delivery pressure and tube integrity have not been measured, and that in the published cohorts the only tube occlusions reported occurred with nasogastric and nasojejunal tubes. The concern that a tube could split above the epiglottis and lead to aspiration is theoretical, and no case has been reported. A parent's account of blended diet via a nasogastric tube is published with the case studies.

3 Treat post-pyloric (jejunal) use as exceptional.

Post-pyloric feeding bypasses the stomach, and the jejunum has less storage capacity, so food must be delivered more slowly to avoid dumping and the volume given at any one time is limited. Bypassing gastric acid also makes food safety more important. It has been done: the scoping review includes a jejunostomy series, and dietitians report outcomes similar to gastrostomy feeding, though with variable confidence and little guidance to work from. Treat it as exceptional rather than routine, and agree it with the multidisciplinary team. Where a gastro-jejunal tube is used, administer blends through the gastric port, noting that the gastric lumen is narrower and the blend may need to be thinner.

4 **Use a 12Fr diameter tube or above where there is a choice.**

Most people using blended diet in the UK have a 12Fr tube, but narrower tubes can be used, and size alone should not preclude it. There is no need to dilate an existing stoma to fit a larger tube. A thinner blend may be required, though adding liquid can reduce the nutrient density delivered. Sieve only when the blend is not smooth or contains seeds or skins, not as a matter of routine (Part 5). Blending for at least two minutes in a high-powered blender may make sieving unnecessary.

5 **Use blended diet with a mature stoma.**

A blocked tube in an unformed tract cannot be changed at home, so judge maturity against the first planned device change rather than elapsed time alone. Practice reported at the roundtables ranges from around six weeks to six months, and services should agree a local position, which may be shortened after discussion with the clinician who placed the tube. Agree with the centre that placed the tube who will replace it and how quickly, and record it. This matters most for gastro-jejunal and other complex devices, where replacement may not be available locally.

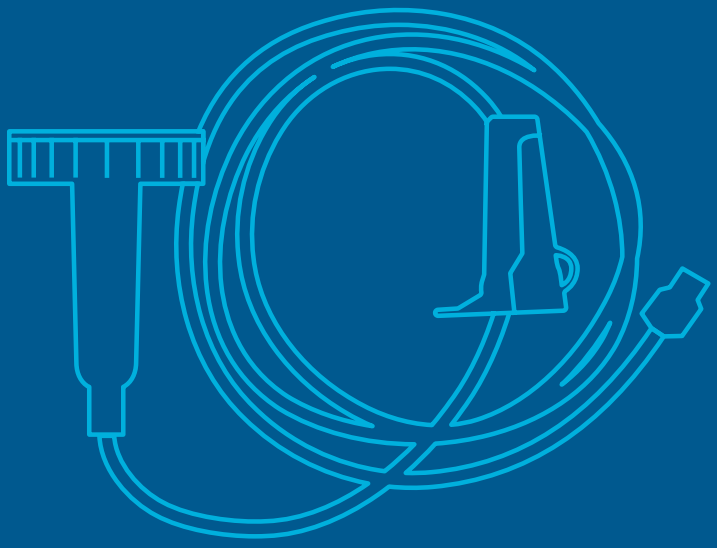
! **Tube blockage**

Tube blockage is uncommon, but it can occur. It is more commonly caused by medication than by food blends. Every tube-fed person or their carers should be taught to check tube and site integrity, to flush to maintain patency, and to have an agreed plan for what to do if the tube blocks. This matters most where the tube is the only route for food, fluid and medication.

4

Ancillaries





Blended diet requires little in the way of additional ancillaries, which are provided by the NHS, This part covers what to provide and how it should be cleaned. The ancillaries used for blended diet are those already used in bolus home enteral tube feeding with a commercial enteral formula: enteral syringes, typically 60ml and often several per day, compatible extension sets for gastrostomy buttons, containers for storing blends and giving sets if a pump is used.

1 Provide ancillaries as per local bolus feeding policy.

The same number of ancillaries is generally provided to people on blended diet as to the wider home enterally fed population, though individual assessment may show otherwise (point 3), and the number supplied varies regionally.

2 Reuse ancillaries with a standardised cleaning procedure.

Syringes and containers should be washed in warm soapy water, rinsed and left to air dry. The cleaning method, drying and inspection determine whether reuse is safe. Equipment that is damaged or degraded should be replaced. Manufacturers' own cleaning instructions vary and can be followed where provided. Some provide guidance on the number of uses. Only food grade storage containers designed for repeated use should be used to store blends, and the manufacturer's guidance followed on whether a container is suitable for the microwave, freezer or dishwashing.

3 Assess the need for additional or O-ring syringes individually.

Professionals note that the numbers on the enteral syringe can wear off with repeated use, although this is not necessarily a problem where the syringe is filled to its full capacity each time. O-ring syringes, which have a thin rubber sealing ring on the plunger, were reported at the roundtables to help where the slow plunge method is used. Lubricating the rubber ring with a cooking oil is reported to extend the life of the syringe and reduce carer hand strain. Depending on the food ingredients chosen, blended diet may result in staining and increased wear on plastics.

4 Use either a straight or right-angled extension set.

Either a straight bolus or right-angled extension set can be used, the choice is one of personal preference. Some people prefer a straight set for ease of administration. Others prefer a right-angled set, since it is then the narrowest part of the feeding system, so a blend that passes through it should pass easily through the button without blocking it.

5 Giving sets are required for people using pumps.

Enteral feeding pumps designed for use with blended foods are now available in the UK market (Part 9). Dietitians who have supported people to access these pumps have needed to access personal health budgets to supply giving sets outside their normal enteral feeding contract.

5

Equipment



Equipment for blended diet is bought by the household, and the initial outlay can be a barrier for those on low incomes. Blender type alone does not determine feasibility: suitable recipes and adequate blending time matter more than the price of the machine.

1 **Trial blended diet before buying a blender.**

Commercial baby food purées and pouches, if age appropriate, or an inexpensive hand-held stick blender allows a trial without the expense. A stick blender is particularly useful when first introducing single, soft, easy-to-blend foods such as fruit and vegetables. Commercially prepared blended food products are also available and can be used to trial tolerance without the need for equipment and preparation.

2 **Blend for at least two minutes.**

Blending time matters more than wattage or price: at least two minutes reduces viscosity, and three to six minutes gives a smooth, uniform consistency. Mid-range domestic blenders are the most commonly used in the professional survey and suit a meal-by-meal approach.

3 **Powerful blenders permit a wider range of foods and batch blending.**

Higher-powered blenders will blend most foods, including seeds and nuts, and suit batch blending, but carry a high initial cost.

Type of blender	Advantages	Considerations
Stick blender	Inexpensive and easy to clean.	Typically low power. Harder work to get a lump-free blend. Seeds and nuts blend less easily. Small volumes and can be messy. Needs a suitable container, and a sieve may be needed as well.
Mid-range, for example a bullet blender	Mid-price. Easy to use and clean. Best for blending meal by meal.	Best with small volumes. Likely not large enough for batch blending. Durability varies.
High-powered blender	Will blend most foods. Good for batch blending and large quantities. Many have self-clean settings, long guarantees and are durable.	Can be very noisy. High initial cost.

Taken from the 2021 edition.

4 **Sieve when starting blended diet or using a finer bore tube.**

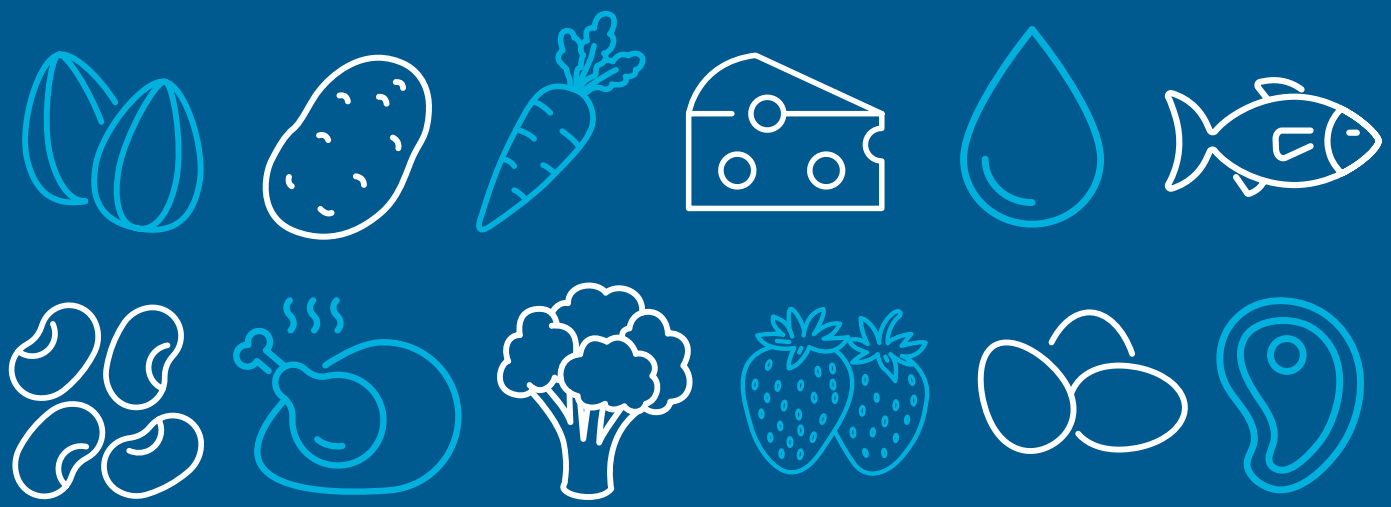
A sieve is particularly useful with tubes narrower than 12Fr and when blending foods with seeds and skins. A raspberry seed, for example, is the right size to block the narrow non-return valve in a button. When starting, sieving the first few blends can build confidence, but it is not necessarily needed long term once blends pass easily. A fine mesh sieve with holes of 1mm or less gives a lump-free consistency, even with a lower-powered blender. Those using a high-powered blender may only need a medium mesh sieve or no sieve at all. Sieves can be difficult to clean and are a potential source of contamination; metal sieves are easier to clean and more durable. Rinse a sieve immediately after use, to avoid food drying on, then wash it in warm soapy water and leave it to air dry.

5 **Additional equipment may make the experience easier.**

A food thermometer, extra fridge or freezer space with thermometers, measuring jugs and spoons, spatulas, and weighing scales can all help but none are essential.

6

Nutrition and hydration



Nutritional requirements can be met with blended diet, whether it is used on its own or in combination with commercial enteral formula or oral diet. Adequacy depends wholly on the food choices made by the person preparing the blend. This part covers estimating and delivering requirements for macro and micronutrients, fluid and fibre. Dietetic support should be available to everyone preparing blends for tube feeding. The dietitian's role throughout is to support and advise on the diet as a whole, not to make the everyday or every meal food decisions. Keep advice in plain language, free of clinical jargon.

1 Estimate nutrition and hydration requirements.

Take age, medical condition and energy expenditure into account using standard prediction equations, bearing in mind that requirements may be much lower in non-mobile children and adults. Protein requirements should be based on recommended intakes, as for oral intake. Predicted requirements are a guide to be used alongside monitoring and should be adjusted as monitoring indicates. Where a person has been weight-stable, or for children tracking growth centiles on commercial enteral formula, matching current intake may be more practical as a starting point.

2 Split delivery across the day to suit volume tolerance.

Daily intake can be met over three to six blends across the day, for example breakfast, lunch, dinner, supper and snacks. The split depends on volume tolerance per feed and at different times of day. A little-and-often approach is useful where there are volume tolerance issues. Blended diet can also be used alongside commercial enteral formula to achieve adequate intake, in a wide variety of ways.

3 Advise on nutrients and consistency, not volume.

Blended diet does not have a uniform nutrient density, unlike commercial enteral formula, and the liquid needed to reach a suitable consistency varies depending on the food ingredients used. It is therefore not necessary to calculate energy per millilitre. A blended diet plan cannot be prescribed by a professional in the way a commercial enteral formula can. Instead, advise on a daily nutritional requirement as a guide and on the consistency required to administer, which can be communicated using the IDDSI framework (Appendix 10).

4 Teach how fluid needs will be met and how to monitor hydration.

Hydration is part of nutritional adequacy and is easily overlooked. The scoping review suggests assuming that around 70 to 75% of the volume of any blend is fluid, as a starting point. This applies whether blended diet is the sole source of nutrition or used alongside commercial enteral formula. Alongside water flushes and medication, this counts toward daily fluid intake. Where calculated intake falls short, assess output and clinical signs before increasing fluid, such as decreased or dark urine, particularly during illness or in warm weather, when meeting fluid needs is harder and should be discussed. Prediction equations can overestimate needs in this group.

5 **Educate on healthy eating and age-appropriate portion sizes.**

The NHS Eatwell Guide is the starting point for how a blended diet should be constructed from the age of two, with a variety of foods from each of the four main groups: starchy carbohydrates, protein sources, fruit and vegetables, and dairy foods or alternatives. It does not apply under the age of two, where complementary feeding guidance applies instead. Healthy eating guidance may need modifying, for example in the case of high or low energy requirements, food allergies, a ketogenic diet or metabolic conditions. Not everyone arrives with a working knowledge of nutrition or portion sizes, and translating the guide into practical and accessible terms is itself a core dietetic skill.

6 **Encourage a variety of foods from each of the food groups.**

Eating a variety of foods from the different food groups ensures adequate micronutrient intake, and variety should extend across days and weeks rather than repeating the same recipe. Some foods are harder to blend, and people may choose to leave them out as a result. Starchy carbohydrates thicken on blending and need additional fluid. Added fats and oils may separate in storage. Meat can be difficult to blend, depending on the cut and cooking method. Watch for these foods being avoided, and for over-reliance on fruit and vegetables, which blend easily but are low in energy and can lead to carotenaemia, which causes an orange tint to the skin, especially palms and soles of the feet, but is easily reversible.

7 **Increase fibre slowly to tolerance, with sufficient fluid alongside.**

Fibre has a beneficial effect on long term gut health and should be encouraged. However, sudden introduction or increase in fibre intake can cause either loose stools or constipation, and individual responses are variable and unpredictable. Aim initially to match previous fibre intake, then slowly increase variety and amount towards the dietary reference value for age. Higher fibre intakes need more fluid, so make sure fluid requirements are met.

8 **Do not supplement micronutrients routinely.**

Follow national public health guidance unless the person's diagnosis, treatment, biochemistry or dietary analysis indicates otherwise. Where a wide variety of foods is used, most people need no supplementation, with vitamin D the usual exception. Where a shortfall has been documented it is rarely confined to one nutrient. A wide range of products carrying health claims that are not supported by evidence are marketed to the general population. Where supplementation is wanted, suggest a product with a balanced nutrient profile rather than a high dose of any single micronutrient. Where a clinical deficiency is identified, treat it in line with local protocols.

9 **Treat any recipe analysis as an estimate, not a measurement.**

Laboratory analysis of blends has shown that the energy and nutrient content actually delivered can differ from values calculated from food composition tables or product labels. The energy and nutrients actually delivered are usually lower than the calculated figures, so analysis may overestimate intake, and monitoring takes precedence. This does not mean the blend is inadequate, only that the calculation is less reliable than it looks, so growth, weight and clinical review are the better guide. Simple dietetic tools such as 24-hour recall or food frequency can confirm that a variety of foods is being used. Reserve detailed analysis for therapeutic diets, multiple exclusions, where whole food groups are omitted, or where the household relies heavily on the same ingredients on repeat. Encourage families to rotate a wide variety of foods to avoid this.

10 **Reflect the household's usual diet.**

Blended diet is an opportunity for the tube-fed person to share the same foods as their family, so the diet should reflect what the household normally eats, while keeping the variety and balance in points 5 and 6. This is also a useful starting point (Part 8). For some families, it is a chance to improve the diet of the whole household, and the dietitian can support them to make healthy, varied choices for everyone.

11 **Therapeutic or modified diet can be blended.**

Dietitians are skilled at supporting people to modify their diet in the treatment of disease. Any therapeutic or modified diet that is used orally can also be blended and given through a tube. This affects food choices and takes more planning and

Nutritional adequacy depends wholly on the food choices made by the person preparing the blend. Dietetic support should be available to everyone preparing blends for tube feeding.

7

Food safety and hygiene



This part follows the consumer guidance of the Food Standards Agency (FSA) and, where it differs, Food Standards Scotland (FSS). It is the same advice given to people preparing food at home to eat orally. Additional food handling legislation applies to businesses where food is prepared and served, including schools, respite and hospital settings (Part 11, Appendix 5).

1 Everyday food safety and hygiene practices apply to blended diet prepared at home.

General food safety principles are sufficient to make blends safe, but they have to be followed. Where standardised safe handling is followed, microbial contamination of home-prepared blends is minimised; where it is not, real-world sampling has found bacterial counts above acceptable thresholds. Safety depends on time, temperature and cleaning practice. Contamination occurs where these lapse.

2 Advise on safe food handling, hygiene and storage.

Advice should cover the whole chain from ingredient to administration: handwashing, separating raw and cooked foods, cooking as if the food were to be eaten orally, cleaning equipment, time at room temperature, storage, defrosting, heating, labelling and transport.

3 Wash hands thoroughly and clean surfaces before preparing blends.

Hands should be washed thoroughly with soap and warm water before handling food, and again between handling raw and cooked foods. Kitchen surfaces should be cleaned before preparation begins.

4 Separate raw and cooked ingredients during storage.

Raw meat and fish should be stored in sealed containers on the bottom shelf of the refrigerator. Use different chopping boards and knives to prepare raw and ready-to-eat foods or wash thoroughly using soap and warm water between preparing different ingredients. Fresh fruit and vegetables need to be washed before use.

5 Store ingredients appropriately and use the use-by date.

Follow food storage instructions. Keep ingredients sealed or in an airtight container. Use by is a safety date, and food should not be used after it even if it looks and smells fine. Best before is a quality date, and food is usually still safe afterwards, though it may have lost flavour or texture. For packaged foods, once opened, use within the time frame specified on the pack. Decant the contents of opened tinned foods into food safe storage containers rather than keeping the open tin in the fridge, as metal transfers into the food once it is exposed to air. Do not use a tin that is blown, leaking, rusted or dented on a seam.

6 **Cook ingredients as if they were to be eaten orally.**

All food ingredients used in blends should be prepared as though they were to be eaten orally. For example, raw chicken should be thoroughly cooked before it is blended. A food thermometer is a useful tool for checking that foods have reached the advised temperature, 70°C for two minutes.

7 **Clean all equipment used to prepare, store and administer blends.**

Wash equipment such as chopping boards and knives in warm soapy water, rinse, and leave it to air dry. A sanitising step, such as boiling water, a sterilising solution or a hot dishwasher cycle, should be used for groups vulnerable to foodborne illness. Wash and dry cloths and sponges before each use, as dirty damp items encourage bacteria to grow.

8 **Keep blends at room temperature for no more than two hours.**

Once cooked, any food, including a blend, should spend as little time as possible between 8°C and 63°C, the temperature range in which bacteria multiply fastest. Two separate limits apply. Cool a blend and get it into the fridge within two hours of cooking. After that, a blend should spend no more than two hours out of the fridge in total, counting travel and the time taken to give it.

9 **Blends can be stored in the refrigerator (0 to 5°C) for up to 48 hours.**

Check the refrigerator temperature with a fridge thermometer. Cool a blend quickly by dividing it into small, shallow, covered and labelled portions. Do not put a large warm volume straight into the fridge, which raises the temperature of the whole fridge. Blends should be stored in an airtight container above any raw foods.

10 **Blends can be frozen below -18°C for one to three months.**

Freezing prevents the growth of bacteria, yeasts and moulds; the storage time depends on the ingredients, with some small nutrient loss over time. Label batch-blended portions with a description, a made-on date and a use-by date. Defrost frozen blends thoroughly in the refrigerator (0 to 5°C): this keeps the blend below the temperatures at which bacteria grow. Defrosting at room temperature means the outer layers thaw and warm, allowing bacteria to multiply, while the core is still frozen. Discard defrosted blends after 24 hours if not used. Frozen or defrosted blends do not need reheating before use but many prefer to warm for comfort (point 12).

11 **Cool cooked rice within one hour and store it for no more than 24 hours.**

Cooked rice can carry Bacillus cereus spores, which survive cooking and multiply if the food is cooled slowly or stored for too long. Rapid cooling and short storage periods keep these blends safe. The toxin produced is not destroyed by heating. Blends containing rice may be given chilled or reheated once until steaming hot throughout.

12 **Give a blend at whatever temperature suits the person.**

Cold from the fridge, at room temperature or warmed, the choice makes no difference to safety, provided the blend was prepared hygienically, cooled rapidly and stored, or frozen and defrosted, as set out in points 1 to 11. It does not need reheating just because it contains meat, fish, poultry or other cooked ingredients. Where there is any uncertainty about cooling, time out of the fridge or storage, discard the blend. Heating will not make it safe, because heat kills bacteria but does not destroy the toxins they may produce.

A cold blend can feel strange going in, and many people prefer to warm it. Warm the container gently under warm running water or in a jug of warm water and mix thoroughly, or take it out of the fridge to come to room temperature. Or microwave it, on a defrost or low setting for longer to reduce hotspots, and stir well. Whichever is used, the blend should be given within the two-hour limit (point 8). A blend should only be reheated once. Warming for comfort does nothing to bacteria, so it is governed by the two-hour limit rather than by a limit on the number of times (Appendix 5). Appendix 5 addresses storage, who the blend is for and where it is being given.

13 **Reheat a blend containing chilled ready-to-eat food where the person is more vulnerable to foodborne illness.**

Some people are more vulnerable to foodborne illness caused by Listeria, an organism that keeps growing at refrigeration temperatures. This group includes infants and young children, people who are pregnant, older adults and those with cancer, organ transplants, uncontrolled HIV or diabetes, chronic liver or kidney disease, or on oral steroids or immunosuppressive treatment. Listeria is carried in chilled ready-to-eat foods rather than in food that has been thoroughly cooked, cooled quickly and kept at 0 to 5°C. So for these people, where the blend contains chilled ready-to-eat foods such as soft cheese, pâté, smoked fish or sliced cooked meats, heat it until steaming hot throughout, which the FSA takes as equivalent to 70°C for two minutes.

A blend of thoroughly cooked ingredients, cooled and stored properly, does not need reheating for safety. If using a microwave, stir to remove any hotspots. The blend then needs to cool to a temperature that could comfortably be eaten orally before being given through the tube and also within the two-hour limit (point 8).

14 **Do not dehydrate blends at home.**

Domestic dehydrators work at 40 to 70°C, which overlaps the range in which bacteria multiply fastest. A balanced blend high in protein and fat can take many hours, or even days, to dry out. Freeze blends instead if preparing in advance. Commercially prepared dehydrated blends are manufactured under controlled conditions and are not the same as a home-dried blend; follow the manufacturer's advice on storage once opened.

8

Starting



How blended diet is introduced depends on individual feeding history: a child tube fed since birth has never been weaned, while an adult who ate until recently has a known history of tolerance to build on. This part covers how to start and progress with blended diet. Support should be most intensive in the early weeks, when small and frequent adjustments are needed.

Professionals new to supporting blended diet can draw on expertise elsewhere
Blended diet is well established across the UK, and the professional survey found most people supporting it learned from someone already doing it. Seek supervision from an experienced colleague, or from a specialist interest group or an established blended diet service where there is none locally. Nobody is expected to work it out alone.

1 For infants, blended food can be introduced from around six months.

In line with UK complementary feeding guidance, food (including blended food) can be introduced from around six months. Start with 5 to 10ml of a single blended food mixed into the infant's breast milk or current infant formula and increase slowly as tolerated. Introduce vegetables, fruit, starchy foods and protein one at a time, widening the range as tolerated. Never add salt or sugar, and do not give honey before twelve months. Introduce common food allergens, including egg, nuts, dairy, fish, wheat and soya, alongside other first foods from around six months and before twelve months. Introduce them one at a time and give them regularly unless they cause a reaction. Shop-bought puréed baby food allows a trial without buying a blender, though it can be higher in sugar and salt than a home blend.

2 Take care with common foods that cause allergies where the person was not weaned.

An older child or adult tube fed with a commercial enteral formula since birth has no known history of food tolerance to build on, so introduce each new food one at a time and monitor for allergic reactions and intolerance. Introduce the main food allergens one at a time in the same way. Introduce blended diet when the person is otherwise medically stable. Start with a small amount and build gradually to an age-appropriate portion if tolerated, remembering that the gut needs time to adapt after a period on commercial enteral formula. One strategy is to replace one commercial enteral formula feed with a blend at a time, for example at breakfast, with an interval between changes, so that tolerance can be judged. Another, used instead or as well, is to mix a single blended food into the commercial enteral formula.

3 Build on what an older child, young person or adult ate previously.

Someone who has eaten orally has a known history of tolerance and established likes and dislikes to build on, which an individual tube fed since birth does not. Start from the foods they ate and enjoyed before tube feeding, and from what the household is cooking now.

Where they still eat or taste some food by mouth, the blend can be the same food. Appendix 6 sets out the approaches for each starting position.

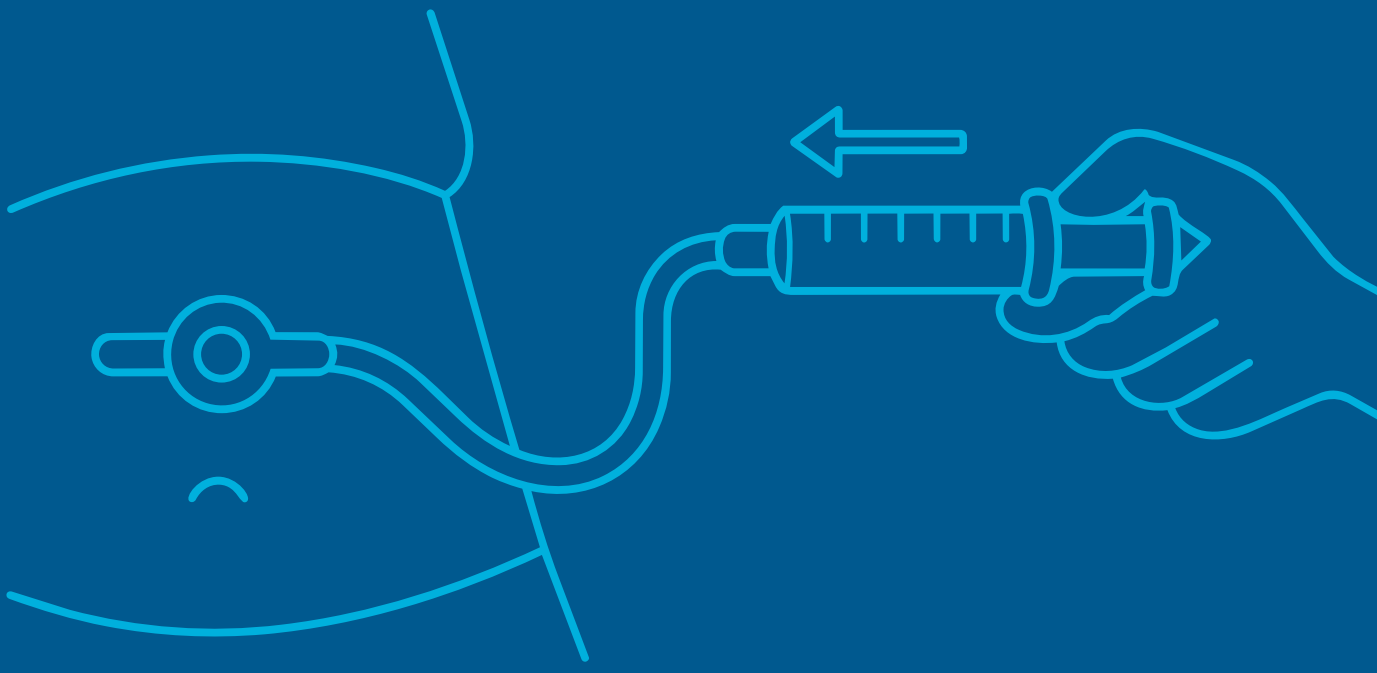
Family meals
People need practical advice to get started. Recipes can be helpful at the beginning to give ideas, but encourage adaptation of meals already prepared in the home, which reduces planning and preparation time. It also means the tube-fed person shares the same food as their family, one of the core benefits of blended diet. Often it is easier to establish blends at home first before considering other places where the person is fed.

4 Weaning from parenteral nutrition is specialist led.

Where blended diet is used to support intestinal adaptation and reduce dependence on parenteral nutrition, it is led by the specialist intestinal failure team. Blends are introduced in small, consistent amounts, advanced slowly, and titrated carefully against the previous feed. This is a newer application and the evidence rests on small case series and UK practice experience. Symptomatic anastomotic ulceration has been reported in short bowel syndrome after the whole food fraction is increased. It is rare but serious, so where there is an anastomosis monitor for gastrointestinal bleeding and raise it with the intestinal failure team. Weaning from parenteral nutrition in intestinal failure is described in the case studies.

9

Administering



This part covers the method of giving a blend, rate, posture and the choice between a syringe method and a pump delivery.

1 Use a slow plunge method to give a thicker blend (Slow Plunge Technique)

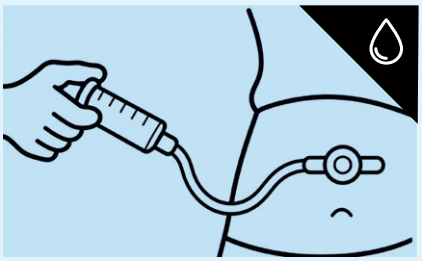
A slow plunge method is the usual method, and it allows a thicker blend to be given. A gravity bolus can only be used with a thinner blend and has a much slower flow rate with ENFit connections. Thinning reduces both viscosity and nutrient density, and a higher viscosity is thought to be one reason for the positive effect on reflux, retching and vomiting symptoms. Sieving removes lumps, and gentle warming helps reduce viscosity and ease flow. Use these instead of thinning the blend with added liquid (Part 3).

2 Give the blend in small amounts, at the pace of a meal

Use a 60ml enteral syringe. Some people prefer to draw the blend up, saying it allows lumps to be seen. Others prefer to pour the blend into the open end of the syringe, or to draw it from a feeding bottle through an enteral adaptor. Any of these methods works, and the choice is a matter of personal preference. Remove air from the syringe by tapping or standing it before giving. Apply gentle pressure, giving 5 to 20ml at a time with a pause between, to mimic the pace of eating, so that a full meal takes approximately as long as if the person were eating orally, watching for signs of fullness or intolerance as you go. If the blend does not flow easily, review the consistency rather than forcing it (Parts 3 and 5). Flush the tube with the agreed volume of water, using a clean enteral syringe, before and after the blended meal rather than between each syringe. Repetitive strain injury has been reported in parents and carers using this method (Part 4).

Slow Plunge Technique - step-by-step

Step 1 **Flush the tube** with the agreed volume of water, using a clean enteral syringe, before the blended meal.



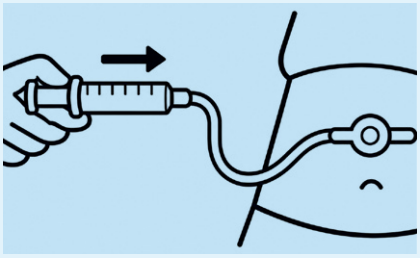
Step 2 **Draw the blend up** using a 60ml enteral syringe. Some people prefer to pour the blend into the open end of the syringe. Either technique works.



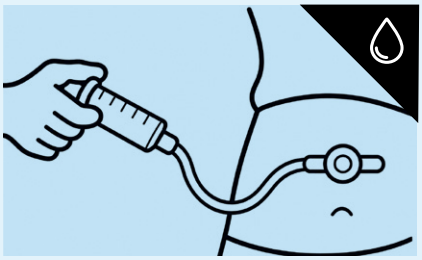
Step 3 **Remove air from the syringe** by tapping or standing it before giving.



Step 4 **Apply gentle pressure**, giving 5 to 20ml at a time with a pause between, to mimic the pace of eating, so that a full meal takes approximately as long as if the person were eating orally, watching for signs of fullness or intolerance as you go. If the blend does not flow easily, review the consistency rather than forcing it (Parts 3 and 5).



Step 5 **Flush the tube again** with the agreed volume of water, using a clean enteral syringe, after the blended meal.



The illustrations shown have been generated using artificial intelligence (AI) and refined to support visual understanding of the procedures described. They are intended as illustrative guides only and may not represent medical equipment or procedures with complete technical accuracy. Always follow the guidance of your healthcare professional and the manufacturer's instructions.

3 Set the rate for the individual; there is no standard rate.

Tolerance varies between people, so a rate for a given volume cannot be applied universally, even within an age range or condition. Start slowly and build with the person, introducing one change at a time and allowing enough time to assess the response before adjusting further, watching for the symptoms in Part 10. Tolerance also varies for the same person from day to day, as it does with oral eating, and is often lower during illness, so the plan should allow the rate to be slowed when it needs to be.

Continues →

4 **Consider a pump where the slow plunge method is not possible.**

Pumps designed for blends now exist in the UK market, and a pump is an option where the slow plunge method is not possible or not tolerated. Not all pumps and giving sets are designed for use with blends. Check the manufacturer's instructions for use and advice on blend consistency. A blend should not be at room temperature for more than two hours, so it is given as a slow bolus by pump rather than as a continuous feed. Some dietitians have been able to access these pumps and extension sets using personal health budgets.

5 **Consider posture and positioning during administration.**

Position the person safely and comfortably throughout and watch how they tolerate it. This matters particularly where a blend is given more slowly or by pump, when the person may be in one position for longer. Involve the family and the carers who know the person well, since they will recognise what is usual for them.

Method	What it offers	What to consider
Slow Plunge Technique	Allows administration of a thicker blend, which allows maintenance of nutrient density as additional fluid is usually not required. The higher viscosity may help improve symptoms and gives greater control over pace and volume given.	Requires active involvement of parent/carer and has a risk of repetitive strain injury. The Blend consistency must be prepared appropriately to flow safely.
Pump-Assisted Blended Diet Feeding	Useful when slow plunge feeding is not possible or not tolerated which can support people requiring slower administration. It reduces physical burden on carers and can provide a more consistent delivery rate.	Not all pumps and giving sets are suitable for blended feeds. Equipment may not be readily available and can require funding arrangements. Feeds should not remain at room temperature for more than 2 hours.
Gravity Bolus Feeding	Less manual effort than slow plunge feeding. It can be convenient for some families.	Requires a thinner blend to flow adequately which can increase volumes required to achieve nutritional adequacy. May not retain potential benefits of a thicker blend for symptoms. Flow rate can be very slow.

10

Monitoring



Monitoring keeps nutrition support safe and effective and identifies complications. It also checks that the goals agreed are being met. Closer monitoring is needed when establishing blended diet or transitioning from commercial enteral formula, particularly during the first twelve months. Once established, a person on blended diet needs the same monitoring as anyone else receiving home enteral tube feeding. This part covers what to agree before starting and what to monitor. Monitoring can frequently fall between services, without agreement on who requests it and acts on the result.

1 Agree a time-bound monitoring plan before starting.

Set the parameters and review intervals in advance, ideally as part of a multidisciplinary discussion with the individual, their family or carers. A baseline should be recorded before starting blended diet. UK home enteral feeding reviews tend to take place every three to six months, but people may need more support in the first few months of starting blended diet. Discuss what is realistic within the resource available. Agree and record who is responsible for each element of monitoring. The dietitian is the expert in enteral tube feeding and should lead the monitoring plan.

2 Monitor weight and body composition.

This may include weight, height or length using actual or proxy measures, BMI, mid-arm circumference and triceps skinfold. In children and young people, growth trajectory should be monitored as well as weight and height. Consider the measurements alongside clinical symptoms and appropriate functional measures rather than on their own. Blended diet can be used for either weight gain or loss depending on food ingredients chosen.

3 Do not increase biochemical monitoring as routine.

Blended diet is not in itself an indication for more biochemical monitoring in comparison to commercial enteral formula as long as a wide variety of foods from each of the food groups is used (point 5). Follow local schedules and panels for biochemical monitoring in home enteral feeding as these vary regionally. Clinical concern should prompt investigation.

4 Monitor gastrointestinal symptoms.

Adverse gastrointestinal symptoms are a common reason why people choose to try blended diet. A baseline discussion before starting is essential if improvement is to be monitored. Most improvement in upper gastrointestinal symptoms appears within the first three months. Where symptom management was the main reason for trialling blends and nothing has improved, consider whether to continue, taking account of any other benefits the person and family value (point 7). Conversely, gastrointestinal symptoms can be triggered by the introduction of blended diet, for example by introduction of a food intolerance or by adding too much fibre to the diet too quickly. Ideally tube-fed individuals and their families and carers should be taught to monitor these symptoms themselves.

5 **Monitor the overall balance of the person's diet.**

Tools such as 24-hour recall and three-day food diaries are useful ways for the dietitian to assess the variety of the diet. They help identify potential gaps and are more practical than analysing each individual blend. Dietary analysis is important in restrictive diets where the same recipes are used repeatedly.

6 **Monitor the tube for patency and stoma site for health.**

As with all enteral tube feeding, tube patency and stoma site health should be routinely monitored, and tube integrity, complications and replacements recorded at each review.

7 **Capture the outcomes that matter to the person and family.**

Social and emotional benefits and improvements in appearance, general health, sleep, comfort, alertness and family life could be missed in a routine clinical appointment focused on gastrointestinal symptoms. Discuss before starting what matters to the person and their family and how it will be measured. Patient reported outcome measures should form part of the monitoring plan and be assessed at each review. These may include quality of life, psychosocial impact, confidence, and perceived burden or stress. A validated tool, such as the Paediatric Quality of Life Inventory used in UK research, or a simple rating agreed with the family can be used.

8 **Monitor more intensively during initiation and at care transitions.**

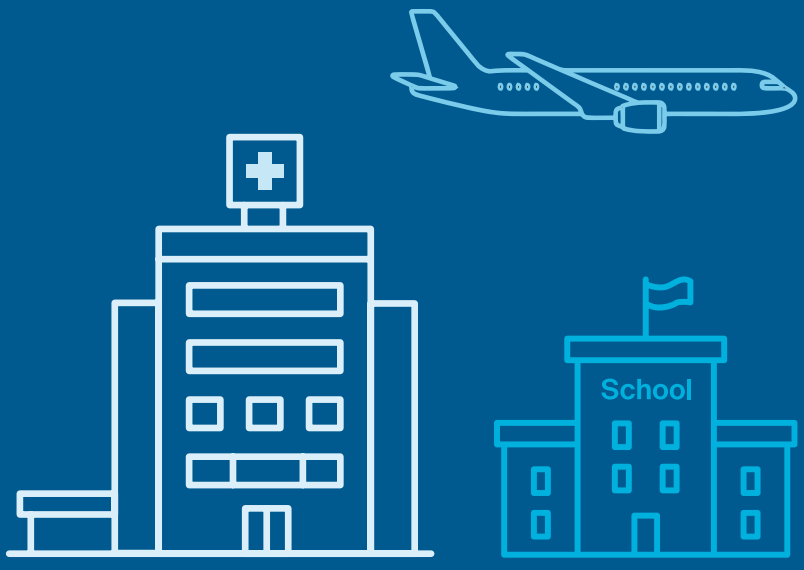
More frequent contact is usually needed in the first weeks and months. Once blends are established, monitoring should step down to that of anyone else receiving home enteral tube feeding, in line with local home enteral feeding guidance. Additional support will be needed when planning for transitions (Part 12).

9 **Allow the choice to use a hybrid approach or stop blends.**

Moving onto blended diet does not have to mean replacing commercial enteral formula entirely. Many people use blends alongside commercial enteral formula, and in adults this appears to be the more common pattern. Circumstances change and the amount of time and energy available for blending can fluctuate.

11

Beyond the home



Tube-fed people are cared for in many settings other than their own home. Providing blended diet in each of them is a common challenge. Good examples exist where blended diet has been successfully prepared and provided on site in education, care respite and acute hospital settings. Where these settings provide blends, tube-fed people have the same choice away from home as they have at home. Obstacles are generally organisational rather than clinical, and a service that works through them can usually resolve them. Any food can be blended, including in restaurants and on holiday (point 8).

1 Consider all settings in which the person is fed.

At the point the decision is made, establish where blends will be given (Part 2). Notify those settings, and send a letter confirming the decision, which reassures staff that the choice has health professional support (Appendix 4). It is easiest to establish blended diet at home first, so that it is clear whether blends will continue before time is invested in training a setting. Developing guidance and training staff takes time, so engage early.

2 In-house provision as a choice should be considered the gold standard.

Working models exist in which catering staff cook and blend on site for the tube-fed person. It gives the tube-fed person the same access and the same level of support an oral eater receives. School meals are the clearest example: a tube-fed pupil eligible for free school meals is entitled to the same meal. School kitchens already plan menus to meet national school food standards. Where blends are prepared on site, reassure the setting that the food hygiene and health and safety assessments it already applies to catering for oral eaters apply equally to a blend. Working models exist in adult residential and supported living settings too (Part 12).

3 The tube-fed person should be able to choose to bring in their own food prepared at home.

Where there are no catering facilities or the person prefers it, blends prepared at home should be accepted. A school already accepts food prepared at home for children who eat orally, by the same parent in the same kitchen. A school trained to give a commercial enteral formula through the same tube is already trained on the medical task. Agree labelling, with a name, the date made, a use-by date and the ingredients, and how the blend is transported and stored on arrival (Part 7). No reheating of blends sent in from home is required, unless the blend contains chilled ready-to-eat food and the pupil is in one of the groups more vulnerable to foodborne illness (Part 7). What matters most is keeping the time the blend spends at ambient temperature under two hours (Part 7). Dedicated fridge space is useful. Where it is not available, a cool bag with ice packs can be used. Agree an alternative for a day when a blend is spilt, spoilt or cannot be given for any reason.

4 **Work across agencies, around the needs of the tube-fed person.**

Bring healthcare staff, the setting's staff and the tube-fed person together to build a plan around the facilities available. The example care plan can be adapted to the setting's own procedures, though every circumstance will differ (Appendix 7). Appendix 8 sets out what a local policy should define. Families need to trust that a setting will prepare and handle blends to the standard they keep at home. Involving them from the outset, and keeping communication open between the family, the setting and healthcare staff, helps build that trust.

5 **Agree who trains staff and keep a record.**

Responsibility for training staff in education, respite and social care is not consistently agreed, so record locally which service trains and which holds the records. Describe the training as enteral tube feeding and blended diet together, rather than as blended diet training on its own. Much of it is the tube feeding the setting may already do, and separating the two is what leads settings to treat blends as a new competency to be built from nothing. Involve whoever prepares and administers the blend: a joint visit in which staff observe preparation and administration is the most effective method described, and they can advise on the signs of intolerance specific to the person. Staff turnover is the main threat to consistency, so build training into induction and mandatory updates, keep a register, provide written procedures, and name a lead in the setting. Where a setting uses competency assessment, it covers the enteral tube feeding task rather than the blend, which varies from meal to meal. Either way it is not a precondition the person must satisfy (Part 12).

6 **Plan ahead for transitions and transfers.**

Starting school, moving between settings, and transfer from paediatric to adult services are all foreseeable. Each is a point at which provision can break down if the receiving setting has not been prepared. Make contact before the move, so that guidance, training and equipment are in place when the person arrives. Pay particular attention to transfer from paediatric to adult services, where models of care, funding and levels of support may differ significantly (Part 12).

7 **Blended diet should continue on admission to hospital.**

Where a person is established on blended diet at home, the default position on admission should be that it continues, with any change agreed with them, not imposed by the admission. Recognised clinical exceptions are critical care, significant immunocompromise, a change to post-pyloric feeding, biochemical instability, and a clinical need for continuous feeding. Several UK hospitals now provide blended diet to inpatients, so where provision is not yet in place, services should look to those examples. A working group of dietetics, catering, nursing and infection prevention can agree who is responsible for each step, how contamination is minimised, how ward-level equipment is cleaned and what training is needed. Appendix 9 sets out the methods available, and the choice depends on catering facilities and systems. Developing an inpatient blended diet service is described in the case studies.

8 **Plan for travel, holidays and eating out.**

Travel, holidays and eating out are all possible using a blended diet but may need more planning and preparation. Time spent travelling counts as part of the storage period, so a cool bag with ice packs is needed where a blend will be out of the refrigerator for any length of time (Part 7). Shop-bought alternatives such as ambient pouches, smoothies or commercial enteral formula containing real food ingredients can cover occasions when a blend cannot be prepared or stored safely. PINNT has prepared a comprehensive guide to travelling with blended food (Appendix 10).

Obstacles are generally organisational rather than clinical, and a service that works through them can usually resolve them.

12

Adults and transition



Adult services are encountering blended diet by two routes. Firstly, inheriting people established on it for years who transition from children's services. Secondly, requests from adults who begin tube feeding later in life, particularly in motor neurone disease and in head and neck and upper gastrointestinal cancer. This part covers both instances, and the planned transfer between paediatric and adult services, which should begin years before it happens. It is the first edition to address adults directly.

1 Offer blended diet as one of the options.

Blended diet may not suit every adult. Make the decision with the individual, based on assessment and clinical judgement as set out in Part 2. Take account of the person's goals and quality-of-life priorities, the availability and capability of carers, and whether the home or care environment can support it. Consider when to start, and practical guidance on how to administer should be discussed directly with the individual. Where a person depends on paid carers, the arrangement depends on the provider as much as on the person, so agree the care plan before starting. Where paid care is needed, agree the arrangement through the multidisciplinary team, and include the dietetic care plan in any application for funding, such as NHS Continuing Healthcare (Part 2). Where an adult cannot make the decision themselves, follow the mental capacity legislation applying in that nation (Part 2).

2 Raise it before gastrostomy insertion in progressive conditions.

Discussing blended diet early, particularly in progressive neurological conditions, may improve acceptance of enteral feeding and help the person make an informed decision. Adults with motor neurone disease have described preferring blended diet because it fits their values and lifestyle. Knowing it is possible can change how a person feels about a gastrostomy placement.

3 The same principles apply in residential and supported living.

The learning from settings that already provide blended diet in education, respite and hospital applies equally to residential and supported living in adult care (Part 11). Working UK models exist, including a residential service where catering staff cook and blend, and a hospice batch blending in advance. The principles are the same throughout: agreed procedures, trained staff, and a documented alternative.

4 Assess competency on the tube feeding task, not on the blend.

Roundtable participants favoured training and support over formal competency assessment systems. Where a setting uses competency assessment, it covers giving an enteral feed through the tube and caring for the tube and stoma as a delegated healthcare task. There is no separate blended diet competency to assess, because ingredients and consistency vary from meal to meal, and a sign-off would only be a snapshot. Check what the care provider's contract already covers. Where it includes giving an enteral feed as a delegated healthcare task, giving a blend falls within it, which

helps to normalise blended diet for staff. Tolerance and consistency are better picked up in training alongside the person who prepares and gives the blend at home (Part 11).

5 **Start transition planning early, from around fourteen.**

Most paediatric services begin transition planning at about fourteen, though this varies with the primary condition and locality. Each trust or health board has a transition policy setting out how the transfer is coordinated. Check that it covers dietetic care, including how home enteral feeding is handed over. Start early and plan the transfer of the feeding plan with the whole team, including the GP, the young person and their family or carers. Link it to the other transition plans already in place for them. Engage the receiving service early, hold joint reviews with both teams, and arrange for receiving staff to attend blended diet training and observe preparation and administration. Care plans, monitoring information and training records should transfer with the person.

6 **Write dietetic transition guidance with your adult colleagues.**

Guidance written jointly by the children's and adult dietetic services, covering how home enteral feeding is handed over, keeps the transfer consistent. Establish what training and support the enteral feeding contract provides in the adult service. Check whether equipment will change, since the adult service may use a different enteral supply contract, with different syringes, extension sets or pumps (Part 4). Nurse provision built into the contract differs between areas, and the family will want to know what carries across.

7 **Accept established users without reassessment.**

When a young person transferring to adult services has followed a blended diet for many years and is established and stable, the decision is long made, so care and feed should not change without a clear reason. Continue it and review it as you would any other established feeding plan, looking at tolerance, the ability to administer blends and nutritional status. Check whether nutritional requirements are being met and, where they are not, the clinical impact. Where adult teams are reluctant, this is usually unfamiliarity, not opposition. Joint visits, shared caseloads and mirrored guidance have all helped.

8 **Plan for the change in decision-making at 18.**

At 18 the legal basis of the decision changes even where the person's capacity has not. Parental responsibility ends and decisions are made under the mental capacity legislation applying in that nation, with a best interests process where the person cannot decide for themselves. Plan this in advance of the transfer, since the adult care package, respite and care settings may decline to administer a non-prescribed feed the person does not have capacity to consent to. The care setting may not have access to training required to meet the competency requirement to fulfil the delegated healthcare task. Parents remain central to that process, and to the day-to-day work of preparing blends and the method of delivery.

9 **Agree what happens on an adult hospital admission.**

Plan the first adult admission before it happens, with the feeding plan agreed and recorded. An enteral tube feed passport, carried by the person, is used in some services to set out the tube, the feeding plan and who to contact, and it saves the person explaining blended diet from scratch on a ward that has not met them. Name the adult healthcare professional to approach for problems with the tube or stoma site (Part 11). Appendix 9 sets out the steps to take on admission.

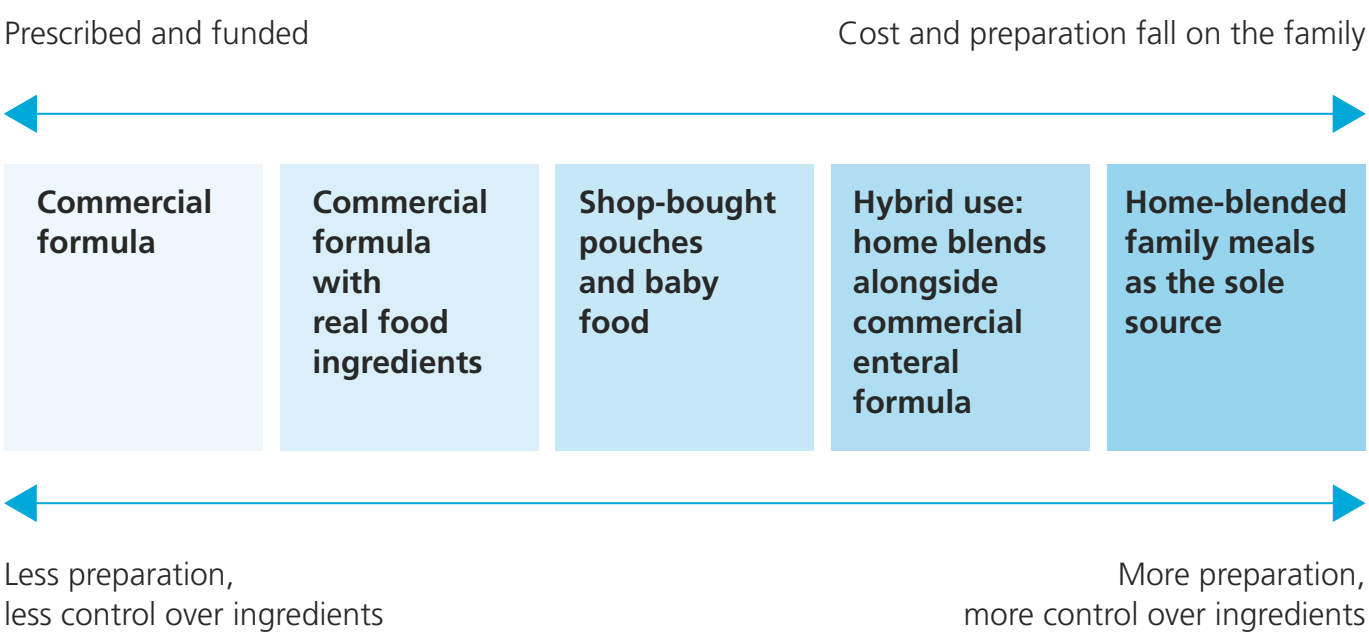
Participants of roundtable 4 recognised the benefits of introducing discussions about blended diet early within the patient journey, particularly for people with progressive neurological conditions.

"It highlighted to me the difference between a reactive and a proactive approach to this."

Appendices

Appendix 1
Approaches to blended diet as a continuum

Blended diet is not all or nothing. There is a range of choices, from a small amount of blended food alongside a commercial enteral formula to home blends as the sole source of nutrition, and people move between them in both directions. This is best understood as a continuum of practice.



The balance may shift, with how busy life is, with a hospital admission or a change of setting. Many people use more than one approach at once; hybrid use is common. **The right position is the one the person and the people preparing the blend can sustain.**

Continues →

Approaches compared

Approach	What it is	What it offers	What to consider
Traditional commercial enteral formula	A nutritionally complete formula designed for use with enteral feeding tubes, prescribed and funded, with a fixed nutrient content and viscosity.	Known nutritional content. No preparation required. Usually supported by an enteral feeding contract, with pumps, ancillaries and industry nursing support.	Some people do not tolerate it well. Offers no food-based or social benefit. The uniformity can be a negative as well as a positive.
Commercial formula with real food ingredients	Commercial enteral formula in which some or all of the nutrition comes from recognisable food ingredients.	Fixed specification and ready to give. Reported to reduce reflux, retching and vomiting and to improve bowel habit in some people.	Not a substitute for a person's choice to use home blends. Availability and prescribing vary between areas.
Shop-bought pouches and baby food	Ambient pouches, smoothies and stage 1 baby food, thinned to consistency with formula, milk or water.	Allows a trial without buying a blender. Consistent texture. Portable, so useful for travel and for settings.	Not nutritionally complete long term. Prepackaged baby food may be higher in sugar and salt than a home blend. A short-term or occasional option.
Hybrid use	Home blends used alongside commercial enteral formula, in any proportion: a small amount, an even split, or most of the day's intake.	Keeps the benefits of blends while easing the workload. Commercial enteral formula can be the liquid base, the overnight feed, or if tolerated, given in settings where blends cannot practically be prepared.	Two regimens to plan and monitor. The balance often shifts with circumstances, which is expected.
Home-blended family meals	Everyday household food, blended meal by meal or in batches.	Shares the family's food and mealtimes. Full control over ingredients and cultural and dietary requirements.	Nutritional content depends wholly on the food choices made. Greatest demands on time, equipment, planning and food safety. Cost is not funded.

Continues →

Preparation methods, whichever approach is used

Method	What it offers	What to consider
Family meals	The tube-fed person eats what the household eats, at the same time. Least storage, least planning, freshest food.	Preparation several times a day. Needs a blender available at each meal, including away from home.
Individual meals	The tube-fed person has their own recipes due to allergies or a therapeutic diet.	The person preparing the blend has to cook a second meal which is more time consuming and costly. Watch for over-reliance on a limited number of recipes or food ingredients.
Batch blending	Blends made in advance, refrigerated for up to 48 hours or frozen for one to three months, then defrosted in the fridge. Frees time on busy days.	Needs fridge and freezer space, labelling and a food thermometer. Freezing and thawing reduce viscosity. Storage limits (Part 7) apply.

Appendix 2
Blended diet: information for you and your family

Blended diet is an option in enteral tube feeding. This leaflet explains what blended diet is and what to think about before deciding to use it.

What is blended diet?

Blended diet means ordinary food and drink, blended smooth enough to go through a feeding tube.

It can be all of the food and drink a person has. Or it can be used alongside a ready-made tube feed. Many people use both. The balance can change from week to week, and that is fine.

Why do people choose it?

The most common reason is comfort. Some people find they have less reflux, retching and vomiting using blended foods. Some have better bowel habits too. Not everyone improves. We cannot yet tell in advance who will.

Families also talk about other benefits such as brighter skin, better sleep, more energy, and being able to share the same meals as everyone else.

Even a small amount of blended food and drink can help with symptoms or there may be special occasions where you would like to share the same food as your family.

Is it safe?

Yes, when food is prepared and stored properly.

Studies have compared people on blended diet with people on a ready-made tube feed. They found no increase in infections, blocked tubes or hospital visits.

Your feeding tube does not necessarily need to change. Some tubes suit blended diet better than others. Your team will talk this through with you.

What does it involve?

Blended diet takes time and work. You or the person preparing the food for you will

need to plan, shop, cook, blend and store food. The cost of food ingredients and a blender is not covered by the NHS.

No one has to do it. And no one should feel bad for deciding it is not for them, or for trying it and deciding to stop.

How do people start?

- Start when you are well, at home, with a small amount. Build up slowly.
- Change one feed at a time. Then you can tell what is being tolerated.
- Your dietitian will be able to support you with a plan to start.

How do I keep it balanced?

Use the same foods you would put on a plate. Something with protein, such as meat, fish, eggs, beans or lentils. A starchy food, such as potato, rice or pasta. Fruit and vegetables. And some fat or oil, such as olive oil or butter. Add milk, tube feed or water until the blend is runny enough to pass through the tube easily.

Variety across the week matters more than any single meal. Your dietitian will advise if you are choosing the right mix of foods.

What about water?

Blends are mostly water, and water flushes count toward intake. Look out for signs of thirst: darker urine, fewer wet nappies or pads, dry lips.

Give extra water in hot weather or when you are unwell.

Your dietitian will advise you on how much fluid is needed per day.

How do I keep food safe?

- Wash your hands.
- Keep raw and cooked food apart.
- Cook food fully, as if you were going to eat it, before blending.
- Cool a blend and put it in the fridge within 2 hours. Use it within 2 days or freeze it.
- A blend does not need reheating to be safe. It can be given cold. There is one exception. If the person is more likely to become ill from food, a baby or young child, someone pregnant, an older person, or someone whose immune system is weakened, and the blend contains chilled ready-to-eat food such as soft cheese, pâté or sliced cooked meat, heat it until it is steaming hot all the way through, then let it cool before giving it.
- You can warm it for comfort by standing the sealed pot in warm water.

- Keep a blend out of the fridge for no more than 2 hours in total. That includes the time it takes to give it.
- Blends with rice need extra care. Cool them within 1 hour and use within 1 day.

What about school, respite or hospital?

Many settings now support blended diet.

Your team can write a plan for them and help with training.

It helps to agree a back-up for days when a blend cannot be given, such as your usual tube feed or a shop-bought pouch.

Who can I contact?

Dietitian:	
Nurse:	

Appendix 3
Talking about blended diet: a conversation guide

This guide is an aid to conversation.
Blended diet does not require an individual risk assessment, and completing this guide is not a condition of going ahead. Use the parts that are useful, skip the rest, and make sure the conversation is recorded in the care record so that everyone involved knows what was decided and why.

Who was part of the conversation?

Name of the tube-fed person: _____

Date: _____

	Organisation or relationship
Family member or carer	
Dietitian	
Nurse	
Other	

Things worth talking through

These are prompts, not requirements. Note anything that matters for this person.
(see table on next page)

Topic	Prompts	Notes
What the person and family hope for	Comfort, symptoms, weight or growth, sharing family food, something else. What would count as success.	
The starting point	What is tolerated now, and what the person currently takes as food, nutrition and fluid. This is the baseline the plan will be measured against (Part 10).	
The feeding tube	Gastrostomy is the usual route, ideally 12Fr or above and balloon retained so it can be changed at home. Narrower tubes and other routes are considered individually (Part 3). What to do if the tube blocks or requires changing.	
Equipment and cost	A blender and any other equipment are bought by the family. A trial with pouches or a stick blender needs no outlay. Local sources of funding (Part 5).	
Giving the blend	Slow plunge bolus with a 60ml syringe, at the pace of a meal. Pumps designed for blends exist; no continuous feeding over more than two hours (Part 9).	
Food safety	Ordinary food hygiene is enough when followed. Wash hands. Cook as though to be eaten orally. Cool and refrigerate within two hours, use within two days. Reheating is not required for safety, except where a blend containing chilled ready-to-eat food is for someone more vulnerable to foodborne illness (Part 7).	

Topic	Prompts	Notes
Keeping the diet balanced	Adequacy depends on the food choices made by the person preparing the blend. A dietitian can advise on a daily recommendation for energy, macronutrients, fibre and fluid. They can advise on general healthy eating and dietary modification in the management of disease. The person preparing the blend makes the everyday food decisions (Part 6).	
Time and capacity	Who will plan, shop, prepare and store blends, and how much time they have. Whether that changes in term time, at work, or when a carer is away. Hybrid use is an option.	
Other settings	Whether school, respite, day service or residential care will give blends, who will train staff, and the back-up on a day a blend cannot be given for example if spilled or spoilt in transit (Part 11).	
Monitoring	What will be watched, by whom, and when the plan will next be looked at (Part 10). The signs of fullness or intolerance specific to this person.	

What we decided

The approach (Appendix 1), how it will start, and, if a trial has been agreed, how long it will run and how success will be assessed.

Who decided

Adults are presumed able to decide for themselves. For a child, the decision rests with those holding parental responsibility, weighting the child's own views by their understanding. Where an adult cannot make this decision, record the mental capacity legislation applying in that nation.

- ☐ The tube-fed person decided
- ☐ Parental responsibility
- ☐ Best interests decision (mental capacity legislation applying in this nation)
- ☐ Lasting power of attorney, health and welfare
- ☐ Other:

When we will look at this again

Appendix 4
Example letter confirming the decision to use blended diet

Fill in the blanks, delete the options that do not apply, and anything in square brackets before use.

To: _____ [GP, community nurse, school or setting, other professionals involved]

Re: _____, date of birth _____, NHS number _____ Date: _____

I am writing to confirm that _____ has chosen to give blended diet through their gastrostomy / other _____ tube, as the sole source of nutrition / alongside a commercial enteral formula, from _____[date].

This was a shared decision made on _____ by _____ and _____ with _____ [names and roles]. A record of the conversation is held in the care record [name the system, for example EMIS, SystmOne, RiO or Cerner].

[Where the person lacked capacity for this decision, add: The decision was made in _____'s best interests under _____ (the mental capacity legislation applying in this nation), taking account of their wishes, feelings and beliefs, with _____ consulted throughout.]

Blended diet means everyday food and drink, blended to a consistency that passes through a feeding tube. It is an established form of enteral nutrition, supported by the BDA and BAPEN Position Statement and Practice Toolkit (2026). Studies have found no increase in infection, tube blockage or hospital presentation compared with commercial enteral formula. Food safety principles are the same as for food eaten orally, and an individual risk assessment is not required.

Planning for use outside of the home:

_____ [setting]: _____ would like to explore provision of blends when _____ is in your care. They would prefer blends to be prepared on site / sent in from home, labelled with name, date made, use-by date and ingredients. The attached care plan sets out storage, administration and the back-up for a day a blend cannot be given. Where _____ already receives commercial enteral formula through the tube with you, a blend is not a new clinical task, and your own food hygiene procedures remain appropriate.

Please contact me with any questions. _____ can demonstrate preparation, and I can support training.

Name and role: _____ Organisation: _____

Contact details: _____ Signature:_____

Developed from the Best Interests Statement in the Shared Decision-Making Tool (Dietitians interested in Special Children, May 2025), used with permission, and the BDA 2021 Practice Toolkit.

Appendix 5
Preparation and reheating: a decision guide

Step 1. How has the blend been stored?

Situation	What to do
Freshly made	Give within two hours of preparation. No reheating needed.
Refrigerated	Ingredients cooked thoroughly, blend cooled and in the fridge (0 to 5°C) within two hours, used within 48 hours. Safe to give chilled or lightly warmed for comfort. No reheating needed for safety.
Frozen	Frozen at below minus 18°C, defrosted fully in the fridge, used within 24 hours of defrosting. Then as for refrigerated.
Contains rice	Cool within one hour, keep in the fridge, use within 24 hours. Then give chilled or reheat once until steaming hot. Reheating does not make a slowly cooled or over-kept blend safe.
Out of the fridge for more than two hours in total	**Do not give.** The two hours are cumulative and include travel and the time taken to give the blend. A blend that has already been reheated once should not be reheated again.

Step 2. Who is it for?

Situation	What to do
More vulnerable to foodborne illness	Infants and young children, people who are pregnant, older adults, and people with cancer, organ transplants, uncontrolled HIV or diabetes, chronic liver or kidney disease, or on oral steroids or immunosuppressive treatment. Where the blend contains chilled ready-to-eat foods, reheat until steaming hot. Consider a sanitising step after cleaning reusable feeding equipment.
Everyone else	No reheating needed for safety.

Step 3. Where is it being given?

Situation	What to do
At home	No reheating needed for safety. Warm for comfort if wanted.
A commercial kitchen in England, Wales or Northern Ireland	There is no legal requirement to reheat. If the setting does reheat, heat until steaming hot throughout, which is equivalent to 70°C for two minutes, and reheat once only. Follow the setting's own procedure.
A commercial kitchen in Scotland	There is no legal requirement to reheat. If the setting does reheat, food heated in the course of a commercial operation and reheated before service must by law reach at least 82°C, and should be reheated once only. This applies to a hospital or school kitchen reheating a blend it prepared.

Reheating as a safety step

Reheating is a safety step in two situations: where a blend containing chilled ready-to-eat foods is for someone more vulnerable to foodborne illness, and where a setting's own procedure requires it. Heat until steaming hot throughout, which is equivalent to 70°C for two minutes. Stir during and after heating, particularly in a microwave, where hot spots leave parts of the blend cool. Reheat once only. Cool to a temperature that would be comfortable eaten orally before giving.Reheating does not correct poor preparation or storage: where there is doubt about cooling, storage time or temperature control, discard the blend.



Warming is not reheating

Warming for comfort needs no set temperature and does nothing to bacteria. Stand a sealed container in warm water, or warm briefly in a microwave and stir thoroughly, and give straight away. A blend can be left at room temperature, provided the total time out of the fridge stays under two hours.

Based on Food Standards Agency and Food Standards Scotland consumer guidance as at October 2026. Check food.gov.uk and foodstandards.gov.scot for the current position.

Appendix 6
Starting blended diet: different approaches

For dietitians working through the introduction of blended diet with an individual and their family. The approach depends on how the person is fed now. Part 8 sets out the practice points behind these approaches.

Individuals with limited previous food exposure

For individuals who have been tube-fed since infancy or have had limited exposure to foods, introduce foods gradually before progressing to larger blend volumes. Consider introducing fruit and vegetables, then starchy carbohydrates and then protein foods.

Common food allergens, such as egg, nuts, dairy, fish, wheat and soya, should be introduced in line with national guidance. Once a variety of foods from these groups has been tolerated, progression to the next stage can be considered.

Individuals established on bolus feeding

Step 1 Introduce a small amount of blended diet

- Choose one feed time to start with.
- Replace part of the usual feed with a small volume of blended diet.
- Set the starting volume from your assessment and the person's feeding history.
- Top up with commercial enteral formula to maintain the usual feed volume.

Example

Usual feed = 200ml commercial enteral formula
Blended diet = 50ml
Commercial enteral formula top-up = 150ml

If there are nutritional or clinical concerns, consider trialling small blend volumes between usual feed times before replacing a bolus feed.

Step 2 Increase the blend volume

- Gradually increase the amount of blended diet at the same feed time.
- Reduce the volume of commercial enteral formula accordingly.
- Continue until the blended diet replaces the full bolus feed volume.
- If new foods are also being introduced, it may be helpful to alternate increases in blend volume with the introduction of additional foods.
- The rate of progression should be guided by tolerance, feeding history, medical complexity and feeding route. Progression may take days to weeks depending on the individual.

Step 3 Replace additional feeds

- Once the first blended meal is well tolerated, replace a second feed with blended diet.
- In most cases, this can be a direct volume swap.
- Continue replacing feeds according to the individual's goals and nutritional requirements.

Individuals receiving continuous pump feeding

Step 1 Introduce a blended meal

- Aim to provide blended diet during an existing break in the feeding plan.
- If no suitable break exists, adjust the feeding schedule to create one.
- Consider leaving a gap between the blended meal and restarting the pump feed.
- Set the starting volume from your assessment.
- If blended diet contributes significantly to nutritional intake, reduce commercial enteral formula accordingly, preferably by reducing the duration of pump feeding while maintaining the prescribed feeding rate.
- If the blended meal is given during an established feeding break, formula volumes may not need to be reduced immediately.

Step 2 Increase the blend volume

- Gradually increase blended diet volume according to individual tolerance.
- Reduce commercial enteral formula provision accordingly.
- Aim for a meal volume that is tolerated and supports nutritional requirements.
- As above, alternate increases in volume with the introduction of new foods, and let tolerance set the pace.

Step 3 Introduce additional blended meals

- If the goal is to reduce or discontinue continuous pump feeding:
- Repeat the process to introduce further blended meals.
- Reduce pump feeding hours accordingly.
- Increase meal volumes gradually where required.

Infants from around six months

Introduction checklist

Before starting, agree goals, expectations, progression and monitoring arrangements with the family. Confirm caregivers can prepare and administer blends safely. Blended diet should ideally be introduced when the infant is medically stable, and in line with UK complementary feeding guidance.

Step 1 Introduce a small volume of blended food

- Begin with approximately 5 to 10 ml of a smooth single-ingredient food, mixed with the infant's breast milk, formula or enteral feed where appropriate.
- Commercial stage 1 baby foods may be a practical starting option for anyone new to blended diet or without suitable equipment.
- The existing feeding plan will usually remain unchanged initially.

Continues →

Step 2 Increase volume and variety

- Introduce new foods one at a time, gradually.
- Increase volumes according to tolerance.
- Volume tolerance often improves with time. Where weight gain is a concern, energy-dense foods can add energy without adding volume.
- Monitor for gastrointestinal symptoms, feed intolerance and allergic reactions.
- Progress towards a varied diet from all food groups, including common food allergens, such as egg, nuts, dairy, fish, wheat and soya, from around six months and before twelve months.

Step 3 Adjust milk or formula feeds

- Continue breast milk, infant formula and/or enteral feed alongside blended diet as required.
- Reduce breast milk, formula or enteral feed in line with age-appropriate complementary feeding. At 6 to 7 months, milk volume stays largely unchanged. From 7 to 9 months, once the infant has two to three meals a day, milk feeds usually fall to three or four a day. By 10 to 12 months, meals and snacks are the main energy source, though milk is still an important contributor. Reduce sooner if weight is rising faster than expected for the infant's growth centile.
- Where a breast milk or formula top-up feed follows a blended meal, reduce that top-up first, before adjusting the wider feeding plan.

Step 4 Introduce additional blended meals

- Once a blended meal is tolerated, repeat the process for additional meals.
- Introduce further blended meals gradually, replacing breast milk, formula or enteral feeds as agreed within the nutrition care plan.
- A hybrid approach combining blended diet and commercial enteral formula may be used where this best meets nutritional and practical needs.

Appendix 7
Blended diet: multiagency care plan

For a setting giving blended diet away from home. One plan, shared by the person and those who care for them, the dietetic team and the setting, and revisited as circumstances change. Sections follow what the Position Statement says a plan should record.

The person

Name	
Date of birth	
NHS number	
Setting	
Feeding tube type and size	
Date plan agreed	
Review date	

Who prepares the blends, and where

- ☐ Prepared at home and sent in. Labelled with name, date made, use-by date and ingredients
- ☐ Prepared on site by the setting
- ☐ Shop-bought pouches or commercial enteral formula used in this setting

Notes

What is given

Time	What (blend, formula, water flush)	Amount	How given (route and method)

Blends are given by slow plunge bolus using a 60ml syringe, 5 to 20ml at a time, at the pace of a meal. Flush with water before and after the blended meal, not between each syringe.

Food storage and hygiene in this setting

- ☐ Refrigerator at 0 to 5°C, blend stored in a sealed labelled container above raw foods
- ☐ Cool bag with ice packs used for transport
- ☐ Blend kept at room temperature for no more than two hours in total, including administration
- ☐ Warmed for comfort only (sealed container in warm water); reheating not required for safety
- ☐ Reheating required in this setting because: _____ (see Appendix 5)
- ☐ Syringes and extension sets washed in warm soapy water, rinsed and air dried

Food choices, allergies and dietary requirements

Allergies and intolerances	Therapeutic, cultural or religious requirements	Foods to avoid or known not to be tolerated

If a blend cannot be given

The agreed alternative for a day when a blend is unavailable, spoilt, or cannot be given:

Signs of intolerance specific to this person, and what to do

Tube blockage

Flush with warm water. If the tube remains blocked:

Training

Staff member	Trained by	Date	Method (joint visit, observation, other)

Contacts

Dietitian	
Enteral Feeding Nurse	
Out of hours	

Developed for the 2026 Practice Toolkit from the 2021 example multiagency care plan and Action 3 of the Position Statement. Settings may transfer the content to their own care plan format; the sections, not the layout, are what matter.

Appendix 8
Updating local policy on blended diet

For services writing or revising a policy, guideline or standard operating procedure. Most barriers to blended diet outside the home are organisational, and provision usually follows a written policy.

How to approach it

- Convene a working group with dietetics, nursing, catering, infection prevention and control, pharmacy where medicines via tube are covered, and someone with lived experience of blended diet, a tube-fed person or a family carer.
- Start from this Toolkit and the Position Statement, not from the previous local policy; the 2021 positions on reheating, stoma maturity, risk assessment and routes have changed.
- Ensure local procedures reflect the facilities, resources, and processes available. A policy that assumes a ward kitchen no one can use will not be followed.
- Name the service responsible for each step: who assesses, who trains, who monitors, who acts on results.
- Set a review date and a named owner.

Continues →

What the policy should contain

Section	Contents
Scope and purpose	Which settings and which people it covers, across the lifespan. That blended diet is a recognised option within personalised care and not a deviation requiring exception.
The decision	Shared decision-making as the basis (Part 2). That an individual risk assessment is not required and is not a precondition. The plan records what has been agreed and by whom.
Roles and responsibilities	Dietitian, nurse, medical team, catering, setting staff and family. Who trains whom, and how competence is recorded.
Continuation on admission	The default is that blended diet continues on admission, with clinical exceptions only (critical care, significant immunocompromise, a change to post-pyloric feeding, biochemical instability, and a clinical need for continuous feeding). The steps to take on admission are in Appendix 9.
Methods of provision	Which of the methods in Appendix 9 the organisation supports, and when each applies.
Preparation, storage and administration	Labelling, transport, refrigeration, time limits, reheating and warming (Part 7, Appendix 5), administration method and flushing (Part 9), equipment cleaning (Part 4).
Infection prevention and control	Confirmation that ordinary food hygiene applies. Any local requirements, and their justification.
Monitoring	What is monitored, at what intervals, and which service requests and acts on results (Part 10).
Contingency	What is given when a blend cannot be, and what happens if a tube blocks.
Training and turnover	Induction for new staff, a record of who has been trained, and a named lead so provision survives staff changes.
Documentation	The care plan (Appendix 7), the conversation guide (Appendix 3), the decision letter (Appendix 4), and where they are filed. Records do not cross organisational boundaries, so the person or family should hold a copy to bring with them, and a receiving service should ask for it.
Review	Owner, review date, and how people using blended diet, and those who care for them, can raise problems with provision.

Things a policy should not do

- Require a competency assessment as a precondition of provision. Where a setting uses competency assessment, it covers the enteral tube feeding task rather than the blend, and it is never a precondition the person must satisfy (Parts 11 and 12).
- Set eligibility criteria that gate access to blended diet. The decision is the person's, supported by their team.
- Require reheating for safety where none is required. Reheating is a safety step only where a blend containing chilled ready-to-eat food is for someone more vulnerable to foodborne illness, or where the setting's own procedures require it (Appendix 5).
- Treat the absence of a national policy, or of a manufacturer's endorsement, as a reason to decline.

Developed for the 2026 Practice Toolkit from the 2021 guidance on updating local policy and from work led by Ruth Stanley on blended diet in settings other than the home.

Appendix 9
Methods for providing blended diet in hospital

Five methods in use in UK hospitals. The choice often depends on catering facilities, systems and staffing, and several may be used in the same hospital.

Method	Description	Advantages	Limitations	Considerations for practice
Hospital-prepared blended diet	A dietitian develops a recipe with the person and family. The feed is prepared in the hospital kitchen, labelled, stored and given according to the regimen. Standardised recipes may be nutritionally analysed and produced through existing catering systems	• Tailored to individual nutritional, cultural and dietary requirements • Greater control over ingredients and preparation • Can use foods available through existing catering • Supports continuity of care for patients already receiving blended diets at home • Standardised recipes can improve governance, staff confidence and consistency of practice	• Resource intensive for dietetic and catering teams • Needs recipe development, analysis and review • Hard to replicate the volume and consistency of home blends • Risk of inadequacy if standard recipes are used without individualisation	Appropriate where the organisation has an established pathway, suitable equipment, trained staff and food safety processes in place. Standardised recipes reduce workload but should be reviewed for adequacy. Consider blending time, staff training and flushing protocols to reduce blockage. Consider catering capacity, approval processes, infection prevention requirements and ongoing service evaluation when implementing a hospital-prepared blended diet service.
Puréed hospital meals, further blended	Food from the hospital puréed menu, blended further to a consistency suitable for the tube.	• Nutritional and allergen data may be available from the caterer • Often a variety of meal options • Uses existing hospital food services	• Some foods contain fibres, husks or textures that can block tubes • Hard to cater to specific dietary requirements • Regenerated meals may dehydrate, affecting consistency	Assess individual menu items for suitability before use. Guidance on dilution and consistency helps standardise practice.

Appendix 9
Methods for providing blended diet in hospital

Method	Description	Advantages	Limitations	Considerations for practice
Family-prepared blended diet	Blends prepared at home by the person, parent or carer and brought into hospital for administration.	• Continues the established home plan • Improves satisfaction for the person and family • Less preparation burden for hospital staff	• Relies on blends being prepared and brought in from home • Nutritional composition hard to verify • Safe transport and storage needed • Difficult where the person lives a long way from the hospital or has no kitchen access	Local policy should define labelling, storage, transport and administration requirements. Plan for the situation where blends cannot be brought in or given and agree an alternative feed.
Commercial baby food	Stage 1 baby food jars or pouches mixed with formula, milk or water to the required consistency. Additional ingredients, such as baby rice, may be added.	• Known nutritional content • Consistent texture, lower risk of tube blockage • No high-powered blender required • Often readily available in hospitals • Less labour intensive than preparing blended meals	• May not provide adequate nutrition long term • Limited product range may be available • May not match the person's preferences about processed food	Useful when initiating or trialling blended diet. More suitable as a short-term option than as a nutritionally complete long-term feed.

On admission

- Establish whether the individual is receiving a blended diet.
- Review the existing feeding plan and nutritional goals.
- Discuss how the feeding plan regimen will be supported during admission.
- Involve the dietitian, nutrition nurse and relevant medical team at an early stage, to confirm how the established plan will be delivered and whether any of the clinical exceptions in Part 11 apply.
- Agree who will give the blends on the ward. Where nursing staff are not yet trained to do so, the family may give them in the interim, but provision should not depend on a family member always being present.
- Agree, document and communicate any temporary changes with the individual and their family.
- Where blends cannot be given, a prescribed commercial formula with real food ingredients may be an acceptable alternative for some people.
- Review feeding plans regularly throughout admission, particularly if clinical status changes.
- Plan discharge so that blended diet continues on leaving hospital.

Developed for the 2026 Practice Toolkit from work led by Ruth Stanley on blended diet in settings other than the home. Part 11 sets out the position on continuation and the clinical exceptions.

Appendix 10
Useful sources of information

Professionally endorsed guidance is listed first. Family-facing and peer resources follow, with a note on where each comes from. All links to be verified before publication.

Guidance and statements

Source	What it is for
The Use of Blended Diet with Enteral Feeding Tubes: Position Statement (2026)	The companion to this Toolkit, setting out the evidence statements and actions. The evidence behind both is published in the separate reports.
Scoping review (Durnan et al, 2026)	The literature published since 2020, and how it aligns with the 2021 Toolkit and international guidance.
Patient and public engagement report (Durnan et al, 2026)	The views and experiences of tube-fed people and their families.
Case studies (Durnan et al, 2026)	Invited accounts of practice, including nasogastric use, weaning from parenteral nutrition and an inpatient blended diet service.
Roundtables 1 to 3 report (Durnan et al, 2026)	Paediatric practice roundtables.
Roundtable 4 report (Cantwell & Kennedy, 2026)	Adult practice roundtable.
Professional survey report (Durnan et al, 2025)	UK survey of professionals supporting blended diet.
Enteral Products Safety Group: Position Statement on the Use of Blended Food with Enteral Feeding Tubes (2026)	The industry position on device compatibility (Part 3).
Food Standards Agency, food.gov.uk	Consumer food hygiene guidance for England, Wales and Northern Ireland: cooking, chilling, storing, reheating, and advice for people more vulnerable to food poisoning.
Food Standards Scotland, foodstandards.gov.scot	The equivalent for Scotland, including the 82°C reheating requirement for commercial kitchens.

Source	What it is for
IDDSI, iddsi.org	The International Dysphagia Diet Standardisation Initiative framework, used in this Toolkit to describe blend consistency (Part 6).
NHS Eatwell Guide	The starting point for constructing a balanced blend (Part 6).
BDA Paediatric Specialist Group: Complementary Feeding Position Statement (2025)	Introducing solid foods from around six months, including allergens (Part 8).
BDA Food Fact Sheet: Complementary feeding, bda.uk.com/foodfacts	Family-facing guidance on introducing solid food. Under review at the time of publication, so check for the updated version.
Allergy UK	Information on food allergy and allergen introduction.
First Steps Nutrition Trust	Portion sizes and eating well guidance for the early years.
ESPGHAN: The use of blended diets in children with enteral feeding tubes, a joint position paper (Köglmeier et al, 2023)	European paediatric position paper, broadly consistent with this Toolkit.
ASPEN: Blenderized tube feedings, practice recommendations (Epp et al, 2023)	North American practice recommendations for children and adults, broadly consistent with this Toolkit.
AuSPEN: Blended tube feeding in enteral feeding, consensus statement (2021), auspen.org.au	Australasian consensus statement for children and adults, broadly consistent with this Toolkit.

For families and people using blended diet

Source	What it is for
Blended Diet UK (Facebook group)	Peer support group for tube-fed people and their families. Provides opportunities to share experiences and practical tips. Information shared is not moderated by healthcare professionals and should not replace any individual clinical advice.
The Blended Diet Family Recipe Book (Kelly Kent)	Recipes written by the parent of a tube-fed child.

Newcastle Children's Hospital	Recipes for blended diet.
Sheffield Children's NHS Foundation Trust, library. sheffieldchildrens.nhs.uk	Recipes for blended diets for enteral feeds.
A growing range of ready-prepared blended meals made from 100% real food are available. Some manufacturers supply also provide dedicated storage and connector systems. These products can be readily identified through an online search.	Provides a convenient option when needed and can support a hybrid feeding approach.
PINNT, pinnt.com	Support and advocacy for people on home artificial nutrition. Its guide to travelling with blended food is available to members (Part 11). (need to be a member to access travel booklet with blended diet)

Professional support networks

Use these groups' professional forums to seek advice and supervision where no experienced colleague is available locally (Part 8).

Source	What it is for
BDA Parenteral and Enteral Nutrition Specialist Group (PENG), bda.uk.com/peng	Specialist group for dietitians working in nutrition support. Its virtual Home Enteral Feeding network is a forum to share practice and ask peers for advice.
BDA Paediatric Specialist Group (PSG)	Specialist group for dietitians working with children.
Dietitians Interested in Special Children (DISC)	Network of dietitians working with children with complex needs. Source of the shared decision-making tool adapted in Appendix 4.
BAPEN British Enteral Therapy Alliance (BETA) Special Interest Group, bapen.org.uk	Multiprofessional group for everyone involved in enteral nutrition in adults and children.
UK Community Children's Nursing Network (UKCCNN), qni.org.uk	Network for community children's nurses across the UK, with sub-groups including equipment and consumables, and continuing care.

Inclusion of a source does not imply endorsement of all its content. Where family-facing material predates 2026, the positions in this Toolkit take precedence.

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bapen.org.uk
bda.uk.com