NDIS LWB 5623 HIDPA Enteral Feeding Support – Plan

- This Enteral Feeding Support Plan is to be offered to an Appropriately Qualified Health Professional such as an Accredited Practising Dietitian, to complete, or they may provide their own template.
- Where additional detail is required or not needed, the AQHP can alter the template to suit the Enteral diet of the person we support.
- Staff members must be appropriately trained to provide Enteral Nutrition support in line with NDISC HIDPA requirements.

Personal Details *(to be completed by staff & person we support)*			
Name:		**CIRTS ID:**	
Weight:		**Height:**	
Date of Plan:		**Review Date:**	

Alerts	
Allergies:	
Precautions:	
PRN Medication e.g. EpiPen	*All PRN medication must administered as GP or AQHP recommendations and signed for in the person's Medication Chart*

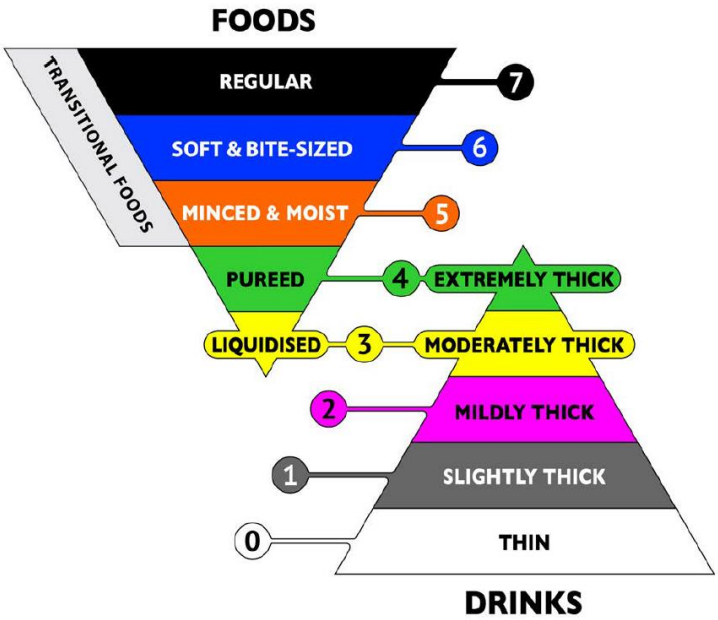
Medications *(to be completed by Health Professional)*	
Special support required to receive medication:	
Water amount given between each medication:	
Administration:	☐ via Peg ☐ Oral
Note: Before giving any medication, refer to the person's Medication Support Plan and Chart for medication preparation, administration and timing	

Enteral Nutrition Support *(completed by AQHP such as an Accredited Practising Dietitian only)*		
Enteral Feeding Procedure:	☐ Bolus Feed ☐ Pump Feed ☐ Gravity Feed	
Nil by Mouth?	☐ Y ☐ N➔	If No, the Oral Intake Section of this plan must be completed.

Enteral Nutrition Support *(completed by AQHP such as an Accredited Practising Dietitian only)*	
Equipment required:	
Delivery route:	
Formula:	
Recipe: *(if making from powder)*	
Rate / volume / breaks / frequency:	
Total volume feed per 24 hours:	
Total calories each day:	
Water flush amount and time:	
Environment:	
Alertness:	
Positioning for enteral feeding – during and after feeds:	
Risks:	
Likes:	
Dislikes:	
Oral care:	
Stoma care:	
Procedure if Tube is dislodged:	
Procedure if Tube is blocked:	
Any other influencing factors to be aware of?	

Person specific support requirements *(To be completed prior to completion/approval by the AQHP)*
Record any information specific to the person's support needs in relation to this plan.

Details about any specific changes or preferences staff must know in order to support the person with this plan: *(This section must be completed by the Health Professional)*
☐ Not Applicable, the person's supports do not require any modification.
☐ Modifications are required as follows:

Oral Intake: *this section must be completed if the person we support also takes food and drink orally. Please also refer to the Preferences section of this plan.*	**N/A** ☐
Foods:	
Fluids:	
Texture Modified Foods or Drinks? ☐N ☐Y if Yes, indicate IDDS Level below ⬇	
IDSSI Level for Foods:	
IDSSI Level for Drinks:	

Equipment and Supply	
Item	**Details of item (name, size, etc.)**
Feeding equipment, tubing, syringes, containers.	

Person's preference for frequency to change of tubing:	

Contact details for food and equipment supply:		
Company:		
Contact person:		
Phone:		
Website:		
Email:		

Photograph

Insert a photo(s) of the person to document:

- safe and appropriate position for tube feeding (and eating orally if applicable)
- equipment required including the use of clothing protectors and aids.

Date photo taken:		**Photo taken by:**	

In the event of an emergency, please contact <u>000</u> plus *Completed by the person we support*			
Name:		**Contact Number:**	
Relationship:			
Name:		**Contact Number:**	

Relationship:	

Plan developed by: *(completed by Health Professional(s))*			
Name:		**Profession:**	
Contact details:		**Date:**	
Name:		**Profession:**	
Contact details:		**Date:**	

Review of Plan	
☐ Set Review:	Date:
Signature:	
☐ As needed review – this plan will be reviewed due to any of the following: • a new problem being identified while following this plan • advice from the person's GP / Appropriately Qualified Health Professional • Other (AQHP to provide details):	
Note: if the person's behaviour, skill levels or needs change, staff must have the person reassessed and plan reviewed by Appropriately Qualified Health Professional.	

Consent and Authorisation

I consent to the support requirements as detailed in this Plan to be implemented to assist in the management of my health supports or receive general emergency response as required. If I am unable to give consent, LWB will seek consent from my guardian/person responsible.			
Name	**Relationship**	**Signature**	**Date**
	Self		
	Guardian / Person Responsible		
	LWB Line Manager		

Upload to CIRTS as follows:

Plans & Assessments > New Plan > Service Type = the service providing the HIDPA > Plan name – [select from drop down] Enteral Nutrition Feeding and Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD