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The use of Blended Diet with Enteral Feeding Tubes

Position Statement (2026)

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The Use of Blended Diet with Enteral Feeding Tubes: Position Statement (2026)

This Position Statement replaces the BDA Policy Statement on the Use of Blended Diet with Enteral Feeding Tubes (2019).

This Position Statement sets out twenty-two evidence statements, drawing on a scoping review of the literature, UK surveys of professionals and of tube-fed people and their families, a series of practice roundtables, invited case studies and correspondence with the Food Standards Agency, each published separately with its own references. Evidence statements describe what is now known; they do not instruct. Fourteen actions follow for healthcare professionals working with tube-fed people. Actions say what should be done in light of the evidence, and are a summary pointing to the accompanying Practice Toolkit (2026). The Toolkit sets out the practice points needed to put these actions into effect.

Evidence statements

1. People have the right to make choices about their own food.

Being tube-fed does not remove that right. Food carries meaning well beyond nutrition, in identity, culture, routine and belonging. The fact that it is delivered through a tube does not change whose decision it is, including the choice of what food or feed to have. Across all four UK nations, adults are presumed able to make their own decisions, including ones which others consider unwise. Where an adult cannot make a particular decision, it must be made according to the framework that applies in that nation, taking account of their wishes, feelings and beliefs. For children, the decision rests with those holding parental responsibility, with the child's own views given weight according to their understanding. Blended diet is therefore not a concession granted to individuals and families who ask persistently enough. It is one legitimate way of exercising a choice which tube-fed people already hold, and which services should be equipped to support.

2. A blended diet is food and drink, blended to a consistency that can pass through a feeding tube.

Blended diet may be used as the sole source of nutrition, or in combination with commercial enteral formula, and alongside eating and drinking by mouth. It is an umbrella term covering a wide range of practice and is best understood as a continuum. At one end, a small amount, for example fruit juice or puree, is given alongside a commercial formula. At the other, blends meet full nutritional requirements. Alternative descriptions remain in use, including homemade formula, liquidised feeds, blenderised food and pureed table food. Because each tube-fed person and their family uses blended diet differently, no single protocol would fit everyone. Guidance therefore describes principles and decision points rather than a single fixed method.

3. Blended diet is used across the lifespan, by children, young people and adults.

Blended diet has been part of UK paediatric practice for over a decade. The BDA first set out a position on it in 2013, and the children whose families were using it then are now moving into adult services. Adult teams are therefore, in many cases, inheriting established, long-standing users rather than initiating a novel practice. The practice roundtables held for this update described blended diet in adult dietetics as roughly where paediatrics stood fifteen years ago. Interest is also growing among adults who begin enteral feeding later in life, particularly in motor neurone disease, head and neck and upper gastrointestinal cancer. Of the professionals responding to the UK professional survey undertaken for this update, 54% worked with adults aged 25 and over. This guidance applies across the lifespan, and adult services should expect to support blended diet as part of routine practice.

4. Tube-fed people and their families consistently describe blended diet as life changing.

The strength of this language is consistent through qualitative research, as well as the surveys and the case studies gathered for this update. Working group members have supported people who described the use of blended diet as transformative. People describe improvement in symptoms, comfort, sleep, growth and family life, and speak of the change holistically. The statements

which follow set out these benefits separately, because that is how evidence is generated and appraised. But that is not how the change is experienced.

5. A blended diet can reduce adverse gastrointestinal symptoms.

Better gastrointestinal tolerance is the most commonly reported outcome in the evidence. It remains the most common reason blended diet is adopted and continued. Reductions in reflux, retching, vomiting and abnormal stools, both diarrhoea and constipation, are described consistently when blended diet is introduced. Evidence published since 2021 extends this to adults and finds the same improvements in routine UK practice as in larger paediatric research cohorts. However, not everyone improves and blended diet will not suit everyone. It is not yet known who benefits most or least, or in which circumstances. This needs further research.

6. Understanding of why blended diet may help is beginning to emerge.

In 2021 there was no evidence to explain why blended diet improves these symptoms. The Practice Toolkit offered two theoretical explanations: thicker blends, and a wider range of fibre. Evidence published since supports both. Blends are measurably more viscous than commercial formula, and fibre intakes on blended diet meet reference values. Gut microbial composition and diversity also differ, and the gut microbiota of children on blended diet looks more like that of their healthy siblings than that of children on commercial formula. None of this proves cause. The effect of the blend is still hard to separate from the changes that come with it, such as bolus delivery. But the improvements families describe now match measurable physical differences.

7. Wider health and wellbeing benefits have been documented.

Alongside the improvement in gastrointestinal symptoms, brighter skin, glossier hair, stronger nail growth, better sleep, greater alertness and improved energy are recurring themes. Improved resistance to common illnesses is also reported. These findings come from qualitative research, from professional experience and from the case studies gathered for this update, in both children and adults. Optimised tolerance, and the improved nutrient absorption which may follow from it, has been offered as an explanation, though no study has measured these outcomes or tested that mechanism directly. Clinicians additionally describe

children established on blended diet requiring less frequent admission and shorter stays in hospital, though the evidence for this is limited.

8. Social and emotional benefits matter as much to tube-fed people and their families.

People fed exclusively by tube are at risk of exclusion from social occasions centred on food. Blended diet allows them to share the same foods as family and friends, and to be included in mealtimes and family routines rather than fed apart from them. Families and professionals alike describe the change as one of normalisation and regained control, with feeding becoming less medicalised. These benefits are frequently central to why blended diet is adopted and continued. Some families may also choose to have blended diet only on special occasions.

9. Blended diet has not been shown to carry greater risk than commercial formula.

The risks most often raised are nutritional inadequacy, tube blockage and microbial contamination. Large prospective cohorts published since 2021 found no increase in stoma site infection, gastrointestinal infection or tube blockage compared with commercial formula, and no increase in hospital presentations or equipment complications. Relative to the size of these cohorts, reports of serious harm are few. They are:

- individual cases of micronutrient deficiency
- one food safety incident
- a signal of symptomatic anastomotic ulceration after whole foods were introduced in children with short bowel syndrome.

The first two points each came down to a specific, avoidable failure.

The risks are real but modifiable. They depend on food choice and safe preparation. Blended diet does not in itself require a formal risk assessment. The purpose of the conversation is to agree what is needed to support the person's choice safely.

10. A blended diet requires more time, equipment and cost for the individual and family than commercial formula.

Preparation, planning and the responsibility fall largely on families, alongside the cost of ingredients, storage containers and a blender, against a commercial formula which is available on prescription through the NHS. Families describe this as acceptable where the benefits feel meaningful. It should be discussed openly at the outset rather than treated as a reason to withhold the option. The initial outlay on equipment can nonetheless be a barrier for families with low incomes. Blender type alone does not determine feasibility. Suitable recipes and adequate blending time matter more than the price of the machine, and domestic blenders can successfully produce feeds which pass through a feeding tube.

11. Use with gastrostomy feeding is well established.

Most of the evidence concerns gastrostomy feeding, and it is the feeding route most commonly used with blended diet. This partly reflects cohort studies having excluded other tube types rather than having compared them. A tube of 12Fr or above is preferable, with a balloon retained device where possible, since these can be changed at home. Narrower tubes are used successfully in practice, and tube size alone should not preclude blended diet. Sieving is preferred to thinning. Adding water reduces viscosity in proportion to the amount added, as does freezing and thawing, and the caution in the 2021 Practice Toolkit, that thinning may negate the benefit attributed to viscosity, still stands. Tube blockage is reported infrequently on blended diet and is usually resolved with water flushes. Blockage is a risk for anyone receiving home enteral tube feeding, most often in association with medication. Everyone receiving tube feeding should have an agreed plan for how nutrition, fluid and medication would be given if a tube is blocked. Use of blended diet with a mature stoma remains the default position, with commercial formula used until then. The reason is that a blocked tube in an unformed tract cannot be changed at home, so the first planned device change is a more meaningful marker than elapsed time alone. Reported practice 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.

12. Other routes and narrower tubes are possible and should be individually assessed.

Blended diet is given via nasogastric and gastro-jejunal tubes in UK practice, reported by 14% and 15% of professionals respectively, though most services still decline nasogastric requests. Long-term use via an 8Fr nasogastric tube is described over four years in one young person, with no blockage attributable to the blend. The blend was sieved, with only a little added liquid since too much water reduces the energy delivered, and it was given by pump. Confidence in these routes is lower than for gastrostomy, reflecting their exclusion from cohort studies as much as any finding against them. Occlusions have been reported with nasogastric and nasojejunal tubes, but in numbers too small to draw inference from. One concern from 2021 remains unanswered: nasogastric tubes are narrower and longer and splitting above the epiglottis could lead to aspiration. No study has measured delivery pressure or tube integrity, and this should be stated when the route is discussed. Gastrostomy remains the preferred route where a choice exists, but a request to use another should not be dismissed outright, since a gastrostomy is not clinically suitable for everyone. Use via these routes depends on feeding plans and troubleshooting advice agreed with the multidisciplinary team, covering blend consistency, rate and flushing. With a gastro-jejunal tube, blends are given via the gastric port only, with the ports clearly distinguished and the regimens written so the two cannot be confused.

13. Post-pyloric use is an exception and should be agreed with the medical team.

Jejunal feeding bypasses the stomach, with its reservoir function, mechanical and chemical processing and acid barrier. Feeds are therefore delivered slowly, and blends may not be tolerated. The first dedicated evidence on this route describes clinicians reporting reduced nausea, vomiting, diarrhoea and pain after moving from commercial formula to blended diet. A case study describes successful use via jejunostomy after full multidisciplinary discussion, with the blend given by pump and the rate and volume increased gradually over several weeks. Professional experience remains rare, reported by 4% of professionals, and clinicians are markedly more cautious about this route than any other. Post-pyloric use should therefore be treated as exceptional. It requires agreement with

the surgical and medical team and clear documentation of what has been decided and why. Where gastric feeding with commercial formula is poorly tolerated, blended diet via a gastrostomy or the gastric port of a gastro-jejunal tube should be considered before moving to jejunal feeding, if needed with a nasojejunal tube while blends are built up.

14. Syringe and pump administration are both in use.

A slow plunge method using a 60ml enteral syringe remains established practice and suits a thicker blend. A gravity bolus requires a thinner blend, which is a reason to prefer the slow plunge method where a thicker blend is tolerated. Pump administration is used by a small minority and is reported by 16% of professionals. For some people it is decisive, allowing volumes to be tolerated which cannot be given by syringe, and it may help those preparing and giving feeds who have reduced dexterity or are at risk of repetitive strain injury. Where a pump is used, the blend consistency must suit the pump and giving set, the manufacturer's instructions should be checked, and the blend should not be kept at room temperature for longer than 2 hours. Pumps do now exist in the UK market which are designed for use with homemade blends and thickened formula. These may require funding outside enteral feeding contracts.

15. Nutritional adequacy is achievable, though dependent on food choices.

Energy and protein requirements can be met on blended diet, but adequacy depends wholly on the food choices made by the person preparing the blend. Many families have educated themselves on nutrition in order to provide balanced blends. Dietetic support should be available so that they are not left to do this alone. A recipe analysis should be treated as an estimate, not a precise measurement: laboratory analysis shows the energy and nutrients delivered are usually lower than calculated. Judge adequacy on clinical and growth monitoring and on the balance of the whole diet, not on the calculation or on energy and protein alone and let clinical concern prompt biochemical review. Vitamin D is the recurring exception to otherwise adequate micronutrient intakes, and supplementation follows national public health guidance. Clinicians also report iron as a concern where blends are the sole source of nutrition, though the largest cohort found iron intakes met reference values. The one case of serious nutritional harm reported since 2021 was vitamin K deficiency presenting as

coagulopathy in a young person on a long-term unsupervised blend. Several other nutrients were also short, so the case points to dietetic oversight of the whole diet, not routine vitamin K supplementation.

16. Everyday food safety, hygiene and storage practices apply to blended diet.

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 in the majority of blends tested. Adherence to time, temperature and cleaning practice is what determines safety, and lapses are the point at which risk arises. Syringes and giving sets may be reused where a standardised cleaning procedure is followed after every use, which challenges the assumption that single use equipment is safer. The cleaning procedure supported is washing preparation and administration equipment in warm soapy water, rinsing and leaving it to air dry, with cleaning method, drying and inspection the determinants of risk.

17. Blended diet is being provided in hospitals, care and education settings.

Provision outside the home is more common and better documented than in the 2021 Practice Toolkit. Children established on blended diet are frequently admitted to hospital because of their underlying conditions, though only around half of hospitals have a supporting guideline. As more adults use blended diet, adult inpatient services will also need guidance. Working UK models exist, including a specialist children's hospital preparing standardised recipes in its own diet kitchen under a trust-wide procedure, a residential service where catering staff cook and blend, and a hospice batch blending in advance. Where an individual is established on blended diet at home, the default position on admission should be that this continues, with any change agreed with them rather than imposed by the admission itself. Recognised exceptions are clinical rather than administrative, and include critical care, immunocompromise, post-pyloric feeding and biochemical instability. Families should nonetheless be advised to keep a contingency plan for circumstances in which blends cannot be given.

18. Barriers outside the home are usually organisational and can be resolved.

Where blended diet is not provided in a school, respite or hospital setting, the obstacle is generally policy, training, staff time or accountability rather than clinical risk. Staff describe willingness conditional on written plans, training and clear responsibility. Families describe attending settings daily to give feeds themselves, and children attending part-time as a workaround. The same barriers dissolve where they are addressed systematically, through a multidisciplinary working group, agreed procedures and training, though approval processes take longer than services expect. Variation between areas should be addressed through local and national policy.

19. Some people will decide blended diet is not for them, and that choice deserves the same support.

Where blended diet is not used, commercial formula remains a wholly legitimate choice. Many tube-fed people tolerate standard commercial formula and have done so for many years. Some may not tolerate blended diet. Some may find the planning, preparation and storage too difficult. Those who decline should receive the same quality of support as those who use blended diet. No workstream undertaken for this update sought the views of people who considered blended diet and decided against it, or who discontinued it, and that gap should be addressed in future work.

20. Hybrid approaches, combining blended diet and commercial formula, are an option.

Many people use blends alongside commercial formula rather than exclusively, and in adults this seems to be the more common pattern. A commercial formula may be used as the liquid base for blends, as an overnight feed, or for particular feeds in settings where blends cannot be given. Preparations which include some commercial formula have been found to meet nutritional adequacy where fully homemade ones sometimes did not. Even one blended meal a day has been described as being beneficial compared with none.

21. Commercially prepared formulas containing real food ingredients now exist.

There is a growing range of commercially prepared enteral formula containing real food ingredients. These products have been manufactured to a fixed specification, have clear nutritional content and are available ready to administer. The evidence exploring their use was excluded from the scoping review undertaken for this update but is adjacent to the literature underpinning these recommendations. They have been reported to reduce reflux, retching and vomiting and to improve bowel habit, even where food-derived ingredients form only a small percentage of the product, though that literature is largely industry funded and should be read with this in mind. They are a useful option but are not a substitute for supporting a person's choice to use home blended diet.

22. Considerable expertise in blended diet exists across the UK, but access to it is uneven.

Of the professionals responding to the UK professional survey, 76% had worked with at least one person using blended diet, but only 48% described themselves as confident. A further 32% needed the support of a more experienced colleague and 8% had no access to one. Awareness of the 2021 Practice Toolkit was high among dietitians (88%) but only 44% among nurses. Provision ranges from services where blended diet is established across the settings children attend, to services where nothing is in place, with variation reported between neighbouring hospitals and between wards of the same hospital. For families, access depends on where they live, and some have paid privately for support or training their own service would not provide.

Actions for healthcare professionals working with tube-fed people

The following fourteen actions follow from the statements above.

Action 1. Seek practical training and supervision when new to blended diet.

Expertise in blended diet exists across the UK, and 48% of survey respondents felt confident or very confident supporting families to use it. Where no experienced colleague is available locally, as 8% report, advice and supervision can be sought through specialist group networks.

Action 2. Offer blended diet as a choice.

Offer blended diet when first discussing enteral tube feeding, rather than waiting to be asked. Tube-fed individuals and their families need the information to decide whether it suits their circumstances, and at present most are not getting it from healthcare professionals: in the public survey undertaken for this update, only 18% first heard about blended diet from a healthcare professional, while 45% heard from other families and 41% found it online.

Action 3. Support people, or those who decide on their behalf, in making choices in relation to blended diet.

Where blended diet is supported within the scope of this guidance, an individual risk assessment is not required and should not be a precondition. This includes the risk assessment template in wide use before 2021. The discussion should produce a plan setting out what has been agreed. The plan should cover the practical matters that determine whether it works:

- who prepares the blends
- food storage and hygiene
- food choices
- how blended diet will be given outside the family home
- what happens on admission to hospital

Record what has been agreed and by whom and revisit it as circumstances change.

Action 4. Train and support families and carers, rather than leaving them to teach themselves.

Families should be taught the practicalities of preparation and administration from the outset, not left to trial and error. Three quarters (76%) report being self-taught in giving blended diet through the tube, and 70% of those starting since 2021. Families and carers should also be partners in training staff in other settings rather than bystanders to it, with joint visits the most effective method described in the roundtables.

Action 5. Support healthy and balanced food choices.

Nutritional adequacy depends on food ingredient choices. Advice should follow government recommendations for the general population, with a variety of foods from each of the main food groups and age-appropriate portions. Not everyone arrives with a working knowledge of nutrition or portion sizes and translating that into practical terms is a core dietetic skill.

Action 6. Support dietary modification depending on the individual's age and medical condition.

How blended diet is introduced depends on feeding history as much as diagnosis. For infants, it should be offered from around six months in line with UK complementary feeding guidance, with common foods that cause allergies introduced alongside other first foods and before twelve months. Older children and adults who have been tube-fed since birth have not been through weaning or been exposed to common foods that cause allergies, so new foods should be introduced one at a time, with monitoring for allergy and intolerance (Toolkit Part 8). Condition-specific modification is possible, for example for a ketogenic diet or intestinal failure.

Action 7. Plan for hydration alongside nutrition.

Fluid requirements should be estimated based on age, weight, medical condition and losses. Water flushes count towards the total fluid intake. Blends may be assumed to contain around 70 to 75% fluid, but that is a starting point only. Assess hydration on output and clinical signs rather than inferring it from intake.

Action 8. Plan how a blended diet is introduced, building volumes and rates up gradually.

Introduction should begin when the person is otherwise medically stable, with a small amount gradually built to tolerance. Replacing one feed at a time, with an interval between changes, allows tolerance to be judged. Most improvement in upper gastrointestinal symptoms appears within the first three months, and support should be most intensive in the early weeks, when small and frequent adjustments are needed.

Action 9. Ensure people are advised on safe food handling, hygiene and storage practices.

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, refrigeration, freezing, defrosting, reheating, labelling and transport. Time spent travelling and stored at school counts as part of the same storage period. Where a setting cannot store or reheat, identify this in advance and agree an alternative (Toolkit Part 7 and Appendix 9).

Action 10. Agree a monitoring plan.

A monitoring plan should be agreed before starting, with parameters and review intervals set in advance. Review should be time-bound, at baseline and at approximately three, six and twelve months, and more often where clinically indicated. Once blends are established, review follows the usual schedule for anyone of the same age receiving home enteral tube feeding. Blended diet is not in itself a reason for more biochemical monitoring, though clinical concern should prompt investigation. Monitoring should include weight, growth, gastrointestinal tolerance, and the tube and stoma site, alongside the outcomes that matter to the person and family. Record who is responsible for requesting and acting on each measure.

Action 11. Signpost people to reliable information about blended diet.

Direct people to this guidance and to peer networks, be clear about which is professionally endorsed, and which is not. Families and clinicians turn to informal sources when official information is hard to find, and a content analysis of 71 YouTube videos on blended tube feeding found attitudes overwhelmingly positive, with most content produced by carers and users rather than professionals. The informal environment is not the problem; the absence of professionally endorsed material within it is. Family-facing professionally endorsed material is needed to fill that gap.

Action 12. Plan transition from children's to adult services.

The first childhood cohorts established on blended diet are now reaching adult services, and 22% of professionals have already supported someone through transition. Some adult teams are reluctant to accept established users without reassessment, despite years of stable use, reflecting unfamiliarity rather than opposition. Joint visits, shared caseloads and mirrored adult and paediatric guidance are all in use and have worked well. Transition should be planned in advance of predictable changes, alongside the change in decision making arrangements as a young person reaches adulthood.

Action 13. Expect to be involved in developing the local policy, training and delegation arrangements.

Responsibility for training staff in education, respite and social care should be explicitly agreed locally and recorded. Local policy on blended diet has been updated by 33% of professionals, and 18% have developed competency training. Agreed competencies and a model policy at national level would prevent every organisation reproducing the same work.

Action 14. Understand and record the resource implications of supporting blended diet.

Services should record how many people on the caseload use blended diet and the resource implications, to inform commissioning. Commercial enteral formula is prescribed and funded; blended diet is not. Families meet the cost of ingredients, equipment and preparation time. Services meet the cost of training, which requires both nursing and dietetic input, is repeated for every new setting, change of staff and transition, and attracts none of the industry nursing support attached to commercial feeding contracts.

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