

Understand disability-related health supports – capital supports

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This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

This article provides guidance for a planner delegate, review officer, planner (non-partnered area) and local area coordinator to understand capital supports for disability-related health needs.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

1 Recent updates

28 July 2025

Technical Advice and Improvement Branch (TAPIB) links updated to the TAPIB Confluence space.

2 Before you start

You have read and understood relevant guidance from:

- [Our Guideline – Disability-related health supports \(external\)](#)
- [Our Guideline – Continence supports \(external\)](#)
- [Our Guideline – Diabetes management supports \(external\)](#)
- [Our Guideline – Dysphagia supports \(external\)](#)
- [Our Guideline – Nutrition supports including meal preparation \(external\)](#)
- [Our Guideline – Podiatry and foot care supports \(external\)](#)
- [Our Guideline – Wound and pressure care supports \(external\)](#)
- [Our Guideline – Creating your plan \(external\)](#)
- [Our Guideline – Justice system \(external\)](#)
- [Our Guideline – Changing your plan \(external\)](#)
- [Guide – Respiratory supports.](#)

You have also read and understood articles:

- [Determine disability-related health supports and meal preparation supports](#)
- [Understand disability-related health supports – core supports](#)
- [Understand disability-related health supports – capacity building supports.](#)

You have:

- checked if the disability-related health support needs advice from the Technical Advice and Practice Improvement Branch (TAPIB) or Children's Taskforce
- received technical advice, if needed, before you include the disability-related health support in the participant's plan.

For more information, go to [TAPIB Requesting Advice](#).

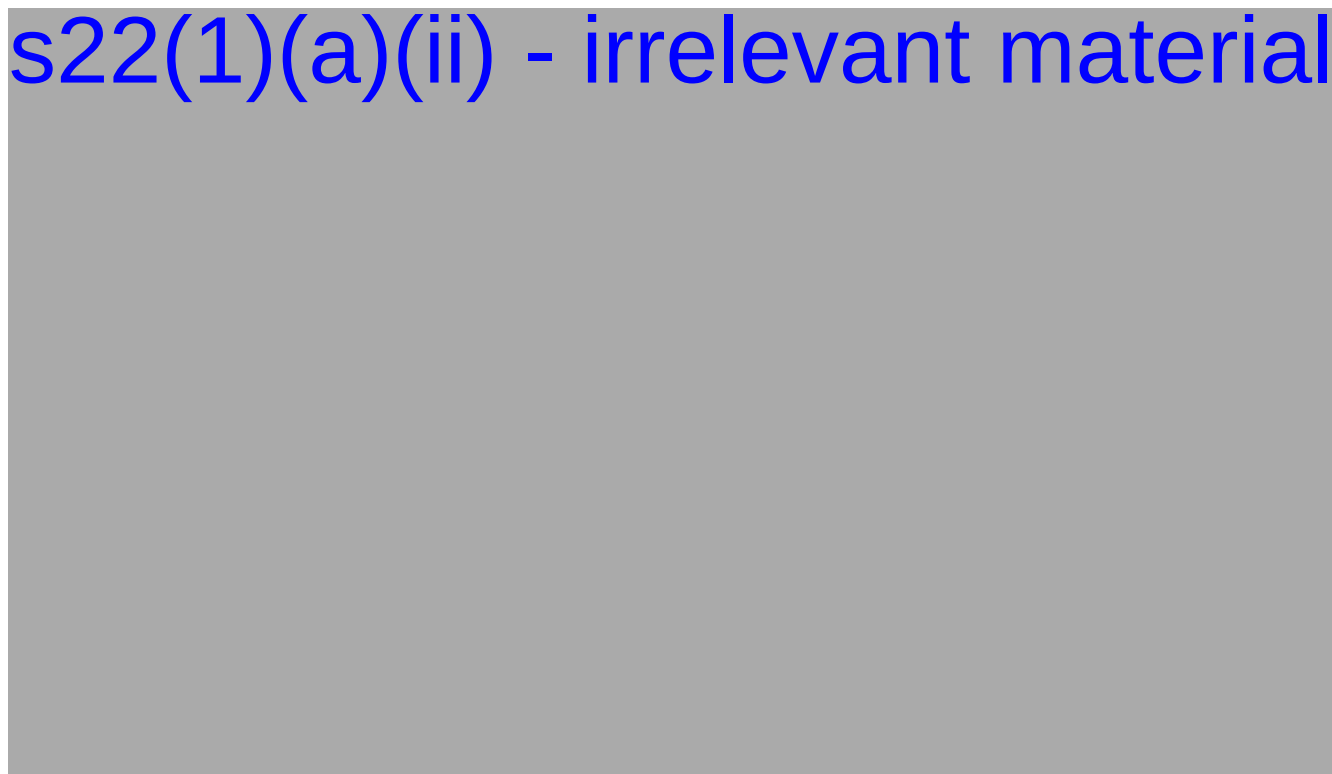
3 Capital supports for disability-related health needs

Use the relevant disability-related health support (DRHS) Our Guideline to work out if capital supports meet the NDIS funding criteria.

The list below outlines the broad type of support and the estimated cost for each of the relevant support categories to include in the participant's plan.

3.1 Wound and pressure care

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4 Next steps

1. Determine what disability-related health supports to include using article [Determine disability related health supports and meal preparation supports](#).
2. To add a funded support in a:
 - **Plan Approval** case, go to article [Change the draft budget](#)
 - **Plan Change** or **Participant Budget Update** case where the plan was approved before 9 October 2024, go to article [Action a budget update](#)
 - **Plan Change** or **Participant Budget Update** case where the plan was approved on or after 9 October 2024, go to article [Action a budget update with funding periods](#).

Understand disability-related health supports – capacity building supports

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This article provides guidance for a planner delegate, review officer, planner (non-partnered area) and local area coordinator to understand capacity building supports for disability-related health needs.

This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.

1 Recent updates

24 November 2025

Guidance updated to add link to Our Guideline – Therapy supports and article Understand therapy supports.

2 Before you start

You have read and understood relevant guidance for:

- [Our Guideline – Disability-related health supports \(external\)](#)
- [Our Guideline – Therapy supports \(external\)](#)
- [Our Guideline – Creating your plan \(external\)](#)
- [Our Guideline – Changing your plan \(external\)](#).

You have also read and understood articles:

- [Guide – Respiratory supports](#)
- [Determine disability-related health supports and meal preparation supports](#)
- [Understand disability-related health supports – core supports](#)
- [Understand disability-related health supports – capital supports](#)
- [Understand therapy supports](#).

You have:

- checked if the disability-related health support needs advice from the Technical Advice and Practice Improvement Branch (TAPIB) or National Early Childhood (NEC) Branch
- received technical advice, if needed, before you include the disability-related health support in the participant's plan.

For more information, go to [TAPIB Requesting Advice](#).

3 Capacity building supports for disability-related health needs

Use the relevant disability-related health support (DRHS) Our Guideline to work out if capacity building supports meet the [NDIS funding criteria \(external\)](#).

The list below outlines the broad type of support and the estimated hours for each of the relevant support categories to include in the participant's plan.

3.1 Nutrition

3.1.1 Improved daily living skills

- Nursing hours for a Registered Nurse (RN) to train a support worker in the individualised needs of the participant's percutaneous endoscopic gastrostomy (PEG) maintenance and care. To calculate the nursing hours, go to article [Determine disability-related health supports and meal preparation supports](#).

Note: PEG general maintenance and care is a standard competency skill expected of disability support workers. The NDIS won't fund training for staff to attain basic competency. It's the responsibility of a provider to employ suitably qualified staff with these basic level competencies.

- Nursing consultation to develop a PEG maintenance care plan. This plan will inform the daily management and care of the PEG and surrounding tissue and the enteral feeding regime by the instructing dietitian. To calculate the nursing hours, go to article [Determine disability-related health supports and meal preparation supports](#).

3.1.2 Health and Wellbeing

Dietitian hours for standard nutrition plan, including:

- initial consultation, assessment, and report: 2 hours
- development of the plan: 1 to 2 hours
- reassessment: 2 hours
- training 2 to 3 family members or support workers specific to the participant's individual nutritional needs: 1 to 2 hours of training once per year (more often if the nutritional plan is updated).

Dietitian hours for complex nutrition plan, for example, enteral feeding plan, including:

- initial consultation and assessment: 2 to 3 hours
- report and development of the plan: 2 to 5 hours

Note: 2 hours for full enteral feeding, stable nutritional status, and constant feeding regime. 5 hours for a combination of enteral feeding and oral feeding, unstable or declining nutritional status and changes to the feeding regime in terms of formula type and pattern.

- reassessment depending upon the above varying factors: 2 hours.

Create a technical advice case if the participant asks for more than 20 hours per year for assessment and development of a meal plan. To learn more, go to article [Create a technical advice case](#).

Learn more in [Our Guideline – Nutrition supports including meal preparation \(external\)](#).

3.2 Wound and pressure care

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3.3 Podiatry and foot care

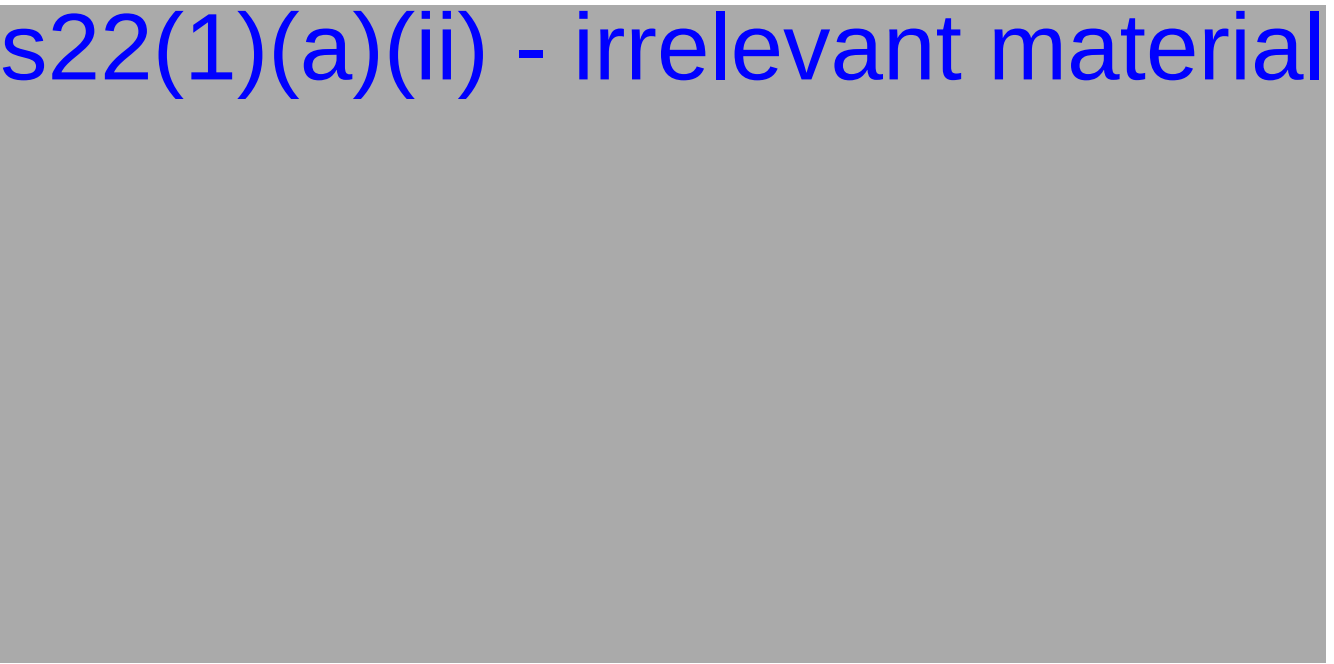
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3.4 Dysphagia

s22(1)(a)(ii) - irrelevant material

3.5 Diabetes

s22(1)(a)(ii) - irrelevant material



4 Next steps

1. Determine what disability-related health supports to include using article [Determine disability-related health supports and meal preparation supports](#).
2. To add a funded support in a:
 - **Plan Approval** case, go to article [Change the draft budget](#).
 - **Plan Change** or **Participant Budget Update** case:
 - go to article [Action a budget update with funding periods](#), if the plan has funding periods
 - go to article [Action a budget update](#), if the plan doesn't have funding periods.

Average cost and consumption of Home Enteral Nutrition formula

The content of this document is OFFICIAL.

Please note:

This document is intended to assist Technical Advice and Practice Improvement Branch (TAPIB) staff with provision of technical advice or practice improvement activities. Branch Manager clearance is required before research documents are shared outside the branch.

The TAPIB Research and Capability team take care to ensure the research presented is accurate at the time of writing. Due to the nature of our work, we are not able to ensure that all relevant research has been considered in the development of this document or that information remains accurate after publishing.

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2. Summary

This paper reports on research into average prices and consumption of Home Enteral Nutrition (HEN) formula in Australia. We did not find any published, evidence-based estimates of typical or recommended HEN formula volumes for different age groups, activity levels or health condition.

Based on the Australian Bureau of Statistics' estimated per person per day energy intake of 8703 kilojoules, a person requiring HEN formula as their sole source of nutrition could pay around \$33.27 per day.

Based on estimates we derived from Australia government nutritional guidelines and HEN formula retailers, a moderately active adult requiring HEN formula as their sole source of nutrition could pay between \$35 and \$44 per day for standard formula.

The cost estimates detailed below are based on the needs of someone requiring HEN formula as their sole source of nutrition. These estimates will not apply if a person requires HEN as only part of their diet.

The volume and type of formula that a person uses should always be guided by a qualified health professional, such as a dietician or nutritionist.

3. Current HEN formula guidance under the NDIS

As of March 2025, the **Core supports for disability-related health needs** knowledge article states, "Enteral feeding formula of up to \$23.66 per day can be included at the budget level for full or partial feeding if not covered by the Pharmaceutical Benefits Scheme".

The standard operating procedure **Include disability-related health supports or meal preparation supports in the participant's plan** states, "Up to \$23.66 per day can be included at the budget level for full or partial HEN feeds if not covered by the Pharmaceutical Benefits Scheme". This standard operating procedure is no longer in use. It was last edited July, 2023.

4. Consumer Price Index and apparent consumption

Average dietary energy consumed in the 2022-23 financial year was 8703 kilojoules per person per day. This was reduced 3.7% from 2021-22. Furthermore:

Overall lower estimates of consumption in 2022-23 compared with previous years may be associated with recent food price inflation. In the two years to June 2023, the cumulative Consumer Price Index (CPI) increase for food and non-alcoholic beverages totalled 13.9% compared with a 4.9% cumulative increase over the three years prior (2018-19 to 2020-21) (ABS, 2024).

The latest release of the Consumer Price Index states food costs have risen 3% from December 2023 to December 2024 (ABS, 2025).

5. Consumption of HEN formula

We did not find any published, evidence-based estimates of typical or recommended HEN formula volumes for different age groups, activity levels or health conditions.

We estimate the cost per day of HEN formula for people who depend on this product for all of their nutritional intake by comparing the average cost of a selection of HEN formula products with the recommended dietary energy needs of different cohorts.

The cost estimates below will not apply if a person requires HEN as only part of their diet.

The volume and type of formula that a person uses should always be guided by a qualified health professional, such as a dietician or nutritionist.

5.1 Estimated dietary energy needs by age, gender and activity levels

The values in the table below are based on reference values provided by the National Health and Medical Research Council (NHMRC, 2022). More detailed estimates of daily dietary energy needs can be found at [Eat For Health](#) or by using the [Daily energy requirements calculator](#).

The estimated dietary energy needed per day for an individual varies by many factors including age, height, weight, gender and activity level. NHMRC reference values vary by month for children under 2 years and by year for children 2 to 18 years. [Table 1 Estimated daily energy needs for infants by age and gender](#) presents these reference values for infants at 1, 6, 12 and 24 months. [Table 2 Estimated daily energy needs by age, gender and activity level](#) presents daily energy need estimates for adults averaged for heights (1.5-2 metres), weights (49.5-88 kilograms) and ages (19-50 years). For children 2 – 18, daily energy needs are not averaged but sample ages are selected:

- Preschooler – 4 years
- School-age – 9 years
- Adolescent – 15 years.

Values for each age group (except infants) are shown based on gender and activity level. Activity levels are defined:

- Inactive – bed rest or very sedentary behaviour, physical activity level 1.2 – 1.4
- Moderately active – light or moderate activity, physical activity level 1.6 – 1.8
- Very active – heavy or vigorous activity, physical activity level 2.0 – 2.2.



Research paper

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Table 1 Estimated daily energy needs for infants by age and gender

Age (months)	Male (kj)	Female (kj)
1	2000	1800
6	2700	2500
12	3400	3200
24	4400	4200

Table 2 Estimated daily energy needs by age, gender and activity level

Age	Inactive (av. kj)	Moderately Active (av. kj)	Very Active (av. kj)
Preschooler (4 year old male)	4800	6250	7200
Preschooler (4 year old female)	4450	5800	7150
School age (9 year old male)	6350	8300	10200
School age (9 year old female)	5950	7750	9550
Adolescent (15 year old male)	9200	11900	14700
Adolescent (15 year old female)	7650	10000	12300
Adult (19-50 year old male)	8850	11550	14300
Adult (19-50 year old female)	7100	9300	11500

5.2 Cost and dietary energy of HEN products

[Table 3 Dietary energy and average cost of adult HEN formulas](#) shows the average cost (AUD) and kilojoules per litre of a selection of adult HEN formula products. We calculated the average cost for each product using the advertised costs of between 3 and 7 online retailers per product. Where possible, we based the costs on liquid, “ready-to-hang” formulations. In some cases, we could only locate price information for powdered versions of the formula.

A wide variety of HEN formula products are listed on the Pharmaceutical Benefits Scheme and therefore available at a substantial discount (Department of Health and Aged Care, 2025). For comparison, [Table 4 Dietary energy and average cost of paediatric HEN formulas](#) shows the average unsubsidised cost and kilojoules per litre of a selection of HEN formula products intended for children.

Table 3 Dietary energy and average cost of adult HEN formulas

(Alphamedical Solutions, n.d. a-d; Avacare Medical, n.d.; Brightsky, n.d. a-f; Incontinence Products, n.d. a-e; Independence Australia, n.d. a-e; Joya Medical Supplies, n.d. a-b; Nutricia, n.d.; Medacart, n.d.; Medexline, n.d.; Medisa, n.d.; Medyplus, n.d.; Superior Healthcare, n.d. a-b; Super Pharmacy Plus, n.d.)

Product	Type	Average \$/L	kJ/L
Osmolite 1.0kcal	Standard	15.85	4184
Ensure Plus 1.5kcal	Standard	15.9	6276
Nutrison 1.0kcal	Standard	16.14	4184
TwoCal HN 2.0kcal	Standard	22.58	8368
Nutren Diabetes 1.0kcal	High Protein	25.9	4184
Perative 1.3kcal	Hydrolysed (Semi-Elemental)	28.8	5486
Vivonex TEN 1.0kcal	Elemental (Fully Hydrolysed)	32.67	4184
Jevity 1.0kcal	Fibre-enriched	17.38	4184
Nutrison Multifibre 1.2kcal	Fibre-enriched	14.96	5020

Table 4 Dietary energy and average cost of paediatric HEN formulas

(Abbot, n.d.; Alphamedical Solutions, n.d. e-f; Brightsky, n.d. g-k; Chemist Direct, n.d.; Chemist Warehouse, n.d. a; David Jones Pharmacy, n.d.; Independence Australia, n.d f-h; Incontinence Products, n.d. f-g; Joya Medical Supplies, n.d. c-f; Medyplus, n.d. b; Nestle Health Science, n.d.; Pharmacy Direct, n.d.; Superior Healthcare, n.d. c-d; Surgical House, n.d.)

Product	Type	Average \$/L	kJ/L
Pediasure 1.0 kcal	Standard	14.34	4184
Nutrini 1.0 kcal/ml	Standard	23.95	4184
Pediasure Plus 1.5kcal	High Protein	23.21	6276
Peptamen Junior 1.0 kcal	Hydrolysed (Semi-Elemental)	29.7	4184
Nutrini Peptisorb 1.0kcal	Hydrolysed (Semi-Elemental)	32.79	4184
Neocate Junior 1.0 kcal	Elemental (Fully Hydrolysed)	30.05	4184

5.3 Estimated daily cost of HEN formula as the sole source of nutrition

Based on the estimated average per person daily energy intake of 8704 kilojoules (as noted in section [4. Consumer price index and apparent consumption](#)), the average daily cost for a standard HEN formula would be around \$33.27.

[Table 5 Estimated cost per adult per day of HEN products by gender, activity level and type of formula](#) and [Table 6 Estimated cost per child per day of HEN products by age, gender, and activity level](#) offer more detailed estimates based on estimated dietary energy needs described in section [5.1 Estimated dietary energy needs by age, gender and activity levels](#) and average prices of retail HEN formula products described in [5.2 Cost and dietary energy of HEN products](#). Pricing for the type of formula in Table 7 is average of price of different products of that type. Pricing for formula in Table 8 is based on the standard paediatric formula for Preschoolers and School Aged children. For adolescents, pricing is based on the average of all the adult formulas.

Table 5 Estimated cost per adult per day of HEN products by gender, activity level and type of formula

Formula Type	Inactive Male	Moderately Active Male	Very Active Male	Inactive Female	Moderately Active Female	Very Active Female
Standard (1.0)	33.84	44.17	54.68	27.15	35.56	44.17
Standard (1.5)	22.56	29.44	36.46	18.10	23.70	29.44
Standard (2.0)	23.90	31.19	38.62	19.17	25.12	31.19
Elemental (Fully Hydrolysed)	69.17	90.27	111.76	55.49	72.68	90.27
Fibre-enriched	33.00	43.06	53.32	26.47	34.67	43.06
High Protein	46.96	61.28	75.87	37.67	49.34	61.28

Formula Type	Inactive Male	Moderately Active Male	Very Active Male	Inactive Female	Moderately Active Female	Very Active Female
Hydrolysed (Semi-Elemental)	46.46	60.63	75.07	37.27	48.82	60.63

Table 6 Estimated cost per child per day of HEN products by age, gender, activity level

Age group	Inactive Male	Moderately Active Male	Very Active Male	Inactive Female	Moderately Active Female	Very Active Female
Preschooler	16.45	21.42	24.68	15.25	19.88	24.51
School age	21.76	28.45	34.96	20.39	26.56	32.73
Adolescent	48.33	62.51	77.22	40.19	52.53	64.62

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Blenderised Tube Feeds

The content of this document is OFFICIAL.

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The TAPIB Research and Capability team take care to ensure the research presented is accurate at the time of writing. Due to the nature of our work, we are not able to ensure that all relevant research has been considered in the development of this document or that information remains accurate after publishing.

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2. Summary

Blenderised tube feeds have recently gained popularity as an alternative to commercially manufactured enteral formulas. Blenderised feeds can be made commercially, at home or in a hospital setting. They may relieve some gastrointestinal and respiratory symptoms experienced by patients on enteral feeds who consume commercially manufactured enteral formulas. Blenderised tube feeds may also increase the bacterial diversity of the gut. However, these feeds have a higher risk of microbial contamination and must be prepared and administered according to specific guidelines to decrease the risk of tube clogging and longer hang times, and to ensure adequate nutrient consumption by the patient.

Blenderised tube feeds are contraindicated for some cohorts and should only be implemented under the supervision of a qualified clinician and dietitian. The Australian Society of Parenteral and Enteral Nutrition states that blenderised tube feeds can be used as a sole source of nutrition on the conditions that the patient is able to maintain nutritional status (and growth in children), the recipes used meet all nutritional requirements, and the patient is regularly monitored by a dietitian.

Given that ingredients used in home-prepared blenderised tube feeds vary considerably, we were not able to find up-to-date information on the average costs of such feeds in the Australian context. However, there is evidence that Australian commercial blenderised tube feeds tend to be more expensive than commercially manufactured enteral feeds available for purchase in Australia.

The evidence base for the efficacy of blenderised tube feeds is growing. However, there is still a lack of high-quality studies that utilise control groups, randomisation and standardised procedures within diverse cohorts. Inconsistencies in recipe formulation and assessment tools also make it difficult to generalise study results.

3. Blenderised Tube Feeds

Blenderised tube feeds (BTFs) refers to whole or pureed foods that are blended and delivered through a feeding tube (Breik et al., 2025; Lampone et al., 2023). Blenderised feeding was widely practised until the 1970s when it was replaced by commercially manufactured enteral formulas (CMFs) as CMFs were considered to have more consistent nutrient profiles, a lower risk of microbial contamination, and to be less labour-intensive during preparation and administration (Weston et al., 2025, p. 2). Recently, BTFs have gained popularity, and studies examining the benefits and risks of BTFs use are on the rise (Weston et al., 2025, p. 1). However, according to Weston et al. (2025, p. 1), the growth in interest and demand for using BTFs has outpaced the availability of robust evidence-based literature that adequately informs the efficacy, indications, monitoring, and outcomes of BTFs.

The consensus opinion of the Australian Society of Parenteral and Enteral Nutrition (AuSPEN) is that BTFs can be used as a sole source of nutrition on the conditions that the patient is able

to maintain nutritional status (and growth in children), the recipes used meet all nutritional requirements, and the patient is regularly monitored by a dietitian (AuSPEN, 2021, p. 6). The AuSPEN consensus statement also contains several guidelines for the use of BTFs. These are discussed in [section 5](#) below.

BTFs that are made commercially are referred to as commercial blenderised tube feeds (CBTFs) or commercial blenderised enteral formulas (CBEFs) (see Steel et al., 2023 for the latter). BTFs that are made in the home or hospital are called home/hospital-prepared blenderised tube feeds (HBTFs) (Weston et al., 2025). Throughout this research paper, we stipulate BTFs as CBTFs or HBTFs if this distinction was used in the original source. If no distinctions was made, we refer to them as BTFs.

4. Blenderised Tube Feeds vs Commercial Manufactured Enteral Formulas

There are a number of studies exploring the benefits and adverse effects of BTFs as compared to CMFs. However, the available evidence is of low certainly due to methodological limitations. These limitations include the lack of a standardised BTF definition across studies, inconsistencies in recipe formulation and nutritional equivalence, and the absence of validated tools to assess outcomes such as nutritional status or quality of life (Breik et al., 2025, p. 7). There is also a need for more randomised studies with control groups including more diverse patient demographics, varieties of BTFs, and medical conditions. Previous work has relied heavily on retrospective and uncontrolled observational studies (Weston et al., 2025, pp. 1/3/6). These limitations make it difficult to draw unequivocal conclusions about the potential impact of different varieties of BTFs in different cohorts.

4.1 The Benefits of Blenderised Tube Feeds

Patients on enteral feeds can develop recurring feeding intolerance, postprandial gagging, retching and dumping symptoms, chronic cough, aspiration pneumonia and may experience frequent hospitalisations for respiratory illnesses (Weston et al., 2025, p. 6). There is evidence from children and young adult populations that switching from CMFs to BTFs can have a positive effect on gastro-intestinal (GI) symptoms such as reflux symptoms, oral feed aversion, gagging, heartburn, vomiting, nausea, diarrhoea, constipation, and abdominal pain and distention (Joosten & Niseteo, 2025, p. 24; Murayi et al., 2025, p. 508; Phillips & Coad, 2023, p. 3; Weston et al., 2025, p. 6). There is also evidence of decreased frequency of hospitalisation for respiratory disease in association with the transition to BTFs (Schmitz et al., 2022, pp. 4/7; Weston et al., 2025, p. 6). The transition from CMFs to HBTFs in particular has also been associated with increased bacterial diversity in the gut (Weston et al., 2025, p. 6).

However, some studies have shown that diarrhoea may worsen in a small number of patients after moving to CBTFs (see Phillips & Coad, 2023, p. 3 and Velly Miguel & Haubrick, 2023, p.

1213). There are also mixed reports on the effect of BTFs on constipation and gas (see Velly Miguel & Haubrick, 2023).

In children, BTFs have been associated with social benefits such as the use of real foods, having more meal choices, the ability to avoid certain ingredients, better psychosocial interactions of the whole family, and improved emotional wellbeing and quality of life perceptions (Joosten & Niseteo, 2025, p. 24). A high frequency of family satisfaction with both HBTFs and CBTFs was also found in an integrative review by Schmitz et al. (2022).

Caregivers of children on enteral nutrition have also reported improvements in children's growth and GI symptoms as the key benefits of HBTFs (Breik et al., 2025, p. 6). Other benefits of BTFs according to caregivers include being able to cater for family and cultural dietary preferences, being able to avoid allergens, improved quality of life perceptions, and feeling empowered via direct involvement in meal preparation (Weston et al., 2025, p. 5).

Studies on the effects of BTFs in adult populations are fewer. A 2024 systematic review by Breik et al. found evidence of a clinically relevant reduction in diarrhoea with a low level of certainty in adults receiving BTFs. Other outcomes such as weight, arm circumference, body mass index (BMI) and tube blockages were associated with inconclusive findings and a very low level of certainty of evidence. Another 2023 systematic review by Schultz and Kim found similar evidence of improvement in diarrhoea but also found that BTFs did not pose a higher risk for deterioration in anthropometric measures. A 2015 study on 55 adults found significantly less reported nausea, vomiting, bloating, diarrhoea and constipation with the use of HBTFs as compared to commercial enteral nutrition (see Hurt et al.). Similar results were found in a study including 51 adolescents/adults by Steel et al. (2023) which found that those prescribed a CBEF diet after discharge from hospital experienced significantly lower rates of constipation, nausea and vomiting compared to before their hospitalisation. Adult patients have reported a range of benefits associated with consuming HBTFs rather than CMFs. These include better GI tolerance, the use more natural foods and being able to consume similar meals to family members (Weston et al., 2025, p. 5).

AuSPEN also acknowledges that BTFs may provide some benefits to patients including improved feeding tolerance, quality of life and satisfaction (2021, p. 4).

4.2 Adverse Effects and Challenges

4.2.1 Administration

There are several challenges associated with the administration of BTFs. BTF formulas may have increased viscosity and thickness compared to CMFs. While this may improve clinical symptoms such as reflux, it also presents an increased risk of tube clogging and incomplete delivery, especially when BTFs are delivered by fusion pumps (AuSPEN, 2021, p. 4; Weston et al., 2025, pp. 6-7). Blockages may lead to longer hang times (Joosten & Niseteo, 2025, p. 24). Longer hang times can be associated with a higher risk of microbial infection (see [section 4.2.2](#) below for more information).



Attention should be paid to the viscosity of the BTF formula, the size of the delivery tube and the delivery method (manual/gravity bolus or infusion by enteral feed infusion pump). A G-tube size that is at least 14 French (Fr) is recommended for BTFs to prevent clogging and ensure safe administration. There is conflicting evidence as to the frequency and severity of tube blockages and the role of tube size in administering BTFs. This suggests that the specific type of BTF formula being used affects these variables (Phillips & Coad, 2023, pp. 3-4; Weston et al., 2025, p. 7).

The International Dysphagia Diet Standardization Initiative (IDDSI) Syringe Flow Test can be used to determine the thickness of liquid with ratings including “thin liquids,” “slightly thick,” “mildly thick,” and “moderately thick.” Liquids that are classified as moderately thick may need to be diluted for ease of administration although this may affect the clinical benefits present in liquids with higher viscosity. Moderately thick liquids can be administered using O-ring syringes, large bore gravity bags, or reusable tube feeding pouches (Weston et al., 2025, p. 7).

Viscosity and thickness of HBTFs are affected by fluid content of ingredients, storage practice, immediate use and particle size. Freezing and thawing changes velocity unpredictably. Smaller particle size can be achieved via longer blend time and higher blend wattage. Sieving can also be used but this decreases the nutritional value through nutrient loss in the sieve (Weston et al., 2025, pp. 7-8).

4.2.2 Microbial Contamination

An increased risk for microbial contamination is cited as one of the reasons for the preference of CMFs over HBTFs (Phillips & Coad, 2023, p. 3; Weston et al., 2025, p. 8). As discussed above in [section 4.2.1](#), the increased viscosity of HBTF formulas may result in longer hang times, more frequent clogging and the need for flushing which, in turn, may increase hang times. The risk of microbial contamination of HBTFs is generally higher when the temperature is higher and when the hang time is longer than two hours (less if the temperature is higher) (Weston et al., 2025, p. 8). AuSPEN recommends the hang time of BTFs at room temperature should be less than 2 hours (AuSPEN, 2021, p. 5). The risk of infection due to contamination is also present due to the preparation of HBTFs in non-sterile environments (AuSPEN, 2021, p. 4).

Quick administration (e.g. bolus administration), immediate cleaning of all reusable equipment according to the manufacturer's instructions, and the use of pasteurised shelf milk, canned source of protein, and frozen fruits and vegetables can significantly reduce microbial contamination rates (Weston et al., 2025, p. 8).

4.2.3 Nutritional Adequacy

While CBTFs and CMFs are standardised in their nutrition composition, HBTFs vary greatly in their nutritional composition based on the ingredients and recipes used when preparing them (Phillips & Coad, 2023, p. 3; Weston et al., 2025, p. 6). There is some preliminary evidence that patients can experience weight gain and increased BMIs while using HBTFs and CBTFs (see Germán-Díaz et al., 2024, Schultz & Kim, 2023 and Spurlock et al., 2022). However, a



lack of consistency and transparency in types of CBTFs and HBTFs used makes these studies hard to compare. In a study on children and young adults up to 26 years of age, Orel et al. (2018) found that even a professionally planned pureed food diet is less effective than CMFs in terms of nutritional rehabilitation of malnourished patients. It is also possible that energy intakes increase when individuals begin to consume HBTFs. This may be because of the thermal effect of using whole food ingredients or a change in digestion due to increased microbiome diversity (Weston et al., 2025, p. 6). CMFs may be the preferable option for managing severe malnutrition (Weston et al., 2025, p. 7).

There is also a risk that the use of ingredients with antinutritional factors (e.g. glucosinolates, trypsin inhibitors, hemagglutinins in legumes, tannins in cereals etc) may interfere with nutritional uptake. Some herbal extracts may also cause drug-nutrient interaction in patients (Weston et al., 2025, pp. 6-7).

For these reasons, reputable sources must be used when preparing HBTF formulas to ensure adequate amounts of macronutrients, micronutrients, electrolytes and adequate fluid intake to avoid malnutrition and impaired growth (AuSPEN, 2021, p. 4; Weston et al., 2025, p. 6). Additionally, a dietitian or a clinician with expertise in caring for the nutritional needs of medically complex patients is essential for nutritional assessment, nutrient prescription, and monitoring of nutritional outcomes in patients on BTFs (Weston et al., 2025, p. 7). Long-term monitoring of BTF consumption at least quarterly or at a frequency suitable for the patient's age and nutrition status must be carried out (Weston et al., 2025, p. 8).

4.2.4 Clinicians

There is the need for consultation with an appropriate clinician when using BTFs (discussed above in [section 4.2.3](#)). However, research has shown that while clinicians are interested in BTFs, they often feel that they lack the knowledge and training in this area (Weston et al., 2025, p. 6). This tendency was confirmed for Australian clinicians in a 2024 study by Reily et al. The authors conducted a cross-sectional survey of 89 health professionals and identified key barriers to supporting BTFs as clinician time constraints, resource limitations, and the absence of formal guidelines. Other clinician concerns include increased risk of infection (discussed above in [section 4.2.2](#)) and facility-related restrictions on preparing HBTFs (Weston et al., 2025, p. 5).

4.3 Cost

There is a high time burden associated with buying ingredients, preparing and storing HBTF formulas and infection avoidance practices (AuSPEN, 2021, p. 4; Weston et al., 2025, p. 8). The requirement of a high-powered blender also constitutes a financial cost in addition to the cost of ingredients (AuSPEN, 2021, p. 4).

We did not find any information providing estimates of the cost of producing HBTF formulas in Australia. This is likely due to the fact that HBTF recipes and ingredients differ between families, and different combinations of ingredients for HBTFs result different overall prices.

More information about the cost of BTFs and CMFs in Australia is presented in [section 4.4](#) below.

Some research has been conducted on the cost of HBTFs formulas or similar dietary interventions (e.g. pureed by gastronomy tube (PGBT)) outside of the Australian context (see Mezzomo et al., 2021 and Pentiuik et al., 2011). Results showed that HBTFs or equivalents can be more economical than commercial enteral formulas but are generally lower in micronutrients (Mezzomo et al., 2021, p. 393).

4.4 Australian Commercial Blenderised Tube Feeds and Commercially Manufactured Enteral Formulas

Blended by Sarah and *Whole Enteral* are both Australian brands selling commercially sterile wholefood formulas (Blended by Sarah, 2025; Whole Enteral, n.d.b). Please note that *Whole Enteral* is currently updating their formula and stock is not available for sale.

To provide an overview of the cost and nutritional density of *Blended by Sarah* and *Whole Enteral* products, and various CMFs in Australia, information was collected about the cost, caloric density, and protein, fat and carbohydrate content per 100mL from four *Blended by Sarah* products, the *Whole Enteral Enrich* product and three CMFs. This overview is presented in [Table 1](#).

Table 1 Australian BTF and CMF Characteristics

Feed Type	Cost/ 100mL	Calories/ 100mL	Protein/ 100mL	Fat/ 100mL	Carbohydrates/ 100mL
Blended by Sarah: Pork and Oats * *Not intended as a sole source of nutrition	\$5.36	112.50kcal	3.71g	7.14g	8.57g
Blended by Sarah: Chicken * *Not intended as a sole source of nutrition	\$5.36	128.93kcal	6.43g	6.07g	12.50g
Blended by Sarah: Cherry Cacao * *Not intended as a sole source of nutrition	\$5.36	125kcal	3.29g	5.29g	10.61g

Feed Type	Cost/ 100mL	Calories/ 100mL	Protein/ 100mL	Fat/ 100mL	Carbohydrates/ 100mL
Blended by Sarah: Vegetarian * *Not intended as a sole source of nutrition	\$5.36	114.29kcal	3.71g	4.29g	15.71g
Whole Enteral Enrich * *No information given on suitability as a sole source of nutrition	\$3.50	116.50kcal	5.97g	4.7g	11.50g
ISOSource 1.5 CAL * (CMF) *Suitable as a sole source of nutrition	\$2.26	148kcal	6.80g	5.92g	17.60g
NOVASOURCE GI Forte * (CMF) *Suitable as a sole source of nutrition	\$2.87	155kcal	6.0g	5.90g	18.30g
Nutrison * (CMF) *Suitable as a sole source of nutrition	\$1.10	100kcal	4.0g	3.90g	12.30g

The table above shows that *Blended by Sarah* products are more expensive than the *Whole Enteral* product and the three types of CMF analysed. *Blended by Sarah* products have comparable amounts of caloric density, protein, fat and carbohydrates to the *Whole Enteral* and CMF products. *Blended by Sarah* products are not intended as a sole source of nutrition, whereas the CMF products are suitable as a sole source of nutrition. It is unclear whether the *Whole Enteral* product is suitable as a sole source of nutrition. Information from the product's website states it is "designed as a meal replacement" and the team has "worked hard to ensure that Enrich meets the recommended Australian Dietary Guidelines for carbohydrates, protein, fat, vitamins and minerals for children aged 12 months to adults" (Whole Enteral, n.d.a).

4.5 Specific Cohorts

4.5.1 Age

AuSPEN (2021, p. 5) recommends BTFs only for children over 12 months. The choice of formula for children aged over 1 year should be based on their growth status, underlying disease and GI tolerance (Weston et al., 2025, p. 7).

More studies are emerging examining the effect of BTFs on infant, child and young adult populations. However, more studies are needed to further understand how BTFs affects clinical outcomes in sub-populations within paediatrics (Allen et al., 2024, p. 520).

4.5.2 Contraindications

HBTFs via post-pyloric delivery are inappropriate as this method of delivery requires slow continuous administration, small diameter enteric feeding tubes, and preference for isotonic feeds (see [section 4.2](#) on why slow administration and smaller tubes are not appropriate for BTFs) (Weston, 2025, p. 8). HBTFs are also not appropriate for individuals with a jejunostomy. According to Weston et al. (2025) “distal jejunal delivery of nutrients activates the ileal brake, which increases secretion of peptide YY and glucagon-like peptide 1 that have the physiological effect of inhibiting exocrine pancreatic enzyme synthesis leading to increased risk for maldigestion and malabsorption” (p. 8).

There is some evidence that disease and symptom remission of Crohn’s disease may involve inducing lower diversity in the gut microbiome via exclusive enteral nutrition therapy with CMFs (Weston et al., 2025, p. 6). For this reason, BTFs that increase diversity in the gut microbiome may be unsuitable for such patients.

Children with short bowel syndrome associated with the surgical anatomy of ileal-colonic anastomoses may experience a higher risk of developing anastomotic ulcer disease. If such patients are consuming whole foods and fibre via BTFs, they should be monitored for the potentially increased risk of developing bacterial overgrowth and inflammation (Weston et al., 2025, p. 8).

Dietary interventions should be selected based on individual’s clinical status and disease (Weston et al., 2025, p. 6). If BTFs are deemed appropriate by the relevant clinician, the selection and administration of BTFs should be personalised based on the nutritional and physical properties of the BTF formulation and the underlying conditions of the patient (Allen et al., 2024, p. 520). More information on vulnerable cohorts is presented in [section 5](#) below.

5. Australian Society of Parenteral and Enteral Nutrition Consensus on the Use of Blenderised Tube Feeds

AuSPEN is a multidisciplinary parenteral nutrition society involved in promoting improved standards, knowledge, education, professional competence and expert advice in the practice of parenteral and enteral nutrition (AuSPEN, 2018b). Its purpose is to be the leading professional society for a multidisciplinary approach to clinical nutrition (AuSPEN, 2018a).

According to the 2021 AuSPEN consensus statement, the multidisciplinary team involved in recommending BTFs in children and adults must include a gastroenterologist or other physician involved in regular care of the patient, a dietitian and the patient or patient’s family/care givers (AuSPEN, 2021, p. 4).

BTFs can be considered for patients who are over 12 months of age, have a mature and healed stoma site, have a low infection risk and have motivated caregivers who are aware of risks associated with BTFs and are willing to work with the dietitian to ensure the adequacy of BTFs (AuSPEN, 2021, p. 5). For paediatric and adult patients using BTFs, the dietitian monitoring timeframes are 1-3 monthly at the initiation of BTFs, and 6 monthly if the patient is stable on BTFs (AuSPEN, 2021, p. 4).

The AuSPEN consensus statement stipulates that special caution and clinical judgement should be exercised for several cohorts of patients including those who:

- require a continuous feed (HBTFs require shorter hang times as they are non-sterile and cannot be used for continuous feeds)
- are on fluid restriction (BTFs often provide larger fluid volumes than commercial formulas)
- have certain medical conditions such as metabolic disorders or multiple food allergies (there may be difficulty in providing a diet that is adequate in the context of multiple food/nutrient exclusions)
- have a high risk of infection (HBTFs are non-sterile, and thus expose children to a higher microbial load than HACCP approved commercial formulas)
- are medically unstable
- have a small feeding tube (<14fr)
- have poor growth
- have a jejunostomy (due to microbial concerns, absorption capacity and limitations with jejunal feeding and HBTFs) (AuSPEN, 2021, pp. 4-6).

For safe consumption of BTFs, parents/caregivers/patients must:

- be able to follow a BTF recipe and regular dietitian reviews to ensure macronutrient, micronutrient, and caloric adequacy
- be able to follow appropriate food preparation and food handling
- have the appropriate equipment, storage space, kitchen, fridge and freezer to safely prepare BTFs
- be able to consider the risk of food allergy with BTFs – e.g., introducing foods in BTFs that may cause an allergenic reaction
- be able to consider the adjustment of the nutritional profile of commercial BTFs if they require the addition of water to thin out

- be able to appropriately sanitise all mechanical equipment (e.g., blenders) used in preparing BTFs after each use
- be able to prepare BTFs using safe food handling techniques and store BTFs in a refrigerator immediately after preparation
- discard any unused BTFs after 24 hours
- administer BTFs via a bolus feed as a feeding pump is at risk of bacterial growth and tube clogs (AuSPEN, 2021, p. 5).

Prior to and after the commencement of BTFs, parents/caregivers/patients should be given the following information:

- food safety information for preparing BTFs
- a list of recommended equipment required for BTFs
- information on the variety of commercial BTFs available
- information on the risks involved with BTFs (e.g., tube blockages)
- if available, support group information available for patients and families e.g.:
 - Oley Foundation - <https://oley.org/>
 - Feeding Tube Awareness Foundation <http://www.feedingtubeawareness.org/Blenderized-Diet.html>
- a copy of an intended use statement for parents/carers to sign if they wish to use BTFs as an inpatient in their local hospital (if available)
- The Australian Guide to Healthy Eating (to be discussed with patient/parent and Dietitian) as a base of recipes: <https://www.eatforhealth.gov.au/eating-well/healthy-eating-throughout-all-life/healthy-eating-infants-children-and-teenagers> (AuSPEN, 2021, p. 6).

Generally, AuSPEN and European Society of Parenteral and Enteral Nutrition (ESPEN) (2022) take a cautious stance towards BTFs and emphasise risk mitigation in their guidelines while American Society of Parenteral and Enteral Nutrition (ASPEN) (2017, 2023) and British Dietetic Association (BDA, 2019) focus on implementation and demonstrate a more accepting approach towards BTFs (Breik et al., 2025, p. 7). The ESPEN practical guideline, ASPEN practice recommendations and BDA position statement can be referred to for further information.

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