NHS Borders

Individual Health Care Plan

Name	
DOB	
Oral feeding instructions	
Type of tube	
Size of tube	
Instructions if tube falls out	
Position for feeding (e.g. sat in chair)	
Equipment required	
Instructions about reuse or single use of syringes	
Type of feed	
Bolus feeds: **Amount and times of feed**	

Pump feeds: Instructions (type of pump, rate of feed for how many hours, time of feed starting)	
Amount of flush	
Instructions about medication	
Instructions about skin care	
Instructions about rotating tube	
Do family use Abbott Homecare Service?	
Other instructions (e.g. are there any problems that staff should be aware about and action to take)	

Name of person completing care plan……..

Signed……Date…….

Individual Health Care Plan Update/Next Visit to

Date……..

Are there any changes to enteral feeding?

YES ☐ NO ☐

If yes then new health care plan must be completed

Signed……..

_____

Date……..

Are there any changes to enteral feeding?

YES ☐ NO ☐

If yes then new health care plan must be completed

Signed……..

_____

Date……..

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YES ☐ NO ☐

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Signed……..

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YES ☐ NO ☐

If yes then new health care plan must be completed

Signed……