TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – Accidental Removal of Bard or New Device

Name Student/Child	Birth Date:	School/ Center	Delegatee: Unlicensed Assistive Personnel (UAP)

*PROCEDURE: ACCIDENTAL REMOVAL OF BARD OR LONG TUBE DEVICE OR NEW/UNSTABLE STOMA (less than 6 weeks since surgery)	Training Record RN Initial & Date
A. States purpose of procedure and location.	
B. PREPARATION	
1. Identifies student's developmental ability to participate in procedure.	
2. Reviews standard precautions.	
3. Reviews student's Individualized Healthcare Plan for instructions/authorizations.	
4. Identifies symptoms indicating need for action.	
C. IDENTIFIES SUPPLIES	
1. Gloves	
2. Foley catheter of the same diameter or one size smaller than the Bard.	
3. Lubricating jelly, gauze, tape, and plastic bag.	
D. PROCEDURE	
1. Calls parent(s)/emergency contact and nurse consultant immediately, or asks a co-worker to complete this task	
2. Assembles supplies and places on clean surface.	
3. Washes hands. Puts on gloves.	
4. Explains procedure to student.	
5. Inserts Foley catheter of the same diameter or one size smaller into gastrostomy site. DO NOT INFLATE THE BALLOON. Tapes the device to the student's stomach using two strips of medical tape in an "x" pattern. Covers with gauze and secures with additional medical tape	
6. If unable to insert, do not force. Cover site with dry, sterile gauze and secure with medical tape in an "x" pattern.	
7. Places Bard device in plastic bag.	
8. Disposes of gloves and supplies appropriately.	
9. Washes hands.	
E. DOCUMENTATION & COMMUNICATION	
1. Documents call to parents and nurse consultant.	
2. Documents procedure and observations.	
Competency Statement	**Training RN Signature & Initial**
PROCEDURE: Describes need for rapid response to accidental feeding tube dislodgement of a new unstable stoma or Bard or Long tube device and demonstrates correct actions.	

DELEGATION AUTHORIZATION

I have read the care/medication plan, been trained and am competent in the described procedures for __________. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: ________________________________ Delegation Decision Grid Score ____ Date ___________

Delegating RN Signature: ________________________________ Initials ____ Date ___________

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Name Student/Child	Birth Date:	School/ Center	Delegatee: Unlicensed Assistive Personnel (UAP)

RN Initial & Date	**Procedure** √ = acceptable performance	**Follow Up/ Supervision Plan / Comments**
	☐ Procedure Reviewed ☐ Emergency management response ☐ Medication administration ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
	☐ Procedure Reviewed ☐ Emergency management response ☐ Medication administration ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐ Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
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Delegating RN Signature ____ Initials _____

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