

TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM: GASTROSTOMY FEEDING SLOW DRIP/CONTINUOUS METHOD

Name:
Student/Child

Birth
Date:

School/
Center:

Delegatee:
Unlicensed Assistive Personnel (UAP)

| GASTROSTOMY FEEDING -SLOW DRIP OR CONTINUOUS METHOD | 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 Individualized Healthcare Plan for instructions/authorizations. | |
| 4. _____mL(amount)_____ Formula/feeding (type of feeding). | |
| 5. _____ mL (amount) of water prescribed for flush | |
| 6. Feeding to be completed at a rate of _____ml/hr. | |
| 7. Places student in a developmentally appropriate position on chair, on bed, or on floor. | |
| 8. Identifies where procedure is performed and student's activity level. | |
| 9. Identifies possible problems and appropriate actions. | |
| C. IDENTIFIES SUPPLIES | |
| 1. Gastrostomy device/brand _____(Fr) _____(cm) _____ Balloon size (mL) | |
| 2. Gloves | |
| 3. Formula at room temperature | |
| 4. 60 mL catheter tipped syringe, if needed for venting. | |
| 5. Feeding pump and pole (if used) device/brand _____ | |
| 6. g-tube extension set | |
| 7. Feeding/pump bag | |
| 8. Tap water at room temperature | |
| D. PROCEDURE | |
| 1. Gathers equipment. Places on clean surface. | |
| 2. Explains procedure to student. | |
| 3. Maintains developmentally appropriate position (as above in PREPARATION). | |
| 4. Encourages developmental and age appropriate mealtime activities. | |
| 5. Washes hands. Puts on gloves. | |
| 6. Observes for any distention. If stomach looks larger than usual, calls parent and nurse consultant for further instructions. | |
| 7. Vents g-tube, if ordered. | |
| 8. Hangs feeding/pump bag on pole (if using), installs pump bag tubing into feeding pump and pours formula into pump bag. | |
| 9. Attaches g-tube extension set to feeding/pump bag tubing. | |

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

- | | |
|---|--|
| <p>10. Unclamps feeding/pump bag tubing and feeding extension set, and uses “prime” button on pump to prime feeding/pump bag tubing and g-tube extension set with formula all the way to the tip. Clamps g-tube extension set.</p> | |
| <p>11. Sets/verifies flow rate.</p> | |
| <p>13. Opens g-tube safety plug. Inserts g-tube extension set into the button.</p> | |
| <p>14. Opens clamp on g-tube extension set and feeding/pump bag tubing. Sets/verifies pump rate, volume and time as ordered. Starts pump.</p> | |
| <p>15. For a continuous feeding, adds more fluid to bag before empty.</p> | |
| <p>16. Checks rate and flow every _____ minutes. Do not change the prescribed flow rate.</p> | |
| <p>17. When feeding is finished, clamps feeding/pump bag tubing and g-tube extension set.</p> | |
| <p>18. Disconnects pump/feeding bag from g-tube extension set.</p> | |
| <p>19. Unclamps g-tube extension set and flushes with ____ mL of water, as ordered.</p> | |
| <p>20. Vents g-tube if ordered. Follows procedure guideline for venting gastrostomy tubes.</p> | |
| <p>21. Disconnects g-tube extension set from g-tube and replaces safety plug.</p> | |
| <p>22. Removes gloves. Washes hands</p> | |
| <p>23. Refers to Individualized Healthcare Plan for position and activity after feeding.</p> | |
| <p>24. Washes feeding/pump bag and other reusable equipment with soap and warm water. Rinses thoroughly. Dries and stores in clean area. Stores formulas as instructed.</p> | |

- | | |
|--|--|
| E. DOCUMENTATION & COMMUNICATION | |
| <p>1. Documents feeding/medication, residual amount, and feeding tolerance.</p> | |
| <p>2. Reports any changes or concerns to family and/or nurse consultant.</p> | |

| | |
|-----------------------------|--|
| Competency Statement | Training RN Signature & Initial |
|-----------------------------|--|

PROCEDURE: Describes understanding of the need for gastrostomy tube/button feedings and demonstrates correct feeding administration using the slow drip or continuous method as well as the ability to identify and solve potential problems.

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 _____ Date: _____
Grid Score

Delegating RN Signature: _____ Initials: _____ Date: _____

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