PROCEDURE GUIDELINE AND COMPETENCY CHECKLIST FOR DELEGATION OF TRACHEOSTOMY CARE TASKS

Name Student/Child | Birth Date: | School/ Center | Delegatee:

PROCEDURE: GO BAG SUPPLIES	Demo Date/ RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials
A. STATES NAME AND PURPOSE OF PROCEDURE					
B. PREPARATION					
1. Current copy of health care plan and authorizations.					
2. Emergency phone number list.					
3. Go bag list.					
4. Resuscitator bag.					
5. Extra tracheostomy tube with ties and obturator (if indicated); one the same size and one a size smaller. If student has a cuffed tracheostomy tube, have an uncuffed tube of the same size available.					
6. Syringe (3cc).					
7. Saline vials.					
8. Suction catheters.					
9. Bulb syringe or Yankauer.					
10. Portable suction machine.					
11. Blunt scissors.					
12. Tissues.					
13. Cotton-tipped applicators and pipe cleaners.					
14. Hydrogen peroxide.					
15. Gloves.					
16. Tracheal gauze or sponges.					
17. Water-soluble lubricant or saline.					
18. Passive condenser.					
19. Other individual items.					
C. DEMONSTRATES PLAN FOR CHECKLIST EMERGENCY SUPPLIES.					

Competency Statement: Describes understanding of the need for tracheostomy go bag supplies and maintains supplies appropriately.

Delegatee Signature ____ Date _______________

DELEGATION AUTHORIZATION

I have read the care 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 _________________

Delegating RN Signature ____ Initials _________

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Name Student/Child	Birth Date:	School/ Center	Delegatee:

Date/ RN Initial	**Procedure:** √ = acceptable performance	**Follow Up/ Supervision Plan / Comments**
	☐Review procedure ☐HCP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐Additional on-site training provided. ☐Supervision plan (minimum annually) date: _______ ☐Continue delegation ☐Withdraw delegation
	☐Review procedure ☐HCP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐Additional on-site training provided. ☐Supervision plan (minimum annually) date: _______ ☐Continue delegation ☐Withdraw delegation
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Delegating RN Signature ____ Initials _____

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