

PROCEDURE GUIDELINE AND COMPETENCY CHECKLIST FOR DELEGATION OF Cecostomy Tract Preservation

Name
Student/Child:

Birth
Date:

School/
Center:

Delagatee:

*PROCEDURE: ACCIDENTAL REMOVAL CECOSTOMY MINI-ACE TUBE FROM STABLE WELL-HEALED STOMA (more than or equal to 8 weeks since surgery)	Training Record RN Initial & Date
A. STATES NAME AND PURPOSE OF PROCEDURE	
B. PREPARATION	
1. Identifies student's developmental ability to participate in procedure.	
2. Reviews standard precautions.	
3. Identifies symptoms indicating need for action.	
C. IDENTIFIES SUPPLIES	
1. Gloves.	
2. Old cecostomy tube OR new cecostomy tube OR Foley catheter (same diameter or smaller than cecostomy tube).	
3. Lubricating jelly, gauze, tape, and syringe.	
D. PROCEDURE	
1. Assembles supplies and places on clean surface.	
2. Washes hands and puts on gloves.	
3. Explains procedure to student.	
4. Rinses old cecostomy tube with water and deflate balloon using syringe (if needed), or open new cecostomy tube kit or Foley catheter packaging and tie in a knot to prevent leaking.	
5. Applies generous amount of lubricating jelly to tip of cecostomy tube or foley catheter.	
6. Inserts cecostomy MiniACE tube (new or old device) into stoma fully OR insert Foley catheter 1 inch into cecostomy site and kink at stoma. 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.	
7. If unable to insert, DO NOT FORCE. Cover site with dry gauze and secure with medical tape in an "X" pattern.	
8. Disposes of gloves and supplies appropriately.	
9. Wash hands.	
E. DOCUMENTATION & COMMUNICATION	
10. Calls parents and RN consultant immediately.	
11. Documents in log.	
12. DO NOT use the cecostomy tube or Foley until parents have verified correct placement and inflated balloon.	
Competency Statement:	Training RN Signature & Initial
PROCEDURE: Describes need for rapid response to accidental cecostomy tube dislodgement and demonstrates correct procedures for maintaining the stoma tract.	

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: _____

Date _____

Delegating RN Signature: _____

Initials _____ Date _____

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RN Initial & Date	<p align="center">Procedure √ = 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"/> 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 _____