TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM: GASTROSTOMY FEEDING SLOW DRIP/CONTINUOS 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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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.	
11. Sets/verifies flow rate.	
13. Opens g-tube safety plug. Inserts g-tube extension set into the button.	
14. Opens clamp on g-tube extension set and feeding/pump bag tubing. Sets/verifies pump rate, volume and time as ordered. Starts pump.	
15. For a continuous feeding, adds more fluid to bag before empty.	
16. Checks rate and flow every _____ minutes. Do not change the prescribed flow rate.	
17. When feeding is finished, clamps feeding/pump bag tubing and g-tube extension set.	
18. Disconnects pump/feeding bag from g-tube extension set.	
19. Unclamps g-tube extension set and flushes with _____mL of water, as ordered.	
20. Vents g-tube if ordered. Follows procedure guideline for venting gastrostomy tubes.	
21. Disconnects g-tube extension set from g-tube and replaces safety plug.	
22. Removes gloves. Washes hands	
23. Refers to Individualized Healthcare Plan for position and activity after feeding.	
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.	

E. DOCUMENTATION & COMMUNICATION

1. Documents feeding/medication, residual amount, and feeding tolerance.	
2. Reports any changes or concerns to family and/or nurse consultant.	

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: _____

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

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

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		Comments:

Delegating RN Signature _____ Initials _____