

TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – Gastrostomy Medication Administration

Name
Student/Child

Birth
Date:

School/
Center

Delegatee:
Unlicensed Assistive Personnel
(UAP)

GASTROSTOMY MEDICATION ADMINISTRATION		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) of water prescribed to flush the tube.	
5.	Places student in a developmentally appropriate position in chair, on bed, or on floor.	
6.	Identifies possible problems and appropriate actions.	
C. IDENTIFIES SUPPLIES		
1.	Gastrostomy device/brand: _____(Fr) _____(cm) Balloon size _____mL	
2.	Gloves	
3.	Liquid medications drawn up in syringe(s)	
5.	g-tube extension set.	
6.	___ ml syringe for water flushes, if ordered.	
7.	Small glass of 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 activities.	
5.	Washes hands. Puts on gloves.	
6.	Observes student's stomach for distention. If stomach looks larger than normal, call parent and nurse consultant for further instructions.	
7.	Ensure the g-tube extension set is flushed/primed with water	
8.	Opens safety plug. Connects medication syringe to g-tube extension set via medication port.	
9.	Unclamps g-tube extension set and administers medication by slowly pushing on plunger, unless otherwise ordered.	
10.	Clamp g-tube extension set.	
11.	If more than one medication is ordered, follow steps 9 through 12, administering one medication at a time until all medications are administered.	
12.	Flushes g-tube extension set with _____mL of water after medications are administered.	

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13. Clamp g-tube extension set.	
14. Vents g-tube if ordered. Follows procedure guideline for venting gastrostomy tubes.	
15. Clamps g-tube extension set and removes from g-tube.	
16. Closes safety plug.	
17. Applies dressing, if needed.	
18. Removes gloves. Washes hands.	
19. Refers to Individualized Healthcare Plan for position and activity after feeding.	
20. Washes medication syringe(s), g-tube extension set, and other reusable equipment with soap and warm water. Rinses thoroughly. Allows to air dry and stores in clean area. Stores formulas as instructed	
E. DOCUMENTATION & COMMUNICATION	
1. Documents medication administration tolerance.	
2. Reports any changes or concerns to family and RN consultant.	
Competency Statement	Training RN Signature & Initial
PROCEDURE: Describes understanding of the need for gastrostomy medications and demonstrates correct medication administration 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
Grid Score

Date: _____

Delegating RN Signature: _____

Initials: _____

Date: _____

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TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – Gastrostomy Feeding Bolus

Name
Student/Child

Birth
Date:

School/
Center

Delegatee:
Unlicensed Assistive Personnel (UAP)

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"/> 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:
	<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 _____