

TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – Gastrostomy Pump Bolus Feed

Name
Student/Child

Birth
Date:

School/
Center

Delegatee:
Unlicensed Assistive Personnel
(UAP)

GASTROSTOMY PUMP BOLUS FEED		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. Completes at _____ time(s).		
5. _____ mL(amount) _____ Formula/feeding (type of feeding).		
6. _____ mL (amount) of water prescribed to flush the tube.		
7. Feeding to be completed in _____ minutes.		
8. Places student in a developmentally appropriate position in chair, on bed, or on floor.		
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. Pump and feeding bag		
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 mealtime 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. Pour _____ mL into feeding bag and attach g-tube extension set to feeding tube.		
8. Insert tubing into feeding pump as instructed by family or RN and turn on feeding pump		
9. Prime the tubing with formula, using the feeding pump, stopping at the end of the g-tube extension set. Ensure there are no bubbles in the line.		
10. Ensure pump is set at _____ rate.		
11. Unclamp the g-tube extension set and push start on pump.		
12. Once feed is complete, flush g-tube extension set with _____ mL of water, if ordered.		

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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. Prime warm water through feeding bag and tubing and 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 feeding tolerance. If completed, documents medication administration and venting.		
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 tube/button feedings and demonstrates correct feeding 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 _____	Date: _____
Delegating RN Signature: _____	Initials: _____	Date: _____

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RN Initial & Date	Procedure <i>✓ = acceptable performance</i>	Follow Up/ Supervision Plan / 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 _____