

PROCEDURE GUIDELINE AND COMPETENCY FOR IDDSI TESTING CHECKLIST FOR Thickened Liquids

Name
Student/Child

Birth
Date:

School/
Center

Delegatee:
Unlicensed Assistive Personnel (UAP)

*PROCEDURE: IDDSI Testing in the School Setting	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.	
4. Identifies when the thickness needs to be tested (the thickening of any new liquid, if student is showing signs of aspiration while drinking currently thickened liquid, or first time providing thickened liquids)	
C. IDENTIFIES SUPPLIES	
1. Liquid needing to be thickened	
2. Thickener provided by family	
3. Two 10mL Luer lock syringes, stopwatch, cup (or bottle), spoon	
D. PROCEDURE	
1. Assembles supplies and places on clean surface.	
2. Washes hands	
3. Mix thickener in ____mL of liquids per provider orders and manufacturer instructions	
4. Remove plunger from one 10mL syringe.	
5. With other 10mL syringe, draw up 10mL of thickened liquids.	
6. Cover the nozzle of the syringe without a plunger with finger and fill the syringe up to the 10mL mark using the syringe with thickened liquids in it.	
7. Release finger from nozzle and start timer	
8. When timer reaches 10 seconds, place finger over the nozzle and measure how much liquid is left in the syringe.	
9. Compare remaining amount of liquid to IDDSI chart to ensure liquid is thickened per provider orders.	
10. Rinse out syringes and allow to dry	
11. Washes hands.	
E. DOCUMENTATION & COMMUNICATION	
12. Document process and when liquids were thickened	
Competency Statement:	Training RN Signature & Initial
PROCEDURE: Describes need for thickened liquids and the correct process to thicken liquids and compare to IDDSI chart.	

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	Procedure ✓ = acceptable performance	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 _____

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