

# **TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – PULSE OXIMETRY READINGS**

Name  
Student/Child

Birth  
Date:

School/  
Center

Delegatee:

<b>PROCEDURE: PULSE OXIMETRY READINGS</b>		<b>Training Record RN Initial &amp; Date</b>
<b>A. STATES NAME AND PURPOSE OF PROCEDURE</b>		
<b>B. PREPARATION</b>		
1. Identifies student's developmental ability to participate in procedure.		
2. Reviews Individualized Health Care Plan for instructions and authorizations.		
3. Identifies where procedure is done and student's activity level.		
4. Identifies possible problems and appropriate actions.		
<b>C. IDENTIFIES SUPPLIES</b>		
1. Pulse oximeter provided by parent/guardian of student.		
<b>D. PROCEDURE</b>		
1. Places student in position of comfort and explains the procedure as developmentally appropriate.		
2. Applies the sensor to the student's finger with the red light placed on the nailbed and alignment marks directly opposite each other.		
3. Turns on the oximeter.		
4. Waits 3-5 seconds for consistent wave/signal to ensure accuracy of reading.		
5. Correctly identifies the oxygen saturation percentage.		
6. Observes and documents student's respiratory effort.		
7. Washes hands.		
8. Documents hourly, or as ordered, in the oxygen administration log.		
9. Identifies when to call EMS, the parent, and nurse consultant.		
<b>COMPETENCY STATEMENT</b>		<b>Training RN Signature &amp; Initial</b>
<b>PROCEDURE:</b> Demonstrates competency on the steps above for obtaining pulse oximetry reading using a pulse oximeter.		

## **DELEGATION AUTHORIZATION**

I have read the care 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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Date/ RN Initial	<b>Procedure:</b> $\checkmark$ = acceptable performance	Follow Up/ Supervision Plan / Comments
	<input type="checkbox"/> Review procedure <input type="checkbox"/> HCP 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"/> Additional on-site training provided. <input type="checkbox"/> Supervision plan (minimum annually) date: _____ <input type="checkbox"/> Continue delegation <input type="checkbox"/> Withdraw delegation
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Delegating RN Signature \_\_\_\_\_

Initials \_\_\_\_\_