

**Confidential Individualized Healthcare Plan:  
Cecostomy Tract Preservation**

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Parent/Guardian Name & Phone #	
Parent/Guardian Name & Phone #	
Primary Care Name & Phone #	
Specialist Name & Phone #	
Preferred Hospital:	
Emergency Contact Name & Phone #	
<b>CURRENT HEALTH ISSUES</b>	<p>A cecostomy tube, also known as a C-tube, is placed using a surgical procedure called an ACE (Antegrade Continence Enema)/Malone where a catheter device is placed into the bowel. This procedure and device allow the family to flush a solution through the intestines to aid in stool evacuation which is typically done 2x per day at home.</p> <p>You may see a cecostomy tube placed as a Mini-Ace or Chait Tube. You may also see a cecostomy stoma with no device in place.</p>
	<p>Date Cecostomy placed: _____</p> <p>Brand/type of device: _____</p> <p>Size: _____ fr, _____ cm</p> <p>Type of Cecostomy:</p> <p><input type="checkbox"/> Mini-Ace- tract preserved with Mini-Ace button or foley catheter</p> <p><input type="checkbox"/> Chait Tube – tract preserved with stopper or foley catheter</p> <p><input type="checkbox"/> ACE/Malone with no device in place- <b>no tract preservation needed</b></p>
<b>PERTINENT HEALTH HISTORY</b>	
<b>ALLERGIES:</b>	
<b>RESTRICTIONS:</b>	
<b>CURRENT MEDICATIONS:</b>	<p><b>AT HOME</b></p> <p><b>AT SCHOOL:</b></p>
<b>HEALTH PROBLEM(S):</b>	<p><b>Problem:</b> Risk of cecostomy stoma closure</p> <p><b>Goal:</b> Preserve stoma opening</p> <p><b>Action:</b> <b>If cecostomy tube comes out, trained/delegated staff may:</b></p> <p><b>C-tube is greater than 8 weeks old:</b></p> <ol style="list-style-type: none"> <li>1. Rinse device with warm water or use replacement device provided by family and deflate balloon if necessary.</li> <li>2. If needed, wipe skin around site with a paper towel to dry prior to reinsertion.</li> <li>3. Apply lubricating jelly to the end of the device.</li> <li>4. GENTLY reinsert device into stoma opening. If using a foley catheter, insert foley one inch, kink the tubing, and tape it to the skin.</li> <li>5. If you meet resistance when attempting to reinsert, try next size down (if available). Do NOT force the replacement device into the stoma.</li> <li>6. Cover site with dry, sterile gauze and secure with tape.</li> <li>7. Notify parent and RN.</li> <li>8. Do NOT inflate balloon or use device until parent arrives and checks placement.</li> </ol> <p><b>C-tube is less than 8 weeks old (DO NOT REPLACE):</b></p> <ol style="list-style-type: none"> <li>1. Notify Parents and RN about dislodgement. Cover site with gauze or paper towel to help with leaking.</li> <li>2. Parents will need to pick up student and take them to see provider for C-tube replacement prior to using the C-tube in the school setting.</li> </ol>

Revised and adopted by CHCO School Health Program 2025 from CDE [http://www.cde.state.co.us/HealthAndWellness/SNH\\_HealthIssues.htm](http://www.cde.state.co.us/HealthAndWellness/SNH_HealthIssues.htm).

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	<input type="checkbox"/> Check box if parent requests that school <b>does not</b> attempt tract preservation. Staff will notify the parent immediately if the C-tube becomes dislodged and the parent will come and replace C-tube.
<b>Problem:</b>	<b>Goal:</b> <b>Action:</b> <input type="checkbox"/>
<b>Problem:</b>	<b>Goal:</b> <b>Action:</b> <input type="checkbox"/>
<b>EMERGENCY ACTION PLAN</b>	Shelter in place Evacuation plan

**Personal Care Services/ Medically Necessary Services (repeat segment if more than one service)**

**ICD-10 Code:**

**Specific task:**

**Scope:**

**Duration:**

**Frequency:**

This service is medically necessary through the following dates, not to exceed one year.

**Start Date:**

**End Date:**

**TO THE PARENT/GUARDIAN:** If \_\_\_\_\_ experiences a change in his/her health condition (such as a change in medication or a hospitalization) please contact the School Nurse Consultant so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I understand that the School Nurse Consultant may delegate this health care plan to unlicensed school personnel. I give permission for school personnel to carry out this care plan for the Child. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure the Child's safety and well-being while at school or during school related activities.

parent/guardian \_\_\_\_\_ date \_\_\_\_\_

school nurse \_\_\_\_\_ date \_\_\_\_\_

health care provider \_\_\_\_\_ date \_\_\_\_\_

administrator \_\_\_\_\_ date \_\_\_\_\_

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