

TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – Manual Resuscitator Bag with Tracheostomy

Name
Student/Child

Birth
Date:

School/
Center

Delegatee:

PROCEDURE: MANUAL RESUSCITATOR BAG WITH TRACHEOSTOMY					Demo Date/ RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials	Return Demo Date/RN Initials
A. STATES NAME AND PURPOSE OF PROCEDURE									
B. PREPARATION									
1. Identifies student’s developmental ability to participate in procedure.									
2. Reviews standard precautions.									
3. Reviews student’s Individualized Healthcare Plan for instructions/authorizations.									
4. Identifies where procedure is done.									
5. Identifies possible trach problems and appropriate actions.									
C. IDENTIFIES SUPPLIES									
1.Oxygen source with appropriate tubing, if needed.									
2.Manual resuscitator.									
3.Adaptor for tracheostomy tube.									
4.Tracheostomy Go-Bag items.									
5.Gloves									
D. PROCEDURE									
1.Gathers equipment. Places on clean surface.									
2.Positions student.									
3.Explains procedure.									
4.Washes hands. Puts on gloves.									
5.Checks that manual resuscitator is functioning properly.									
6.Attaches resuscitator bag to tracheostomy tube.									
7.Coordinates manual breaths with student’s own breaths, if student breathes independently.									
8.Squeezes manual resuscitator at regular rate to give prescribed breaths per minute, if student unable to breathe independently.									
9.Removes resuscitation bag from tracheostomy tube when appropriate.									
10. Removes gloves and washes hands.									
11. Documents procedure and observations.									
12. Reports any changes or concerns to family and nurse consultant.									
Competency Statement: Describes understanding of the need for tracheostomy tube, identifies need for manual resuscitator bag and demonstrates correct performance of use.									
Delegatee Signature _____					Date _____				

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: _____

Delegation
Decision
Grid
Score _____ Date _____

Delegating RN Signature: _____ initials _____ Date _____

Delegating RN Signature _____ Initials _____
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 The Children’s Hospital Denver School Health Program Denver, Colorado 2009

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Date/ RN Initial	<p align="center">Procedure: √ = acceptable performance</p>	<p align="center">Follow Up/ Supervision Plan / Comments</p>
	<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
	<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 _____