TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION FORM – VENTING GASTROSTOMY TUBES

Name Student/Child	Birth Date:	School/ Center	Delegatee: Unlicensed Assistive Personnel (UAP)

VENTING GASTROSTOMY TUBES *Brief description*	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. Identifies symptoms indicating need for decompression (venting).	
5. Places student in a developmentally appropriate position in chair, on bed, or on floor.	
C. IDENTIFIES SUPPLIES	
1. Feeding extension set	
2. 60 mL catheter tip syringe	
3. Gloves	
D. PROCEDURE	
1. Gathers equipment. Places on clean surface.	
2. Explains procedure to student.	
3. Maintain developmentally appropriate position (as above in PREPARATION).	
4. Washes hands. Puts on gloves.	
5. Removes safety plug from g-tube button.	
6. Clamps feeding extension set and connects to g-tube.	
7. Removes plunger from 60 ml catheter tip syringe and connects syringe to feeding extension set.	
8. Holds 60 ml catheter tip syringe several inches above stomach to allow air to escape and stomach contents to flow up and down the feeding extension set tubing. May ask or help student change positions to aid in air evacuation.	
9. Clamps feeding extension set and disconnects from g-tube. Reinserts safety plug.	
10. Removes gloves and washes hands.	
11. Washes 60 ml catheter tip syringe, feeding extension set, and other reusable equipment with soap and warm water. Rinses thoroughly. Allows to air dry and stores in clean area.	
E. DOCUMENTATION & COMMUNICATION	
1. Documents in log.	
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 venting and demonstrates correct technique as well as the ability to identify and solve potential problems.	

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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 Grid Score	____	Date	___________
Delegating RN Signature:	______________________________	Initials	____	Date	___________

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Name Student/Child	Birth Date:	School/ Center	Delegatee: Unlicensed Assistive Personnel (UAP)

RN Initial & Date	**Procedure** √ = acceptable performance	**Follow Up/ Supervision Plan / Comments**
	☐ Procedure Reviewed ☐ Emergency management response ☐ Medication administration ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
	☐ Procedure Reviewed ☐ Emergency management response ☐ Medication administration ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐ Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
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Delegating RN Signature ____ Initials _____

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