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| Competency Evaluation Tool for Gastrostomy (G) Tube ‘Bolus Feeding’ |
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| **Name of Individual:**        |
| **Type of G Tube:**        |
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|  | Pass (P), Fail (F), N/A | Comments | Procedure for Bolus Feeding: |
|  |  |  | The Certified staff: |
| 1. |       |       | Checks the individual’s Health Care Provider (HCP) Orders and/or Protocol. |
| 2. |       |       | Washes hands. |
| 3. |       |       | Gathers equipment (e.g., ordered amount of formula, water, 60 mL catheter tip syringe [with barrel separated from plunger], clean towel, etc.). |
| 4. |       |       | Informs individual what is being done. |
| 5. |       |       | Positions individual in correct position. |
| 6. |       |       | Clamps/Pinches G Tube before unplugging Tube. Removes plug and places plug so that it remains free of contamination. |
| 7. |       |       | Inserts tip of 60 mL catheter tip syringe into G Tube. |
| 8. |       |       | Pours HCP ordered amount of water into barrel of syringe; un-pinches the G Tube; allows water to slowly enter stomach by gravity and pinches the G Tube just prior to syringe being completely emptied of water. |
| 9. |       |       | Slowly pours formula into barrel of syringe; un-pinches the G Tube to allow the formula to enter the stomach; continuously refills the barrel of the syringe before it completely empties; (to prevent air from entering); until the entire HCP ordered amount of formula has been poured into the syringe. |
| 10. |       |       | Clamps/Pinches G Tube just prior to syringe being completely emptied. |
| 11. |       |       | Pours HCP ordered amount of water into syringe, un-pinches Tube, and allows water to enter stomach (to flush Tube). |
| 12. |       |       | Clamps/Pinches G Tube when syringe has just completely emptied of water. |
| 13. |       |       | Reinserts plug prior to un-pinching Tube. |
| 14. |       |       | Documents that feeding has been given. |
| 15. |       |       | Ensures that individual sits up for at least sixty (60) minutes after feeding is complete. |

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| Based on this Competency Evaluation Tool, I, as approved Trainer (RN or HCP), have determined that the Certified Staff named below is competent to administer G Tube Bolus Feedings to the **identified Individual**. |
| Date:  |       | Trainer’s Printed Name: |       |
| Certified Staff’s Printed Name: |       | Trainer’s Signature: |       |
| Certified Staff’s Signature: |       | Trainer’s Contact Information: |       |
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