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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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