SKILLS COMPETENCY CHECKLIST—DIGITAL STIMULATION

(Sample checklist to be individualized as needed to address specific care needs of the individual receiving proxy caregiver services)

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| Name of Instructor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name of Individual Receiving Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name of Proxy Caregiver Being Trained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Training Completion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (Licensed Healthcare Professional (LHP) Sign-Off Required—Skills Competency Assessment)    I certify that this unlicensed caregiver (without prompting or error) has satisfactorily  demonstrated the following skills or tasks with 100% accuracy to me, a healthcare professional. I am licensed in good standing in Georgia as indicated below. (Check applicable box.)    Registered nurse Physician’s assistant Physician Pharmacist      LHP Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License Number: \_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_ |

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| Digital Stimulation—Competency Checklist  (DIL) | Satisfactory Demonstration:  Date: | LHP  Initials | Needs Additional Training— notes | LHP  Initials |
| **Requirements**   1. **Received orientation to policies and procedures on how the facility handles procedures** 2. **Received orientation to rules and regulations for proxy caregiver used in licensed Healthcare Facilities** 3. **Proxy caregiver is identified in the informed Consent signed by the disabled resident (or authorized representative) as permitted to provide medication assistance activities.** 4. **Received orientation to the written plan of care specific to medication assistance (Digital stimulation).** 5. **Completed Test of Functional Health Literacy for Adults (TOFHLA) with a minimum score of 75**   Definition: A gastrostomy feeding tube is either a tube or a button (skin level device) that is surgically placed into the stomach through the abdominal wall. There are a wide variety of tubes and skin level devices available. Your surgeon will choose the device which best meets you and your child's needs with the least invasive technique.   1. State the purpose and reason for the procedure  * Children require gastrostomy feeding tubes for a variety of reasons. The primary indication for gastrostomy is the child's inability to take adequate nutrition or liquids by mouth for growth and development. The reasons why the child is unable to take proper nutrition can be developmental, mechanical, or secondary to other health problems. | \*  Attached Copy of signed Informed Consent  TOFLA Score:--- |  |  |  |
| B. Why vent the G tube? |  |  |  |  |
| Venting the G tube will help reduce and prevent stomach cramping and distention by allowing trapped gas to escape through g tube.   * Children treated for Gerd with additional operation * Have difficulty or are unable to vent * Helps the child relieve Gas |  |  |  |  |
| C. How to do a Dil (digital stimulation)   * Wash hands * Prepare all needed supplies and place on a towel * Explain Procedure to member * If doing the dil in bed, turn member to the left side with knees flexed (right leg over left leg) and place disposable pad under the buttocks. * If doing the dil in the bathroom, transfer to appropriate bowel equipment (raised seat, Activeaid). * **Put gloves on both hands or place dil stick in the hand** * **Lubricate pointing finger or dil stick (whichever will be entering the rectum).** * **Insert the gloved, Lubricated finger gently through the anal sphincter** * **Move Finger in a circular motion slowly and gently** * **Make the circular Motion for 30 seconds or longer until stool is felt against the finger and the sphincter muscle begins to relax** * **When the stool begins to empty from the rectum, move the finger or dil stick to one side or remove so the stool can pass.** * **Do this for at least 20 minutes if no stool is coming. If stool is produced, do the dil as long as the stool is coming dil and for five additional minutes afterward without getting any more stool.** |  |  |  |  |
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| D. Finishing Up |  |  |  |  |
| * When finished with the dil, wipe rectal area and buttocks with toilet paper; wash with soap and water; dry with a towel * Clean dil stick with soap and water; dry well, if any. * Position member for comfort * **Remove and discard soiled supplies and equipment** * Dispose of equipment in appropriate waste receptacle * **Throw out waste and wash hands** |  |  |  |  |
| E. Member is experiencing Autonomic Dysreflexia |  |  |  |  |
| **The dil may cause dysreflexia in persons with spinal cord injuries at T6 and above. Always observe for symptoms of autonomic dysreflexia:**   * **Increased blood pressure** * **Headache** * **Blotchy skin** * **Sweating** * **Stuffy nose** * Caregiver can state the signs and symptoms of autonomic dysreflexia (increased blood pressure , Headache, Blotchy skin, Sweating, and stuffy nose) |  |  |  |  |
| F. If the person experiences autonomic dysreflexia during the dil, then do the following |  |  |  |  |
| * Stop the dil * Sit up if not already doing so. Sit up in the bed or in the chair, depending on the location. * Insert a local numbing agent like Nupercainal Ointment into the rectum, if available * Call 911 if symptoms does not resolve * Caregiver can state what to do if the member is experiencing autonomic dysreflexia) |  |  |  |  |
| G.   * Removes gloves and disposes of them properly. Wash hands * Record procedure and results on the bowel care record * Report any abnormalities or problems to nurse or doctor as indicated and or on your progress notes as appropriate * Caregiver knows when and how to contact a licensed healthcare professional where signs and symptoms of autonomic dysreflexia. |  |  |  |  |

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Proxy Caregiver Signature:––––––––––––––––––––––––––– Date:––––––––––––––––––––––––

Signature of Trainer: –––––––––––––––––––––––––––––-–-- Date:–––––––––––––––––––––––––

(Registered nurse/Physician’s Assistant/Pharmacist/Physician)