SKILLS COMPETENCY CHECKLIST—  
G tube Venting/ Ileostomy changing and Empting

(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? |  |  |  |  |
| * Children treated for Gerd with additional operation * Have difficulty or are unable to vent * Helps the child relieve Gas   Items needed:   * Gloves * 60ml catheter tipped syringe * Soap, water, washcloth * Toilet paper, under pads (if done in bed) |  |  |  |  |
| C. How to do a G Tube Venting   * Wash hands * Prepare all needed supplies and place on a towel * Explain Procedure to member * **Attach a 60 ml catheter tipped syringe to the end of the peg** * **Hold the syringe lower than the stomach allows gas to be expelled** * **Rolling from side to side may help to expel gas** * **Stomach contents may come up into syringe** * **Return the stomach contents back into the stomach after venting.** * **If large volumes of stomach contents come out with venting. Or if the color of the content is dark green, notify supervisor or Doctor.**   **D. Changing and emptying Ileostomy**  **Definition:**  **Your ostomy pouch is a heavy-duty plastic bag that you wear outside your body to collect your stool. Using an ostomy pouch is the best way to handle your bowel movements after certain kinds of surgery on the colon or small intestine. Your stool may be liquid or solid, depending on the kind of surgery you had. You may need your ostomy for just a short time. Or, you may need it for the rest of your life.** |  |  |  |  |
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| The ostomy pouch attaches to your belly, away from your belt line. It will be hidden under your clothing. The stoma is the opening in your skin where the pouch attaches. Usually you can do your normal activities, but you will have to change your diet a bit and watch for skin soreness. The pouches are odor-free, and they do not allow gas or stool to leak out when they are worn correctly.  Your nurse will teach you how to care for your ostomy pouch and how to change it. You will need to empty it when it is about 1/3 full, and change it about every 2 to 4 days, or as often as your nurse tells you. After some practice, changing your pouch will get easier. |  |  |  |  |
| E. Getting Your Supplies Ready |  |  |  |  |
| * A new pouch (a 1-piece system, or 2-piece system that has a wafer) * A pouch clip * Scissors * A clean towel or paper towels * Stoma powder * Stoma paste or a ring seal * Skin wipes * A measuring card and a pen |  |  |  |  |
| F. **Changing your ileostomy pouch:** |  |  |  |  |
| The bathroom is a good place to change your pouch. Empty your used pouch into the toilet first, if it needs emptying   1. Wash your hands with soap and water. Be sure to wash between your fingers and under your fingernails. Dry with a clean towel or paper towels. 2. If you have a 2-piece pouch, press gently on the skin around your stoma with 1 hand, and remove the seal with your other hand. (If it is hard to remove the seal, you can use special pads. Ask your nurse about these.) 3. Remove the pouch. 4. Keep the clip. Put the old ostomy pouch in a bag and then place the bag in the trash. 5. Clean the skin around your stoma with warm soap and water and a clean washcloth or paper towels. Dry with a clean towel. 6. Check and seal your skin: Check the member skin. A little bleeding is normal. The member skin should be pink or red. Call the doctor if it is purple, black, or blue. 7. Wipe around the stoma with the special skin wipe. If your skin is a little wet, sprinkle some of the stoma powder on just the wet or open part. 8. Lightly pat the special wipe on top of the powder and your skin again. Let the area air-dry for 1 to 2 minutes. 9. Measure your stoma: Use your measuring card to find the circle size that matches the size of your stoma. DO NOT touch the card to your skin. 10. If you have a 2-piece system, trace the circle size onto the back of the ring seal and cut out this size. Make sure the cut edges are smooth. 11. Attach the pouch: Attach the pouch to the ring seal if you have a 2-piece ostomy system. 12. Peel the paper off the ring seal. Squirt stoma paste around the hole in the seal, or place the special stoma ring around the opening. 13. Place the seal evenly around the stoma. Hold it in place for a few minutes. Try holding a warm washcloth over the seal to help make it stick to your skin 14. Attach the pouch clip or use Velcro to close the pouch. Wash your hands with warm soap and water. |  |  |  |  |
| 1. G. When to call the doctor: Call the health care provider if: 2. The stoma smells bad, there is pus draining from it, or it is bleeding a lot. 3. Your stoma is changing in some way. It is a different color, it is getting longer, or it is pulling into your skin. 4. There is blood in the stool. 5. If the member has a fever of 100.4°F (38°C) or higher, or you have chills. 6. If the member feels sick to your stomach, or you are vomiting. 7. If the member stools are looser than normal. 8. If the member has a lot of pain in your belly, or you are bloated (puffy or swollen. 9. If the member has had no gas or stool for 4 hours   References  American College of Surgeons, Division of Education. Ostomy skills: Emptying and changing the pouch. |  |  |  |  |

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

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

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