RCSD ROSEVILLE CITY SCHOOL DISTRICT
Est. 1869

Parent Consent and Authorized Healthcare Provider Authorization for Management of Gastrostomy at School and School-sponsored Events

Name:		**Teacher/Grade:**		**Site:**		**DOB:**	

Gastrostomy Tube Type:		**Gastrostomy Button:**	☐ MIC-KEY ☐ BARD ☐ Other:_____
Size:		**Size:**	☐ Balloon ☐ Non-Balloon

Gastrostomy tube dislodgement

Emergency procedure:	☐ Cover site and notify parent ☐ Reinsert gastrostomy tube/skin-level button by RN/LVN ☐ Call 9-1-1
Reinsertion will occur within:	☐ 20 minutes ☐ 30 minutes ☐ 1 hour ☐ Other:
Balloon Inflation with:	☐ Sterile Saline (provided by parent) ☐ Bottled Water (provided by parent) ☐ Clean Water

Gastrostomy Feeding

Time(s)		**Type of Formula:**		**Amount/feeding:**	
Duration of Feeding:		**Feeding Method:**	☐ Bolus ☐ Slow-drip, ***Gravity/Pump rate:***_____		
Water:	☐ Before or After: ☐ None	Water before feed:_____mL Water after feed:_____mL	**Student's position during feeding:**	☐ Sitting up ☐ Laying Down ☐ Other:	

Water Bolus:

Time(s)		**Student Position**	☐ Up Right ☐ Laying Down ☐ Other:	**Amount:**	
Bolus Method:	☐ By Gravity ☐ Slow Push over _____ seconds				

Oral Feedings

☐ NPO (nothing by mouth) ☐ Tiny tastes of food/liquids ☐ Thin Liquids ☐ Thick Liquids ☐ Pureed foods ☐ Other:

Residual:

☐ Residual check not necessary ☐ Check residual: ☐ Feed if residual <_____mL ☐ Hold feeding if residual >_____mL

Venting:

☐ Before Feeding ☐ After feeding ☐ During Feeding ☐ PRN for sign/symptoms		**Duration:**	
Fundoplication:	☐ No ☐ Yes, date:	**Other pertinent information:**	

Medication Authorization for Medication administered via g-tube at school:

☐ No medication administered via g-tube ☐ Yes (medication authorization must be completed below)

Medication #1 Name:						**Dose:**	
Route:	☐ Gastrostomy port ☐ Other:					**Time:**	
Medication Prep:	☐ Mixed ☐ Crushed	**Amount of Water For Dilution:**		**mL**	**Water Flush:**	☐ Before and After ☐ Only After	Water before feed:_____mL Water after feed:_____mL

Authorized Healthcare Provider Authorization for Management of Gastrostomy In School Setting

My signature below provides authorization for the above-written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the credentialed school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

MD/DO/PA Name (printed):			**Stamp:** (or address and phone)	
MD/DO/PA Signature:		**Date:**		

SIGNATURES			
Parent/Guardian (Authorization and Disclaimer): The parent(s)/guardian(s) of the above-named pupil, request that the specialized physical healthcare service, gastrostomy management, be administered to my (our) child in accordance with state laws and regulations. I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary. I (we) will: 1. provide the necessary supplies and equipment; 2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and 3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.			
Parent/Guardian Signature:		**Date:**	
District Nurse Signature:		**Principal Signature:**	

Gastrostomy Tube/Button Replacement Standard Healthcare Procedure

Student:		**DOB:**		**Date:**	
School:		**Teacher:**		**Grade:**	

Purpose	To maintain patency of surgical opening (ostomy); a clean (not sterile) procedure Procedure performed when tube is accidentally dislodged and/or is out of position and patency of stoma is in jeopardy. * Temporary ostomy patency steps may be performed by designated qualified school staff if authorized.	
Equipment and Supplies	1. Catheter (Foley or MIC) or MIC-Key replacement kit of appropriate size 2. Clamp 3. Catheter plug or rubber band 4. Water-soluble lubricant 5. Water (sterile or distilled) or normal saline; small container 6. Cleaning solution for stoma 7. 60 cc syringe	1. Gauze squares (2x2 and 4x4) 2. Luer-Lok or slip tip syringe 3. Disposable towel 4. Non-latex gloves 5. Nontoxic permanent marking pen 6. Hypoallergenic tape 7. Plastic bags for waste material

PROCEDURE

Essential Steps-Suction Set Up	Key Points and Precautions-Suction Set Up
1. Immediately cover stoma with gauze square. ● Tape gauze in place using hypoallergenic tape. ● If no steps to reinsert tube or insure patency will be taken, contact parent or caregiver immediately. **New g-tubes (< 3 weeks) must be replaced within 2–3 hours to prevent closure of stoma.**	**1. REINSERTION PROCEDURE PRECAUTIONS:** ● IF G-TUBE INITIALLY INSERTED 6 WEEKS OR LESS, REINSERT TO MAINTAIN TEMPORARY PATENCY IF AUTHORIZED. DO NOT USE. Contact healthcare provider. ● IF MIC-KEY INSERTED 8–10 WEEKS OR LESS, do not reinsert unless specifically ordered by healthcare provider.
2. Wash hands.	2. Standard Precautions
3. Position pupil lying on back (supine position). Explain procedure as appropriate.	3. Supine position allows easier insertion of catheter into stoma. Pupil's head may be slightly elevated.
4. Assemble equipment on a clean, flat surface. ● Put on non-latex gloves. ● Squeeze small amount of water-soluble lubricant onto paper towel.	4. Insertion is easier if catheter/tube is lubricated. Do not use petroleum jelly or other oil-based lubricant.
5. **Remove catheter or MIC-KEY set from package.** ● **FOR CATHETER INSERTION, FOLLOW STEPS 6–14 (page 2)** ● **FOR MIC-KEY DEVICE, FOLLOW STEPS 6.1–14.1 (page 3)**	5. Check expiration date and correct size of catheter or MIC-KEY device. AVOID TOUCHING TIP.

STEPS 6–17: PROCEDURE FOR INSERTION OF CATHETER (Performed by licensed nurse only)

6. Test balloon for leaks: fill syringe with specified amount of fluid per physician's orders ● Insert tip into end of catheter and instill fluid. If there are no leaks, withdraw water from balloon.	6. After testing for leaks, refill syringe with fluid per physician's orders. Set syringe and catheter aside on clean work surface. See manufacturer's instructions for balloon inflation.

7. Cleanse stoma area with gauze & cleansing solution.	7. If soap solution is used for cleansing, rinse with water using 4x4 gauze squares.
8. Lubricate tip of catheter by rotating it in water-soluble lubricant on paper towel.	8. Do not use petroleum jelly or other oil-based lubricant.
9. Insert catheter: Hold catheter at a right angle to surface of abdomen. Insert it slowly and gently straight into stoma 2–2 ½ inches (5-6 cm). **If any resistance is felt, STOP procedure.** **Do not force tube into stoma.**	9. Cover area with sterile 4x4 gauze pad and tape in place. Contact parent/caregiver immediately. Pupil must see a healthcare provider as soon as possible.
10. Inflate balloon. ● Holding catheter in place, insert syringe tip. ● Inflate balloon by instilling fluid from syringe. ● Pull back gently on catheter until resistance is felt to ensure proper placement against stomach wall.	10. Do not use a needle on the syringe.
11. If using Foley, mark catheter with a circle around the tube approximately 1 inch (2.54 cm) above the stoma using a nontoxic permanent marking pen. The tube may also be marked using a circle of tape. **If using MIC tube,** after insertion of tube and inflation of balloon, move bolster down until resistance is felt to ensure proper placement against stomach wall.	11. This mark on Foley provides a placement landmark to ensure that the catheter does not move into the lower stomach and small intestine during peristalsis. Marks on MIC are present from manufacturer.
12. Check placement of catheter ● Attach 60 cc syringe to tip of catheter. ● Slowly lower syringe below level of stomach until gas or stomach contents are observed.	12. If scant or no flow occurs, gently push catheter inward approximately 1 inch and twirl it slightly.
IF RED BLOOD RETURNS, CLAMP TUBE & SECURE WITH TAPE. CALL HEALTHCARE PROVIDER IMMEDIATELY.	**MONITOR VITAL SIGNS AND CALL 911 IF INDICATED.**

PLACEMENT MUST BE VERIFIED BEFORE FEEDINGS RESUME.
IF UNABLE TO VERIFY PLACEMENT, HEALTHCARE PROVIDER'S VERIFICATION MUST OCCUR PRIOR TO FURTHER FEEDING.

13. Close end of catheter with catheter cap/plug or by folding tubing and wrapping a rubber band securely around fold in tube.	**Pupil-specific instructions:**
14. Secure the tube using tape or stretch netting. Replace pupil's clothing.	
15. Discard waste materials in plastic bag. Remove and discard gloves. Wash hands.	
16. Notify parent/caregiver immediately so that replacement with permanent g-tube can be done as soon as possible.	
17. Document procedure on feeding log and in IHP log.	

STEPS 6.1–17: PROCEDURE FOR REINSERTION OF MIC-KEY GASTROSTOMY BUTTON

Performed by licensed nurse only

IF BLEEDING IS PRESENT, DO NOT REINSERT BUTTON. NOTIFY HEALTHCARE PROVIDER IMMEDIATELY.

6.1. Test the balloon on new MIC-KEY for leaks: ● Inflate the balloon with 5 cc sterile water or saline. ● Remove syringe and observe balloon.	6.1. Balloon should be symmetrical and have no leaks.
7.1 Deflate the balloon by withdrawing liquid: ● Attach syringe to balloon valve of MIC-KEY. ● Pull back on plunger until all water is withdrawn from balloon.	
8.1. Lubricate tip of replacement MIC-KEY with water-soluble lubricant.	8.1. Do not use petroleum jelly or other oil-based lubricant.
9.1. Insert MIC-Key: Holding tube at right angle to surface of abdomen, gently insert tube into stoma. Continue inserting tube until MIC-Key is flat against skin.	
10.1. Hold tube in place. ● Insert syringe filled with specified amount of water/saline per physician's orders into balloon valve. ● Inflate balloon by instilling fluid from syringe. ● Remove syringe.	10.1. Do not use air or tap water in syringe.
11.1. Position balloon against stomach wall by gently pulling MIC-KEY up and away until it stops.	
12.1. Wipe fluid & lubricant away from tube & stoma.	
13.1 Check placement of MIC-KEY tube. ● Insert the extension set in feeding port. ● Insert 60 cc syringe into tube. Slowly lower syringe below level of stomach until gas or stomach contents are observed.	
14.1. Check for wetness around stoma. If there is leakage of stomach contents, check tube position. Replace pupil's clothing.	14.1 Add sterile water or saline to balloon in 1–2 cc increments. Never fill balloon with more than 10 cc of fluid.
PLACEMENT MUST BE VERIFIED BEFORE FEEDINGS RESUME. IF UNABLE TO VERIFY PLACEMENT, HEALTHCARE PROVIDER'S VERIFICATION MUST OCCUR PRIOR TO FURTHER FEEDING.	
15. Discard waste materials in plastic bag. Remove and discard gloves. Wash hands.	15. Before removing gloves, place dislodged tube/button in plastic bag. Return device to parent.
16. Notify parent/caregiver immediately that MIC-Key has been replaced.	16. Remind parent to replace supplies when pupil returns to school.
17. Document procedure on feeding log and in IHP log.	
Pupil-specific instructions:	

Guidelines for Maintaining Ostomy Patency

If authorized, steps to maintain <u>temporary ostomy patency</u> may be performed by designated qualified school staff under supervision of licensed credentialed school nurse.

1. Wash hands and put on non-latex gloves.	1. Standard Precautions
2. <u>Immediately</u> cover stoma with sterile gauze square. ● **Tape gauze in place using hypoallergenic tape.** **Remove gloves.** ● **Notify school nurse that gastrostomy tube/button is dislodged. Request direction regarding whether to proceed with steps to maintain patency.** ● **If directed by school nurse to provide steps to ensure ostomy patency, proceed with following steps.**	2. If <u>gastrostomy tube</u> was initially inserted 6 weeks ago, do not attempt to ensure patency. School nurse may reinsert tube, if authorized by healthcare provider. If <u>MIC-Key</u> was initially inserted 8–10 weeks or less, school nurse may reinsert device, if authorized by healthcare provider. Parent/caregiver must be notified immediately. New gastrostomy tubes must be replaced within 2-3 hours.
3. Position pupil lying on back (supine position). Explain procedure as appropriate.	3. Head may be slightly elevated.
4. Wash hands. **Assemble equipment on clean, flat surface:** ● Catheter (Foley or MIC) ● Water-soluble lubricant ● Hypoallergenic tape	4. Standard Precautions
5. Put on clean non-latex gloves. ● Remove gauze square. ● Squeeze small amount of water-soluble lubricant onto paper towel.	5. Catheter is easier to insert if lubricated. Do not use petroleum jelly or other oil-based lubricant.
6. Remove catheter from package. ● Check expiration date and correct size of catheter.	6. AVOID TOUCHING TIP OF CATHETER
7. Insert catheter. ● Hold catheter at a right angle to surface of abdomen. ● Insert it slowly and gently straight into stoma 2–2 ½ inches (5-6 cm). ● **If any resistance is felt, STOP procedure.** **DO NOT FORCE TUBE INTO STOMA.** ● **Cover area with sterile 4X4 gauze pad.** **Tape in place.**	7. Contact parent/caregiver immediately. Pupil may need to see a healthcare provider as soon as possible.
8. Secure catheter on abdomen with tape.	8. Place dislodged tube/button in plastic bag to return to parent.
9. Remove and discard gloves. Wash hands.	
10. Keep pupil still and lying down until school nurse and/or parent arrives at school site.	
11. Document incident and actions taken in collaboration with school nurse.	

Pupil-specific instructions:

Gastrostomy Tube/Button Medication Administration Standard Healthcare Procedure

Student:		**DOB:**		**Date:**	
School:		**Teacher:**		**Grade:**	
Purpose	To provide medication directly to pupil's stomach when oral route must be bypassed.				
Equipment and Supplies	8. 10 or 12 cc syringe with adaptable tip 9. Prescribed medication 10. Warm water and container		1. Calibrated cup 2. Device to crush medication in tablet form		

PROCEDURE

Essential Steps-Suction Set Up	Key Points and Precautions-Suction Set Up
1. Wash hands.	1. Standard Precautions
2. Assemble equipment on a clean, flat surface.	
3. Prepare medication. ● Use liquid medication whenever possible. ● Allow adequate time for tablets and capsules to dissolve thoroughly before administration. **(a) Liquid medication:** measure dose in calibrated cup; mix with 10–20 cc warm water. **(b) Tablet:** crush into very fine powder; dissolve in 10–20 cc warm water. **(c) Capsule:** open capsule; dissolve in 10–20 cc warm water, if possible. ● DO NOT MIX MEDICATION WITH FORMULA UNLESS FLUID IS RESTRICTED. See Note #2 at end of procedure.	3. Medication and any required diluent should be at room temperature. (a) If possible, avoid oily medications that tend to cling to sides of tube. (b) Never crush enteric-coated or sustained-release tablets or capsules. (c) Avoid sprinkle-type medication if possible. (d) See Note #1 at end of procedure for alternative technique if capsule contents are difficult to dissolve.
4. Position pupil and explain procedure.	4. Use developmentally appropriate communication.
5. Prepare tube or button for instillation of fluids.	5. For gastrostomy button: small amounts of medication diluted with water can be administered directly into feeding port with luer tip syringe. This eliminates need for extension tubing.
6. Attach syringe with adaptable tip (without plunger) to tube or feeding port. ● Unclamp tube and instill 5–10 cc water to flush port before administering medication. ● Pour liquefied medication into syringe and allow medication to flow by gravity. ● When medication has drained out of syringe, follow with 5–10 cc water to flush tube. ● Clamp tube or replace cap; secure tube.	6. Additional water for flushing tube may be needed after administering some types of medication (e.g., suspensions). ● If administering more than one medication at the same time, flush tube with water after each medication.
7. Record procedure on medication log.	

NOTE # 1: Mix sprinkles with small amount of pureed fruit and thin with water. The fruit keeps sprinkles suspended so they don't float to top of solution. Tube should be flushed very well after instilling medication solution.
This method should only be used if tube gauge is 18 French or greater; NOT recommended for skin-level devices.

NOTE #2: If medication must be added to formula—(a) Check with pharmacist for compatibility. (b) Shake formula well and observe for any physical reaction (e.g., separation, precipitation). (c) Label formula container with name of medication, dosage, date and time feeding started, if feeding is administered via continuous drip or pump.

Gastrostomy Tube/Button Decompression Standard Healthcare Procedure

Student:		**DOB:**		**Date:**	
School:		**Teacher:**		**Grade:**	
Purpose	To relieve air or gas from the stomach.				
Equipment and Supplies	11. 60 cc syringe 12. Decompression tube/tool or extension set compatible with button			1. Disposable towel 2. Non-latex gloves 3. Container for equipment/supplies	

PROCEDURE

Essential Steps-Suction Set Up	Key Points and Precautions-Suction Set Up
1. Verify need for decompression (venting). Follow authorization and/or observe pupil's symptoms.	1. Pupil's symptoms indicating need for decompression: See physician's orders
2. Position pupil sitting with head elevated at least 30 degrees or lying on right side. Provide privacy.	2. Explain procedure to alleviate anxiety. Use developmentally appropriate communication.
3. Wash hands.	3. Standard Precautions
4. Assemble equipment on a clean, flat surface.	4. Decompression is a clean procedure. Preparation and organization ensures efficient delivery of the service and the pupil's safety.
5. Put on disposable non-latex gloves.	5. Standard Precautions
6. Button: attach decompression tube/extension set to syringe. Inspect tube carefully. Clamp tube near distal end. **G-tube**: **clamp tube; remove cap & attach syringe.**	6. Decompression tube/extension set should fit securely into syringe. If damaged, do not use.
7. Sit beside pupil on the side closest to the gastrostomy tube/button.	
8. Expose gastrostomy tube/button. ● Place disposable towel close to device. ● Observe area around site.	8. Towel provides protection against leakage of gastric contents. Report any unusual observations to school nurse.
9. Open gastrostomy button slowly by supporting side closest to stomach with one hand and opening safety plug with other hand.	
10. Button: insert decompression tube or extension set into button feeding port.	10. Some brands of button require a special decompression tube or tool.
11. Cover end of syringe with gloved hand. ● Hold syringe above stomach level and unclamp tube. ● Slowly lower syringe to level lower than stomach, controlling return of stomach content.	11. This decreases possibility of exposure to stomach fluid and facilitates emptying of stomach fluids and/or air.
12. Allow stomach contents and/or air to flow out for authorized amount of time: ____	12. This usually takes between 1–3 minutes.
13. ☐ Return stomach contents to stomach as authorized ● Elevate syringe above stomach level to allow stomach contents to flow back into stomach. ● Clamp tube before contents completely empty. ☐ Pupil-specific authorization: see physician's ordrs	13. Stomach contents contain important electrolytes and nutrients. Do not allow air to flow back into stomach.

Gastrostomy Tube/Button Bolus Feeding Standard Healthcare Procedure

Student:		**DOB:**		**Date:**	
School:		**Teacher:**		**Grade:**	

Purpose	1. To deliver adequate fluid and nutrition directly to the stomach. 2. To administer medication when the oral route must be bypassed (licensed nurse task only).	
Equipment and Supplies	13. Prescribed formula/feeding & medication, if ordered, at room temperature 14. 60 cc catheter-tipped syringe 15. Measuring containers for formula & water 16. Non-latex gloves 17. Container for equipment and supplies 18. Disposable towel	4. Optional: tray to hold feeding equipment 5. ☐ Gastrostomy tube: clamp or plug for catheter 6. ☐ Skin-level device (button): ● bolus extension set ● decompression tube, if needed 7. Liquid detergent for washing equipment 8. Plastic bags for waste disposal

PROCEDURE

Essential Steps-Suction Set Up	Key Points and Precautions-Suction Set Up
1. Explain procedure to pupil. Provide privacy during feeding if indicated.	1. Use developmentally appropriate communication. Encourage pupil to participate to extent possible.
2. **Wash hands.**	2. Standard Precautions
2. Assemble equipment on a clean flat surface. ● Verify that feeding is at room temperature. ● Check formula expiration date. Shake can(s) well. ● Measure prescribed amounts of formula and water in clean containers.	3. Maintain a clean field during procedure. ● Refrigerate any unused portion in a clean, covered container labeled with pupil's name, date and time.
4. Position pupil in a semi-sitting position or lying with head elevated at least 30 degrees unless contraindicated. ● Arrange pupil's clothing to expose gastrostomy tube/button site for continual observation during feeding. ● Place a disposable towel on pupil's lap.	4. Elevation of pupil's head facilitates digestion and prevents vomiting and aspiration of fluid into lungs. ● Authorized healthcare provider may specify an alternative position.
5. Put on non-latex gloves.	5. Standard Precautions
6. Administer feeding. A licensed nurse may administer prescribed medication before or after feeding, according to authorization. **6.1 <u>Follow these steps for</u> <u>feeding via</u> <u>gastrostomy tube</u>** **a. Verify placement of tube in stomach.** **Check residuals and decompress (vent) if ordered.** ● Remove cap from end of g-tube. ● Insert catheter-tipped syringe <u>without</u> plunger into end of g-tube. Cover end of syringe with gloved hand. ● Unclamp tube; slowly lower syringe barrel until stomach contents can be seen in tube or gas is released. ● Clamp tube close to distal end. Pupil-specific notes: _____	6. Administer feeding **6.1 <u>Feeding via</u> <u>gastrostomy tube</u>** **a.** If stomach contents are seen and/or gas is released, this verifies that tube is in stomach. ● If residual fluids containing formula are obtained, follow authorization for steps regarding measuring volume and postponing feeding for a specified amount of time: _____ ● <u>If stomach contents or gas are not obtained, do not proceed; notify school nurse.</u> ● Provide decompression (venting) during or after feeding, or as needed for specified signs and symptoms, according to authorization: _____ See decompression procedure for guidelines.
b. Pour feeding into tilted syringe and fill tube. Unclamp tube; allow liquid to flow in slowly by gravity. ● **Continue to pour feeding into syringe as liquid flows into stomach.**	**b.** Filling tubing prevents excess air from entering stomach **Hold syringe 3–6 inches above level of stomach. Raise or lower syringe to adjust flow.**

● Give formula slowly over 20–30 minute period. ● If needed, occasionally hold syringe below level of stomach to allow any gas buildup to escape. ● Be alert to any changes in pupil's tolerance of feeding. STOP FEEDING IMMEDIATELY IF PUPIL HAS DIFFICULTLY BREATHING OR COLOR CHANGES. NOTIFY SCHOOL NURSE. ● After feeding is completed, let formula drain to bottom of syringe and clamp tube. **c. ☐ Vent, if ordered, prior to flushing.** **d. Flush g-tube when venting is complete: using syringe, instill, by gravity flow, prescribed amount of water.** **e. Clamp g-tube, allowing some water to remain in tube; remove syringe and insert cap into end of g-tube. Secure tube and tuck inside clothing.** **f. Remove gloves and wash hands.**	● Keep syringe partially filled to prevent air from entering stomach. Tilting syringe allows air bubbles to escape instead of entering stomach. ● If formula will not flow in by gravity, try rotating tube slightly or squeezing the length of tube. Notify school nurse if unable to clear tube by these means. DO NOT USE PLUNGER TO FORCE TUBE TO CLEAR. ● Nausea/vomiting, cramping or diarrhea may indicate that the feeding is being given too quickly or formula is too cold. ● If pupil shows signs of regurgitation or abdominal distention, STOP feeding. Leave tube open to relieve pressure. Contact school nurse for direction regarding decompression. Document incident on daily log. **c.** Venting prevents abdominal distention and discomfort. **d.** Flushing prevents buildup of formula. Water should be at room temperature.
6.2 <u>Follow these steps for</u> <u>feeding via gastrostomy button</u> **a. Verify placement of tube in stomach. Check for residuals and vent if ordered.** ● Remove plunger from syringe; attach syringe to bolus extension tubing. Clamp close to opposite end of tubing. ● Remove the feeding port cover (plug) from button; Stabilize button with one hand; attach bolus extension tube set to feeding port. Align lock and key connector. Follow manufacturer's instructions to lock extension set in place. ● Remove clamp. Slowly lower syringe barrel until stomach contents can be seen in tube or gas is released. Clamp tube close to distal end. ● Some skin-level devices require use of a special decompression tube or air-releasing tool. Follow manufacturer's instructions (attach to procedure). ● **b. Pour feeding into tilted syringe and fill tube. Unclamp tube; allow liquid to flow in slowly by gravity. Hold syringe 3–6 inches above level of stomach; raise or lower syringe to adjust flow.** ● Continue to pour feeding into syringe as liquid flows into stomach. ● Give formula slowly over 20–30 minute period. ● After feeding is completed, let formula drain to bottom of syringe and clamp tube. ● Be alert to any changes in pupil's tolerance of feeding. STOP FEEDING IMMEDIATELY IF PUPIL HAS DIFFICULTLY BREATHING OR COLOR CHANGES. NOTIFY SCHOOL NURSE. **c. ☐ Vent, if ordered, prior to flushing.** **d. Flush g-tube when venting is complete: using syringe, instill, by gravity flow, prescribed amount of water.** **e. Clamp tubing, remove syringe and extension set; close feeding port with plug.** **f. Remove and discard gloves. Wash hands.**	**6.2 <u>Feeding via gastrostomy button</u>** **a.** If stomach contents are seen and/or gas is released, this verifies that tube is in stomach. ● <u>If stomach contents or gas are not obtained, do not proceed; notify school nurse.</u> ● If residual fluids are obtained, follow authorization for steps regarding measuring volume and postponing feeding for a specified amount of time: _____ ● Use of decompression extension tube is not recommended for feeding because this weakens the one-way valve. **b.** Keep syringe partially filled to prevent air from entering stomach. Tilting syringe allows air bubbles to escape instead of entering stomach. ● If formula will not flow in by gravity, try squeezing the length of tube. Notify school nurse if unable to clear tube by these means. DO NOT USE PLUNGER TO FORCE TUBE TO CLEAR. ● If needed, occasionally hold syringe below level of stomach to allow any gas buildup to escape. ● Nausea/vomiting, cramping or diarrhea may indicate that the feeding is being given too quickly or formula is too cold. If pupil shows signs of regurgitation, STOP feeding. Leave tube open to relieve pressure. Notify school nurse and document incident. **c.** When venting a button other than MIC-KEY, insert decompression tube into button, then attach syringe. Venting prevents abdominal distention and discomfort. **d.** Water should be at room temperature. Flushing prevents build-up of formula inside tube, which can cause a clogged tube.
7. Post-feeding care of pupil a. If pupil is non-ambulatory, maintain him/her in upright position or on right side with head elevated at least 30 degrees for 30 minutes.	7. Post-feeding care of pupil a. Elevation reduces risk of vomiting and aspiration. Ambulatory pupil may resume school activities when tolerated.

b. Observe pupil closely for symptoms that indicate untoward effects of feeding. c. Contact school nurse, authorized healthcare provider and/or parent if complications occur.	b. Watch for gagging, sweating, restlessness, color change or distended abdomen.
8. Clean and store feeding equipment. a. Put on gloves. Flush feeding equipment thoroughly with cool tap water immediately after use. b. Wash syringe, bolus extension set, if used, and other reusable equipment with warm, soapy water. Rinse thoroughly. c. Shake excess water off equipment; allow to air dry. d. Place cap on syringe tip after drying to prevent bacteria from settling on tip. Store equipment in a designated container in a clean area. e. Open formula should be stored in a clean, labeled plastic container, not the original can. Refrigerate; discard unused formula after 24–48 hours. f. Dispose of waste materials. Remove gloves.	8. Clean and store feeding equipment. a. Rinsing with cool water helps to remove milk products. d. Equipment can be placed in zippered plastic bag and refrigerated to inhibit bacterial growth.
9. Remove and discard gloves. Wash hands.	9. Standard precautions
10. Document procedure on Daily Log: ● date, time and duration of feeding ● results of decompression and residual check ● amount of feeding/formula and water given ● pupil's response/tolerance.	10. Note pertinent information such as appearance of abdomen and stoma, problems reported to school nurse or parent.
Pupil specific notes:	

Gastrostomy Tube/Button Feeding Standard Healthcare Procedure—Pump Delivery Method

Student:		**DOB:**		**Date:**	
School:		**Teacher:**		**Grade:**	

Purpose	1. To deliver adequate fluid and nutrition directly to the stomach over an extended period of time to avoid complications such as vomiting, aspiration and abdominal distention caused by excess gas in the stomach. 2. To administer medication when the oral route must be bypassed (licensed nurse task only).	
Equipment and Supplies	1. Prescribed formula/feeding 2. 60cc catheter-tipped syringe 3. Non-latex gloves 4. Feeding pump and tubing 5. Feeding bag 6. Power cord	7. Disposable towel 8. Feeding poles for various situations & positions 9. Clamp 10. Liquid detergent for washing equipment 11. Plastic bags for waste disposal 12. Container for equipment and supplies

PROCEDURE

Essential Steps-Suction Set Up	Key Points and Precautions-Suction Set Up
1. See procedure for continuous slow-drip feeding regarding preparation of pupil, hand washing and checking g-tube placement. ● Rate and volume of fluid delivered will probably be preset by parent or residential nursing personnel prior to pupil's arrival at school.	1. The rate and volume settings should not be changed by unlicensed designated school staff. Staff should direct questions on rate and volume setting to the school nurse, who will contact the appropriate person to verify settings.
2. The pump can operate on battery power or be plugged into a wall outlet. Determine the pupil's activity during feeding. If pupil will remain in a stationary position, plug power cord into unit and a convenient wall outlet. Turn on pump; it may perform a system check.	2. If battery is fully charged and pupil will be active and moving around the school site, the pump can operate on battery power during the school day. If battery is low, plug cord into wall unit to continue feeding. Follow pump manufacturer's instructions.
3. Prepare feeding. Add formula to bag, if necessary. ● Clamp tubing. Attach drip chamber according to pump directions. ● Slowly open clamp and fill entire line with fluid. ● Clamp tubing.	3. Bag of formula and attached tubing may be sent to school daily with pupil. ● Avoid filling drip chamber more than half full. ● Monitor feeding bag during feeding; add room temperature formula if authorized.
4. Load pump set in pump according to pump directions. Attach distal connector to feeding tube or button.	4. Verify that pump set is properly loaded before proceeding. An improperly loaded pump set could result in uncontrolled flow and possible injury to pupil.
5. Press the START/HOLD button. Proceed with feeding.	5. See manufacturer's directions regarding alerts for pump malfunctions.
6. When feeding is completed or a break is scheduled, remove the tubing from the gastrostomy tube/button, and then remove it from the pump. ● Send equipment home with pupil at end of school day. Left over formula in the bag should be refrigerated if school dismissal will be more than 15-20 minutes after feeding is stopped. ● The feeding pump should remain clamped to the pupil's wheelchair unless there are alternative authorized instructions.	6. It is unlikely that any post-feeding complications will occur due to the slow speed of infusion, so it is not necessary to keep the pupil in any special position during breaks from the feedings. ● Venting and/or flushing the g-tube are not necessary for the student on continuous feedings, unless specifically ordered by authorized healthcare provider.
7. Document procedure on Daily Log: ● date, time and duration of feeding ● amount of feeding/formula and water given	7. Note any other pertinent information such as appearance of abdomen and stoma, problems reported to school nurse or parent.

(Attach pump manufacturer's instructions to procedure)