LEON COUNTY SCHOOLS

Specialized Health Care Procedure:

Gastrostomy Button Feeding Procedure – Bolus Method

Purpose: To provide a means of nourishment when the Oral (by mouth) route is not an option.

Requirements: Parents/guardians are required to sign a written authorization for the gastrostomy tube feeding. A written physician order must also be obtained. Parents/guardians are required to provide all necessary equipment/supplies.

Personnel authorized to perform procedure: Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

Equipment required: Liquid feeding solution/formula; 60-ml catheter-tipped syringe or other container for feeding (bottle/bag); tubing with clamp; adaptor; water; gloves

Special Considerations: Food should be given at room temperature or slightly warm. If the student is given medication through the tube, the tube should be flushed with water prior to and immediately after the procedure.

Procedure:

1. Wash hands.
2. Assemble equipment.
3. Explain the procedure to the student at his/her level of understanding.
4. Position student. (Student may be sitting or lying on right side.)
5. Remove plunger from syringe and attach the tubing and adaptor to feeding syringe.
6. Prime tubing with feeding and clamp tubing.
7. Open safety plug from device and insert adaptor and tubing into device.
8. Elevate syringe and unclamp tubing.
9. Raise or lower syringe to adjust flow to prescribed rate.
10. Continue to pour feeding into syringe as contents empty into stomach.
11. Flush tubing and device with water, if ordered.
12. When feeding is complete, clamp tubing and remove the adaptor with feeding syringe.
13. Close the safety plug.
14. Remove gloves. Wash hands.
15. Refer to student-specific guidelines regarding position and activity after feeding.
16. Wash syringe and tubing with warm water and mild soap. Rinse, dry, and store in clean area.
17. Document feeding/medication and feeding tolerance on log sheet.

Parent Authorization for Specialized Health Care Procedure

I, the undersigned, who is the parent/guardian of _____ request that the following health care service:

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be administered to my child. I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

Signature of parent/guardian _____

Date _____

Physician's Order for Specialized Health Care Procedure

Student's Name _____ DOB _____

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Check one:

_____ I have reviewed the Health Care Procedure and approve of it as written.

_____ I have reviewed the Health Care Procedure and approve of it with the attached amendments.

_____ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): _____

Physician's Signature: _____ Date: _____