Memorial MEDICAL CENTER

Springfield, Illinois

Patient Care Policy/Procedure

Date: June, 2016

Subject: Nasogastric Tube Insertion, Care, and Removal

Purpose: Inserted to decompress the stomach after major surgery or with conditions affecting the GI tract when normal peristalsis is slowed or absent.

EQUIPMENT

Nasogastric tube
Towel or linen-saver pad
Emesis basin
Facial tissues
Hypoallergenic tape
Gloves
Water-soluble lubricant
Glass of water with straw (if appropriate)
Stethoscope
Irrigation set
Suction equipment if ordered

Procedure:

1. Insertion:
   - A. Wash hands.
   - B. Explain procedure to patient and provide privacy.
   - C. Apply gloves.
   - D. Assist the patient to a high Fowler's position unless contraindicated.
   - E. Place towel/linen-saver pad over patient's chest. Place emesis basin and facial tissues within patient's reach.
   - F. Stand to the patient's right side if right-handed or left side if left-handed.
   - G. To determine how long the NG tube must be to reach the stomach, hold the end of the tube at the tip of the patient's nose. Extend the tube to the patient's earlobe, then down to the xiphoid process. Mark this distance on the tubing with tape
   - H. Lubricate 3-4 inches of the end of the tube with water-soluble lubricating gel.
   - I. Instruct patient to hold head straight and upright.
   - J. Insert tube gently and slowly through naris with curved end pointing down. Aim toward the ear and advance slowly (do not force past resistance).
   - K. When the tube reaches the nasopharynx, resistance will be felt. Instruct the patient to lower head slightly to close trachea and open esophagus.

L. Ask the patient to sip a glass of water through a straw (if not contraindicated) as tube is slowly advanced. If water is not used, ask the patient to dry swallow.

M. If the patient begins to cough, gag, or choke, withdraw tube slightly and stop advancement. Instruct the patient to breathe normally and take sips of water.

i. If the patient continues to cough or gag, check the back of the throat with a flashlight and tongue blade to be sure the tube isn't coiling in the oropharynx.

ii. If coiling is seen, withdraw till tip is seen in oropharynx, then reinsert with patient swallowing.

iii. If coughing continues or the patient develops signs of respiratory distress, remove the tube immediately.

N. Continue advancing until the tape mark reaches the patient's nostril.

O. Attach irrigation syringe and try to aspirate stomach contents. If none obtained, position the patient on Left side to move contents into the stomach's greater curvature and aspirate again.

P. If still unable to aspirate stomach contents, advance tube 1-2 inches, then inject 10cc of air into the tube. At the same time, auscultate for air should with stethoscope placed over the epigastric region.

Q. Secure the NG to the patient's nose with hypoallergenic tape. Split one end of the tape up the center about 1 ½ inches. Stick the uncut tape to the patient's nose then crisscross the loose ends around the tube. Apply a second piece of tape over the bridge of the nose.

R. Attach the tube to suction equipment if ordered and set the designated suction pressure.

S. Note: NG/OG tubes used ONLY for suction do not require placement verification via xray.

i. If the NG/OG tube is to be used for medication or tube feeding, placement verification via xray is **required**. A physician's order is necessary for the placement xray. The radiologist will contact the floor nurse to confirm placement. The floor nurse will document on the ClinDoc flowsheet that they received placement verification. It is not necessary to contact the ordering physician for an 'OK to use' order.

ii. Immediately following radiographic confirmation of correct tube placement, mark the tube with indelible ink at the exit site from the nare/lip. This mark is confirmed at a minimum of every shift to validate correct placement before feeding or administering medication through the tube.

2. **Routine tube care:**

A. Provide mouth care at least once a shift or as needed.

B. Change the tape securing the tube at least daily. Clean the skin, apply fresh tape, and dab water-soluble lubricant on the nostrils as needed.

C. Regularly check that the tape secures the tube because sweat/nasal secretions may loosen the tape.

D. Measure drainage amount every 8 hours. Inspect drainage for color, consistency, odor and amount.

E. Irrigate the NG with 30 ml of irrigant before and after instilling medication. Wait about 30 minutes (or as ordered) after instillation before reconnecting the suction equipment.

F. If no drainage appears, check suction equipment for proper function.

G. The NG may also be clogged or incorrectly positioned. Attempt to irrigate or reposition the tube. If still no drainage, notify the physician.

3. **Removal**

A. Explain procedure to patient and provide privacy.

B. Wash hands.

C. Apply gloves.

D. Use irrigation catheter to flush tube with 10ml normal saline to ensure the tube doesn't contain stomach contents that could irritate tissue during tube removal.

E. Untape the tube from the patient's nose.

F. Clamp the tube by folding it in your hand to prevent additional drainage during removal.

G. Instruct the patient to hold their breath to close the epiglottis then withdraw tube gently and steadily.

H. Assist with mouth care and clean tape residue from nose with adhesive remover.

References:

Perry, A.G., Potter, P.A., & Ostendorf, W.R., (2014). Clinical Nursing Skills & Techniques (8th Edition). St. Louis: Mosby. pp. 857-863.

AACN Practice Alert—Initial and ongoing verification of feeding tube placement in adults. Critical Care Nurse 36(2):e8-e12. Updated April 2016.

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