University of the Philippines Manila
THE HEALTH SCIENCES CENTER
COLLEGE OF NURSING
World Health Organization Collaborating Center for Nursing Leadership and Development
Commission on Higher Education Center of Excellence
Sotejo Hall, Pedro Gil St., Ermita, Manila

N11 – NURSING FOUNDATION II

Name: **Group:** **Date:**

TITLE:	**INSERTING A NASOGASTRIC TUBE (NGT)**
DEFINITION/ DESCRIPTION:	For medical, surgical, or diagnostic procedures, access into the gastrointestinal system (GI) is necessary. Enteral access is commonly achieved using the nasogastric tube (NGT). Other means include nasointestinal (nasoenteric) tube, and gastrostomy or jejunostomy tubes. It is a medical process involving the insertion of a plastic tube through the nose, past the throat, and down into the stomach.
PURPOSES:	NG tube insertion is done for the following purposes: • To administer tube feedings and medications to clients unable to eat by mouth or swallow a sufficient diet without aspirating food or fluids into the lungs. • To establish a means for suctioning stomach contents to prevent or relieve gastric distention, nausea, and vomiting. • To remove stomach contents for laboratory analysis. • To lavage (wash) the stomach in case of poisoning or overdose of medications.

PROCEDURE: INSERTING A NASOGASTRIC TUBE AND CHECKING OF PATENCY OF TUBE

	PROCEDURE	Done	Observed	Not Done	REMARKS
1.	Verify doctor's order for NGT insertion or placement; the patient's name; the size of the tube to be inserted and whether the tube is to be attached to a suction.				
2.	Prior to performing the insertion, introduce self and verify the client's identity using institutional protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate.				
3.	Assemble equipment and supplies				
4.	Provide for client privacy Position the client: assist the client to a high-Fowler's position if his health condition permits;				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	support his head on a pillow.				
5.	Drape a linen saver pad or towel over the patient's chest and hands him an emesis basin and tissue. Wash hands and observe other appropriate infection control procedures. Don non-sterile gloves.				
6.	Prepare the tube If rubber tube is used, place on ice for 5 to 10 min. If plastic tube is used, place in warm water until tube is softer and more flexible, as needed, according to hospital policy. Or use directly from the open NGT pack. Cut a 4-inch (10 cm) piece of hypo- or non-allergenic tape. Set aside for anchoring the tube.				
7.	Determine the length of the tube to be inserted. Use the tube to mark off the distance from the tip or the client's nose to the tip of the earlobe, then down to the tip of the xiphoid process. Mark the tube at that place with tape, if the tube does not have markings.				
8.	Insert the tube a. Lubricate the tip of the tube (approximately 4 inches) with water-soluble lubricant. b. If the patient is awake, alert, and able to swallow, hand him a glass of water with a straw. c. Ask the client to hyperextend his or her neck. d. Insert the tube with its natural curve toward the client, into the selected nostril. and gently advance the tube toward the nasopharynx. e. Direct the tube along the floor of the nostril aiming downward and toward the ear on that side, not up the nose. f. Apply slight pressure to pass the tube into				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	the nasopharynx. g. If the tube meets resistance, withdraw it, relubricate, and prepare to insert it in the other nostril. h. Once the tube reaches the oropharynx (throat), ask the client to tilt head forward (chin to chest), then to drink through a straw, and swallow. (If the patient is not allowed to have water, have him swallow as you pass the tube). i. Pass the tube 5 – 10 cm (2 – 4 in) with each swallow until indicated length is inserted (taped mark is reached). Rotate tube if it meets resistance. But do not force down. j. If the client gags, stop passing the tube momentarily. Have the client rest, take a few breaths, take sips of water to calm the gag reflex. k. If the client continues to gag and the tube does not advance with each swallow, withdraw it slightly; inspect the back of the throat with penlight because the tube may be coiling.				
9.	Determine correct placement of the tube a. When tube is in place, secure it temporarily with one piece of tape b. Check tube placement: • Obtain chest x-ray to determine placement of tube (as ordered by physician). • Attach bulb or asepto syringe to end of tube and aspirate a small amount of stomach contents. Measure Ph. • Inject 10-20 cc of air through the tube with the asepto syringe while listening with a stethoscope over the gastric area. A rush of air (gurgling) can be heard if the tube is in the stomach (Whoosh test) • Ask the patient to hum. • Listen for air movement through the distal end of the tube.				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	c. If signs do not indicate correct placement in the stomach and the client is breathing without difficulty, advance the tube 5 cm (2 in), and repeat the tests. d. Clamp the tube to prevent excess air from entering the stomach and causing distention.				
10.	Once the position of the tube is confirmed, secure the tube by taping it to the bridge of the client's nose. a. If the client has oily skin, wipe the nose first with alcohol or saline solution. b. Cut a 4-inch and 2-inch piece of tape, split the 4-inch tape lengthwise at one end, leave a 1-inch tab at the end c. Place the tape over the bridge of the client's nose, bring the split end either under and around the tubing or under the tubing and back up over the nose. d. Place the 2-inch piece of tape over the bridge of the nose.				
11.	Attach the tube to a suction source or feeding apparatus as ordered or clamp the end of the tubing.				
12.	Secure the tube to the client's gown. Loop an elastic band around the end of the tubing and attach the elastic band to the gown with a safety pin or adhesive tape.				
13.	Make the patient comfortable and continue to assess level of anxiety. Assist or provide patient with oral hygiene and plan it at regular intervals.				
14.	Remove all equipment. Wash hands or perform hand hygiene.				
15.	**EVALUATION** Determine client's response and attainment of objectives. Regular monitoring for NG tube placement.				

	PROCEDURE	Done	Observed	Not Done	REMARKS
16.	Document: insertion of the tube, naris located, the means used to determine correct placement in the stomach, type and size of tube, measure of tube from tip of nose to end of tube, client responses. Note date and time of tube placement.				

Name of Student Observer & Signature	***Name of Faculty & Signature / Date***

Care of Client with NGT

This should be completed at least once daily for any patient with a nasogastric tube.

	PROCEDURE	Done	Observed	Not Done	REMARKS
1.	Assess: • The integrity of the client's skin where the tube is secured with tape. • The nares for irritation or skin breakdown. • The patient's mouth for dryness and mucosal breakdown. • The patient's psychosocial response to having the tube in place. • Whether the patient is allergic to tape (if so, ties may need to be substituted).				
2.	Assemble equipment: • Adhesive or paper tape • Soap and water • Hydrogen peroxide • Cotton-tipped applicators • Washcloth or 3 x 4 sponges				
3.	Implementation: • Explain the procedure to the patient. • Remove old tape carefully so as not to displace the tube or cause the patient discomfort. Make sure the tube is still fastened to the patient's gown. Apply wet cotton on the tape if difficult to remove. • Inspect area for irritation and crusts. • Cleanse nose and NG tube with soap and warm water. Use alcohol if the patient's skin is very oily. • Cleanse nostrils with cotton-tipped applicator. Apply water-soluble lubricant to				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	the nostril if it appears dry or encrusted • Gently rotate the tube 180° to prevent adherence of the tube to the GI tract. • Reapply the tape as previously discussed. • Assist the patient with mouth care, including brushing teeth and tongue, if able. • Check to make sure the tube is clamped or attached to suction. • Assess the patient's response to the procedure. • Chart as appropriate using a checklist or, if an alteration is observed, record on nurse's notes.				
4.	If suction is applied, ensure patency of both NGT and suction tubes is maintained a. Irrigation of NGT with 30ml NSS may be required at regular intervals after careful check of NGT placement b. Keep accurate record of fluid intake and output; record the amount and characteristics of the drainage.				

Name of Student Observer & Signature	***Name of Faculty & Signature / Date***

TITLE:	ADMINISTERING A TUBE FEEDING VIA NASOGASTRIC TUBE (NGT)
DEFINITION/ DESCRIPTION:	A nasogastric tube feeding refers to the delivery of a nutritionally complete feed (containing protein, fat, carbohydrate, vitamins, minerals, fluid and possibly dietary fiber) directly into the gastrointestinal tract via a tube. The tube feeding is used for patients who are unable to ingest adequate nutrients orally and have active bowel sounds, or unable to swallow enough nutrients to maintain nutritional status. A tube feeding does require a physician's order. A tube feeding may be given continuously over a 24-hour period or intermittently, i.e. at prescribed intervals, such as every four hours. In adults and children, the tube is left in place for days, up to a week, and then replaced when it is no longer patent or is irritating the mucosa. For infants who require tube feedings, the tube is usually introduced through the mouth (orogastric tube) just prior to each feeding. Various types of formula (commercially prepared, home-made blenderized food, and those prepared by the dietary section of the hospital or institution) are used for tube feedings. There are several preparations which must be mixed with the prescribed amount of water. Water and liquids are also administered through the NGT. Whatever type of preparation is ordered, proper storage is necessary to prevent growth of microorganisms. It is the nurse's responsibility to teach this to the client and the family.
PURPOSES:	Feeding via the NG tube is done for the following purposes: • meet the nutritional requirements of the client • avoid further loss of bodyweight or improve nutritional status • correct significant nutritional deficiencies • maintain hydration • stop the related deterioration of quality of life of the client due to inadequate oral nutritional intake. Indications for enteral tube feeding are as follows: • patient is unable to meet nutritional needs through oral intake alone (due to medical or surgical conditions, or diagnostic/treatment procedures) • the gastrointestinal tract is accessible and functioning (with clearance from physician, as needed) • it is anticipated that intestinal absorptive function will meet all nutritional needs, given the presence or absence of medical or surgical health conditions

PROCEDURE: ADMINISTERING A TUBE FEEDING VIA NASOGASTRIC TUBE

	PROCEDURE	Done	Observed	Not Done	REMARKS
1.	Verify physician's order regarding the client's name, type, and amount of formula to be given. All the 10 rights of giving medications also apply to giving feeding formula.				
2.	Wash your hands and don clean gloves, or follow infection control procedures based on institutional protocol.				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	Prepare the equipment and formula. Remember to give formula at proper temperature.				
3.	Explain to the client what you are going to do, why it is necessary, and how he/she can cooperate. Provide for client privacy. Assist the patient to a comfortable position. If this position is not possible, a semi-Fowler's position should be used. Elevate the head of the bed to at least 30 degrees; or, support his head on a pillow. Place a linen or towel under the connection end of the feeding tube				
4.	Assess correct tube placement. This needs to be done before each feeding.				
5.	Assess residual feeding contents: a. Measure the amount of stomach contents before administering the feeding. b. If 50 – 100 ml (or more than half the last feeding) is withdrawn, check first with the nurse in charge, attending physician or refer to hospital policy. Some policies require withholding the next feeding. c. Re-instill gastric contents to maintain fluid and electrolyte balance.				
6.	Administer the feeding a. Remember to administer feeding warmed to room temperature b. Syringe (Open System) When correct tube placement has been confirmed, unclamp tubing and pinch it off to prevent unnecessary air from entering. c. Remove the plunger from the asepto syringe and attach the syringe to a pinched or clamped NG tube. d. Flush the feeding tube with 30 mL of tap water. Pinch the tube when finished. e. Add the feeding to the syringe barrel f. Permit feeding to flow slowly at prescribed rate. Raise or lower the syringe to adjust the flow as needed. g. Pinch or clamp the tubing for a minute, if client experiences discomfort, then				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	continue the feeding at a slower rate. h. When the syringe is 3/4 empty, clamp tube or hold it above the level of the stomach; refill syringe; unclamp & continue feeding until prescribed amount is administered. i. After the feeding has been administered, flush the feeding tube with 30 ml of water before the feeding solution has drained from the neck of the syringe.				
7.	After feeding: a. Clamp and cover the distal end of the feeding tube b. Cover the end of the tube with gauze and make sure the tube is secure. Pin the tubing to the client's gown c. Ask the client to remain sitting upright in Fowler's position or slightly elevated right lateral position for at least 30 minutes Provide oral care as needed. d. Dispose of equipment used appropriately If equipment or supplies are to be reused, wash thoroughly with soap and water, for ready use.				
8.	**EVALUATION** Document: a. The feeding: amount and kind of solution taken; rate and duration of the feeding; client responses, behavior, and attitude toward the feeding; any discomfort experienced by the client; amount & characteristics of gastric residual contents obtained. b. Record volume of feeding and water administered on the client's intake and output record. c. Keep accurate records of the client's fluid intake and output and record the amount and characteristics of the drainage.				
9.	Monitor client: a. Assess the patient's tolerance to the feeding 1/2 to 1 hour following the feeding				

	PROCEDURE	Done	Observed	Not Done	REMARKS
	b. Assess for possible complications c. To prevent dehydration, give client supplemental water in addition to the prescribed tube feeding, as ordered.				

Name of Student Observer & Signature	***Name of Faculty & Signature / Date***

TITLE:	**REMOVING A NASOGASTRIC TUBE**
DEFINITION/ DESCRIPTION:	A nasogastric tube may be removed because it has become dislodged or displaced or if it is no longer required for feeding. If it is for removal without replacement, it should have been established that the client is able to meet his/her fluid and dietary requirements through the oral route and with the ability to swallow safely and without risk of aspiration.
PURPOSES:	Removal of the NG Tube • The NG tube is no longer required, and client can tolerate its removal. • It has become dislodged, displaced, or blocked and requires replacement. • The client is able to meet his/her fluid and dietary requirements via the oral route, with good swallowing reflex.

IMPLEMENTATION

	PROCEDURE	Done	Observed	Not Done	REMARKS
1.	a. Verify patient using two identifiers. b. Explain to the client what you are going to do, why it is necessary, and how he can cooperate c. Provide for client privacy d. Position the client: assist the client to a high- Fowler's or sitting position if his health condition permits; support his head on a pillow. e. Wash hands and observe other appropriate infection control procedures. Apply clean gloves.				

	PROCEDURE	Done	Observed	Not Done	REMARKS
2.	a. Place the disposable pad or towel across the client's chest b. Provide tissues to the client to wipe then nose and mouth after tube removal c. Using a catheter-tip syringe, flush the tube with 10ml. of normal saline solution or drinking water				
3.	Detach the tube: a. Disconnect the NGT from the suction apparatus if present b. Unpin the tube from the client's gown c. Gently remove the adhesive tape securing the tube to the nose				
4.	Remove the nasogastric tube: a. Ask the client to take a deep breath and to hold it b. Pinch the tube, then quickly and smoothly withdraw the tube c. Place the tube in the plastic bag d. Observe the intactness of the tube				
5.	Ensure client comfort: a. Offer tissue or assist client as desired to blow his nose b. Provide mouth care if desired c. Position client comfortably d. Assess and measure the amount of nasogastric drainage if suction was applied e. Monitor the patient for signs of GI dysfunction				
6.	a. Dispose of used supplies and tubes removed appropriately. b. Remove gloves. Wash hands				
7.	Document all relevant information: Record removal of the tube, the amount & appearance of any drainage, any response of the client.				
8.	**EVALUATION** a. Re-assess and check for presence of bowel sounds, absence of nausea or vomiting when tube is removed, and intactness of tissues of the nares. b. Report significant deviations from normal to the physician.				

	PROCEDURE	Done	Observed	Not Done	REMARKS
9.	Document all relevant information: Record removal of the tube, the amount & appearance of any drainage, any response of the client				

Name of Student Observer & Signature	***Name of Faculty & Signature / Date***