

PARKLAND HEALTH & HOSPITAL SYSTEM
Nursing Services

Section: Gastrointestinal
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Distribution: Nursing Procedure Manual

**INSERTION / IRRIGATION / REMOVAL OF
NASOGASTRIC TUBE AND CARE OF THE PATIENT**

PRACTICE

STATEMENT: Nasogastric tubes may be inserted by licensed nursing personnel upon the order of the provider.

Nursing personnel shall irrigate a nasogastric tube with 10-20 ml irrigant at least every 8 hours, unless ordered otherwise by the provider.

Nursing personnel may remove a nasogastric tube upon the order of the provider. *(PCA's must be credentialed to perform this procedure.)*

The nurse will not insert a nasogastric tube in a patient with a known basilar skull fracture.

PURPOSE: To gavage or lavage the stomach.
To prevent vomiting by decompressing the stomach.
To maintain patency of the tube.
To provide proper suction.

EQUIPMENT: Nasogastric tube with reflux valve, size appropriate
Catheter tip irrigation syringe
Water soluble lubricant
Benzoin
Tape
Stethoscope
Emesis basin, tissues
Suction machine or wall suction
Cup of water with a straw
Container
Tap water
Personal Protective Equipment (PPE)
(Non-sterile gloves, plastic apron/gown, goggles)

PROCEDURE:

A. Insertion

1. Identify patient using 2 identifiers (name and medical records or no armband, name and date of birth). Provide privacy and explain procedure, if feasible.

2. Assist the patient into comfortable sitting or recumbent position. Remove dentures if appropriate.
3. Wash hands and don PPE.
4. Measure the tube by placing the tube tip on the patient's earlobe. Then extend the tube to the bridge of his/her nose, and from there to the xiphoid process. Mark the tube.
5. Apply small amount of water-soluble lubricant to 6-8 inches of the tube.
For Pediatric patients only: Apply lubricant to 2-4 inches of the tube.
6. Inserts tube into the nostril and pass it backward along the nasal passage. As the tube reaches the back of the nose, have patient bend head forward.
7. Instruct the patient to begin swallowing when s/he feels the tube in the back of the throat, and continue swallowing until the tube is inserted to the desired length. Have patient take sips of water to facilitate swallowing.
8. To determine the location of the tube:
 - a. Aspirate with a catheter tip syringe for gastric contents.
 - b. Check position by simultaneously injecting 20-30 ml air into the tube while auscultating the stomach.

For Pediatric patients only: Check position by injecting 5-10 ml air into the tube.
9. Remove the tube immediately if it is positioned incorrectly.
10. When correct position has been determined, secure the tube in place. Attach to ordered suction. The blue air vent must never be clamped and must be above patient's midline.
11. Leave patient comfortable. Replace dentures if indicated.
12. Remove gloves and wash hands.
13. Document pertinent observations in the Nurses Notes, including the time and name of the person who inserted the tube, and verification of tube location with 2 methods (air auscultation and aspiration of contents).

B. Irrigation

1. Assemble equipment.
2. Identify patient using 2 identifiers (name and medical records or no armband, name and date of birth). Provide privacy and explain procedure, if feasible.

3. Wash hands and don PPE.
4. Pour tap water in a container.
5. Trace tube to the source and disconnect tube from the connector. Attach syringe to tube.
6. Gently aspirate gastric contents to ensure that tube is in the stomach and return the contents to the stomach.
7. Instill irrigant per order or unit's guidelines.
8. To maintain negative pressure in abdomen, irrigate blue air vent with 20-30 ml air as necessary.
9. Reconnect the tube to suction.
10. Note the appearance and amount of return.
11. Ascertain whether or not the suction is functioning properly before leaving the bedside and place in appropriate container labeled with patient's name and medical record number.
12. Remove PPE and wash hands.
13. Document the following in Nurses Notes:
 - a. Time of irrigation
 - b. Amount of solution
 - c. Description of return
 - d. Condition of patient

NOTE: Place reflux valve into blue air vent.
Do not inject fluid/medications through blue air vent.
Blue air vent should be above patient's midline.

C. Patient Care

1. Provide mouth care once a shift or more often as necessary.
2. Inspect daily. If needed, change the tape securing tube and provide nasal care. Remove the tape residue with adhesive remover. Rotate position of the tube in the nose.
3. Assess bowel sounds once a shift, or as often as necessary for gastrointestinal function.
4. Inspect the color, consistency and odor of gastric drainage. A coffee-ground color may indicate bleeding and should be reported immediately.
5. Observe for symptoms of complications:
 - a. Epigastric pain and vomiting indicate a clogged or improperly placed tube
 - b. Hemorrhage
 - c. Dehydration and electrolyte imbalance
 - d. Parotitis
 - e. Nasal skin breakdown
 - f. Aspiration pneumonia
6. Recheck connections and trace the tube to the point of origin on arrival to the unit and at change of shift.
7. Trace the tube from the patient to the point of origin before connecting any device or infusion.
8. Educate the patient and family to notify a staff member if the tube becomes disconnected.
6. Document nursing assessments on the Nurses Notes or Flow Sheet as appropriate.

D. Removal

1. After the suction has been discontinued, flush the nasogastric tube with a small amount of air to clear it of stomach contents that would cause irritation during removal.
2. Wash hands and don PPE.
3. Instruct the patient to hold his breath to verify closure of the epiglottis, then withdraw the tube gently and steadily.
4. Assist the patient with mouth care and clean the tape residue with adhesive remover.

5. Monitor the patient for signs of gastrointestinal dysfunction, such as distention and nausea, until normal bowel function is certain.
6. Remove PPE and wash hands.
7. Document on the Nurses Notes or Flow Sheet as appropriate, the time of removal and subsequent observations.

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