Subject: Nasogastric Tube Insertion

Policy: Insertion of a nasogastric tube requires a physician order. RNs and LPNs will utilize standard precautions when inserting an NG tube. Placement must be verified by radiology report stating that tip of tube is in stomach.

Purpose: To decompress the stomach; administration of fluids, medications or feedings; perform gastric lavage; and obtain gastric contents for lab analysis.

Additional Information:
1. Physician to determine:
   - The type of suction
   - The type, amount and flow rate of the solution
2. Alternate insertion orally (OG) may be desirable for intubated patients to limit nasal flora contamination in the ventilator patient.
3. Validation of tube location in the stomach requires two nurses.

Equipment:
- NG Tube
- Gloves
- Towel and wash cloth
- Facial tissues
- Emesis basin
- Light source
- Tape
- Cup of water with straw
- Water-soluble lubricant
- Safety pin
- Stethoscope
- Alcohol pad or Benzoin
- NG strip

Key Points
- 2% Lidocaine jelly may be used per Nursing Judgment Order after checking patient allergies.
- Consider Skin Prep or Mastisol for adhesive for NG strip.

Procedure:
1. Check physician order for NG placement.
2. Check two forms of patient identification.
3. Explain the procedure to the patient.
4. Wash hands, put on gloves.
5. Place patient in high Fowler’s position.
3. Inform patient of nasal discomfort, that patient may gag, eyes may water and or nose may bleed. Emphasize that swallowing may ease the tube’s advancement.
6. Measure tube from tip of nose to earlobe then down to the xiphoid process. Mark this distance on the tubing with tape or a pen.

7. Assess patency of nares with light source.

8. Lubricate the distal 3 inches of tube with water-soluble gel.

9. Insert the tube into nostril; aim the tube downward and toward the ear closer to the chosen nostril.

10. You will feel resistance when the tube reaches the nasopharynx; have the patient lower their head slightly.

11. Then rotate the tube 180° towards the opposite nostril.

12. Have the patient take small sips of water with a straw.

13. Advance the tube to the point of premeasured tape mark.

14. Verify placement with another licensed nurse. Confirm placement by attaching a catheter-tip syringe to the tube and try to aspirate stomach contents or inject 10 ml of air into the tube while auscultating for air sounds with your stethoscope placed over the epigastria region.

15. Secure the NG tube to the patient’s nose with tape or designated NG tube securement device. If the patient’s skin is oily, wipe the bridge of the nose with an alcohol pad or Benzoin (after checking patient allergies).

16. Wrap a piece of tape around the tube and leave a tab. Fasten the tape tab to the patient’s gown using a safety pin.

17. Document on CPSI the date and time of procedure, the size of the tube used, nare used for insertion, placement verification method, how the patient tolerated the procedure and the education provided.

18. If the NG tube is to be used for feeding, check x-ray for placement. X-ray report must state that the tip of the tube is in the stomach.

6. Orally intubated patient: measure from lip to earlobe to xiphoid process, for OG.

7. Ask patient if they have ever had nasal surgery or a nasal injury.

8. 2% Lidocaine jelly may be used per Nursing Judgment Order (refer to Policy 4:25/SCC14) after checking patient allergies.

9. Advance tube slowly to avoid pressure on the turbinates and resultant pain and bleeding.

10. To close trachea and open the esophagus.

11. This will redirect the tube so it won’t enter the patient’s mouth.

12. Unless contraindicated, otherwise just ask patient to swallow as you advance the tube.

13. A. As the tube advances, watch for signs of respiratory distress and remove immediately if occurs.

B. OG is advanced along the ETT through the posterior oropharynx, should resistance be significant and signs of respiratory distress, remove immediately.

14. With auscultation, you should hear a whooshing sound if the tube is patent and properly positioned in the stomach. The verifying nurse should also hear or see to confirm tube’s gastric location.

15. OG tubes can be taped to ETT.

16. This helps to reduce discomfort from the weight of the tube.

18. This may be ordered as Nursing Judgment Order. Refer to Policy 4:25/SCC14.
19. The RN must enter an order for “x-ray tube tip placement confirmation for tube feeding use.”

20. Feeding is not to be initiated until x-ray confirmation stating OK to use for feeding is available.