Gastro-intestinal Intubation (NasoGastric Tubes)

Insertion of short or long flexible silicone or plastic tube from the nose to the stomach

Nasogastric tubes
From nose to _____
Single or Double lumen
Single lumen = _____ suction
Double Lumen = _____ suction
Common sizes:
Uses:

- Decompress
- Administer
- Treat
- Obtain
- Diagnose

Salem Sump
Double Lumen
Sump port: blue pigtail or second hole to allow for air venting
Suction:

Patency:

Insertion of NG tubes

- Start with patient teaching
- Obtain equipment
    - o
    - o
    - o
    - o
    - o
    - o
    - o
- Position in high fowlers
- Pillow behind shoulders
- Drape towel over chest
- Have patient gently blow nose
- Place tissues, emesis basin, and cup of water nearby
- Measure tube from tip of nose to ear lobe to xiphoid process
- Mark this distance on tube
- Lubricate end of tube with water soluble gel to minimize injury to nasal passage

- Instruct patient to hold head upright
- Carefully insert tube into nostril
- Aim tube downward and toward ear closer to nostril
- Advance slowly
- When tube reaches nasopharynx, instruct patient to lower head slightly to close trachea and open esophagus
- Have patient swallow or take sips of water with a straw.
- Sip and swallow slowly as tube advances
- Watch for signs of respiratory distress
- If tube in bronchus, remove immediately
- Stop advancing when reach marked length.

<u>Confirming Placement:</u>

Attach syringe to tube and try to aspirate gastric contents.

Gastric contents are greenish-yellow

Strip test for pH – should be acidic (if ordered)

If no return, advance tube one to two more inches and try again (reposition).

X-ray is best way for placement confirmation (not always ordered)

Inject 10cc of air into tube and auscultate over the epigastrium (outdated practice)

no longer advocated as best practice (best = aspirate)

When properly placed, secure to patient's nose

Avoid pressure on the nares

Secure tube to gown to prevent pulling

Safety Pin

Tape

Provide frequent mouth care

<u>Removing an NG</u>

- Explain procedure
- Assess bowel sounds
- Place patient in semi-fowlers
- Drape towel across chest
- Loosen tape and untape from nose
- Flush with 30 ml of air to empty gastric juices
- Ask patient to hold breath to close epiglottis
- Gently and steadily withdraw tube
- Wrap in towel
- Provide tissues and mouth care, clean tape residue
- Monitor patient closely for GI function
- Always wear gloves

<u>Intestinal or Nasoenteric tubes</u>

Insertion of intestinal tubes

- **Done by physicians**
- Inserted same as gastric tubes
- Once tube is in stomach, patient lies on right side for 2 hours, supine with head elevated for 2 hours, left side for two hours
- Tube carried to intestines by peristalsis
- May take several hours to reach ileum
- Monitored daily by x-ray for placement
- DO NOT secure until desired point in intestines is reached.

Removal of intestinal tubes

- Remove slowly to prevent damage
- Remove 1-2 inches at a time
- If the tube has passed through the ileocecal valve, cut tube at the nose and remove by peristalsis via the rectum
- “This too shall pass”

Nursing Care

- Ensure patency
- Correct suction
- Accurate I & O
- Amount irrigated should be aspirated or included in intake
- Irrigate with normal saline
- With gastric surgery, never irrigate without a physician order
- With gastric surgery, never manipulate the tube

Prevent oral inflammations

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-
-
-
-
-

Promote Comfort

- Gently cleanse around nares
- Use only water-soluble gel around nares
- Chloroseptic spray or lozenges
- Viscous lidocaine gargle

Monitor for complications

- Fluid and electrolyte losses

- Aspiration pneumonia

- Gastric ulceration

- Laryngeal edema and obstruction

Emotional Support