PURPOSE:
To introduce a tube through the nose and into the stomach to administer medications and feedings when oral route is contraindicated. (Does not include Dobhoff or other soft, pliable tubes with stylets.)

CONSIDERATIONS:
1. It is important to explain the procedure to the patient to relieve apprehension.
2. Position patient upright and assess gag reflex before inserting tube. If high-Fowler’s position is contraindicated, place patient on side.
3. Nasogastric tube should never be forced if obstruction is encountered. Discontinue insertion immediately if excessive coughing or signs of respiratory distress are present.
4. Feeding tubes should be changed every 4 to 6 weeks or as otherwise specified to prevent erosion of esophageal, tracheal, nasal and oropharyngeal mucosa. Alternate nostrils with each tube change.
5. Frequent oral and nasal hygiene is required.
6. If the patient is unconscious, bend the head toward the chest. This will help close the trachea. Also, advance the tube between respirations to make sure it does not enter the trachea. You will need to stroke an unconscious patient's neck to facilitate passage of the tube down the esophagus.
7. Watch for cyanosis while passing the tube in an unconscious patient. Cyanosis indicates that the tube has entered the trachea.
8. Never place the end of the tube in a container of fluid while checking for placement. If the tube is in the trachea, the patient could inhale the water.
9. DO NOT tape the tube to the forehead; it can cause necrosis of the nostril.
10. Pain or vomiting after the tube is inserted indicates tube obstruction or incorrect placement.
11. Recognize the complications when the tube is in for prolonged periods: nasal erosion, sinusitis, esophagitis, esophageotraheal fistula, gastric ulceration and pulmonary and oral infections.
12. Per Joint Commission recommendations, all tubes and catheters should be labeled to prevent the possibility of tubing misconnections. Staff should emphasize to all patients the importance of contacting a clinical staff member for assistance when there is an identified need to disconnect or reconnect devices.

EQUIPMENT:
Nasogastric tube, of specified size
Clamp
Water-soluble lubricant
Glass of water or ice chips
Tape
Stethoscope
Irrigating syringe
Gloves
Towel or disposable pads
Flashlight

PROCEDURE:
Insertion
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Assemble equipment and examine tube for defects (rough edges or partially closed lumens).
4. Position patient, preferably in high-Fowler’s, if not contraindicated. Drape patient with towel or disposable pads.
5. Instruct patient to blow nose to clear nostrils. Use a flashlight and occlude one nostril at a time to assess patency of nostrils before choosing site for insertion. Ascertain from patient any history of nasal surgery, injury or deviated septum.
6. Measure tube for placement from tip of nose to ear lobe to bottom of xiphoid process; mark tube with tape. Note location on tube; you may mark tube with tape or nontoxic marker.
7. Provide patient with glass of water or ice chips. Lubricate tip of tube with water-soluble lubricant and begin insertion. Rotating tube 180 degrees after it reaches the nasopharynx may help to prevent tube from entering patient's mouth. Instruct patient to take a swallow of water or suck on ice chips once tube passes nasopharynx. It is helpful to have the patient, unless contradicted, keep his/her chin tucked toward chest so that the tube passes into the stomach and not lungs.
8. Continue insertion in rhythm with swallowing until desired length of tube is passed.
9. Determine that tube is in stomach:
   a. Place stethoscope over stomach, inject 10 mL of air into tube and listen for air passage.
   b. Gently aspirate stomach content with irrigating syringe. Fluid from stomach or small bowel may be green, tan, brown, clear, yellow, bloody or bile-colored. Pulmonary fluid may be tan, off white, clear or pale yellow. Ph from stomach is 1.0 to 6.5, from small intestine 7.5 to 8.0, from the lungs over 6.0; however, none of these is fail-safe. If any doubt exists, placement should be checked with X-rays. It should be noted that chest X-ray is the only way to confirm correct placement.
10. Anchor tube with tape or securement device. Discomfort from weight of tube may be relieved by using a rubber band and safety pin to secure tube to patient's clothing. Remove safety pin from clothing before changing clothing.
11. Cap end of tube or proceed to Digestive – Nasogastric Tube Feeding.
12. Discard soiled supplies in appropriate containers.
Removal
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Place a towel across the patient's chest and inform him/her that the tube is to be withdrawn.
4. Rotate tubing and inject approximately 10 mL of saline before clamping tubing.
5. Remove the tape from the patient's nose.
6. Instruct the patient to take a deep breath and hold it.
7. Slowly but evenly withdraw tubing and cover it with a towel as it emerges. (As the tube reaches the nasopharynx, you can pull quickly.)
8. Provide the patient with materials for oral care and lubricant for nasal dryness.
9. Monitor the patient for signs of gastrointestinal difficulties or changes.

AFTER CARE:
1. Cleanse reusable equipment, rinse, dry and cover with clean towel.
2. Document in patient's record:
   a. Procedure and observations.
   b. Size and type of tube inserted.
   c. Time of insertion or removal.
   d. Patient's response to procedure.
   e. Instructions given to patient/caregiver.
   f. Communication with physician.