Module 24
NASOGASTRIC TUBE PROCEDURES

INTRODUCTION

PURPOSE

The goal of this module is to enable you to perform the nursing procedures of

- nasogastric intubation
- tube feeding
- nasogastric tube care
- administration of medication through a nasogastric tube

RATIONALE

Nasogastric tubes are being used today in numerous health care setting including hospitals, nursing homes, and the home. There are various reasons for the use of nasogastric (NG) tubes. It is the nurse’s responsibility to be able to perform NG procedures competently as well as assist the client with emotional responses to the procedures. The NC Board of Nursing has determined that the insertion of enteral feeding tubes and other tubes with mercurial bulbs is within the scope of nursing practice for the RN and the LPN. These are Category I functions. Individual institutions however, may choose for this function to not be carried out by the LPN. You will need to check your institutions policy and procedure manual to ascertain whether this activity is appropriate for you to perform.
Unit 1
Nasogastric Tube Insertion

OBJECTIVES

Upon completion of this unit, you should be able to

- Describe the purpose of a gastric tube.
- Identify characteristics of nasogastric tubes.
- List the necessary equipment for nasogastric intubation.
- Discuss the preparation of the patient to assist in alleviating psychological problems related to intubation.
- Describe the steps of nasogastric tube placement.
- Explain how to determine the correct length of tube to be inserted.
- State two methods to confirm placement of the nasogastric tube in the stomach.
- Explain how to tape the nasogastric tube to prevent complication.
- Describe the essential data which needs to be recorded.
- Describe the nursing evaluation necessary for determining patient response (physical and psychosocial) to the nasogastric tube.
- Explain the complications that can occur with tube insertion.
- Discuss nursing interventions to prevent complications.

COMMENTS

Gastric intubation is the insertion of a tube into the stomach, generally through the nose. A nasogastric (NG) tube may be inserted for one of several reasons:

- to provide nutrients
- to prevent and/or relieve gastric upset and/or distention
- to lavage the stomach in case of poisoning
- to remove the gastric contents for laboratory analysis

Insertion of the NG tube is done by nurses. However, the physician should assume responsibility for clients with the following conditions:

- pre or postoperative gastric surgeries.
- unconsciousness
- confusion or deliriousness
- abnormalities of the mouth or esophagus
- gastric hemorrhage

The NG tube comes in several sizes. The Levin tube (see Figure 1A) is commonly used for NG intubation. It is a flexible, plastic, single lumen tube with holes near the tip. The Entriflex tube is 90 cm (36 inches) long and used for gastric feeding; the Dobbhoff tube is 108 cm (43 inches) long and used for duodenal feeding (see Figure 1B). These tubes are much smaller in
diameter that the Levin, require a stylet for insertion due to their soft, pliable nature, and are less traumatic to insert as related to size. The Salem sump tube (see Figure 1A) is very similar to the Levin tube except that it has a double lumen to provide an air vent so that the tube does not attach to and damage the stomach mucosa when suction is applied. The Miller-Abbott tube (see Figure 1C) is a double lumen; one lumen allows for inflation of the balloon and the other is open to the intestine. This tube is used for diagnostic studies and irrigation of the small intestine. The Cantor tube (see Figure 1D) is a single lumen with an inflatable balloon. The balloon is filled with mercury before the tube is inserted. The weight of the mercury allows the tube to move into the intestines. The Harris tube (see Figure 1E) is similar to the Cantor except that it has a metal tip. This tube is used for irrigation and suction in the small intestines. If the size is not ordered by the physician, determine the size based on its use. For example, following gastric surgery when a patient is receiving blenderized food per NG tube feedings, a smaller NG tube is necessary to allow greater ease of swallowing. The composition of the tube may be either rubber or plastic. Plastic tubes are currently being used to a greater extent, primarily because of their clearness. All tubes have some type of small opening at their end. They may be placed all on one side or on all sides. Tubes are now being made with weighted ends and stylets for easier insertion and stable placement.

**PROCEDURE**

Prior to inserting a nasogastric tube, you should assess the patient’s:

**Assessment**

- emotional response to having a tube inserted. Depending on the reason for having the NG tube inserted and previous experiences, patients’ reactions vary.

- nostrils for any obstructions or deformities. If possible, ask the patient of any known deformities. Observe the nares using a flashlight and have the patient breathe through the naris while the other is occluded. Select the naris that has the greatest airflow.

- abdomen for distention. This serves as a baseline for later comparison.

- ability to swallow. If the patient is unable to respond (semi-conscious patient), check the gag response. This is important since the unconscious patient has lost the gag and cough reflex and will not cough if the tube is misplaced.

- past health history of factors which could affect the NG tube insertion, such as esophageal varices or recent oral or gastric surgery. Contact the physician if a factor is noted.
Figure 1
Nasogastric Tubes Used for Gastric and Intestinal Feeding, Suction, and Irrigation
Planning

Follow these steps:

Wash hands and assemble equipment:

a. nasogastric tube  
b. water-soluble lubricant  
c. hypo-allergenic tape (usually one inch wide)  
d. towel  
e. emesis basin  
f. 20-30 cc syringe or asepto syringe which will fit the tube end  
g. stethoscope  
h. clamp  
i. safety pin and rubber band  
j. a glass of water and drinking straw  
k. facial tissues  
l. nonsterile gloves  
m. PH test strips (measure gastric aspirate acidity)

Intervention

Follow these steps:

1. Check the order for the tube, the patient’s name and room number, and the patient’s identification bracelet.

2. Explain the procedure to the patient. Include the following information in your explanation:

   a. The procedure may be unpleasant because the gag reflex is often stimulated during insertion.

   b. The patient can assist by swallowing water during the procedure. If the patient is unable to have water, have him/her dry swallow or suck in air through a straw.

   c. Have the patient agree on a signal, such as raising a hand, so that the patient can tell you to pause. This will give the patient some control in the procedure.

   d. Relaxation is important. Have the patient breath in slowly and deeply, or use any one of a number of relaxation techniques.

   e. Tearing may occur when the tube is inserted. Be sure to asses your patient’s anxiousness and alter your explanation accordingly.
3. Place the patient in high-Fowler’s position if possible. This position is safer for preventing aspiration and allows the patient to swallow easier.

4. Place a clean towel on the patient’s chest.

5. Determine the length of tube to be inserted. Measure from the tip of the patient’s nose to the ear lobe to the xiphoid process (see Figure 2A). Mark the tube at that place with tape. Measurement is important for each individual since distance from the nares to the stomach varies.

6. With the water-soluble lubricant, coat the tip of the tube (approximately 4 inches). It is essential that a water-soluble lubricant is used since oil-based lubricants such as petroleum jelly could cause respiratory complications, unless coated with a dry substance called Hydromer, which, when moistened, becomes lubricative.

2A
Measuring the Correct Length of NG Tube
A: Tip of nose to ear lobe.
B: Ear lobe to xiphoid.
2B
Figure 2
Anatomical Location Of Esophagus, Trachea, And Epiglottis
7. Instruct the patient to hyperextend his or her neck. This reduces the curvature of the nasopharyngeal junction.

8. Insert the tube, passing backward along the floor of the nasal passage toward the patient’s ear, not up the nose. Avoid the bony projections (turbinates) along the lateral wall. If you meet resistance, withdraw the tube and prepare to insert it in the other nostril.

9. Once the tube is in the oropharynx, instruct the patient to then tilt his/her head forward, drink through a straw, and swallow. (If the patient is not allowed to have water, have him swallow as you pass the tube). Passage of the tube is facilitated into the esophagus by these two measures (see Figure 2B).

10. Continue to pass the tube 2-4 inches with each swallow until the taped mark is reached. If the patient gags and the tube is not advancing, inspect the throat thoroughly because the tube may be coiling.

11. Check for the proper position of the tube by at least the first two procedures below:
   a. Aspirate the stomach contents with a syringe. Clear or yellow fluid with mucous should be aspirated if the tube is in the stomach. The fluid can be checked with litmus paper to determine if it is acid (gastric secretions). If using a small gauge tube, aspiration may not be possible. Reinsert the contents aspirated to maintain gastric content electrolyte balance.

   b. Inject 10-20 cc of air through the tube with a 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.

   c. Ask the patient to hum. If the tube is in a lung, the patient will not be able to hum, yet will be able to talk.

   d. Listen for air movement through the distal end of the tube. If it is in the stomach there will be no sound; if in the lung there will be a crackling sound.

   e. Use x-ray confirmation, if necessary. Make sure that the tube has radio opaque substance.

12. If none of the procedures indicate the tube is in the stomach and the patient is breathing without difficulty, advance the tube another 3-4 inches and repeat the procedure.

13. Clamp the tube to prevent excess air from entering the stomach and causing distention.

14. Once the position of the tube is confirmed to be in the stomach, secure the tube in position by the following steps (see Figure 3):
a. Cut a 3-inch and 2-inch piece of tape. Split one end of the 3-inch piece 1-1/2 inches in the center.

b. Place the unsplit end on the patient’s clean nose, slightly off-center toward the side of the nose where the tube is inserted.

c. Wrap the split ends around the tube.

d. Place the 2-inch piece of tape over the bridge of the nose, securing the first piece of tape.

Taping in the above manner keeps the tube in position and prevents pressure against the nostril.

15. Prevent tube drag by attaching tape or a rubber band to the tube and pinning it to the patient’s gown.

16. Make the patient comfortable and continue to assess level of anxiety.

Figure 3

Securing the Nasogastric Tube

17. Perform other procedures, such as suction, irrigation, and tube feeding, as ordered.
18. Record the procedure and observations. Be sure to include the following:

   a. size of tube
   b. naris located
   c. patient’s response
   d. confirmation that tube is in stomach
   e. tube secured

**Evaluation**

The evaluation component is based on the client attaining the objectives. This is discussed in Unit 5.

**Complications**

Some of the potential complications you may encounter while inserting a nasogastric tube include the following:

1. Traumatization of mucous membrane resulting in infection or hemorrhage.

   **Nursing interventions:**
   a. Use gentleness; do not force the tube.
   b. Use clean technique.
   c. Always be sure to inspect nares before insertion, and use lubrication.

2. Improper placement of the tube.

   **Nursing interventions:**
   4. Be sure to measure client with the tube.
   5. Always use at least two different checks for position of NG tube.

3. Obstruction of both nares. Sometimes after placement of the tube, the client complains of being unable to breathe from either naris – one nostril is blocked with tube, the other is mechanically blocked for other reasons.

   **Nursing interventions:**
   a. Have client attempt to clear nostril without tube.
   b. Put in a small diameter tube to allow air exchange around the tube.

4. Abdominal distention remains unchanged after insertion.

   **Nursing interventions:**
   a. Recheck tube placement.
   b. Move the tube a little to see if it is up against lining (be sure to shut off suction while moving tube to prevent stripping of the lining).
Unit 2
Tube Feeding through a Nasogastric Tube

OBJECTIVES

Upon completion of this unit, you should be able to:

- Identify various clients who may need nasogastric tube feedings
- List items necessary for tube feeding procedure
- Describe the steps of the tube feeding procedure
- Identify the procedure steps which provide for client safety
- State the rationale for checking tube placement prior to administration of the feeding
- Describe the data which needs to be recorded following a tube feeding

COMMENTS

A nasogastric tube feeding, or gastric gavage, is the administration of nourishment through an NG tube introduced into the stomach. The tube feeding is used for patients who are unable to ingest adequate nutrients orally and have active bowel sounds, such as a patient who has had a CVA and is 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, 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 just prior to each feeding.

Many types of formula are used for tube feedings. Several are commercially prepared and may come in cans or in prepared bottles. There are several preparations which must be mixed with water. Blenderized food can also be administered through the tube, as well as water and liquids. Whatever type of preparation is ordered, proper storage is necessary to prevent growth of microorganisms.

When an individual will need tube feedings for a long period of time, a gastrostomy feeding or jejunostomy feeding may be performed. Each requires an initial surgical procedure in which a tube is placed in the stomach or jejunum through the abdominal wall.

Procedure / Assessment

1. Since the patient is receiving the tube feeding to provide for his/her nutritional status, assessment of this status is essential. The following factors should be assessed:

   a. Weight (loss/gain/maintenance).
b. Fluid and electrolyte (F/E) balance (many preparations are hyperosmolar and cause F/E imbalance).

c. General nutritional status including skin turgor, condition of skin, especially mucous membranes.

2. If the patient is also taking food and/or fluids orally, assess oral intake.

3. Determine if the patient has any special nutritional needs at this time related to the presence of such things as fever, infection or trauma.

4. Note any recent diarrhea and/or vomiting. Diarrhea may be a result of osmolar overload, related to the feeding formula.

5. Determine whether the patient has been experiencing any discomfort previously with the feedings.

6. Review the nursing care plan to determine any information related to the care plan, such as the position in which the patient best tolerates the feeding.

7. Check the patient’s allergy list to see if the feeding preparation contains any ingredient to which the patient is allergic.

Planning

Assemble equipment:

a. Nasogastric tube, in place (see Unit 1).

b. Feeding preparation, as ordered (usually 300-500 ml per meal for adults). Be sure to check the expiration date if ready prepared formula is used and any agency rules for length of time a formula may be kept. If all of can is not used, indicate date and time open on can. Feedings are usually administered at room temperature unless otherwise ordered. Continuous feeds are usually kept cold. Feedings containing milk and egg may coagulate when they are exposed to heat. For feedings which are to be warmed, take care not to get them too warm since this can irritate the mucous membrane. Also, feedings which are too cold can reduce the output of digestive juices related to vasoconstriction with resulting cramps.

c. Delivery system, depending on physician’s preference and availability of equipment, may be either via gravity (container bag or bottle with tubing and drip control or 50-60 cc syringe) or feeding pump (comes with its own bag and tubing). The pump is used when a small diameter NG tube is used or when the gravity flow is insufficient.

d. Equipment to check tube placement as discussed in Unit 1 (syringe, stethoscope).
e. Water at room temperature (approximately 60 cc).

Follow these steps:

1. Wash your hands. This is a clean procedure, just as is inserting an NG tube.

2. Check the order regarding the patient’s name, type, and amount of formula to be given. All of the 6 rights of giving medications (see Module 9 on Medication Administration) also apply to giving feeding formula.

3. Prepare the equipment and formula. Remember to give formula at proper temperature.

4. Explain the procedure to the patient. Include the following information in your explanation:
   a. The feeding should not cause discomfort, but may cause a full feeling.
   b. The patient needs to inform you if any is experienced.
   c. The length of time the feeding will take.

5. Assure privacy for the client. Remember that even though this is a commonplace procedure for nurses, it is not for the patient or others.

6. Assist the patient to a comfortable position. Sitting up in the bed or chair is usually best – whatever the normal position for eating is. If this position is not possible, a semi-Fowler’s position should be used. The possibility of aspiration is decreased in these positions.

7. Test the placement of the tube (see Unit 1). This needs to be done prior to each feeding or at least three times daily if a continuous feeding is ordered. There is always the possibility that the tube has been dislodged.

8. When aspirating gastric contents as a check for tube placement and undigested formula is aspirated, continue to aspirate to determine residual. In some hospitals, if more than 50 cc is aspirated, the next feeding is withheld. Replace the aspirated gastric contents to maintain fluid and electrolyte balance.

9. When correct tube placement has been confirmed, unclamp tubing and pinch it off to prevent unnecessary air from entering.

10. Attach the syringe to the NG tube.

11. Determine tube patency by allowing 30 cc of water to flow in by gravity. Pinch the tube when finished.

12. Add the feeding little by little for a continuous gravity flow if the syringe method is used. If using a bag or bottle with tubing, simply pour in the entire feeding. Clear the
tubing of air by allowing the formula to drain through. Permit the feeding to flow in slowly by adjusting gravity flow or, if a tubing method with a bag or bottle is used, set the drip factor according to the manufacturer’s directions. For intermittent feedings, 250 cc of formula can be administered in approximately 15-20 minutes. If the patient experiences discomfort, pinch the tubing for a minute and then slow the feeding.

13. After the feeding has been administered, instill 30 cc of water to clear the NG tube.

14. Clamp the tube to prevent air from entering. Cover the end of the tube with gauze and make sure the tube is secure (taped and pinned to the patient’s clothing).

15. Instruct the patient to remain in semi or high Fowler’s position for at least half an hour to prevent aspiration if regurgitation or vomiting occurs.

16. Chart on the medication sheet or nurse’s notes as appropriate. The following should be included:
   a. Residual obtained
   b. Rate and volume of feeding
   c. Patient’s response, behavior, and attitude toward feeding.
   d. Any discomfort during or after the procedure.

17. Clean equipment. Wash the tubing bag and syringe with soap and water and make sure it is rinsed thoroughly. Just as a plate and silverware are cleaned between meals, the same is true of tube feeding equipment.

18. Assess the patient’s tolerance to the feeding 1/2 to 1 hour following the feeding.

19. If the feeding is continuous, follow the procedures outlined above when starting the feeding. Continual assessment (at least every hour) of the patient’s tolerance of the feeding is essential. The feeding should be hung for only eight hours. The temperature of the formula must be monitored since formula in a bag for eight hours would be an excellent medium for microorganism growth. This is a time when ice may be added to the packet of a feeding bag to maintain appropriate temperature of the formula. The administration equipment must be cleaned at least every 24 hours. Feeding bags are replaced every 24 hours and labeled appropriately with date and time.

**Evaluation**

Evaluation is based on the goals and expected outcomes (see Unit 5 for a discussion).
OBJECTIVES

Upon completion of this unit, you should be able to:

- Describe the procedure for daily nasogastric tube care.
- Explain the importance of oral care.
- Describe the nursing assessment essential for a client who has a nasogastric tube.

COMMENTS

Nasogastric tube care should be completed at least once every day for any patient with an NG tube.

Procedure

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).

1. Assemble equipment
   a. Adhesive or paper tape
   b. Soap and water
   c. Hydrogen peroxide
   d. Cotton-tipped applicators
   e. Washcloth or 3 x 4 sponges
   f. Acetone (optional)

Implementation: Follow these steps:

1. Explain the procedure to the patient.

2. 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. If the tape is difficult to remove, use acetone with extreme care. Remember, acetone is irritating to eyes and nose.

3. Inspect area for irritation and crusts.
4. Cleanse nose and NG tube with soap and warm water. Use alcohol if the patient’s skin is very oily.

5. Cleanse nostrils with cotton-tipped applicator. If crusts are noted, remove with a applicator with solution of equal portions of hydrogen peroxide and water.

6. Gently rotate the tube 180° to prevent adherence of the tube to the GI tract.

7. Retape as discussed in Unit 1.

8. Assist the patient with mouth care, including brushing teeth and tongue. Mouth breathing and lack of oral secretions usually result when an NG tube is in place. If the patient has an extremely dry mouth, instruct her or him to chew gum or suck on candy, if possible.

9. Check to make sure the tube is clamped or attached to suction.

10. Assess the patient’s response to the procedure.

11. Chart as appropriate using a checklist or, if an alteration is observed, record on nurse’s notes.
Unit 4
Administration of Medication
Through a Nasogastric Tube

OBJECTIVES

Upon completion of this unit, you should be able to

- List the steps for administering medications through a nasogastric tube.
- State the rationale for the steps listed in the above objective.
- State the procedure for correct charting of the medication.

COMMENTS

Administering medication through a nasogastric tube is necessary for the same reason that tube feeding might be required. The procedure is the same as that discussed for tube feedings in Unit 2. The following suggestions may assist you:

1. Obtain a physician’s order for liquid preparation, if possible.

2. Read medication labels carefully before crushing a tablet or opening a capsule. Do not crush buccal or sublingual tablets. Do not crush enteric-coated or sustained-action medications.

3. If a medication in tablet form needs to be given, crush it finely. To dissolve the medication mix it with 3-5 cc of water (warm is usually best) or 1-3 cc oil substance such as mineral oil (if not contraindicated) depending on medication, to enhance passage through the tube.

4. As in tube feeding procedure, always instill water (50-150 ml) first, then the medication.

5. Give medication through syringe via gravity prior to tube feedings if they are scheduled for the same time. This insures that the entire medication is given, which would not be true if the medication was mixed in the tube feeding.

6. Flush NG tube with water (50-150 cc).

7. Chart.
OBJECTIVES

Upon completion of this unit, you should be able to

- Discuss the use of the nursing process for a client who has a nasogastric tube.
- State the appropriate nursing intervention for complications that can occur related to the nasogastric tube insertion and tube feedings.

COMMENTS

The registered nurse providing care for a client with a nasogastric tube must develop a plan of care specific to this client. The LPN assists the RN in the collection of data and the client’s response to the specific nursing interventions. The registered nurse is legally responsible for developing a nursing care plan, as stated in the Nurse Practice Act.

Since you will participate in carrying out the plan of care three examples of nursing care plans for several patients who have an NG tube for different reasons follow. Remember it is legally the responsibility of the RN to develop a plan of care, set goals and evaluate the patients' response to nursing interventions.

Example 1

Nursing diagnosis: Alteration in nutritional status: less than body requirements related to inability to swallow (CVA).

Goal: Maintain nutritional status.

Expected outcomes: Patient will gain two pounds by [date]. Patient will experience no complications of NG tube feeding at any time.

Planning/Intervention:

1. Perform gastric intubation (see previous units).
2. Administer 250 cc every 4 hours with at least 100 cc water every 4 hours/per order.
3. Assess nutritional and fluid and electrolyte status every day (check weight, I & O, skin turgor, etc.)
4. Assess for complications at each feeding, including

a. Aspiration  
b. Over 50 cc residual  
c. Non-patent tube  
d. Nausea / vomiting  
e. Diarrhea  
f. Fluid & electrolyte imbalance  
g. Stress ulcer  
h. Psychological effect on body image

Evaluation: Refer to the goal and expected outcomes. If the goal and expected outcomes were met, the evaluation would be as follows:

Nutritional status improved. Two pounds gained in two weeks. No complications noted. Continue with all plans. Patient states he “needs the feeding to live.”

As the patient improves, another expected outcome focused on patient education should be added, if appropriate: **Client and husband will demonstrate administration of a tube feeding one week following beginning of teaching.** New interventions which reflect the expected outcome then need to be added.

If the goal and expected outcomes were not met determine the reasons and changes that need to be made. There may be many reasons. Below are some examples and changes that may need to be made in the plans/interventions.

**Nutritional status remains inadequate. Patient’s weight remains 100 lbs. Patient experienced nausea three times during four feedings. Vomited 100 cc undigested formula at last feeding.**

**Changes in the plan:** Administer the 250 cc feeding ordered in one hour rather than 15 minutes. Assess tolerance following next feeding. Recheck position during feeding to assure that head is elevated.

Another example of change when the goal and expected outcomes are not met may be as follows:

**Nutritional status remains stable. Complication of aspiration of formula following 4:00 a.m. feeding resulted. Suctioned. Respiratory rate presently 20/nim. Lung fields clear upon auscultation.**

**Changes in plan:** Keep head of bed elevated at least 30 degrees for one hour following feeding.

**Example 2**

**Nursing diagnosis:** Client will state that pain is relieved within one hour of intervention. Client’s abdominal girth measurement will be decreased by three inches within one hour of intervention.
Planning/Intervention:

1. If patient does not have an NG tube, contact physician for tube placement. (Following gastric surgery, it is the physician’s responsibility to place the tube.)

2. If tube is in place and connected to suction, check
   
a. Tube patency. If not patent:
      • Irrigate with 20 cc of normal saline (NS) solution.
      • Reposition tube and irrigate again if necessary.
      • Change tube if it continues to be obstructed.

   b. Suction machine function
      • Is it plugged in?
      • Is pressure setting correct?

3. Measure abdominal girth at regular intervals.

4. Administer pain medication as ordered.

5. Provide for the support of patient.
   
a. Explanation of procedure
   b. Staying with the patient

Evaluation: If the tube was occluded and patency was restored with irrigation, the evaluation may be as follows:

Patient reports that pain has decreases and is tolerable. Abdominal girth declined by 4 inches. Tube was irrigated with 20 cc NS without difficulty. Gastric secretions returned immediately when reconnected to suction.

Change in plan: Check tube patency every hour.

Example 3

Nursing diagnosis: Alteration in psychosocial status: social isolation related to change in body image (NG tube placement).

Goal: Social contacts will increase.
Expected outcome: Patient will leave room with tube in place within one week on own initiative.

Planning/Interventions:

1. Allow time for patient to express feelings about tube placement.
2. If tube is temporary, reassure of this fact.
3. Assess interaction with family and visitors that come to the room.
4. Involve family significant others in care and support of patient.
5. Allow patient to make decisions about appropriate care procedures to gain control.

Evaluation: With appropriate support from staff and family, it is hoped that evaluation would be as follows:

Client stated that he feared the response of others in hospital. Wife walked in hall with him x4. Out of room on own. Continue to give support.

Conclusion

This module has given the necessary actions and nursing responsibilities for performing the following procedures:

1. nasogastric intubation
2. tube feeding
3. nasogastric tube care
4. administration of medications through an NG tube
5. using the nursing process with examples

If you are unable to meet the objectives as listed in the beginning of this module, you may want to consult the bibliography.

BIBLIOGRAPHY

