PERFORMANCE CHECKLIST SKILL 47-2 INSERTING AND MAINTAINING A NASOGASTRIC TUBE FOR GASTRIC DECOMPRESSION

**ASSESSMENT**
1. Performed hand hygiene.
2. Inspected condition of patient's nasal and oral cavity.
3. Asked if patient has history of nasal surgery, noted if deviated nasal septum is present.
4. Auscultated for bowel sounds, palpated patient's abdomen for distention, rigidity, and pain.
5. Assessed patient's LOC and ability to follow instructions.

**PLANNING**
1. Identified patient using two identifiers.
2. Explained procedure.
3. Determined if patient had an NG tube insertion in the past and which naris was used.
4. Checked record for health care provider's orders, type of tube, and to what solution the tube is to be attached.
5. Prepared equipment at the bedside, prepared appropriate fixation.

**IMPLEMENTATION**
1. Positioned patient and bed appropriately.
2. Had patient blow nose, placed towel over patient's chest, gave tissues to patient, placed emesis basin within reach.
3. Provided privacy.
4. Stood on the appropriate side of the patient.
5. Performed hand hygiene, applied clean gloves.
6. Instructed patient to relax and breathe normally while occluding each naris, repeated action for other naris, selected nostril with greater airflow.
7. Measured distance to insert tube properly.
8. Marked length of tube to be inserted with tape that can be removed easily
9. Curved 10-15 cm (4 to 6 inches) of end of tube around index finger and released.
10. Lubricated 7.5 to 10 cm (3 to 4 inches) of end of tube with water-soluble lubricating jelly.
11. Initially instructed patient to extend neck back, inserted tube properly through naris, aimed end of tube downward.
12. Continued to pass tube, advanced appropriately if resistance is met. Applied downward pressure as necessary.
13. If resistance was met, rotated tube to see if it would advance, if not, withdrew tube and allowed patient to rest if necessary, relubricated tube, inserted into other naris.
14. Continued insertion until just past nasopharynx and stopped advancement, allowed patient to rest, provided tissues, explained that next step requires swallowing and gave patient water as allowed.
15. With tube just above oropharynx, instructed patient to flex head, sip water, and swallow, advanced tube with each swallow, instructed patient to dry swallow if necessary.
16. If patient began to gag, choke, or cough, withdrew tube, instructed patient to breathe and sip water.
17. If patient continued to gag or cough, checked back of oropharynx using tongue blade, withdrew tube if necessary and reinserted with patient swallowing.
18. After patient relaxed, advanced tube with swallowing, anchored tube appropriately until placement is verified.
19. Verified tube placement according to agency policies.
20. Anchored tube:
   a. Clamped end or connected to drainage or suction.
   b. Taped tube to nose properly, avoided putting pressure on nares.
   c. Fastened end of NG tube appropriately to patient's gown.
21. Elevated head of bed 30 degrees unless ordered otherwise.
22. Placed red mark where tube exited nose, measured tube length from nares to connector if necessary, and documented tube length once placement is confirmed.
23. Removed gloves, performed hand hygiene.
24. Tube irrigation:
   a. Performed hand hygiene, applied gloves.
   b. Checked for tube placement, reconnected tubing.
   c. Drew normal saline into the appropriate syringe.
   d. Clamped NG tube, disconnected from tubing and laid connection tubing on towel.
   e. Inserted tip of irrigating syringe into end of NG tube, removed clamp, held syringe properly, did not force solution.
   f. Checked for kinks if resistance occurs, turned patient onto left side, reported repeated resistance.
   g. Aspirated or pulled back slowly on syringe to withdraw fluid, recorded difference between amount aspirate and instilled appropriately. Recorded any differences as intake or output.
   h. Reconnected NG tube to drainage or suction, repeated irrigation if necessary.
   i. Removed glove, performed hand hygiene.

EVALUATION

1. Determined amount and character of contents draining from NG tube, asked if patient felt nauseated.
2. Noted distention, rigidity, or pain after palpating patient's abdomen, auscultated for bowel sounds, turned off suction while auscultating.
3. Evaluated condition of nares and nose.
4. Observed position of tubing.
5. Asked if patient feels sore throat or irrigation in pharynx.
6. Used Teach Back to determine patient's/family's understanding about the NG tube.

**Discontinuation of NG tube: ASSESSMENT**
1. Auscultated for presence of bowel sounds.

**PLANNING**
1. Verified order to discontinue NG tube.
2. Identified patient using two identifiers.
3. Explained procedure to patient, reassured that removal is less distressing than insertion.

**IMPLEMENTATION**
1. Performed hand hygiene, applied clean gloves.
2. Turned off suction, disconnected NG tube from drainage or suction, removed fixation, unpinned tube from gown.
3. Stood on appropriate side of patient.
4. Handed patient tissue, placed clean towel across chest, instructed patient to take and hold a deep breath.
5. Clamped tubing securely, pulled tube out steadily into towel while patient holds breath.
6. Cleaned nares, provided mouth care.
7. Disposed of tube and drainage into proper container.
8. Removed gloves, performed hand hygiene.

**EVALUATION**
1. Auscultated patient's bowel sounds, checked for abdominal distention after tube removal.
2. Measured amount of drainage in container, noted character of content.
3. Explained procedure for drinking fluids if not contraindicated.
4. Used Teach Back to determine understanding of the procedure for removing nasogastric tube.

**RECORDING AND REPORTING**
1. Record all information about NG tube insertion in the appropriate log.
2. Recorded placement checks and character of contents draining from NG tubes every shift or more often as necessary.
3. Recorded date and time that NG was removed, patient's tolerance of procedure, and patient's status in the appropriate log.