NASOGASTRIC TUBE FOR DECOMPRESSION AND GASTRIC LAVAGE

PURPOSE: To outline the management of the patient who has a nasogastric (NG) or orogastric (OG) tube in place for gastric decompression or gastric lavage.

SUPPORTIVE DATA: NG/OG tubes vary depending on method of decompression ordered:

- Straight, non-vented tube for patients requiring low intermittent suction or to gravity drainage
- Vented (Salem sump-type) for patients requiring continuous suction

NG or OG tubes that are used only for lavage in an emergency situation (e.g., for drug overdose or gastrointestinal bleed) or for decompression do not need provider placement confirmation.

After placement has been verified by provider and order entered "okay to use" tube may be used for medication/fluid administration or tube feeding.

Specially trained RNs may insert enteral feeding tubes (pre- or post-pyloric) using the Cortrak∗ Enteral Access System (EAS), with a provider order.

See Enteral Feeding and Medication Administration Nursing Clinical Standard for more information.

ASSESSMENT:

1. Verify the placement and patency of tube
   - At time of insertion and prior to lavage/ irrigation by assessing for:
     - Absence of gagging, coughing, respiratory distress, inability to talk (would indicate tube is in trachea)
     - Aspiration of gastric contents (fluid or blood)
   - Every 4 hours for:
     - Presence of fluid or blood draining into suction catheter or per aspiration from tube
     - Respiratory distress
2. Assess for the following a minimum of every 8 hours (ICU: 4 hours):
   - Abdominal distention
   - Quantity and color of drainage
   - Bowel sounds (turn off suction to assess)
   - NGT/OGT insertion site/ presence of skin breakdown/pressure injury
3. Measure the following a minimum of every 8 hours:
   - Abdominal girth in pediatric patients as ordered
   - Intake and Output
   - Residual to ensure suctioning is working
4. Monitor the following during gastric lavage:
   - Respiratory distress
   - Drainage/aspirate

LAVAGE/ IRRIGATION:

5. Irrigate NG tube with water if clogged
   - 5-10 mL for pediatric patients as ordered
   - 30 - 50 mL for adults
6. Lavage stomach per NG/OG tube with water as ordered – instill no more than 250 mL at a time (per provider order for pediatrics)

SUCTION:

7. Instill 20 - 25mL air into vented port of vented tubes every 4 hours (use air only, do not instill fluid or medications). 5ml – 10ml for pediatrics
8. Do not clamp or tie vented port, use anti-reflux valve if available (to prevent drainage seepage)
9. Maintain suction (intermittent or continuous) as ordered

MOUTH CARE:

10. Provide mouth and naris cares a minimum of every 4 hours

TUBE MAINTENANCE:

11. Prevent injury to nose/naris by positioning tubing to create least amount of pressure on tissue.
12. Provide care daily (every 24 hour) or as needed for NG or OG to include:
    - Inspect and clean skin
    - Laterally reposition tube to avoid pressure injury
    - Apply fresh tape
    - Dab water-soluble lubricant on the nostrils as needed

SAFETY:

13. Check tube placement prior to irrigation, or instillation of medication/feeds
14. Tape tube securely, mark site and document
15. Clamp tube for transport of patient
16. Clamp tube 30 minutes after medication administration if on suction

SPECIAL CONSIDERATIONS; PEDIATRICS

17. Emergent use (e.g., Hypoglycemic event); may place NGT/OGT to administer emergent medication after confirmation by provider and order entered "ok to use"

PATIENT/CAREGIVER EDUCATION:

18. Teach the following:
    - Purpose and function of NG/OG tube
    - How to avoid accidental dislodgement
    - Signs and symptoms to report
      - Respiratory distress
      - Nausea/emesis
      - Pain at naris
      - Abdominal pain
    - Role in maintaining accurate intake and output
    - Not to reattach disconnected tubing and notify nurse

REPORTABLE CONDITIONS:

19. Notify the provider immediately for the following:
    - Emesis
    - Respiratory distress
    - Suspected misplacement of the tube (e.g., gagging, coughing, inability to speak). Remove tube before notifying provider *unless* provider has ordered not to remove tube, e.g.. if tube was placed in the operating room
    - Increased abdominal girth
    - Loss of bowel sounds

ADDITIONAL STANDARDS:

20. Implement the following as indicated:
    - Intravenous Therapy
    - Restraints

DOCUMENTATION:

21. Document in accordance with documentation standards.
22. Document in Orchid – Systems Assessment – Gastrointestinal Tubes Information – add Dynamic Group – label accordingly
23. Document assessment and care including daily tube repositioning and tape change.

REFERENCES:

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AACN Procedure Manual for High Acuity, Progressive, and Critical Care. 7th Edition. Debra L. Wiegand. Elsevier. (2017)

Phillips, J. K. (2011). Gastric lavage in hemorrhage and overdose. In D. L. M. Wiegand (ed), *AACN Procedure manual for critical care,* 6th Ed. St. Louis: Elsevier Saunders.

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