Today we're going to talk about inserting an NG or a nasogastric tube and the removal.

So today's patient is Mr. Smith. And Mr. Smith has a suspected bowel obstruction. So in order to give his GI track a rest, we are going to put a tube down into his stomach to get contents out.

So I'm going to gather my equipment, what I've done is I've gathered an NG tube which would have come in packaging. I've gathered a basin, some water soluble lubricant, for the manikins we have to use something different, but in the hospital, you'd use water soluble lubricants and tape.

And I've already cut my tape into, I have one piece like this. And I have another piece that almost looks like a pair of pants.

Now I would not put this on the bedside table or the side of the bed because studies have shown, there's a lot of microorganisms growing there.

I have pH paper. And I've cut off a small piece and put it into my tub. I have an anti-reflux valve. This is if you need to transport your patient to a procedure, you would want to use this. And then I also have a male, female adapter. I have a swab that I am going to do oral care afterwards. And I have a glass of water with a straw to help the patient.

This is a clean procedure and not a sterile procedure. So I'm just going to use clean gloves.

So I'm going to go ahead and perform hand hygiene. And I'm going to verify my order for this before I walk into the room.
So Mr. Smith. Hi, I'm Barb. And I'm your registered nurse for the shift. Can you tell me your full name and your birth date? OK.

I'm going to go ahead and assess your pain. On a scale from zero to 10, zero being no pain at all, 10 being the worst pain you've ever felt, what would you say your pain is right now? A two. Are you comfortable at that level? And he is.

So, I would have checked my suction and made sure that that's working, and it is. And I would have that ready to go.

I would place a towel across Mr. Smith's chest because this can cause gaging or sometimes a little bit of vomiting. So you want to have that available.

I would also move this basin over in front of Mr. Smith. And if he was able, he could hold it. But today he is not. So I'll just rest it right there.

I'm going to go ahead and put my gloves on. I'm going to have my water right here. And what I'm going to have Mr. Smith do at the beginning of this procedure is I'm going to have him tip his chin down to his chest. And then when I reach the back where he starts gagging a little bit then he can hyper-extend.

So the first thing I'm going to do is measure this. So I'm going to measure from his nose to his ear. And then I'm going to measure down to approximately the xiphoid process a little bit further.

And what I'm going to do for that measurement is I'm going to put the small piece of tape on it. And that's just going to give me a tactile reminder of how far I need to go in.

The other tape that I secured is tape that I'm going to utilize to secure it to the nose.
So I'm going to check the patency of the nose to decide which side I'm going in or ask the patient if they've had one before. I'd also want to assess the integrity of the skin on top of the nose because I'm going to be securing this to the top of the nose. There are other securing mechanisms that you can use. And I would check with the policy at your facility.

There's also two different ways of checking for placement that research shows is appropriate. One is through radiology and one is pH paper. So I would check and see which is the policy for your facility.

So I'm going to go ahead and lubricated the tip with water soluble lubricant. And normally the patient's head would be tipped to the chest.

I'm going to go in. When I get to the back of the throat, I'm going to twist to the other [? nair ?] and continue to go down.

This is the point at which the patient can start taking small steps of water and swallow. And I like to explain to the patient that the most difficult part of this normally is going through the nasal passages. Once we get to the back of the throat, and they start swallowing, that helps it go down just like food goes through your esophagus and down into your stomach.

So you want to encourage the patient to swallow, swallow, swallow. You're doing a great job. We're almost there. Swallow, swallow, swallow.

Once you are to this point what you want to do is you want to confirm placement before you hook it up to suctioning.

So as I said, I would either confirm placement by taking a syringe, taking back a little bit of the secretions in the tube, put it on the pH paper, and see what that is or call radiology.
You do want to always document how you confirmed placement, and what came out, and how much, and how the patient tolerated it.

So the way this works is the white part goes on the top of the nose. And then the other two pieces just wrap around the tube.

And you do want to keep your gloves on because you're dealing with body fluids.

Once that's secure, you have this anti-reflux valve. The white goes to the clear. And the blue goes to what we call the pigtail. And you don't ever put anything in or take anything out of this blue pigtail. There is a valve in there that allows air to be released. If the patient is hooked up to suction what you do is you put this male, female adapter in. And then you hook it up to suction per the orders.

You could then secure this tubing to the patient's gown per the policy of the facility where you're working. There're several different ways of doing that.

And then you can put the patient back down. But they should not be any lower than 30 degrees normally. Now I did not raise the bed up. Because I was not needing to bend over to do this procedure. If you did need to bend over, you would want to raise the bed up to an appropriate working height. And I didn't need to put down the side rail. But before you leave the patient's room, both side rails need to be up. The bed needs to be in the closest position to the floor, and the call light within reach.

So magically, through a time warp, we are now going to remove this from the patient.

So I would have come in, performed hand hygiene, verify that I have an order.

Mr. Smith, I'm Barb. I'm your registered nurse. And we get to take this NG tube out today. So can you go ahead and tell me your full name and your date of birth? Great. And I'd like to assess
your pain on a scale of zero to 10. Zero being no pain. Ten being the worst pain. What would you say your pain level is? A three. Are you comfortable with that? OK. So we are going to go ahead and remove this.

Again this is a clean procedure not sterile. So I can put on clean gloves. I like to have a basin and a towel available. This could get a little messy.

And I'm also going to perform oral care after I've inserted it, and then also after I remove this. And oral care while this is actually in the patient for however long is very, very important to do. And I actually brought in a swab that I would use to do oral care. It would be gentler on the mouth.

So to remove this, you can take in a 30 ml syringe. And you're going to inject 30 ml's of air into the tubing. And then what I'm going to do is take off the tape. And then I'm going to have the patient hold their breath. And I'm going to remove it in kind of a rope, like you're climbing up a robe.

And then what I can do is I can wrap the whole tube up into my gloves. So I can take the one set of gloves off, off with the tube. Ball it up into my other. And then toss that in the trash. Then I would also remove the basin. Remove the towel. Perform oral care. Make sure the bed is in the lowest position. Two side rails up. Bed locked. And document accordingly.