NASOGASTRIC TUBE INSERTION
WEST COAST UNIVERSITY

Student: _____

		Peer 1	Peer 2	Faculty Evaluation
NPSG	Wash hands per CDC guidelines.			
	Provide patient privacy.			
NPSG	Introduce yourself.			
NPSG	Identify patient correctly using two identifiers (check to chart).			
NPSG	Verify allergy status.			
	Perform environmental safety check.			
	Ensure proper body mechanics.			
	Gather all supplies, equipment, and PPE as needed.			
	Verify MD order. Assess for procedure need.			
	Explain procedure. Educate patient about the rationale of procedure and associated adverse reaction.			
Assess & Evaluate	Perform GI Assessment – assessing need for NG Tube placement.			
Position	Place patient in high fowler's position and cover chest with towel or chux.			
Patient teaching	Explain the procedure and develop appropriate hand signal for patient.			
Facial assessment	Use the penlight to view the client's nostrils. Assess for any facial or nasal passage issue contraindicated for this procedure. Have patient blow nose one nostril at a time if needed.			
Prepare	Obtain the appropriate equipment for NG tube placement. If suctioning is ordered, verify suction source at this time. Connect suction tube to source of negative pressure setting control per physician's order.			
Measure	Using the NG tube, measure the distance from tip of the nare to the earlobe, and then to the xiphoid process of the sternum. Mark the distance on the tube with a piece of tape or marker.			
Lubricate	Lubricate first 4 inches of the tube with water soluble lubricant.			
Insert	Ask Patient to slightly flex the neck backward. Gently insert tube into a nare. When the patient starts to gag, pull back tube slightly (until gaging ceases) and ask patient to tip forehead forward (give water with straw if applicable, have patient dry swallow if necessary). Advance the tube several inches at a time as the client swallows. Advance the tube until the taped or marked point reaches the nare.			
Respiratory Distress	If there are any signs of respiratory distress – pull back tube immediately.			
Secure	Secure NG tube in place (do not let go of the tube until secured).			
Verify	Verify placement of the tube. Aspirate stomach contents to test pH.			
Evidenced based guidelines	After placement is verified per evidenced based guidelines, connect the distal end of the tube to suction, draining bag or adapter, according to the purpose of this nursing intervention or MD order.			
NPSG	Dispose of soiled supplies.			
Safe Environment	Ensure a safe environment returning bed to appropriate height with brakes locked and appropriate side rales up, and call light within reach.			
NPSG	Wash hands per CDC guidelines.			

PEER #1:

PEER #2:

Faculty Evaluator:

Comments: