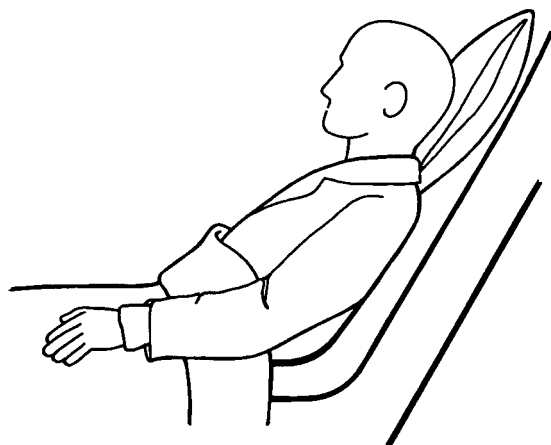
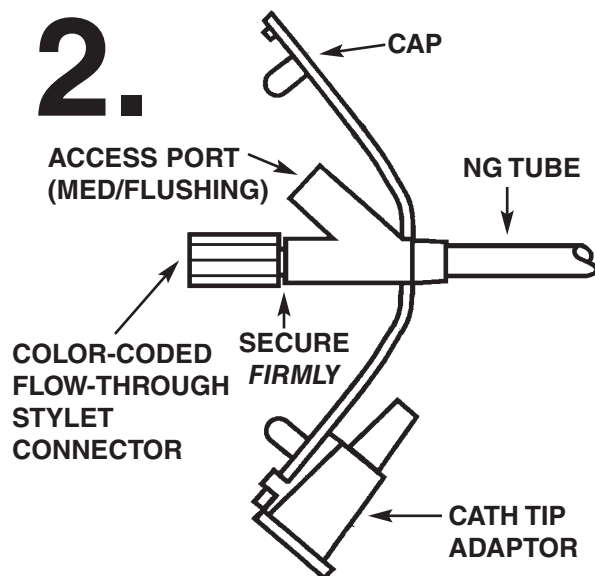


1.



- Explain procedure to patient.
 - Position patient in a sitting or Fowler's position as tolerated.
- WARNING: The patient should not lean forward, nor should the head and neck be extended.

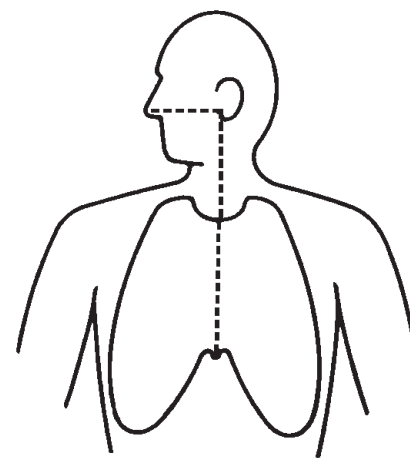
2.



- Remove NG tube and stylet from package. (Save tube package for stylet storage.) Make sure stylet connector stays firmly seated in administration set port during insertion.
- NOTE: Stylet is packaged with tube. Its use, however, is optional and may not be required in the conscious, cooperative patient.
- Cap access port.

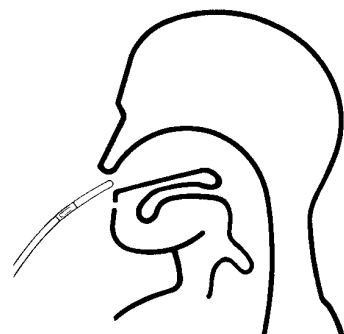
3.

TUBE MANAGEMENT



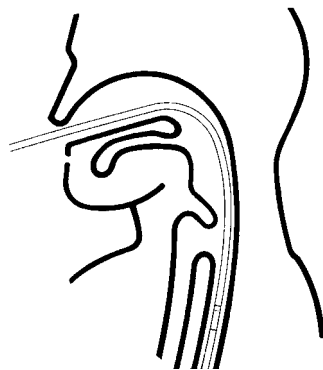
- Place exit port of tube at tip of nose. Extend NG tube to earlobe, then to Xiphoid process. Use the printed centimeter marks on the tube to aid intubation and to check for tube migration.
- WARNING: Premeasurement of tubing length is essential. DO NOT INSERT EXCESS. OCCLUSION MAY RESULT FROM KINKING OF TUBE.

4.



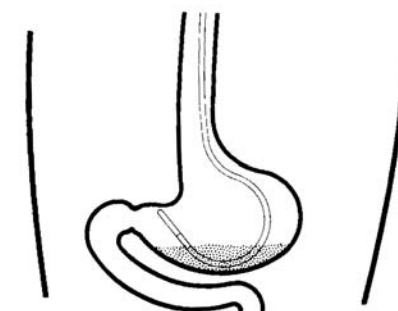
- Determine preferred nostril for insertion.
 - Activate lubricant on guide tip by dipping distal end in tap water.
 - Provide cooperative patient with glass of water and straw.
 - WARNING: One of the following procedures may be recommended for safe placement in high risk patients, e.g. those who are intubated, unconscious, have minimal or absent gag reflex, or are otherwise debilitated:
 1. Placement under fluoroscopy
 2. Placement under endoscopy.
 3. Placement under 2 stage x-ray.
 - Stage 1: Confirm tube has not entered the bronchial tree.
 - Stage 2: Confirm final placement.
- WARNING: NEVER RETRACT STYLET DURING INTUBATION.

5.



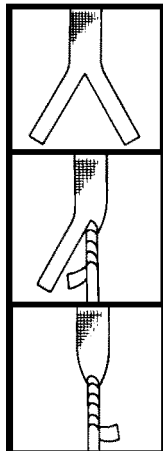
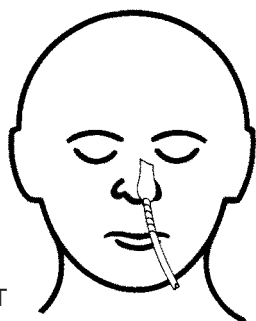
- Direct NG tube posteriorly, aiming tip parallel to nasal septum and superior surface of hard palate. Advance tube to nasopharynx, allowing tip to seek its own passage. As patient swallows sips of water, advance tube through esophagus into stomach with gentle motion.
- WARNING: Coughing may indicate passage of tube into trachea. If this is suspected, remove tube and reinsert once patient is comfortable. If resistance is encountered, remove tube. Notify physician.
- Particular care should be taken if an endotracheal tube is in place, as it may tend to guide feeding tube into trachea.

6.



- Confirmation of NG tube position can be done with or without stylet in place. Confirm nasogastric position by auscultation and aspiration of gastric contents using a 50 cc syringe. When using 50 cc syringes, withdraw plunger slowly. If it is difficult to obtain a gastric aspirate, distal tip of tube may be above fluid level in stomach. To overcome this, place patient on left side and wait a few minutes for tip to fall below fluid level. Attempt aspiration of gastric contents again.
 - WARNING: Confirmation by x-ray may be indicated in patients who are intubated, unconscious, or when gag reflex is absent. Confirmation by x-ray is usually indicated when duodenal/jejunal placement is desired.
- NOTE: Some institutions require x-ray prior to feeding.

7.

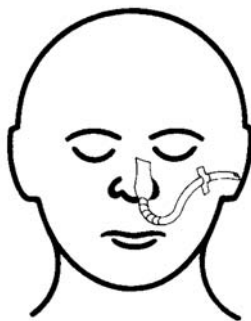


- **STYLET REMOVAL. ACTIVATE INTERNAL LUBRICANT BEFORE STYLET IS REMOVED.** Cap access port (if open) and flush tube THROUGH stylet connector with 10 ml of tap water.
 - WARNING: Tube position **MUST BE CONFIRMED** PRIOR TO FLUSHING NG tube with tap water.
 - Remove stylet, recoil and place in NG tube package.
 - Secure tube to nose per institution's protocol.
- NOTE: Applying tincture of Benzoin to tube before taping will enhance its stickiness and make it less slippery.

SUGGESTED TAPING

1. Split tape into two tails halfway up. The broad piece is taped to patient's nose and one tail is spiraled around feeding tube.
2. The other tail is spiraled down tube in opposite direction.

8.



- The NG tube is gently looped and taped to patient's cheek to allow access to mouth while removing tube from patient's line of vision. As noted in Step #3 above, do not insert excess tube. Occlusion may result from kinking of tube.
- Attach administration set and begin feeding per physician's order and usual institution protocol.

9.

TUBE MAINTENANCE

- If NG tube is to be reinserted, coat stylet and tube tip with water-soluble lubricant prior to reinsertion. Do not use stylet if it is bent.

WARNING: NEVER REINSERT STYLET WHEN TUBE IS IN PATIENT.

- The tube should be flushed with water whenever feeding formula is interrupted and before and after medication administration. Tubes should be irrigated routinely every four hours.
- Although feeding port has been designed to lessen possibility of clogging, vigorous pressure should not be used for irrigation. A new tube may be required. Do not use stylet to dislodge clog or manipulate obstructed tube.
- Although the bursting strength of this tube is approximately 80 psi, some infusion pumps (e.g. the IVAC 500 and 530 series) may exceed this pressure. It is also possible to exceed with pressure using hand syringes smaller than 50 cc.
- To maintain optimum tube performance in long term enteral feeding, the feeding tube should be considered for replacement every four weeks. Alternating nostrils is also suggested.