STUDENT'S NAME _____

DATE _____

FOR FACULTY USE ONLY

DATE _____

EDUCATOR'S NAME _____

PASS / FAIL

Skills Modules 3.0 Checklist
Enteral Tube Feeding: Inserting Nasogastric Tube

Step by Step	SATISFACTORY	UNSATISFACTORY	EVALUATOR'S COMMENTS
Inserting Nasogastric Tube			
*Provide privacy as needed.			
*Introduce yourself to the client.			
*Perform hand hygiene.			
*Verify client identification.			
*Determine whether the client has allergies.			
*Provide client education. Develop signals for client to communicate during procedure.			
Inspect client nares and check for patency			
Assist client into high-Fowler's position or at a 45-degree angle.			
Place a towel over the client's chest.			
Measure the length of tubing required for the client, then mark it with an indelible marker.			
If using a stylet, ensure it is secure and inject 10 mL of water into the tube.			
Prepare tape or fixation device.			
Apply clean gloves.			
Lubricate the tip of the tube and apply anesthetics if policy indicates.			
Give the client a cup of water with straw, and either have the client keep their neck in neutral position or have them flex their head back on a pillow, depending on policy.	☐	☐	
Insert tube following nasal passage. Rotate tube to help pass through the nasopharynx.	☐	☐	
Provide reassurance to client if gagging occurs when tube reaches pharynx. Ensure the tube is not coiled in the pharynx.	☐	☐	

**Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.*

Step by Step	SATISFACTORY	UNSATISFACTORY	EVALUATOR'S COMMENTS
Have the client flex their chin to their chest and encourage client to sip through a straw while tube advances.	☐	☐	
Stop the procedure if the client becomes cyanotic, is unable to speak or hum, or has continuous coughing or gagging, or if unable to advance the tube after rotating it.	☐	☐	
Continue advancing tubing until measured mark is reached. Secure tubing temporarily with tape			
Determine tube placement by checking aspirate pH or bilirubin or use a CO_2 detector.			
Mark the tube at the client's nostril.			
Apply skin barrier to the nose and secure tube in place with tape or a fixation device.			
Secure tubing to the client's gown. If a double-lumen is used, ensure vent is above stomach level.			
Remove gloves and perform hand hygiene.			
Arrange for an x-ray to confirm placement.			
Apply clean gloves and provide oral hygiene.			
Discard supplies, remove gloves, and perform hand hygiene.			
*Ensure that the client is in a safe position prior to leaving the room and has the call light within reach.			
Following x-ray confirmation, remove stylet.			

**Document the relevant information (assessment findings, pharmacological and nonpharmacological interventions) in the client's medical record.*

References

Berman, A., Snyder, S., & Frandsen, G. (2016). *Kozier & Erb's fundamentals of nursing: Concepts, process, and practice* (10th ed.). Upper Saddle River, NJ: Prentice-Hall, pp. 1154-1157.

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