埔里榮民醫院

鼻胃管灌食
（英文版）

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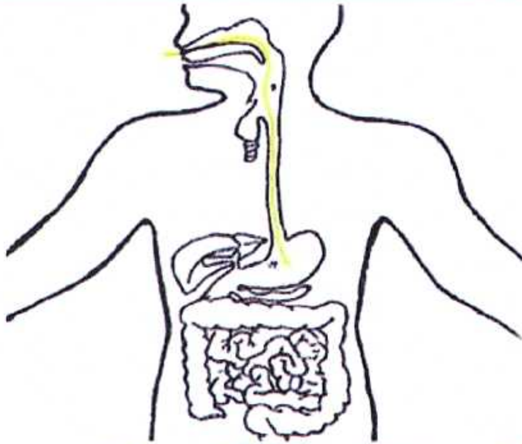
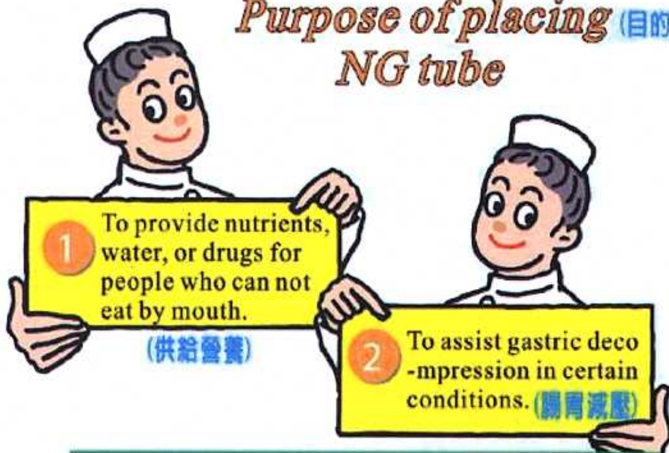
Tube position (管子放置位置)

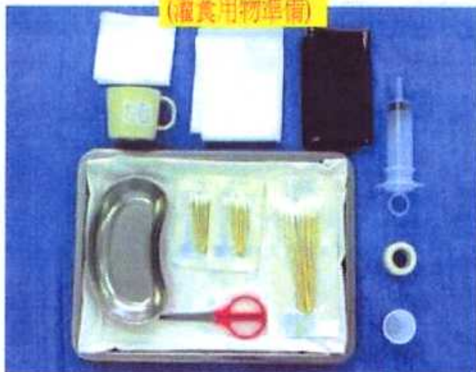


From a nostril through pharynx into stomach (放在胃內)



Preparations

(灌食用物準備)

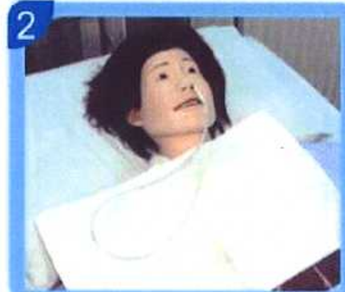


Food、feeding syringe、warm water、tissues or towel、tapes、cotton sticks、a gathering dish.
(食物、灌食空針、溫開水、衛生紙或毛巾、膠布、棉棒、盛物盤)

1 Preparation before feeding (灌食前)

1. Explanation.
(向病人解釋)

2. Hand washing.
(洗手)



3. Semi-sitting position (45 degree).
(半坐臥)

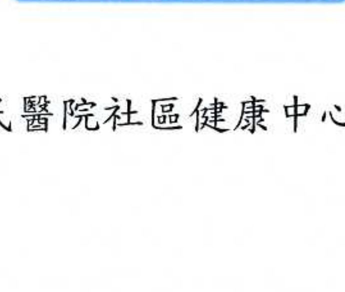
4. Towel covering.
(鋪上毛巾)

5. Aspiration and confirmation of tube position. digestion.color
(反抽觀察)

- Push back.
(胃液推回)

6. Feeding of 30 CC warm water for clear the tube.
(灌溫水30cc潤滑管路)

7. Preparation of food 250-300cc milk or food,temperature (37-40 degree).
Preparing warm water and feeding device.
(準備食物：量250-300cc，溫水，灌食器)



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2 *Steps during feeding* (灌食中)

1.Kinking NG tube:

Kinking NG tube and connect to feeding sy -ringe to prevent air e -ntry.

(反折胃管接灌食器防止空氣進入)

2.Feeding height:

Height: maintaining 35-40 cm height from fluid level in syringe to the stomach.

(灌食高度35-40cm)

3.Speed:

Keeping slow infusion for 10-30minutes.

(速度10-30分，緩慢流入)

4.Watch for patient's respones:

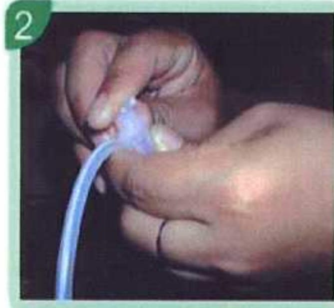
If persisting cough ,stom -ache ,sweating ,or vomiting,stop feeding immediately and observe and tell the nurses as well.

(觀察病人反應，如有持續咳嗽、發汗、嘔吐馬上停止灌食並觀察其變化)

3 *Steps after feeding* (灌食後)

1.Clean feeding tube with 30 cc warm water.

(溫水30cc將管子洗淨)

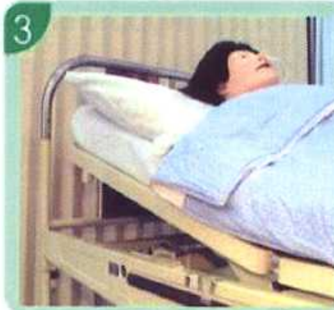


2.Kinking the NG feeding tube end.

(反折胃管末端)

3.Fix the tube.

(蓋好蓋子及固定管子)



4.Maintain patient's posi -tion for 30 minutes.

(姿勢維持不變30分鐘)

5.Clean and keep the supplies dry.

(清洗用物晾乾)

6.Hand washing.

(洗手)

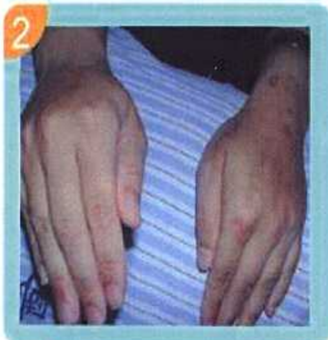
Special concerns on nursing care

(照護的注意事項)

1. Before feeding:

- Watch for absorption situation by observing aspiratin on syringe: If more than 100cc food content are aspirated,delay feeding by 30 ~60 minutes and recheck the abso -rption.

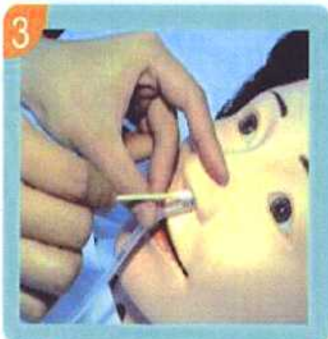
(灌食前反抽胃液觀察如大於100cc需延後30分再看吸收狀況)



2. Clean off secretion:

- Clean off secretions from lung, oral and nasal cavities, suction, or chest percussion 30 minuters before feering.
- Avoid sputum suction within 30 minutes after feeding.

(灌食前30分先去除肺、口鼻腔分泌物，灌時候30分內不可抽痰)



3. Nostril and mouth care:

(每天清潔口鼻腔)

4.Change fixed tapes everyday, watch for the marked scale on the tube.
Slightly rotate amd fix tube be tween the 2 and 3 mark or 50-55 cm in length.
In the mean while,the other hand secures the tube in place.
(每天更換膠布固定在50-55cm或第2-第3刻度)

5.Depending on intestinal absorp -tion rate, 5~6 times offeeding are required tocomplete.
(灌食次數5-6次)

6.Feed 250-300 cc at a time (do not exceed 500 cc at one time)
(一次灌食量不超過500cc)

7.Provide warm food (37-40- Celsius degrees).
Too hot will damage gastric mucosa and too cold will cause gastric spasm. (食物溫度約37-40度)

8. Know feeding formula and food preparation methods to maintain patient's adequate untritional state.
(知道如何沖泡牛奶及製作食物)

9. Leave food for no more 30 minutes at room temp erature to prevent souring
(食物置於室溫勿超過30分)

Prevention of obstruction

(預防管子阻塞)

- Rinse with at least 30 cc warm water before and after feeding to prevent obstruction.
- Do not feed with milk and medications together. Separate them by 30 minutes.
  Medications must be in a powder form and mixed well with water.
- Mixed milk well with water and filter fruit juice and food well to avoid tube obstruction.

(灌食前後要灌溫水，藥跟牛奶需分開灌並泡勻，製作果汁及食物要過濾)

Prevention of tube dislodgement:

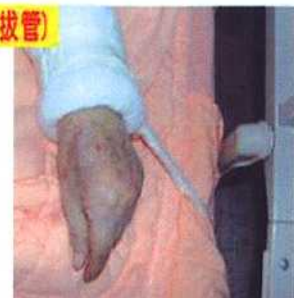
(預防管子脫落)

- Watch for the NG tube during bat -hing or ambulation or changing tapes.
  Make sure the tapes work and fix well.

(下床、洗澡、換膠布不要扯到管子及適當固定)

Prevention of intentioned tube removal

(預防拔管)



- If the patient agitates or mentally disturbs, wear him or her proper protection gloves.

(病人意識混亂躁動不安要穿戴保護性手套)

Management of special circumstance

(異常狀況處理)

- Report to nursing stuff if NG tube is intentionally removed by the pa -tient or disloged.
- Seek for medical help if the aspira -ted fluid is coffee or red in color or tarry stool is observed .
  These are the possible singns of gastrointestinal tract bleeding.

(管子脫落，反抽胃液出現咖啡色或紅色及解黑便需告知護理師即送醫處理)