留置鼻胃管之照護重點(英文)
Key Issues in NG Tube Retaining Care

一、鼻胃管之固定與清潔照護
A. Fixation and cleaning care of NG tube

（一）口腔清潔
(A) Oral cleaning

留置鼻胃管之病人，每天須至少執行一次口腔護理，以維持口、鼻清潔與衛生。若病人意識清醒可配合，建議可以刷牙清潔。

For NG tube retaining patients, it is necessary to perform oral care at least one time every day to keep the mouth and nose clean as well as hygiene. For conscious and cooperative patients, cleaning by tooth brushing is recommended.

（二）管路固定
(B) Tubing fixation

1.每天需更換固定鼻胃管的膠布或紙膠，更換前應將臉部皮膚擦拭乾淨再粘貼。

1. It is necessary to replace the tapes or masking tapes for NG tube fixation every day, facial skin is to be wiped clean before replacing and sticking.

2.固定過程中勿移動鼻胃管所插入的深度，若管路不慎拉出，不可自行強行推入，應告知醫護人員處理。

2. Do not alter the depth of NG tube inserted during fixation, it is not allowed to voluntarily push it back before noticing medical personnel for intervention in case of incidental pulling out the tubing.

3.男性病人若鬍子太長，應選擇固定在鼻部，或考慮刮除鬍子以利管路固定。

3. For male patients with longer moustache, choose to fix on the nose or consider shaving moustache for better tubing fixation.

4.更換膠布時不要貼在相同位置，可向左或向右側固定，避免向上固定且輕輕旋轉管子（但要避免拉出管子），如此可避免管子固定在鼻腔的同

一部位，以預防鼻翼受壓，產生壓瘡，並注意勿移動胃管所插入的深度。

4. Do not stick on the same location while replacing tapes, fix on the left or right side of previous location and avoid upward fixation, gently rotate the tubing (but avoid pulling it out) which may prevent the tubing from fixing on same location of nasal cavity thus avoid pressing nasal ala to develop decubitus, also notice not to alter the depth of NG tube inserted.

5.臉部易出油病人，其固定膠布或紙膠更換頻率應增加。

5. The frequency of replacing fixation tapes or masking tapes shall be increased for patients with greasy faces.

二、留置鼻胃管病人之灌食與注意事項

B. Feeding and precautions for NG tube retaining patients

（一）灌食步驟

(A) Feeding procedure

1.每次灌食前應先洗手。

1. Wash hands before performing each feeding.

2.將病人床頭搖高約30度以上（無法坐臥者採左側臥式）。

2. Keep head of the bed elevated for more than 30 degrees (take a left lateral position for patients unable to be in Fowler’s position).

3.每次灌食前先確定鼻胃管位置是否在胃內，檢視方法為確認鼻胃管之膠布是否鬆脫，刻度是否正確。

3. First verify if NG tube is in the stomach before performing each feeding, the viewing method is to ensure the tapes of NG tube are not loose and the scale is correct.

4.鼻胃管位置確定無誤後，先以灌食空針反抽胃內容物，了解前一餐消化情形，再以灌食空針抽20cc溫開水灌入，確保管路通暢。

4. After confirming the proper position of NG tube, first pull back feeding syringe plunger to draw gastric content to interpret the digestion of previous meal and then draw 20cc of warm water to flush with feeding syringe to ensure the passage unobstructed.

5.以灌食空針抽取食物，並排除過多的空氣。

5. Draw out food with feeding syringe and eliminate excessive air.

6.灌食速度應緩緩地灌入，或將灌食空針舉高超過病人胃部約45cm，利

用重力自然引流讓食物緩慢經鼻胃管流入。

6. Feeding speed shall be slow enough or raise the feeding syringe about 45 cm higher than patient’s stomach to utilize gravity for natural draining to slowly flow in food through NG tube.

7.灌食期間每次以灌食空針抽取管灌食物時，應反折管子，或先蓋上蓋子，以避免灌入空氣造成脹氣。

7. The tubing shall be out-folded or the cap shall be covered each time drawing out food with feeding syringe during feeding period, so to prevent flatus resulted from filled air.

8.食物灌完後抽20~30c.c.溫開水沖洗鼻胃管，避免鼻胃管阻塞或食物殘留。

8. Flush NG tube with 20-30cc warm water after food feeding to avoid NG tube obstruction or residual food.

9.灌食完畢，用具需用清水洗淨晾乾，並置於清潔容器內。

9. After feeding, all apparatus shall be cleaned with water, air-dried and stored in a clean container.

（二）注意事項

(B) Precautions

1.若病人有裝置氣管內管或氣切套管時，灌食前應先請護理師抽痰。

1. For patients who received endotracheal intubation or tracheaostomy tube, it is necessary to ask nurses for phlegm suction.

2.食物之溫度應維持溫熱（有特殊醫囑者例外），以不燙手為原則。

2. Food temperature shall be kept warm (exceptions for particular medical advices), better not to scald hands.

3.為避免食物腐敗，醫院提供的管灌食物，請於半小時內灌畢；若為罐頭裝食物，打開後請於4小時內灌畢，否則請冷藏保存以防食物腐壞，並於24小時使用完畢；冷藏後先回溫才可再灌食；當您返家後，所自製的一天量管灌食物，也請放冰箱冷藏，再依每餐灌食量隔水加熱後，於半小時內灌畢，當日無法灌畢的食物則須丟棄。

3. To prevent food from spoilage, feeding food provided by the hospital shall be completely fed within half an hour; for canned food, please complete feeding within 4

hours after opening, otherwise it shall be stored in the refrigerator avoiding food spoilage and used up within 24 hours; refrigerated food shall be reheated before feeding; please also store the self-made tube feeding food for daily using in the refrigerator, complete feeding within half an hour after double-boiled feeding amount of each meal, remaining feeding food on that day shall be discarded.

4.但若於灌食前反抽有多量未消化內容物，應將之再灌回，並減少流質灌食或停止灌食。

4. In case of undigested content existed in back-drawing before feeding, re-fed back and reduce liquid feeding or stop feeding.

5.灌食時若感覺不易進入，可擠壓鼻胃管，試著用灌食空針反抽，再灌溫開水沖通管子。

5. While difficulty in flowing occurred, press NG tube and try to draw with feeding syringe then flush through the tubing with warm water.

6.灌食量通常一次不超過300c.c.，灌食前應反抽，作為評估病人消化情形。若病人連續兩次均出現反抽之胃內容物大於100~150c.c.，表示消化情形不佳，並告知醫護人員處理。

6. Feeding amount is usually less than 300 cc, drawing-back content prior to feeding may be used to evaluate patient's digestive status. Gastric content of the patient continuously presents more than 100-150 cc for two times indicates impaired digestion, notice medical personnel for intervention.

7.灌食過程中，若病人有異常情形，如：不停咳嗽、嘔吐、臉色發紫時，應立即停止灌食，通知醫護人員處理。

7. If the patient shows abnormality during feeding, e.g. persistent cough, vomiting, face turning cyanosis, feeding shall be immediately stopped and notice medical personnel for intervention.

8.灌食後應維持半坐臥姿勢至少30分鐘至1小時，而且不要隨便翻動病人、拍背或抽痰，以免嘔吐發生而引發吸入性肺炎之危險。並觀察病人有無腹瀉、腹脹、便秘等腸胃不適表現，若有以上症狀，立即通知醫護人員處理。

8. Patient shall be kept in semi-Fowler's position for at least 30 minutes to 1 hour after feeding, do not arbitrarily move over the patient, slap the back or suck phlegm to prevent the risk of aspiration pneumonia resulted from vomiting. Furthermore, observe

patient's GI upset appearances such as diarrhea, bloated abdomen and constipation, etc., immediately notice medical personnel to handle these symptoms above.

9.鼻胃管應避免受壓、扭曲或灌食時被拉出，若不慎拉出，不可強行推入，應告知護理人員處理。

9. Prevent NG tube from being pressed, writhed or pulled out during feeding, it is not allowed to voluntarily push it back in case of incidental pulling out the tubing before noticing medical personnel for intervention.

三、參考文獻

C. Reference

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