

# 鼻胃管灌食及照護指導【英文版】

## Nursing Guidelines for Nasogastric Tube Feeding

### 壹、何種病人需放置鼻胃管

#### I. Who needs nasogastric tube?

- 一、不能由口進食者(如:昏迷、吞嚥困難、食道受損等)，可藉由鼻胃管獲得營養、藥物及執行相關的治療。
- 二、疾病所需協助的胃部減壓(如:腸阻塞、胰臟發炎、腹脹及手術等)。
  1. Patients who cannot eat through the mouth (due to coma, difficulty swallowing, damage to the esophagus...etc.), so they need to receive nutrients, medications, or relevant treatment through nasogastric tube.
  2. Stomach pressure relief required by certain disease treatments. (For example, intestinal obstruction, pancreatitis, bloating, or surgery preparation.)

### 貳、鼻胃管灌食步驟

#### II. NG tube feeding procedures

##### 一、洗手(避免細菌感染)。

1. Wash hands. (To avoid bacterial infection.)

##### 二、告知病人並協助抬高床頭至半坐臥約 30-45 度(圖一)。

2. Notify the patients about the procedure and raise the bed 30-45 degrees. (Fig. 1)

##### 三、反抽檢查位置是否正確並觀察胃消化液的情形，再將消化液灌回胃內幫助消化(空氣則不打入)，之



圖一  
Fig.1

後將空針內管取下(圖二)。

3. Aspirate to check if the tube was placed at the right place and how the digestive juices looks. Push the digestive juices back to help with digestion (exclude the air) and then take off the syringe plunger. (Fig.2)



圖二  
Fig.2

四、移除灌食空針時“反折”鼻胃管開口避免空氣進入，以免造成病人腹脹(圖三)

4. “Fold” the NG tube when removing the syringe plunger to prevent air from going in the patient’s stomach, which will lead to bloating.(Fig.3)



圖三  
Fig.3

五、手握空針高度距離胃部45-60公分，利用重力原理灌食；當牛奶快流完時，須反折鼻胃管開口，並灌入30-50ml的溫水沖洗管路，保持鼻胃管通暢及清潔(圖四)。

5. Hold the syringe 45-60cm above the stomach and feed the patient. When the milk is almost gone, fold the opening of NG tube and pour in 30-50ml of warm water to clean the tube and



圖四  
Fig.4

Keep 45-60cm to control the flow rate

keep it unobstructed and clean. (Fig. 4)

- 六、灌食後需維持半坐臥姿勢約 30-60 分鐘以利消化。  
6. Patient should remain half-seated for 30-60 minutes after feeding to help with digestion.

### 參、注意事項

- 一、灌食後 30 分鐘內不可抽痰、翻身，避免嘔吐造成吸入性肺炎。
- 二、反抽胃剩餘物若超過 200ml，則暫停灌食至下一餐。
- 三、反抽胃剩餘物若呈現墨綠色、紅色、咖啡色、暗紅色時應停止灌食，並立即告知醫護人員。
- 四、灌食中若出現咳嗽不止、呼吸變化、嘔吐時，應立即停止灌食，並告知醫護人員。

### III. Precautions

1. Within the 30 minutes after feeding, mucus suction or position change on the patient are not allowed. This is to prevent vomiting, which could lead to aspiration pneumonia.
2. Stop feeding the patient and wait until the next meal when the amount of aspirated gastric residuals is more than 200ml.
3. When the color of aspirated gastric residuals is dark green, red, brown, or dark red, stop feeding the patient and notify the medical staff immediately.
4. Notify the medical staff and stop feeding whenever patients start experiencing continuous coughing, change in respiration rate, or vomiting.

### 肆、照護指導

- 一、每天清潔鼻腔內部及膠布固定處皮膚，更換宜拉膠布，保持固定處皮膚清潔及觀察有無破損，若固定膠布有脫落或鼻部弄濕，應立即告知護理人員給予更換，避免造成滑脫。

亞東紀念醫院 祝您健康

Far Eastern Memorial Hospital Wishes You Well

- 二、每次灌食前需確認鼻胃管固定刻度，須注意管路有無滑脫，如管路不在固定刻度上請勿灌食並通知護理人員。

#### IV. Nursing guidelines

1. Clean the nasal passageway (inner wall of the nose) and the taped area everyday. Replace the tape daily, keep the skin of the taped area clean, and check if there are any ruptures on the skin. If the tape falls out or gets wet around the nose, medical staff should be notified immediately to change the tape.
2. Before every feeding, check if the measurement marking on the tube remains the same and if the tube has fallen out. If the marking on tube is not consistent with the previous marking, notify the medical staff and stop feeding.

#### 伍、諮詢服務電話

- (02) 89667000 轉 4841 (胸腔內科病房)  
(02) 89669000 (預約掛號專線)

#### V. Consulting service line

- (02) 89667000 #4841 (Department of Thoracic Medicine)  
(02) 89669000 (Special line for appointment)

#### 陸、參考資料

亞東紀念醫院護理部標準工作指導書 (2016年8月26日) · W15000-01-116  
灌食暨管路照護標準。

吳麗琳、周繡玲 (2020) · 消化系統疾病之護理 · 於劉雪娥總校閱，成人內  
外科護理 (八版，301-506頁) · 台北市：華杏。

#### VI. References

- Standard Work Instructions of the Nursing Department of Far Eastern Memorial Hospital (August 26, 2016). W15000-01-116 Standard for Feeding and Tube Care
- Wu, L.L. and Chou, H.L. (2020). Digestive Disease Care. Reviewed by Liu, H.E., *Adult Medical/Surgical Care* (8th Edition, pp.301-506). Taipei: Farseeing Publishing.

柒、複習一下

問題 1：( )協助病人鼻胃管灌食前，需先抬高床頭至半坐臥約 30-45 度。

問題 2：( )灌食後 30 分鐘內可以抽痰、翻身。

問題 3：( )反抽胃剩餘物若呈現墨綠色、紅色、咖啡色、暗紅色時應停止灌食，並立即告知醫護人員。

正確答案

問題 1: O 問題 2: X 問題 3: O

## VII. Quick Quiz

Q1:( ) Before assisting the patient with NG tube feeding, raise the head of the bed about 30-45 degrees.

Q2:( ) Within 30 minutes after feeding, mucus suction and turning the patient over are allowed.

Q3:( ) When the color of aspirated gastric residuals is dark green, red, brown, or dark red, stop feeding the patient and notify the medical staff immediately.

Correct answer: Q1: True; Q2: False; Q3: True

編印單位:護理部外語-英 (ND-11-E)
編印日期:2005 年 12 月 11 日第 1 版
修訂日期:2022 年 06 月 30 日第 4 版
全院編碼:亞東醫院出版品 (SH062-E)
材物編碼: MS4905Z431
宗 旨: 持續提升醫療品質 善盡社會醫療責任
願 景: 成為民眾首選的醫學中心