NURSING CARE OF THE CLIENT WITH A Gastrostomy or Jejunostomy Tube

Clients who have had extensive gastric surgery or who require long-term enteral feedings to maintain nutrition may have a gastrostomy or jejunostomy tube inserted.

PROCEDURE
Gastrostomy tubes are surgically placed in the stomach, with the stoma in the epigastric region of the abdomen (see Figure 23–13). Jejunostomy tubes are placed in the proximal jejunum. Immediately following the procedure, the tube may be connected to low suction or plugged. If the client has been receiving tube feedings, these may be reinitiated shortly after tube placement.

NURSING CARE
- Assess tube placement by aspirating stomach contents and checking the pH of aspirate to determine gastric or intestinal placement. A pH of 5 or less indicates gastric placement; the pH is generally 7 or higher with intestinal placement. Recent studies show auscultation to be ineffective in determining tube placement. Measuring the pH of aspirate from the tube is more reliable as a means of determining tube placement.
- Inspect the skin surrounding the insertion site for healing, redness, swelling, and the presence of any drainage. If drainage is present, note the color, amount, consistency, and odor. Changes in the insertion site, drainage, or lack of healing may indicate an infection.
- Assess the abdomen for distention, bowel sounds, and tenderness to evaluate functioning of the gastrointestinal tract.
- Until the stoma is well healed, use sterile technique for dressing changes and site care. Clean technique is appropriate for use once healing is complete. Sterile technique reduces the risk of wound contamination by pathogens that can lead to infection. Once healing has occurred, clean technique is acceptable because the gastrointestinal tract is not a sterile body cavity.
- Wearing clean gloves, remove old dressing. Cleanse the site with saline or soap and water, and rinse as appropriate. A well-healed stoma may be cleansed in the shower with the tube clamped or plugged. Pat dry with 4 × 4 gauze pads, and allow to air dry. Apply Stomahesive, karaya, or other protective agents around tube as needed to protect the skin. Gastric acid and other wound drainage is irritating to the skin. Meticulous care is important to maintain the integrity of the skin surrounding the stoma.
- Redress the wound using a stoma dressing or folded 4 × 4 gauze pads. Do not cut gauze pads, because threads may enter the wound, causing irritation and increasing the risk of inflammation.
- Irrigate the tube with 30 to 50 mL of water, and clean the tube inside and out as indicated or ordered. Soft gastric tubes may require cleaning of the inner lumen with a special brush to maintain patency. Tube feeding formulas may coat the inside of the gastrostomy tube and eventually cause it to become occluded. Regular irrigation with water and brushing as indicated maintain tube patency.
- If indicated, teach the client and family how to care for the tube and feedings. Refer to a home health agency or visiting nurse for support and reinforcement of learning. Gastrostomy tubes are often in place long term. When the client and family are able to assume care, independence and self-image are enhanced.

NURSING CARE PLAN A Client with Gastric Cancer

George Harvey is a 61-year-old estate attorney who lives with his wife, Harriet. For the last 3 months, Mr. Harvey has had increasing anorexia and difficulty eating. He has lost 10 pounds. His physician has diagnosed gastric cancer, and Mr. Harvey is admitted for a partial gastrectomy and gastrojejunostomy. The oncologist has recommended postoperative chemotherapy and radiation. Mr. Harvey reports that the doctor told him "that will give me the best chance for cure."

ASSESSMENT
On admission before surgery, Mr. Harvey tells his nurse, Lauren Walsh, that he has eaten very little in the past few weeks. He asks, "What will happen to my wife if something happens to me? I'm afraid this cancer will get me." Mr. Harvey weighs 147 lb (67 kg) and is 72 inches (183 cm) tall. He is pale and thin; his vital signs are BP 148/86, P 92, R 18, and T 97.8°F PO. A firm mass is palpable in the left epigastric region. The rest of his physical assessment data are within normal limits. Mr. Harvey’s hemoglobin is 12.8 g/dL, hematocrit is 39%, and serum albumin level is 3.2 g/dL, indicating that he is mildly malnourished. All other preoperative laboratory and diagnostic studies are within normal limits.

DIAGNOSES
- Imbalanced Nutrition: Less than Body Requirements related to anorexia and difficulty eating
- Acute Pain related to surgical incision and manipulation of abdominal organs
- Risk for Ineffective Airway Clearance related to upper abdominal surgery
- Anticipatory Grieving related to recent diagnosis of cancer

EXPECTED OUTCOMES
- Maintain present weight during hospitalization.
- Resume a high-calorie, high-protein diet by time of discharge.
- Verbalize effective pain management, maintaining a reported pain level of 3 or less on a scale of 1 to 10.
- Maintain a patent airway and clear breath sounds.
- Verbalize feelings regarding diagnosis and participate in decision making.

PLANNING AND IMPLEMENTATION
- Weigh daily.
- Maintain nasogastric tube placement, patency, and suction as ordered.
- Maintain intravenous fluids and total parenteral nutrition as ordered until oral food intake is resumed.
- Arrange for diet teaching, including strategies to prevent dumping syndrome, before discharge.
- Maintain patient-controlled analgesia until able to take oral analgesics.

(continued)
Consult with dietitian for a complete nutrition assessment and diet planning. The client is at risk for protein-calorie malnutrition, which impairs the ability to heal and recover from extensive surgery.

Weigh daily. Monitor laboratory values such as hemoglobin, hematocrit, and serum albumin levels. Daily weights are a valuable measurement of both fluid and nutritional status. Laboratory values provide further evidence of nutritional status.

Provide preferred foods; have family prepare meals when possible. Provide supplemental feedings between meals. Small, frequent feedings and preferred foods encourage intake of nutrients.

PRACTICE ALERT
Assess ability to consume adequate nutrients. Nausea and feelings of early satiety may impair nutrient consumption, indicating a need to institute enteral or parenteral feedings.

Arrange for visitors to be present during meals. Eating is a social function as well as a physiologic one. Companionship often improves food intake.

Administer pain and antimetic medications as needed before meals. Pain and nausea suppress the appetite; relief promotes food intake.

Anticipatory Grieving
Encourage family members to spend as much time as possible with the client. The family may feel helpless and ineffectual. Supporting family members’ presence can encourage this vital interaction.

Do not negate denial if present. Denial is a coping mechanism that protects the client from hopelessness.

Allow clients to talk openly if desired about their condition and the prognosis. Acceptance of the clients’ fears helps reduce anxiety and promote coping behaviors.

Actively listen to the client’s and family’s expressions of grieving. Avoid interrupting or offering meaningless words of consolation. Being present and listening actively are often the most effective interventions for the grieving client.

Using NANDA, NIC, and NOC
Chart 23–4 shows links between NANDA nursing diagnoses, NIC, and NOC when caring for a client with gastric cancer.