Society of Gastroenterology Nurses and Associates, Inc.

POSITION STATEMENT

The Role of the Nurse/Associate in the Placement of Percutaneous Endoscopic Gastrostomy (PEG) Tube

Disclaimer

The Society of Gastroenterology Nurses and Associates, Inc. (SGNA) assumes no responsibility for the practices or recommendations of any member or other practitioner, or for the policies and procedures of any practice setting. Nurses and associates function within the limitations of licensure, state nurse practice act, and/or institutional policy.

Definitions

For the purpose of this document, SGNA has adopted the following definitions:

Percutaneous endoscopic gastrostomy (PEG) tube placement refers to an endoscopic technique for placing a gastrostomy/jejunostomy tube for enteral feeding.

Nurse refers to registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN).

Associate refers to unlicensed assistive personnel such as technicians, technologists, and assistants.

Background

Percutaneous endoscopic gastrostomy (PEG) was first introduced in 1980 (Gauderer, Ponsky & Izant, 1980) as an alternative to laparotomy for surgical placement of feeding tubes (American Society for Gastrointestinal Endoscopy [ASGE], 2003). PEG tube placement has profoundly impacted nutritional management, particularly in patients unable to maintain sufficient oral intake, and has become worldwide standard for direct gastric access (Dumortier et al., 2004; Society of American Gastrointestinal Endoscopic Surgeons [SAGES], 2003). Traditionally two physicians have performed the procedure. Recent studies with adult patients have shown the efficacy of training an experienced gastroenterology nurse to assist with PEG tube placement (Verschuur, Kuipers, and Siersema, 2007; Patrick, Kirby, McMillion, DeLegge, & Boyle, 1996; Wilson, 2000).

Placement of PEG Tube

Position

SGNA supports the position that the registered nurse educated and experienced in gastroenterology nursing and endoscopy can be given the responsibility for performing an expanded role if it falls within the scope of their state nurse practice act and institutional policy. This role would be performed in the presence of and under the direct supervision of a physician endoscopist. The RN is required to maintain current knowledge, competency and experience in PEG tube placement to fill this role. This competency should include, but is not limited to:

1. Anatomy of stomach and abdomen;
2. Sterile technique;
3. Preparation of a patient's abdomen;
4. Manipulation of endoscope;
5. Digital indentation of the stomach;
6. Infiltration of the patient's abdomen with local anesthetic;
7. Incision technique(s);
8. Trocar insertion;
9. Gastrostomy tube insertion;
10. Gastrostomy tube traction for proper positioning;
11. Indications and contraindications; and
12. Potential complications.

There are **three distinct and separate procedure roles (**excluding the endoscopist) that occur during the placement of a PEG tube.

1. **Direct patient care role**

This includes but is not limited to: administration of medication as ordered; continuous assessment and intervention as necessary; maintaining a patent airway; monitoring tolerance of the procedure; and documenting care.

This role may be performed by an RN, CRNA, or anesthesiologist.

2. **RN expanded role**

This includes but is not limited to: providing assistance to the physician/endoscopist by either:

a. Maintaining position of the endoscope; manipulating controls as directed; insufflating of viscera; and snaring the wire/thread; or

b. Preparing the abdomen; local infiltration; incision; trocar placement; threading the wire/thread; and positioning gastrostomy tube.

This role may be performed by an RN in the expanded role, second

endoscopist, surgeon, or fellow.

3. **Technical support role**
This includes but is not limited to providing technical support to the physician endoscopist and RNs.
This role may be performed by an RN, LPN/LVN or associate.

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