Securing Oral Endotracheal Tubes (ETT) CoMET Guideline

This guideline is for use by healthcare staff, at CoMET undertaking critical care retrieval, transport and stabilization of children, and young adults.

CoMET is a Paediatric Critical Care Transport service and is hosted by the University Hospitals of Leicester NHS trust working in partnership with the Nottingham University Hospitals NHS Trust.

This guidance supports decision making by individual healthcare professionals and to make decisions in the best interest of the individual patient.

This guideline represents the view of CoMET, and is produced to be used mainly by healthcare staff working for CoMET, although, professionals, working in similar field will find it useful for easy reference at the bedside.

We are grateful to the many existing paediatric critical care transport services, whose advice and current guidelines have been referred to for preparing this document. Thank You.

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Education and Training

1. Annual Transport team update training days
2. Workshops delivered in Regional Transport Study days/ Outreach

Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Incident reporting	Review related Datix	Abi Hill – Lead Transport Nurse abi.hill@uhl-tr.nhs.uk	Monthly	CoMET Lead Governance Meeting
Documentation Compliance	Documentation Audit	Abi Hill – Lead Transport Nurse abi.hill@uhl-tr.nhs.uk	3 Monthly	CoMET Lead Governance Meeting

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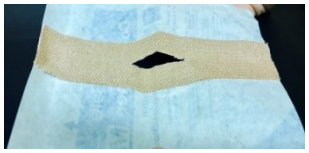
The Melbourne strapping technique is a method of securing oral and nasal endotracheal tubes (ETT) to provide a safe fixation. This is a two person process at all times as small head movements can cause significant tracheal tube migration.

As shown below, prepare 3 pieces of Elastoplast. Cut two pieces into “trouser legs” (A) and one with a slit (B) – this piece is optional. Each piece of Elastoplast should be measured to fit the individual taking care not to cover their hair or ear lobes. Before securing, ensure the required tube length is visible and the nose, face and tube are dry and free from secretions.

A) 

B) 

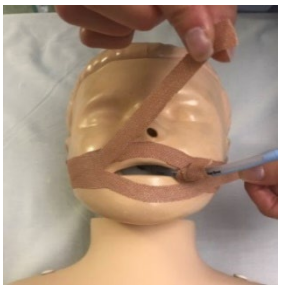
1

Position the ETT in the angle of the child’s mouth. Starting on **this side**, apply the wide part of the first trouser leg to the cheek meeting the corner of the lip.
The top of the “leg” goes over and fixes to the top lip on to the cheek, ensuring the lip is visible.

2

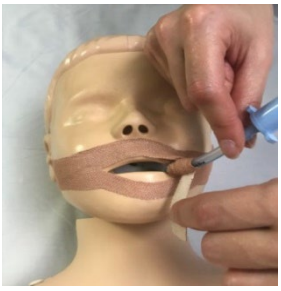
The bottom trouser leg is then spiralled up around the ETT. The end of this “leg” is folded back on its self for easier removal at a later stage.

3



With the second trouser leg start on the **opposite** side as the ETT and repeat the process in reverse.

4

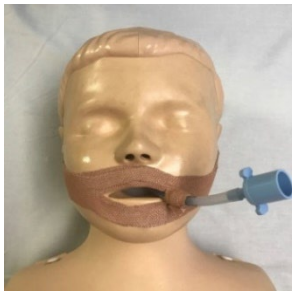


This time the bottom leg goes under the bottom lip and the top leg is wound around the tube

5

It is optional to place the ETT through the “slit” tape securing the trouser leg tapes or apply a third trouser leg to the same side of the mouth as the ETT.

6



If there is an oral gastric tube this should also be passed through the “slit” tape.

Reference:

Securing a nasal endotracheal tube (April 2017). The Royal Children's Hospital Melbourne. https://www.rch.org.au/uploadedFiles/Main/Content/rchcpg/hospital_clinical_guideline_index/Secure%20ETT%20Nasal%20and%20Oral%20Illustrations_March2017.pdf

Version	Issue Date	Author(s)	Description
3	August 2023	Emma Lount (was Lawrence) Agata Holecova	Box 5; changed from an instruction to optional to "place tube through "slit tape"".