Nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Skill Assessment Competency Checklist**

**\*Refer to Trainer Preparation- Scenario 1**

**Emergency Scenario: Identifying Distress**

You are assisting the mother of a 9 month old ex-premie who is trach and ventilator dependent to his first ENT clinic visit. Patient is breathing faster than usual and working harder to breathe.

**What do you do?**

|  |  |
| --- | --- |
| **Expected Interventions** | **Instructor Initials/date** |
| Nurse checks vital signs and assesses child for signs of distress and cyanosis |  |
| Nurse checks that tracheostomy is in place |  |
| Nurse identifies signs of possible infection (elevated temp, increased secretions) |  |
| Nurse suctions child’s trach |  |
| Nurse recognizes probable causes of respiratory distress and plans appropriate interventions |  |
| Nurse identifies who to communicate with and how to document change in status |  |

**Trainer Preparation**

**Scenario 1- Identifying Distress**

**Scenario:** You are assisting the mother of a 9 month old ex-premie who is trach and ventilator dependent to his first ENT clinic visit. Patient is breathing faster than usual and working harder to breathe. **What do you do?**

A baby in a stroller

Description automatically generated

**Learning objectives:**

1. Identify mild respiratory distress (change from patient baseline)

2. Demonstrate skills of in-line suction/ and or manual suction

4. Recognize who and when to call/document about change in patient status

**Nurse initial assessment (cues to give trainee of mannequin’s appearance):**

Vital signs:

* Respiratory Rate: 10 above baseline
* Temp: 100.9 F

Airway: thick yellow secretions

Color: pale/flush

Work of breathing: mild retractions

**Expected Interventions:**

* Nurse recognizes child in mild distress
* Nurse recognizes need to assess child’s vital signs, including temperature
* Nurse recognizes change in secretions
* Nurse suctions child
* Nurse gathers appropriate information and communicates with parent/provider

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