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

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

**Emergency Skill Assessment Competency Checklist**

**\*Refer to Trainer Preparation- Scenario 2**

**Emergency Scenario: Plug in trach (continuation from Scenario 1)**

As you suction you notice that the suction catheter is able to go down the entire pre-measured length of the trach tube but is tighter than usual. You are getting yellow secretions and child is breathing comfortably. You choose to do nothing but monitor the child. Mom steps away to get assistance finding ENT clinic. Child getting restless and making whistling breath sounds. The ventilator starts alarming high pressure. **What do you do?**

**What do you do?**

|  |  |
| --- | --- |
| **Expected Interventions** | **Instructor Initials/date** |
| Nurse attempts to suction using normal saline  |  |
| Nurse determines if he/she has adequate access to trach site—child may need to be removed from stroller |  |
| Nurse attempts to give breaths with Ambu bag to see if air will pass |  |
| Nurse performs an emergency trach change |  |
| Nurse gives a few manual breaths with oxygen |  |
| Once child returns to baseline and trach is secure, then nurse places child back on ventilator |  |
| Nurse communicates change in status to parent/provider |  |
| Nurse documents event |  |

**Trainer Preparation**

**Scenario 2- Plug in trach**

**Scenario:** (continuation from Scenario 1)As you suction you notice that the suction catheter is able to go down the entire pre-measured length of the trach tube but is tighter than usual. You are getting yellow secretions and child is breathing comfortably. You choose to do nothing but monitor the child. Mom steps away to get assistance finding clinic. Child getting restless and making whistling breath sounds. The ventilator alarming high pressure. **What do you do?**



**Learning objectives:**

1. Identify signs of respiratory distress

2. Recognize signs of plug in trach

3. Demonstrate appropriate interventions for plug in trach, including emergency trach change

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

Vital signs:

* Respiratory Rate: 20 above baseline

Airway: plugged

Color: dusky

Work of breathing: retractions with nasal flaring and poor air movement

**Expected Interventions:**

* Upon recognition of respiratory distress, nurse attempts to use Ambu bag
* Nurse recognizes trach is plugged and attempts to suction
* When suctioning does not clear the plug, nurse initiates emergency trach change
* Once trach is changed and baby is showing signs of being back to baseline, nurse will contact parent and physician to update about event