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

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

**Emergency Skill Assessment Competency Checklist**

**\*Refer to Trainer Preparation- Scenario 3**

**Emergency Scenario: Dislodged Trach**

You have just transitioned your patient to their stroller in preparation for a clinic visit. Patient’s ventilator begins to low pressure alarm. Child looks stable.

**What do you do?**

|  |  |
| --- | --- |
| **Expected Interventions** | **Instructor Initials/date** |
| Nurse starts patient assessment and identifies trach is out of stoma |  |
| Nurse quickly grabs patient’s to go bag and replaces trach with back up trach |  |
| Nurse gives breaths with Ambu bag (using oxygen if available) while assessing breath sounds and bilateral chest rise. |  |
| Nurse identifies trach properly in place and can now secure ties |  |
| Nurse places patient back on ordered equipment |  |
| Nurse reports event to child’s parent/provider |  |
| Nurse documents event |  |

If child looks unstable and showing signs of moderate to severe distress.

**What do you do?**

|  |  |
| --- | --- |
| **Expected Interventions**  | **Instructor Initials/date** |
| Nurse begins assessment at patient and identifies trach out of stoma |  |
| Nurse quickly re-inserts dislodged trach, using spare obturator if available |  |
| Nurse gives breaths with Ambu bag while assessing breath sounds and bilateral chest rise  |  |
| Nurse identifies trach properly in place and can now secure trach ties |  |
| Nurse places patient back on ordered equipment |  |
| Nurse reports event to child’s parent/provider |  |
| Nurse documents event |  |

**Trainer Preparation**

**Scenario 3- Dislodged Trach**

**Scenario:** You have just transitioned your patient to their stroller in preparation for a clinic visit. Patient’s ventilator begins to low pressure alarm. **What do you do?**

**Learning objectives:**

1. Recognize that the trach is displaced

2. Assess the child and prepare to act accordingly

3. Perform appropriate interventions according to assessment of child.

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

|  |  |
| --- | --- |
| A: patient stableVital signs:* Respiratory Rate: 10 above baseline
* Heart rate: normal

Airway: compromised Color: normal Work of breathing: normal**Expected Interventions:** A: patient stable * Nurse recognizes child not in distress
* Nurse recognizes need to replace trach
* Nurse replaces trach with new/ clean trach
* Nurse assesses patient after insertion of new trach
* Nurse will communicate with parent/provider
 | B: patient unstableVital signs:* Respiratory Rate: 20 above baseline
* Heart Rate: above baseline

Airway: compromisedColor: cyanoticWork of breathing: substernal retractionsB: patient unstable * Nurse identifies severe distress
* Nurse does not hesitate and identifies need to put dislodged trach back in

*\*( talking point) - Keep extra obturator close by at all times** Nurse will observe child return to baseline. *\*( talking point)- Possible need for bagging child with FiO2*
* Nurse will communicate with parent/pediatrician
 |