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 stable
Vital signs:

- Respiratory Rate: 10 above baseline
- Heart rate: normal

Airway: compromised
Color: normal
Work of breathing: normal

B: patient unstable
Vital signs:

- Respiratory Rate: 20 above baseline
- Heart Rate: above baseline

Airway: compromised
Color: cyanotic
Work of breathing: substernal retractions

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 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