**Nurse**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Skill Assessment Competency Checklist**

**\*Refer to Trainer Preparation – Scenario 4**

**Scenario 4- CPR with a trach**

Your child’s monitor is alarming. Upon entering the room your patient is unresponsive and blue around the lips.

**What do you do?**

|  |  |
| --- | --- |
|  **Expected interventions** | **Instructor Initials/ Date** |
| Nurse identifies child is critical |  |
| Nurse calls 911 |  |
| Nurse removes patient from equipment and attempts to bag assessing for patent airway |  |
| Nurse continues ABC’s checking for pulse – no pulse |  |
| Nurse begins compressions at correct rate and depth for patient age/size |  |
| Nurse able to demonstrate appropriate 30:2 ratio |  |
| Nurse verbalizes need to continue CPR until 911 responders arrive or patient begins to show signs of life |  |

**Trainer Preparation**

**Scenario #4: CPR with a trach**

**Scenario:** Your child’s monitor is alarming. Upon entering the room your patient is unresponsive and blue around the lips. **What do you do?**

**Learning objectives:**

1. Identify quickly that child is critical

2. Identify need for CPR

3. Administer appropriate CPR

4. Identify who to call and what to say

**Nurse initial assessment:**

Vital signs:

* Respiratory rate: absent
* HR: no pulse

Airway: patent

Breathing: no signs of life, no chest rise

Color: cyanotic

 **Expected Interventions:**

* Nurse immediately recognizes life threatening emergency
* Nurse demonstrates need to call 911- what to say
* Nurse immediately takes child off of ventilator and attempts breaths with Ambu bag
* Nurse checks for patent airway
* Nurse checks pulse and identifies need for CPR
* Demonstrates proper CPR with a trach

*\*( talking point) if unable to insert both back up and downsize trach, and patient needs CPR, demonstrate bag mouth or bag stoma breaths. Nurse should be able to verbalize importance of knowing why patient has a trach.*