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| **Learning Objectives:**By the end of the debriefing the participants should be able to:Competencies (Knowledge, Skills, Attitudes, and Judgment):* Recognize respiratory destress & oxygen desaturation
* Complete focused assessment. Demonstrate systematic approach to assessment
	+ Demonstrate airway assessment troubleshooting airway patency and correct placement.
	+ Demonstrate Respiratory assessment
	+ Apply supplemental O2
	+ Demonstrate suctioning
	+ Early activation of resources: MD, ICU, Anesthesia.

Crisis Resource Management:* Early intervention: call for help early
* Communicate situation to interdisciplinary team and physician using SBAR
 |
| **Required personnel:*** + Facilitators
	+ SRTs
 | Who are my learners?* + Student Respiratory Therapists
 |
| **Additional notes regarding pre-brief:*** Use all equipment as if it were real
* Voice out thought process –
* Clarify vitals & assessment if unclear.

**Patient Description:** Name: JimAge: 38 MalePreviously healthy.***Hx of current condition***: MVA: Patient intubated in the field by EHS secondary to hypoxia and brought to the hospital. During the MVA, the patient sustain the following injuries:* Sternal and rib fractures
* Minor concussion
* Femur fracture

Patient has been in the ICU for 8 days. Patient remains intubated secondary to requiring more OR’s.  | Case Briefing:* It is 2pm and the RN calls you because your patient has been intermittently desating and requiring 100% O2. The RN states that she is unsure if she is suctioning appropriately as she is not getting much up. When you arrive, you notice that the patient’s SpO2 is 87% on 40% O2 and the “High Ppeak” alarm is alarming on the ventilator.

*Diagnosis*: Pneumonia. |

| **Vital Signs /** **Scenario Transitions**  | **Patient Status** | **Effective Management** | **Modifiers / Triggers** |
| --- | --- | --- | --- |
| **Phase 1: Initial Assessment**  |
| The patient has

|  |  |
| --- | --- |
| HR | (68) 95 |
| BP | (112/78) 110/75 |
| RRVt  | 24bpm150-250 mls |
| SpO2 | (95%) 88% on 40% O2. |
| Temp | 36.8 C |

*Neuro* – Awake, alert, appropriate. Pupils equal and reactive. He just received pain meds for his fractures. *Resp* – Patient nods to feeling short of breath. Tracheal tug, nasal flaring present. O/A decreased air entry to left upper lung fields. Absent to mid & lower lung fields. New onset of chest pain. *CVS –* sinus rhythm. *GI –* Temporarily on enteral feed. Tolerating feeds well. Last BM 1 day ago. *GU* – Foley insitu. U/O= 60-100 mls/hr | * + 1. Recognize respiratory distress

- Perform a set of vitals & focused assessment (obtain baseline & identify potential problems based on history & diagnosis.)- Auscultate lungs. & Head to toe assessment- Perform OETT assessment - Safety equipment checks* + 1. Identify need to increase
			- Delegate tasks
			- Communicate respiratory status & desaturation, assessment findings and interventions done & result to RT.
		2. Notify doctor
			- Communicate respiratory status & desaturation, assessment findings and interventions done & result to MD.
		3. Provide comfort to patient
		4. Document vitals
		5. Increase frequency of assessment.
 | Rule out / possible reasons respiratory distress:* + - Mechanical obstruction: mucus plug (would hear crackles, attempt suction)
		- Ventilation – collapsed lung from pathology process or procedure 🡪 auscultation. Monitor chest expansion: air entry, compromised respiratory muscle function 🡪 uneven chest movement
		- Lung compliance (history of lung disease?)
		- Oxygenation- inadequate perfusion?
		- Hemoglobin level (check lab work)
		- Circulatory volume?
	+ Aspiration?
	+ Trouble shoot for related OETT problems:
		- Mechanical Obstruction: mucus, dislodged OETT (right main stem), pneumothorax.
		- Tubing disconnection? Oxygen source.

Modifier: O2 decrease gradually to 80% during assessment. 🡪 Improve to 85% with application of oxygen.  |