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Description of the critical incident

In 2009, I was assigned in one of the operation rooms as an anaesthesia technician and one of my new colleagues, who joined the department three weeks before that time, was assigned in another room as an anaesthesia technician as well. One day, we had finished our theatre list earlier than other theatres, and I was shifting the last case to the recovery room with my team.
Same time, I saw my colleague outside his theatre in the anaesthesia room looking for something between the equipments in a way like a confused and panic while the patient was anaesthetized in his operation room. I directly asked him what's wrong and if I could help him, he answered me that his anaesthetist has induced the patient to sleep and found difficulties to intubate the patient; so the anaesthetist was shouting to have the stylet with the endotracheal tube to manipulate the intubation process.
I quickly realized that the new technician did not know where the right place of the stylet is, so I told him to get some help and call our chief while I entered the operation room to assist the anaesthetist with intubation procedure. I found the patient's oxygen saturation was dropping down and the anaesthetist could not intubate him because the patient was difficult to be intubated. I quickly pulled out the stylet from the drawer, which was placed in the same intubation trolley, and fixed it into the endotracheal tube while the anaesthetist was trying to oxygenate the patient and maintain high oxygen levels to the patient. Afterward, the help team arrived and we facilitated the intubation and maintained the vital signs of the patient.
By thinking about the incident, there were many feelings and thoughts to be considered. The new anaesthesia technician should receive enough training programme as a new employee, which should be more than three weeks, to be familiar with the equipments and the area of work. He always should keep in his mind the concept of teamwork, not as an individual work especially when he struggled searching for the stylet.
A routine check-up of the instruments and equipments for availability and validity must be undertaken prior every operation case. On the other hand, the main concern was the patient. Definitely, the patient should not be vulnerable to many failed intubation attempts as it might cause harm or injuries for the patient. Also, it is unfair to waste the time searching and preparing the equipments while the anaesthetized patient was waiting to be intubated.