

HEART FAILURE

Estimated Time: 40 minutes • Debriefing Time: 30 minutes



Scan to Begin



Patient Name: Henry Foster

SCENARIO OVERVIEW

Henry Foster is a 62-year-old male patient who presented via ambulance to the emergency department with shortness of breath secondary to end-stage heart failure and COPD. He also has cellulitis in his right lower extremity and multiple other comorbidities. Students are asked to get his current medication history. During the interview, they learn he is from a local skilled nursing facility. Since he is unable to remember his medications, students must call the skilled nursing facility to obtain an accurate history. Towards the end of the scenario, an order is received for Vancomycin IV.

LEARNING OBJECTIVES

1. Obtain an accurate interfacility medication history
2. Demonstrate appropriate communication
3. Follow established laws/regulations including HIPAA
4. Compound IV medications
5. Document accurately

CURRICULUM MAPPING

WTCS PHARMACY TECHNICIAN PROGRAM OUTCOMES

- Demonstrate personal/interpersonal knowledge and skills in the practice of pharmacy
- Demonstrate foundational professional knowledge and skills for the practice of pharmacy
- Prepare prescriptions/medication orders and pharmaceutical products for dispensing, distribution, and disposal
- Compound sterile and nonsterile medications
- Follow established policies and procedures for procurement, billing, reimbursement, and inventory management
- Utilize pharmacy technology and informatics
- Adhere to state and federal regulations governing the practice of pharmacy
- Apply the principles of quality assurance to the practice of pharmacy

SIMULATION LEARNING ENVIRONMENT & SET-UP

PATIENT PROFILE

Name: Henry Foster

DOB: 09/03/19xx

Age: 62

MR #: 41219

Gender: Male

Height: 173 cm (5 ft 8 in)

Weight: 64.6 kg (142.5 lbs)

Allergies: Penicillin

Admitting Diagnosis: Right lower extremity cellulitis and CHF

Medical History: Congestive heart failure, coronary artery disease, anterior MI with stenting – 4 years ago, chronic atrial fibrillation, hypertension, chronic renal insufficiency, COPD, OSA, restless leg syndrome, hypothyroidism, diabetes mellitus 2, chronic constipation

Surgical History: R TKR – 15 years ago

Code Status: Full

Ethnicity: Caucasian

Spiritual Practice: Unknown

Primary Language: English

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Hospital gown
- No moulage
- ID band present with QR code
- Nasal cannula on at 2 lpm

Monitor Settings

- No monitor
- No specific simulator vitals needed.

Supplies

- Medications
 - Facilitator Note: All medications in this scenario have a QR Code available. When scanned, students see a realistic medication label. The

QR Codes could be applied to actual medications for use during the scenario.

QR CODES

PATIENT 	REPORT 	PATIENT ID 	FACILITATOR 
VANCOMYCIN LABEL 	KCL 	FUROSEMIDE 	ACETAMINOPHEN 
LISINOPRIL 	METOPROLOL ER 	SPIRONOLACTONE 	COUMADIN 
ATORVASTATIN 	DILTIAZEM 	CARBIDOPA & LEVODOPA ER 	GLIPIZIDE & METFORMIN 
LEVOTHYROXINE 	ASPIRIN 	NITROGLYCERIN 	MILK OF MAGNESIA 

DUCOSATE SODIUM



SPIRVIA RESPIMAT



PULMICORT
FLEXHALER



TEACHING PLAN

PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the **QR Code: “Scan to Begin”** while students are in Prebrief.
- “Meet Your Patient” (on iPad) and explain how the iPad works in the simulated learning environment including:
 - Explain how to use the iPad scanner and QR codes.
 - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
 - Level tab – This tab “tells” the content in the iPad to change to what is needed for the next state of a simulation.
 - MAR Hyperlinks – On the MAR all medications are underlined and hyperlinked to DailyMed, which is a medication reference housed by the National Library of Medicine. Students can click on these links during the simulation for up-to-date medication content, labels, and package insert information.
 - The Medication Reconciliation Form:
 - The “Medication” fillable part of the form is a fillable dropdown. When students begin typing a medication, a list of medications that start with the letters they were typing will populate in a dropdown. Students can touch the correct medication from those listed. The iPad will highlight what was touched in “blue.” When students tap the highlighted medication again, it will be listed in the previously blank area.
 - The “Notes” fillable part of the form is a freeform fillable area. This is where students can type the route, frequency, etc...
 - The “Submit” button should be tapped when the students feel the information in the medication and notes sections are accurate. Once tapped, the entered medication will be listed on the form below.

- Students can leave each medication as listed or tap the discontinue button and start over. In addition, a link to the DailyMed site is included for each medication.
 - The form will save all entered medications into the next state of the scenario.
- Discuss the simulation “Learning Objective(s)” (on iPad) as well as any other Prebrief materials
- Get “Report” on iPad
 - Possible Facilitator Questions
 - What are your priorities for this patient?
- View “Patient” video on iPad
 - Possible Facilitator Questions
 - What communication strategies could you employ to obtain his medication history?
- Advance to the “Patient Profile” screen (on iPad). This will act as a simulated patient chart.
- Students can view the tabbed content on the iPad (see below) prior to entering the patient’s room and throughout the simulation as needed.
 - You should give student some time (5 minutes) to review this content now, prior to entering the patient’s room.

ADMISSION DATA

REGISTRATION FORM

Date: Today		PCP: ARISE Skilled Nursing Facility	
PATIENT INFORMATION			
Legal Name: Foster, Henry		Marital status: (select one)	
<input checked="" type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input checked="" type="checkbox"/> Widowed	
(Former name):	Birth date: 9/3/19xx	Age: 62	Gender: Male

Street Address: ARISE Skilled Nursing Facility 100 Main Street		Social Security: 987-654-3210	Primary Phone: 555-555-5555
P.O. box:	City: Anytown	State: USA	ZIP Code: 98765-4321
Occupation: Retired	Employer:	Employer Phone:	

INSURANCE INFORMATION				(Scan a copy of the patient's card.)
Person responsible for bill:		Birth Date:		
Address (if different):		Primary Phone (if different):		
Occupation:	Employer:	Employer Address:	Employer Phone:	
Is this patient covered by insurance? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Insurance Provider: Medicaid				
Subscriber's Name: Foster, Henry	Social Security: 987-654-3210	Birth Date: 9/3/19xx		
Group Number: See scanned card	Policy Number:	Co-payment:		
Patient's relationship to subscriber: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Secondary Insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				

IN CASE OF EMERGENCY
Name of local friend or relative (not living at same address): Marshall Foster

Relationship to Patient: Grandson	Primary Phone: 555-555-5555	Secondary Phone: 555-555-5555
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any balance. I also authorize ARISE Hospital or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:

ORDERS

See Appendix A for hyperlinked K+ protocol.

Patient Name	DOB	MR#
<i>Henry Foster</i>	<i>09/03/19XX</i>	<i>41219</i>
Allergies	Height (cm)	Admission Weight (kg)
<i>Penicillin (hives)</i>	<i>173</i>	<i>64.6</i>

Provider Orders

Date	Time	Order
Today	now	Emergency Department Orders
		Continuous telemetry and SpO2 monitoring
		Obtain current weight
		Insert Foley catheter for strict I & O
		Obtain accurate medication history
		STAT Labs: CBC with differential, Chem 7, Magnesium, BNP, Liver Enzymes, CK & Troponin, INR
		Obtain blood cultures x 2, wound culture, urinalysis
		STAT portable chest x-ray: shortness of breath
		STAT ECG
		STAT Respiratory Therapy Consult
		O2 to keep SaO2 > 90%
		500 mg acetaminophen PO, 2 tablets now and then Q6 PRN for fever > 38 and/or mild pain
		80 mg furosemide IV, STAT
		<u>K+ replacement protocol</u> -----Dr. Hospita, MD

MAR

Patient Name	DOB	MR#
<i>Henry Foster</i>	<i>09/03/19XX</i>	<i>41219</i>
Allergies	Height (cm)	Admission Weight (kg)
<i>Penicillin (hives)</i>	<i>173</i>	<i>64.6</i>

Medication Administration Record

Scheduled		
Continuous Infusion		
PRN		
KCL (potassium chloride) Replacement Protocol, 10 mEq/100 ml over 1 hour	Last Given	
Acetaminophen 500 mg PO, 2 tablets Q6 PRN for fever > 38 and/or mild pain	Last Given	
	10 minutes ago	
Discontinued		
Furosemide 80 mg IV, STAT	Discontinued	Last Given
	10 minutes ago	10 minutes ago
Acetaminophen 500 mg PO, 2 tablets now	Discontinued	Last Given
	10 minutes ago	10 minutes ago

MEDICATION RECONCILIATION

This is a fillable form with dropdown choices. Directions on how to use this form are located in Prebrief.

Patient Name	DOB	MR#
<i>Henry Foster</i>	<i>09/03/19XX</i>	<i>41219</i>
Allergies	Height (cm)	Admission Weight (kg)
<i>Penicillin (hives)</i>	<i>173</i>	<i>64.6</i>

Medication Reconciliation

Medication <input type="text"/>	Notes <input type="text"/>	<input type="button" value="Submit"/>
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Current Medication	DailyMed Link	Notes	Edit
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LEVEL

The iPad reads, "The iPad is at Level 1."

SCANNER

Use this to scan available QR Codes.

EXIT

The iPad reads, "Are you sure you want to exit? All data will be lost."

- If "No" is selected, the iPad will return to the tabbed content.
- If "Yes" is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

STATE 1

OBTAIN MEDICATION HISTORY

- Patient Overview
 - Henry is cranky, but willing to try and answer questions about his medication history. Eventually, he gets very frustrated and asks why the skilled nursing facility hasn't just told them what he takes.
- Expected Student Behaviors
 - Demonstrate proper infection control
 - Introduce themselves and identify the patient (may scan **QR Code: Patient ID**)
 - Interview the patient in order to obtain an accurate medication history
 - Employ appropriate communication techniques during the patient interview
- Technician Prompts
 - Henry is irritated and cranky, but will try to answer questions. He will get more irritated as the questioning continues. Eventually, he gets exasperated and asks, "Why don't you just call the home?"
 - Patient responses can include:
 - "What do you want? Are you going to poke me too?"
 - "Why do you need to know all of the pills I take? I'm not gonna be here that long anyways!"
 - "I take aspirin every day and one of those water pills."
 - "I'm on insulin stuff now, so that's great."
 - "I take a couple of those puffer things, although I really don't think they do anything."
 - "Why don't you just call the home? They know what they give me more than I do!"
- Possible Facilitator Questions
 - How can you more effectively communicate with Henry?

- How can you find out where Henry’s “home” is?
- How would you obtain an accurate medication history if Henry didn’t live in a skilled nursing facility?
- Tabbed iPad Prompts & Content

LEVEL 1/2

- When the Level 1 tab is tapped, the iPad reads, “The iPad is at Level 1.”
- The Level 1 tab will automatically change to a Level 2 tab (students are not prompted about this) when **QR Code: Facilitator** is scanned.
- When the Level 2 tab is tapped, the iPad reads, “The iPad is at Level 2.”

STATE 2

CALL THE SKILLED NURSING FACILITY

- Patient Overview
 - Students need to call the skilled nursing facility to obtain Henry's current medication history.
- Expected Student Behaviors
 - Review the patients admission data to find the number of Henry's skilled nursing facility
 - Call the skilled nursing facility to obtain a current medication history
 - Students should ask for the unit secretary or the patient's nurse. The medication history should be faxed.
 - Maintain HIPAA throughout the facility to facility interaction
- Technician Prompts
 - Nothing needed from the patient at this time.
 - Technician or facilitator to play the role of the unit secretary or patient's nurse from the skilled nursing facility.
 - Make sure the student maintains HIPAA and that the information from the skilled nursing facility will be faxed to the student.
- Possible Facilitator Questions
 - How will you assure HIPAA is maintained throughout this interaction?
 - What questions do you need to ask the skilled nursing facility to ensure the medication history you receive is accurate?
- Tabbed iPad Prompts & Content

LEVEL 2/3

- When the Level 2 tab is tapped, the iPad reads, "Have you called the Skilled Nursing Facility to obtain the patient's current medication history?"
 - If "No" is selected, the iPad returns to the main screen.

- If “Yes” is selected, the iPad advances to State 3 and a fax is received. See State 3.

STATE 3

COMPLETE MEDICATION HISTORY

- Overview
 - The students do not interact with the patient for the remainder of the scenario. The iPad displays a plaque of a fax machine (accompanied by the sound of a fax machine) with text that reads, “You are receiving a fax.” Using that fax, students should document an accurate medication history on the medication reconciliation form located on the iPad.
 - Facilitator Note: A printable copy of the fax is located in Appendix B.
- Expected Student Behaviors
 - Review the fax from the skilled nursing facility for completeness and accuracy
 - Accurately document the patients medication history on the medication reconciliation form provided on the iPad
 - Facilitator Note: The iPad does not check to see that the medications are correct. Therefore, students can enter incorrect medications. When students are satisfied that the medications are entered correctly, they will need to check with the Facilitator and then scan **QR Code: Facilitator**. This will allow the scenario to progress to State 4.
- Technician Prompts
 - Nothing is needed from the technician for the remainder of the scenario.
 - Optional: Students may choose to let the RN know that the medication reconciliation is complete. This can be done face-to-face or over the phone with the technician or facilitator playing the role of the RN.
- Possible Facilitator Question
 - How could the facility send the patient’s medication history if a fax machine wasn’t available?
 - What is the process for ensuring that the interprofessional staff know that the medication reconciliation is complete?
- Tabbed iPad Prompts & Content

MEDICATION HISTORY

A printable copy of the fax in located in Appendix B.

LEVEL 3/4

- When the Level 3 tab is tapped, the iPad reads, “The iPad is at Level 3.”
- The Level 3 tab will automatically change to a Level 4 tab (students are not prompted about this) when **QR Code: Facilitator** is scanned.
- When the Level 4 tab is tapped, the iPad reads, “The iPad is at Level 4.”

STATE 4

VANCOMYCIN IV ORDER RECEIVED

- Overview
 - The iPad displays a plaque of a “zebra printer” (accompanied by a sound of it printing) with text that reads, “You are receiving a new order.” This is followed by an image of the printed Vancomycin IV label (a printable version of this label is located in Appendix C). In addition, new orders and MAR are available under the corresponding tabs in the iPad. Optional: Students can make the Vancomycin IV per individual lab policy.
- Expected Student Behaviors
 - Review IV Vancomycin label for accuracy
 - Optional: Make the Vancomycin IV compound using aseptic technique according to national standards.
- Technician Prompts
 - Nothing is needed from the technician for the remainder of the scenario.
- Possible Facilitator Question
 - How can you assure that the Vancomycin IV label is accurate?
 - How does the Pharmacist dose the Vancomycin – as stated in the provided orders?
- Tabbed iPad Prompts & Content

ORDERS

Patient Name	DOB	MR#
<i>Henry Foster</i>	<i>09/03/19XX</i>	<i>41219</i>
Allergies	Height (cm)	Admission Weight (kg)
<i>Penicillin (hives)</i>	<i>173</i>	<i>64.6</i>

Provider Orders

Date	Time	Order
Today	1 hour ago	Emergency Department Orders

		Continuous telemetry and SpO2 monitoring
		Obtain current weight
		Insert Foley catheter for strict I &O
		Obtain accurate medication history
		STAT Labs: CBC with differential, Chem 7, Magnesium, BNP,
		Liver Enzymes, CK & Troponin, INR
		Obtain blood cultures x 2, wound culture, urinalysis
		STAT portable chest x-ray: shortness of breath
		STAT ECG
		STAT Respiratory Therapy Consult
		O2 to keep SaO2 > 90%
		500 mg acetaminophen PO, 2 tablets now and then Q6 PRN for fever > 38 and/or mild pain
		80 mg furosemide IV, STAT
		<u>K+ replacement protocol</u> -----Dr. Hospita, MD
Today	now	15-20 mg/kg Vancomycin IV (not to exceed 2 g/dose) IV, Q8
		hours – Pharmacy to dose per protocol-----Dr. Hospita, MD

MAR

Patient Name	DOB	MR#
Henry Foster	09/03/19XX	41219
Allergies	Height (cm)	Admission Weight (kg)
Penicillin (hives)	173	64.6

Medication Administration Record

Scheduled	
Continuous Infusion	
Vancomycin 15-20 mg/kg (not to exceed 2 g/dose) IV, Q8 hours – Pharmacy to dose per protocol	Last Given
PRN	
	Last Given

KCL (potassium chloride) Replacement Protocol, 10 mEq/100 ml over 1 hour		
Acetaminophen 500 mg PO, 2 tablets Q6 PRN for fever > 38 and/or mild pain	Last Given	
	50 minutes ago	
Discontinued		
Furosemide 80 mg IV, STAT	Discontinued	Last Given
	50 minutes ago	50 minutes ago
Acetaminophen 500 mg PO, 2 tablets now	Discontinued	Last Given
	50 minutes ago	50 minutes ago

MEDICATION RECONCILIATION

This form will save and display what was entered by students in State 3.

LEVEL 4/EXIT

- When the Level 4 tab is tapped, the iPad reads, “The iPad is at Level 4.”
- When **QR Code: Facilitator** is scanned, the iPad reads, “Scenario objectives have been met. You may exit at any time.”
- When the Exit tab is tapped, the iPad reads, “Scenario objectives have been met. Are you sure you want to exit?”
 - If “No” is selected, the iPad returns to the main screen.
 - If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

DEBRIEF

Nothing needed from the iPad.

QUESTIONS

1. How did you feel this scenario went?
2. Review understanding of scenario learning objectives.
 - a. Obtain an accurate interfacility medication history
 - i. Describe the process of obtaining interfacility patient information.
 - ii. Did this go smoothly? How would you handle the situation differently if it hadn't?
 - b. Demonstrate appropriate communication
 - i. Did you have any issues communicating with Henry, the Skilled Nursing facility, etc?
 - ii. If you could "do over," any part of your communication what would it be and why?
 - c. Follow established laws/regulations including HIPAA
 - i. What concerns do you need to be aware of when transmitting patient information?
 - ii. What other concerns did you have regarding laws and regulations?
 - d. Compound IV medications
 - i. What process did you use to prepare the Vancomycin IV?
 - ii. How does the Pharmacist adjust the delivered Vancomycin?
 - e. Document accurately
 - i. How did you document your interactions today?
 - ii. Why is proper documentation important?
3. If you could "do over," any part of today, what would it be and why?
4. Summary/Take Away Points:
 - a. "Today you performed a medication reconciliation involving an interfacility transfer of patient information. What is one thing you learned from participating

in this scenario that you will take with you into your Pharmacy Technician practice?” (Each student must share something different from what the others’ share.)

NOTE: Debriefing technique is based on INASCL Standards for Debriefing

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
 - a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
 - b. This QR Code will not work in the ARIS app.



2. Copy and paste the following survey link into your browser.
 - a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

APPENDIX A

K + REPLACEMENT PROTOCOL

Protocol Guidelines

1. See Mg⁺⁺ and Ca⁺ replacement protocols as needed
2. All IV electrolytes must be infused via pump
3. If K⁺ less than 3.0 and no Mg⁺⁺ and Ca⁺ level in last 2 days, draw Mg⁺⁺ and Ca⁺ after K⁺ run when repeat K⁺ level drawn
4. Use PO replacement for all patients unless NPO or if medically contraindicated per physician
5. PROTOCOL MUST BE RENEWED BY PHYSICIAN EVERY 72 HOURS

Protocol (Normal K⁺ Range = 3.5-5.4)

Oral K⁺ Protocol

K ⁺ Level	K ⁺ Dose	Repeat K ⁺ Level
< 3.2 – Notify MD	KCL 40 mEq po STAT then, 40 mEq by mouth every 4 hours x 2 doses	4 hours after last dose
3.3 – 3.8	KCL 40 mEq by mouth every 4 hours X 2 doses	Next AM
> 3.8	No treatment	

1.

IV K⁺ Protocol

K ⁺ Level	K ⁺ Dose		Repeat K ⁺ Level
	Central access with cardiac monitor	Peripheral access or central access without cardiac monitor	
< 3.2 – Notify MD	20 mEq/100 ml over 1 hour X 3 doses	10 mEq/100 ml over 1 hour x 6 doses	30 min after last dose infused
3.3 – 3.8	20 mEq/100 ml over 1 hour X 2 doses	10 mEq/100 ml over 1 hour x 4 doses	Next AM
> 3.8	No treatment	No treatment	

Protocol Initiated By: *Aamir Hospita, MD*

Date: *Today*

Time: *20 minutes ago*

APPENDIX B

ARISE DOCUMENTS

Fax Cover Sheet

HEALTH INFORMATION:

FAX COVER SHEET

FROM: Marietta A. Greenway, RN

FAX#: 555-555-5555

TO: ED - ARISE Hospital: Care of Pharmacy

FAX#: 555-555-5555

DATE: Today

COVER SHEET PLUS 2 PAGES

COMMENTS: let me know if you need anything else.

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GENERAL DOCUMENTS

UPDATED: JUNE 14, 2017

1

ARISE SKILLED NURSING FACILITY
100 Main Street
Anytown, USA
555-555-5555

Patient Name	DOB	MR#
<i>Hector Fernandez</i>	<i>09/06/19XX</i>	<i>41219</i>
Allergies	Height (cm)	Admission Weight (kg)
<i>Penicillin (hives)</i>	<i>175</i>	<i>86.4</i>

Medication Administration Record - Summary

DATE: TODAY

Scheduled	
Lisinopril 2.5 mg PO daily	Last Given
	Today – 3 hours ago
Metoprolol ER 100 mg PO daily	Last Given
	Today – 3 hours ago
Spironolactone 25 mg PO daily	Last Given
	Today – 3 hours ago
Atorvastatin 20 mg PO daily	Last Given
	Today – 3 hours ago
Diltiazem ER 120 mg PO mg daily	Last Given
	Today – 3 hours ago
Levothyroxine 100 mcg PO daily	Last Given
	Today – 3 hours ago
Glipizide and Metformin 2.5 mg/250 mg PO with breakfast	Last Given
	Today – 3 hours ago
Carbidopa & Levodopa ER 50 mg/200 mg PO daily	Last Given
	Today – 3 hours ago
Aspirin enteric coated 81 mg PO daily	Last Given
	Today – 3 hours ago
Coumadin 3 mg PO daily on M, W, F	Last Given
	Yesterday
PRN	

ARISE SKILLED NURSING FACILITY
 100 Main Street
 Anytown, USA
 555-555-5555


Acetaminophen 500 mg PO 2 tabs every 4-6 hours for pain or fever PRN	Last Given
	Today – 4 hours ago
Nitroglycerin 0.4 mg SL every 5 minutes times 3 doses PRN for angina, if angina pain persists call Provider	Last Given
	13 days ago
Milk of Magnesia 30 ml PO daily PRN for constipation, may repeat once per day if no relief	Last Given
	6 days ago
Docusate sodium 100 mg PO 2 times per day PRN for constipation, hold if diarrhea or abdominal pain	Last Given
	6 days ago

APPENDIX C

ARISE Hospital Pharmacy

Foster, Henry RX#00023587
MR #: 41219 DOB: 09/03/19XX
ER 100
Date: 00/00/00 Bag #1
Vancomycin 1200 mg
0.9% NaCL 250 mL

Infuse over 60 min IV piggyback every
8 hours



Prep By _____ Check By _____
Exp: _____

CREDITS

Fax Cover Sheet adapted from Medical Fax Cover Sheet. Downloaded from

<https://www.template.net/business/sheet-templates/medical-fax-cover-sheet/>

Medication information from National Library of Medicine: Daily Med at

<http://dailymed.nlm.nih.gov/dailymed/>

REFERENCES

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- Clinical approach to management of nonpurulent cellulitis in adults (2017). Downloaded from https://www.uptodate.com/contents/image?imageKey=ID%2F111732&topicKey=ID%2F110530&rank=1~150&source=see_link&search=cellulitis%20anitbiotics
- Drew, R. & Sakoulas, G. (2017). Vancomycin: Parental dosing, monitoring, and adverse effects in adults. Downloaded from https://www.uptodate.com/contents/vancomycin-parenteral-dosing-monitoring-and-adverse-effects-in-adults?source=search_result&search=vancomycin%20dosing&selectedTitle=5~150
- International Nursing Association for Clinical Simulation and Learning (2016). Standards of Practice: Simulation. Downloaded from <http://www.inacsl.org/i4a/pages/index.cfm?pageid=3407>
- Yancy CW, Jessup M, Bozkurt B, Butler J, Casey DE Jr, Drazner MH, Fonarow GC, Geraci SA, Horwich T, Januzzi JL, Johnson MR, Kasper EK, Levy WC, Masoudi FA, McBride PE, McMurray JJV, Mitchell JE, Peterson PN, Riegel B, Sam F, Stevenson LW, Tang WHW, Tsai EJ, Wilkoff BL. (2013) ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circulation*. 2013;128:e240–e327. DOI: 10.1161/CIR.0b013e31829e8776



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