

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Heart Failure	
Original Scenario Developer(s):	M. Miller, MA, RN, CHSE	
Date - original scenario	080/11	
Validation:	09/11 A. Lucero, MSN	
Revision Dates:	10/11, 02/12, 03/13	
Pilot testing:	9/28/11	
QSEN revision:	2/15/12 Marjorie Miller, MA, RN, CHSE	
Estimated Scenario Time: 15-20 minutes Debriefing time: 30-40 minutes		
Target group: Advanced Medical Surgical Nursing students; New Grad Transition students, staff nurses, critical care teams		
Core case: heart failure in previously controlled 75 year old woman		
QSEN Competencies:		
<ul style="list-style-type: none"> • Safety • Patient Centered Care • Teamwork and Collaboration 		
Brief Summary of Case:		
<p>Ms. Paula Cho, a 75 year old female is admitted to Telemetry Unit from ED complaining of shortness of breath and anxiety. She is an Asian American, English speaking woman who is treated medically for chronic heart failure. Her last hospitalization was 6 months ago. She drove herself to the ED after progressive shortness of breath and paroxysmal nocturnal dyspnea. She is widowed and lives alone in an upstairs apartment without an elevator. Adult daughter lives in another part of the state a couple of hours away</p>		

EVIDENCE BASE / REFERENCES (APA Format)
American Heart Association. (2015) Handbook of emergency and cardiovascular care for health care providers. <i>Acute heart failure</i> . American Heart Association: Dallas
Vallerand, A. & Sanoski, C. (2019) Davis Drug Guide (16 th Edition). FA Davis Co., Philadelphia.
Quality and Safety Education for Nurses (QSEN) Institute. (2018). QSEN Competencies. Retrieved May 13, 2018, from http://qsen.org/competencies/pre-licensure-ksas/#safety
The Joint Commission. (2018). Targeted Solutions Tool for Preventing Falls. Retrieved May 13, 2018, from https://www.centerfortransforminghealthcare.org/tst_pfi.aspx

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Provide patient care that promotes safety and minimizes risk of error.
2. Apply effective clinical decision making skills in changing situations.
3. Integrate understanding of multiple dimensions of patient centered care.
4. Communicate effectively with nursing and members of interprofessional team
Specific Learning Objectives
1. Apply principles of hand hygiene, infection control and personal protection.
2. Introduce self, colleagues and role to involve patient and family members in attendance.
3. Correctly identify patient using 2 patient identifiers.
4. Gather relevant patient assessment and contextual data to identify patient's current problem.
5. Recognize acute changes in patient condition that require immediate intervention.
6. Communicate effectively with patient and family to inform and minimize anxiety.
7. Recognize need for additional orders; collaborate with team and report change in status to MD.
8. Utilize strategies to minimize risk when reporting change in status and receiving telephone orders.
9. Perform timely interventions to address urgent primary problems as they unfold.
Critical Learner Actions
1. Perform hand hygiene; correctly identify patient; introduce selves and role.
2. Demonstrate focused cardiopulmonary assessment; assess vital signs; O ² sats; check IV patency
3. Repositions patient with HOB ↑ 30° and reestablishes oxygen therapy per order
4. Recognizes cluster of assessment findings indicating acute heart failure
5. Call for help (charge nurse or RRT) or communicate/collaborate with other nurses in situation.
6. Notify the primary care provider of a change of status using standardized SBAR format, requesting orders and taking telephone orders accurately. (write, read back and verify)
7. Administers IV Lasix using principles of safety, 2 identifiers & evaluates patient response.
8. Communicates calmly w/ patient/family throughout scenario to ↓ anxiety & involve in plan of care
9. Reassess patient at appropriate intervals.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies (Required prior to participating in the scenario)	
Knowledge Competencies	Skill/ Attitudes Competencies
<input type="checkbox"/> Principles of Cardiopulmonary assessment	<input type="checkbox"/> Cardiopulmonary assessment and vital signs
<input type="checkbox"/> Focused cardiopulmonary assessment	<input type="checkbox"/> Determining significance of change in status
<input type="checkbox"/> Significance of abnormal findings	<input type="checkbox"/> Oxygen therapy and protocols
<input type="checkbox"/> Pathophysiology, clinical manifestations and management of patients with heart failure	<input type="checkbox"/> SBAR communication; taking and initiating telephone orders
<input type="checkbox"/> Structured Communication Tools (SBAR)	<input type="checkbox"/> Request for assistance in escalating situations
<input type="checkbox"/> Legal aspects of taking telephone orders	<input type="checkbox"/> Strategies for involving patient/family in plan of care
<input type="checkbox"/> Pharmacology of IV diuretic therapy.	<input type="checkbox"/> Therapeutic communication in acute situations

SECTION III: SCENARIO SCRIPT

A. Case summary

Ms. Paula Cho, a 75 year old female is admitted to Telemetry Unit from ED complaining of shortness of breath and anxiety. She is an Asian American, English speaking woman who is treated medically for chronic heart failure. Her last hospitalization was 6 months ago. She drove herself to the ED after progressive shortness of breath.

She is widowed and lives alone in an upstairs apartment without an elevator. Adult daughter lives in another part of the state.

B. Key contextual details

Medical/Surgical-Telemetry Unit: 7 am, following hand off, shift report. Patient was admitted from ED at 0600; nurse has started admission process. Left patient room to give report.

C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Primary nurse		L
Orienting nurse		L
Family member	Arrives after 5 minutes of scenario time. Acts rushed, concerned and annoyed with patient. Stresses that patient needs to move in with family for her own safety. Does respond to nurses appropriate interventions	SP
Charge nurse	Faculty member comes into room to end scenario. Receives SBAR report	SP
Provider	Takes SBAR report; asks appropriate questions; gives requested order for Lasix and orders more labs. (See script)	SP

D. Patient/Client Profile

Last name:	Cho		First name:	Paula
Gender: Male	Age: 75	Ht: 5'4"	Wt: 150 #	Code Status: Full
Spiritual Practice: Buddhist		Ethnicity: Asian American		Primary Language spoken: English
1. History of present illness				
Patient with acute exacerbation of chronic heart failure. Patient states she became short of breath climbing the stairs a couple of days ago and it progressed to shortness of breath even while sitting in the chair. Last night she awakened suddenly and wasn't able to breathe. She became frightened and drove herself to the ED in the middle of the night. Patient has been successfully managed with diet and diuretics and antihypertensives. Last hospitalization was 6 months ago. She is widowed, and lives independently in a 4 th floor walkup apartment. Family lives a couple of hours away by car.				
Primary Medical Diagnosis		Exacerbation: Acute heart failure		

2. Review of Systems	
CNS	Alert and oriented x 3; anxious; senses – slightly hard of hearing
Cardiovascular	Sinus tachycardia at 110 bpm; diminished peripheral pulses 1+; no murmurs or gallops
Pulmonary	Bibasilar crackles
Renal/Hepatic	Voiding concentrated urine, no pain, frequency or nocturia; no liver tenderness or enlargement
Gastrointestinal	No abnormalities
Endocrine	Normal elderly female; no diabetes or other endocrine disease
Heme/Coag	No abnormalities
Musculoskeletal	Walking-gait with good balance.
Integument	Clear and intact.
Developmental Hx	Within normal limits
Psychiatric Hx	None reported
Social Hx	Widowed x 4 years; wide circle of female friends; very active; family lives 2 hours away
Alternative/ Complementary Medicine Hx	None reported

Medication allergies:	N/A	Reaction:	
Food/other allergies:	None known	Reaction:	

3. Current Medications			
Drug	Dose	Route	Frequency
HCTZ	25 mg	PO	Every morning
ASA	325 mg	PO	Daily
Lisinopril	5 mg	PO	Daily
Multivitamin	1 cap	PO	Daily

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 107	HCO ₃ : 24	BUN: 30	Cr: 1.2
Ca:	Mg:	Phos:	Glucose: 112	HgA1C:	
Hgb: 14.2	Hct: 40	Plt: 325	WBC: 6.0	RBC: 4.2	
PT: 10.5	PTT: 22 sec	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO ₂ :	paCO ₂ :	HCO ₃ ⁻ /BE:	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR:		ECG:			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State

(This may vary from the baseline data provided to learners)

1. Initial physical appearance				
Gender: female	Attire: Hospital gown			
Alterations in appearance (moulage): Age appropriate glasses, grey straight wig; pale blue color around lips, skin pale and dusky appearing. Patient positioned ½ in and ½ out of bed, scooted down in the bed with HOB at 10-15°				
ID band present, accurate information		ID band present, inaccurate information	x	ID band absent or not applicable
Allergy band present, accurate information		Allergy band present, inaccurate information	x	Allergy band absent or not applicable

No monitor display	x	Monitor on, no data displayed (<i>do not display data until learner connects equip. & takes VS</i>)		Monitor on, standard display
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BP: 105/70	HR: 120	RR: 30	T: 97.8° F.	SpO ₂ : 90 %
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETCO ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: crackles ¾ way up, loud		Right: crackles ¾ way up, loud	
Heart:	Sounds:	S ¹ , S ²		
	ECG rhythm:	Sinus tachycardia		
	Other:			
Bowel sounds:	Active bowel sounds x 4		Other:	

3. Initial Intravenous line set up						
	Saline lock #1	Site:				IV patent (Yes/No)
x	IV #1	Site:	RA	Fluid type: NS	Initial rate: 20 mL/hour	IV patent (Yes/No)
x	Main					
	Piggyback					
	IV #2	Site:		Fluid type:	Initial rate:	IV patent (Yes/No)
	Main					
	Piggyback					
4. Initial Non-invasive monitors set up						
x	NIBP		x	ECG First lead:		ECG Second lead:
x	Pulse oximeter		x	Temp monitor/type		Other:
5. Initial Hemodynamic monitors set up						
	A-line Site:			Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:
6. Other monitors/devices						
	Foley catheter		Amount:		Appearance of urine:	
	Epidural catheter			Infusion pump: agency pump	Pump settings: 125 mL/hr.	
	Fetal Heart rate monitor/tocometer				Internal	External
Environment, Equipment, Essential props						
Recommend standardized set ups for each commonly simulated environment						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Medical surgical monitored unit						

2. Equipment, supplies, monitors							
(In simulation action room or available in adjacent core storage rooms)							
x	Bedpan/ Urinal	x	Foley catheter kit	x	Straight cath. kit	x	Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag	x	Wall suction
	Nasogastric tube		ETT suction catheters	x	Oral suction catheters		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit		Dressing Δ equipment
	IV fluid type: NS @ 20 mL/hr. 900 mL credit				Tubes/drains Type:		Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent	x	Simple Face Mask	x	Non rebreather mask
x	BVM/Ambu bag	x	Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med AdminRecord	x	H & P	x	Lab Results
x	Progress Notes	x	Graphic record		Anesthesia/PACU record	x	ED Record
x	Medication reconciliation		Transfer orders	x	Standing (protocol) orders		ICU flow sheet
x	Nurses' Notes	x	Dx test reports		Code Record		Prenatal record
x	Actual medical record binder, constructed per institutional guidelines				Other Describe:		

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
2	Lisinopril	5 mg	Oral		2	Lasix	10 mg/1 ml	IV
2	ASA	325 mg	Oral					
1	HCTZ	25 mg	Oral					

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario : (Shift Report @ 0700)

Ms. Paula Cho, a 75 year old female is admitted from the Emergency Department. Yesterday she became short of breath with exertion which progressed to shortness of breath at rest. Last night she awakened suddenly and couldn't catch her breath. She described the feeling as "suffocating". After sitting up for a while she felt better but very frightened, so she drove herself to the Emergency Department.

ED just brought her up about 45 minutes ago. She is complaining of shortness of breath and is anxious. This Asian-American, English-speaking woman lives alone in an upstairs apartment without an elevator. A daughter lives in another part of the state and has been notified

EKG: Sinus rhythm

O₂ sats: 92% on 2L per minute by nasal cannula, afebrile, sinus tachy @ 100 bpm, RR 24, BP 120/70

Breath sounds: Bibasilar crackles

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline Patient found in room partly out of bed with O₂, electrodes and O₂ sat monitor off.</p> <p>Anxious and confused. Short of breath with interrupted speech.</p>	<p>Operator Show vital signs and lung sounds when learner attaches appropriate equipment</p> <p>ST HR 120 RR 30 O₂ Sats 90% BP 105/70 Crackles throughout</p> <p>Trigger: Learners perform initial assessment and actions within 5 minutes</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Reposition with head of bed elevated 45° 2. Reapply O₂ per NC as ordered 3. Reattach appropriate equipment 4. Focused cardiopulmonary assessment 5. Reorient patient 6. Notices absent ID band and calls for replacement 7. Reattach O₂ monitor and check O₂ sats. 	<p>Debriefing Points:</p> <p>Patient Safety</p> <p>Assess before interventions Check O₂ sats before replacing O₂.</p> <p>Assessment of baseline status.</p> <p>Possible reasons for disorientation</p> <p>Positioning for dyspnea</p>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Patient remains dyspneic even after position change and O2 replacement. Continues with labored breathing, interrupted speech and anxiety.</p> <p>Daughter rushes into room highly anxious about mother's condition, asking mother and nurses what happened.</p> <p>Daughter responds to appropriate communication from nurses</p>	<p>Operator: Make crackles louder SpO₂ 86% RR 36 ST 120 BP 90/60</p> <p>Triggers: Learner Actions completed within 3 minutes. If not, continue to next frame with further deterioration</p> <p>Cues: If learners don't respond appropriately, can send RT in to make rounds or can call Rapid Response.</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Change to simple or non-rebreather mask 2. ↑ liter flow to 6-10 3. Re-position patient with HOB 45° or more with legs flat 4. Responds to daughter using strategies to calm her down and enlists support to calm her mother. 5. Calls for additional help from teammates/ RT 6. Gives effective SBAR 7. Reassess and validate assessment with teammate 	<p>Debriefing Points: Any gaps in assessment? Causes of deterioration: drop in BP, increase in RR and effort Significance of deterioration Importance of calling for help</p>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3. Anxiety and labored breathing continue. States “I can’t breathe”..</p> <p>Daughter gets more upset as mother’s shortness of breath continues. Starts to tell mother it is unsafe for her to live alone. Insists that mother will come to live with daughter and family.</p> <p>Patient very upset.</p>	<p>Operator: Loud crackles throughout</p> <p>Change VS Sat 88% ST 120 RR 36</p> <p>Triggers: 5-7 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Call MD/report change in status using SBAR 2. Accurately take physician phone orders, writing and repeating back. (may need to cue or send in Charge Nurse) 3. Prepares IV Lasix and administers following flushes and safety procedures 4. Communicates actions to patient and family with rationale 5. Bedpan available 	<p>Debriefing Points: Importance of teamwork & collaboration</p> <p>SBAR communication</p> <p>What is needed for this patient at this time?</p> <p>Techniques for dealing with impatient prescribers</p> <p style="text-align: center;">↓</p> <p>Telephone Orders: Lasix 40 mg IV push NOW Chem panel with BNP Bedrest</p>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Patient's breathing becomes less labored.</p> <p>Able to speak in 5 word sentences</p> <p>Daughter calms down.</p> <p>Patient states "I feel better now, thank you."</p>	<p>Operator:</p> <p>Make changes per patient status with improvement trend over 2 minutes following Lasix</p> <p>Crackles decreased to bibasilar</p> <p>O₂ sats – 94%</p> <p>RR 26</p> <p>BP 100/70</p> <p>SR 95</p> <p>Triggers:</p> <p>5 minutes</p> <p>Comment: CNA states patient voided 300 ml clear yellow urine.</p>	<p>Learner Actions:</p> <p>Reassess patient following administration of Lasix</p> <p>Put side rails up.</p> <p>Document on patient's record</p>	<p>Debriefing Points</p> <p>Legalities with verbal orders</p> <p>Onset of action of Lasix (5 minutes)</p> <p>Patient safety</p> <p>Strategies for dealing with daughter to involve her with patient plan of care.</p>
<p>Scenario End Point: Patient's condition improves. Charge nurse comes in to relieve learners for a break, begins discussion with daughter about resources.</p>			
<p>Suggestions to <u>decrease</u> complexity: Leave family member out of scenario</p> <p>Suggestions to <u>increase</u> complexity: Patient deteriorates further, requiring rapid response, bi-PAP, transfer to ICU. Can progress to full code as interprofessional simulation involving Medicine, Nursing, RT, Pharmacy, Social Service.</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Paula Cho DOB: Age: 75 MR#:	Diagnosis: Acute Heart Failure
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No Known Allergies
 Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to Telemetry: Diagnosis – Acute Heart Failure
		1. IV: Normal Saline @ 20 mL/hr
		2. Aspirin 325 mg PO daily
		3. Lisinopril 5 mg PO daily
		4. HCTZ 25 mg PO daily
		5. O2 to keep O2 sats equal to or greater than 92%
		6. Bedrest with BRP with assistance
		7. 1000 mg Sodium diet
Signature		<i>Jennifer Cheng, MD</i>

APPENDIX B: Digital images of manikin and/or scenario milieu

Insert digital photo here

Insert digital photo here

Insert digital photo here

Insert digital photo here

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input type="checkbox"/> Objectives	<input type="checkbox"/> Debriefing Points	<input type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork/Collaboration	<input type="checkbox"/> Evidence-based Practice	
<input type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 5. How would you handle the scenario differently if you could? 6. In what ways did you check feel the need to check ACCURACY of the data you were given? 7. In what ways did you perform well? 8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 11. Discuss actual experiences with diverse patient populations. 12. Discuss roles and responsibilities during a crisis. 13. Discuss how current nursing practice continues to evolve in light of new evidence. 14. Consider potential safety risks and how to avoid them. 15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			

Laboratory Results:

WBC	6.0	(4.8 – 10.8)	_____
RBC	4.2	(4.2 – 6.0)	_____
HGB	14.2	(12.0 – 16.0)	_____
HCT	40	(34.0 – 43.0)	_____
MCV	_____	(81.0 – 99.0)	_____
MCH	_____	(27.0 – 31.0)	_____
MCHC	_____	(32.0 – 36.0)	_____
RDW	_____	(11.5 – 14.5)	_____
PLAT COUNT	325	(150–400)	_____
M PLAT CT	_____	(7.4 – 10.4)	_____
PT	10.5	(10.5-13.0sec)	_____
IN	_____		_____
PTT	22 sec	(21-36sec)	_____
CHEMISTRY			
NA	140	(135-153)	_____
K+	4.0	(3.6-5.4)	_____
CL-	107	(98-108)	_____
CO2	_____	(23-33)	_____
ANION GAP	_____	(7-19)	_____
OSM CA++	_____	(275-300)	_____
CA++ BLD	_____	(8.7-10.4)	_____
ALBUMIN	_____		_____
SERUM PROTEINS	_____		_____
GLU	112	(70-110)	_____
BUN	30	(7-29)	_____
CREAT	1.2	(0.5-1.4)	_____
BUN/CREAT	_____	(10.0-20.0)	_____
GFR	_____		_____
AST(SGOT)	_____	(8.42)	_____
ALT(SGPT)	_____	(0-55)	_____
ALK PHOS	_____	(50-136)	_____
TOTAL BILI	_____	(0-1.0)	_____
BNP	600	(0-99)	_____
CPK	wnl		_____
Troponin	wnl		_____

LABORATORY REPORT

Order Date and Time	Date/time noted	Noted By:	PLEASE WRITE ORDERS AND CONFIRM TELEPHONE ORDERS ON NEXT VISIT	Date Pharm Processed	24 ^o Ccheck
			<ol style="list-style-type: none"> 1. Admit to Telemetry: Diagnosis – Heart Failure 2. IV: D5 ½ NS w/20 mEq KCl TKO 3. Aspirin 325 mg PO daily 4. Lisinopril 5 mg PO daily 5. HCTZ 25 mg PO daily 6. O2 to keep O2 sats equal to or greater than 92% 7. Bed Rest with BRP with assistance 8. 1000 mg Sodium diet <p style="text-align: right;"><i>Jennifer Cheng, MD</i></p>		
PHYSICIAN'S ORDERS					

ROUTINE MEDICATION ADMINISTRATION RECORD

DATE:

SITE CODES	SIGNATURE	INT
RD = Right deltoid LD = Left deltoid RA = Right arm LA = Left arm RQ = Right outer quad LQ = Left outer quad RV = Right ventral gluteal LV = Left ventral gluteal	RC – Right cchest LC – Left cchest RT – Right thigh LT – Left thigh	

MEDICATION, DOSE, ROUTE, FREQUENCY	7-3 Day	3-11 PM	11-7 Noc
Aspirin 325 mg PO daily	09		
Lisinopril 5 mg PO daily	09		
Hydrochlorthiazide 25 mg PO daily	09		
IV: NS @ 20 mL/hr continuously			

<p>ROUTINE MEDICATION ADMINISTRATION RECORD</p>	<p><i>DIAGNOSIS: Heart Failure</i></p> <p><i>ALLERGIES: NKDA</i></p>
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SITE CODES		SIGNATURE	INT
RD = Right deltoid LD – Left deltoid RA – Right arm LA – Left arm RQ – Right outer quad LQ – Left outer quad RV – Right ventral gluteal LV – Left ventral gluteal	RC – Right chest LC – Left chest RT – Right thigh LT – Left thigh		

MEDICATION, DOSE, ROUTE, FREQUENCY	7-3 Day	3-11 PM	11-7 Noc

PRN MEDICATION ADMINISTRATION RECORD

DIAGNOSIS: Heart Failure

ALLERGIES: NKDA