Student Name: Andrea M Unit: NICU Pt. Initials: K Date: 04/09/24

Pediatric Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
N/A	Isotonic/ Hypotonic/ Hypertonic	N/A	N/A	N/A

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Carcit	methylxanthine	tx apnea of Prematurity	OG 28mg 1x daily	5-10 mg/kg Yes		-tachycardia -restlessness -↓feeding -N/V	1. watch for tachycardia. 2. cardio assessment. 3. If Pt already has ↑ BP give 4. Call HCP if Pt still has tachycardia
Versed midazolam	benzo-diazepine	Sedation	OG 0.2mg every feeding 8,11,2,5	0.25-2mg/kg/dose yes		-N/V -hypotension -agitation -hiccups	1. monitor, BP, O2 2. watch to see if patient becomes unsedated so they pull out tube 3. Stay on top of patients 4. respiratory status. Have suction near.
Poly-Visol w/ Iron	multi-vitamin	growth + improve health	OG 0.5ml 2x a day @ 9-11	0.5ml 2x a day w/ feeding yes		-upset stomach -diarrhea -Belly pain	1. Pt is ok for stool to be dark. 2. watch electrolytes if baby develops diarrhea 3. Always Give with feeding. 4. Do legs to chest movement to help baby w/ belly pain.
Sildenafil Revatio	PDE5-1	↓ pressure in lungs Pulmonary HTN	OG 4-6.25mg 3x a day	0.5-01mg/kg/dose yes		-diarrheal -Insomnia -nose bleeding -nausea	1. watch electrolytes if Pt gets diarrhea/vomit. 2. Have suction available if Pt does throw up 3. Check Baby hearing often 4. monitor blood Pressure
Hidactazide Spironolactone	D Mineralocorticoid receptor antagonist	Pull out Fluid	OG 2-6mg 2x a day	2-4mg/kg in 2 doses yes		-hyper K -N/V/D -↑ blood sugar -fever, rash	1. watch K+ level 2. Monitor electrolytes because N/V/D 3. skin assessment 4. Daily weight to see if fluid is being pulled off

Student Name: ____________ Unit: ________ Pt. Initials: ______ Date: ________

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Allergies: ____________

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range? Is med in therapeutic range? If not, why ?	IVP – List solution to dilute and rate to push. IVPB – concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
methadone	Narcotic opioid	pain	OG 5.41mg w/every feeding 8.11.2,5	0.1mg/kg/ dose yes		constipation n/v constipation ↓BP	1. watch respiratory status 2. electrolyte monitor 3. make sure you watch stool output 4. often BP checks
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.

Adopted: August 2016

NICU Disease Process Map

D.O.B. 11/12/24 APGAR at birth: 5 | 7

Gestational Age 24 4/7 Adjusted Gestational Age 38 4/7

Birthweight 1 lbs. 15 oz./ 890 grams

Current weight 6 lbs. 13.4 oz./ 3100 grams

Disease Name:

What is happening in the body?

The lungs were not fully developed and surfactant production is not a good amount, so my patient is on a vent

(chronic lung disease with significant areas of atelectasis)

What am I going to see during my assessment?

- Lungs have crackles/wheezing associated with patients poor lung development/ low surfactant production

What tests and labs will be ordered?

- X-Ray ← locate to see if ventilation tube is in place
- ABG? ← making sure my patient is getting good oxygenation through body
- CPT ← break up any fluid built up in lungs

What trends and findings are expected?

Our ABG should now be at normal level

- pH @ 7.35-7.45
- CO2 45-35
- HCO3 22-26

- want our vent tube to stay @ same length shown on x-ray that it has not moved
- CPT - should see secretion come out patient

What medications and nursing interventions/treatments will you anticipate?
-we will consistantly measure vent tube to make sure it has not moved
- we will listen to lung sounds on our patient
- RT will come in & do CPT to break down all that build up
- Artificial surractant replacement

How will you know your patient is improving?
- less sounds or crackles
- slowly lower oxygen rate in vent & our patient stays at a stable O2 rate

What are risk factors for the diagnosis?
- my patient is @ risk for pnemonia & infection because fluid easily sits in the patients lungs. / also because a vent is a foreign object in the child
- child is still ø fully of age so lungs may ø develope properly

What are the long-term complications?
My patient may have to have ↑ risk of infections, collapse lung, possible tracheostomy

What patient teaching for management and/or prevention can the nurse do?
-we would teach mom about possible complication & ways to break up fluid.
- to watch baby that they ø pull out intubation or make sure it does ø move