Cincinnati Children's Hospital Medical Center	**NUMBER:** V-1.04
RCNIC MANUAL	**PAGE:** 1 of 2
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SUBJECT: Standard of Care for the Patient with PPHN in the RCNIC

APPROVAL

Outcome Criteria

1. Patient will maintain optimal oxygenation

Process Criteria

- See SOC V-322 for ventilated/intubated patient.
- Monitor preductal and postductal saturation levels as ordered.
- Position to enhance respiratory status/effort: (e.g. semi-fowlers, prone).
- Monitor and document response to care.
- Provide rest and recovery periods from stimuli.
- Control the environment with minimal stimulation and developmentally supportive care.
- Monitor inhaled Nitric Oxide and obtain met hemoglobin levels as ordered.
- Ensure anesthesia bag is connected to iNO Vent.

2. Patient will maintain stable cardiac status

Process Criteria

- See SOC V-325 Patient with altered cardiac output.

3. Patient will demonstrate an acceptable level of comfort

Process Criteria

- See SOC V-301 Pain Management
- Maintain minimal stimulation: (e.g. lights low, noise level low, paced care, earmuffs).
- Utilize bed scale.
- Utilize tray for x-rays.
- Premedicate for procedures and assessments as needed.

4. Patient will maintain adequate nutritional status

Process Criteria

- Monitor vital signs, including blood pressure.
- Monitor I/O as ordered, notify physician if urine output is less than 2 ml/kg/hr.
- Obtain daily weight as tolerated.
- Obtain, monitor, and report lab values as ordered.

- Monitor for signs and symptoms of dehydration: (e.g. decreased urine output, decreased blood pressure, increased heart rate, sluggish capillary refill, depressed fontanel, dry mucous membranes, poor skin turgor).
- Monitor for signs and symptoms of over hydration: (e.g. increased blood pressure, edema, bulging fontanel, weight gain).
- Replace excess fluid losses as ordered: (e.g. gastric output, chest tube drainage, urine output).
- Administer IV fluids as ordered.
- Administer medications such as diuretics as ordered.
- Maintain neutral thermal environment.
- When feeds are initiated, monitor for feeding intolerance: (e.g. emesis, abdominal distention, diarrhea, constipation, bloody stools).

5. Family/caregivers will be able to communicate fears, anxieties, and concerns and support will be available as needed.

Process Criteria

- Assess Family/caregiver knowledge of infant status and related treatment.
- Provide information and educate about infant status and related treatment: (e.g. daily plan of care, rounds, care conference)
- Collaborate with family/caregiver to provide support services: (e.g. pastoral care, social services, holistic health, child life and community resources).
- Assess family/caregivers readiness to interact with infant.
- Provide opportunities for family/caregivers participation based on comfort level and infant state: (e.g. mouth care, containment, general baby care).

Related standards of care
See following nursing standards

V-303 Sepsis, Patient with
V-341 Immobility, Patient with

References

Merenstein, G. B. & Gardner, S. L. (Eds.). (2006). Handbook of Neonatal Intensive Care (6th ed.). St. Louis: Mosby, Inc.

Verklan, M. T. & Walden, M. (Eds.). (2004). Core Curriculum for Neonatal Intensive Care Nursing (3rd ed.). St. Louis: Elsevier Saunders.

Wong, D. L., Hockenberry, M.J., Wilson, D., Winkelstein, M.L., Kline, N.E., & Hockberry-Eaton, M. (2003). Whaley & Wong's Nursing Care of Infants and Children (7th ed.). St. Louis: Mosby, Inc.