■ NURSING MEDICATION CHEAT SHEET

Top 50 High-Alert Drugs | 8 Critical Categories | Dosing, Actions & Nursing Considerations

■	**Anticoagulants & Thrombolytics**	6 drugs
■	**Vasopressors & Inotropes**	6 drugs
■	**Insulin & Glucose Agents**	6 drugs
■	**Opioid Analgesics**	6 drugs
■	**Cardiac Medications**	6 drugs
■	**Electrolytes & IV Fluids**	6 drugs
■	**Antibiotics — High Use**	7 drugs
■	**Sedation, Pain & Neuro**	6 drugs

■■ HIGH ALERT REMINDER: These medications have a heightened risk of causing significant patient harm when used in error. Always verify: RIGHT patient • RIGHT drug • RIGHT dose • RIGHT route • RIGHT time • RIGHT documentation.

■ ANTICOAGULANTS & THROMBOLYTICS

■ **HIGH ALERT — Verify dose, weight, renal function. Monitor bleeding.**

DRUG (Generic/Brand)	CLASS	INDICATION	TYPICAL DOSE	KEY NURSING CONSIDERATIONS	ANTIDOTE/REVERSAL
Heparin (Unfractionated)	Anticoagulant	DVT, PE, ACS, AFIB	IV: per protocol (PTT-based) SQ: 5,000u q8–12h	Monitor PTT (goal 60–100s) Check platelets (HIT risk) No IM injections	Protamine sulfate
Enoxaparin (Lovenox)	LMWH	DVT prophylaxis/treatment	Prophylaxis: 40mg SQ daily Tx: 1mg/kg SQ q12h	Adjust for renal function (CrCl<30) Monitor anti-Xa SQ abdomen only	Protamine sulfate (partial)
Warfarin (Coumadin)	Vit K Antagonist	AFIB, DVT, PE, valves	Individualized (INR-guided)	Monitor INR (goal 2–3; 2.5–3.5 for valves) Food/drug interactions Patient education critical	Vit K (Phytonadione) FFP/4-factor PCC for urgent
Rivaroxaban (Xarelto)	Factor Xa Inhibitor	AFIB, DVT, PE	AFIB: 20mg daily w/ dinner DVT/PE: 15mg BID x21d then 20mg	Take with food No routine monitoring Avoid in CrCl <15	Andexanet alfa (Andexxa)
Apixaban (Eliquis)	Factor Xa Inhibitor	AFIB, DVT, PE	AFIB: 5mg BID DVT/PE: 10mg BID x7d then 5mg BID	Renal dose adjustment if 2 of 3 criteria No routine monitoring	Andexanet alfa (Andexxa)
Alteplase (tPA)	Thrombolytic	Ischemic stroke, PE, STEMI	Stroke: 0.9mg/kg IV (max 90mg) PE: 100mg over 2h	STRICT exclusion criteria Monitor for bleeding No IM/arterial sticks x24h	No specific antidote Cryoprecipitate/FFP

■ VASOPRESSORS & INOTROPES

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■ HIGH ALERT — Central line preferred. Titrate to MAP ≥65. Monitor for tissue ischemia.

DRUG (Generic/Brand)	ACTION	INDICATION	DOSE RANGE	KEY NURSING CONSIDERATIONS	SIDE EFFECTS
Norepinephrine (Levophed)	α1>β1 agonist	Septic/distributive shock	0.01–3 mcg/kg/min IV	Gold standard vasopressor Titrate to MAP ≥65 Monitor for limb ischemia	Tissue necrosis (extravasation) Reflex bradycardia Hypertension
Epinephrine (Adrenalin)	α1,α2,β1,β2 agonist	Anaphylaxis, cardiac arrest, refractory shock	Arrest: 1mg IV q3–5min Shock: 0.01–0.5 mcg/kg/min	1st line for anaphylaxis (IM thigh) Strong inotrope + vasopressor Monitor lactic acid	Tachycardia, arrhythmias Hyperglycemia Myocardial ischemia
Vasopressin (Pitressin)	V1/V2 agonist	Adjunct in septic shock, DI	Shock: 0.03–0.04 u/min (fixed) DI: 2–4u IM/SQ q6–8h	Do NOT titrate in septic shock Monitor fluid balance Can cause mesenteric ischemia	Hyponatremia Mesenteric ischemia Skin necrosis
Dopamine	DA, β1, α1 (dose-dep)	Cardiogenic shock, bradycardia	2–20 mcg/kg/min IV (titrate by effect)	Low dose = renal effect (not proven) Medium = cardiac High = vasopressor	Tachyarrhythmias Nausea/vomiting Extravasation necrosis
Dobutamine (Dobutrex)	β1>β2 agonist	Cardiogenic shock, low CO	2–20 mcg/kg/min IV	Pure inotrope (no vasopressor effect) May cause hypotension (vasodilation) Monitor for arrhythmias	Tachyarrhythmias Hypotension Angina
Phenylephrine (Neo-Synephrine)	Pure α1 agonist	Hypotension without tachycardia	0.5–6 mcg/kg/min IV	Causes reflex bradycardia Good for tachycardia-induced hypotension Pure vasoconstrictor	Reflex bradycardia Hypertension Tissue ischemia

■ INSULIN & GLUCOSE AGENTS

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■ HIGH ALERT — Double-check all insulin doses. Verify type, dose, route, patient.

DRUG (Generic/Brand)	TYPE	ONSET / PEAK / DURATION	TYPICAL USE	KEY NURSING CONSIDERATIONS	HYPOGLYCEMIA TREATMENT
Regular Insulin (Humulin R / Novolin R)	Short-acting	Onset: 30–60 min Peak: 2–4h Duration: 5–8h	Sliding scale, IV drip, DKA protocol	Only insulin given IV DKA: verify protocol Monitor BG q1–2h on drip	D50 IV (0.5–1 amp) Orange juice PO if alert Glucagon 1mg IM/SQ
Insulin Lispro (Humalog) Insulin Aspart (NovoLog)	Rapid-acting	Onset: 5–15 min Peak: 30–90 min Duration: 3–5h	Mealtime coverage, correction doses	Give 0–15 min before meals MUST have meal available Hold if patient NPO	Glucagon 1mg IM/SQ D50 IV if no IV access
Insulin Glargine (Lantus) Insulin Degludec (Tresiba)	Long-acting basal	Onset: 1–2h Peak: Minimal Duration: 20–24h+	Basal insulin once daily	Do NOT mix with other insulins Clear (not cloudy) Do not shake — roll gently	Glucagon 1mg IM/SQ Monitor BG 4h after dose
Insulin NPH (Humulin N)	Intermediate-acting	Onset: 1–2h Peak: 4–12h Duration: 14–24h	Twice-daily basal coverage	CLOUDY — gently roll to mix Time peak to meals Monitor overnight hypoglycemia	Glucagon 1mg IM/SQ Snack before bed
Dextrose 50% (D50)	Hypoglycemia Tx	Immediate onset	BG < 70 with symptoms or BG < 50	0.5–1 amp (25–50g) IV push Verify IV patency (vesicant) Recheck BG in 15 min	N/A — This IS the treatment Follow with complex carbs
Glucagon (GlucaGen)	Hyperglycemic agent	Onset IM: 5–15 min	Severe hypoglycemia, no IV access	1mg IM/SQ deltoid or thigh Patient must have glycogen stores Recheck BG in 15 min May cause nausea/vomiting	N/A — This IS the treatment

■ OPIOID ANALGESICS

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■ HIGH ALERT — Monitor respiratory status. Have naloxone at bedside. Assess pain scale.

DRUG (Generic/Brand)	ONSET / ROUTE	TYPICAL DOSE	EQUIANALGESIC	KEY NURSING CONSIDERATIONS	REVERSAL
Morphine Sulfate (MS Contin, Kadian)	IV: 5–10 min PO: 30–60 min SQ/IM: 10–30 min	IV: 2–4mg q2–4h PRN PO: 15–30mg q4h	IV 10mg = PO 30mg	Monitor resp rate (>12/min) Assess pain 30–60 min post-dose Caution: renal impairment (M6G accumulation) Offer antiemetics	Naloxone (Narcan) 0.4–2mg IV/IM/IN q2–3min
Hydromorphone (Dilaudid)	IV: 5 min PO: 30 min	IV: 0.2–0.6mg q3–4h PO: 2–4mg q4–6h	IV 1.5mg = PO 7.5mg (~5–7x potency of morphine)	MORE potent than morphine Small volume (less dilution) Monitor resp depression closely	Naloxone (Narcan) 0.4–2mg IV/IM
Fentanyl (Sublimaze, Duragesic)	IV: 1–3 min Transdermal: 12–24h	IV: 25–100 mcg q30–60 min Patch: 12.5–100 mcg/h	IV 100 mcg = Morphine 10mg IV	Do NOT use heat over patch (increased absorption) Patch: 3-day duration Respiratory depression risk Cough suppression	Naloxone (Narcan) Higher doses may be needed
Oxycodone (OxyContin, Percocet)	PO: 30–60 min	IR: 5–15mg q4–6h CR: 10–80mg q12h	PO 20mg = Morphine PO 30mg	Avoid abrupt discontinuation Monitor bowel function (constipation) Percocet has acetaminophen limit (4g/day)	Naloxone (Narcan) 0.4–2mg IV/IM/IN
Tramadol (Ultram)	PO: 30–60 min	PO: 50–100mg q4–6h (max 400mg/day)	Weak opioid + SNRI	Lowers seizure threshold Serotoninergic syndrome risk Avoid in seizure disorder CrCl <30: decrease dose	Naloxone partially effective Monitor for serotonin syndrome
Naloxone (Narcan)	IV: 1–2 min IM/IN: 2–5 min SQ: 3–5 min	0.4–2mg IV/IM/IN Repeat q2–3 min PRN	REVERSAL AGENT	Short duration — may require redosing Monitor 1–2h for re-narcotization May precipitate acute withdrawal Continuous monitoring post-dose	N/A — This IS the reversal agent

■ CARDIAC MEDICATIONS

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■ Monitor HR, BP, ECG. Hold if HR <60 or per protocol. Check electrolytes before admin.

DRUG (Generic/Brand)	CLASS	INDICATION	TYPICAL DOSE	KEY NURSING CONSIDERATIONS	MONITOR / HOLD IF
Metoprolol (Lopressor, Toprol XL)	β1-blocker	HTN, AFIB rate control, ACS, CHF	IV: 5mg q5min x3 doses PO: 25–200mg BID (tartrate)	Do NOT crush XL tablet XL = once daily; tartrate = BID Abrupt discontinuation → rebound HTN/angina	HR < 60 SBP < 90 2nd/3rd degree AV block
Amiodarone (Cordarone, Pacerone)	Class III antiarrhythmic	V-fib, V-tach, AFIB	V-fib arrest: 300mg IVP Drip: 150mg over 10min, then 1mg/min x6h	Filter required for IV Phototoxicity — sunscreen Thyroid, pulmonary, hepatic toxicity Long half-life (40–55 days)	Monitor LFTs, TFTs, PFTs QT prolongation Bradycardia
Digoxin (Lanoxin)	Cardiac glycoside	CHF (HFrEF), AFIB rate control	PO/IV: 0.125–0.25mg daily Loading: 0.25–0.5mg then 0.125–0.25mg q6h x2	Narrow therapeutic index (0.5–2 ng/mL) Check apical pulse 1 min before Hypokalemia increases toxicity Renal dosing critical	HR < 60 Signs of toxicity: N/V, visual changes, bradycardia K+ < 3.5
Furosemide (Lasix)	Loop diuretic	CHF, pulmonary edema, edema, HTN	IV: 20–200mg; PO: 20–600mg IV push no faster than 4mg/min	Monitor electrolytes (Na, K, Mg) Ootoxicity at high IV doses Measure strict I&O; Weigh daily (goal -0.5-1kg/day)	SBP < 90 CrCl deterioration K+ < 3.0 (replace first)
Nitroglycerin (Nitrostat, Nitrobid)	Nitrate vasodilator	Angina, ACS, hypertensive urgency, CHF	SL: 0.4mg q5min x3 IV: 5–200 mcg/min (titrate)	Causes headache (normal) Hypotension — have patient sit/lie Use glass bottles and non-PVC tubing IV Do NOT use with PDE-5 inhibitors (Viagra)	SBP < 90 Tolerance develops with continuous use HR changes
Atropine	Anticholinergic	Symptomatic bradycardia, asystole, organophosphate poisoning	Bradycardia: 0.5mg IV q3–5min (max 3mg) Organophosphate: 2–4mg IV	First-line for symptomatic bradycardia INEFFECTIVE for Mobitz II/3rd degree block Tachycardia, urinary retention, dry mouth	HR > 100 post-dose Hypertension

■ ELECTROLYTES & FLUIDS

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■ **IV potassium and magnesium must be administered slowly. NEVER IV push concentrated potassium.**

ELECTROLYTE / FLUID	INDICATION	IV ADMINISTRATION	ORAL FORM	KEY NURSING CONSIDERATIONS	MONITORING
Potassium Chloride (KCl)	Hypokalemia (K+ < 3.5)	Peripheral: ≤10 mEq/h Central: ≤20 mEq/h (Never IV push)	K-Dur, Klor-Con 20–40 mEq PO BID	NEVER push concentrated KCl (fatal arrhythmia) Burns in peripheral IVs Monitor telemetry during IV replacement	K+ level q4–6h EKG: peaked T-waves Urine output
Magnesium Sulfate (MgSO4)	Hypomagnesemia, Torsades, Eclampsia, Asthma	Replacement: 1–2g IV over 30–60 min Eclampsia: 4–6g load, 1–2g/h maintenance	Magnesium oxide 400–800mg PO	Monitor DTRs (loss = toxicity sign) Antidote: Calcium gluconate 1g IV Can cause hypotension if infused too fast	Mg level DTRs q1h Respiratory rate Urinary output
Calcium Gluconate / Chloride	Hypocalcemia, hyperkalemia, Mg toxicity	Gluconate: 1–2g IV over 10–20 min Chloride: 1g IV (3x more elemental Ca)	Calcium carbonate (Tums) 500–1500mg PO	Calcium chloride central line preferred (burns veins) Gluconatepherred peripherally Slow infusion (arrhythmia risk)	Serum calcium ECG (QT interval) Mental status
Normal Saline (0.9% NaCl)	Volume replacement, flush, Na correction	Wide range (varies by clinical indication)	N/A — IV only	Risk of hyperchloremic acidosis with large volumes Preferred for hyponatremia correction Watch for fluid overload	Na levels I&O; Fluid balance Edema
Lactated Ringer's (LR)	Volume replacement, surgery, burns, resuscitation	Wide range (often 500mL–2L bolus)	N/A — IV only	Do NOT use with blood products (Ca binds citrate) Closer to physiologic pH Preferred resuscitation fluid	Electrolytes I&O; Fluid balance Acid-base status
Sodium Bicarbonate (NaHCO3)	Metabolic acidosis, hyperkalemia, TCA OD	1–2 mEq/kg IV for acidosis 50 mEq IVP for hyperkalemia	650mg tab for metabolic acidosis	Can cause alkalosis — recheck pH Can cause hyponatremia and hypernatremia Incompatible with calcium salts	Arterial blood gas Na level Serum pH K+ level

■ ANTIBIOTICS — HIGH-USE

■ **Verify allergy history before every dose. Culture BEFORE first antibiotic dose.**

DRUG (Generic/Brand)	CLASS	SPECTRUM	TYPICAL DOSE	KEY NURSING CONSIDERATIONS	MONITOR / CONCERNS
Vancomycin (Vancocin)	Glycopeptide	Gram+, MRSA, C. diff (PO)	IV: 15–20mg/kg q8–12h (AUC/MIC guided dosing)	Culture before 1st dose Infuse over ≥60 min (Red Man Syndrome) Renal dosing critical — monitor troughs/AUC Hear loss with ototoxicity	Trough levels (< 1h before dose) SCr, BUN q48–72h Urinary output
Piperacillin-Tazobactam (Zosyn)	Penicillin + β-lactamase inhibitor	Broad (G+, G-, anaerobes, Pseudomonas)	3.375g q6h or 4.5g q8h IV extended infusion	Give over 4h (extended infusion preferred) Monitor for seizures (high doses) Cross-reactivity with PCN allergy (rare) WBC differential changes (neutropenia)	SCr, LFTs WBC Seizure precautions
Cefazolin (Ancef)	1st Gen Cephalosporin	Gram+ (SSIs, UTIs, surgical prophylaxis)	1–2g IV q8h Surgical prophylaxis: 2g x1	Common surgical prophylactic antibiotic Safe in PCN allergy (< 1% cross-reactivity) Bile elimination — dose adjust in severe hepatic dx	SCr Allergy history Wound assessment
Ceftriaxone (Rocephin)	3rd Gen Cephalosporin	Gram- (pneumonia, meningitis, gonorrhea)	1–2g IV/IM q12–24h Meningitis: 2g q12h	Avoid with calcium-containing IV fluids Do NOT give IM same site as Lidocaine Can cause biliary sludge with prolonged use	LFTs Allergy history Diarrhea (C. diff risk)
Metronidazole (Flagyl)	Nitroimidazole	Anaerobes, C. diff, parasites, H. pylori	500mg IV/PO q8h C. diff (mild): PO preferred	Patient must avoid ALCOHOL during tx and 48h after Can cause metallic taste Neurotoxicity with prolonged use Teratogenic — avoid in 1st trimester	Neurological status LFTs Pregnancy status
Azithromycin (Zithromax)	Macrolide	Atypical organisms, CAP, STIs	Z-pack: 500mg day 1, 250mg days 2–5 Pneumonia: 500mg daily IV	QT prolongation risk — check ECG Drug interactions (multiple CYP450) GI upset common Avoid in prolonged QT syndrome	QTc interval Drug interactions GI symptoms
Ciprofloxacin (Cipro)	Fluoroquinolone	Gram- (UTI, respiratory, anthrax)	IV: 400mg q8–12h PO: 500–750mg q12h	Tendon rupture risk (esp. elderly, steroids) Avoid sunlight Seizure risk in CNS disorders Alter BG in diabetics	Renal function Tendon pain Mental status changes QTc interval

■ SEDATION, PAIN & NEUROLOGICAL

■ Assess level of sedation (RASS score). Monitor for respiratory depression and delirium.

DRUG (Generic/Brand)	CLASS	INDICATION	TYPICAL DOSE	KEY NURSING CONSIDERATIONS	REVERSAL/ANTIDOTE
Propofol (Diprivan)	IV Anesthetic / Sedative	ICU sedation, procedure sedation	ICU: 5–50 mcg/kg/min (titrate to RASS goal)	Soybean/egg allergy precaution Contains 1.1 kcal/mL (fat) Change tubing q12h (infection risk) Monitor triglycerides q48–72h Propofol infusion syndrome (rare)	No specific antidote D/C infusion, supportive care
Midazolam (Versed)	Benzodiazepine	ICU sedation, procedure, seizures	ICU: 0.02–0.1 mg/kg/h Procedure: 1–2.5mg IV titrated	Causes delirium with prolonged use Respiratory depression Amnestic effect Avoid in elderly (Beers Criteria)	Flumazenil 0.2mg IV (repeat q1min, max 1mg)
Dexmedetomidine (Precedex)	α2 agonist	ICU sedation (less delirium risk)	0.2–0.7 mcg/kg/h IV	Does NOT cause respiratory depression Preferred for delirium prevention Can cause bradycardia and hypotension Do NOT bolus dose	No specific antidote Atropine for bradycardia
Lorazepam (Ativan)	Benzodiazepine	Anxiety, seizures, alcohol withdrawal, sedation	IV: 0.02–0.06 mg/kg q2–6h PO: 0.5–2mg BID–TID	Propylene glycol toxicity with high doses/prolonged Monitor for respiratory depression Falls risk — bed alarms Elderly: start with lowest dose	Flumazenil 0.2mg IV (reverses benzodiazepines)
Ketamine (Ketalar)	Dissociative anesthetic	Procedural sedation, pain, induction	Sedation: 0.5–2 mg/kg IV Analgesic: 0.1–0.5 mg/kg IV/IM	Dissociative — patient may appear awake Emergence reactions (hallucinations) Bronchodilator (good for asthma) Increases secretions — have suction ready Do NOT use in HTN emergency	No specific antidote Benzodiazepines for emergence reactions
Phenytoin (Dilantin) / Fosphenytoin	Anticonvulsant	Seizure prophylaxis and treatment	Loading dose: 15–20 mg/kg IV Maintenance: 300mg/day (divided)	Infuse ≤50mg/min (hypotension, arrhythmia) Purple glove syndrome with extravasation Monitor level (10–20 mcg/mL) Multiple drug interactions	No specific antidote Supportive care Levetiracetam alternative

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