1 Patient Information

1 PATIENT DETAILS

Name:	Gloria M. Washington	Date / Time:	04/22/2026, 07:00 AM
DOB / Age:	02/28/1955 / 71 years	Unit / Room:	Medical ICU (MICU), Room 6, Bed A — St. Catherine Medical Center, Memphis, TN
MRN:	MICU-2026-071854	Nurse:	Rachel T. Okonkwo, RN, BSN, CCRN

S Subjective

2 CHIEF CONCERN

Patient admitted 04/20/2026 from ED with septic shock secondary to urosepsis. Currently Day 3 of ICU admission. 0700 assessment initiated per MICU q4h nursing protocol. Patient remains on vasopressor support with norepinephrine infusion; ventilator-dependent. Assessment triggered by nursing shift start and patient status change alert (MAP trending down overnight).

3 PATIENT-REPORTED SYMPTOMS

Patient is sedated and intubated; unable to verbally communicate symptoms. Per family (daughter, Karen Washington, at bedside): patient had 3 days of dysuria, urgency, and suprapubic pain prior to ER presentation; became confused and febrile at home on day 3, prompting 911 call. Per nursing assessment: patient shows signs of discomfort with suctioning — bilateral upper extremity withdrawal, tachycardia (HR 112 bpm) during ETT suctioning. No purposeful movement. RASS -2 (light sedation).

Pain level (0-10 scale): CPOT (Critical-Care Pain Observation Tool) score: 4/8 during suctioning; 1/8 at rest — behavioral indicators (facial grimacing, body tension) assessed due to inability to self-report

Daughter (Karen Washington) expressing anxiety regarding prognosis; requesting update from attending before 10:00 AM. Family verbalized concern about "tubes everywhere" and patient discomfort. Palliative care consult pending — family has not yet discussed goals of care formally. Patient is full code per current orders; advance directive not on file per medical records review.

O Objective

4 VITAL SIGNS

BP:	88/54 mmHg (MAP 65) — on norepinephrine 0.12 mcg/kg/min	Temperature:	38.9°C (102°F) — fever persists; acetaminophen 650 mg PR administered at 0600
HR:	112 bpm, sinus tachycardia on telemetry	O2 Saturation:	96% on FiO2 0.50, PEEP 6 cmH2O, TV 420 mL (6 mL/kg IBW)
RR:	18 breaths/min (ventilator-controlled, AC/VC mode)	Weight / BMI:	68 kg / BMI 26.4 kg/m²

5 PHYSICAL OBSERVATIONS

General: Sedated, intubated; RASS -2. Non-responsive to voice, withdrawal to noxious stimuli bilaterally.
Skin: Warm, flushed; mottling noted bilateral lower extremities from mid-calf distally — representing vasodilatory shock pattern. Capillary refill 3 seconds bilateral fingers. No skin breakdown or pressure injuries identified; SKIN bundle measures in place (repositioned q2h, foam heel protectors in place).
Respiratory: ETT secured at 22 cm at lip; bilateral breath sounds with scattered expiratory crackles at bases; secretions moderate volume, yellow-green, suctioned via closed-circuit suction catheter. Ventilator alarms: none active at time of assessment.
Lines/Tubes: Right subclavian triple-lumen CVC in place (Day 3, site clean/dry, no erythema); 18G PIV left AC (Day 1, patent); Foley catheter draining cloudy, dark amber urine (10 mL/hr this shift).

6 INTAKE & OUTPUT

Oral intake: NPO — intubated; oropharyngeal care per VAP bundle q4h

IV fluids: Normal saline 30 mL/hr (maintenance); norepinephrine 0.12 mcg/kg/min via CVC port

Other intake: Propofol 20 mcg/kg/min (sedation) + fentanyl 25 mcg/hr (analgesia); tube feeding held pending GI motility assessment

Urine output: 10 mL/hr (80 mL total this 8-hour shift) — oliguria; AKI Stage 2 per KDIGO (Cr 2.8 mg/dL from baseline 0.9 mg/dL)

Other output: NGT in place; gastric residual 35 mL at 0600 (within acceptable limit); no stool this shift

Net balance: Cumulative 72-hour fluid balance: +4.2 L; daily balance today (0000-0700): +320 mL

A Assessment

7 NURSING ASSESSMENT

Ms. Washington is a 71-year-old female on Day 3 of MICU admission for septic shock secondary to Gram-negative urosepsis (E. coli bacteremia — blood cultures positive 04/20/2026; urine culture growing pan-sensitive E. coli >100,000 CFU/mL). She remains hemodynamically compromised requiring vasopressor support, with MAP 65 mmHg on norepinephrine — down from MAP 70 at end of previous shift, indicating persistent or worsening cardiovascular instability. Respiratory status stable on current ventilator settings; weaning not yet initiated pending hemodynamic improvement. AKI Stage 2 with oliguria concerning for progression to Stage 3; nephrology following. Persistent fever despite broad-spectrum antibiotics (cefepime + metronidazole).

8 CHANGES FROM BASELINE

CHANGE FROM BASELINE: MAP declined from 70 to 65 over the preceding 4 hours despite norepinephrine at 0.12 mcg/kg/min (dose increased from 0.08 mcg/kg/min at midnight per physician order). Urine output decreased from 18 mL/hr (previous shift average) to 10 mL/hr this shift — representing 44% decrease in hourly UO, triggering AKI monitoring protocol activation. Lactate drawn at 0600 — pending result; previous lactate 3.8 mmol/L at 2200 (04/21). Fever persisted through prior shift; repeat blood cultures ordered by intensivist.

I Interventions

9a MEDICATIONS ADMINISTERED

Cefepime 2 g IV q8h (Day 3) — 0600 dose administered; infusing over 30 min. Metronidazole 500 mg IV q8h — 0600 administered. Norepinephrine 0.12 mcg/kg/min via CVC (titrating to MAP >65). Propofol 20 mcg/kg/min (sedation — RASS target -2). Fentanyl 25 mcg/hr IV (analgesia — CPOT target <3). Acetaminophen 650 mg PR — 0600 for fever >38.5°C. Pantoprazole 40 mg IV daily — 0700 administered. Enoxaparin 40 mg SQ held today per intensivist (thrombocytopenia workup).

9b PROCEDURES PERFORMED

ETT closed-circuit suctioning performed x2 (0700 assessment, 0715 repositioning) — moderate yellow-green secretions. Oral care per VAP bundle: chlorhexidine 0.12% oral rinse applied, oropharynx suctioned. Patient repositioned from left lateral to supine to right lateral (q2h rotation log maintained). Foley catheter site cleaned per protocol. CVC dressing intact — no change needed (Day 3, next scheduled change 04/24). Blood drawn from PIV for 0600 lactate and repeat CBC/CMP.

9c PATIENT POSITIONING & CARE

Repositioned q2h per pressure injury prevention protocol — Braden score 11 (high risk). Foam heel protectors in place bilaterally. Moisture barrier cream applied to sacrum and bilateral ischials. Head of bed elevated at 30-45° continuously per VAP prevention protocol. Eye care: artificial tears instilled bilaterally q4h (eyes taped closed per protocol). Family oriented to patient room, call light, and visiting policy.

R Response to Care

10a PATIENT TOLERANCE

Patient tolerated all interventions without significant adverse response. During ETT suctioning, tachycardia increased to HR 118 bpm transiently, resolving within 90 seconds of discontinuation — fentanyl infusion increased to 30 mcg/hr per PRN analgesia protocol (CPOT score 4 during suctioning). Acetaminophen PR administered without complications; temperature decreased to 38.4°C at 0730 (30-minute post-dose reassessment). No ventilator desaturations below 94% during nursing interventions.

10b SYMPTOM RESPONSE

Fever partially reduced following acetaminophen (38.9°C → 38.4°C at 0730). Hemodynamic status: MAP 65 — unchanged from pre-assessment despite norepinephrine at current dose. Oliguria continues — no improvement in urine output post-intervention. Pending intensivist call regarding MAP trending: reported to charge nurse and ICU attending paged at 0718 per MICU deterioration protocol. Lactate result pending — will reassess upon receipt.

P Plan

11a ONGOING MONITORING

Continuous cardiac monitoring (telemetry), continuous SpO2, arterial line BP q1min (right radial A-line in place). Nursing reassessment q4h per MICU protocol; more frequent if MAP <65 or UO <0.5 mL/kg/hr for 2 consecutive hours. Lactate q6h until <2.0 mmol/L x2 draws. Daily: CBC, CMP, coagulation panel, blood culture if fever >38.5°C. Ventilator checks q2h; spontaneous breathing trial deferred until vasopressors weaned.

11b ESCALATION CRITERIA

ESCALATION TRIGGERS (will page intensivist immediately): MAP <60 mmHg despite current norepinephrine dose; SpO2 <90% sustained >2 min despite ventilator adjustments; new cardiac arrhythmia (AF with RVR, VT, VF); UO <5 mL/hr sustained >2 hours; RASS >+1 (agitation) or <-4 (oversedation); lactate >4.0 mmol/L on repeat draw. ICU attending already paged at 0718 for current MAP decline — awaiting callback.

Nurse name & credentials:	Rachel T. Okonkwo, RN, BSN, CCRN	**Date / Time:**	04/22/2026, 07:45 AM
Signature:		**Unit / Department:**	Medical ICU (MICU) — St. Catherine Medical Center, Memphis, TN