

1 Patient Information

1 PATIENT & RECORDING DETAILS

Name	Darnell M. Washington	Date of Measurement	05/06/2026
DOB / Age / Sex	06/12/1972 53M	Time of Measurement	0600
MRN	ICU-2026-0312	Recorded By	RN Tiffany Okafor, BSN

V Vital Signs

2 MEASURED VALUES

Temperature	103.6°F (39.8°C) — rectal	Blood Pressure	78/44 mmHg — arterial line, left radial — vasopressor-dependent
Heart Rate	128 bpm — sinus tachycardia, confirmed on telemetry	Respiratory Rate	28 breaths/min — labored, accessory muscle use noted
SpO ₂	91% on FiO ₂ 0.70 via high-flow nasal cannula at 60 L/min — prior to intubation discussion	Height	5'11" (180 cm)
Weight	198 lbs (90 kg) — estimated (dry weight, family-reported)	BMI	27.6 kg/m ²

C Clinical Context

3 INTERPRETATION CONTEXT

Baseline vs. Current Values	Circumstances of Measurement
Baseline BP approximately 120/78 per outpatient records. HR baseline 72–80. SpO ₂ 98–99% on room air. No prior temperature abnormalities documented.	Vitals obtained at 0600 nursing assessment. Patient is post-72h of ICU admission for gram-negative septicemia (E. coli bacteremia from urosepsis). Currently on norepinephrine 0.18 mcg/kg/min and vasopressin 0.03 units/min via central line (right internal jugular). Unresponsive to verbal commands; responds to painful stimuli only. GCS 7.
O ₂ / Device in Use	
High-flow nasal cannula (HFNC) at 60 L/min, FiO ₂ 0.70. Anesthesia at bedside for intubation if SpO ₂ fails to improve with prone positioning trial.	

T Trends & Abnormal Findings

4a TRENDS

Trend	Significant Deviations from Baseline
Worsening — MAP declining from 62 mmHg at 0200 to 43 mmHg at 0600 despite current vasopressor doses. SpO ₂ declining from 95% to 91% over 4-hour monitoring period. Temperature rising despite broad-spectrum antibiotics now 72h into course.	MAP 43 mmHg — 19 mmHg below target MAP of 65 mmHg. SpO ₂ 91% — 6–8% below target. Temperature 103.6°F — persistent fever despite piperacillin-tazobactam and vancomycin. HR 128 — 48 bpm above baseline.

4b CLINICALLY SIGNIFICANT ABNORMALITIES

1. Refractory septic shock — MAP 43 mmHg on dual vasopressors, meeting definition of refractory shock per Surviving Sepsis Campaign. 2. Hypoxemic respiratory failure — SpO2 91% on FiO2 0.70 at high flow rate, consistent with ARDS physiology (P/F ratio estimated <150). 3. Fever — 103.6°F despite 72h of antibiotics; source control cultures pending; concern for secondary infection or inadequate antimicrobial coverage. 4. Sinus tachycardia — compensatory in context of vasodilatory shock; no arrhythmia on telemetry.

I Interventions & Response

5a INTERVENTIONS TAKEN

1. Norepinephrine increased from 0.12 to 0.18 mcg/kg/min per MAP target protocol. 2. Vasopressin 0.03 units/min continued at fixed dose. 3. Hydrocortisone 200 mg IV continuous infusion initiated (corticosteroid-refractory shock protocol). 4. Prone positioning trial initiated at 0615 (SpO2 improved to 94% at 30 minutes into proning). 5. Blood cultures x2 sets drawn at 0600 prior to antibiotic change. 6. Piperacillin-tazobactam broadened to meropenem 1g IV Q8h given clinical deterioration and pending sensitivities. 7. Anesthesia called for intubation — decision made to proceed with RSI given worsening hypoxemia. 8. Tylenol 1g IV given for fever.

5b RESPONSE TO INTERVENTIONS

MAP improved from 43 to 54 mmHg at 0700 following vasopressor uptitration and steroid initiation. SpO2 improved from 91% to 96% post-intubation on mechanical ventilation at FiO2 0.60, PEEP 12, VT 450 mL (6 mL/kg IBW). Temperature unchanged at 1-hour recheck (103.4°F). Heart rate minimally improved to 118 bpm at 0730.

A Assessment

6 CLINICAL INTERPRETATION

Patient is in refractory septic shock with evolving ARDS, 72 hours into ICU management for gram-negative urosepsis complicated by E. coli bacteremia. Hemodynamic instability is inadequately controlled on prior vasopressor regimen; broadening antibiotics and initiating corticosteroids with hydrocortisone represents appropriate escalation. Respiratory failure necessitating intubation indicates progression to ARDS, warranting lung-protective ventilation strategy per ARDSNet protocol. Clinical trajectory is critical; prognosis guarded.

P Plan

7 NEXT STEPS

Monitoring Frequency

Continuous arterial line BP monitoring. Hourly urine output, MAP, SpO2. Q4h temperature and neurological assessment. Q6h ABG while on mechanical ventilation. Daily BMP, CBC, lactate.

Escalation Criteria

Notify intensivist immediately for: MAP <65 on current vasopressors, SpO2 <88%, new arrhythmia, UOP <0.5 mL/kg/h x2 hours, sudden change in neuro status, or worsening on vent settings.

PROVIDER NAME

RN Tiffany Okafor, BSN

CREDENTIALS

BSN, RN — MICU

DATE & TIME

05/06/2026