1 Patient Information

1 PATIENT DETAILS

Name
Darnell M. Washington

Date of Service
05/06/2026

DOB
03/09/1973

Provider
Dr. Alicia T. Morales, MD — Pulmonology / Critical Care

Age / Sex
53 / Male

MRN
ICU-2026-0411

ICU Day
4

Hospital Day
5

Attending Intensivist
Dr. Alicia T. Morales, MD

Unit / Room
Medical ICU — Bed 6

Primary ICU Diagnosis
Septic shock secondary to community-acquired pneumonia (CAP) with ARDS, acute kidney injury (AKI) on CKD, and multi-organ dysfunction

CC Reason for ICU Admission

2 ADMISSION REASON

Mr. Washington was transferred to the MICU on 05/03/2026 (Hospital Day 2) from the general medical floor after rapid clinical deterioration with hypotension refractory to fluid resuscitation, worsening hypoxemia requiring intubation, and new bilateral pulmonary infiltrates consistent with ARDS in the setting of right lower lobe community-acquired pneumonia. He presented to the ED on 05/02/2026 with 3 days of fever, productive cough, dyspnea, and lethargy. Blood cultures x2 sets grew Streptococcus pneumoniae (pan-sensitive) on Day 2. Currently vasopressor-dependent and on continuous renal replacement therapy (CRRT) for oliguric AKI with acidosis.

IE Interval / Overnight Events

3 EVENTS SINCE LAST NOTE

OVERNIGHT (05/05/2026 PM — 05/06/2026 AM): (1) HEMODYNAMICS: Norepinephrine requirement DECREASED from 0.22 mcg/kg/min to 0.14 mcg/kg/min overnight — most encouraging change in 4 days. MAP consistently above 65 mmHg goal (ranging 68–76 mmHg). Vasopressin 0.03 units/min continued unchanged. (2) RESPIRATORY: ABG at 06:00: pH 7.38, PaCO2 42, PaO2 76 (improved from PaO2 62 yesterday at same FiO2 0.65). P/F ratio: 117 (up from 95 yesterday — moderate ARDS, improving from severe). PEEP held at 14 cmH2O. (3) RENAL: Urine output via Foley: 28 mL in 24 hours (0.3 mL/kg/hr — anuric to oliguria range). CRRT running overnight at effluent rate 25 mL/kg/hr — tolerating without hemodynamic compromise. Electrolytes correcting per CRRT. (4) FEVER CURVE: Temperature 38.4°C at 02:00, down from 39.2°C peak yesterday — trending in the right direction. (5) CULTURES: Day 2 blood cultures (05/03) — Streptococcus pneumoniae — final sensitivity report confirmed: fully sensitive to ceftriaxone. De-escalation from vancomycin + pip-tazo completed yesterday per ID recommendations; now on ceftriaxone 1g IV Q24h. (6) SEDATION: RASS -1 to 0 overnight — cooperative and calm. SAT performed at 06:30: patient opened eyes to voice, followed commands, but appeared distressed with tracheal suctioning — midazolam bolus 2 mg given with resolution. (7) NUTRITION: Tube feeds (Peptamen 1.5 at 45 mL/hr) running throughout night — no tube feed intolerance noted. (8) FAMILY: Wife visited at 18:00 yesterday — family meeting held with Dr. Morales (see GOC section).

S Subjective

4 PATIENT-REPORTED SYMPTOMS

Mr. Washington is intubated, orally (ETT 8.0 oral, secured at 23 cm at lip) and on mechanical ventilation. He is currently maintained on a light sedation protocol (midazolam infusion 2 mg/hr + fentanyl 50 mcg/hr). He is not able to provide a meaningful verbal history at this time. He communicates by eye contact and nodding when sedation lightens during RASS -1 to 0 assessments. During SAT this morning he grimaced when

asked about pain and pointed toward his throat and chest — fentanyl bolus given with improvement. Source of interval history: nursing notes, bedside ICU nurse (RN Marcus Hill), medical records, and wife's report from yesterday evening.

O Objective

5 CURRENT MEASURABLE ICU DATA

V VITAL SIGNS (07:00 AM)

Temperature
38.1°C (100.6°F) — trending down

Blood Pressure / MAP
101/58 mmHg / MAP 72 mmHg — on vasopressors

Heart Rate
96 bpm — regular

Respiratory Rate
Vent rate 18 + patient 2–4 spontaneous above vent = total ~20–22

O2 Saturation
94% on FiO2 0.65, PEEP 14

Weight
94 kg (admission dry weight 88 kg; net +6 kg fluid balance)

Pain Score
CPOT 2 — minimal behavioral pain indicators

Sedation Score
RASS -1 (drowsy but arousable to voice)

5a HEMODYNAMICS

VASOPRESSORS: Norepinephrine 0.14 mcg/kg/min (reduced from 0.22 yesterday — improving). Vasopressin 0.03 units/min (unchanged). MAP 65–76 mmHg — meeting goal >65 mmHg. No inotropes. Central venous access: right internal jugular triple-lumen CVC (placed 05/03/2026) — CVP 10–12 mmHg (trending). Arterial line: right radial (placed 05/03/2026) — waveform consistent, no dampening. FLUID BALANCE: Total input 05/05: 3,240 mL. Total output 05/05: 780 mL (urine 28 mL + CRRT net ultrafiltration 752 mL). Net fluid balance on CRRT: +162 mL in 24h (CRRT ultrafiltration rate intentionally modest given hemodynamic fragility). Cumulative fluid balance since ICU admission: +12.4 L (significant fluid overload — goal to slowly reduce cumulative balance via CRRT as hemodynamics allow).

5b RESPIRATORY / VENTILATOR STATUS

O2 Delivery / Mode
Mechanical ventilation — Volume Control (VC-AC)

FiO2
0.65

PEEP
14 cmH2O

RR / TV
Set RR 18 / TV 448 mL (6 mL/kg IBW 74.6 kg)

Plateau Pressure
22 cmH2O — within lung-protective target <30

ABG (06:00)
pH 7.38 / PaCO2 42 / PaO2 76 / HCO3 24 / SpO2 94%

P/F Ratio
117 — moderate ARDS (improved from severe at 95 yesterday)

SBT
Not ready — FiO2 0.65, PEEP 14, hemodynamically tenuous

Secretion Burden
Moderate — suctioned Q4h; yellow-green thick secretions, moderate volume

5c INTAKE & OUTPUT

Total Intake (24h)
3,240 mL — IV fluids 2,100 mL + medications 480 mL + tube feeds 660 mL

Urine Output (24h)
28 mL — anuric/oliguric; CRRT managing fluid and solute

CRRT Ultrafiltration
752 mL removed over 24h via CRRT

Net Balance (24h)
+162 mL (cautious ultrafiltration given hemodynamic fragility)

Cumulative ICU Balance
+12.4 L — significant; slow removal planned as vasopressors wean

5d LINES / TUBES / DRAINS

(1) Endotracheal tube (ETT): 8.0 oral, secured 23 cm at lip. Cuff pressure 25 cmH2O — appropriate. Daily oral care performed. (2) Right internal jugular triple-lumen CVC (05/03/2026): site dry, intact, no erythema. All ports patent. (3) Right radial arterial line (05/03/2026): intact, good waveform, site clean. (4) Foley catheter (05/03/2026): site intact. Draining 28 mL in 24h — oliguric/anuric as expected. Urine dark amber, concentrated. (5) CRRT catheter: right femoral vein double-lumen dialysis catheter (05/04/2026): site intact, no bleeding or hematoma. Circuit running — effluent clear, flows adequate. (6) Nasogastric tube (NGT): left naris, confirmed by CXR 05/03/2026. Tube feeds running at 45 mL/hr. No gastric residuals >250 mL in past 24h. (7) Oral care kit: in use Q4h per VAP prevention bundle.

PE Physical Examination

6 FOCUSED CRITICAL CARE EXAM

6a NEURO / CV / RESPIRATORY

Neurological

RASS -1. Opens eyes to voice, follows simple commands. Pupils 3 mm, equal, reactive. No spontaneous movement of upper extremities. GCS estimated at 9 (E2V1T M6). No seizure activity. CAM-ICU: positive for delirium — disorganized thinking and altered LOC during SAT.

Cardiovascular

Tachycardic at 96 bpm, regular. Hemodynamically supported on vasopressors. Radial and dorsalis pedis pulses 2+ bilaterally. Bilateral 2+ lower extremity pitting edema (fluid overloaded +12.4 L cumulative).

Respiratory

ETT in place. Ventilator-synchronous. Breath sounds: bilateral crackles (R > L) consistent with ARDS/pneumonia pattern. No wheeze. Moderate yellow-green secretions on suctioning. No subcutaneous emphysema. Work of breathing: supported by ventilator.

6b ABDOMEN / RENAL / SKIN / EXTREMITIES

Abdomen

Distended, soft, non-tender to palpation. Bowel sounds: diminished. Tube feeds running. No nausea/vomiting. NGT in place.

Renal / GU

Anuric (28 mL/24h). CRRT running. Foley intact. Right femoral dialysis catheter in place — site clean.

Skin / Wounds

Diffuse pallor. 2+ bilateral lower extremity pitting edema. Right radial and right IJ CVC sites: intact, no erythema. Right femoral CRRT site: intact. No pressure injuries on sacrum, occiput, or heels — repositioned Q2h per protocol. Mottling: absent today (was present at thighs on Day 2).

Extremities

Bilateral 2+ pitting edema to mid-calf. Radial and DP pulses present. Capillary refill 2 seconds. Bilateral leg compression devices in place for DVT prophylaxis.

L Lab & Diagnostic Results

7 ICU DATA

7a LABORATORY STUDIES

CBC (07:00): WBC 18.4 (down from 22.6 yesterday — improving). Hgb 8.9 (stable — anemia of critical illness; transfusion threshold Hgb <7 per protocol). Plt 98 (low, down from 134 yesterday — thrombocytopenia; monitoring for HIT given 4 days of heparin). CMP: Na 138, K 3.8 (CRRT replacement solution balancing), Cl 102, HCO3 22 (improving from 15 on admission), BUN 68 (elevated — AKI), Cr 4.8 (up from 3.2 on admission — severe AKI; CRRT managing). Glucose 142 (on insulin protocol, target 140–180). LFTs: AST 68, ALT 52, Alk Phos 110, Total Bili 2.1 (mild transaminitis — shock liver improving). Albumin 1.9 (severely low — inflammation and critical illness). Lactate (06:00): 1.6 mmol/L (normalized from 5.2 on admission — significant improvement; perfusion restoring). Procalcitonin: 14.2 ng/mL (down from 48.6 on Day 1 — improving, antibiotic response). CRP 186 mg/L (down from 312). Coagulation: PT 17.2, INR 1.4, aPTT 48 (therapeutic on CRRT heparin protocol), Fibrinogen 420 (elevated — acute phase reactant). D-dimer 8,400 (elevated — ongoing sepsis/inflammation). HIT antibody sent today — pending.

7b BLOOD GAS / MICROBIOLOGY / IMAGING

ABG (06:00)

pH 7.38 / PaCO2 42 / PaO2 76 / HCO3 24 / SpO2 94% — compensated, improving oxygenation. P/F ratio 117 (moderate ARDS, improving from severe at P/F 95 yesterday).

Microbiology

Blood cultures x2 (05/03): Streptococcus pneumoniae — fully sensitive to ceftriaxone. Repeat blood cultures 05/05: no growth to date (48h). Sputum culture (05/03): Sparse growth S. pneumoniae, mixed oral flora. Urine culture: no growth. BAL not performed (clinical decision — not needed given blood cultures positive and responding to ceftriaxone).

Imaging

CXR (05/06, portable, 06:30): Bilateral patchy airspace opacities — right > left, consistent with multifocal pneumonia and ARDS. ETT tip at 3 cm above carina (appropriate). NGT in stomach. Right IJ CVC tip at SVC/RA junction (appropriate). No new pneumothorax. Compared to 05/04 CXR: mild improvement in right lower lobe opacity.

A Assessment

8 ICU CLINICAL INTERPRETATION

Mr. Darnell Washington is a 53-year-old male, ICU Day 4, with pneumococcal pneumonia-associated septic shock, ARDS (moderate, P/F 117 — improving from severe), acute kidney injury requiring CRRT, and delirium. He is showing measured improvement over the past 24 hours: (1) HEMODYNAMICS: Vasopressor requirements decreasing (norepinephrine 0.22 → 0.14 mcg/kg/min) — most significant positive sign. MAP consistently above 65. Lactate normalized (1.6 from 5.2 on admission). (2) RESPIRATORY: P/F ratio improving (95 → 117); however, still on FiO2 0.65 and PEEP 14 — not yet liberable. ARDS protocol ongoing. (3) RENAL: Anuric/oliguric — CRRT-dependent. AKI from septic acute tubular necrosis. Creatinine not yet trending down (4.8, up from admission 3.2). Cautious ultrafiltration with hemodynamic fragility. (4) INFECTIOUS: Appropriately de-escalated to

ceftriaxone for pan-sensitive pneumococcus. Procalcitonin trending down. Fevers trending down. (5) THROMBOCYTOPENIA: Plt 98, down from 134 — HIT antibody sent. Low-molecular-weight heparin exposure; UFH held and replaced with argatroban pending HIT results. (6) DELIRIUM: CAM-ICU positive today. Sedation minimization ongoing. (7) NUTRITION: Adequate tube feeds running — albumin 1.9, anabolic support essential.

PBS Plan by System

9 SYSTEM-BASED ICU MANAGEMENT

Neuro NEUROLOGIC

Continue sedation minimization strategy. RASS target -1 to 0. SAT performed today — patient communicating but CAM-ICU positive for delirium. Reorientation Q4h. Family voice recordings at bedside. Avoid benzodiazepines if possible — consider dexmedetomidine if sedation needed beyond current fentanyl + midazolam once hemodynamics allow (not today — MAP borderline). Neuro checks Q4h.

CV CARDIOVASCULAR

GOAL: Continue to wean norepinephrine as MAP tolerates — target MAP >65. Wean NE by 0.02 mcg/kg/min Q2h if MAP >68 mmHg sustained. Hold vasopressin at 0.03 units/min until NE below 0.08, then attempt vasopressin wean. No inotropes required. Monitor for arrhythmia on telemetry. Echo not yet performed — bedside TTE to be scheduled this PM to assess LV/RV function and guide further fluid decisions. DVT prophylaxis: UFH changed to argatroban (HIT precaution) — target aPTT 45–65 sec; prophylactic dose 0.5 mcg/kg/min.

Resp RESPIRATORY

Continue lung-protective ventilation: VC-AC, TV 6 mL/kg IBW (448 mL), PEEP 14, RR 18, FiO2 0.65. Plateau pressure 22 — compliant. Goal: wean FiO2 to <0.60 before PEEP reduction. Repeat ABG in 4 hours after FiO2 trial of 0.60. Prone positioning: considered — patient on vasopressors; will re-evaluate if P/F <150 persists after vasopressor wean. SBT criteria not yet met. Daily SBT readiness check: currently FiO2 too high, PEEP too high, hemodynamically supported. Secretion management: albuterol MDI 4 puffs Q4h via in-line adapter (mild bronchospasm component); suctioning Q4h; chest PT considered. VAP bundle: HOB 30°, oral care Q4h, tube cuff pressure Q8h, circuit change protocol followed.

Renal RENAL / FLUIDS / ELECTROLYTES

CRRT: Continue CVVHDF at effluent 25 mL/kg/hr. Ultrafiltration: +20 mL/hr net removal (cautious — vasopressor-dependent). Goal: gradually de-resuscitate as hemodynamics allow — target net negative balance as MAP stabilizes. Electrolytes: CRRT replacement fluid potassium adjusted — K 3.8 today, target 4.0–4.5. Monitor Ca, Mg, Phos Q6h given CRRT replacement. Nephrotoxins: all NSAIDs, aminoglycosides, and contrast avoided. HIT precaution: argatroban replacing heparin in CRRT circuit — coordinate with renal/pharmacy for circuit anticoagulation.

GI GI / NUTRITION

Tube feeds: Peptamen 1.5 at 45 mL/hr = 1,620 kcal/day, 90g protein/day — meeting estimated needs. HOB at 30°. Gastric residuals Q4h — if >250 mL, hold feeds and notify. Stress ulcer prophylaxis: pantoprazole 40 mg IV Q24h — continue (mechanically ventilated >48 hours, coagulopathy). Bowel regimen: no bowel movement in 4 days — ileus expected in septic shock; hold stimulant laxatives currently. Constipation to be reassessed as vasopressors wean and gut perfusion improves. LFTs mildly elevated — monitor; ischemic hepatitis improving as lactate normalizes.

ID INFECTIOUS DISEASE

Ceftriaxone 1g IV Q24h — Day 4 (de-escalated from vancomycin + pip-tazo per ID Day 2). Culture-directed therapy for pan-sensitive pneumococcal bacteremia. Duration: planned 7-day total course (complete 05/09/2026). Repeat blood cultures 05/05 — no growth at 48h. Procalcitonin trending down (48.6 → 14.2). Fevers trending down (39.2 → 38.1). Source identified — right lower lobe pneumonia; no other source (no line infection, no UTI, no abdominal source). Empiric antifungals not started — clinical picture consistent with bacterial source.

Heme HEMATOLOGY / COAGULATION

Thrombocytopenia: Plt 98, 4-T score for HIT = 4 (intermediate probability). HIT antibody pending. Action taken: UFH replaced with argatroban (prophylactic 0.5 mcg/kg/min). If HIT positive: argatroban therapeutic dosing and hematology consultation. Transfusion: Hgb 8.9 — hold transfusion (threshold Hgb <7 in non-actively bleeding patient without cardiac ischemia). Monitor. Coagulopathy: INR 1.4, fibrinogen 420 — not clinically significant; no FFP or product transfusion indicated. DVT prophylaxis: argatroban as above (dual purpose — DVT ppx + HIT precaution).

Endo ENDOCRINE / METABOLIC

Glucose: 142 mg/dL — on insulin infusion protocol per MICU protocol. Target 140–180 mg/dL. Q1h glucose checks. Insulin drip currently at 2.5 units/hr. No known diabetes (admission HbA1c 5.8% — stress hyperglycemia only). Cortisol stimulation test: not performed (no refractory vasopressor requirement; vasopressors weaning). No thyroid concerns. Metabolic acidosis: pH 7.38, HCO3 22 — normalizing with CRRT bicarbonate replacement. Anion gap: 18 (improving from 28 on admission).

GOC **GOALS OF CARE / CODE STATUS**

Code status: FULL CODE (confirmed with wife yesterday). Family meeting held 05/05/2026 PM with wife (Andrea Washington) and Dr. Morales. Prognosis discussed: improving trajectory over past 24h but patient remains critically ill with significant organ dysfunction. If vasopressors successfully weaned this week and CRRT requirements decrease, favorable outlook for respiratory recovery and potential renal recovery. Wife expressed understanding. Palliative care not yet engaged — will reassess if trajectory reverses. Next family update: today at 18:00 by phone or bedside.

CK ICU Daily Checklist

10 **SAFETY & QUALITY**

DVT Prophylaxis
Argatroban (HIT precaution) + bilateral SCDs

Stress Ulcer Prophylaxis
Pantoprazole 40 mg IV Q24h — YES (vent >48h, coagulopathy)

Sedation Target / RASS
RASS -1 — midazolam 2 mg/hr + fentanyl 50 mcg/hr

Pain Control
CPOT 2; fentanyl infusion + PRN boluses; SAT performed

Delirium Screening
CAM-ICU POSITIVE — reorientation Q4h, family voice, minimize BZDs

SAT
Performed 06:30 — patient communicates but delirium present; sedation re-started

SBT
NOT performed — FiO2 0.65, PEEP 14, hemodynamically supported; SBT not appropriate today

Ventilator Bundle / Oral Care
HOB 30°, oral care Q4h, cuff pressure checked, circuit intact

Glycemic Control
Target 140–180; insulin infusion 2.5 units/hr; glucose 142 at 07:00

Nutrition
Peptamen 1.5 at 45 mL/hr = 1,620 kcal — meeting estimated needs

Bowel Regimen
No BM x4 days — ileus expected; hold stimulants; reassess as vasopressors wean

Foley Necessity
YES — anuric, CRRT-dependent, strict I/O required

Central Line Necessity
YES — vasopressors, CRRT access, multiple infusions; review daily for removal readiness

Mobility
Bedrest — PT to assess; repositioning Q2h; passive ROM by nursing

Restraints
Bilateral soft wrist restraints — ETT protection per protocol; reassess with sedation lightening

Code Status
FULL CODE — confirmed with wife 05/05

DISP Disposition / ICU Needs

11 **ICU LEVEL OF CARE JUSTIFICATION**

Mr. Washington continues to require ICU-level care for the following active organ support needs: (1) VASOPRESSOR SUPPORT: Norepinephrine + vasopressin — hemodynamic instability precludes floor care. (2) MECHANICAL VENTILATION: Intubated for ARDS/respiratory failure — requires ventilator management, ABG monitoring, and potential urgent airway intervention. (3) CRRT: Anuric AKI — continuous renal replacement therapy requires ICU monitoring and CRRT nurse expertise. (4) CRITICAL MONITORING: Arterial line for continuous MAP and serial ABGs; CVP monitoring; delirium management; Q1h glucose; strict I/O. Transfer criteria: vasopressors weaned to off, FiO2 <0.40 and PEEP <8, hemodynamically stable for >24h, and CRRT either transitioned to intermittent HD or renal recovery evident.

FU Follow-Up / Reassessment

12 **REASSESSMENT PLAN**

Follow-Up Schedule
Repeat ABG in 4 hours (11:00 AM) after FiO2 trial of 0.60. Bedside TTE today PM. Vasopressor wean assessment Q2h. HIT antibody results expected today — review and adjust argatroban if positive. Family call at 18:00. Hematology consultation if HIT positive. Repeat CXR tomorrow AM. Repeat comprehensive labs tomorrow AM. ID to review procalcitonin trend and confirm antibiotic end date (05/09/2026). Goals of care re-discussion if clinical trajectory changes.

TIME DOCUMENTATION & BILLING (CRITICAL CARE)

Total Critical Care Time
62 minutes

Critical Care Code
99291 — Critical care, first 30–74 min

Counseling / Coordination Time

Basis for Billing

15 minutes	Critical care time-based billing — all time spent in direct management of critically ill patient

Primary ICD-10 Code

A40.3 — Sepsis due to Streptococcus pneumoniae

Secondary ICD-10 Code(s)

R65.21 — Severe sepsis with septic shock; J18.1 — Lobar pneumonia; J80 — ARDS; N17.9 — AKI; F05 — Delirium due to known physiological condition

PHYSICIAN / PROVIDER	CREDENTIALS	DATE	TIME
Alicia T. Morales, MD	MD — Pulmonology / Critical Care | Board Certified (ABIM-CC)	05/06/2026	08:45 AM