1 PATIENT INFORMATION

1 PATIENT & ENCOUNTER DETAILS

PATIENT NAME	Rosalind T. Achterberg
DOB	02/09/1958
AGE / SEX	68 / Female
MRN / PATIENT ID	SICU-903471
DATE OF SERVICE	07/30/2026 — 07:20 rounds
PROVIDER	Dr. Idris N. Fontaine, MD — Critical Care
LOCATION / UNIT	Surgical ICU, Tower 4
ROOM / BED	4-North 12 / A

PRIMARY DIAGNOSIS / REASON FOR ADMISSION

Perforated sigmoid diverticulitis with fecal peritonitis and septic shock; emergency laparotomy with Hartmann procedure 07/26/2026 (POD 4). Complicated by moderate ARDS, KDIGO stage 3 AKI on CRRT, new-onset atrial fibrillation, and hyperactive ICU delirium.

2 REASON FOR ASSESSMENT

2 INDICATION

Daily ICU rounding head-to-toe assessment on POD 4, with three specific drivers: (1) **assessment of weaning readiness** after 48 hours of lung-protective ventilation with improving oxygenation; (2) **reassessment of vasopressor and CRRT requirements** following successful de-escalation overnight; and (3) **line and drain necessity review** — the femoral CVC placed emergently in the ED is now day 4 and requires either resiting or removal. A **change in clinical status** also prompts review: new-onset atrial fibrillation at 02:40 with a rate-related pressure drop.

3 OVERNIGHT EVENTS

3 SIGNIFICANT INTERVAL EVENTS

- **02:40 — New-onset atrial fibrillation** with rates 150–165 and MAP fall to 54. Received amiodarone 150 mg IV bolus followed by 1 mg/min infusion; magnesium 2 g and potassium 20 mEq replaced. **Converted to sinus rhythm at 04:15** and has remained sinus since. Likely multifactorial — sepsis, electrolyte shifts on CRRT, volume flux.
- **Hemodynamic de-escalation:** Norepinephrine weaned from 0.14 to **0.03 mcg/kg/min** over the shift; vasopressin discontinued at 23:00 without rebound hypotension. No fluid boluses required in the last 12 hours.

- **Respiratory improvement:** FiO2 weaned 0.60 → **0.40**, PEEP 12 → 8. P/F ratio improved from 138 to **202**. Prone positioning discontinued 07/29 after 16-hour session. Spontaneous awakening trial passed at 06:00; **SBT deferred** pending resolution of overnight arrhythmia.
- **Renal:** CVVHDF continued. Net ultrafiltration **–1,240 mL** over 24 hours toward a negative-balance goal. Circuit clotted at 21:15 requiring change-out with ~120 mL blood loss; **regional citrate anticoagulation adjusted** for a post-filter iCa of 0.42.
- **Surgical / abdominal:** Midline incision reviewed by surgery at 20:00 — intact, no dehiscence. Left lower quadrant Jackson-Pratt output **180 mL serosanguinous** (down from 310 mL). Colostomy functioning, first gas output overnight.
- **Delirium:** Hyperactive episode 23:30–01:00 with attempted line self-removal. Non-pharmacologic measures failed; received **haloperidol 2 mg IV × 2.** Bilateral soft wrist restraints applied per protocol with q2h reassessment. Family notified.
- **Labs / imaging:** Portable CXR 05:30 — improving bibasilar opacities, ETT 3 cm above carina, no pneumothorax. **Blood cultures from 07/28 returned no growth at 48 hours.** Peritoneal fluid culture from OR final: **E. coli and Bacteroides fragilis**, both susceptible to current therapy.
- **Transfusion:** 1 unit PRBC at 01:00 for Hgb 6.9 with tachycardia; post-transfusion Hgb 8.1. No reaction.

V VITALS

4 CURRENT VALUES & 24-HOUR TRENDS

PARAMETER	RANGE (24 H)	CURRENT
Temperature	37.1 – 38.6 °C	37.4 °C
Heart Rate	78 – 165 bpm	92 bpm (sinus)
Blood Pressure	88/48 – 138/74	112/62 mmHg
MAP	54 – 88 mmHg	78 mmHg
Respiratory Rate	16 – 28 / min	20 / min
Oxygen Saturation	89 – 98%	95%

CURRENT OXYGEN REQUIREMENT
Mechanical ventilation — FiO2 0.40, PEEP 8

PAIN SCORE
CPOT 2 / 8 at rest; 4 / 8 with repositioning

N NEURO

5 NEUROLOGIC STATUS, SEDATION & PAIN

RASS
+1 at present (was +3 overnight); goal –1 to 0

GCS
E4 VT M6 — 10T (intubated)

CAM-ICU
POSITIVE — hyperactive delirium, third consecutive day

PAIN SCALE
CPOT 2 / 8 rest, 4 / 8 with turns

SLEEP PATTERN
Severely fragmented; <2 h consolidated sleep, day-night reversal

NEURO CHECK FREQUENCY
q2h with RASS and CAM-ICU q4h

- **Sedation / analgesia drips:** Fentanyl 50 mcg/h (down from 125 mcg/h on POD 2); **propofol discontinued 07/29** at 14:00 in favour of an analgesia-first strategy. Dexmedetomidine 0.4 mcg/kg/h started 05:00 targeting RASS –1 to 0 and delirium control; tolerating without bradycardia.
- **Hospital neuro / psychiatric / sedating medications:** Haloperidol 2 mg IV q6h PRN agitation (2 doses in 24 h), melatonin 5 mg PO at 21:00 via OGT, scheduled acetaminophen 650 mg q6h via OGT. **No benzodiazepines** — deliberately avoided given delirium.
- **Relevant home medications:** Sertraline 100 mg daily (**held** — restart planned once gut function reliable), zolpidem 5 mg PRN (**held indefinitely**), gabapentin 300 mg TID for diabetic neuropathy (resumed at reduced 100 mg TID for renal clearance).
- **RN update:** Intermittently oriented to person only; not oriented to place or time. Pulls at ETT and lines during agitation peaks — **bilateral soft wrist restraints in place**, least-restrictive documentation current, reassessed q2h. Pain control adequate between turns. **Not safe for mobility without two-person assist.** Daughter present 09:00–20:00 daily, which measurably reduces agitation; reorientation board and hearing aids in use, glasses requested from home.

CV CARDIOVASCULAR

6 HEMODYNAMICS & CARDIOVASCULAR SUPPORT

EKG RHYTHM
Normal sinus rhythm, rate 92 — converted from AF at 04:15

CVP
9 mmHg (femoral CVC, trend 14 → 9 with negative balance)

PA CATHETER
Not in place

LACTATE
1.6 mmol/L (peak 6.8 on admission)

PA CATHETER DATA / ALTERNATE MONITORING
Bedside echo 07/29: LVEF 55%, no RV strain, IVC variable, no effusion or vegetation

- **Active drips:** Norepinephrine **0.03 mcg/kg/min** and weaning; vasopressin **off** since 23:00. **Amiodarone 1 mg/min** infusion (started 02:40, hour 5 of 6 at this rate, then 0.5 mg/min × 18 h).
- **Hospital cardiovascular medications:** Amiodarone infusion as above. Home antihypertensives held. Aspirin 81 mg held peri-operatively — restart under surgical review.
- **Relevant home cardiovascular medications:** Metoprolol succinate 50 mg daily (**held** — vasopressor requirement), lisinopril 20 mg daily (**held** — AKI), atorvastatin 40 mg daily (resumed 07/29), aspirin 81 mg (held).
- **RN update:** Rhythm now stable; telemetry continuous with AF alarm limits set. Extremities warm with capillary refill <3 s — a clear change from the mottled, cool periphery on admission. **2+ pitting edema** of both lower extremities and moderate anasarca from resuscitation, slowly improving with net-negative CRRT. No chest pain reported or inferred. Right radial arterial line waveform damped twice overnight, re-zeroed and re-squared, currently reliable.

P PULMONARY

7 RESPIRATORY STATUS & SUPPORT

7a VENTILATOR SETTINGS

SUPPORT TYPE / DEVICE
Invasive mechanical ventilation, oral ETT 7.5 secured at 22 cm

MODE
Volume-control assist/control → trialing PSV today

PEEP
8 cmH2O (from 12)

TIDAL VOLUME
380 mL — 6.1 mL/kg predicted body weight

SET / ACTUAL RESPIRATORY RATE
18 set / 20 actual

FIO2
0.40 (from 0.60)

PEAK PRESSURE
26 cmH2O

PLATEAU PRESSURE
21 cmH2O — driving pressure 13

COMPLIANCE / P:F
Static compliance 29 mL/cmH2O · P/F ratio 202 (moderate ARDS, improving from 138)

7b GAS EXCHANGE & IMAGING

ABG — PH
7.36

PACO2
41 mmHg

PAO2
81 mmHg

HCO3
23 mmol/L

BASE EXCESS
−2.1

O2 SATURATION
95%

FIO2 AT TIME OF ABG
0.40

ABG DATE / TIME
07/30/2026, 05:45

CHEST X-RAY — INTERVAL CHANGE
07/30 05:30 portable: bilateral lower-zone opacities — improved aeration versus 07/28. ETT tip 3 cm above carina. No pneumothorax, no new effusion. Right IJ not present; femoral CVC not visualized on this film.

- **Respiratory medications (hospital):** Ipratropium/albuterol nebulizer q6h scheduled, albuterol q4h PRN, N-acetylcysteine not indicated. Chlorhexidine oral care q12h and HOB 30° per VAP bundle.
- **Relevant home respiratory medications:** Tiotropium 18 mcg daily for mild COPD (held while intubated; resume post-extubation), no home oxygen.
- **RN and RT update:** Moderate **thick tan secretions**, suctioned q3–4h, volume decreasing. Strong cough with adequate reserve. Ventilator synchrony good since propofol discontinuation; **no double-triggering or flow starvation** noted. **Weaning readiness: FiO2 ≤0.40, PEEP 8, RSBI 62, adequate cough, RASS trending to goal** — SBT planned for 09:00 today now that rhythm is stable. Cuff leak test pending; airway swelling risk noted after prone positioning and 4 days of intubation.

R RENAL

8 RENAL FUNCTION, FLUIDS & ELECTROLYTES

Current fluids: No maintenance crystalloid. CRRT replacement and dialysate per prescription. Sodium bicarbonate not required. Medication carriers minimized to ~180 mL/day given the negative-balance goal.

Most recent electrolyte panel (07/30, 05:30): Na 138 · K 4.1 · Cl 105 · CO2 23 · **BUN 68** · **Creatinine 3.4 mg/dL** (baseline 0.9) · Ca 8.2 (iCa 1.12) · Mg 2.1 after replacement · Phos 4.6 · Glucose 168. Post-filter iCa 0.42 — citrate adjusted.

INTAKE — LAST 24 H
2,410 mL (CRRT replacement, meds, PRBC, enteral feeds)

OUTPUT — LAST 24 H
3,650 mL (net UF 1,240 + urine 310 + JP 180 + ostomy 620 + insensible est.)

NET I/O — LAST 24 H
–1,240 mL · cumulative since admission +6.8 L (down from peak +9.4 L)

URINE OUTPUT
310 mL / 24 h — 0.18 mL/kg/h, oliguric but **trending up** from 95 mL

8a CRRT

CRRT STATUS / MODALITY
CVVHDF, day 3, femoral dialysis catheter, regional citrate anticoagulation

BLOOD RATE
150 mL/min

DIALYSATE FLOW RATE
1,600 mL/h

ULTRAFILTRATION & FLUID GOAL
Net UF 60 mL/h — goal –1,000 to –1,500 mL / 24 h while MAP ≥65 off pressors

- **Hospital renal / electrolyte medications:** Potassium and magnesium replaced per CRRT protocol. Phosphate binder not required. **Diuretics deliberately withheld** while on CRRT. All nephrotoxins avoided; **no contrast studies** without discussion.
- **Relevant home medications:** Lisinopril 20 mg (**held — AKI**), hydrochlorothiazide 25 mg (**held**), empagliflozin 10 mg (**held — euglycemic DKA and AKI risk**), ibuprofen PRN (**discontinued; counselling required at discharge**).
- **RN update:** Urine output slowly improving, a favourable early sign. Foley draining clear amber, patent, day 4. **Anasarca improving** with negative balance — periorbital edema reduced. Electrolytes replaced twice this shift. **One circuit clot at 21:15** requiring change-out with ~120 mL blood loss; filter pressures currently stable, access and return pressures within range. Femoral dialysis catheter site clean and dry.

GI GASTROINTESTINAL

9 NUTRITION, BOWEL & ENTERAL ACCESS

DIET / NUTRITION STATUS
Trophic-to-goal enteral nutrition via OGT; NPO by mouth (intubated)

PERCENT OF NUTRITIONAL GOAL ACHIEVED
≈72% — advancing as tolerated

CALORIE GOAL
1,700 kcal/day (25 kcal/kg)

PROTEIN GOAL
115 g/day — 1.7 g/kg, increased for CRRT amino-acid losses

LAST ALBUMIN
2.2 g/dL (07/30)

PRE-ALBUMIN
9 mg/dL (07/29)

CRP
142 mg/L — down from 288 on 07/27

DATE OF NUTRITION LABS
07/29 – 07/30/2026

MALNOURISHED
Yes — ASPEN criteria for acute-illness malnutrition: >5% weight loss, intake <50% for >5 days, visible

LAST BOWEL MOVEMENT
Colostomy output 620 mL liquid-to-soft / 24 h; **first flatus overnight**

muscle wasting

GI PROPHYLAXIS
Pantoprazole 40 mg IV daily

ENTERAL ACCESS
Orogastric tube 14 Fr, position confirmed on 05:30 CXR

SPEECH EVALUATION STATUS
Deferred until extubation; **post-extubation swallow screen mandatory** after 4 days of intubation and prone positioning

- **Hospital GI / nutrition medications:** Pantoprazole 40 mg IV daily; ondansetron 4 mg IV q8h PRN; **bowel regimen not indicated** — new colostomy with output. Prokinetic not currently required.
- **Relevant home GI medications:** Omeprazole 20 mg daily (converted to IV pantoprazole), no home laxatives.
- **RN update:** Feeding tolerance improved — **gastric residual volumes 40–90 mL**, down from 250 mL on POD 2. No vomiting; one episode of nausea relieved by ondansetron. Abdomen soft, mildly distended, appropriately tender at the incision; **no rigidity or new guarding.** Colostomy stoma **beefy red, viable**, faceplate intact, peristomal skin without breakdown; ostomy nurse consulted and family teaching to begin once the patient is awake. Aspiration precautions maintained: HOB 30°, cuff pressure verified q shift.

H HEMATOLOGY

10 COUNTS, COAGULATION & PROPHYLAXIS

Most recent CBC (07/30, 05:30): WBC **14.2** K/µL (peak 26.8 on admission, trending down) with 82% neutrophils · Hgb **8.1 g/dL** post-transfusion (nadir 6.9) · Hct 24.6% · Platelets **96 K/µL** — down from 214 on admission.

Most recent coagulation studies (07/30): PT 15.8 s, INR **1.4** · aPTT 38 s · Fibrinogen 402 mg/dL · D-dimer elevated (non-specific in sepsis). **No overt DIC** — ISTH score 3; the thrombocytopenia is attributed to sepsis plus CRRT circuit consumption rather than HIT (4T score low, no heparin exposure beyond flushes).

ACTIVE TYPE & SCREEN DATE
07/29/2026 — valid through 08/02

DVT PROPHYLAXIS
Mechanical only — bilateral sequential compression devices. Pharmacologic prophylaxis deferred for platelets <100 and recent laparotomy; reassess daily

- **Hospital hematology medications:** No systemic anticoagulation. Regional citrate for the CRRT circuit only. 1 unit PRBC transfused 01:00 (transfusion threshold 7 g/dL, exceeded for symptomatic tachycardia).
- **Relevant home medications:** Aspirin 81 mg daily — **held** peri-operatively; no anticoagulant, no antiplatelet beyond aspirin.
- **Concerns: Platelet trajectory is the item to watch** — recheck at 14:00; if <50 or falling further, send HIT panel and hold citrate review with nephrology. Anemia is multifactorial: surgical loss, circuit loss, phlebotomy, and inflammatory suppression. **Now in new-onset AF with a CHA2DS2-VASc of 4** — anticoagulation indicated in principle but **contraindicated today**; revisit when platelets recover and surgery clears bleeding risk.

ID INFECTIOUS DISEASE

11 FEVER TREND, CULTURES & ANTIMICROBIALS

TMAX (24 H)
38.6 °C at 14:10 — down from 39.4 °C on POD 1

CURRENT TEMPERATURE
37.4 °C

ISOLATION PRECAUTIONS
Contact precautions — ESBL screening pending

WBC TREND
26.8 → 19.4 → **14.2** K/µL over 4 days

- **Blood cultures:** 07/26 (admission, ×2 sets) — **E. coli, ESBL-negative**, susceptible to piperacillin-tazobactam. 07/28 repeat ×2 sets — **no growth at 48 hours. Clearance documented.**
- **Other cultures:** Intra-operative peritoneal fluid (07/26) final — **E. coli and Bacteroides fragilis**, both susceptible to current regimen. Urine culture 07/27 — no growth. Tracheal aspirate 07/29 — mixed respiratory flora, **not treated** (colonization, no VAP criteria met). C. difficile not tested — no indication with a new colostomy and no unexplained diarrhea.
- **Antimicrobials: Piperacillin-tazobactam 3.375 g IV q8h** (extended infusion, CRRT-dosed) — started 07/26, **day 5 of therapy.** Micafungin 100 mg IV daily started 07/27 for fecal peritonitis with Candida risk — **day 4; stop date 07/31** unless yeast isolated. Vancomycin **discontinued 07/28** after MRSA nares screen returned negative — de-escalation documented.
- **Current assessment: Source control achieved** at laparotomy with Hartmann resection and washout. Fever curve, WBC, CRP, and lactate all trending toward resolution — a coherent picture of **resolving intra-abdominal sepsis.** Planned total antibiotic course **7 days from adequate source control (through 08/01)** per intra-abdominal infection guidance; no extension without new signs. Watch for a secondary source if fever recurs: consider CT abdomen for undrained collection, and the femoral CVC as a candidate source.

E ENDOCRINE

12 GLUCOSE & ENDOCRINE MANAGEMENT

BLOOD SUGAR RANGE (24 H)
126 – 214 mg/dL — 3 values above target, no hypoglycemia

CURRENT INSULIN REGIMEN
IV insulin infusion 2.4 units/h, target 140–180 mg/dL; q1h POC glucose

A1C ON ADMISSION
8.2% — pre-existing type 2 diabetes, poorly controlled

ADRENAL ASSESSMENT
No steroid requirement; vasopressor-responsive, hydrocortisone not indicated

- **Steroids / endocrine-relevant medications: No corticosteroids.** Stress-dose hydrocortisone was considered on POD 1 for refractory shock and **not required** once norepinephrine fell below 0.25 mcg/kg/min.
- **Relevant home endocrine medications:** Metformin 1,000 mg BID (**held — AKI**), empagliflozin 10 mg daily (**held — euglycemic DKA risk**), levothyroxine 88 mcg daily (**continued** via OGT, TSH 2.4 on 07/28).
- **Concerns:** Glycemic variability driven by inflammatory stress and changing enteral feed rates, not steroids. **No hypoglycemic events.** Transition from IV infusion to subcutaneous basal-bolus once enteral nutrition is at a stable goal rate — **overlap the infusion by 2 hours** at conversion. Metformin remains contraindicated until creatinine recovers.

W WOUNDS / DRAINS / LINES

13 INVASIVE DEVICES — NECESSITY & REMOVAL PLAN

DEVICE	STATUS / SITE	INSERTION	CAN IT COME OUT?
Central Line	Left femoral triple-lumen, site clean, no erythema	07/26 (day 4)	**No — but RESITE TODAY.** Femoral placement was emergent; convert to right IJ this morning to reduce CLABSI risk
Urinary Catheter	16 Fr Foley, clear amber, patent	07/26 (day 4)	**No** — strict output measurement required for CRRT balance. Reassess at CRRT discontinuation
Arterial Line	Right radial, waveform re-zeroed ×2 overnight	07/26 (day 4)	**No** — active pressor wean and q6h ABGs. Remove within 24 h of pressor-free status
Dialysis Catheter	Right femoral 13 Fr, functioning after circuit change	07/28 (day 2)	**No** — active CVVHDF
Drain	Left lower quadrant Jackson-Pratt, 180 mL serosanguinous / 24 h	07/26 (intra-op)	**Not yet** — surgery to remove when output <50 mL/24 h and non-purulent
Orogastric Tube	14 Fr, feeding, position CXR-confirmed	07/26 (day 4)	**No** — enteral access; convert to NG or oral diet after extubation and swallow screen

- **Surgical wound:** Midline laparotomy incision, staples intact, edges approximated, **no dehiscence, no erythema, no purulent drainage.** Dressing changed 20:00 — dry. Reviewed by surgery daily.
- **Ostomy:** End colostomy left lower quadrant, stoma beefy red and viable, appliance intact, **peristomal skin intact.** Ostomy nurse following; teaching deferred until the patient is alert enough to participate.
- **Pressure injury risk:** Braden score 12 — high risk after 16 hours of prone positioning. **Stage 1 pressure area at the right iliac crest** and a **device-related area at the left cheek** from the prone circuit; both offloaded, foam dressings applied, **q2h turns documented.** Heels floated. Wound care consulted.
- **Device-related concerns:** The femoral CVC is the single highest-value removal target today. **Chlorhexidine dressings intact** on all vascular sites; all lines dated and CLABSI bundle audit current.

M MOBILITY

14 FUNCTIONAL MOBILITY & ACTIVITY GOALS

- **Yesterday's highest level of mobility: Passive range of motion in bed only** plus q2h repositioning. No dangle, no chair position — prone session and pressor requirement precluded progression.
- **Mobility goal for today: Head of bed to 45°, then dangle at the edge of bed with two-person assist** if the SBT is passed and norepinephrine is off. If extubated, advance to **standing at the bedside with a lift-assist** in the afternoon session. Active-assisted range of motion in all four limbs twice today regardless of extubation status.

- **Barriers to mobility: Delirium with restraints** — the dominant barrier and a genuine safety issue for line dislodgement. Residual pressor requirement (0.03 mcg/kg/min). Mechanical ventilation. **Six invasive devices** including two femoral catheters that limit hip flexion. ICU-acquired weakness with MRC sum score ~44/60. Incisional pain with movement. Fall risk high (Morse 65).
- **PT / OT involvement:** PT evaluated 07/29 — **ICU early-mobility protocol level 2.** OT consulted for delirium-directed cognitive engagement and splinting review. Nursing mobility plan: **two-person assist minimum, three at first dangle**, with RN, RT, and PT present for any out-of-bed activity while ventilated. Safety concerns communicated to the family so expectations match the plan.

D DISPOSITION

15 LEVEL OF CARE & TRANSITION PLANNING

CURRENT LEVEL OF CARE
Surgical ICU — level 3, ventilated with organ support

ANTICIPATED DISPOSITION
Surgical stepdown in **2–4 days** if extubated and off CRRT; then inpatient rehabilitation

TRANSFER READINESS
No — ventilated, on CRRT, pressor-dependent

TARGET DATE, IF KNOWN
Stepdown target 08/02–08/04; rehab referral to be initiated 08/01

- **Anticipated needs: Inpatient rehabilitation is the most likely destination** — this is a previously independent 68-year-old with new ICU-acquired weakness, a new colostomy requiring self-care training, and probable ongoing renal follow-up. Home is a two-storey house with a first-floor bathroom; she lives with a spouse who works full-time. Home health with ostomy nursing will be required whichever pathway is taken.
- **Barriers to disposition:** Ventilator dependence · CRRT and uncertain renal recovery (**outpatient dialysis planning may become necessary**) · delirium · ICU-acquired weakness · malnutrition · new ostomy requiring competent self- or caregiver care · six invasive devices · new AF with an unresolved anticoagulation decision · insurance authorization for acute rehab not yet initiated.
- **Actions today:** Case management to **open the rehab authorization file now** rather than at extubation. Nephrology to state a renal-recovery prognosis. Ostomy teaching cannot begin until delirium clears — flagged as a rate-limiting step for discharge, not a late detail.

A/P ASSESSMENT & PLAN

16 SYSTEM-BASED ASSESSMENT & DAILY PLAN

Overall: 68-year-old woman, POD 4 from emergency Hartmann procedure for perforated diverticulitis with fecal peritonitis and septic shock, who is **clearly improving across every organ system** — cultures cleared, lactate normalized, pressors nearly off, oxygenation improved from severe to moderate ARDS, urine output beginning to return. The three problems now limiting progress are **delirium, ICU-acquired weakness, and renal non-recovery**, none of which are resolved by more intensive care — they are resolved by liberation, mobility, and time. Overnight AF was a predictable electrolyte-and-sepsis event, is rate-controlled and rhythm-converted, and should not delay the weaning plan beyond this morning.

Today's three priorities, in order: (1) **SBT at 09:00 with a view to extubation by midday** if passed and rhythm holds; (2) **resite the femoral CVC to the right internal jugular** — day 4 femoral access is the largest avoidable infection risk on this chart; (3) **get her out of bed** — dangle with two-person assist, which is

simultaneously the delirium intervention and the weakness intervention.

- **Neuro / delirium:** Continue dexmedetomidine to RASS −1 to 0; fentanyl to 25 mcg/h if SBT passes. **No benzodiazepines.** Haloperidol PRN only, ECG QTc monitored on amiodarone (QTc 448 today — recheck at 14:00). **Non-pharmacologic bundle is the primary treatment:** glasses from home, hearing aids in, blinds open by 07:00, lights out and no non-urgent care 23:00–05:00, reorientation at every contact, daughter at the bedside. **Restraints reassessed q2h with a goal of removal today** once dexmedetomidine is at effect.
- **Cardiovascular:** Wean norepinephrine off by 10:00 if MAP ≥65. Amiodarone to 0.5 mg/min at 08:40, then oral conversion at 24 hours. **Anticoagulation for AF deferred** — CHA2DS2-VASc 4, but platelets 96 and POD 4 laparotomy; **formal reassessment 08/01** with surgery. Resume metoprolol once pressor-free ×12 h. Hold lisinopril until creatinine recovers.
- **Pulmonary:** SBT on PSV 5 / PEEP 5 / FiO2 0.40 for 30 minutes at 09:00. **Cuff leak test before extubation** — 4 days intubated plus prone positioning; if leak is absent, dexamethasone ×1 and delay 4–6 hours rather than extubating into a stridor. Post-extubation: HFNC 40 L/min at FiO2 0.35, incentive spirometry q1h awake, chest physiotherapy. Continue lung-protective settings and VAP bundle until extubated.
- **Renal / fluids:** Continue CVVHDF with net UF 60 mL/h; **reduce to 40 mL/h if the pressor wean stalls** — hemodynamics take precedence over the fluid goal. Target another −1,000 to −1,500 mL today. **Trial of CRRT discontinuation on 07/31 or 08/01** if urine output exceeds 0.5 mL/kg/h and potassium and acid-base are stable. Nephrology to comment on recovery prognosis. Strict nephrotoxin avoidance; **no contrast without a nephrology conversation.**
- **Nutrition / GI:** Advance enteral feeds to full goal (1,700 kcal, **115 g protein** — CRRT losses). Hold feeds 4 hours pre-extubation, resume 4 hours post with a swallow screen before any oral intake. Continue pantoprazole. Ostomy output monitored; **watch for high-output stoma** (>1,200 mL/24 h) as feeds advance and treat early with loperamide if it develops.
- **Infection:** Continue piperacillin-tazobactam and micafungin. **Antibiotic stop date 08/01** — 7 days from source control — written into the chart today so it is not extended by inertia. **Stop micafungin 07/31** unless yeast is isolated. No repeat cultures without a new fever or a clinical change; **resist the urge to re-culture a resolving patient.**
- **Hematology:** Recheck CBC at 14:00. **If platelets <50, send HIT panel** and review citrate with nephrology. Continue mechanical DVT prophylaxis; **reassess pharmacologic prophylaxis daily** — start when platelets >100 and surgery clears. Transfuse for Hgb <7 or symptoms.
- **Endocrine:** Continue IV insulin, target 140–180. Convert to subcutaneous basal-bolus once feeds are at stable goal, **overlapping the infusion by 2 hours.** Continue levothyroxine. Metformin and empagliflozin remain held.
- **Lines / drains: Resite femoral CVC to right IJ this morning** with ultrasound guidance and full barrier precautions. Foley, A-line, and dialysis catheter all remain necessary today with documented justification. JP drain per surgery. **Every line gets this question again tomorrow.**
- **Mobility:** PT twice today. HOB 45°, dangle with two-person assist, standing attempt in the afternoon if extubated. Active-assisted ROM regardless. Pressure-injury offloading maintained; q2h turns; heels floated.
- **Disposition:** Case management to initiate the acute rehabilitation authorization today. Nephrology prognosis needed for placement planning. Ostomy teaching queued for the moment delirium clears.
- **Team plan review:** Discussed at 07:20 multidisciplinary rounds with critical care, surgery, nephrology, pharmacy, RN, RT, PT, nutrition, and case management. **Antibiotic stop date, CVC resiting, and the mobility goal were the three items requiring consensus** — all agreed. Family update by the intensivist at 11:00; daughter is the designated contact and healthcare proxy.
- **RN considerations:** q1h POC glucose · q2h turns, restraint reassessment, and CAM-ICU q4h · hourly CRRT balance with filter pressures · strict I/O including ostomy and drain · **escalation triggers:** MAP <65, norepinephrine requirement rising, SpO2 <90%, recurrence of AF with rate >120, urine output <0.3 mL/kg/h,

new abdominal rigidity or guarding, ostomy output >1,200 mL/24 h, JP output turning purulent, platelets <50, or new bleeding — **call the intensivist, do not wait for rounds.**

T TIME DOCUMENTATION

17 TIME SPENT

TOTAL TIME SPENT
98 minutes

BEDSIDE ASSESSMENT TIME
42 minutes

CARE COORDINATION TIME
21 minutes

TEAM DISCUSSION TIME
19 minutes (multidisciplinary rounds)

FAMILY / CAREGIVER DISCUSSION TIME
16 minutes (daughter / healthcare proxy, 11:00 update)

CRITICAL CARE TIME
75 minutes of critical care time, exclusive of separately billable procedures

B BILLING CONSIDERATIONS

18 BILLING ELEMENTS

E/M LEVEL
Not applicable — critical care time billed

CRITICAL CARE TIME
99291 — first 30–74 minutes (75 min documented; 99292 not met)

CARE COORDINATION CODE(S)
Included within critical care time; not separately billed

PROCEDURE CODE(S)
36556 — central venous catheter insertion, age 5+ (right IJ resiting, planned today, to be documented separately with ultrasound guidance 76937)

BASIS FOR BILLING
Critical care — high-complexity decision making with organ-system failure and immediate interventions required; procedure billed separately with appropriate modifier

PRIMARY ICD-10
K65.0 Generalized (acute) peritonitis · A41.51 Sepsis due to Escherichia coli · R65.21 Severe sepsis with septic shock

SECONDARY ICD-10
J80 ARDS · N17.9 Acute kidney failure · Z99.2 Dependence on renal dialysis · I48.91 Unspecified atrial fibrillation · F05 Delirium due to known physiological condition · Z93.3 Colostomy status · E11.65 Type 2 diabetes with hyperglycemia · E43 Unspecified severe protein-calorie malnutrition · D69.6 Thrombocytopenia, unspecified · J96.01 Acute respiratory failure with hypoxia

SO SIGNATURE

PROVIDER NAME	CREDENTIALS	SIGNATURE	DATE	TIME
Idris N. Fontaine	MD, FCCM	Idris N. Fontaine	07/30/2026	08:56