**Nursing Care Plan Assignment**

**Case Study – Bacterial Pneumonia**

Linda Cerullo is a 56-year-old female who was brought to the hospital by ambulance on January 25, 2021. She presented to the emergency department and was diagnosed with left sided bacterial pneumonia. She has a history of iron deficiency, high cholesterol and hypertension. Past surgical history includes a caesarian section. She is taking ramipril 10mg PO, daily, atorvastatin 20 mg PO, daily and ferrous fumarate, 300 mg, PO BID. She has an IV of 2/3 & 1/3 running at TKVO in her left hand and is currently on IV ceftriaxone 1gm q24 hours plus Tylenol 1g, PO q6H prn for fever or pain. Linda is currently a secretary at a dental office. She lives at home with her husband and her adult daughter. She is Italian by birth and attends Roman Catholic mass weekly. At home the family speaks Italian but she is fluent in English. She is a full code status and has allergies to penicillin and vancomycin. Linda wears reading glasses.

Today is the second day of her admission and you are the nurse caring for her on the medical unit. Upon your assessment her vital signs are temp 38.9 degrees Celsius, pulse (radial) 99 beats/min, RR 24/min, BP 118/79 and O2 sat 92% on 2L of oxygen via nasal prongs. You use your stethoscope to auscultate her chest and note decreased breath sounds to the LLL. She has a productive cough still and complains of being short of breath frequently. You ask her to sit up in the bed and notice that she becomes increasingly short of breath with bed mobilization. There is evidence of accessory muscle use (abdominal breathing).

When asked if she has any pain the patient states “Yes I have pain when I breathe deeply or cough.” She rates her pain as 2/10 at rest and 6/10 when breathing deeply or coughing. You ask Linda when she first noticed the pain, “I first noticed the pain at 5am today”. Linda explains to you that she is feeling “unwell and tired”. She expresses frustration with her inability to sleep due to noise in the hallway at night. She also reports difficulty in getting into a comfortable position to rest as she normally sleeps on her side at home but gets very short of breath when lying down now. You notice she is short of breath during the interview. She can get no more than two words out before having to stop talking and rest.

You compare that to the blood pressure that the previous nurse had obtained overnight from the patient. Her blood pressure overnight was 99/69. You recognize that this was lower than normal and ask her if she gets dizzy or lightheaded. She tells you that she is not now but sometimes when she gets up suddenly she does get dizzy and lightheaded.

Linda also expresses frustration to you about being constipated, “I think I need some bran flakes. I haven’t had a bowel movement in 2 days”. She says that her medication makes her constipated but at home she is active and drinks more fluid to assist with this. Her abdomen does appear distended. You auscultate for bowel sounds and note that they are hypoactive in all 4 quadrants. You palpate all four of her abdominal quadrants and note they are slightly firm. She tells you that a month ago she was 135lbs but when came to the ER she was only 128 lbs. You ask her why she thinks she has lost weight and she says, “I haven’t eaten well since I started to get sick almost 2 weeks ago. I haven’t had an appetite and it takes a lot of effort to eat due to my shortness of breath.” Linda eats a low cholesterol, regular diet at home.

Her bloodwork showed a WBC is 16.2 and her CXR shows consolidation to the left lower lung.