

N311 Care Plan 1

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N311: Foundations of Professional Practice

Dowell/Henry

9/12/2025

Demographics

Date of Admission	Patient Initials	Age	Biological Gender
9/9/2025	MR	50	Male
Race/Ethnicity	Occupation	Marital Status	Allergies
White/Caucasian	Veteran/Unemployed	Widowed	NKA/NKDA
Code Status	Height	Weight	
Full code	5'8"	65kg	

Medical History

Past Medical History:

The patient was diagnosed with mitral valve prolapse and mitral regurgitation with systolic murmur in November of 2024, essential hypertension and depression in January of 2025 and post-traumatic stress disorder in April of 2025. The patient also has hepatic steatosis and pancreatitis as a result of prolonged alcohol abuse as well as sensorineural hearing loss from previous military service.

Past Surgical History:

The patient has previously had surgery on his right hand, eyes, and has had a vasectomy.

Family History:

The patient's maternal grandmother had diagnoses of cancer and osteoporosis, and his maternal grandfather has emphysema. His paternal grandfather has depression and heart disease. His mother and father have history of heart disease, with only his mother having a history of heart surgery as well.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

The patient has recently stopped using smokeless tobacco and has a history of smoking a pack-a-day for the last 23 years (23 pack-years). He is recovering from alcohol abuse with a former weekly intake of 106oz/wk. He also uses marijuana two to three times per week.

Education:

Not documented in chart.

Living Situation:

Not documented in chart but was noted as uncertain/high risk.

Assistive devices:

Hearing aid in L ear.

Admission Assessment

Chief Complaint:

The patient reported to the ER at the VA on 9/9/2025 complaining of abdominal pain and was quoted as saying “I got pancreatitis again” and “it feels like last time, but this is worse.”

History of Present Illness (HPI)– OLD CARTS:

The patient reports that the abdominal pain started on 9/7/2025 when he consumed one can of beer and has been persistent for the past 2 days. He states that he normally waits for the pain to resolve on its own but the pain he was experiencing was worse than normal and was not getting better. Pain was described as an 8/10, constant, sharp pain originating around the upper middle abdominal region reaching around his right side and lower back on the right. Associated symptoms include nausea and decreased oral intake for the past two days due to pain. No

relieving factors were documented. Treatment includes Q4H pain medication with additional pain management prescribed PRN.

Primary Diagnosis

Primary Diagnosis on Admission:

The patient was admitted with acute-on-chronic pancreatitis.

Secondary Diagnosis (if applicable):

The patient has a secondary diagnosis of abdominal pain.

Pathophysiology

Pathophysiology of the Disease, APA format:

Pancreatitis is an inflammatory disease affecting the pancreas where the digestive enzymes present in the pancreas start to damage the pancreas and surrounding area. Chronic pancreatitis is most common among those with alcohol use disorder and is only considered chronic after several instances over the patient's life, of which the patient is in recovery from alcohol addiction and has had at least four instances of pancreatitis in the past 12 months. Heavy consumption of alcohol increases the amount of digestive enzymes present in pancreatic cells as well as activating the digestive enzymes and proteins too early. Additionally, heavy alcohol use increases the protein content of pancreatic juice which leads to clumps of protein blocking the pancreatic duct or common bile duct. (Capriotti, 2024)

Clinical presentation of acute pancreatitis includes sudden and gradually increasing epigastric abdominal pain which radiates into the back and side, nausea, vomiting, anorexia, and

hypotension. Of which, the patient presented with all but hypotension and vomiting. Indicative lab values include hyperamylasemia of 10-20 times higher than reference range and elevated serum lipase around 48-72 hours after symptoms first appear, with the patient having both. Diagnosis is aided by noninvasive imaging such as abdominal ultrasound, Magnetic Resonance Cholangiopancreatography (MRCP), and CT scans. The patient had an abdominal ultrasound as well as a CT scan. (Szatmary, 2022).

Pathophysiology References (2) (APA):

- Capriotti, T. (2024). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives*. Philadelphia: F. A. Davis. Retrieved 09 12, 2025
- Szatmary, P. G. (2022). Acute Pancreatitis: Diagnosis and Treatment. *Drugs*, 1251-1276.

Vital Signs, 1 set – **HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen SAT	Oxygen Delivery Method
0805	89	126/80	18	98.1	97	RA

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0529	1-10 numeric	Abdomen	8/10	Constant, sharp	Pain medication, 1.5mg IV Hydromorphone IV Q4H