N311 Care Plan 3

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N311: Foundations of Professional Practice

Professor Dowell

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Demographics

Date of Admission	Client Initials	Age	Biological Gender
9/22/2025	PH	55 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Unemployed at this time, used to do robotic engineering	Single	No known allergies
Code Status	**Height**	**Weight**	
Full Code	5 ft 9 inch (175.3 cm)	94.3 kg (208 lbs.)	

Medical History

Past Medical History: Gastritis, pancreatitis

Past Surgical History: Colonoscopy (07/28/2023)

Family History: mother had hypertension, father had asthma

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient stated he does not use any tobacco, alcohol, or drug products. Upon looking in the chart, it states that he chews tobacco, is a current alcohol user, and does not have any drug use.

Education: High school and ITT degree

Living Situation: Patient lives at home with significant other

Assistive devices: glasses

Admission Assessment

Chief Complaint: Chest pain

History of Present Illness (HPI) – OLD CARTS: Patient states the onset of his pancreatitis was Monday (9/22/2025). Location is the upper middle of the abdomen. Patient states the duration is all day long. Patient states the characteristics are throbbing pain. Patient states that his pancreatitis was aggravated by him hiccupping or coughing. Patient states that he used

acetaminophen to relieve and treat his pain from his pancreatitis. Patient states his pancreatitis is not severe but becomes mild when hiccupping or coughing.

Primary Diagnosis

Primary Diagnosis on Admission: Pancreatitis

Secondary Diagnosis (if applicable): Gastrititis

Pathophysiology

According to Capriotti and Frizzell, pancreatitis is known as inflammation of the pancreas (Capriotti & Frizzell, 2023). Pancreatitis causes pancreatic deficit, inability to absorb nutrients from food, and diabetes (Capriotti & Frizzell, 2023). Pancreatitis is an acute or chronic disorder (Capriotti & Frizzell, 2023). In patients with acute pancreatitis, they have sudden and short occurrences of inflammation (Capriotti & Frizzell, 2023). Pancreatitis is mostly caused by biliary tract disease and alcohol abuse (Capriotti & Frizzell, 2023). In biliary tract disease, the main cause is blockage of the pancreatic duct by a gallstone that releases enzymes that get backed up (Capriotti & Frizzell, 2023). Alcohol pancreatitis causes accumulation of enzymes to be prematurely activated and released (Capriotti & Frizzell, 2023).

The main symptom seen in acute pancreatitis is severe abdominal pain that is sudden and increases, it's detailed as dull, penetrating, and steady (Capriotti & Frizzell, 2023). The pain is often seen in the epigastric region and extends to the back (Capriotti & Frizzell, 2023). This explains why the patient was experiencing chest pain upon admission (9/22/2025) and was then diagnosed with pancreatitis after running an ultrasound, MRI, x-ray scan, and ERG 12 lead. Some patients experience nausea, vomiting, and diarrhea with this diagnosis (Capriotti & Frizzell, 2023). During a physical examination, abdominal tenderness, guarding muscles, and

abdominal distention are commonly seen (Capriotti & Frizzell, 2023). During the physical examination, the patient experienced abdominal tenderness and abdominal distention, which explains his diagnosis.

With pancreatitis, blood work and noninvasive imaging is done to test for this diagnosis (Capriotti & Frizzell, 2023). Blood testing encompasses complete blood count, blood sugar concentration, blood urea nitrogen, serum calcium, lactic dehydrogenase, amylase, and lipase (Capriotti & Frizzell, 2023). Imaging entails abdominal and endoscopic ultrasound, CT scan, and magnetic resonance cholangiopancreatography (Capriotti & Frizzell, 2023). C-reactive protein (CRP) is mostly tested and procured in patients in the hospital (Capriotti & Frizzell, 2023). Levels of CRP that are higher than 190 mg/L in 48 hours of being admitted are pictured to have a severe illness (Capriotti & Frizzell, 2023).

According to Pagana et al., the main cause of increased serum lipase levels is acute pancreatitis (Pagana et al., 2025). Lipase is an enzyme that is produced by the pancreas that travels to the duodenum to disintegrate triglycerides into fatty acids (Pagana et al., 2025). With acute pancreatitis, lipase levels become elevated within multiple hours of when symptoms appear, they get worse for a day and continue to be elevated for as long as two weeks (Pagana et al., 2025). When lipoprotein lipase is decreased, triglycerides accumulate in multiple organs like the skin, bloodstream, muscles, liver, spleen, and brain (Pagana et al., 2025).

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J. P. (2023). *Pathophysiology: Introductory concepts and clinical perspectives.* (4th ed.). F.A. Davis Company.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic and laboratory test reference* (17th ed.). Mosby.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	139 mEq/L	131 mEq/L	136-145 mmol/L (Pagana et al., 2025)	Sodium could be abnormal due to deficient dietary intake (Pagana et al., 2025).
Potassium	3.5 mEq/L	3.4 mEq/L	3.5-5.0 mEq/L (Pagana et al., 2025)	Potassium could be abnormal due to deficient dietary intake (Pagana et al., 2025).
Chloride	102 mEq/L	98 mEq/L	98-106 mEq/L (Pagana et al., 2025)	Within normal levels
BUN	17 mg/dL	11 mg/dL	10-20 mg/dL (Pagana et al., 2025)	Within normal levels
Glucose	127 mg/dL	62 mg/dL	82-115 mg/dL (Pagana et al., 2025)	Glucose could be elevated upon admission due to his diagnosis of acute pancreatitis (Pagana et al.,

				2025). Glucose could be decreased due to being NPO for multiple days (Pagana et al., 2025).
Calcium	9.1 mg/dL	8.2 mg/dL	9.0-10.5 mg/dL (Pagana et al., 2025)	Calcium could be abnormal due to his diagnosis of pancreatitis (Pagana et al., 2025).
Albumin	4.1 g/dL	3.3 g/dL	3.5-5.0 g/dL (Pagana et al., 2025)	Albumin could be abnormal due to an acute reaction due to his pancreatitis (Pagana et al., 2025).
Total Proteins	7.2 g/dL	5.9 g/dL	6.4-8.3 g/dL (Pagana et al., 2025)	Total proteins could be abnormal due to his pancreatitis and the patient being NPO for multiple days before having diet changed this morning (9/25/2025) (Pagana et al., 2025).

Blood Creatinine	0.70 mg/dL	0.60 mg/dL	0.6-1.2 mg/dL in males (Pagana et al., 2025)	Within normal levels
Alkaline Phosphatase	95 units/L	73 units/L	30-120 units/L (Pagana et al., 2025)	Within normal levels
BUN/Creatinine Ratio	24 mg/dL	18 mg/dL	10-20 mg/dL (Pagana et al., 2025)	BUN/creatinine ratio could be abnormal upon admission due to hypovolemia (Pagana et al., 2025).
Anion Gap	11.0 mEq/L	7.0 mEq/L	12 ± 4 mEq/L (Pagana et al., 2025)	Within normal levels

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
Imaging miscellaneous scan (x-ray) An x-ray was done to detect ulcerations, tumors, inflammations, and physical improper positions of the stomach (Pagana et al., 2025).	Patient complained of severe abdominal pain	The x-ray showed there were signs of buildup of fluid in the lung's blood vessels (Pagana et al., 2025).
ECG 12 lead An electrocardiogram (ECG) is done to show unusual heart rhythms and to assist in diagnosing coronary artery build up, conduction defects, and enlarged ventricles of the heart (Pagana et al., 2025).	Patient complained of chest pain upon admission.	The electrocardiogram (ECG) showed no irregular heart rhythms and the ECG came back normal (Pagana et al., 2025).
MRCP WO/W contrast MRI A magnetic resonance imaging (MRI) is used to visualize and evaluate abdominal organs (Pagana et al., 2025).	Patient complained of severe abdominal pain.	After testing was done, the results showed inflammation in the groove between the pancreas and duodenum present (Pagana et al., 2025).

		Diagnosis includes underlying abnormal tissue growth, the complications are usually seen in adjoining inflammation of the lining of the stomach/ stomach ulcers, or a condition that starts unprompted (Pagana et al., 2025). The pancreas has shrunk with wide ducts, which suggests inflammation of the pancreas (Pagana et al., 2025). The chart stated that the gallbladder walls are thicker than normal and the main bile duct is wider than usual. There are no gallstones

		in the bile duct or abnormal widening of the bile ducts in the liver (Pagana et al., 2025).
Ultrasound abdomen complete To visualize gallbladder and pancreas An ultrasound of the abdomen is done to show visualization of the abdominal aorta, bile ducts, ureters, and abdominal organs (Pagana al et., 2025).	Patient complained of severe abdominal pain.	Upon looking at the chart, the results said the abdominal ultrasound showed an enlarged gallbladder and no visible hard deposits in the fluid of the gallbladder. Also, it stated that the sonographer noted Murphy's sign was not found. The results are ambiguous to inflammation of the gallbladder (Pagana et al., 2025). The chart stated that the common bile duct that goes

		through the head of the pancreas is a little enlarged. The chart stated that knowing this, common bile duct build up is not an idea driven out. The chart stated that more assessment of the abdomen and pancreas with a CT is suggested, and an enlarged spleen was noted.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic and laboratory test reference* (17th ed.). Mosby.

Assessment

Physical Exam – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

General, Psychosocial/Cultural, and TWO focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

GENERAL: **Alertness:**. Patient is alert to person, date, place, and time **Orientation:** Patient is oriented to name, date, place, and chief complaint. **Distress:** Patient shows no signs of distress. **Overall appearance:** Patient appears well groomed.	
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	.

CARDIOVASCULAR: **Heart sounds:** S1 and S2 were heard upon auscultation of the aortic, pulmonic, ERB's point, tricuspid, and apical pulses. The aortic, pulmonic, ERB's point, tricuspid, and apical pulse were normal rate and rhythm. **S1, S2, S3, S4, murmur etc.** S1 and S2 were auscultated and heard with normal rate and rhythm. No murmurs were noted upon auscultation. **Cardiac rhythm (if applicable): N/A** **Peripheral Pulses:** Bilateral dorsalis pedis pulses are 2+ with normal rhythm and rate. Bilateral posterior tibial pulses are 2+ with normal rhythm and rate. Bilateral popliteal pulses are 2+ with normal rhythm and rate. Bilateral femoral pulses are 2+ with normal rate and rhythm. Bilateral radial and ulnar pulses are 2+ with normal rate and rhythm. Bilateral brachial pulses are 2+ with normal rate and rhythm. Bilateral carotid pulses are 2+ with normal rate and rhythm. **Capillary refill:** Capillary refill in bilateral fingers and toes returns in less than two seconds. **Neck Vein Distention:** No neck vein distention is noted. **Edema:** No edema present on bilateral arms and legs. **Location of Edema:** No edema present on bilateral arms and legs.	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.

GASTROINTESTINAL: **Diet at home:** Low Carb Diet **Current Diet:** Clear Liquid Diet **Height:** 5 feet 9 inches (175.3 cm) **Weight:** 94.3 kg (208 lb) **Auscultation Bowel sounds:** Bowel sounds heard in all four quadrants. Normal tinkling sounds heard. No hyperactive or absent bowel sounds heard. **Last BM:** Monday morning (9/22/2025) **Palpation: Pain, Mass etc.:** No masses were noted upon palpation in all four quadrants. Patient stated pain along the middle of his abdomen down the four quadrants. Patient stated no pain upon palpating bilateral sides of abdomen **Inspection:** Upon inspection, the abdomen is pink, dry, and warm. **Distention:** Patient's abdomen is distended. **Incisions:** none **Scars:** none **Drains:** none **Wounds:** none **Ostomy:** None **Nasogastric:** None **Size:** N/A **Feeding tubes/PEG tube:** None **Type:** N/A	.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:**	

Pain with urination: Y ☐ N ☐ **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.
PSYCHOSOCIAL/CULTURAL:	

Coping method(s): Patient talks to family to cope with stress. **Developmental level:** Patient's developmental level is appropriate to age and educational level. **Religion & what it means to pt.:** Protestant, no religious **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient lives in his home with his wife in Williamsport, Indiana. Patient receives support from Veterans Affairs (VA).	

Fall Risk: Universal/Low (Not a Fall Risk)

Morse Fall Scale: 35

Braden Score: 19

Mobility Status: Up as tolerated (Independently)

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:30 AM	65 beats per minute	154/85	18 breaths per minute	97.6℉	97% Room Air

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
08:13 AM	4	Middle of chest	Not severe pain	pressure	Pain medications

Intake and Output

Intake (in mL)	Output (in mL)
1,000mL	200 mL

Nursing Diagnosis
Must be NANDA approved nursing diagnosis

Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components ● Listed in order by priority – highest priority to lowest priority pertinent to this client	Rationale ● Explain why the nursing diagnosis was chosen	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to pancreatitis. As evidenced by, patient stating pain in his chest and abdominal areas. (Phelps, 2023).	I picked this nursing diagnosis because the patient is experiencing pain that has lasted less than 3 months.	**1.** Assess patient's signs and symptoms of pain behavioral cues and administer pain medication as prescribed. Monitor and record the medication's effectiveness and adverse effects (Phelps, 2023).	**1.** Patient will decrease the amount and frequency of pain medication needed before the day of discharge (Phelps, 2023).	I would evaluate the patient for acute pain by using the numerical rating scale (NRS) to evaluate his pain level upon discharge.

		2. Perform comfort measures to promote relaxation, such as massage, bathing, repositioning, and relaxation techniques (Phelps, 2023).		
2. Risk for electrolyte imbalance related to insufficient fluid volume. As evidenced by the patient having some abnormal labs (Phelps, 2023).	I picked this nursing diagnosis because some of the patient's electrolytes were abnormal.	**1.** Assess the patient's fluid status (Phelps, 2023). **2.** Monitor patient for physical signs of electrolyte imbalance (Phelps, 2023).	**1.** The patient will maintain electrolyte levels within normal limits upon discharge (Phelps, 2023).	I would evaluate the patient for risk of electrolyte imbalance by doing a complete blood work on discharge date.

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.