N311 Care Plan 4

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Lakeview College of Nursing

N311: Foundations of Professional Practice

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Demographics

Date of Admission 9-30-2025	**Client Initials** LM	**Age** 37 years-old	**Biological Gender** Male
Race/Ethnicity African American	**Occupation** Construction	**Marital Status** Single	**Allergies** No known allergies
Code Status Full	**Height** 180.3 cm	**Weight** 122 lbs. 9.6 oz	

Medical History

Past Medical History:

- History of pancreatitis
- Hypertension

Past Surgical History: No surgical history

Family History: No family history

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

- Smokes 5 to 6 cigarettes a day for the past 10 years
- Marijuana user
- Patient drinks 12.6 ounces of alcohol per week
- No smokeless tobacco
- No vaping

Education: High school diploma

Living Situation: Lives in Danville IL with his little brother

Assistive devices: No assistive devices used

Admission Assessment

Chief Complaint: Abdominal pain

History of Present Illness (HPI) – OLD CARTS:

Patient presented to the emergency department for abdominal pain that started three to four days from date of admission. Patient stated that the pain is still going on as of 10/02/2025. Patient has diffused abdominal pain. Patient described the pain as a sharp pain. Patient stated that some movements that he makes will make the pain worse. Patient said that the only thing that helps the pain is pain medication. Patient did not do anything at home to treat the pain, and the severity of the pain is a 10 on a scale from zero to ten.

Primary Diagnosis

Primary Diagnosis on Admission: Acute pancreatitis

Secondary Diagnosis (if applicable): No secondary diagnosis

Pathophysiology

Pathophysiology of the Disease, APA format:

Acute pancreatitis can be a mild organ disfunction to life-threatening (Capriotti, 2024). When the pancreas is functioning correctly it keeps digestive enzymes from causing injury and destroying the gland (Capriotti, 2024). When it is not working properly it will undergo inflammation and cellular injury due to the leakage of activated pancreatic digestive enzymes in the glandular parenchyma (Capriotti, 2024). The destruction of the glad can range from mild to severe. The severe forms of the disease include necrotizing and hemorrhagic pancreatitis (Capriotti, 2024). Even though the glandular tissue takes a hard hit, the disorder can be reversible and there is a chance for complete resolution (Capriotti, 2024). In the United States between 110 and 140 persons per 100,000 visit the emergency department each year because of acute pancreatitis. Pancreatitis is known to affect males more than females and is also more common in African Americans (Capriotti, 2024). One-fifth of patients end up developing a severe case with a mortality rate of about 20% (Capriotti, 2024). When it comes to pancreatitis the most common causes are biliary tract disease and alcohol use disorder (Capriotti, 2024). The causative factor for biliary tract disease is obstruction of the pancreatic duct, which could be by gallstones or other reasons (Capriotti, 2024). In alcohol-related pancreatitis, ethanol causes intracellular accumulation of digestive enzymes and the premature activation and release (Capriotti, 2024). 5% of abdominal trauma causes clinical pancreatitis, and it occurs more often in penetrating injuries, such as knives and bullets, than with blunt abdominal trauma (Capriotti, 2024). Another thing that can cause pancreatis is several infectious diseases especially when it comes to children. (Capriotti, 2024). When it comes to medication there are up to 500 of them that have pancreatitis as a potential side effect (Capriotti, 2024). With a patient that has pancreatitis you

will want to “Assess patient’s signs and symptoms of pain behavioral cues and administer pain medication as prescribed” (Phelps, 2023). My patients presented to the emergency department for abdominal pain and had nausea going one. With his history of pancreatitis, they ordered a CT scan which revealed that he had inflammation changes to the peripancreatic fat. These changes are a sign of acute pancreatitis. The changes that were seen on the CT scan were what lead to the primary diagnosis and admission of the patient.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

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

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today’s Value	Normal Range	Reasons for Abnormal
Sodium	131	138	136-145mmol/L	Could be abnormal due to a fluid and electrolyte because of the inflammation caused by pancreatitis. From admission day 9/30/2025 to 10/2/2025 the sodium started out low but is trending back up to normal. Which could be a response

				to treatment of the acute pancreatitis.
Potassium	3.3	3.6	3.5-5.1mmol/L	Could be abnormal due to vomiting because of pancreatitis. From admission day 9/30/25 to 10/02/25 the potassium started out low and is trending back up. Which could be due to the patient's body responding to treatment.
Chloride	93	97	98-107mmol/L	Could be abnormal due to fluid loss from vomiting because of pancreatitis. From admission day 9/30/25 to 10/02/25 the chloride started out low and is trending back up. Which could be due to the patient's body responding to treat meant.
CO2	29	33	22-30mmol/L	Could be abnormal due to

				the inflammation and chemicals being released because of pancreatitis. From admission day 9/30/25 to 10/02/25 the C02 started out low and is trending back up. Which could be due to the patient's body responding to treatment.
Bun	7	<3	9-21mg/dL	Could be abnormal due to dehydration because of pancreatitis. From admission day 9/30/25 to 10/02/25 the BUN started out low and is trending down. Which could be due to the patient not getting enough fluids.
Glucose	129	109	77-90mg/dL	Could be abnormal due to the inflammation caused by pancreatitis. From admission day 9/30/25 to

				10/02/25 the glucose started high and is trending back down. Which could be due to the patient's body responding to treat meant. Also, could be due to the patient being on an all-liquid diet and not being able to eat.
Calcium	8.6	8.7	8.7-10.5mg/dL	Could be abnormal due to the inflammation that is caused by pancreatitis. From admission day 9/30/25 to 10/02/25 the calcium started out low and is trending back up. Which could be due to the patient's body responding to treatment.
Magnesium Serum	1.5	1.5	1.6-2.6mg/dL	Could be abnormal due to vomiting because of pancreatitis. From admission day 9/30/25 to

				10/02/25 the magnesium serum started out low and stayed the same. Which could be due to patient not really intaking anything due to the pain.
Total Protein	6.5	5.9	6.0-8.0mg/dL	Could be abnormal due to malabsorption of protein from impaired digestion and absorption because of pancreatitis. From admission day 9/30/25 to 10/02/25 the total protein started out normal and is trending down. Which could be due to the patient's body not being in a normal state due to pancreatitis.
Albumin	3.5	3.2	3.5-5.0	Could be abnormal due to inflammation, fluid shifts or malnutrition because of pancreatitis. From

				admission day 9/30/25 to 10/02/25 the albumin started normal and is trending down. Which could be due to the patient not being able to get all the nutrition that he needs.
RBC	3.95	3.69	4.40-5.80 10(6)/mcL	Could be abnormal because patient is border line anemic and isn't taking his medication folic acid like, he should. From admission day 9/30/25 to 10/02/25 the RBC started out low and is trending down. Which could be due to the patient not taking the folic acid he was prescribed like he should.
Hemoglobin	13.1	12.1	13.0-16.5g/dL	Could be abnormal due to the patient being border line anemic and not talking their medication as they

				should. From admission day 9/30/25 to 10/02/25 the hemoglobin started out normal and is trending down. Which could be due to the patient not taking the folic acid that he was prescribed like he should.
Hematocrit	35.2	33.2	38.0-50.5%	Could be abnormal due to the patient being border line anemic. From admission day 9/30/25 to 10/02/25 the hematocrit started out normal and is trending down. Which could be due to the patient not taking the folic acid that was prescribed to him like he should.
MCH	33.2	32.8	26.0-32.0pg	Could be abnormal due to the patient being border line anemic or due to the inflammation caused by the

				pancreatitis. From admission day 9/30/25 to 10/02/25 the MCH started high and is trending back down. Which could be due to the patient's body responding to treatment.
MCHC	37.2	36.4	31.0-36.0g/dL	Could be abnormal due to dehydration because of pancreatitis. From admission day 9/30/25 to 10/02/25 the MCHC started normal and is trending up. Which could be due to the being dehydrated from not wanting to drink because of the pain.
Platelet count	148	130	140-440 10(3)/mcL	Could be abnormal due to the inflammation that is caused by pancreatitis. From admission day 9/30/25 to 10/02/25 the platelet count started out

				normal and is trending down. Which could be due to the inflammation that is still going on in the patient's body.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
CT w/contrast	pain and nausea	Patient had a CT done which showed inflammatory changes in the peripancreatic fat, which is consistent with acute pancreatitis.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's Diagnostic & Laboratory Test Reference*. Elsevier.

Current Medications

Brand/Generic	Protonix (Pantoprazole)	Norvasc (Amlodipine)	Folic acid	Prinivil (Lisinopril)	Miralax (Polyethylene glycol)
Dosage, Route, Frequency given	40mg tablet, taken once daily, orally	10mg tablet, taken once daily, orally	1 mg tablet, taken once daily, orally	40 mg tablet, taken once daily, orally	17 g packet, 1 packet twice daily as needed, orally
Reason Client Taking	Patient taking for esophagus inflammation	Patient is taking to control hypertension	Patient is taking to help prevent anemia	Patient is taking to help control hypertension	Patient is taking to help with constipation

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 what is going on. **Orientation:** Patient is orientated to person, place, time and situation. **Distress:** Patient's respirations are not elevated, and patient is sitting calmly. Patient is not in distress. **Overall appearance:** Patient is well groomed.	
INTEGUMENTARY: **Skin color:** N/A	

Character: N/A **Temperature:** N/A **Turgor:** N/A **Rashes:** Patient has no rashes **Bruises:** Patient has no bruises **Wounds:** Patient has no wounds **Braden Score:** Patients Braden score is 19. **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	.
CARDIOVASCULAR: **Heart sounds:** Clear S1 and S2 without murmurs, gallops or rubs. **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Patients has a normal rhythm. **Peripheral Pulses:** Carotid pulses bilaterally are +2 and strong Brachial pulses bilaterally are +2 and strong Radial pulses bilaterally are +2 and strong Popliteal pulses bilaterally are +2 and strong Posterior tibial pulses bilaterally are +2 and strong Dorsalis pedis pulses bilaterally are +2 and strong	.

Capillary refill: Capillary refill is less than 3 seconds bilaterally on toes and feet. **Neck Vein Distention: Y ☐ N ☒ Edema Y ☐ N ☒** **Location of Edema:**	
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.
GASTROINTESTINAL: **Diet at home:** Patient follows a regular diet at home **Current Diet:** Patient's current diet is full liquid. **Height:** 180.3 cm **Weight:** 122lbs 9.6oz **Auscultation Bowel sounds:** Patients bowel sounds are faint but can be heard in all four quadrants **Last BM:** Three days ago from 10/02/2025 **Palpation: Pain, Mass etc.:** Diffused abdominal tenderness. **Inspection:** **Distention:** Patient has no distention. **Incisions:** Patient has no incisions. **Scars:** Patient has no scars. **Drains:** Patient has no drains. **Wounds:** Patient has no wounds. **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:**	.

Feeding tubes/PEG tube Y ☐ N ☒ **Type:**	
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: N/A** **ROM:** Patient has full range of motion **Supportive devices:** Patient uses no supportive devices **Strength: N/A** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** Fall score of 20 due to IV running. **Activity/Mobility Status:** **Independent (up ad lib) ☐x** **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 states that he copes by listening to music, watching funny movies or going on a walk. **Developmental level:** Normal physical and psychosocial development for a 37-year-old male. **Religion & what it means to pt.:** Patient stated that he does not have a religion. **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient stated that he is very supported by his family.	.

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	56 bpm	152/104 mmHg	16 RR	98.1 ˚F	98%

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0730	0-10	Stomach	10	Sharp	Pain medications

Intake and Output

Intake (in mL)	Output (in mL)
Breakfast-(clear liquid diet)- 290mL	Urination X 2 (Patient was independent and output was not being measured)

Nursing Diagnosis

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications

order by priority – highest priority to lowest priority pertinent to this client				to plan.
1. Acute pain related to a chemical injury agent as evidenced by patient drinking 12.6 ounces of alcohol per week.	Chosen because patient is complaining of his pain being 10 on a scale from 0 to 10.	**1.** Assess patient's signs and symptoms of pain behavioral cues and administer pain medication as prescribed. **2.** Demonstrate acceptance when patient reveals pain.	**1.** Patient will express relief within 30 minutes after being given pain medication.	Patient reports achieving pain relief with analgesia or other measures.
2. Risk for infection related to dysfunctional gastrointestinal motility as evidenced by inflammation in the stomach.	Chosen because patient has inflammation going on due to acute pancreatitis.	**1.** Monitor WBC count as ordered and report any elevations or depressions. **2.** Ensure adequate nutritional intake.	**1.** Patient will intake at least 600mL per shift of nutritional liquids.	Patient's WBC count and differential remain within normal range.

Other References (APA):

2025 NDH: Nurse's Drug Handbook. (2024b). Jones & Bartlett Learning.

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