N431 Care Plan # 3

Lakeview College of Nursing

Shawna Stewart

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11/10/19	J. Y.	88 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired Contractor	Married	Fenofibrate
Code Status	**Height**	**Weight**	
Full Code	5'6" (66 inches)	200 lbs. (90.7 kg)	

Medical History (5 Points)

Past Medical History:

-Parkinson's Disease -Obesity -Hyperlipidemia

-GERD -Diabetes Mellitus -Cataract

-TIA -CAD

Past Surgical History:

-Cataract surgery (4/2017) -Thyroid surgery

-PTCA/Stent

Family History: Not on file

Social History (tobacco/alcohol/drugs):

The patient currently does not consume alcohol or use tobacco products. States he quit smoking years ago. States he has never used drugs.

Assistive Devices: The patient ambulates with the aid of a cane at home.

Living Situation: Lives in Arthur with his wife of 60 years in a single story home.

Education Level: Graduated from high school and owned his own construction company.

Admission Assessment

Chief Complaint (2 points): Shortness of breath, Altered Mental Status

History of present Illness (10 points): The patient presented to the ED with complaints of a headache, urinary frequency, dysuria, and lower abdominal discomfort that started within the last week. Recently, the patient started taking a new prescription for Tramadol 200mg SR tablets. Since starting Tramadol the patient has experienced an unsteady gait, slow response, slurred speech, snoring/loud breathing at night, and generalized weakness. No significant abnormal labs noted. UA did test positive for bacteria and esterase. The patient was given a dose of ceftriaxone in the emergency department.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI w/o hematuria, AMS, Hypertension

Secondary Diagnosis (if applicable): None

Pathophysiology of the Disease, APA format (20 points): Urinary tract infections (UTIs) are caused by pathogenic microorganisms in the urinary tract (Hinkle & Cheever, 2018). UTIs are generally classified as infections involving the upper or lower urinary tract, although upper UTIs are much less common. Cystitis is an infection of the bladder and the most common bacterial infection. In order for the infection to occur, the bacteria attaches to the epithelium and begins to colonize, then initiates inflammation. UTIs are the most common infections in older adults (Hinkle & Cheever, 2018). Diabetes Mellitus, familial predisposition, obstruction, neurogenic bladder and the use of spermicides and diaphragms have been associated with the increased risk of developing cystitis.

Signs and symptoms of a UTI depend on whether the infection occurs in the lower or upper urinary tract. Signs of a lower urinary tract infection include burning with urination, urinary frequency (voiding more than every 3 hours), urgency, nocturia (awakening at night to urinate),

incontinence, and suprapubic or pelvic pain. Hematuria and back pain may also be present. Older adults may also develop a fever and delirium with the onset of a UTI. Diagnosis testing is usually by lab work such as, bacterial colony counts, cellular studies, and urine cultures. A urine culture identifies the specific bacteria present which determines the antibiotic of choice for treatment. This patient presented to the emergency room complaining of a headache and dysuria. His spouse also mentioned that he has had an increase in confusion and unsteady gait recently. He did show signs of altered mental status and generalized weakness.

Lab testing revealed an elevated neutrophil level which indicates the presence of infection, although the decreased lymphocytes indicates a viral infection present. The WBC although slightly elevated, was not out of normal range. The patient also had a urine culture which indicated the presence of bacteria and esterase. The patient was given a dose of ceftriaxone while in the emergency room. The patient was then admitted for observation and to rule out influenza. Further testing for influenza A & B were presumptive negative.

Pathophysiology References (2) (APA):

Hinke, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th.ed.). Philadelphia, PA: Wolters Kluwer

Sorenson, M., Quinn, L., & Klein, D. (2019). *Pathophysiology: Concepts of Human Disease* (1st.ed.). Philadelphia, PA

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40-5.80 10(6)/mcL	4.25	3.86	May be decreased due to anemia
Hgb	13.0-16.5 g/dL	13.6	12.6	May be decreased due to anemia
Hct	38.0-50.0%	39.4	36.1	May be decreased due to anemia
Platelets	140-440 10(3)/mcL	190	174	
WBC	4.00-12.00 10(3)/mcL	6.30	4.80	
Neutrophils	40.0-68.0%	68.6	53.3	Admission level could indicate infection.
Lymphocytes	19.0-49.0%	18.7	30.8	Admission level could indicate viral infection.
Monocytes	3.0-13.0%	9.9	10.7	
Eosinophils	0.0-8.0%	2.3	4.2	
Bands	0.0-1.0%	0.5	1.0	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today’ s Value	Reason For Abnormal
Na-	133-144 mmol/L	136	139	
K+	3.5-5.1 mmol/L	3.8	3.9	
Cl-	98-107 mmol/L	99	103	
CO2	21-31 mmol/L	30	28	
Glucose	70-99 mg/dL	112	114	The patient currently has diabetes mellitus.
BUN	7-25 mg/dL	18	14	

Creatinine	0.50-1.20 mg/dL	0.98	1.02	
Albumin	3.5-5.7 g/dL	4.2	NA	
Calcium	8.6-10.3 Mg/dL	9.1	8.6	
Mag	1.6-2.6 mg/dL	NA	NA	
Phosphate	2.5-4.5 mg/dL	NA	NA	
Bilirubin	0.2-0.8 mg/dL	0.6	NA	
Alk Phos	34-104 u/L	61	NA	
AST	13-39 u/L	12	NA	
ALT	7-52 u/L	11	NA	
Amylase	23-85 u/L	NA	NA	
Lipase	11-82 u/L	NA	NA	
Lactic Acid	0.5-2.0 mmol/L	0.9	NA	
Troponin	0.000-0.040 ng/mL	<0.030	NA	
CK-MB	3.0-5.0%	NA	NA	
Total CK	5-25 iu/L	NA	NA	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.9-1.1	1.1	NA	
PT	10.1-13.1 Seconds	12.6	NA	
PTT	25-36	32	NA	

	Seconds			
D-Dimer	<0.50	NA	NA	
BNP	0-100 pg/mL	90	NA	
HDL	40-110 mg/dL	32	NA	
LDL	<100 mg/dL	59	NA	
Cholesterol	<200 mg/dL	117	NA	
Triglycerides	0-150 mg/dL	115	NA	
Hgb A1c	4.8-5.6%	6.7	NA	Elevated due to diabetes
TSH	0.4-4.0 u/L	NA	NA	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal**
Color & Clarity	Yellow	Yellow	NA	
pH	5.0-9.0	7.0	NA	
Specific Gravity	1.003-1.030	1.011	NA	
Glucose	Negative	Neg	NA	
Protein	Negative	Neg	NA	
Ketones	Negative	Neg	NA	
WBC	Neg 0-5/hpf	0-5	NA	
RBC	Neg 0-2/hpf	Neg	NA	
Leukoesterase	NA	NA	NA	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	NA	NA	
PaO2	85-105 mmHg	NA	NA	
PaCO2	35-45 mmHg	NA	NA	
HCO3	22-26 mmol/L	NA	NA	
SaO2	95-98%	NA	NA	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	NA	NA	NA	
Blood Culture	NA	NA	NA	
Sputum Culture	NA	NA	NA	
Stool Culture	NA	NA	NA	

Lab Correlations Reference (APA):

Van Leeuwen, A. M., Poelhuis-Leth, O. J., & Bladh, M. L. (2013). Davis's Comprehensive Handbook of Laboratory & Diagnostic Tests with Nursing Implications (5th.ed.). Philadelphia, PA: F. A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

-CXR, single view for the shortness of breath.

Impression: No infiltrates or signs of pulmonary edema.

-CT Head w/o contrast for headache

Impression: No intracranial bleed, no mass lesion, no mass effect identified. The ventricles, cisterns and sulci are appropriate for age of patient. Few sections through the orbits and paranasal sinus reveal no abnormalities.

Diagnostic Test Correlation (5 points): The chest x-ray was done due to the patient's complaint of shortness of breath. The x-ray ruled out the possibility of pneumonia. The head CT was performed to rule out stroke due to the slurred speech and confusion the patient presented with.

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., Poelhuis-Leth, O. J., & Bladh, M. L. (2013). Davis's Comprehensive Handbook of Laboratory & Diagnostic Tests with Nursing Implications (5th.ed.). Philadelphia, PA: F. A. Davis Company

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Symmetrel (amantadine)	Sinemet (carbidopa-Levodopa)	Xarelto (rivaroxaban)	Ultram (Tramadol)	Glucophage (metformin)
Dose	100 mg	25-100mg	20 mg	200 mg SR 24 hr	850 mg
Frequency	BID	QID	Daily	Daily	Daily

Route	PO	PO	PO	PO	PO
Classification	Anti-viral	Anti-Parkinsonian	Anti-coagulants	Analgesic	Anti-diabetic
Mechanism of Action	May exert its anti-parkinsonian effect by causing the release of dopamine in the substantia nigra	Levodopa, a dopamine precursor relieves Parkinson by being converted to dopamine in the brain. Carbidopa inhibits the decarboxylation of peripheral levodopa allowing more levodopa to travel to the brain.	Selectively blocks the active site of factor Xa, which is necessary for coagulation	Unknown. Thought to bind to opioid receptors and inhibit reuptake of norephinephrine and serotonin	Decreases hepatic glucose production and intestinal absorption of glucose and improves insulin sensitivity (increase peripheral glucose uptake and use)
Reason Client Taking	Parkinson's disease	Parkinson's disease	Stroke/ embolism risk reduction	Back pain	Diabetes mellitus
Contraindications (2)	-Hypersensitivity -ESRD	-hyper-sensitivity -within 14 days of MAO inhibitor	-hyper-sensitivity -prosthetic heart valves	-Hyper-sensitivity -GI obstruction	-hyper-sensitivity -Type 1 diabetes or diabetic ketoacidosis
Side Effects/Adverse Reactions (2)	-headache -confusion	-Nausea, confusion, headache, peripheral neuropathy	-bleeding events -syncope	-dizziness -constipation	-dizziness -hypoglycemia
Nursing Considerations (2)	-elderly patients may be more susceptible to adverse neurologic	-determine optimum daily dose by careful titration in each patient.	Monitor for s/sx. of neurologic impairment. Monitor carefully for	Reassess patient's level of pain at least 30 min after administratio	Assess patient's renal function annually -Monitor

	effects. -Monitor for mental status changes	-hallucinations may require reduction or withdrawal of drug	bleeding.	n. -monitor cardiovascular and respiratory status	glucose levels regularly
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Renal function test & LFTs		Coagulant labs	Assess pain	Blood glucose monitoring
Client Teaching needs (2)	-if dizziness occurs, change position slowly. -Avoid alcohol while taking this drug.	-take with food to minimize GI effects. -Perform skin checks regularly.	-Watch for bleeding risks. -Take drug as directed and not to discontinue without consulting MD.	Take as prescribed. -Check with provider before taking OTC drugs due to interactions.	-Do not consume excessive alcohol while taking drug. -Carry medical identification at all times.

Hospital Medications (5 required)

Brand/Generic	Synthroid (levothyroxine)	Zestril (Lisinopril)	Humulin R (regular insulin)	Aspirin	Lasix (furosemide)
Dose	137 mcg	10 mg	2-12 units	325 mg	20 mg
Frequency	Daily	Daily	TID before meals	Daily	Daily
Route	PO	PO	Subcut	PO	PO
Classification	Thyroid hormone	Anti-hypertensive	Anti-diabetic	NSAID	Anti-hypertensive

					Loop diuretic
Mechanism of Action	Not completely defined, stimulates metabolism of all body tissues by accelerating rate of cellular oxidation.	Causes decreased production of angiotensin II and suppression of the RAAS	Lowers blood glucose level by stimulating peripheral glucose uptake by binding to insulin receptors on skeletal muscles.	Appears to interfere with clotting by keeping platelet-aggregating substance from forming.	Inhibits sodium and chloride reabsorption at the proximal and distal tubules and the ascending loop of henle.
Reason Client Taking	Hypo-thyroidism	HTN	DM	Reduce risk of recurrent TIA or stroke	HTN/ Edema
Contraindications (2)	-hyper-sensitivity. -use cautiously in patients with diabetes mellitus.	-hyper-sensitivity -impaired renal function	-Hypo-glycemia -hyper-sensitivity	-hyper-sensitivity -severe hepatic impairment	-hyper-sensitivity -hepatic cirrhosis
Side Effects/Adverse Reactions (2)	-headache -heat intolerance	-dizziness -headache	-hypo-glycemia -peripheral edema	-confusion -dizziness	-hypotension -dizziness
Nursing Considerations (2)	-observe carefully for coronary insufficiency in CAD pts. DM pts may need increase antidiabetic medication.	Monitor BP frequently. -Monitor WBC w/diff periodically	Monitor blood glucose levels. Monitor for s/sx of hypoglycemia	Monitor elderly pts more closely b/c they may be more susceptible to toxic effects. Monitor for hyper-sensitivity reactions	Monitor weight, BP and pulse rate routinely. -monitor fluid intake and output
Key Nursing Assessment(s)/Lab(s) Prior to	Thyroid hormone level	Assess BP and pulse	Frequent glucose monitoring.	Monitor platelet labs	Assess BP and pulse. Monitor

Administration	routinely		HgA1C monitoring		potassium and magnesium labs.
Client Teaching needs (2)	-take same time every day. -replacement therapy life long therapy	-light headedness can occur, change position slowly. -Do not use salt substitutes.	-Eat within 30 minutes of administration. -Rotate injection sites.	-Avoid aspirin if allergy to tartrazine. -take with food, milk, antacid or water to avoid GI upset.	Take in morning to prevent need to urinate at night. -may need potassium and magnesium supplement.

Medications Reference (APA):

Albanese, M., & Wilson, M. (2018). *Nurse's Drug Handbook.* (17th.ed.). Burlington, MA: Jones & Bartlett learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:**	Alert and oriented x3. No distress noted. General appearance is of a well-groomed adult male.

Distress: **Overall appearance:**	
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 18 **Drains present: Y☐ N ☒** **Type:**	Skin intact, dry, warm to touch. Skin turgor rapid recoil. No rash, bruises, lesions or open areas noted. No drains present. Braden scale 18.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and ears symmetrical. Pina rapid recoil, no discharge noted. Eyes PERLA, sclera white. No discharge noted. Nose midline, no septum deviation noted. Mouth and teeth moist, uvula midline. No sores present in mouth.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	S1, S2 audible with no murmur or gallop noted. Regular rhythm noted. Peripheral pulses palpated. Capillary refill <3 seconds. No neck vein distention. Mild edema noted to BLe.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Lung sounds clear, no cough noted. Respirations even and non-labored. No use of accessory muscles noted.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:**	Bowel sounds active in all quads. Continent of bowel with assistance for personal hygiene. Last BM 11/11/19. No pain or mass noted to abdomen. Patient is 5'6" and weighs 200 lbs. Patient is on regular diabetic diet same as at home. Able to consume food orally with no assistance from staff.

Drains: **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Continent of bladder with assistance to use urinal. Urine yellow, no odor noted. Voided 150 mL. No pain associated with urination. No catheter in place.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 21 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	MAE x4. Up with 1 assist using gait belt and personal cane. Gait slow but steady. Equal strength. Does require some assistance with hygiene. The patient is considered a fall risk, score of 21.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is alert and oriented x3, speech clear. Eyes PERLA. MAE x4. Equal grip strength bilaterally. Patient was awake during exam.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	Patient lives in Arthur with wife. Has 4 grown children, as well. Patient is retired contractor who owned his own business for years. Patient and spouse active in church. States they live in a small community where everybody helps their

Personal/Family Data (Think about home environment, family structure, and available family support):	neighbor and their children also help out when needed.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	70	148/80	18	97.5 or	95% RA BS 114
1100	79	148/76	18	97.4 or	96% RA BS 110

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	NA	No pain	NA	NA
1100	Numeric	NA	No pain	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The patient has a 20g. saline lock in the LAC. The date on the IV is 11/10/19, infusing when used. No signs of erythema, drainage or infiltration.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

480mL	150ml Void x1.

Nursing Care

Summary of Care (2 points)

Overview of care: Introduced myself to patient. Asked patient if he would like a bath to get cleaned up. Wife refused stating patient was going to be going home later that day. Was able to perform assessment of patient.

Procedures/testing done: The patient was not scheduled to have any testing done this day. Was looking forward to discharge before snow storm came.

Complaints/Issues: The patient had no complaints during this day.

Vital signs (stable/unstable): Vital signs remained stable. Patient denied pain when asked.

Tolerating diet, activity, etc.: The patient's diet was regular, similar to home diet. Activity was as tolerated. Was able to ambulate with assistance.

Physician notifications: Physician came by for rounds. Informed patient she would discharge patient that day.

Future plans for patient: Patient was to be discharge later with wife.

Discharge Planning (2 points)

Discharge location: The patient would discharge home.

Home health needs (if applicable): Did not need any services at home according to wife.

Equipment needs (if applicable): Has cane used for ambulation and also has other equipment to help at home.

Follow up plan: Will follow up with primary care physician with a week.

Education needs: Discuss with PCP concerns the patient and wife have concerning new medication.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for falls related to unsteady gait occurring with bradykinesia, tremors, rigidity and postural instability as evidence by shuffling gait when ambulating.	Due to the Parkinson's disease the patient's safety is jeopardized.	**1.** Remind the patient repeatedly to maintain an upright posture and look up, not down, especially when walking. **2.** Encourage patient not to hurry or rush.	The patient was able to remain upright while ambulating. The patient had a slow but steady gait.
Acute pain: dysuria related to inflammation process in bladder as evidence by the patient's claim of dysuria.	If the patient is experiencing pain during urination he may not want to urinate when needed.	**1.** Assess for pain routinely. Treat pain in a comprehensive manner.	The patient had no complaints of pain. Pain was treated when complaints were made.
Risk for infection related to impaired healing as evidence by	Risk of UTIs and other infections increase with	**1.** Encourage fluid intake.	The patient drank plenty of fluids.

diabetes mellitus disease and infectious process.	diabetes mellitus.	**2** Recommend responsible use of antibiotics; use antibiotic sparingly.	Antibiotic therapy was discontinued when infection result was viral.
Acute confusion related to UTI as evidence by family's statement of increased confusion recently.	The patient did appear confused at times. Wife answered majority of questions when asked.	**1.** Treat the underlying risk factors or causes of delirium. **2.** Conduct a medication review and eliminate unnecessary medications.	The patient was under observation for the night. The patient's wife is going to discuss the new medication patient received with his PCP.

Other References (APA):

Ackley, B. J. & Ladwig, G. B. (2014). *Nursing Diagnosis Handbook: An Evidence-Based Guide To Planning Care* (10th.ed.). Maryland Heights, MI: Elsevier

Concept Map (20 Points):

N431 Care Plan

Subjective Data

-Complaints of headache
-Urinary frequency
-Dysuria
-Lower abdominal pain

Nursing Diagnosis/Outcomes

-Acute confusion related to urinary tract infection as evidenced by wife's statement of recently increased confusion.

*The patient will demonstrate restoration of cognitive status to baseline.

-Acute pain: dysuria related to inflammation process in the bladder as evidenced by complaints of dysuria.

*The patient will report that pain management regimen achieves comfort-function goals without side effects.

Objective Data

-Unsteady gait
-Slow response
-Slurred speech
-Positive UA for bacteria and esterase

Patient Information

The patient presented to the ED with complaints of headache, urinary frequency, and dysuria. His wife stated that he has had an increase in confusion and slurred speech, along with an unsteady gait.

Nursing Interventions

-Treat underlying risk factors or causes of delirium.
-Conduct a medication review and eliminate unnecessary medications.

-Assess for presence of pain routinely.
-Treat pain in a comprehensive manner.

N431 Care Plan

N431 Care Plan