

# Nursing care plan

# NURSING CARE PLAN TEMPLATE

## NURS 101L, NURS 210L-AB, NURS 211L, NURS 316L, NURS 317L

Student \_\_\_\_\_

Date 5/11/2021

Instructor \_\_\_\_\_

Course N101

Patient Initial Janis Jordon Unit/Room # \_\_\_\_\_

Age/gender 78/F

Code Status \_\_\_\_\_ Full code

Height/Weight 170cm/71kg

Allergies NKA (No known allergies)

Time	Temp (C/F Site)	Pulse (Site)	Respiration	Pulse OX (O.Sat)	Pulse OX (O.Sat)	Pulse OX (O.Sat)
0500	37.4°C/99.4°F (Temporal)	96 bpm (Radial)	24 breaths/min.	91% (on room air)	136/76	Numeric
0700	37.2°C/99.0°F (Temporal)	88 bpm (Radial)	22 breaths/min.	91% (on room air)	128/84	Numeric
0745	37.3°C/99.2°F (Temporal)	90 bpm (Radial)	24 breaths/min.	90% (2L nasal cannula)	130/88	Numeric
0833	38.1°C/100.6°F	98 bpm (Radial)	28 breaths/min.	84% (2L nasal cannula)	130/94	Numeric
0834				94% (4L nasal cannula)		Numeric
1200	37.3°C/99.8°F	90 bpm (Radial)	28 breaths/min.	93% (4L nasal cannula)	124/86	Numeric
1600	37.2°C/99.2°F	88 bpm (Radial)	24 breaths/min.	92% (3L nasal cannula)	122/82	Numeric
2000	37.2°C/99.0°F	92 bpm (Radial)	22 breaths/min.	92% (2L nasal cannula)	130/86	Numeric

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History of Present Illness including Admission Diagnosis & Chief Complaint (normal & abnormal) supported with Evidence Based Citations	Physical Assessment Findings including presenting signs and symptoms supported with Evidence Based Citations
<p><b>HPI:</b> Female Patient, age 78, Came from home and admitted to the emergency room department at 05:00. Urosepsis is a life-threatening condition that can develop in a patient from community settings. According to Tsertsvadze et al. (2016), there is a lack of a standard approach for defining sepsis. Therefore, the lack of standard approach to defining sepsis makes difficult to determine the true incidence of sepsis that develops in patients from community settings. However, based on the situation of the current patient, the sepsis developed in the community setting and the patient was admitted into the emergency department for the management of the condition. On the other hand, the patients ageis of specisl interest following the development of the condition of urosepsis. For instance, in the study by Martín, Pérez, and Aldecoa (2017), it is reported that the incidence of sepsis has been increasing in the general population at around 9% annually. The rate of increase in the incidence of sepsis has specially been recorded among the elderly persons, a group that the patient fits its demographics.</p>	<p>Date of Bowel movement  Date of Foley Catheter  Shortness of Breath, Wheezing, Coughing, Struggling talking  Nurses play a critical role in the assessment of patients presenting with sepsis in the emergency department. Nurses play an important part in the management of the patient since their documentation is used by physicians to make decisions. Urosepsis is a critical condition and the emergency assessment is necessary for improved patient care and outcome for a patient reporting in the emergency department (ED). The emergency assessment for the patient was performed through subjective and objective processes. The assessment of the patient's condition was performed through the use of the ABCDE approach. Notably, airway assessment is of significant in evaluating patients reporting with septic conditions, but only initated when a patient has a reduced level of consciousness. Septic shoch is known to cause hypoperfusion, which triggers airway loss. The patient, Janis Jordon, was conscious when brought into the emergency</p>

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**Chief Compliant:** Shortness of Breath, difficulty breathing, and feeling cold

**Admission Diagnosis:** Patient was admitted due to Urosepsis. Uropsepsis is sepsis caused by infections of Escherichia coli in the urinary tract (Porat et al., 2021). Additionally, patient has diabetes and the two correlate. Conversely, Martín, Pérez, and Aldecoa (2017) argue that diagnosing urosepsis among the elderly population is not straightforward. The authors mention that the difficulties in diagnosing sepsis in elderly patients come as a consequence of lack of cooperation due to frailty, dehydration, debilitation, and cognitive impairment that patients are likely to experience following the development of the condition.

department and airway assessment was not initiated. The breathing assessment was used to identify the patient's respiratory rate and was performed through inspection, auscultation, palpitation and percussion. During the assessment, the primary focus was on the asymmetry of the chest movement, expiratory wheezes, silent chest, or crepitations of the chest, which are indications that the patient requires emergency attention. Circulation assessment for the patient was performed by paying attention to the patient's that include the adequacy of blood flow and heart rhythm. Skin color was also assessed in the peripheral areas. The assessment was important in determining whether the patient is in the state of hypoperfusion with low cardiac output and whether there was an impending circulatory collapse. Disability assessment is commonplace whenever a patient experiences urosepsis and is often seen through depressed consciousness levels, confusion, and even agitation. The patient was agitated and this is an indication of disability. Exposure was also performed by evaluating the patient from head to toe to determine the sources of the sepsis.



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<b>Relevant Diagnostic Procedures/Results &amp; Pertinent Lab tests/ Values (with normal ranges), include dates and rationales supported with Evidence Based Citations</b>	<b>Past Medical &amp; Surgical History, Pathophysiology of medical diagnoses (include dates, if not found state so) Supported with Evidence Based Citations</b>
<p>Xrays, CT, ultrasound, urinalysis, blood culture (separate page for this) Only explain abnormal labs not normal</p> <p>Clinical signs and symptoms are used for diagnosing a patient with sepsis. Additionally, for optimal diagnosis, laboratory biomarkers are also essential. The laboratory biomarkers of interest in diagnosing sepsis include white blood cell count, cytokine levels, procalcitonin levels, C-creative protein levels, and coagulation markers. There are difficulties associated with diagnosing sepsis and the tool that was used is Sequential (Sepsis-related) Organ Failure Assessment Score (SOFA). Blood pressure, urine output, creatinine, bilirubin, platelets , and hypoxemia were used for the case of the patient. Normal range for the mentioned tests are known and deviations or changes specific to sepsis were assessed (Fan et al., 2016). Notably, for lactate, an abnormal recording can be <math>&gt; 2 \text{ mmol/L}</math> , which is an indication of hyperlactatemia or <math>&gt; 4 \text{ mmol/L}</math>, which indicates</p>	<p>The information gathered about a patient at any point in the care setting and cycle is important. The patient's history concerning past medical history (PMH), surgical history, and social history.</p> <p><u>Past Medical History</u></p> <p>The patient's past medical history shows that she has been diagnosed with congestive heart failure (CHF). As a medical condition, CHF, is characterized by reduced cardiac output, together with increased venous pressure. The episodes of reduced cardiac output and venous pressure lead to damage and death of the cardiac muscles. CHF is a progressive condition and the body has a mechanism of increasing a lowered cardiac output, which is characterized by three basic components. The components are hemodynamic defense reaction, inflammatory response, and hypertrophic response. The patient also has a medical history of diabetes. Individuals with diabetes are also highly likely to have heart disease, which is confirmed by the patient's medical history of both diabetes</p>

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lactic acidosis. For blood pressure, arterial hypoxemia is experience whenever there is a record of  $< 300$  and all the patient's blood pressure recorded between 0500 hours and 2000 hours were all below the threshold, with the lowest recorded at 1600 hours (122/82) and highest recorded at 0500 hours (136/76). For cratinine, an increase of  $> 0.5$  mg/dL is an abnormal finding for a patient with sepsis. In the case of total bilirubin,  $> 4$ mg/dL is an abnormal finding, whereas serum glucose a concentration of  $> 140$  mg/dL (in the absence of diabetes) is an abnormal finding. On the other hand, for white blood cells,  $> 12,000$  uL<sup>-1</sup> is an indication of leukocytosis, while  $< 4,000$  uL<sup>-1</sup> indicates leucopenia. Urosepsis is often accompanied by pyuria at  $> 10$  white blood cells per high power field) (Chen, Simpson, & Pallin, 2019).

and congestive heart failure (CDC, 2020).

Surgical History

Surgical history is also of significance when analyzing a patient's current medical situation to determine the best course of action. However, it is noted that the patient has no known surgical history since the patient did not report o any during the assessment of the patient's history.

Social History

Drinking, Smoking, Elicit Drugs (Do they use any)

Substance use must also be evaluated whenever a patient's current condition is being evaluated. Alcohol consumption, smoking, and illicit drug use must be given special consideration due to their potential damages in a patient's health and the signs with which they present in the emergency department or a doctor's office. The patient has no history of alcohol consumption reported. At the same time, the patient has not reported cigarret smoking and even the use of other illict drugs. On the other hand, it is reported that the patient lives alone in the community and only has a neighbor who will be visiting. In other words, no family history is given or captured during the conversation with the patient.

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<b>Erikson's Developmental Stage with Rationale And supported by Evidence Based Citations</b>	<b>Socioeconomic/Cultural/Spiritual Orientation &amp; Psychosocial Considerations/Concerns (3) supported with Evidence Based Citations</b>
<p>Based on Erikson's postulation, personality develops in a series of stages. Erikson's interest in developing his theory was in how human development and growth are affected by social interactions and developments. Consequently, the theorist developed eight stages that influential in the growth and development of a human being. According Erikson's theory, there are conflicts in each stage that people experience and such act as turning points for the said individual's development. Equally, preceding stages pave ways for the stages that follow. On the other hand, mastery of each stage leads to ego strength.</p> <p>The stages developed by Erikson include "Trust vs. Mistrust," "Autonomy vs. Shame and Doubt," "Initiative vs. Guilt," "Industry vs. Inferiority," Identity Vs. Role Confusion," "Intimacy vs. Isolation," "Generativity vs. Stagnation," and "Ego Intergriy vs. Despair" (Orenstein &amp; Lewis, 2020).</p> <p>The development stages developed by Erikson are age-dependent and the patient handled is in the final stage, which is Ego Integrity vs. Dispair. According to Erikson people, in their</p>	<p><u>Socioeconomic</u></p> <p>Social economic status encompass a vast array of issues or things, which include quality of life attributes and the privileges and opportunities that an individual has within the society. The social economic status is a known predictor of many outcomes in across the lifespan of an individual, which include psychological and physical health. The patient is retired and lives alone within the community. The patient may be subjected to the challenges that face senior citizens in the united states. Most senior citizens in the united states experience reduced quality when compared to the lives lived before their retirement ages. There is no retirement income for the group due to limited opportunity to continue working post the retirement age, thereby leading to increased demand for social security. Consequently, Janis Jordon is collecting social security to support her living within the community. With reduced quality of life, the patient's physical and psychological life are bound to deteriorate deu to her social economic status. Such issues may also impact the patients outcomes</p>

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growth and development cycle, enter this stage when they turn 65 years or age. The patient is aged 78 years, which means she has surpassed the 65 years-old mark that makes an individual to enter the final stage of development as postulated by Erikson (Orenstein & Lewis, 2020).

Arguably, understanding Erikson's development stage that a patient fits into is significant in nursing practice. Erikson's stages of psychosocial development help nurses and other healthcare practitioners in managing patients who are experiencing turning points in their lives. Janis Jordon stage in life is a typical turning point in life and understanding the stage of development that she fits into will be helpful in improving interactions with the patient and the subsequent care outcome (Orenstein & Lewis, 2020).

concerning her current engagement with health care services. Although she has medicare, the health insurance may not be sufficient in providing her with access to quality healthcare services, at the moment, or in the future.

Spiritual Orientation

The patient's spiritual orientation is Shaman, which centers on hunting and healing cultures. Becoming a shaman is not by choice, but by the spirits leading an individual to believe in a course. Moreover, it is recorded in the study by Gerdner (2012) that a majority of people practicing the Shaman culture are women. Since the patient is a woman, the assertion made in the research becomes true for the patient.

Psychosocial

The elderly aging in the community in the United States face several financial challenges. With the total lack of income from work after the retirement age is reached, patients like Janis are bound to go through times of financial difficulties. The patient solely relies on social security, which is always below the amount that an individual earned during their work years. Although the patient lives alone in the community, the financial and psychosocial challenges faced by people in this group may lead her to being homeless in the future. On the other hand, the patient has no record of drug use.

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<b>Potential Health Deviations, Predisposing &amp; Related Factors;          (At least two) Include three independent nursing interventions          for each          (“At Risk for...” nursing dx)</b>	<b>Inter-professional Consults, Discharge Referrals, &amp; Current          Orders (include diet, test, and treatments) with Rationale          supported with Evidence Based Citations</b>
<p>Risk for fall related to urosepsis</p> <p>Patient falls in inpatient settings are common and unwanted experiences. When falls are experienced in inpatient settings, it is an indication of a reduced quality of care accorded to patients. The incidents come significant impacts to the patient, their families, and cost health care billions of dollars every year. The risk falls among patients is compounded by a patient’s age and medication use, which impairs a patient’s motor skills and coordination as well as cognitive function. The damaging outcome of falls when experienced may include no harm, minimal to severe injuries, and even fatalities. The first nursing intervention to prevent an incidence of falling is orienting the patient to her surroundings and closely monitoring the patient. The second nursing intervention proposed is keeping the two top side rails up, with the third nursing intervention as securing the locks on the patient’s bed.</p> <p>Risk for aspiration related to increased sputum</p> <p>Aspiration is another with significant morbidity and mortality</p>	<p>Top three people to help patient get better</p> <p>Based on the patient’s condition, there are people whose roles in her life will play a significant role in ensuring her recovery and getting better. The patient’s nurse will play a significant role or will be influential in ensuring that the patient gets better. The nurse or nursing team will be responsible for implementing patient centered interventions aimed at managing the condition of the patient. Since Janis lives alone in her place of residence patient education is necessary and nurses are better placed to provide the patient with such information and knowledge.</p> <p>Janis, as the patient, also has a significant role in her recovery and getting better. Janis will contribute in improving her condition through the conceot of slef-care. The knowledge provided to the patient during patient education play a role in improving the patient’s self-care strategies or practices.</p> <p>The patient’s neighbor, who has confmed a visit to the hospital will also play a vital role in the recovery of the patient. After discharge Janis will proceed home where she stay alone.</p>

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that the patient is at risk for and requires appropriate management. Aspiration is a medical condition that can happen to even healthy individuals, and for the patient's case, she is at risk for aspiration due to increased sputum. The risk factors for the condition include cognitive neurologic impairment,

focal neurologic impairment, pulmonary disease, and even supraglottic disease. Therefore, preventing an occurrence of the mentioned medical condition nursing interventions must be in place. The first nursing intervention for the condition is collecting appropriate sputum cultures for culture sensitivities to be performed. The second nursing intervention to be used for the patient's case is antibiotic therapy by using broad-spectrum antibiotics. The third nursing intervention is feeding the patient in upright position.

Risk for pressure ulcer related to restricted movement

The prevalence of pressure ulcer among older adults continues to be high and costly, especially patients with chronic conditions. The patient has a history of diabetes, which is also known to increase the risk of pressure ulcers due to diabetic neuropathy. Arguably, diabetic neuropathy is a major cause of non-healing wounds. Additionally, prolonged stay in bed with restricted movement is another way pressure ulcers can

The neighbor will be helpful in the patient's recovery while at home. The neighbor will be checking in on the patient to help monitor her progress.

Consult case manager for discharge

After discharge home health is proposed for the patient. Home health will require the use of nurses for home visits as well as community health workers. Nurses will be visiting to monitor the progress of the patient and implementing nursing interventions based on the outcomes of assessments conducted at home. Community health workers will be influential in assessing the living setting of the patient and other social aspects that can hinder the process of recovery.

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develop. However, for Janis, hospital stay is projected to be only within 24 hours. The nursing intervention for pressure ulcer is investigating and managing incontinence, with the second nursing intervention as keeping the skin clean and dry. The third nursing intervention is using a pH appropriate skin cleanser and drying the skin thoroughly to help remove excess moisture.

Diagnostic Label

Related to

Contributing  
Factors

As evidenced  
by

Signs and  
Symptoms



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Priority Nursing Diagnosis (at least 2) Written in three part statement	Planning (outcome/goal) Measureable goal during your shift (at least 1 per Nursing diagnosis)	Prioritized Independent and collaborative nursing interventions; include further assessment, intervention and teaching (at least 4 per goal)	Rationale Each must be supported with Evidence Based Citations	Evaluation Goal Met, Partially Met, or Not Met & Explanation
1.Urosepsis. The first nursing diagnosis, which is prioritized for the patient case is urosepsis. The diagnosis is considered because it is the reason why the patient visited the hospital through emergency services. The assessments and tests performed confirmed that the patient has urosepsis.	The goal formulated for the diagnosis is to establish the specific anatomic site infection within the first six hours of presentation.	The first nursing intervention for the diagnosis is drainage.	Specific procdures will be required for the intervention and such may include the drainage of thoracic empyema or intra-abdominal abscess	Goal met
		The second intervention is debridement.	Debrdement is an important procedure and will specifically target infected pancreatic necrosis and even necrotizing fasciitis.	
		The third intervention to be used for the patient's case is pharmacotherapy.	Medications are essential in the management of the Janis' condition. Medications will be used for managing the infection. Additionally,	



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			there is need for pain medications to help in the management of the pain experienced by the patient.	
		The fourth nursing intervention for the diagnosis is definitive control.	As an important step in the management of the patient's diagnosis, definitive control will be achieved through sigmoid resection or cholecystectomy.	
<p>2.Diabetes. the second diagnosis, which is prioritized for Janis case is diabetes. Diabetes is condition that is present in the patient's medical history. Diabetes is a medical condition that has the potential of adversely impacting the patients outcomes and requires prompt management.</p>	<p>The goal formulated for managing the patient's diabetes is to attain the normal serum glucose concentration</p>	The first intervention concerns reviewing factors in glucose instability.	The intervention is necessary since several factors contribute to the patient's glucose instability. Examples of the said factors include infections or missing meals.	Goal met
		Educating the patient about glucose monitoring at home	The intervention centers on improving the patient's self-care, which play a role in the	

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			overall outcome of a patient's engagement with care.	
		Encouraging the patient, Janis Jordon, regarding reading labels.	Appropriate management of diabetes requires choosing food items or foods with low fat content, high fiber, and low glycemic index.	
		Reviewing the type of insulin used and discussing how the medications work.	The method helps in understanding the insulin to be administered and its method of delivery. Additionally, Janis must be informed of the combination of drugs work.	

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**MEDICATION LIST**

Medications (with APA citations)	Class/Purpose	Route	Frequency	Dose (& range) If out of range, why?	Mechanism of action Onset of action	Common side effects	Nursing considerations specific to this patient
						Pertinent side effects to patient	What to consider before giving med and after
Glyburide (DiaBeta)	Glyburide is drug belonging to the class of sulfonylureas	PO	Daily	2.5mg	The drug's specific mode of action concerns increasing the insulin secretion from the beta cells in the pancrease.	The side effects associated with the use of the drug include stomach fullness, heartburn, nausea and weight gain.	Before and after the medicine is given, the allergies must be well understood. Additionally, special consideration must be made regarding the patient's medical history, specifically the history of thyroid disease, kidney disease, and liver disease.

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Levofloxacin (Levaquin)	The drug belongs to a class known as quinolone antibiotics.	IV bolus	Every 12 hr	250mg	The drug's mechanism of action entails the inhibition of bacterial topoisomerase IV and DNA gyrase.	The side effects of the drug include irritability, sweating, hunger, headache, fast heart rate, nausea, dizziness, feeling anxious and shaky, nervousness, confusion, and agitation.	The thing to consider before giving the medicine is its potential in causing irreversible and serious events. After the medication is given to a patient, there should a look out for issues such as hallucination, depression, confusion, insomnia, and even anxiety.
Acetaminophen (Tylenol)	The selected drugn falls into the class of drugs known as analgesics.	PRN PO	Every 4 hr	325 mg	The exact mechanism of action regarding the use of Acetaminophen (Tylenol) is not known. However, it is suggested that it may lead to a reduction in the production of prostaglandins.	Side effects associated with the use of the drug include thrombocytopenia, anemia, serious skin infection, hypersensitivity reactions.	The considerations include drug interactions and drugs that might interact with Acetaminophen (Tylenol) must be known. The drug has a potential of causing kidney failure and such must be assessed following the administration of the drug.

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Lorazepam (Altivan)	Lorazepam (Altivan) is a drug that falls into the drug class known as benzodiazepines	PRN PO	Every 6 hr	2mg	The drug action centers on the central nervous system. Lorazepam (Altivan) works by binding benzodiazepine receptors GABA –A and is legend related	The side effects associated with the drug include blurred vision, headace, nausea, loss of coordination, dizziness, changes in secual interest, constipation, and drowsiness.	Precautions include understanding if the patient has allergies to the drug.
Lactated Ringer's IV	Lactated Ringer's IV belongs to the drug class kniwn as alkalinizing agents.	IV	30mL/hr	1000 mL	The drugs mechanism of action concerns the restoration of fluid and electrolyte balance, thereby producing diuresis.	Side effects include chest discomfort, pain, and tightness, agitation, headache, decreased heart, cough, confusion, fever, increased thirst, and blurre vision.	The precautions to the use of the drug and the considerations after adminission include assessing for known allergies and interactions with other medications.

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Porat, A., Bhutta, B., & Kesler, S. (2021). Urosepsis. Ncbi.nlm.nih.gov. Retrieved 17 May 2021, from <https://www.ncbi.nlm.nih.gov/books/NBK482344/>.

Martín, S., Pérez, A., & Aldecoa, C. (2017). Sepsis and Immunosenescence in the elderly patient: A review. *Frontiers in Medicine*, 4. <https://doi.org/10.3389/fmed.2017.00020>

Tsertsvadze, A., Royle, P., Seedat, F., Cooper, J., Crosby, R., & McCarthy, N. (2016). Community-onset sepsis and its public health burden: A systematic review. *Systematic Reviews*, 5(1). <https://doi.org/10.1186/s13643-016-0243-3>

Chen, A. X., Simpson, S. Q., & Pallin, D. J. (2019). Sepsis guidelines. *New England Journal of Medicine*, 380(14), 1369–1371. <https://doi.org/10.1056/nejmcldel815472>

Fan, S., Miller, N. S., Lee, J., & Remick, D. G. (2016). Diagnosing sepsis – The role of laboratory medicine. *Clinica Chimica Acta*, 460, 203–210. <https://doi.org/10.1016/j.cca.2016.07.002>

CDC. (2020, July 2). Diabetes and your heart. Centers for Disease Control and Prevention. <https://www.cdc.gov/diabetes/library/features/diabetes-and-heart.html>

Orenstein, G. A., & Lewis, L. (2020). Eriksons stages of psychosocial development. StatPearls [Internet]. Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK556096/>

Gerdner, L. A. (2012). Shamanism: Indications and use by older Hmong Americans with chronic illness. *Hmong studies journal*, 13(1), 1–22. Retrieved from: <https://core.ac.uk/download/pdf/27040208.pdf>