

Dorothea Orem's
Self-Care Deficit Theory

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Dorothea Orem's self-care deficit theory, a general theory of nursing, is one of the most widely used models in nursing today. In 1914, Dorothea Orem was born in Baltimore, Maryland. She received her nursing diploma in the early 1930's from Providence Hospital School of Nursing, Washington D.C. In addition to earning a BSN Ed. (1939) and MSN Ed. (1945), she has received three honorary doctorates and an Alumni Achievement Award for Nursing Theory in 1980 from Catholic University of America (Hartweg, 1995).

Early in her career, Orem gained experienced as a staff nurse in a variety of hospital clinical settings. While serving as director of nursing service at a Detroit hospital, she recalls that she was asked a substantive question and didn't have an answer because she "had no conceptualization of nursing" (McLaughlin-Renpenning & Taylor, 2002, p. xii).

Orem goes on to say while working at Indiana University where her goal was to upgrade the quality of nursing in general hospitals throughout the state, she noted that nurses had difficulty articulating needs to hospital administrators in the face of demands made upon them regarding such issues as length of stay, scheduling admissions and discharges, etc. (McLaughlin-Renpenning and Taylor, 2002). As a result, Orem recognized a need to look for the uniqueness of nursing. Specifically she was looking for an answer to questions such as "What is nursing?", "What is the domain and what are the boundaries of nursing as a field of practice and a field of knowledge?", and "What condition exists when judgments are made that people need nursing?" In a 1996 newsletter to the International Orem Society she puts it this way, "What do nurses encounter in their worlds as they design and produce nursing for others? What meaning can and should nurses attach to persons, things, events, conditions, and circumstances they encounter?" In 1978, Orem (cited in Fawcett 2005) commented that the task required identification of the domain and boundaries of nursing as a science and an art. After

reflecting upon her own nursing experiences, Orem says the answer came to her as a “flash of insight, an understanding that the reason why individuals could benefit from nursing was the existence of...self care limitations” (Orem, 1978, cited in Fawcett, 2005, p. 230). Orem summarized her initial ideas about nursing in an Indiana State Board of Health report (Hartweg, 1991).

After moving to Washington D.C. in 1957, Orem further developed her ideas, first as a consultant in the Office of Education where her task was to improve the nursing component of a vocational nursing curriculum. She realized that the curriculum couldn't be determined until there was an understanding of the subject matter of nursing in general. Then in 1959, she became an assistant professor at The Catholic University of America, where she continued to develop her concept of nursing and self-care. Orem's ideas were further formalized after her participation in the Nursing Development Conference Group (NDCG). This group, who came together in 1968, was “committed to the development of structured nursing knowledge and to nursing as a practice discipline” (Hartweg, 1995). Orem (2001) explained that “all of the conceptual elements [of the Self-Care Framework] were formalized and validated as static concepts by 1970.” Orem says her ideas are primarily the result of reflecting upon her experiences and she was not influenced by any one person, but she states formal logic and metaphysics were among other disciplines that influenced her work (Hartweg, 1991).

Nursing: Concepts of Practice (Orem, 1971) was the original publication of the conceptual framework. Her work certainly contributed to the 1970's as being characterized as “a time for changes within the nursing profession, being a time for planning, researching and expanding nursing roles.” (Chinn & Kramer, 2004, p. 36). Her ideas, along with others, helped

to start shifting nursing away from a medical model of practice. Nursing was beginning to be recognized as a legitimate science (Chinn & Kramer, 2004, p. 36).

In the subsequent five editions of her book, Orem has added assumptions, propositions and definitions of concepts. She has developed her ideas to extend beyond the individual, with increasing emphasis on multiperson situations, family and community groups in our society. Orem describes her theory as a general nursing theory, and indeed it has influenced nursing research and practice not only in the United States, but internationally (Taylor et al, 1998).

In her theory, Orem defines the four concepts that constitute nursing's metaparadigm, as proposed by Fawcett: human beings, environment, health, and nursing (Fawcett, 2005). In 1971, Orem described a **human being** (humanity) as "...an integrated whole composed of an internal physical, psychologic, and social nature with varying degrees of self-care ability" (Chinn & Kramer, 2004). Orem later defines a human being as "a substantial or real unity whose parts are formed and attain perfection through the differentiation of the whole during the process of development." (Orem, 1985, cited in Meleis, 1997). A human being has the capacity to reflect, symbolize, and use symbols. When referring to **humans**, Orem uses the **terms** individual, patient, multiperson unit, self-care agent, dependent-care agent (Fawcett, 2005).

In addressing the concept of **health**, Orem (1980, cited in Meleis, 1997, p. 396) says "health and healthy are terms used to describe living things... [it is when] they are structurally and functionally whole or sound...includes that which make a person human, operating in conjunction with physiological and psychophysiological mechanisms and a material structure (biologic life) and in relation to an interacting with other human beings (interpersonal and social life)." She further clarifies her position by defining health as "a state of physical, mental, and social well-being, and not merely the absence of disease or infirmity" (p. 184, cited in Foster &

Bennett, 2001). Orem also sees health as a state of well-being, which refers to a person's perceived condition of existence, characterized by experiences of contentment, pleasure, happiness, and movement toward self ideals and continuing personalization (Chinn & Kramer, 2004). Orem, in addressing the current sociopolitical climate, has further expanded her definition of health to include the concept of preventive health care (Foster & Bennett, 2001). When referring to **health**, Orem uses the **terms** health, health state, and well-being (Fawcett, 2005).

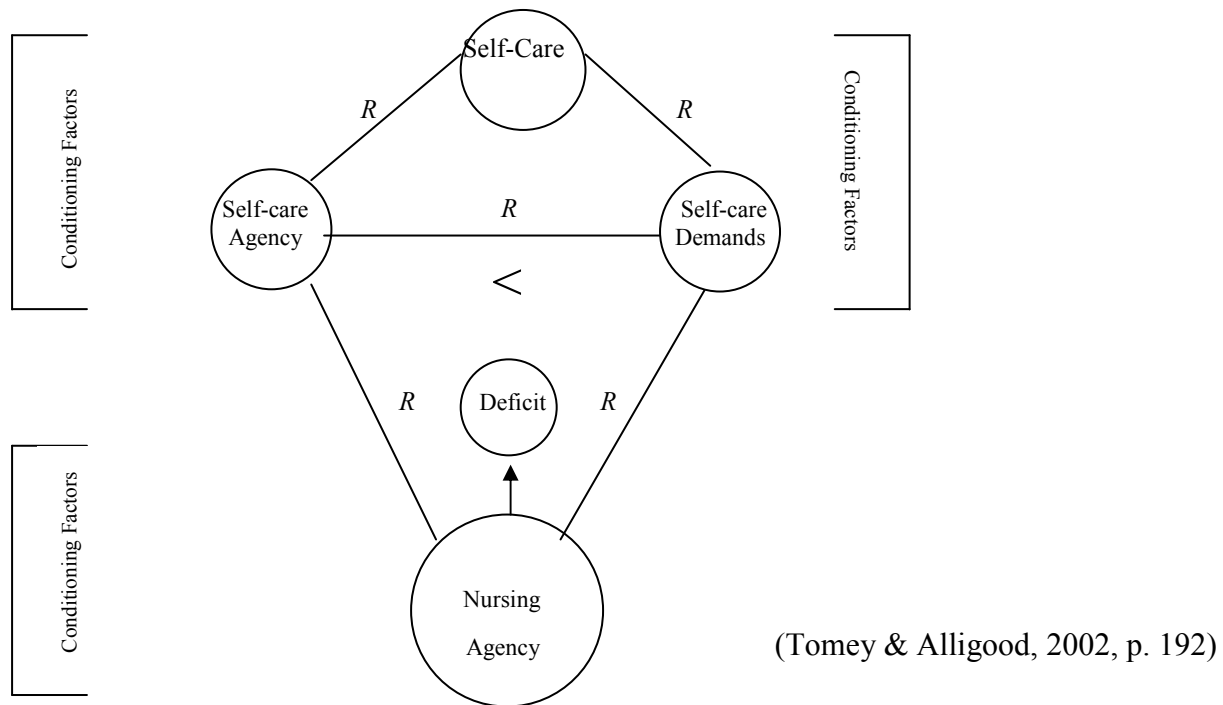
Orem sees **nursing** as “an art through which the practitioner of nursing gives specialized assistance to persons with disabilities of such a character that greater than ordinary assistance is necessary to meet daily needs for self care and to intelligently participate in the medical care they are receiving from the physician” (Orem, cited in McLaughlin-Renpenning, 2002). Nursing consists of actions deliberately selected and performed by nurses to help individuals or groups under their care to maintain or change conditions in themselves or their environment. (Orem, 1985, cited in Meleis, 1997). When speaking of **nursing**, Orem uses the **terms** nursing and nursing agency.

Orem (1995) sees **environment** as encompassed by two dimensions---physical, chemical and biologic features and socioeconomic features. Physical, chemical, and biologic features include things such as atmosphere, pollutants, weather conditions, pets, infectious organisms and the like. Socioeconomic features of the environment focus on the family and the community and include such things as gender and age roles, cultural roles, and cultural prescriptions of authority. Orem points out that these two dimensions may be interactive. She underscores the potential contribution of environment to a person's development, stating that “It is the total environment, not any single part of it that makes it developmental” (Orem, 2001, p. 58, cited in Fawcett,

2005). In her newsletter (1996), Orem refers to environment as "...prevailing internal and external conditions in some time and place frame of reference." The **terms used** by Orem are environment and environment features (Fawcett, 2005).

Orem's Self-Care Deficit Theory

A Conceptual Framework for nursing. R=relationship, <= deficit relationship, current or projected.



There are different thoughts regarding the **origins** of Orem's theory. Meleis (1997) regards it as an example of the needs category of models, while Marriner-Tomey (1989, cited in Fawcett, 2005) places Orem's work in her humanistic category. Fawcett (2005), however, feels the Self-Care Framework is most appropriately placed in the developmental category of knowledge because it addresses self-care agency, self-care deficits, and therapeutic demands as they present throughout life. There seems to be consensus that regarding world view, Orem's view of the relationship between the person and his environment clearly reflects the reciprocal

interaction world view. Orem describes her philosophical view as moderate realism (Tomey & Allgood, p. 190).

Orem's **purpose** for developing the Self-Care Framework was two-fold: she was trying to find the meaning of nursing and to develop a body of nursing knowledge based on research. According to McLaughlin-Renpenning and Taylor (2002, p. 301), Orem states that "my work in theory development has focused on the beginning development of scientific knowledge in the field of nursing."

The Self-Care Framework is comprised of two **concepts** that express the patient variables and nine other concepts. The referents of these nine concepts are of importance in understanding the theory (McLaughlin-Renpenning & Taylor, 2002, p. 174). The concepts and referents are arranged in four sets:

Set One: Self-Care and Self-Care System

Wang and Laffrey (2004, p. 123) stated that self-care is a "human regulatory function" that is based on individual's capabilities of the performing their own care. Nurses can draw from their own experiences that there is a relationship among self-care, self-care agency and therapeutic demand. When a client is unable to perform his own self-care, a self-care deficit exists and the nurse performs the tasks the patient is unable to do for him/herself.

Self-Care refers to actions of individuals directed to self or environment to regulate factors or conditions in the interest of that individual's life, health, and well-being. **Self-Care System** consists of self-care (actions) performed over time that are analyzed and arranged into a coordinated system of action. **Dependent-Care System** is the term applied to a coordinated system of action performed over time to meet self-care requirements of a dependent person.

Finally, **Data descriptive of self-care** denotes data that is analyzed to arrive at the self-care system (McLaughlin-Renpenning & Taylor, 2002)

Set Two: Self-Care Agency

Self-Care Agency refers to: (1) power inherent in human capabilities essential for deliberate action, (2) a self-care action repertoire, and (3) relationship between 1 and 2. **Self-Care Limitation** includes the following: (1) actual, defined as absences of an essential action or system of action from the repertoire; (2) predicted, of the human absence or restriction of one or more human capabilities for engagement in deliberate action; and (3) positive/negative, the temporary or permanent or relatively permanent effect of the value of a capability on an individual action repertoire (McLaughlin-Renpenning, & Taylor, 2002).

The theory of self-care expresses the purpose of taking care of self, referred to as the self-care requisites; the how of taking care of self, referred to as the self-care agency; and the outcome of these, known as the self-care practices for self-care system (Taylor, Geden, Isaramalai & Wongvatunyu, 2000, p. 104).

Set Three: Therapeutic Self-Care Demand

“Therapeutic self-care demand represents the totality of action required to meet a set of self-care requirements using a set of technologies” (McLaughlin-Renpenning, & Taylor, 2002, p. 175). **Self-care requirements** consist of: (1) formulated goals, (2) orientations of Self-care action systems, and (3) expressions of input requirements for human functioning, for growth and development, for preventing, curing, and controlling disease processes. Types of self-care requirements include **Universal Type**, referring to requirements that are general for all people require adjustments to age, sex, developmental state, and health state, and **Health Deviation Type**, meaning requirements that have their origins in disease processes and their effects; or in

medical technologies. **Technologies for Meeting Requirements** refer to methodologies involving use of specific resources that are valid in meeting a requirement. (McLaughlin-Renpenning & Taylor, 2002).

Set Four: Self-Care Deficit

Orem states that “if a person’s capabilities are inadequate to meet the therapeutic demand (TS-CD) a self–care deficit exists” (Jaarsma, Halfens, Sente, Abu Saad, & Dracup, 1998, p.80).

There are two different terms relating to self-care deficit. The first is **actual self-care deficit**, defined as a descriptive statement of the relationship between the therapeutic self-care demand and self-care system in which the actions specified by the therapeutic self-care demand and present or absent from the self-care system. Secondly, there is the **potential self-care deficit**, a descriptive statement of the relationship between the therapeutic self-care demand and predicted self-care limitations (McLaughlin-Renpenning & Taylor, 2002).

Nursing agency is the name for the human power and action repertoire associated with nursing practice (Taylor & McLaughlin-Renpenning, 2003, p. 176). Exercise of nursing agency includes: (1) establishing the legitimacy of the relationship, (2) initial operationalization and maintenance of an interpersonal system with client and his/her significant others, and (3) diagnosis related to the two patient variables.

Nursing systems theory suggests that nursing systems form when nurses prescribe, design, and provide nursing that regulates the individual’s self-care capabilities and meets therapeutic self-care requirements (Kozier, Erb, & Blais, 1997, p.38). There are three types of nursing systems: (1) Wholly compensatory systems, required for individuals who are unable to control and monitor their environment and process information; (2) Partly compensatory systems, designed for individuals who are unable to perform some (but not all) self-care activities; and

3) Supportive-educative (developmental) systems, designed for persons who need to learn to perform self-care activities (Kozier et al, 1998, p.39).

Orem's theory is applicable in today's economic climate, as there are smaller insurance reimbursements, and shorter hospital stays are strongly enforced. Therefore patients and their families are encouraged do as much for themselves according to their abilities and nurses partly compensate for the patients' areas of self-care deficit.

“A **proposition** is a statement or assertion of the relationship between concepts. A propositional statement may indicate the relationship between concepts in several ways” (Nieswiadomy, 1998, p.92). There are currently three propositions in Orem's theory of self-care. According to (Hartweg, 1995, p. 175), the first set of propositions is related to the Theory of Self-Care Deficit (or Dependent-Care Deficit). Concepts of self-care agency (capabilities), basic conditioning factors (age, developmental state, etc), and the relationship between self-care agency and demand a definition of the type of relationship, and nursing as a legitimate service are further explained through these statements. In addition, relationship can be made clearer through the use of figures or diagrams. Following are examples of propositions/relationships set forth in Orem's theory as listed in Hartweg (1995, pp. 175-176).

Theory of Self-Care Deficit (Dependent-Care Deficit)

1. Persons who take action to provide their own self-care or care for dependents have specialized capabilities for action.
2. The individual's abilities to engage in self-care or dependent care are conditioned by age, developmental state, life experience, sociocultural orientation, health, and available resources.

3. The relationship of individual's abilities for self-care or dependent care to the qualitative and quantitative self-care or dependent-care demand can be determined when the value of each is known.
4. The relationship between care abilities and care demand can be defined in terms of equal to, less than, more than.
5. Nursing is a legitimate service wherein: (a) care abilities are less than those required for meeting a known self-care demand [a deficit relationship], and (b) self-care or dependent-care abilities exceed or are equal to those required for meeting the current self-care demand, but a future deficit relationship can be foreseen because of predictable decreases in care abilities, qualitative or quantitative increases in the care demand, or both.
6. Persons with existing or projected care deficits are in, or can expect to be in, states of social dependency that legitimate a nursing relationship.

Theory of Self-Care (Dependent Care)

1. Self-Care is intellectualized as a human regulatory function deliberately executed with some degree of completeness and effectiveness.
2. Self-Care in its concreteness is directed and deliberate action that is responsive to person's knowledge how human functioning and human development can and should be maintained within a range that is compatible with human life and personal health and well-being under existent conditions and circumstances.
3. Self-Care in its concreteness involves the use of material resources and energy expenditures directed to supply materials and conditions needed for internal functioning

and development and to establish and maintain essential and safe relationships with environmental factors and forces.

4. Self-Care in its concreteness when externally oriented emerges as observable events resulting from performed sequences of practical actions directed by persons to themselves or their environments.

5. Self-Care that has the form of internally oriented self-controlling actions is not observable and can be known by others only by seeking subjective information. Reasons for the actions and the results being sought from them may or may not be known to the subject who performs the actions.

6. Self-Care that is performed over time can be understood (intellectualized) as an action system—a self-care system—whenever there is knowledge of the complement of different types of action sequences or care measures performed and the connecting linkages among them. Constituent components of a self-care system are sets of care measures or tasks necessary to use valid and selected means (i.e., techniques).

Theory of Nursing System(s)

1. Nurses relate to and interact with persons who occupy the status of nurse's patient.
2. Legitimate patients have existent and projected continuous self-care requisites.
3. Legitimate patients have existent and projected deficits for meeting their own self-care requisites.
4. Nurses determine the current and changing values of patient's continuous self-care requisites, select valid and reliable processes or technologies for meeting these requisites, and formulate the courses of action necessary for using selected processes or technologies that will meet identified self-care requisites.

5. Nurses determine the current and changing values of patient's abilities to meet their self-care requisites using specific processes or technologies.
6. Nurses estimate the potential of potential of patients to a) refrain from the engaging in self-care for therapeutic purposes or (b) develops or refine abilities to engage in care or in the future.
7. Nurses and patients act together to allocate the roles of each in the production of patients' self-care and in the regulation of patients' self-care capabilities.
8. The actions of nurses and the actions of patients (or nurses' actions that *compensate for patients' action*) that regulate patients' self-care capabilities and meet patients' therapeutic self-care needs constitute nursing systems.

According to Leddy and Pepper (1998, p. 308), those courses and sequences of action which are performed by the persons in multiperson units for the purpose of meeting the self-care requisites and the development and exercise of self-care agency of all members of the group and to maintain or establish the welfare of the unit...the sub-systems of the multiperson system are the self-care systems of the individuals. Taylor and McLaughlin-Renpenning (2002) state "these three types of enabling constitute a model of the structure of self-care agency. Self-care agency develops and operates as a power of individual human beings".

The concept of health in Orem's Self-Care Framework refers to all the conditions that are interacting with the patient. The nurse not only treats the disease but take into consideration the patient as whole. His or her mental, physical, biological and spirituals needs have to be met. In 1991, Orem added an additional concept to the theory of self-care in the form of self-care requisites. These requisites can be defined as action directed toward the provision of self care. There are three categories of self-care requisites, or requirements: (1) universal, (2) developmental,

and (3) health deviation. **Universal self-care requisites** are associated with life processes and maintenance of the integrity of human structure and functioning. They are common to all human beings during all stages of life cycle and should be viewed as interrelated factors each affecting the others. These requisites are common to all human beings and include the maintenance of air, water, food, elimination, activity and rest and solitude and social interaction, prevention of hazards and promotion of human functioning. **Developmental self-care requisites** promote processes for life and maturation and prevent conditions deleterious to maturation or mitigate those effects. **Health deviations self-care requisites** refer to disease or injury that affects not only specific structures and physiologic or psychological mechanisms but also integrated human functioning. When integrated functioning is seriously affected... the individual's developing or developed powers of agency are seriously impaired either permanently or temporarily ... or frustrations resulting from medical care also create requisite for self-care to bring about relief (Donohue et al, 1994, p.183).

Major assumptions of Orem's general theory of nursing are as follows: (1) Human beings require continuous deliberate inputs to themselves and their environments to remain alive and functions in accord with natural human endowments. (2) Human agency, the power to act deliberately, is exercised in the form of care of self and others in identifying needs for and in making needed inputs. (3) Mature human beings experience privations in the form of limitations or action in care of self and others involving and making of life sustaining and functioning-regulating inputs. (4) Human agency is exercised in discovering, developing, and transmitting to others ways and means to identify needs for and make inputs to self and others. (5) Groups of human beings with structures relationships cluster tasks and allocate responsibilities for

providing care to group members who experience privation for making required deliberate input to self and others (Taylor et al, 1998, p. 179).

According to researchers (Taylor et al, 1998, p. 180), the Theory of Nursing Systems is the most general and includes all the essential terms. It establishes the structure and content of nursing practice. The Theory of Nursing Systems subsumes the Theory of Self-Care Deficit and with it the Theory of Self-Care. The Theory of Self-Care Deficit develops a reason a person may benefit from nursing. The theory of Self-Care is foundational.

In this model, the purpose of nursing is to help people meet their self-care needs (Leddy & Pepper, 1998, p. 179).

Critique of Orem's Self Care Deficit theory

We used Tomey and Alligood critique because it best fit Orem's self-care practice model. When considering **clarity**, the terms used by Orem are precisely defined.

The language of the theory is consistent with the language used in action theory and philosophy. There are no created words. The terminology of the theory is congruent throughout. The term self-care has multiple meanings across disciplines; Orem has defined the term and elaborated the substantive structure of the concept in a way that is unique but also congruent with other interpretations. References to the difficulty of Orem's language are thought to reside in the reader's lack of familiarity with the field of action science (Tomey & Alligood, 2002).

The next consideration is **simplicity**. Orem's general theory comprises three constituent theories, that of self-care, self-care deficits and nursing systems. The self-care deficit theory of nursing is a synthesis of knowledge about the theoretical entities self-care (and dependent care), self-care agency (and dependent-care agency), therapeutic self-care demand, the relational entity self-care deficit and nursing agency. The entity nursing system

is also included. The development of the theory using these six entities is parsimonious. The relationship between and among these entities can be presented in a simple diagram. The substantive structure of the theory is found in the development of these entities (Tomey & Alligood, 2002).

Generality is the next criteria addressed. The self-care deficit theory of nursing is not an explanation of the individuality of a particular concrete nursing practice situation, but rather the expression of a singular combination of conceptualized properties or features common to all instances of nursing. As a general theory, it serves nurses engaged in nursing practice, in development and validation of nursing knowledge, and in teaching and learning nursing (Tomey & Alligood, 2002).

When evaluating its **accessibility**, it must be noted that Orem's theory has been used for research using both qualitative and quantitative methodologies. The theoretical entities are well defined and lend themselves to being measurable; however, instruments have not been developed for all of the entities, for example, nursing agency. Furthermore, the value of the theoretical entities are not constant across populations. For example, the theory of Self-Care Deficit. The most appropriate methods of inquiry for this theory, as well as for all nursing theories are yet to be determined. The beauty of Orem's theory lies in the scope, complexity, and clinical usefulness; it is useful for generating hypotheses and adding to the body of knowledge that is nursing (Tomey & Alligood, 2002).

Lastly, we look at the **importance** of this theory. The Self-Care Deficit Nursing Theory differentiates the focus of nursing from other disciplines. While other disciplines find the theory of self-care helpful and contributes to its development, the theory of nursing systems provides the unique focus for nursing. There is ample evidence in the literature that the theory is useful in

developing and guiding practice and research. It gives directions to nursing-specific outcomes related to knowing and meeting the therapeutic self-care demands, regulating the development and exercise of self-care agency, establishing self-care and self-management systems, and others. The theory is also useful in the design of curriculums for preservice, graduate, and continuing nursing education. The theory also gives direction to nursing administration. The development of theory-based computer systems, assessment forms, and the overall structuring of the delivery of care attests to the usefulness of the theory (Tomey & Allgood, 2002).

According to Melnyk (1983), the analysis devised by Barbara Stevens shows that Orem's theory does contain inconsistencies. However, upon examination, it proves to be remarkably coherent in the view it takes of the world of nursing and the actions of people in it. Because of the congruity among its parts, it is a nearly ideal model with which to demonstrate the process of analysis devised by Steven. It also provides a vivid example of the necessity for probing analysis of nursing theories. cursory evaluation of the theory may suggest implications and applications that are not borne out by more rigorous examination. The exercise of such rigor in scrutinizing theories of nursing is something that nurses and nursing can no longer afford to neglect.

George (2002) critiques Orem's theory as simple yet complex. The essence is cloudy by ancillary description. The term self-care is used with numerous configurations. This multitude of terms, such as self-care agency, self-care demand, self care premise, self-care deficit, self-care requisites, and universal self-care, can be very confusing initially until the essence of each concept is understood. Another limitation, according to George, includes her discussion of health. Health is often viewed as dynamic and ever changing. Orem's model of the boxed nursing system implies three static conditions of health. She

refers to a concrete nursing system, which connotes rigidity. Another impression from the model of nursing system is that a determining factor for placement of a patient in a system is the individual's capacity for physical movement. Throughout her work there is limited acknowledgement of the individual's emotional needs.

Whelan's devised analysis and application of Orem's self-care practice model quotes Stevens, "The complexity of Orem is viewed as balanced between highly complex and parsimonious. The elements are identified but there is room for growth and inclusion of other elements in the model" (Whelan, 1984, p.344).

The case study we are considering involves a patient, Sarah Martin, with the diagnosis of congestive heart failure/pulmonary edema. The basic conditioning factors presented here (age, gender, height, and weight) show Ms. Martin to be a 61-year-old woman who is 5 feet 6 inches tall and weighs 154 pounds. Additionally, initial assessment and history data reveal that she has been having difficulty maintaining the universal self-care requisite of sufficient intake of air because she has required two to three pillows in order to sleep comfortably and experiences shortness of breath with household duties. She was also noted to be short of breath while sitting with feet dangling over the edge of the bed. She has possibly had difficulty maintaining the proper balance between fluid intake and elimination as evidenced by a weight gain of several pounds over the last two months. The fact that Ms. Martin has been experiencing increasing fatigue indicates she has had difficulty maintaining a balance between activity and rest. Nothing is specified here regarding her developmental state, but it would be reasonable to assume that because of her increased therapeutic self care demands, Ms. Martin's social interaction is quite limited. At age 61, Ms. Martin has probably peaked regarding fulfillment of her life potential

and is preparing to enter retirement and enjoy the fruits of her labors. This illness constitutes a real threat to the realization of that goal.

A review of previous medical records reveals Ms. Martin has a history of several health deviation requisites, including coronary artery disease with a large anterior myocardial infarction six months ago. Her left ventricular ejection fraction is 30%, an indication of moderate to severe heart failure. Noncompliance with medication and diet protocols indicates Ms. Martin lacks knowledge regarding her disease.

Even though Ms. Martin's self-care agency is severely compromised she may still be able to participate in her care in a limited way, indicating implementation of a partly compensatory nursing system, at least initially. Ms. Martin's care plan, including self-care deficits with estimative self-care operations (Jaarsma et al, 1998) in column one, and nursing system measures, or transitional self-care operations (Jaarsma et al, 1998) to meet her therapeutic demands in column two. For the most part, only those mentioned in the document are included.

Universal Requisites/Self-Care Deficits

Nursing System Measures

Impaired Gas Exchange related to excessive fluid in lungs, as evidenced by dusky nailbeds. ABG results (PaO₂ 80). Tachypnea with shallow respirations. (Ackley & Ladwig, 1999).

Decreased cardiac output related to impaired cardiac function as evidenced by slow capillary refill, skin cool and moist, weak peripheral pulses, enlarged cardiac

O₂ per order. Elevate head of bed. Monitor rate, quality of respirations frequently.

Monitor ABG's prn. Pulse oximetry.

Monitor LOC. Provide well ventilated room environment.

Maintain venous access at KVO rate to limit fluids. Lidocaine bolus and infusion for PVCs. Digoxin to increase cardiac output (Dig. Level below therapeutic range)

silhouette on chest x-ray, displaced PMI, irregular heart sounds, heart murmur, and cardiac arrhythmias (Ackley & Ladwig, 1999).

Fluid volume excess related to impaired cardiac and renal function as evidenced by pitting edema on lower legs, inspiratory crackles, increased creatinine level, JVD at 45 ° head elevation and hepatomegaly (Ackley & Ladwig, 1999).

Lasix and Potassium replacement as ordered.
Foley catheter to help monitor intake and output carefully. Elevate legs.

Fear related to disease process (Ackley & Ladwig, 1999).

Morphine per order for dyspnea and discomfort.
NTG per order for chest pain.

Fatigue related to disease process (Ackley & Ladwig, 1999)

Assist with personal activities as needed.
Provide frequent rest periods between nursing care procedures. Quiet, restful environment.

As a result of the continuing evaluation of her plan of care, nurses noted that Ms. Martin's condition had deteriorated, creating an increased therapeutic self-care demand. Now the nursing system was recognized to be wholly compensatory. Signs of increased deficits regarding cardiac function included an S₃ gallop per heart sound auscultation, increased cardiac arrhythmias, and pulsus alternans. Increased crackles throughout lung fields, an occasional cough productive of pink-tinged sputum (pulmonary edema), and a severe drop in urinary output indicated increased fluid excess. Morphine was given to make Ms. Martin more comfortable and additional Lasix was given to help alleviate the fluid volume excess. A thermodilution balloon-tipped flow

directed pulmonary artery catheter was inserted to more closely monitor fluid status and heart function. An arterial catheter was inserted radially to more closely monitor vital signs.

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