Theory Based Nursing Practice (TBNP)

A working document

by

The University of Tennessee at Chattanooga

School of Nursing Faculty & Students
PREFACE

We hope this packet will be a helpful reference for students, faculty, as well as for Clinical Teachers. Scholarship and professional practice is only possible with reflection, critique and growth, thus, this is a “working” document; suggestions for content and clarity are actively solicited. An obligation of professionalism is lifelong learning and reflection. Orem recognizes that development in a professional role grows throughout the nurse’s lifetime; this Handbook will develop as we grow as Orem scholars and practitioners.

Some of the terminology will be new to you; some will be familiar, but used in a different way. *Italicized words* are those with a specific theoretical definition as defined by Dorothea Orem.

The practice of Nursing is complex requiring time and experience to have the knowledge needed to practice nursing—to this end, the courses in this curriculum have been developed to build on each other to provide you the knowledge to enter professional practice. Upon graduation, the responsibility for maintaining and developing your capabilities, lies with you. We expect you to leave this program as developing leaders, valuing lifelong learning, and with a desire to nurture and support other colleagues, especially the newest members of the profession. We hope you develop and grow your passion in nursing.

**About Dorothea Orem**

Dorothea Orem was born in Baltimore, Maryland in 1914. She received her diploma in nursing in 1934 from Providence Hospital School of Nursing, Washington, D.C. Orem received her bachelor of science in nursing education in 1939 and a master of science in nursing education in 1945 from Catholic University of America, Washington D.C. She had a varied background in clinical practice: OR, pediatrics, adult med-surg, private duty, and ER supervisor. She taught biological sciences, served as director of nursing service and director of the school of nursing at Providence Hospital, Detroit, Michigan. In 1949, she went to the Indiana State Board of Health, Hospital Division, where she worked to help upgrade the nursing services in general hospitals in Indiana.

As part of her master’s degree work, Orem had to formulate a definition of nursing. During 1958-59, she worked as a consultant to the Office of Education, Department of Health, Education and Welfare in Washington and participated in a project to improve practical nurse training. This work stimulated her to seek to identify the condition or circumstances under which a decision is made that nursing care is needed. Her answer encompassed the idea that a nurse is “another self”. This idea evolved into her nursing concept of “self-care” and later into the Self Care Deficit Nursing Theory. Self-care implies that when they are able, individuals care for themselves. When the person is unable to care for themselves, the nurse provides the assistance needed. For children, nursing care is needed when parents or guardians are unable to provide the amount and quality of care needed.

This concept was first published in 1959. She worked with other nurse faculty members from the Catholic University of America to continue the work and develop this concept further. In 1971, Orem published Nursing: Concepts of Practice. It is now in its 6th edition.

Throughout her career, she was the recipient of numerous honorary degrees; several doctor of science degrees, national awards, and Sigma Theta Tau International awards. Dorothea Orem died in June of 2007.
CHAPTER ONE
Introduction to Theory-Based Nursing

The healthcare environment is relentlessly growing more complex as have the responsibilities for professional nursing. Often it is not clear “what is nursing” and “what is not,” to quote Florence Nightingale (1859). The UTC School of Nursing is preparing students for this complex environment with a foundation for all of the possibilities that lie ahead—to this end, we committed to a curriculum based on a Nursing Model, The Orem Self-care Deficit Nursing Theory. This is just one nursing model of several, but was one that was philosophically congruent with the faculty.

What Is Nursing Theory?

Nursing theory is the term given to the body of knowledge that is used to support nursing practice. Theory is the creative and systematic way of looking at the world or an aspect of it to describe, explain, predict, or control it. The first term to consider in learning about theory is the concept. Concepts may be empirical or abstract depending on their ability to be observed in the real world. Concepts are said to be empirical when they can be observed or experienced through the senses. Example: A stethoscope is an example of an empirical concept because it can be seen and touched. Abstract concepts are those that are not observable, such as caring, hope and infinity.

A nursing theory provides the framework that links nursing research, nursing practice, and nursing knowledge.

Why Use Orem’s Self Care Deficit Theory of Nursing?

It provides a positive frame of reference about nurses, patients, and the interactions between the two. It promotes clear understanding of the nature and scope of nursing, clarifying what nursing is, what it is not, and what it could be. It provides communication, structure, focus, links relevant knowledge, provides clarity and specifies outcomes or goals for nursing that facilitate ways in which to demonstrate the effectiveness of nursing care and accountability for nursing actions.

Orem-Based Nursing Practice

The debate whether Nursing is a profession is over and even though the development of her theory began at a time when this was a philosophic question, Orem (2001) leaves no doubt that nursing is a profession, and describes the knowledge needed for practice in the context of health care. The following is based on her last book (2001).

All of the health professions share knowledge in the broad liberal arts. There are also some specialized pre-requisites for most of the professions—e.g., Anatomy and Physiology. Each profession, however, makes a unique contribution to the person receiving health care. Furthermore, Orem (2001) says the role each profession plays is determined by the health care needs of the person (patient), such as a disease, for example. The phenomenon “disease” is the focus of medical practice (medical diagnosis, treatment, prevention, etc). The health care needs of a patient requiring nursing care relate to the self-care requisites. If the person is unable to meet his/her self-care requisites, nursing is needed. How do you know if a patient has self-care needs?
By a nursing history in which self-care requisites are systematically assessed. (UTC SON Nursing Health History: Based on Orem’s SCDNT, Appendix A)

What is the knowledge needed for a practice of nursing in Orem’s SCDNT? Orem recognizes the complexity of nursing knowledge; she delineates three (3) interrelated theories within SCDNT. The first theory, theory of self-care, assumes people innately desire self-care agency, and as such self-care agency is learned. The second theory, theory of self-care deficit, establishes the need for nursing. The third theory, theory of nursing system, directs the nursing role in helping the person (or dependent care agent) overcome, or adapt to the self-care deficit. The role of nursing in the health care system is to facilitate self-care agency for the patient.

It is important that concepts in a model or theory are clearly delineated so everyone is speaking the same language. Clarity of terms means we are all “speaking the same language, whether a practitioner, researcher, or theorist. Practice linked to research and theory build Nursing Science.

Metaparadigm

Each discipline has a focus or concept(s) that guides its knowledge development; this overarching focus is termed metaparadigm. From your general education requirements many of these are familiar: for example, for linguistics, the metaparadigm concept is language in all its permutations. And many other disciplines use that knowledge, in this example, perhaps, anthropology. In health care, the professions commonly use the empirical knowledge that was developed from metaparadigm concepts from other disciplines. There are many examples: anatomy, physiology, microbiology, pathophysiology, pharmacology. For a health care provider example, movement is the metaparadigm concept central to physical therapy; knowledge for PT rests with all aspects of movement: assessing and treating musculoskeletal problems; rehabilitation, etc.; for pharmacologists, drugs, in all related manifestations is the metaparadigm; medicine for physicians, etc.

The metaparadigm concepts for Nursing are: Person (man), Health, Environment, and Nursing. While these overarching concepts are identified as nursing phenomena, the definitions and relationships among them are found in specific Nursing Models and Theories, developed by Nursing Theorists. The models provide perspective and meaning to Nursing. Inherent in all nursing models is the perception of Person (man) as a holistic being. With this commonality, knowledge needed for nursing practice is built on this perception: the pathophysiology of diabetes is not in itself nursing knowledge. We must know this, however, because diabetes has manifestations on the person as a whole.

Nursing is both a profession and discipline. The word profession comes from Latin meaning a public declaration. This declaration is to society and is our commitment to care for individuals, groups, and communities, often when they are in their most vulnerable state. In return, society grants us a license to practice. The license tells the public that its practitioners are safe to practice that which the profession has deemed necessary.

Discipline also is derived from Latin, meaning both teaching and learning. The knowledge needed to practice professional nursing is developed in the Nursing discipline—this body of knowledge is known as Nursing Science. Nursing Science is built on rigorous study of practice, theory, and research. The shared knowledge from other disciplines is what shapes the science. Thus, Nursing
can be interpreted as a noun to mean a body of knowledge \textit{(discipline)}, as well as a verb \textit{(the practice} of nursing).

There are at least seven well developed \textit{Nursing Models} or paradigms. These paradigms help to study and explain the mind. The Nursing Model which will direct your studies and clinical practice in the SON is Orem’s (2001) Self Care Deficit Nursing Theory (SCDNT).

The UTC SON Curriculum is five semesters. Each semester has an “agency” course, a “systems” course, and a clinical practicum. The agency courses are for the development of the nurse as a professional; the systems courses have “valid and reliable knowledge,” in other words are “content-driven.” The clinical practica are for the synthesis and application of the agency and systems courses.
CHAPTER TWO

Theory of Self Care

Self-care is a human regulatory function that persons must perform for themselves in order to maintain life. Self-care must be learned and it must be deliberately performed. As a result, persons through this learning, exercise intellectual and practical skills to manage themselves to sustain the motivation essential for daily care in an effective manner. The way an individual engages in self-care will vary due to influences from their culture, environment and outside influences. Engaging in self-care and dependent-care are affected by a person’s limitations in knowing what to do, when to do it and how to do it.

The theory of self-care is the essential element of self-care deficit nursing theory. This first part of the theory explains and develops the reason why persons require nursing care. In the theory of self-care, Orem explains self-care as the activities carried out by the individual to maintain their own health.

This theory proposes the concept of self-care agency, what it means, assumptions, and propositions regarding the relationship among self-care, self-care requisite, self-care agency, and therapeutic demand. Moreover, Orem proposes these concepts as being valid as explanations for health and well-being.

A. What does Self-care mean?

1. A regulatory function that “stands in distinction from other types of regulation of human functioning” (Orem, 2001, p.143) such as GI system, endocrine system, etc.

2. Deliberate action is necessary for self-care and care of dependents

3. Deliberate action is not innate or inborn

4. Abilities are learned

An example: an infant and young child do not have the ability to be independent with toileting. The parent in this case would be the dependent care agent. This role has someone other than the person in question take care of this self-care requisite. As the child grows, s/he become toilet trained, a deliberate and learned action. Different societies have different actions for the child to learn this self-care action, and it may be quite different from ours. Once the child learns this deliberate self-care action, the dependent care agent has no need to intervene. If the child has diarrhea, and loses control, the dependent care agent would again need to perform this function for the child.

If the dependent care agent wants the child to be completely toilet trained before the second birthday, nursing care may be needed. Does the dependent care agent not have an understanding of child development, and thus begins scolding of the child? In this case the dependent care agent needs nursing care, specifically, supportive-educative interventions to guide the parent in understanding the child’s self-care ability for that goal.
So now the child grows up (presumably toilet trained), becomes an adult and is hospitalized with a stroke. Among the constellation of signs of a stroke is urinary incontinence, by definition an unwanted deficit. The patient does not have the ability to meet this self-care requisite, though he has learned it in the past. At this point nursing care is needed. With interventions and time, the person has regained the ability to manage this self-care requisite. Suppose the patient will have to manage his incontinence post discharge? The nurse will teach the patient until he has the ability for *learned, deliberate* action to meet this self-care requisite.

B. *What is a Self-care requisite?*

1. “Requirements” necessary for health and well-being or “The reasons for which self-care is undertaken” (Orem, 2001, p.522)
3. There are 3 types of self-care requisites: universal, developmental and health deviation

Self-care requisites are based on three assumptions: Human beings have common needs for the intake of materials necessary to sustain and maintain life; human development from in utero to mature adult requires action to maintain conditions to promote growth and development at each period of the life cycle; and deviation from normal structure and function and well-being requires action to prevent occurrences and action to control the effects of the deviation.

*Universal Self-Care Requisites* (USCR) are common to all human beings during all stages of the life cycle with adjustments according to age, developmental state, the environment and other factors.

1. Maintenance of sufficient intake of *air, water, food*
   a. Taking in that quantity required for normal functioning with adjustments for internal and external factors that can affect the requirement or, under conditions of
scarcity, adjusting consumption to bring the most advantageous return to integrated functioning
b. Preserving the integrity of associated anatomic structures and physiologic processes
c. Enjoying the pleasurable experience of breathing, drinking and eating without abuse

2. Provision of care associated with eliminative process and excrements
   a. Bringing about and maintaining internal and external conditions necessary for the regulation of eliminative processes
   b. Managing the processes of elimination and disposal of excrement
   c. Providing subsequent hygienic care of body surfaces and parts
   d. Caring for the environment as needed to maintain sanitary conditions

3. Maintenance of a balance between activity and rest
   a. Selecting activities that stimulate, engage, and keep in balance physical movement, affective responses, intellectual effort and social interaction
   b. Recognizing and attending to manifestations of needs for rest and activity
   c. Using personal capabilities, interests, and values as well as culturally prescribed norms as bases for development of a rest-activity pattern

4. Maintenance of a balance between solitude and social interaction
   a. Maintaining that quality and balance necessary for the development of personal autonomy and enduring social relations that foster effective functioning of individuals
   b. Fostering bonds of affection, love, and friendship; effectively managing impulses to use others for selfish purposes, disregarding their individuality, integrity, and rights
   c. Providing conditions of social warmth and closeness essential for continuing development and adjustment
   d. Promoting both individual autonomy and group membership

5. Prevention of hazards to life, functioning, and well-being
   a. Being alert to types of hazards that are likely to occur
   b. Taking action to prevent events that may lead to the development of hazardous situations
   c. Removing or protecting oneself from hazardous situations when a hazard cannot be eliminated

6. Promotion of normalcy
   a. Developing and maintaining a realistic self-concept
   b. Taking action to foster specific human developments
   c. Taking action to maintain and promote the integrity of one’s human structure and functioning
   d. Identifying and attending to deviations from one’s structural and functional norms (Orem, 2001).
Now let’s translate these USCR into examples you can use in your practice.

- **Air** – breathing without use of oxygen equipment at 12-18 times per minute (adult)
- **Water** – drink six to eight 8 oz glasses of water daily (adult/adolescent)
- **Food** – consume an 1800-2000 calorie, balanced diet daily using the food groups for guidance (adult)
- **Elimination** – bathe daily
- **Activity/Rest** – exercise for at least 30 minutes/day at least 5 times/week; sleep 8 hours/night
- **Solitude/Social Interaction** – interact with family and friends daily; spend time alone for one hour daily
- **Prevention of Hazards/Promotion of Well Being** – avoid foods high in fat and sugar; stop smoking; use seat belt whenever in a moving vehicle
- **Normalcy** – be able to verbally describe your perception of yourself and level of competency (Dennis, 1997).

**Developmental Self-Care Requisites (DSCR)** are associated with human growth and development processes and with conditions and events that occur during various stages of the life cycle (e.g., prematurity, pregnancy) and disruptions or events that can adversely affect development. Developmental self-care requisites have a strong connection with the universal self-care requisites. The focus of DSCR is how they are expressed with developmental stages. Orem defined the conditions associated with DSCR as coming from the following six stages of the life cycle:

- Fetal, including birth (intrauterine)
- Neonatal
- Infancy
- Childhood and adolescence
- Adulthood
- Pregnancy in either adolescence or adulthood

Orem recognizes that each person develops as a separate, unique person and at their own rate. Environmental conditions and the availability of resources that promote the natural development of individuals vary within families, communities and even societies. Each person throughout these stages experiences internal and external conditions that can change or adversely affect their development. At certain stages of development, the person becomes involved in his or her development and movement toward maturity. Initially, during the stages of intrauterine life, infancy, and childhood, the developmental requisites are met by dependent-care agents, parents, or others. As a result of her work, Orem suggested three sets of developmental requisites for determination of their usefulness in practice situations.

**Provisions of Conditions that Promote Development**

These are the developmental requisites that are met by dependent care agents in the early stages of the life cycle.

Updated Fall 2014 (citation corrections Sept 2016)
1. Provide and maintain an adequacy of materials (food and water) as well as living conditions to promote development of the human body
2. Provide and maintain physical, environmental and social conditions to promote comfort and safety
3. Provide and maintain a balance between sensory overload and sensory deprivation
4. Provide and maintain conditions that promote cognitive development
5. Provide experiences to facilitate beginning and advanced skill development essential for life in society
6. Provide experiences that facilitate awareness of one’s own unique sense of self and his or her place within the family, community and world
7. Regulate the physical, biologic, and social environment to prevent development of states of fear, anger, or anxiety

Engagement in Self-Development

These are the developmental requisites that require deliberate involvement of the person (self) in the processes of development.

1. Seek to understand and form habits of reflection to develop insight about self, perception of others, relationships to others, and attitudes toward them
2. Seek to accept feelings and emotions, after reflection, as necessary to develop insight about self, relationships, objects, or life situations
3. Use talent and skill in preparing for engaging in productive work in society
4. Engage in clarification of values and goals in situations that require personal involvement
5. Act with responsibility in life situations
6. Seek to understand the value of positive emotions in developing the habits known as virtues
7. Seek to understand that negative emotions and impulses occur when conduct is out of balance with one’s goals and self-perception.
8. Promote positive mental health through deliberate action

Interferences with Development

Throughout the life cycle there are events, conditions and problems that can adversely affect human development at any stage of the life cycle. Orem suggests two goals for successful navigation of human development. The first is to provide conditions and encourage behaviors that will prevent the occurrence of adverse effects on development. The second is to provide conditions and experiences to overcome adverse effects on development.

Adverse conditions may include:

1. Educational deprivation
2. Problems of social adaptation
3. Failures of healthy individuation
4. Loss of relatives, friends, associates
5. Loss of possessions, loss of occupational security
6. Abrupt change of residence to an unfamiliar environment
7. Status associated problems
8. Poor health or disability

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9. Oppressive living conditions
10. Terminal illness and impending death

The conditions Orem (2001) listed above are self-explanatory. Some occur more commonly, but any may impact the person’s ability to engage in self-care. For example, educational deprivation of school aged children. If the parent removes the child from school where the child has many friends, the child may not do as well being moved to a new school. Another example would be failures of healthy individuation. This deprivation may manifest itself as a six year old sleeping with parents. This deprivation is reciprocal: the child not wanting to sleep in their own bed and the parents not wanting to make the child leave.

**Health Deviation Self-care Requisites (HDSCR)** are associated with genetic, human and functional deviations and their effects along with the medical diagnosis and treatment interventions and their effects. By meeting health deviations requisites, pathology may be controlled in its early stages (secondary prevention) and in the prevention of defects and disability (tertiary prevention). Effectively meeting the USCR and DSCR (primary prevention) is essential when dealing with HDSCR in order to maintain structure, function, promote development and contribute to rehabilitation. Health deviations may arise from illness, injury, defects, disability (either physical or mental) or from the medical treatment prescribed. These requisites may be temporary or long-term in duration. Orem (2001) identifies the following six HDSCR:

1. Seeking and securing appropriate” kinds of help from health care provider
2. Aware of and appropriately attending to effects of health deviation
3. Following prescribed therapeutic regimen
4. Aware and attending to effects of therapeutic regimen [a slight variation of (2)]
5. Modify self-concept to accept current condition
6. Learning to live with effects of condition, including lifestyle

Examples for practice might be:

1. Go to the emergency room when you experience persistence chest pain and shortness of breath

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2. Record the time and pattern of fever during infectious processes
3. Take Tylenol 650 mg by mouth when fever exceeds 101F
4. Record occurrences of insulin shock for one week following a change in insulin dosage
5. Join a chemotherapy support group of cancer patients to discuss feelings about loss of hair
6. Participate in senior Olympics (Dennis, 1997).

All patients who have a health deviation have HDSCR. This means that all of your patients will have HDSCR, otherwise they would not be your patients and be seeking nursing care. As nurses we may not be able to fix a self-care deficit but it does not mean that we cannot help the patient. Knowing your patients USCR and DSCR will assist you in helping them meet the challenges of their HDSCR. It is important to treat each patient as an individual when planning their care because each patient will react and respond differently. Asking the right questions will help you determine where your patient stands and how you should plan their care as well as provide education for them and or their family in treating their specific health deviations. Let’s look at each HDSCR specifically.

1. Seeking and securing appropriate medical services
   a. Does the person or dependent care agent recognize there is a health deviation? This includes acute onset (sudden injury) and gradual onset or occurrence of mild symptoms that progressively get worse (such as gallbladder disease). If a health deviation is not recognized, medical care will not be sought.
   b. How long has it been since the onset of injury or noticeable symptoms? This can give clues into the patient’s insight and at what point they see the need to get medical attention. If that point is too late, educating the patient about when medical care is needed may be appropriate.
   c. Does the person or dependent care agent know where to get help? Is there a primary care provider? Where did the person seek medical care this time? Was it
the emergency room after a wound became severely infected? Would it have been appropriate for this person to seek medical attention sooner?
d. Does the patient know what symptoms to report, when and how to report those symptoms, after diagnosis of a medical condition or surgery?
e. Are there any limitations to seeking and securing medical care? Transportation issues? Finances or insurance issues? Is there another family member whose health issues take priority? Is there anything that would limit a person who knows there is a need for medical care from seeking and/or securing care?

2. Being Aware of and Attending to the Effects of the Health Deviation
   a. Does the person or dependent care agent know and understand what the health deviation is and how to manage it effectively? For example, the patient with diabetes understanding the role of insulin in regulating blood sugar. Does the person know when and how to administer insulin? Does the person understand diet restrictions? Does the patient that underwent hip replacement or fracture repair surgery understand the movement and position restrictions in the early and late post-operative period? Does the patient know how to care for the wound and change the dressing? If not, is there a family member (dependent care agent) that could do it for them?
   b. Basically, ask yourself, “Does the patient understand the health deviation and how to manage it effectively?”

3. Effectively Carrying out Medically Prescribed Diagnostic, Therapeutic and Rehabilitative Measures
   a. This refers to number two, but focuses more on whether the patient has the ability and motivation to carry out prescribed measures, whereas number two focuses on whether the patient knows what the measures are.
   b. Medication regimen, complying with NPO status for diagnostic procedures (the patient is more likely to comply if they know why), dressing changes, self-injections, colostomy or urostomy changes.
   c. Does the patient have the means to carry out the above? Can the patient with diabetes handle a needle with steady hands? Can he/she see well enough to draw up the insulin from the vial into the syringe?
   d. If the patient is not able to carry out manual and technical tasks necessary to manage the health deviation, who is available at home that can assist the patient, or do it for them? Is a referral for home health care needed?
   e. Does the patient experience pain? Is there adequate pain control to participate in physical therapy?
   f. Be aware of anything that would limit the patient’s ability to carry out prescribed measures and treatments. Ask the patient, “Do you anticipate having trouble with any of these prescribed treatments?” “Have you had trouble in the past carrying out the treatments that were prescribed by your physician?”

4. Being Aware of and Attending to the Discomforting Effects of Medically Prescribed Measures
a. Medication side effects – knowing what they are and how to minimize them if possible
b. Surgical procedures – all will cause some discomfort in the post-operative period. The degree of pain and discomfort depends on the procedure but make sure the patient knows how to minimize this as much as possible.
c. Anything else that would cause pain, discomfort, or bothersome side effects. For example, some patients may feel better when changing positions frequently but are they able to do this? Do they need a caregiver that can help them move in bed?

5. Modifying Self-Concept and Accepting One’s Health State
a. A female patient that recently underwent a mastectomy for breast cancer – what are her feelings about body image? Not all women will feel the same, it is important to individualize your responses and care of the patient.
b. A patient has been recently diagnosed with diabetes, either type 1 or 2. Regardless, it is a lifelong condition and cannot be cured. It is important for the patient to understand they will have to monitor the disease for the rest of their life and that effectively managing the disease requires lifestyle changes.

6. Learning to Live with Effects of Health Deviation and Treatment of that Health Deviation
a. This relates closely to number 5 but is more focused on the patient’s lifestyle and the understanding of the need for change.
b. The patient may be unable to do the things they once enjoyed because of a permanently disabling injury. Even severe arthritis can drastically change a person’s lifestyle.
c. Ask: What is the patient’s primary support system? Is this adequate? (Usually best to let the patient make the determination).
d. Is referral to a support group appropriate?
e. What is the patient’s overall outlook of life since the injury or diagnosis of the illness? Ask, “How do you anticipate this will affect your life?”

Remember that each HDSCR is highly individualized and specific to each patient. By knowing your patient’s USCR and DSCR can assist in how you approach nursing care for this patient and whether a dependent care agent or outside referral is needed.
CHAPTER THREE

The Theory of Self-Care Deficit

The theory of self-care is mainly concerned with establishing what self-care means. Establishing this theory as legitimate is required in order to understand the other two theories Orem developed. The self-care requisites as discussed in chapter two are conditioned or influenced by several factors. These are the basic conditioning factors and the power components. The basic conditioning factors (BCF) influence both the need and abilities of the person for performing self-care. Basic conditioning factors are factors that affect all persons. They are listed as follows:

- Age – current chronological age of the person
- Gender – as either male or female
- Developmental state – the person’s physical, functional, cognitive and psychosocial level
- Health state – the current and past health states of the person and their perception of their health
- Sociocultural orientation – the interrelated systems of the person’s social environment, spiritual beliefs, social relationships and functioning of the family unit
- Health care system – the resources in which health care is accessible and available to the person for medical diagnostic and treatment modalities
- Family system factors – roles/relationships of family members and significant others; the person’s role in the family
- Patterns of living – the person’s usual normal activities of daily living
- Environmental factors – the setting in which the person normally conducts self-care; the home environment
- Available resources – this includes economic, personnel, agencies and time

(Orem, p. 245, 2001)

It is important to understand the basic conditioning factors for persons as they perform self-care or dependent care. Persons must develop knowledge of the ways in which these factors influence both the self-care requisites and the abilities for meeting self-care or dependent care. Nurses need this knowledge to distinguish individual characteristics of persons so that they are better able to help and collaborate with meeting and achieving therapeutic self-care. Knowledge of the basic conditioning factors may also help the nurse to predict the type and amount of assistance persons will accept. Nurses must also have insight into their own basic conditioning factors as this will influence their nursing agency and the nursing care they provide.

A person also has power components. These are the person’s capabilities that enable the person to meet self-care requisites. The power components can be assessed by observing the patient when conducting the health history and physical assessment. There are ten power components according to Orem. These were first published in 1979.

1. Attention and vigilance – Can the patient repeat instructions that were given? Can the patient recall previous information given? Is the patient easily distracted? The amount of
attention and vigilance the patient gives can be affected by several factors, such as how much pain s/he is in, medications taken, developmental issues, attitudes, etc. These factors need to be taken into consideration when assessing the patient. When a patient can express their understanding of preventive measures and the treatment regimen, they are demonstrating vigilance.

2. Energy – What is the person’s capacity for taking action? This will be influenced by the severity of the patient’s condition, medication effects, age, lifestyle, etc. The person may have a high level of energy and be able to ambulate without assistance or have a low level of energy and not be able to turn themselves in bed every two hours. Energy can be measured by observing how many tasks the person can do independently, such as bathing, feeding themselves, ambulating, etc.

3. Control of body position – How well can the patient perform activities of daily living (ADLs) and perform treatment regimens? For example, does the patient have enough strength to press down and turn the cap to open a pill bottle? Does the patient have enough strength in their fingers to grasp a fork and lift it to their mouth? This action can be connected to a patient that has had a stroke who may have lost some motor function.

4. Ability to reason – Is the patient mentally, physically or emotionally able to reason and make decisions? It is important to assess the patient’s power to think and their orientation. It is important that the patient understands instructions and can carry them out. An example of reasoning would be the statement by a patient, “I can take a bath by myself, but you can change the bed linens while I take a bath”.

5. Motivation – If a patient is not motivated then they will not make performing their treatment regimen a priority. If the patient is doing all that they can to try and get well, this is an indication of a high level of motivation. Is the patient goal oriented in wanting to take over their own care?

6. Ability to make decisions – This power component may be affected by the patient’s pain level, severity of the patient’s condition, developmental level, etc. When determining the patient’s ability to make decisions, it is important to remember that if you disagree with a patient’s decision, that does not mean that the patient is incapable of making a decision. Can the patient actually decide they are going to reduce their stress by cutting down on work hours and then actually do it?

7. Ability to acquire, retain, and operationalize technical knowledge – Is the patient able to carry out the treatment plan independently? Is the patient able to ask for help (consulting with the right person) when he/she is unable to figure out the insulin pump and then able to make adjustments or take care of the problem with instructions?

8. Cognitive, manipulative, communication, and interpersonal skills – Does the patient have the overall knowledge necessary to live alone, take medication and attend to their universal self-care requisites? How does the patient interact with others? Does the patient engage others in conversation?

9. Ability to prioritize and connect actions – The best way to determine the patient’s ability to prioritize is to observe the patient’s actions and to listen intently during assessment. An example might involve a diabetic patient. The patient states, “I know I cannot eat my meal
without first having my insulin injection, so I will wait for the nurse to give me my injection before eating”. The patient knew that since s/he was a diabetic, getting the insulin injection before the meal was a higher priority than eating the meal as soon as it was brought to him/her.

10. Ability to be consistent and integrate – If the patient learns and can consistently apply the treatment regimen during hospitalization, then they are more likely to continue when discharged. Review the steps of the treatment regimen with the patient and have them verbalize and/or demonstrate they understand and can perform on their own.

Again, assessing basic conditioning factors and power components can be part of the health history and physical assessment. This will reveal the person’s self-care abilities. For example, you have a patient that is newly diagnosed with diabetes and has not had any teaching about its management. Knowing what you know and what the patient knows, enables you to prioritize relevant teaching needs.

What does Self-Care Agency mean?

Agency is “the power to engage in action to achieve specific goals” (Orem, 2001, p. 514). Self-care agency refers to the power or ability to engage in actions to meet the self-care requisites (universal, developmental, and health deviation). In other words, the action performed in caring for self. This power or these abilities develop over time and may vary in degree of adequacy from one time to another. What affects the degree of adequacy is the basic conditioning factors such as age and developmental state.

What is a Therapeutic Demand?

This is the summation of care measures that are necessary at any given time for meeting all of an individual’s known self-care requisites. As a result, the person is able to achieve self-care. The theory of self-care proposes that the concepts (self-care requisites, basic conditioning factors, and power components) as being valid explanations for the requirements necessary for health and well-being.

The Theory of Self-Care Deficit

The theory of self-care deficit explains and develops the reasons why persons require nursing care. An assessment of the self-care requisites (universal, developmental, health deviation) will establish that there is a therapeutic demand. The next step is to determine the person’s ability to meet the therapeutic demand. This is done through assessing the basic conditioning factors and power components which will then establish the need for nursing.

The theory of self-care deficit is the identification of the “what” nature of the self-care deficit and the actions that will be necessary to meet the therapeutic demand. This analysis provides the basis for how nursing will assist the person in self-care agency. Self-care deficit nursing is identified as a general theory on what nursing is and should be as it is formed in concrete nursing practice situations. The theory of self-care deficit focuses on the relationship
between the therapeutic self-care demand (TSCD) (the total of all self-care requisites) and the self-care or dependent care agency (the abilities for meeting the self-care requisites). Eight functions of self-care deficit nursing theory have been identified by nurses as being essential to explaining what the theory is. The functions are:

- To set forth the views of human beings proper to nursing
- To express the specific focus or proper object of nursing in human society
- To set forth the key concepts of nursing considered as a field of knowledge and practice and to establish a system of symbols or language
- To set limits on and orient thinking and practical endeavor in nursing practice, research, development, and education for nursing
- To reduce cognitive load by providing subsumers for incoming information and enable persons who understand the theory to categorize and form concepts from related insights about features of concrete nursing situations
- To allow inferences to be made about the articulations of nursing with other fields of human service and with patterns of daily living of individuals and families in communities
- To generate in nurses and nursing students a style of thinking and communicating nursing
- To bring nurses together as communities of scholars engaged in the continuing development, the structuring, and the validation of nursing knowledge (Orem, 2001, p. 137)

These eight functions of the self-care deficit theory are based on nurses’ perceived and expressed values of the theory in guiding their observations, their intellectual activities, their style of thinking, and their use of a developing language in their communications about nursing. The self-care deficit theory of nursing not only identifies what nursing is, but also provides the concepts that guide the initial and continuing development of a practical science of nursing (Orem, 2001).

See Appendix B for the Practice Model of Orem’s Self-Care Deficit Nursing Theory
CHAPTER FOUR

The Theory of Nursing Systems

The first two theories describe the nature of self-care and self-care deficits. People with health derived or health related self-care deficits (or dependent care deficits) have a need for nursing. The theory of nursing system includes the first two theories and defines the nature of the helping service provided by nurses. This theory introduces the nursing variable called nursing agency and concepts related to it. To understand the theory of nursing systems, one must accept that:

- Nursing is a helping service sanctioned and institutionalized by society
- Nursing is a complex, deliberate action performed by nurses to assist others (Orem, 2001).

The central idea behind the theory of nursing systems is that nurses provide a helping service. Nursing systems are a “series and sequences of deliberate practical actions of nurses performed at times in coordination with actions of their patients to know and meet components of their patients’ therapeutic self-care demands and to protect and regulate the exercise or development of patients’ self-care agency” (Orem, p. 519). This is done through the exercise of nursing agency. The concept of nursing agency arises when there is a need for nursing.

Nursing agency at its most basic definition is the skills and life experiences that nurses have gained through years of education and practice that they use to effectively treat patients. One cannot gain the skills to achieve a successful nursing agency overnight. The first thing to be mastered is a “construct of required operations” that consists of social, interpersonal, and professional-technologic domains. The first domain, the social characteristics refer to having knowledge of how to accept other cultures, values, ethics, and morals. The nurse is able to interact with patients, their families, and other health care providers with kindness and courtesy. The social refers to the profession of nursing as a whole and the social contract inherent in Nurse Practice Acts, for example. The nursing license confers legal legitimacy of nursing practice. In other words, someone who does not have the education of a nurse, cannot practice nursing, or even say he/she is a nurse. Society gives us our legitimacy as a nurse when we have the education and have passed a licensure exam (NCLEX) (Secrest, 2008).

The second domain, interpersonal, refers to the knowledge of how to interact with people on a deeper level. What this means is that the nurse is able to show empathy for a patient as well as have the desire to help that patient reach their self-care goal. The nurse realizes the importance of relationships and how to communicate effectively with the patient and others. Nurses who reflect upon these relationship experiences will have a much richer growth in the interpersonal domain. It also develops aesthetic knowledge. Experiences with demonstrations of empathy grow from each interaction. Intuition develops as knowledge, attitudes, and skills develop. Repetition will help transfer these skills to embodied knowledge where you do not need to think about each step. Embodied knowledge contributes to your intuition.
The last domain, professional-technologic refers to the knowledge of how to perform nursing tasks, like blood pressure, with confidence and ease as well as critical thinking abilities required for nursing process and nursing research. For example, the nurse is able to help the patient meet their self-care goal using a methodical process (nursing process). All of these characteristics define the complex development of the capabilities of the nurse. As we continue to grow as nurses, we constantly gain knowledge and capabilities of these social, interpersonal, and professional-technologic domains. We can add this growth to our repertoire which causes our personal nursing agency to become more powerful (Fulkerson, 2007). See Appendix C for the key elements of the social, interpersonal, and professional-technologic components of the process of nursing.

Orem speaks to the characteristics that are considered desirable in the three domains of nursing agency. The School of Nursing Faculty has identified seven characteristics essential to nursing agency:

1. Effective repertoire of communication skills
2. Transformative teaching
3. Leadership
4. Ethical practice
5. Prudent (legal) practice
6. Cultural sensitivity
7. Professional behavior (Keatley, 2008).

In order to recognize and apply these characteristics, however, one must first have enabling capabilities, such as art and prudence.

Whereas one can be taught the three required operations of nursing agency, the enabling capabilities of art and prudence are acquired through life experiences and one’s own personality and will differ with every nurse. Orem defines art as being “an intellectual quality of persons that is revealed in what they make, that is, the products of their endeavors” (Orem, p. 293). Art is the act of looking into a patient and seeing beyond the obvious deviations from which he/she is suffering, and truly seeing the patient and working towards goals to aid him/her. It is like working a puzzle; the nurse has the skills to see that patient not just as a patient but as a mother, sister, brother, husband, care provider and is able to piece together what is really going to help this patient beyond just medication. The truly skilled nurse takes these logical solutions gained through his/her art and is able to put these solutions into action through his/her qualities of prudence.

Orem defines nursing prudence as “the quality of nurses that enables them (a) to seek and take counsel in new or difficult nursing situations, (b) to make correct judgments about what to do and what to avoid when particular conditions prevail or suddenly develop in nursing situations, (c) to decide to act in a particular way, and (d) to take action” (p. 293).

Art is the creative investigations into the patient’s needs and prudence is how the nurse approaches fixing the deviations/problems. Since every nurse is an individual and has a different personality as well as ways of approaching situations, prudence is not something that can be
taught in absolute terms. Prudence is something that one has to gain over time and through education and life experiences, because there is not always a right or wrong way to handle a situation, there is just what feels right or wrong to the individual. There will never be a nursing situation in which one universal solution will work for every patient; you have to be willing to adjust and stretch your own limits and ideas to adapt to different patient’s needs. Both the art of nursing and nursing prudence develop in a nurse with life experiences and with diligent effort towards their development. How these develop is based on each individual nurses talents, personality characteristics, modes of thinking, personal moral development, abilities to conceptualize complex situations, abilities to analyze and synthesize factual information, and the kinds of life experiences they have had both personal and professional.

There are three basic variations in nursing systems:

- Wholly compensatory
- Partly compensatory
- Supportive-educative

These variations are associated with the question: Who can or should perform those self-care operations? If it is the nurse because the patient is unable, the system of nursing is wholly compensatory because the nurse will be compensating for the patient’s total lack of ability to engage in self-care activities. If the answer is that the patient can perform some but not all of the self-care actions, then the nursing system is partly compensatory. If the answer is that the patient can and should perform all self-care activities while engaging in self-care development, then the nursing system should be that of supportive-educative (Orem, p. 350). See Appendix D.

This theory governs how nurses help patients meet their self-care requisites. This requires persons educated as nurses who will design and regulate care to help restore self-care agency.

Imagine riding in the back seat of a tandem bicycle in which the patient is in the front seat. Initially, he is too weak or in pain to peddle: at this point you are peddling madly alone to keep the bike moving forward (wholly compensatory). As time passes, the pain is reduced and the patient becomes stronger, so he/she begins to help with the pedaling (partly compensatory). Farther along, the pain is negligible, the patient is strong enough to do all of the pedaling, but he/she does not know how to reach the destination. You as the nurse tell the patient where to go, pointing out landmarks for future reference (supportive-educative).

Again, the concept of nursing agency results in the designing, planning, and producing of a nursing system that includes nursing actions necessary for the sustaining and promoting of health and well-being of others as well as protecting the health of the nurse. Becoming a good nurse is a process that is ever changing and grows daily with the nursing experiences you encounter. The strength of one’s nursing agency is a reflection of one’s ability as a nurse; it is something that you build on your entire life, during your career, and something that continues to grow even after retirement.
OREM BASED DIAGNOSTIC PROCESS**

DETAILED ADULT ASSESSMENT

(**Subjective-Orem Health History:

Objective-Physical Exam (inspection [first], auscultation, palpation and percussion)

Interviewer’s Name ____________________________ Date ________________

<table>
<thead>
<tr>
<th>A. BASIC CONDITIONING FACTORS</th>
<th>THERAPEUTIC DEMAND</th>
<th>POWER COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Check if a demand is present)</td>
<td>(Ability to meet therapeutic demand – Y/N)</td>
</tr>
<tr>
<td>1. Age _____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gender ______</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>d. Who do you consider family? ________________</td>
<td></td>
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</tr>
<tr>
<td>e. What is your role in the family? ________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Do you have a family history of health/medical problems? If yes, list family member and health problems. ________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Attach a genogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sociocultural and Spiritual:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. What is your ethnicity? ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. What is your primary language? ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Do you have any trouble reading or writing? _____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Do you have a set of spiritual beliefs? ________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Do you have regular spiritual practices? ________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. **Health State**: (subjective and objective data)

**SUBJECTIVE:**

a. What is your current reason for seeking care? (use OLD CARTS as applicable)
   i. __________________________

b. Medical Diagnosis; DSM IV: Axis I – V; co-morbidies)
   i. __________________________

c. What are you most concerned about for this visit?
   i. __________________________

d. Usual health state (rate on scale of 1-10 with 10 being excellent and why) __________________________

e. Past health history (include medical, mental; surgeries; family history) __________________________

f. Medications (list all prescriptions, OTC, herbs, vitamins, etc.) (cite Patient explanation for use)

g. Other than medications, are you under any treatments for current illnesses? __________________________

h. Allergies (describe reaction to each) __________________________

**OBJECTIVE:**

a. Physical Exam – (section F)

b. Pertinent Laboratory and diagnostic tests – (section G)

6. **Health Care System Factors:**

a. Health Care Agencies (e.g. home health care, PT, OT, etc.)
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

7. **Patterns of Living**: What are your usual daily activities?
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

8. **Environmental factors**:

a. What in the home environment or work may contribute to your current health state?
   __________________________________________
   __________________________________________
b. Do you have concerns about your home or other environment related to your current health state? If yes, explain.

___________________________________

___________________________________

9. Resource availability/adequacy:
   a. Are your resources/finances adequate to meet the needs for medications and prescribed treatments?
      __________________________________

   b. What type of insurance (if any) is available?
      __________________________________

   c. What sources of help do you currently use to manage your health?
      __________________________________
      __________________________________

10. Developmental Stage: Intrauterine, neonatal, infancy, childhood, adolescence, adult. (circle the appropriate Orem stage)

B. POWER COMPONENTS: The abilities to meet therapeutic demands. Assess each component (with written description and supporting evidence) and make a clinical decision if they are adequate to meet any therapeutic demands.

1. Vigilance:
2. Energy:
3. Body Control:
4. Reason:
5. Motivation:
6. Decision Making:
7. Technical Knowledge:
8. Repertoire of skills:
9. Connect actions:
10. Perform/integrate:
### C. UNIVERSAL SELF-CARE REQUISITES:

Include details re: pertinent positives and negatives

<table>
<thead>
<tr>
<th>THERAPEUTIC DEMAND</th>
<th>POWER COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Check if a demand is present)</td>
<td>(Ability to meet therapeutic demand – Y/N)</td>
</tr>
</tbody>
</table>

#### 1. Air:

a. Do you have problems with SOB or use any devices to aid in breathing? If yes, describe.
   
   ______________________________________

b. Describe any problems with sinus/nasal symptoms? When you have a URI, how long does it take to recover and what is the usual progression?
   
   ______________________________________

c. Have you had unexplained cough, frequent colds, exposure to smoke or other respiratory irritants?
   
   ______________________________________

d. Have you experienced chest pain? (OLD CARTS)
   
   ______________________________________

#### 2. Water:

a. What liquids (including amount and types) do you drink in a 24hr. period?
   
   ______________________________________

b. Has your consumption changed in the last year?
   
   ______________________________________

#### 3. Food:

a. What do you routinely eat in a 24-hour day? (if directed, attach a 1 – day diet recall nutritional analysis form)
   
   _____________________________________

b. Describe your appetite.
   
   ______________________________________

c. Are you on, or have you been on in the past, any specifically prescribed diet? (if yes, describe)
   
   ______________________________________

d. Have you experienced any difficulties with eating, chewing, or swallowing? (if yes, describe)
   
   ________________
e. Have you experienced weight gain/loss in the last year? __________
f. Have you noticed problems with your skin (dryness, swelling, lesions or itching)?
________________________________________
g. When you have a wound, do you heal quickly? __________

**4. Elimination:**

| a. | How many times a day do you urinate? __________ | How many times at night? __________ |
| b. | What color is urine? __________ |
| c. | Do you experience any problems with urination, such as pain, burning, dribbling, incontinence, retention, or frequency? __________ |
| d. | Are any assistance devices used for urinating (i.e. incontinence pads, catheters or cystostomy)? |
| e. | Describe your normal bowel elimination pattern—frequency __________; color __________; consistency __________ |
| f. | Are any assistive devices used for bowel elimination such as laxatives, suppositories, enemas, or colostomy/ileostomy? |
| g. | Describe any experience of indigestion __________, diarrhea __________, N/V __________, abdominal pain __________ |
| h. | Male—testicular pain or masses, penile discharge or hernia? __________ |
| i. | Female—Have you noticed vaginal discharge or odor? __________ | Age of onset of menses __________, LMP __________ |

**5. Activity/Rest:**

| a. | Do you have problems sleeping? If yes describe __________ |
| b. | Describe your usual pattern of sleep (amount/when) __________ |
| c. | Has your sleep pattern changed recently? ______ If yes, how __________ |
| d. | Do you use any means to help facilitate sleep/rest? If yes, describe (e.g. medications, OTC, alcohol, meditation, etc.) __________ |
| e. | Describe your activity level: __________ |
| f. | Do you exercise? If yes, list type, frequency and duration __________ |
| g. | Do you experience any of the following during exercise? SOB, chest pain, palpitations, leg pain, or pain in muscles or joints. If
yes, describe.

h. Do you require assistance for the following daily activities?
   Feeding ______  bathing ______
   toileting ______  bed mobility ______  dressing ______
   grooming ______
   general mobility ______  cooking ______
   home maintenance ______  shopping ______

6. **Solitude/Social Interaction:**
   a. How much interaction do you have with family members?
      ______________________________________________________
   b. How much time a day do you spend alone?
      ______________________________________________________
   c. How do you handle conflict?
      ______________________________________________________
   d. Do you have close friends other than family members?
      ______________________________________________________
   e. Do you participate in social groups?
      Describe ____________________________________________
   f. Do you have any sensory impairments? E.g., hearing loss, vision problems?
      __________________________________________________________

7. **Prevention of Hazards:**
   a. What safety measures do you take? i.e. smoke alarms, seat belts, etc.
      ______________________________________________________
   b. Do you know of any risk factors you have for disease?
      ______________________________________________________
   c. Are sexually active? _________ If yes, at what age did you first engage in sexual activity? _________ How many partners do you currently have? _________
   d. Are you currently up to date on age appropriate immunizations? ________________________________
   e. Do you routinely engage in preventive health maintenance? i.e. self-breast exam, testicular exam, colonoscopy, other ________________________________
   f. Do you currently consume harmful, addictive substances? _________ If yes, describe
      ______________________________________________________
      ______________________________________________________
      ______________________________________________________
   g. Have you tried to quit? _________ If you have not tried to quit, why not? ________________________________ If you have
tried to quit, were you successful?______________.
Would you like help? ______________________________

8. Normalcy:
   a. How do you describe your current state of being?
      ________________________________
   b. Do you have persistent feelings of depression, anxiety, anger, suicide? ________
      If yes, please elaborate
      ____________________________________________________________
   c. Do you currently suffer from any problems with memory, intellectual functioning/
      psychological well being? _____ If yes, what/when started/what is being done about
      it?_____________________________________________________
   d. How would rate your current stress level? (1-10: 10=worst) ________
      If you consider this a high stress level, how do you manage your stress?
      _________________________________________________________
   e. Do you feel you need help managing your stress?
      _________________________________________________________
   f. Do you anticipate any major life changes in the near future?
      E.g., marriage, divorce, birth of child, etc._______________________

D. DEVELOPMENTAL SELF-CARE REQUISITES

<table>
<thead>
<tr>
<th></th>
<th>THERAPEUTIC DEMAND</th>
<th>POWER COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Check if a demand is present)</td>
<td>(Ability to meet therapeutic demand – Y/N)</td>
</tr>
</tbody>
</table>

List developmental stage of your patient according to Erikson, Sullivan, Kolberg, and Piaget. Present subjective and objective data to support your assessment of their developmental stage.

1. How does the patient engage in age appropriate developmental tasks? ______________________________
2. How does the patient promote healthy behaviors? __________
3. Describe any interference with the patient’s developmental self-care requisites. ____________________
4. How does the patient overcome adversity? (see Orem Handbook for the list of adversities) ________________________________________

5. What role does the patient’s developmental stage have on their therapeutic demand? ________________________________________

6. How would the developmental stage affect your role as a nurse?
__________________________________________________

### E. HEALTH-DEVIAION SELF-CARE REQUISITES

<table>
<thead>
<tr>
<th>Health Deviations:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First:</strong> List Any illness, injury, defects, disabilities, medical diagnosis and/or treatment. <strong>Next:</strong> Answer the questions that follow for each health deviation.</td>
</tr>
</tbody>
</table>

| 1. __________________________ |
| a. Seeks appropriate medical assistance |
| b. Aware of effects of condition |
| c. Carries out prescribed measures |
| d. Aware of deleterious effects of condition |
| e. Modifies self concept to accept state of health |
| f. Learns to live with condition |

| 2. __________________________ |
| a. Seeks appropriate medical assistance |
| b. Aware of effects of condition |
| c. Carries out prescribed measures |
| d. Aware of deleterious effects of condition |
| e. Modifies self concept to accept state of health |
| f. Learns to live with condition |

| 3. __________________________ |
| a. Seeks appropriate medical assistance |
| b. Aware of effects of condition |
| c. Carries out prescribed measures |
| d. Aware of deleterious effects of condition |
| e. Modifies self concept to accept state of health |
| f. Learns to live with condition |

### POWER COMPONENT

(Ability to meet therapeutic demand – Y/N)
4. 
   a. Seeks appropriate medical assistance
   b. Aware of effects of condition
   c. Carries out prescribed measures
   d. Aware of deleterious effects of condition
   e. Modifies self concept to accept state of health
   f. Learns to live with condition

5. 
   a. Seeks appropriate medical assistance
   b. Aware of effects of condition
   c. Carries out prescribed measures
   d. Aware of deleterious effects of condition
   e. Modifies self concept to accept state of health
   f. Learns to live with condition

F. PHYSICAL EXAM – (10 MINUTE ASSESSMENT)

<table>
<thead>
<tr>
<th>Universal Self-Care Requisite and corresponding system</th>
<th>Physical Exam</th>
<th>Findings</th>
<th>Therapeutic Demand: (check if a demand is present)</th>
<th>Power Component; (ability to meet therapeutic demand- Y/N)</th>
</tr>
</thead>
</table>
| Prevention of Hazards / Environmental Survey           | • Hand hygiene  
• Introduce self and purpose of visit  
• Identify patient (2 identifiers)  
• Allergies  
• Room survey and safety checks |              |                                      |                                                         |
| Normalcy / Neuro                                      | • LOC: alertness, interaction, orientation (person, place, time)  
• Speech/vision/hearing  
• Comfort level (any anxiety or restlessness)  
• Facial symmetry and pupils (PERRLA and Size)  
• Vital Signs (HR, RR, BP, Temp, O2 Sat, pain scale) |              |                                      |                                                         |
| Air / Resp and CV                                     | • Respiratory rhythm, depth, symmetry.  
• Supplemental oxygenation or respiratory support  
• Tubes or drains (with/without suction)  
• Heart sounds and rhythm  
• Breath sounds  
• Peripheral pulses (bilateral comparison of rhythm and amplitude for radial; Bilateral comparison of |              |                                      |                                                         |
| Water / Skin | • Mode of fluid intake (PO, enteral, IV)  
• Tubes/drains  
• Skin (color, temp, moisture, turgor, lesions, pressure points: occiput, scapula, sacrum, gluteus, elbows, heels)**  
• Edema |
| Food and Elimination / Abdomen | • Intake: appetite, nausea  
• Output: Voiding, last BM, vomiting  
• Abdominal contour, incisions, tenderness or firmness.  
• Tubes or drains (with/without suction)  
• Bowel sounds (4 quadrants) |
| Activity-Rest / Extremities | • Mobility, strength and symmetry  
• ROM  
• Therapies (Restraints, TEDs/SCDs, CPM, TENs, ice/heat) |
| Solitude-Social Interaction | • Family or friends present |

**Integrate skin assessment into each USCR and physical exam above**

**G. Pertinent Lab and Test results:**

| Findings: | Therapeutic Demand: (check if a demand is present) | Power Component: (ability to meet therapeutic demand- Y/N) |
**H. Summary of Self-Care Deficits:** (list those therapeutic demands for which the patient lacks the power components to manage)
APPENDIX B

Practice Model of Orem's Self-Care Deficit Nursing Theory

UNIVERSAL SELF-CARE REQUISITES

DEVELOPMENTAL SELF-CARE REQUISITES

HEALTH DEVIATION SELF-CARE REQUISITES

Self-Care Requisites are individualized by the
BASIC CONDITIONING FACTORS

Resulting in the determination of the
THERAPEUTIC SELF-CARE DEMAND
which is compared with

SELF-CARE AGENCY
Assessed by analyzing the ten power components to
evaluate development, operability and adequacy for
meeting self-care demands
and demonstrates or identifies the

SELF-CARE DEFICIT
TSCD - SCA = SCD
or
TSCD > SCA = SCD

which determines the

NURSING SYSTEM
Wholly compensatory, Partly Compensatory, Supportive-Educative

Implemented by the METHODS OF ASSISTING
Acting for/doing for Another, Guiding Another, Supporting Another,
Providing an Environment for the development of Self-Care Agency,
Teaching Another

Reassess TSCD, Evaluate Outcomes, and Replan/Redesign
the NURSING SYSTEM

Updated Fall 2014 (citation corrections Sept 2016)
APPENDIX C

FIGURE 23
Key elements of the social, interpersonal, and professional-technological components of the process of nursing.
Figure 13-2  Basic nursing systems.
References


