Application of Orem’s Self-Care Deficit Nursing Theory to Postpartum Nurses

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**Introduction**

 “Why do people need nursing?” This question was the fundamental focus when Dorothea Orem started developing her Self-Care Deficit Nursing Theory (SCDNT) (Taylor, 2007). Initially, she had set out to develop an articulation of what nursing is in order to design a curriculum for a nursing program in her book, *Guides for Developing Curricula for the Education of Practical Nurses* (1959) (Fawcett, 2005; Taylor, 2007). Since then in collaboration with fellow colleagues and other nursing professionals, Orem expounded on and clarified the SCDNT in her book, *Nursing: Concepts of Practice* (1971, 1980, 1985, 1991, 1995, 2001) to what nursing professionals recognize as the SCDNT today (Fawcett, 2005; Taylor, 2007).

 Application of SCDNT is used in a wide variety of areas of nursing practice. This applicability recognizes the general theory of Self-Care Deficit Nursing Theory (SCDNT) as a conceptual framework consisting of three grand theories: Self-Care Theory, Self-Care Deficit Theory, and Nursing System Theory (Fawcett, 2005). Utilizing this self-care conceptual framework and the rural nursing theory, rural postpartum nurses can improve their practice to provide quality care to their patients.

**Analysis of Self-Care Deficit Nursing Theory**

Addressing the metaparadigms of human beings, environment, health, and nursing, the SCDNT has a Unitarian, modern realist point of view (Banfield, 2008; Fawcett, 2005). Orem delineates humans as unitary beings that exist in their environment inseparably and that can deliberately act to promote self-care to achieve health, soundness of body and mind (Bandfield, 2008; Fawcett, 2005). She also defines nursing as an art and practice that helps these unitary beings achieve health through teaching and providing self-care to those who are limited or deficient in self-care and self-care knowledge (Fawcett, 2005; Wilson, et al, 2003).

 The SCDNT is based on the philosophy of modern realism, which views the world as existing beyond just the thoughts of the one experiencing the world (Banfield, 2008). “The beliefs and views of the human beings that inhabit the world do not determine the nature of reality” (Banfield, 2008, pp. 35). Modern realists believe that human beings can determine the true reality of the world by testing their own biased views (Banfield, 2008; Fawcett, 2005). Similarly, Orem uses this philosophy to define the nature of reality and human nature (Banfield, 2008).

 The SCDNT also reveals a reciprocal interaction world view (Fawcett, 2005). Both theory and world view define human beings as more than a collection of parts but as a whole. Secondly, they describe human beings interaction with their environments in a reciprocal relationship (Fawcett, 2005). Thirdly, both theory and world view characterize that changes will occur as a result of many human and environmental factors and may be continuous or only when survival deigns it (Fawcett, 2005). Since SCDNT has a reciprocal interaction world view, emphasis on qualitative – through empirical observations in a controlled environment – and quantitative methods is made in research (Fawcett, 2005).

 Using the metaparadigm concept of human beings, Orem assumed human beings were viewed as person, agent, symbol user, and organism and had the power to deliberately act by their own free will (Banfield, 2008; Fawcett, 2005). She also presupposed that self-care was a deliberate act to achieve optimal health (Banfield, 2008; Fawcett, 2005). When an individual cannot perform these self-care acts for themselves or their dependents, that individual will seek a healthcare service (namely a nurse) to assist in self-care to preserve life and promote health (Banfield, 2008; Fawcett, 2005). The concept of human beings is represented in SCDNT by “patient, therapeutic self-care demand, self-care, self-care agent, dependent-care, dependent-care agent, self-care agency, dependent-care agency, basic conditioning factors, power components, self-care deficit, and dependent-care deficit” (Fawcett, 2005, pp. 233).

 SCDNT also addresses the other concepts of environment (demarcated by environmental features: physical, chemical, and biological; and socioeconomic-culture) and health (classified by health state and well-being) (Fawcett, 2005). In the environment, features, such as air, food, water, family interaction, economy, and community/governmental effects, all affect the development of human beings in an interactive state (Fawcett, 2005). In addition, SCDNT defines health state as soundness in physiological, sociological, and mental functioning in a human being (Fawcett, 2005). SCDNT also views well-being as the human beings perception of their optimal self actualization in their current existence (Fawcett, 2005).

 The last metaparadigm concept, nursing, is denoted as nursing agency. Under this term, nurses are defined as

a complex power of persons educated and trained as nurses that is enabling when exercised for knowing and helping others know their therapeutic self-care demands, for helping others meet or in meeting their therapeutic self-care demands, and in helping others regulate the exercise or development of their self-care agency or their dependent-care agency. (Orem, 2001, pp. 491)

Orem also divided the concept of nursing agency into three different categories: social system, interpersonal system, and professional-technological system (Fawcett, 2005).

The social system reveals the contractual and professional relationship between the nurse and the patient and defines the nurse’s professional behavior and comprehension of care (Fawcett, 2005). The interpersonal system analyzes and outlines the interaction and communication between the nurse and the patient (Fawcett, 2005). The professional-technological system examines the techniques and skills of nurses needed to provide self care (Fawcett, 2005). All three systems are needed and used by nurses to establish and provide therapeutic care to their patients (Fawcett, 2005).

These characteristics and definitions of the SCDNT can apply to various types of nursing as well as various populations of patients (Fawcett, 2005). Massive amounts of research studies in many different areas of nursing practice use and test the SCDNT framework (Fawcett, 2005). Also, several nursing schools and programs have adopted Orem’s theory as their institutional framework (Fawcett, 2005). In nursing practice, Orem has classified nursing and its focus unique from any other healthcare profession (Fawcett, 2005). Using Orem’s SCDNT, postpartum nurses can positively impact and improve their patient’s care.

**Application of Self-Care Deficit Nursing Theory to Postpartum Nurses**

 The postpartum period is the time from one hour to six weeks after birth and refers to the mother (versus postnatal for infants) (Lowdermilk & Perry, 2006). Postpartum nurses take care of both the mother and the baby during this period beginning from one hour after birth to discharge from the hospital (48 to 72 hours after birth) (Lowdermilk & Perry, 2006). These nurses collect vital signs and lab work, monitor intake and output, perform full physical assessments, massage fundus and monitor lochia to reduce the incidence of postpartum hemorrhage, administer medications and therapeutic interventions to provide comfort from surgical, uterine, or perineal pain, evaluate emotional health and mother-infant bonding, and educate patients on postpartum, surgical, breastfeeding, and infant care (Lowdermilk & Perry, 2006).

 Initially, these mothers are unable to care for themselves or their infants due to anesthesia, birth trauma, lack of energy, large blood loss, severe pain, and/or nausea and vomiting. Like SCDNT describes, postpartum nurses provide this self-care and dependent-care (for newborns) when these patients have these self-care limitations. Usually within four hours after birth, the mother’s symptoms that cause these limitations are under control or resolved. After this time, the postpartum nurse starts teaching and encouraging the patients to provide their own self-care and dependent-care for their infants.

Nurses educate their patients how to alleviate pain and prevent infection during perineal or surgical care, when to call a doctor for presence of postpartum complications, how to breastfeed and/or prevent breast engorgement, and how to properly perform care for their infants (such as feeding, diapering, bathing) (Lowdermilk & Perry , 2006). This education is intended to empower patients to act as a self-care and dependent-care agent (Slusher, Withrow-Fletcher, & Hauser-Whitaker , 2010). Promoting self-care can promote patient autonomy, give them a sense of empowerment and responsibility, and over all improve their quality of life (Slusher et al., 2010). According to Slusher et al. (2010, pp. 85), “the success of self-care is dependent on the active participation of individuals in their own [and their dependents] health care.”

When an infant has to be admitted to Neonatal Intensive Care Unit (NICU), or the mother has complications from childbirth (such as severe hypertension, hemorrhage, infection), or the mother mentally or emotionally cannot be a self-care agent or dependent-care agent, nurses then have to provide more self-care for a longer period of time. Eventually the first two situations will be resolved, and then the patient can provide self-care and dependent-care with adequate education. However, in the last situation, often social services or case management is required to ensure adequate support for these mothers and that some other caregiver can give appropriate dependent-care to the new mother and her infant.

**Congruence of Self-Care Deficit Nursing Theory to Rural Nursing Theory**

The rural nursing theory, a middle range theory, explains the definition of health held by rural residents, and how and when they seek health professionals (Winters & Lee, 2010). In this theory, rural inhabitants view good health as the ability to work, tend to resist any “outside” help and are self-reliant, and rural health providers lack anonymity and must have a more general-based knowledge and skill set (Winters & Lee, 2010). In comparison with Orem’s SCDNT, rural nursing theory defines the person as an individual or a multiperson unit (such as family or community) and care and well-being are based on patient’s perception of health state (Fawcett, 2005; Slusher et al., 2010; Winters & Lee, 2010). Both the SCDNT framework and rural nursing theory focus on self reliance and self-care (Fawcett, 2005; Winters & Lee, 2010). Only when severely limited in providing self-care do patients (in Orem’s construct) and/or rural residents seek out health providers (Fawcett, 2005; Slusher et al., 2010; Winters & Lee, 2010). Similar to Orem’s SCDNT, rural nursing theory takes into account all environmental factors, including economy, culture, physical, educational levels, etc. and views nursing as an agent to promote the patient’s active participation in their own health care and health practices (Fawcett, 2005; Slusher et al., 2010; Winters & Lee, 2010).

 In Slusher et al.’s study, the rural Appalachian women showed that they participated in self-care activities to achieve optimal health, findings congruent with both SCDNT and rural nursing theory (2010). In fact, the tendency of self reliance of rural inhabitants better facilitates the nurses to use Orem’s SCDNT to provide care since the focus is on self-care activities. Using this knowledge of rural culture, nurses can utilize these “positives inherent in the culture” to improve their care (Slusher et al., 2010, pp. 88).

**Conclusion**

Although SCDNT is sufficiently comprehensive in scope, logically congruent, and supported by research, the language is obtuse and never defines important elements, such as environment or illness (Fawcett, 2005). This framework also lacks a clear nursing process (Fawcett, 2005). Through more systematic research in nursing practice, more refinements of this framework will slowly strengthen its weaknesses (Fawcett, 2005). Most importantly, this construct defines nurses and the nursing profession separately from any other healthcare providers (Fawcett, 2005).

 Using both SCDNT and rural nursing theory, due to their congruence, is feasible in a patient care setting, especially in a postpartum care unit. Keeping SCDNT and rural nursing theory in mind, nurses can improve their care and practice by involving the patient in her and her infant’s care to improve both their health (Fawcett, 2005; Slusher et al., 2010; Winters & Lee, 2010).

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