Self-Care & Dependent-Care Nursing
volume 11, no. 1 APRIL, 2003
The Official Journal of the International Orem Society

From the President

One of the purposes of the International Orem Society for Nursing Science and Scholarship is to expand, refine and clarify understanding of Orem's conceptualizations of nursing. Toward this end, I am pleased to inform you of a new publication: Self-Care Theory in Nursing: Selected Papers of Dorothea Orem, edited by Katherine Renpenning and Susan Taylor. This collection of papers is being published by Springer Publishing Company and will be released in March 2003, ISBN: 0826117252. This includes unpublished papers and presentations obtained from the personal files of Dr. Orem. Of particular interest to me are the papers on nursing education. Ideas expressed by Orem in the 1960's and 1970's are still valid. A paper that I found most helpful throughout my career as a nursing educator and curriculum specialist was "Levels of nursing education and practice" presented in 1968. The seminal conceptualizations of self-care as the object of nursing are included [Essential Requirements for the Practice of Nursing: An Analysis. (1956), and. The Art of Nursing in Hospital Nursing Service: an Analysis. (1956)]. Others will find papers on use of nursing theory in practice of interest. We are grateful for Orem's willingness to make these papers available to us. ■

Susan G. Taylor, PhD, RN, FAAN
President IOS

Editor's note:

The IOS Board has approved a plan to evolve Self-care, Dependent-care, & Nursing into an electronic-format. Starting with Volume 12 (2004), the Journal will be made available to subscribers via a website, accessible with a password that will be furnished via the subscriber's email address. Freed from the costs associated with printing, more articles can be accommodated.

In addition, we have signed a contract with Cinahl to have full-text articles available immediately available via their website for those wishing to purchase articles. This development vastly improves the availability of articles. I welcome your comments, suggestions, and manuscripts. ■

Michael J. Morgan, RN, PhD, Editor

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Information For Authors

The editor of *Self-care, Dependent-care, and Nursing*, The Journal of the International Orem Society for Nursing Science and Scholarship, welcomes manuscripts that address the mission of the Journal. Send the manuscript via email attachment to m.j.morgan@wayne.edu Use Microsoft Word or WordPerfect format for the attachment. For surface mail, send to *Michael J. Morgan, MPH, PhD, RN*, Editor, *Self-care, Dependent-care, and Nursing*, WSU College of Nursing, 374 Cohn, 5557 Cass Avenue, Detroit, MI 48202 USA.

Manuscripts may be forwarded to associate editors. In general, manuscripts from the Americas and East Asia will be reviewed by the editor. Manuscripts from Europe, Africa, and Western and South Asia will be reviewed by *Associate Editor, Georges C.M. Evers, RN, PhD, FEANS*, Centre for Health Services and Nursing Research, Faculty of Medicine, Catholic University Leuven, Kapucijnenvoer 35, B-3000 Leuven, Belgium. His email is: georges.evers@med.kuleuven.ac.be.

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To be the venue of choice for interdisciplinary scholarship regarding self-care.

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Original Manuscripts
Scientific or theoretical interest. Subjected to full peer review.

Brief Reports
Abstracts of dissertations (abstracts will be required to contain results); clinical case reports regarding self-care, self-care deficit, or nursing care systems; project reports.

IOS News
News of the International Orem Society for Nursing Science and Scholarship

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Reports of proceedings; calls for abstracts related to self-care are encouraged.

Book reviews
In-depth reviews will include the strengths and weaknesses of a book and must contain the author's specific recommendation regarding the book.

Editorial
Letters to the editor are encouraged. Occasionally, editorials will be invited. ■

Calculating Therapeutic Self-Care Demand For A Nursing Population Of Normal Newborns

Connie M. Dennis
Sheila Jesek-Hale

ABSTRACT

In Orem's self-care deficit nursing theory of nursing, calculation of therapeutic self-care demand (TSCD) is a vital step in which the client care needs are specified. Both clients and nurses need to have an understanding of this prescription for self-care (or dependent care). The process of determining therapeutic self-care demand involves the formulation of action-oriented statements that particularize the individualized type and amount of self-care action needed for persons. Particularized self-care requisite (PSCR) statements are developed with a focus on individualized and desired care activities to meet known needs for self-care or dependent care (Orem, 2001, p. 250). Authors illustrate the development of PSCR statements and exemplify how a set of such statements can be developed for a nursing population of normal newborns. The authors discuss implications for such core sets of particularized self-care requisites in nursing practice and offer suggestions for research. [Key Words: Orem, self-care deficit nursing theory, therapeutic self-care demand, self-care requisites, normal newborn, nursing process]

OREM'S SELF-CARE DEFICIT THEORY: CALCULATING THERAPEUTIC SELF-CARE DEMAND FOR A NURSING POPULATION OF NORMAL NEWBORNS

A fundamental component in any philosophy of nursing is that nursing is a helping service and profession. A primary purpose of nursing theories and models is to provide a view of humans, human events, and the real world with the ultimate intent of explaining, describing, predicting, and controlling actions that enable some events to occur and others to not occur (McKenna, 1997). Theory applied at the practice level attempts to (a) guide nurses in making decisions about the type and amount of help needed and (b) identify what nursing's role is in meeting those needs. In this sense, theory "renders practice more efficient and more effective" (Meleis, 1991, p. 21). Meleis (1991) emphasizes that theory guides practice. The link of theory to practice has been widely discussed (Conant, 1992; Firlit, 1994; Mariner-Tomey, 1994; Nicholl, 1992).

Orem's self-care deficit nursing theory (SCDNT; Orem, 2001) provides a framework for determining which persons are in need of nursing assistance. This theory stipulates that the need for nursing assistance legitimately exists when persons have self-care or dependent care deficits. Persons have self-care deficits when the demand for care (expressed by the self-care requisites) exceeds their abilities for meeting those self-care requisites. In situations of dependent care, dependent care deficits exist when persons providing dependent care lack abilities or are unable to exercise current abilities that are needed for meeting the self-care requisites of the person receiving dependent care.

Self-care requisites are formulated insights about the actions needed to perform self-care combined with the actions necessary for meeting those needs (Orem, 2001; Dennis, 1997). Through the process of particularization, the specifics of the need(s) and related actions are clarified. Once self-care requisites are known, the assessment of abilities in relation to particularized self-care requisites permits determination of the adequacy of a person's self-care (or dependent care) agency. Consideration of the relationship between known self-care requisites and self-care (or dependent care) agency determines whether or not self-care (or dependent care) deficits exist or can be projected. Identification of particularized self-care requisites is, then, the cornerstone for beginning the process which identifies persons who can most benefit from nursing, i.e., nursing proper object (Orem, 2001).

In general, a nursing population refers to "individuals who can benefit from nursing" (Orem, 2001, p. 251). Persons in need of nursing are those with existing or emerging self-care (or dependent care) deficits. In specific, nursing populations can be identified as a group of individuals/persons who share common characteristics. The actual nature of specific nursing populations depends on the characteristics that are selected for inclusion. The characteristics shared by members of the nursing population suggest that there are also commonalities in the self-care requisites of the individual members of the group (Orem, 2001, p. 224).

The purpose of this article is to illustrate how to identify core sets of particularized self-care requisite (PSCR) statements for a specific nursing population. The nursing population selected includes healthy, term

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normal newborns. Inclusion of persons in this nursing population is based on criteria related to three basic conditioning factors: age, developmental state, and health state. The factor of age specifies the term (38-42 week gestation) normal newborn (birth to 28 days). Developmental state factors include all the cognitive and psychomotor skills of the normal newborn as well as Erikson's psychosocial stage of trust versus mistrust (Erikson, 1968; Murray & Zentner, 1997). Health state factors specify the term newborn who may evidence common variations within norms but show no health deviations.

Following a discussion of how self-care requisites are particularized within the framework of self-care deficit nursing theory, the authors discuss a proposed set of particularized self-care requisite statements for healthy, term newborns. Emphasis is placed on why particularization of self-care requisites is foundational for nurses' decision-making about care delivery (Orem, 2001). Implications for application in practice and potential for research conclude the discussion.

SELF-CARE DEFICIT NURSING THEORY AND SELF-CARE REQUISITES

Orem defines self-care as the self-directed activities learned and performed for the purpose of maintaining life, health, and well being (Orem, 2001). The self-care requisites are the targets toward which the action of self-care is directed. Therapeutic self-care demand is the sum of all care measures necessary at any one point in time for the production of self-care. Self-care is therapeutic when it contributes to structural and functional integrity, developmental processes, and health and well being (Orem, 2001; Dennis, 1997).

In self-care deficit nursing theory, three separate, but interrelated, categories of self-care requisites are identified: the universal, developmental, and health deviation self-care requisites (Orem, 2001). Eight universal self-care requisites address actions essential to maintaining the integrity of human function and structure (Orem, 2001; Dennis, 1997). These requisites are universal in that they address needs fundamental and essential to all persons. The eight universal self-care requisites (Orem, 2001, p. 225) represent subcategories essential for: maintaining sufficient intake of air, water, food and nourishment, managing care of elimination processes and excrement, maintaining a balance between activity and rest, managing and preventing hazards threatening human life, structure and functioning, and maintaining and promoting a sense of self as normal in accord with human potential and function in social groups.

Developmental self-care requisites (DSCRs) address needs associated with human growth and development (Orem, 2001; Dennis, 1997). There are two basic types of developmental self-care requisites (Dennis, 1997, pp. 46-52). The first, Type 1, addresses actions that promote and/or maintain life and human functioning resulting in progression to a higher level of development in accordance with one's human potential. For all individuals, Type 1 developmental self-care requisites exist continually and place demands upon individuals for daily self-care. Therefore, Type 1 developmental self-care requisites are strongly interrelated with each of the eight universal self-care requisites. A second type of developmental self-care requisite, Type 2, addresses those activities associated with conditions and/or events that may occur during an individual's lifetime. The purpose of self-care activities associated with Type 2 developmental self-care requisites is to prevent or mitigate adverse effects of a condition or event on human development. Type 2 developmental self-care requisites may be interrelated to universal self-care requisites depending on the nature of the condition or event or may result in new requirements for self-care. In dealing with a nursing population such as healthy, normal newborns, the authors postulate that no such conditions or events associated with Type 2 developmental self-care requisites pertain. Type 2 developmental self-care requisites should be explored in the future for other nursing populations especially for those populations which could be defined according to a criteria involving selected event or condition, for example a population of newborns born with clefts of the lip and/or palate.

The last of the three categories for self-care requisites is health deviations self-care requisites (Orem, 2001; Dennis, 1997). Requisites in this category focus on entirely new requirements for self-care that arise from physical or psychological health deviations. During periods of illness or injury, one may also see alterations in universal and/or developmental requisites. As the nursing population under consideration was defined as normal newborns with no health deviations or complications, no further discussion of health deviation self-care requisites is included.

CALCULATION OF THERAPEUTIC SELF-CARE DEMAND

Therapeutic self-care demand (TSCD) is the specified, total set of actions or care measures and their related technologies necessary, at any one point in time, to meet known self-care requisites (Orem, 2001). Therapeutic self-care demand (TSCD) is constructed or "calculated" by first identifying the self-care requisite and the frequency of actions necessary to meet the universal and developmental requisites as well as any health deviation self-care requisites in cases of illness or injury. This process involves both the recognition of action sequences necessary to meet self-care requisites and the delineation of how to produce those valid activities. Important baseline information includes knowing what self-care actions are necessary, why they are essential, and what consequences exist if these self-care actions are not performed. Additional information includes identification of factors that are unique to each person. Categories of factors, which modify, and thus, individualize each person's situation are termed basic conditioning factors. Orem (2001) identifies ten basic conditioning factors, which modify not only the action associated with meeting a self-care requisite but also influence quantity and quality of those measures (Orem, 2001). Orem specifies three that must be investigated by nurses in order to understand the health aspects of persons seeking or under nursing care. These three significant basic conditioning factors are age, developmental state, and health state (Orem, 1991).

Particularization of the self-care requisite involves taking the general idea expressed by a self-care requisite and making it a specific, unit act or care measure (Orem, 2001). Based on identification of the general method and knowledge of the person and the person's situation, one can determine the specifics about the type of actions to be performed, the means of achieving those actions, and the parameters necessary to define the degree and/or level to which action should be accomplished. The result is a particularized self-care requisite (PSCR).

A particularized self-care requisite (PSCR) statement is an action-oriented statement which includes a subset of specific actions necessary for an individual to meet a self-care requisite, e.g., adequate intake of water (Dennis, 1997). Particularization of a self-care requisite begins with an analysis of the client's basic conditioning factors and an analysis of the general methods and technologies of care measures associated with the requisite. The following example helps to clarify. While various means (general methods) of fluid intake exist, the most common general method for the meeting this universal self-care requisite is drinking fluids orally. In cases of illness or injury (the factor of health state), this general method may need to be altered; examples might include prescribed measures such as intravenous or enteral routes. The general method may also be altered by age or developmental state as "suckle" as the usual action performed by infants. The phrase "technologies" refers to all relevant knowledge, skills, and resources associated with the general method. For the requisite pertaining to water intake, such things as knowing how much and what types of fluid, how to safely obtain them, relevant time factors, preparation, monitoring of intake are technologies, which may be relevant.

Following analysis of basic conditioning factors and the general method for meeting the requisite, a statement can be formulated which represents the specific action for meeting the requisite (Dennis, 1997). The selected general method delimits the form of the action to be taken and can be conveyed via the selection of an appropriate action verb. Addition of all

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essential qualifiers and modifiers that clarify the degree and extent to which the action should be taken to meet the requisite effectively and therapeutically completes the particularized self-care requisite statement. Most often, the qualifiers or modifiers of the action are derived from valid knowledge about the effects of basic conditioning factors. Following the above example for the self-care requisite for water intake, the amount of water that one needs to "drink" is related to age and health state. Normal newborns have different daily fluid requirements than do adults or older children. Additionally, qualifiers may address factors such as time, duration, degree, and amount. Frequency of taking in water varies greatly as newborns may need to "drink" every three to four hours initially. See Table 1 for examples of particularized self-care requisite statements relevant to water intake in the normal newborn population.

As self-care requisites are generalizations, they pertain to complex sequences of actions. Several particularized self-care requisite statements may be needed to fully address the scope of any one self-care requisite. The self-care requisites of each category are interrelated. While the above example regarding the generation of a particularized self-care requisite statement refers primarily to the requisite for water, clearly the action of taking in adequate amounts of water affects other self-care requisites. Other self-care requisites related to this include elimination, food, prevention of hazards, and activity/rest. Should an individual become dehydrated, necessary adjustments in the intake of water may become part of the prescribed therapy and thus related to some of the health deviation self-care requisites (Orem,2001).

Particularization of all self-care requisites results in a set of action-oriented statements specifying the amount and type of action necessary for therapeutic self-care for an individual (Orem, 2001). This cumulative set of particularized self-care requisite statements that delineate actions to be taken to meet all the self-care requisites at a point in time constitutes therapeutic self-care demand (Orem, 2001). Taken to this level of understanding, then, therapeutic self-care demand is the sum total of all particularized self-care requisites for each and all self-care requisites.

When calculating therapeutic self-care demand, questions of what action(s) could or should be taken for the accomplishment of therapeutic self-care are addressed. In addition, basic conditioning factors that enable or inhibit action for meeting self-care requisites are relevant. In both self-care and dependent care situations the focus is on the self-care requisites of person receiving care. Questions of who can and should perform those actions are not addressed in the decision-making step of calculating therapeutic self-care demand TSCD.

PARTICULARIZED SELF-CARE REQUISITES FOR NURSING POPULATIONS

Nurses build and develop the knowledge of care demands for defined nursing populations via identification of common sets of action for meeting self-care needs (Orem, 2001). Sets of particularized self-care requisite (PSCR) statements depict what is known about care needs and actions to meet these needs for selected populations under nursing care. The developing knowledge base about self-care action demands can be used to identify variations of therapeutic self-care demand among various nursing populations and for individuals within the same nursing population. The first step to this process is to define the nursing population. The basic conditioning factors of age, developmental state, and health state serve as effective organizers for identifying common types of nursing populations.

UTILIZING CORE SETS OF PARTICULARIZED SELF-CARE STATEMENTS

The authors work with students in an undergraduate-nursing program. With faculty guidance, students apply self-care deficit nursing theory when caring for clients in maternal/newborn clinical settings. After working with students caring for normal newborns, the authors began to notice repetitions in normal newborn particularized self-care requisite statements formulated by students. These observations led the authors to speculate that there may be some common roots in the therapeutic self-care demands of normal newborns. The authors began to write and compile particularized self-care requisites for the normal newborn. Nursing and medical texts, science texts, research journals, clinical practice journals, guidelines established by the American Academy of Pediatrics, and American College of Obstetrics and Gynecology, provide information regarding valid parameters that qualify and quantify self-care actions related to the common care needs of the normal newborn. Orem (2001) supports the use of various knowledge sources when identifying technologies for meeting self-care requisites.

Table 1 (see page 8) presents the resulting set of particularized self-care requisite statements formulated through these efforts. Particularized self-care requisite statements for nor-

mal newborns in Table 1 represent action-oriented statements that include a general method of action and parameters qualifying and/or quantifying the action. For example, the statement, "Dress appropriately for maintaining an axillary or rectal temperature of 36.5-37.2C/ 97.7-99.5 F degrees or a skin temperature of 36-36.5 C degrees/98.6-97.7 F degrees," includes the general method "dress" and valid temperature parameters as cited in valid, reliable sources (Behrman, Kliegman, & Jenson, 2000; Guyton, 1996). Position infant in side-lying or supine position for sleep" includes parameters related to recommendations from the American Academy of Pediatrics (1992) based on research on sudden infant death syndrome (SIDS). Perform perineal hygiene with every diaper change, using super absorbent disposable diapers" is a statement that incorporates research related to prevention of diaper dermatitis (Arnsmeir & Paller, 1997). "Establish en face position [mother][caregiver] when interacting with infant" represents quality of interaction between mother and infant as supported by Rubin's (1984) work.

The authors consider this core set of particularized self-care requisite statements a work 'in progress' that should continuously be expanded as further requisite statements are formulated. In clinical practice situations, basic conditioning factors specific to each newborn provide the basis for further individualization of particularized self-care requisite statements. For example, brackets surrounding words within some statements in the table illustrate options for individualizing the statement. Unique features arising form gender and sociocultural-spiritual factors must be addressed when calculating therapeutic self-care demand (TSCD).

Over the years, students used this core set of particularized self-care requisite statements when calculating therapeutic self-care demand for normal newborns. With occasional faculty input, students easily, modify and individualize the statements for each normal newborn. Use of the set of statements keeps the student focused on the care measures necessary for meeting the therapeutic self-care the normal newborn. Utilization of this core set of self-care requisites allows students to focus on making judgments about the type and amount of care needed by the normal newborn and other aspects of nursing care planning.

Students are repeatedly exposed to common parameters of care action prescribed for the normal newborn. Students have opportunity to discuss the validity of parameters, those founded in research and those not. Based on these discussions, students can be encouraged to pose additional PSCR's, questions for future research and ideas for care modification.

CONCLUSION

The authors find through repeated use and observation, the core set of particularized self-care requisite statements provide a strong foundation for calculating therapeutic self-care demand

in normal newborns. In clinical practice, determination of care demand is a necessary step for diagnosis of self-care/dependent care deficits which in turn validate the need for and type of nursing action. Opportunities for future research and development include a) validation of parameters not yet supported by research included in PSCR statements, b) dependent care giver perceptions of requisites for normal newborns, and 3) multi-disciplinary perceptions of requisites for normal newborns. Other research might focus on particularizing self-care requisites for nursing populations defined by criteria other than those used in this article; for example, premature or low birth weight newborns, ill children, or patients classified by health deviation factors. ■

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TABLE 1
Set of Particularized Self-Care Requisites (PSCR) for Healthy, Term Newborns
PSCR Statement   Self-Care Requisites
Universal   Developmental

- Breathe 30-60 BPM [easily or effortlessly] with no apneic spells > 15 sec. while maintaining pink color, awake or asleep.
  Air
  (activity/rest, prevention of hazards)
- Maintain pulse oximetry readings of >94% continuously while in room air.
  Air
  (activity/rest, prevention of hazards)
- Maintain patent nasopharyngeal pathways with positioning and prn suctioning.
  Air
  (activity/rest, prevention of hazards)
- Cry lustily with easy consolability,
  Air,
  (solitude/social interaction activity/rest, normalcy)
  Type I
- Suckle from [breast or bottle] without respiratory compromise.
  Food, Water
  (air, activity/rest, solitude/social interaction, prevention of hazards, normalcy)
  Type I
- Suckle from each breast without difficulty on demand (at least every 4 hours) losing no [more than 5-10% of birth] weight. –or– Suckle easily from bottle every 3-4 hours, taking [1-2] ounces of formula each feeding losing no [more than 5-10% of birth] weight.
  Food, Water
  (air, elimination, activity/rest, solitude/social interaction, prevention of hazards, normalcy)
  Type I
- Regain birth weight by 10th day.
  Food, Water
  {prevention of hazards, normalcy)
- Gain at least 5-7 ounces weekly from 10th day.
  Food., Water
  {prevention of hazards, normalcy)
  Type I
- Interpret growth and growth patterns using culturally sensitive tools.
  Food, Water
  (prevention of hazards, normalcy)
  Type I
- Consume at least [100] cc/kg/d.
  Water
  (food, elimination, prevention of hazards)
  Type I
- Consume at least 120 cal/kg/d.
  Food
  (water, elimination, prevention of hazards)
  Type I
- Perform perineal hygiene with every diaper change.
  Elimination
  (prevention of hazards)
- Wet 6-8 diapers daily.
  Elimination
  (food, water, prevention of hazards)
- Void without difficulty within 6-8 hours of male circumcision.
  Elimination
  (food, water, prevention of hazards)
- Void/Stool within the first 24 hours of birth.
  Elimination
  (food, water, activity/rest, prevention of hazards)
- Pass pasty to mushy yellow to brown stools daily.
  Elimination
  (food, water, activity/rest, prevention of hazards)
- Position body, side-lying or head elevated, after feedings and during sleep.
  Activity/Rest
  (food, water, elimination, prevention of hazards,)
- Sleep 12-18 hours daily awakening every 2-4 hours for feedings.
  Activity/Rest
  (food, water, normalcy)
  Type I
- Communicate needs with strong lusty cry.
  Solitude/Social Interaction
  (air, normalcy)
  Type I
- Elicit caregiver response using culturally determined/reinforced cues.
  Solitude/Social Interaction
  (activity/rest, normalcy)
  Type I

- Respond to environmental stimuli of light, sound, and touch.
  Solitude/Social Interaction
  (activity/rest, normalcy)

- Interact with caregiver(s) during the 6-8 daily awake cycles.
  Solitude/Social Interaction
  (activity, normalcy)
  Type I

- Soothe in response to [caregiver's] comforting efforts [feeding, cuddling, holding, etc.].
  Solitude/Social Interaction
  (activity/rest, normalcy)
  Type I

- Establish eye contact with caregiver.
  Solitude/Social Interaction
  (activity/rest, normalcy)
  Type I

- Interact with family members/siblings during adjustments to changes in family constellation.
  Solitude/Social Interaction
  (activity/rest, normalcy)
  Type I

- Burp/Bubble during and/or after feedings.
  Prevention of Hazards
  (food, water, activity/rest)

- Prevent post-feeding aspirations.
  Prevention of Hazards
  (food, water, activity/rest)

- Perform cord care daily and prn until cord falls off within 10-14 days without signs of infection.
  Prevention of Hazards
  (elimination, activity/rest)

- Perform male circumcision care with every diaper change until healed.
  or
  Perform penile care/hygiene with every diaper change.
  Prevention of Hazards
  (elimination, activity/rest, normalcy)

- Maintain normothermia (36.6 to 37.2oC R) daily with appropriate [and culturally determined] dress.
  Prevention of Hazards
  (activity/rest)

- Maintain skin integrity with [daily] hygiene/bathing.
  Prevention of Hazards
  (elimination)

- Take medication prophylactically for opthalmia neonatorum and hemorrhagic disease of newborn.
  Prevention of Hazards

- Facilitate elimination of bilirubin, with levels remaining <10 mg/dl.
  Prevention of Hazards
  (food, water, elimination)

- Travel only in approved car seat.
  Prevention of Hazards
  (activity/rest,solitude/social interaction)

- Avoid suckling from propped bottles.
  Prevention of Hazards
  (activity/rest, solitude/social interaction, food, water, elimination)

Completes health screening in timely manner.
Prevention of Hazards

Attain hepatitis immunization when indicated.
Prevention of Hazards

Notes. Adapted with permission from Dennis and Jesek-Hale (1993).
a Words in brackets [ ] indicate conditions or qualifiers to be modified for individual newborn.
b Words in parentheses ( ) indicate universal self-care requisites related to the particularized self-care requisite statement in addition to the primary one(s) cited.

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Orem's Self-Care Deficit Nursing Theory: Actual and Potential Sources for Evidence-Based Practice

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Adapted from a keynote address presented at the 7th International Self-Care Deficit Nursing Theory Conference, Atlanta, Georgia, November 1, 2002

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Evidence is in the forefront of virtually all contemporary discussions of nursing research and nursing practice. As Ingersoll (2000) pointed out two years ago, evidence-based practice "seems to be the up-and-coming buzzword for the decade" (p. 151). The discussions of evidence-based nursing practice are largely situated in an atheoretical, biomedically dominated, empirical perspective (Fawcett, Watson, Neuman, Hinton-Walker, & Fitzpatrick, 2001), in which the randomized controlled clinical trial is the only legitimate source of evidence (Ingersoll). I believe that that perspective threatens the very foundation of nursing's focus on discipline-specific theory-guided practice (Walker & Redmond, 1999).

Accordingly, the purpose of this paper is to present a different perspective. I will present a perspective that is theory-guided, nursing dominated, encompassing of but beyond the empirical domain, in which evidence comes from many sources. I will share a perspective of evidence-based practice that is guided by Dorothea Orem's Self-Care Deficit Nursing Theory (SCDNT) and that encompasses evidence from the generation and testing of empirical, ethical, personal, aesthetic, and sociopolitical nursing theories.

EVIDENCE-BASED NURSING PRACTICE

Evidence typically is regarded as an atheoretical entity, which only widens the theory-practice gap (Upton, 1999). There is, however, no compelling reason to regard evidence as atheoretical. Rather, we can think of evidence as data or other systematically gathered information that supports or refutes a theory. We are, of course, most interested in the SCDNT.

Nursing practice refers to actions taken by nurses on behalf of or in conjunction with people who need nursing care. Within the context of the SCDNT, nursing practice refers to actions taken by nurses to help individuals and multiperson units who seek and can benefit from nursing because of existing or predicted health-derived or health-related self-care or dependent care deficits.

Evidence-based nursing practice is the conscientious, explicit, and judicious use of SCDNT-guided, research-based information in making decisions about care delivery to individuals or multiperson units and in consideration of individual needs and preferences (Ingersoll, 2000).

The domain of SCDNT-guided, evidence-based practice encompasses five areas of activity:

Entering into and maintaining nurse-patient relationships with individuals, families, or groups until patients can legitimately be discharged from nursing

Determining if and how patients can be helped through nursing

Responding to patients' requests, desires, and needs for nursing contacts and assistance

Prescribing, providing, and regulating direct help to patients and their significant others in the form of nursing

Coordinating and integrating nursing with the patient's daily living, other health care needed or being received, and social and educational services needed or being received (Orem, 1991, p. 340)

SOURCES OF EVIDENCE

My perspective of SCDNT-guided, evidence-based practice requires a broad view of the sources of evidence. I propose that the evidence needed to guide the domain of SCDNT-guided practice requires evidence from empirical, ethical, personal, aesthetic, and sociopolitical theories (Table 1). Readers may already know about these five types of theories through the work of Carper (1978), Chinn and Kramer (1999), and White (1995) on patterns of knowing in nursing. Readers also may already know about the work I have done with Jean Watson, Betty Neuman,

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Patricia Hinton-Walker, and Joyce Fitzpatrick (Fawcett et al., 2001) in reframing the patterns of knowing as types of theories. In this paper, I extend that work by linking each type of theory and evidence with at least one of the five areas of activity that make up the domain of SCDNT-guided practice. The linkages are admittedly arbitrary—it would be easy to argue that all five areas of activity require evidence from all five types of theories. Indeed, the argument could be strengthened by Carper's (1978) and Chinn and Kramer's (1999) assertion that the patterns of knowing are fully integrated in practice and White's (1995) assertion that sociopolitical theories are "essential to an understanding of all [other types of knowing]" (p. 83). Thus, I ask you only to consider the linkages I offer as one way to begin to expand our understanding of SCDNT-guided, evidence-based practice.

Empirical theories are publicly verifiable, factual descriptions, explanations, or predictions based on subjective or objective group data. In other words, empirical theories are about "averages." They constitute what most people regard as the science of nursing. Empirical theories are generated and tested by means of empirical research. Both qualitative and quantitative methods may be used. The evidence produced by empirical research is scientific data, which are used as the basis for scientific nursing practice. Empirical evidence is needed to guide at least two areas of activity within the domain of SCDNT-guided practice, namely, determining if and how patients can be helped through nursing; and prescribing, providing, and regulating direct help to patients and their significant others in the form of nursing.

Ethical theories are descriptions of obligations, values, and beliefs about desired ends. More specifically, ethical theories are formalized statements of nurses' and nursing's values. They constitute what most people regard as the ethics of nursing. Ethical theories are generated by means of ethical inquiries that focus on identification and analysis of the beliefs and values held by individuals and groups and the clarification of those beliefs and values. Ethical theories are tested by means of ethical inquiries that focus on dialogue about the beliefs and values and establishing justification for those beliefs and values. The product of ethical inquiry is a theory that may be expressed in such documents as standards of practice, codes of ethics or philosophies of nursing. Those documents constitute the evidence needed to guide ethical nursing practice. Ethical evidence is needed to guide at least one area of activity within the domain of SCDNT-guided practice, namely, determining if and how patients can be (or should be) helped through nursing.

Personal theories are concerned with the knowing, encountering, and actualizing of the authentic self. This means that personal theories focus on how nurses come to know how to be authentic in relationships with patients and with colleagues, and how nurses come to know how to express their concern and caring for another human being. Personal theories constitute the interpersonal relationships of nursing. Personal theories are generated and tested by means of opening and centering, by thinking about how one is or can be authentic, and by listening to responses from others and reflecting on those responses. Personal theories may be extracted from autobiographical stories about the genuine, authentic self. Those stories constitute the evidence needed to guide the interpersonal relationships that are such an integral part of nursing practice. Personal evidence is needed to guide at least one area of activity within the domain of SCDNT-guided practice, namely, entering into and maintaining nurse-patient relationships with individuals, families, or groups until patients can legitimately be discharged from nursing.

Aesthetic theories focus on particulars rather than universals. They emphasize the nurse's perception of what is significant in the individual patient's behavior. Aesthetic theories also address the "artful" performance of manual and technical skills. Aesthetic theories constitute the art of nursing. Aesthetic theories are generated and tested by means of envisioning of possibilities, rehearsing the art and acts of nursing, and observing or performing nursing art, with emphasis on developing appreciation of aesthetic meanings in practice and inspiration for the development of the art of nursing. Aesthetic theories are manifested or expressed as aesthetic criticism of the art of nursing and nursing acts,

as well as through works of art, such as fiction and nonfiction, poetry, drawings, paintings, sculpture, singing, acting, and dancing. The artistic criticism and the various art forms constitute the evidence needed to guide aesthetic nursing practice. Aesthetic evidence is needed to guide at least one area of activity within the domain of SCDNT-guided practice, namely, responding to patients' requests, desires, and needs for nursing contacts and assistance.

Sociopolitical theories help nurses to understand the context of nursing practice and facilitate acceptance of multiple perspectives of a situation. They provide the context or cultural location for nurse-patient interactions and the broader context in which nursing and health care take place. In addition, they focus on exposing and exploring alternate constructions of reality. Sociopolitical theories constitute the politics and policies of nursing. Sociopolitical theories are generated and tested by means of critiques of situations and critiques of alternate constructions of reality, as well as by hearing and attending to the voices of all who are concerned with a particular situation, that is, the stakeholders. Thus, the knowledge embedded in sociopolitical nursing theories comes from hearing and acknowledging the many voices involved in nursing practice. The critiques and the voices heard and acknowledged constitute the evidence needed to guide sociopolitical nursing practice. Sociopolitical evidence is needed to guide at least one area of activity within the domain of SCDNT-guided practice, namely, coordinating and integrating nursing with the patient's daily living, other health care needed or being received, and social and educational serviced needed or being received.

COMPREHENSIVE OREM-BASED NURSING PRACTICE

The concepts of the SCDNT are labels for the phenomena of central interest to those of us who subscribe to Orem's perspective of nursing. Empirical, ethical, personal, aesthetic, and sociopolitical theories specify particular actions and activities required for all five areas of activity that constitute the domain of SCDNT-guided practice. The challenge is to identify empirical, ethical, personal, aesthetic, and sociopolitical theories as actual and potential sources of evidence for each concept of the SCDNT (Table 2).

My analysis of the research and practice literature based on the SCDNT revealed that the empirical research and reports of nursing practice have focused primarily on self-care agency, dependent care agency, therapeutic self-care demands, basic conditioning factors, nursing agency, and the technologic dimension of practice. To date, the power components and the social and interpersonal dimensions of practice have been neglected. My analysis uncovered a great deal of empirical evidence but few systematic programs of research. Evers (2001) reached a similar conclusion. He commented:

Most of our research is done as single studies. Many good qualitative descriptive studies are not followed by rigorous quantification. Most of our quantitative studies lack sufficient external validity in the research design to allow for general evidence-based statements. (p. 140).

Furthermore, Taylor and colleagues' (2000) review of 66 research reports uncovered "few studies that extend the boundaries or expand the theory through research" (p. 107). They did, however, note that several studies have focused on development of instruments to measure self-care agency, self-care practices, self-care limitations, basic conditioning factors, and foundational capabilities and dispositions. Other studies have focused on basic conditioning factors, including gender, ethnicity, health state, and healthcare system factors. Still other studies have focused on the product of human action, self-care, dependent-care, and nursing, as well as case studies of persons receiving nursing. Taylor and colleagues identified just one rigorous experimental study and two replication studies.

Taken together, my review and those of Evers (2001) and Taylor et al. (2000) indicate that the strength of the available empirical evidence is weak, due to lack of series of studies about one or more concepts of the SCDNT. The research being presented at this conference extends the available empirical evidence. The challenge for those of you who are presenting the results of your empirical research is to begin or continue to engage in the programmatic research that is needed for strong empirical evidence that will

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support SCDNT-guided, empirical evidence-based "best practices."

But what evidence—weak or strong—do we have of the ethics of SCDNT-guided practice, the interpersonal relationships of SCDNT-guided practice, the art of SCDNT-guided practice, and the politics and policies of SCDNT-guided practice? And, how do we rate the strength of that evidence? Systems to rate the strength of empirical evidence already exist (West et al., 2002). We now need to develop rating systems for the strength of ethical, personal, aesthetic, and sociopolitical evidence.

Taylor's (1999) discourse on the ethics of SCDNT is a landmark work in the development of ethical evidence for SCDNT-guided practice, with hints of evidence for the interpersonal relationships of SCDNT-guided practice. She pointed out that Orem believes "The relationship of nurse to patient is … complementary" (p. 205). Elaborating, Taylor noted, "This complementary relation of nurse to patient is dependent on an established interpersonal relationship (interaction) between nurse and patient and others. There are times when sensing professional virtue embodied in a nurse is extremely important to the patient. At other times, it is skillful, ethical decision making that makes the difference" (pp. 205-206).

Additional ethical evidence can be extracted from Orem's philosophic claims, which are clearly articulated in her assumptions and premises about human beings; presuppositions about self-care; assumptions about self-care requisites, deliberate action, nursing, human beings and deliberate action, and deliberate action and nursing; her philosophical claim about human beings and nursing; and her presuppositions for the theories of self-care, self-care deficit, nursing system, and nursing administration (see Fawcett, 2000). Evaluation of these assumptions, premises, and presuppositions indicates that Orem "values individuals' abilities to care for themselves and dependent others, with intervention from health care professionals only when actual or potential self-care deficits or dependent-care deficits arise. Furthermore, Orem expects people to be responsible for themselves and to seek help when they cannot maintain therapeutic self-care or dependent-care" (Fawcett, 2000, p. 289).

Some sociopolitical evidence that can be used to guide the politics and policies of SCDNT-guided practice also is evident in Orem's work. My evaluation of her philosophical claims reveals that "Orem … values the person's perspective of his or her health status, as well as that of the physician. Consequently, she does not expect nursing to be based solely on the nurse's view of the patient's situation" (Fawcett, 2000, p. 289). At a minimum, then, the voices of the patient, the nurse, and the physician are heard and acknowledged.

What other existing but perhaps implicit evidence can be extracted from the SCDNT literature? What evidence of the ethics of nursing, the interpersonal relationships of nursing, the art of nursing, and the politics and policies of nursing is still needed to guide comprehensive SCDNT-guided practice? What is the code of ethics for SCDNT-guided practice? What stories do SCDNT practitioners tell of their interpersonal relationships with patients? How is the art of SCDNT-guided practice performed? What are politics and policies of SCDNT-guided practice? All SCDNT scholars are urged to begin the work needed to answer those questions, and to publish their work in this journal, other nursing journals, and in books.

TABLE 1
Types of Nursing Theories, Modes of Inquiry, and Evidence*

Type of Theory
Description Mode of Inquiry
Examples of Evidence

Empirical Theories
The science of nursing
Publicly verifiable, factual descriptions, explanations, or predictions based on subjective or objective group data

Empirical research
Scientific data
Ethical TheoriesThe ethics of nursing
Descriptions of moral obligations, values, and desired ends
Identification, analysis, and clarification of beliefs and values; dialogue about and justification of beliefs and values
Standards of practice, codes of ethics, philosophies of nursing

PersonalTheories
The interpersonal relationships of nursing
Expressions of the quality and authenticity of the interpersonal process between each nurse and each patient
Opening, centering, thinking, listening, and reflecting
Autobiographical stories
Type of Theory Description
Mode of Inquiry
Examples of Evidence
Aesthetic theories

The art of nursing
Expressions of the nurse's perception of what is significant in the individual patient's behavior.
Performance of nursing procedures in an artful manner
Envisioning possibilities
Rehearsing nursing art and acts
Observing or performing nursing art
Aesthetic criticism
Works of art-fiction, nonfiction, poetry, drawings, paintings, sculpture, singing, acting, dancing

Sociopolitical Theories
The politics and policies of nursing
Descriptions and expressions of the context or cultural location for nurse-patient interactions and the broader context in which nursing and health care take place
Critique of situations
Critique of alternate constructions of reality
Hearing and attending to all relevant voices

Written or verbal criticism
Written or verbal documentation of voices heard and acknowledged

*Adapted from Fawcett, J., Watson, J., Neuman, B., Hinton-Walker, P., & Fitzpatrick, J. J. (2001). On theories and evidence. Journal of Nursing Scholarship, 33, 115-119.

TABLE 2
Actual and Potential Sources of Evidence for Comprehensive Orem-Based Nursing Practice

Concepts of Orem's Self-Care
Deficit Nursing Theory
Empirical Theories
Ethical Theories
Personal Theories
Aesthetic Theories
Sociopolitical Theories

Therapeutic Self-Care Demand

Self-Care Agency

Dependent-Care Agency

Basic Conditioning Factors

Power Components

Nursing Agency

Social Dimension of Nursing Practice

Interpersonal Dimension of Nursing Practice

Technologic Dimension of Nursing Practice

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Self-care, Dependent-care, and Nursing ISSN 1081-7700
(formerly published under the title of The International Orem Society Newsletter)
is published three times a year by the International Orem Society for Nursing Science and Scholarship,
S28 School of Nursing University of Missouri, Columbia, MO 65211, USA.
Manuscripts should be e-mailed to the editor,
Michael J. Morgan, MPH, PhD, RN, mjmorgan@wayne.edu
Membership in the society which includes the Journal is
$50.00 per year for individuals and institutions.
Society information is posted on the Self-Care web site at:
www.muhealth.org/%7enursing/ *and follow the link to International OREM Society*
Articles appearing in the Journal are indexed by CINAHL.