



Continuing Education

Relationship of a Pelvic Floor Rehabilitation Program for Urinary Incontinence to Orem's Self-Care Deficit Theory of Nursing: Part 1

Francie Bernier

Urinary incontinence (UI) is considered a significant social problem affecting many individuals' quality of life. Studies estimate more than 13 million Americans suffer from involuntary urine loss (Agency for Health Care Policy and Research [AHCPR], 1996). Since the late 1980s, there has been an increase in the number of continence centers providing conservative management for incontinent clients. Those who present to these centers should expect a well-educated continence nurse who creates a secure and confidential environment and offers support, empathy, education, and a therapeutic rehabilitative program.

Within the continence centers, clients will have evaluations of present and past health histories including surgical interventions, activities of daily life, and continence symptomatology. While trying to identify the cause of incontinence, the continence nurse and the client will create an individualized therapeutic plan to dimin-

Urinary incontinence is considered a significant social problem affecting many individuals' quality of life. Nursing theory is a set of concepts or propositions derived from philosophical beliefs about the phenomena of interest to the discipline. The ability to use theory to guide nursing practice brings reasoning and logic to professional nursing practice. Orem's Self-Care Deficit Theory of Nursing gets to the heart of what nursing is and how continence nursing care can be offered and delivered as a broadly inclusive professional, rather than narrowly procedural, practice offering individual care targeting the self-care agent (client) rather than the medical diagnosis

ish or eliminate incontinence symptoms. Those who complete the rehabilitative program usually show symptom improvement of 75% to 100% (Bernier, 2001; Bernier & Davila, 1995). Clients report that the new information from the continence nurse on lifestyle changes significantly reduces symptomatology resulting in an overwhelmingly positive effect on their quality of life.

Dorothea Orem created The Self-Care Deficit Theory of Nursing to define the role of nursing. She puts the emphasis on actions needed to support the client in acting as his/her own agent for health care rather than assuming nursing responsibility for all needs, including those the client can maintain for him or herself. Thus, she uses nontraditional but meaningful terms such as "self-care," "agent," "agency," "demand," and "therapeutic." Because of this emphasis on client responsibility, her theory is well-suited to continence care. Nurses do not cure the inconti-

nence but, rather, provide the *self-care agent* (client) with the means to regain *self-care agency* (capabilities needed to take control) over bladder dysfunction. The ultimate goal is promotion of *self-care* (deliberate action) to meet the *therapeutic self-care demand* (actions needed) to improve or eliminate the *self-care deficit* (limitations) related to UI. *Nurse agency* (nursing ability) is needed because the *therapeutic self-care demand* exceeds *self-care agency* and the incontinence-related *self-care requisites* (requirements) necessary to eliminate the *self-care deficit* include education, focused assessment, and a therapeutic rehabilitative process, all within the defined practice role of the continence nurse.

Orem's Self-Care Deficit Theory of Nursing is used by various nursing specialties within the health care environment including oncology nursing (Morse & Werner, 1988), ambulatory care (Vasquez, 1992), and

Francie Bernier, MSN, RN, C, is Certified in Ambulatory Women's Health Care by the National Certification Corporation, is currently employed as the Clinical Education Specialist for InCare's PRS Division of Hollister, Libertyville, IL, and is a Doctoral Student, University of Virginia.

Note: CE Objectives and Evaluation Form appear on page 391.



other specialty fields. In an informal random survey of 20 continence nurses attending the Society of Urologic Nurses and Associates Annual Convention in Anaheim, CA, in June 2001, 100% of those asked did not actively apply a nursing theory. When asked why, the overwhelming response was due to the cumbersome nature of nursing theory. The nurses interviewed visualized their role as procedural rather than theory based. Interestingly, when Orem's theory was reviewed with them in relation to continence care, 95% said they could understand the use of this theory in practice. What these nurses did not realize is that they were actually using many of the principles of Orem's theory to guide their practice of nursing but had never realized that their methodology of practice was directly linked to Orem's Self-Care Deficit Theory of Nursing. To date, Orem's theory has not been applied to continence care in the literature. Thus, the purpose of this article is to review the components of continence care and demonstrate the relationship of the Self-Care Deficit Theory of Nursing to the care of the client with incontinence.

Definition of Continence Care

Urinary incontinence is defined as the "involuntary loss of urine sufficient to be a problem" (AHCP, 1996). Controlling bowel and bladder habits is a function learned in childhood. As adults age, the fear of losing bowel or bladder function is synonymous with shame leading to isolation, embarrassment, lowered self-esteem, and, for some, nursing home admission. Although aging does not cause incontinence, it can be a predisposing factor that may result in the development of UI. It is estimated that 10% to 30% of women suffer from UI (Burgio, Matthews, & Engel,

1991; Harrison & Memel, 1994). Trauma from childbirth and a decrease in circulating estrogen predisposes a woman to UI and other urogenital dysfunction. Additionally, the genetics associated with heredity and structural integrity of the tissues play an important role (Bernier & Jenkins, 1997). Men often relate their symptoms of incontinence to prostate conditions or surgical interventions associated with prostate disease. Neurologic disease, diabetes, surgical trauma, and certain medications can also predispose a person to UI (AHCP, 1996).

The social stigma associated with the development of UI often places a person in fear of public exposure related to their inability to control elimination. Perhaps fewer than half of the clients suffering with UI report symptoms to their health care professional. Nonreporting of incontinence is also thought to be due to the lack of knowledge and understanding about treatment options, the convenience of increased availability of absorbent products, and limited perceptions of the benefit of reporting the conditions to their physician or other health care provider (Branch, Walker, Wetle, DuBeau, & Resnick, 1994).

It is estimated that the cost of treating incontinence exceeds \$11 billion while the cost associated with long-term care residents is estimated to be at \$5 million annually (Newman, 1997). Newman also estimates actual costs to be higher than reported costs.

Many specialty nurses work in close collaboration with physicians who provide continence care. Continence nurse specialists are qualified to independently develop, design, and provide complete continence programs for most types of bladder dysfunction.

Defining Nursing Theory

Nursing theory is a set of con-

cepts or propositions derived from philosophical beliefs about the phenomena of interest to the discipline. Relationships between concepts and propositions of a nursing theory purport to describe and explain a characteristic phenomenon of interest to nursing (Firlit, 1994; Marriner-Tomey, 1994). Theory creates a setting to combine the organization of ideas, concepts, and beliefs relating a phenomenon of interest and philosophical conviction to professional practice. Theory gives reason to nursing and justifies its existence by providing the framework for practice, knowledge, and research.

One purpose of theory is to provide a greater understanding of nursing practice. Nursing theory clarifies the nursing role, separating it from a procedure-based practice to a distinct discipline reflecting an independent professional role in collaboration with other health care disciplines. The use of theory in practice promotes a logical method for nurses to provide services by identifying the necessity of nursing interventions. Although nursing theorists describe their individual philosophies and descriptions differently, the use of theory in nursing gives justification to the art and science of nursing practice, thus creating a need for nursing. Ultimately, theory and practice promote research encouraging practicing nurses to question and develop methodologies to enable change, growth, and progress.

History of Orem's Self-Care Deficit Theory

Dorothea Orem developed her model of nursing while a consultant for the Indiana State Board of Health from 1949 to 1957. It was during this time that she noticed the inability of nurses to talk about what nursing was or to clearly define the role of a nurse. As a result of her consulting role, she summarized her



findings in an Indiana State Board of Health report. She later expanded her initial report when she developed the basis for nursing while working as a consultant in the Office of Education, U.S. Department of Health, Education, and Welfare (Orem, 1956). Here, her task was to improve the nursing component of the vocational nursing curriculum. She realized she was unable to determine the curriculum until the subject matter of nursing was better understood and defined within the profession (Hartweg, 1991). Therefore, Orem asked the questions, "What is nursing?" and "What condition exists when judgments are made that people need nursing"? She reasoned that nursing occurred when there are "the inabilities of people to care for themselves at times when they need assistance because of their state of personal health" (Helene Fuld Health Trust, 1988; Orem, 1959).

While nurses can use this definition to give justification for nursing intervention, questions still remained as to the specific role of a nurse. To provide clear direction for nursing education and practice, knowledge must be expanded regarding basic conceptual elements, core elements, and the relationship to practice (Orem, Taylor, & Renpenning, 2001). The development of key concepts to expand knowledge development that is useful to nursing must be the basis for research which will, then, test theory and practice. Learning and understanding self-care practices of individuals with specific needs and values are the core requirements needed to promote self-care and self-management.

Orem's Self-Care Deficit Theory of Nursing

While terms used in Orem's Self-Care Deficit Theory of Nursing seem cumbersome at

first, application to continence care helps make them less perplexing.

1. *Self-care* is the intentional action that regulates and controls activity within and around the person's own functional and developmental processes and promotes personal well-being (Orem, 1991; & Orem et al., 2001). It is more easily defined as self-directed activity to maintain life, healthful functioning, and development throughout all of the life cycles. The philosophy of a continence clinic promotes the intentional action of self-care to eliminate or improve UI appropriate to adult development.
2. The person who provides self-care is the *self-care agent*. For those unable to complete their own self-care such as children, infants, or adults, a *dependent-care agent* acts in their behalf to provide self-care. The client in a continence clinic setting usually acts on his/her own behalf as the self-care agent in charge of the intentional action, or self-care, needed to regain continence.
3. *Self-care requisites* are formulated and expressed insights about the kinds and sequences of action that are known to be necessary or hypothesized to have validity in individual regulation of aspects of functioning, development, or well-being, so as to live day to day in stable or changing environments (Orem et al., 2001). An incontinent self-care agent who drinks several caffeinated beverages daily and voids every hour has self-care requisites related to nutritional intake and voiding habits conducive to decreasing bladder irritability and increasing bladder capacity.
4. *Universal self-care requisites* are the common requirements of all human beings.

These are related to the intake of air, water, and food; normal elimination; activity and rest; solitude and social interactions; safety and normalcy. Without these requisites, a balanced state of existence is not achieved and maintained, prompting an incontinent client to act as his/her own self-care agent in seeking help from a continence clinic.

5. *Developmental self-care requisites* are related to the specific stages of the life cycle. These are associated with normal maturation as one progresses through the stages of life. A developmental self-care requisite of adulthood is continence.
6. *Health-deviation self-care requisites* relate to the development of illness, medical and nursing interventions, and treatment. Urinary incontinence is a health deviation from the adult norm prompting the need for intervention and treatment.

The Self-Care Deficit Theory of Nursing provides a descriptive explanation of the elements and relationships that are common to all instances of nursing. It is the essence of the need for nursing interventions and directs the intervention to help self-care agents (clients) increase their level of self-care while decreasing the need for nursing involvement. This provides direction for nursing practice and a relationship to the self-care agent's needs or self-care requisites, and limitations or self-care deficits (Orem, 2001).

Orem's Self-Care Deficit Theory of Nursing consists of three aspects of theory that are interrelated: the theory of self-care, the theory of self-care deficit, and the theory of nursing system. The three theoretical aspects propose an answer to the question, "When and why do people require the health service nursing?" (Orem, 1987).



Three Interrelated Aspects Of Theory

As part of the assessment and evaluation process, the continence nurse uses the *theory of self-care/dependent care*. This theory evaluates health care practices the self-care agent (client) uses including the ability to act deliberately to regulate functioning and development. The theory of self-care/dependent care answers the question, "What is self-care and what is dependent care?" (Orem, 1987). Self-care is described as deliberate action. It is behavior that is learned from interaction and communication in large social groups (Hartweg, 1991). Dependent care includes activities performed by responsible adults for socially dependent individuals, children, or adults to meet portions of their therapeutic self-care demand or activities that promote and maintain health and well-being (Hartweg, 1991).

The theory poses the concept that persons perform actions or specific activities directed at him or her or the environment or direct care of those dependent on them (Dennis, 1997). Actions needed to meet self-care requisites are known as the self-care demand. Orem (1991, p. 124) says "A therapeutic self-care demand is essentially a prescription for continuous self-care action [for meeting] self-care requisites [(needs)]." These requisites may be met by the self-care agent (client), dependent-care agent (caregiver), or by nursing. They include universal, developmental, and health-deviation self-care requisites. When the self-care demand (actions necessary to meet needs) is greater than the self-care agency (client ability to meet needs), and when nursing intervention will help meet the self-care demand, the need for nursing is established.

Usually the self-care agent (client) is the person seeking nursing intervention in a continence clinic. Self-care practices appro-

priate to the theory of self-care would include interactions and communications that encourage health-seeking behaviors, methods currently used to contain incontinence, and attitudes determining the self-care agent's ability to successfully enter into a program designed to enable one to handle a socially delicate health-deviation self-care requisite such as urinary incontinence.

The theory of self-care deficit develops the reasoning for nursing intervention of human beings for health-related needs exceeding the self-care agent's (client's) ability to alleviate the deficit. The continence nurse defines deficits in the client's ability to perform self-care or care for their dependents. Although most continence nurses would consider UI requiring daily containment measures to constitute a self-care deficit, the incontinent person who is satisfied with containment strategies would not, in Orem's definition, require nursing intervention. Using this theory, the continence nurse employs various modalities of continence evaluation such as diagnostic testing for incontinence, quality of life assessments, bladder diaries, dietary influences, medication evaluation, and pelvic floor assessments.

Continence nurses evaluate and assess the complete self-care agency, taking into account the social aspects of the self-care agent's environment as well as the past and present medical problems. A complete history of medical and surgical interventions takes place on the first visit to the continence nurse who will review the diagnosis that is received from the physician and compare the medical diagnosis to the client's symptomatology. Other aspects of the client's history worthy of consideration are: dietary intake to include bladder irritants, location of the bathrooms, ability to manage toileting habits, woman's estrogen status,

cognitive awareness, and a complete urogenital evaluation.

Continence programs often begin with a client's self-reporting bladder diary or voiding journal. The diary consists of a weekly or daily journal of activities that precipitate an incontinent episode, describe the urine loss, record the type and amount of fluid intake, and report frequency, amount, and time of voiding. A well-kept bladder diary allows the continence nurse to assess, compare, and relate the client's symptomatology to the diagnosis. Without this evaluation, symptoms may not improve resulting in frustration that may ultimately compromise compliance with the program. Before the rehabilitative program begins, responsibility of the self-care agent and the nurse agent is explained.

History and physical examinations are an important part of the evaluation along with assessment of UI symptoms. It is important to note that UI is often a symptom of other physiologic conditions. The presenting problem of urine leakage is secondary to other medical conditions or even functional events, such as distance from the bed to the bathroom; therefore, the nurse reviews the onset of symptoms, medical and surgical history, dietary experience, voiding habits, and medications, and addresses the client's psychological status.

Quality of life assessments are often included before and after treatments to gain a better insight into the effect of the rehabilitation program on the person's lifestyle. Sleep deprivation as a result of nocturia or shame and fear of personal exposure of incontinence may lead to isolation from caring friends and family. These are common elements related to sadness and depression in the incontinent client resulting in an altered quality of life.

History and physical examination include a review of all



biological systems and psychological and sociological factors. Initial diagnostic testing includes a urine culture and a postvoid residual to determine bladder compliance. A urine culture, not a urinalysis, should be done at the initial visit. The urine culture is important as some bacteria do not convert to nitrites during an office dipstick evaluation (Bernier, 2001). Urodynamic testing, a computerized evaluation of pressure measurements along the lower urinary system, is also commonly done. Individuals presenting with a medical or surgical history that complicates their present symptomatology should undergo more in-depth urodynamic evaluation.

The use of the theory of self-care deficit can provide a consistent method for assessing each individual presenting for pelvic floor rehabilitation. To require nursing interventions, deviations in the self-care requisites must be assessed and found to exceed the self-care agent's ability to do self-care. This theory defines and explains why and how people can be helped through a nursing intervention by answering the question "Is this person handling the situation satisfactorily or is nursing intervention needed to meet the health care requisite (need)?" Incontinent clients must deliberately present in the continence center for care, seek information about their condition, and be motivated to take the responsibility to add the lifestyle changes to their activities of daily life.

The theory of nursing systems provides an excellent methodology for developing individual client treatment plans for the specific level of nursing intervention. This theory determines if nursing is needed and what level of nursing care the client requires. Each level is based on the self-care agency (status and functioning capacity) of the self-care agent (client). The

wholly compensatory system is used when the nurse provides or controls all of the actions for the client. Continence care is not offered to wholly compensatory clients as their health care needs are directed at the more critical life-sustaining interventions.

When the self-care agent (client) is able to share in the responsibility for care, the nursing system is considered to be *partially compensatory*. Included would be help with activities of daily life such as assistance with toileting, electrical stimulation for pelvic floor rehabilitation, or keeping a bladder diary to evaluate continence needs and status.

The *supportive-educative nursing system* is offered to the self-care agent who can perform all of the self-care actions and is in need of understanding, education, and information from the nurse agent. Continence care for this person might include teaching Kegel exercises (Kegel, 1948) for pelvic floor strengthening, providing information on needed dietary alterations, and supporting efforts toward continence, without physical assistance in toileting or other activities of daily life.

The nursing systems offered to the person presenting for continence services will most often be of the partly compensatory or supportive-educative nursing systems. The self-care agent (client) may progress from one to the other as the program proceeds or the condition changes.

Nursing intervention in response to identified deficits for maintaining self-care prescribes and designs nursing care that regulates the individual's self-care capabilities and meets therapeutic self-care requirements (Chinn & Kramer, 1999). Intervention includes nursing diagnoses and specific nursing actions applicable to the client situation. The nurse-client interactions are aimed at encouraging that the self-care requisites be met by cre-

ating an atmosphere for complementary actions.

Assessment of the self-care agent's ability to meet universal, developmental, and health-deviation self-care requisites (needs) define if and when nursing is required. Universal self-care requisites are common to all human beings during all stages of the life cycle and may be adjusted to age, developmental state, environmental, and other factors (Orem, 1991). They include maintaining air, water, food, elimination, activity and rest, solitude and social interaction, prevention of hazards, and normalcy (Dennis, 1997). Universal self-care requisites relate to continence care by requiring the client to learn elimination-related self-care actions in an age and maturity-appropriate way (Hartweg, 1991). Questions to be answered regarding universal self-care requisites include: Does the client ingest enough fluid? What types of fluids are ingested? Is the client suffering from insomnia due to the nocturia or experiencing depression as a result of incontinence? How many hazards interfere with safe toileting? Does the problem of urinary incontinence cause the client to feel less than normal? Is the client able to address her self-care needs? What deficits are present? Are the deficits related to developmental concerns or conditions within the environment? When universal self-care requisites are not met, the self-care agent (client) will seek intervention to promote normal health care. If the client is unable to act in her own behalf, another person assumes the role of dependent self-care agent, working with the continence nurse. An example of this may be a daughter caring for her incontinent mother who seeks information to reduce the number of incontinent episodes or prevent skin breakdown or injury.

Developmental self-care requisites are actions specific to pro-



moting development of self. They focus on behaviors necessary to relieve or prevent interference from conditions, events, or situations that could have a deleterious effect on development. There are two types of developmental self-care requisites: (a) those arising from conditions/events that normally occur at various stages of the life cycle and (b) those associated with deviations in self-care requisites or alterations in the health care status of the individual (Dennis, 1997). Developmental requisites may be related to events throughout human development or significant events that occur, such as death of a significant other (Hartweg, 1991). Incontinence may be a result of such conditions or maturational events as pregnancy or menopause, or prostate conditions.

Health deviation self-care requisites are the needs and goals created as a result of illness, defects, disabilities, or while undergoing diagnostic testing. For the self-care agent seeking intervention from a continence nurse, these requisites (needs) might include diagnosis, medication, education, pelvic floor rehabilitation, or information on effective containment products. Variables may relate to cultural and social experiences of each person. Beliefs about bladder control problems will vary from person to person. If incontinence is considered normal following pregnancy or as one grows older, women will be less likely to seek care for the condition. Identifying health deviation self-care requisites helps the continence nurse develop the treatment plan based on the assessment and needs of the individual.

Using the theory of nursing systems as a tool for development and evaluation of an individualized nursing system in a nurse-managed continence clinic assures that universal, developmental, and health-deviation self-care requisites are met. The continence nurse

must employ a multifaceted approach. The nurse agent (continence nurse) must follow the self-care agent's progress for 6 to 12 visits. At each visit, status is reviewed and essential adjustments are made to the treatment plan. Continence nurses provide ongoing education and encouragement to continue in the program while monitoring improvement and change. Often, a close relationship builds between the client and the nurse. This is based on respect, trust, and empowerment of client self-care as they take charge of their continence problem and maximize their ability to regain control of this body function.

On occasion, the continence nurse may encounter the challenging client who may not want to take the responsibility for all or some of the components of the program by acting as her own self-care agent. While the purpose of the continence program is to actively involve the client in every step of the process, clients may not understand the concept of self-care agency and may anticipate that the continence nurse will take responsibility for improving their symptoms. In such a case, the goal of the continence nurse and the program must be clarified, individualized, mutually agreed upon, and well communicated to the client. Motivation for success must come from within the self-care agent (client) if long-term benefit is to be gained from the program. The role of the continence nurse is to serve as facilitator, educator, resource person, and cheerleader while acknowledging the steps toward self-care taken by the client. To achieve success, the client must ultimately take responsibility for this rehabilitation program and maintain the program's activities following discharge.

Summary

The ability to use theory to guide nursing practice brings reasoning and logic to professional nursing practice. Orem's Self-Care

Deficit Theory of Nursing gets to the heart of what nursing is and how continence nursing care can be offered and delivered as a broadly inclusive, rather than narrowly procedural, professional practice offering individual care targeting the self-care agent (client) rather than the medical diagnosis. By treating the whole person and not just the urinary incontinence, the continence nurse can provide purposeful therapeutic intervention, resulting in client awareness of contributing factors, causes, and help for UI symptoms. The program's success is often directly related to the client's self-care agency (ability) to understand and embrace necessary self-care requisites (requirements) to make lifestyle changes as they apply to the diagnosis and symptoms.

Dorothea Orem created the Self-Care Deficit Theory of Nursing to differentiate the true role of nursing and provide a methodology for effective nursing intervention. This concept creates a reason for nursing care and produces the utilization of a theoretic and universal method for its delivery. It defines the role of continence nursing and brings purpose in the nursing care provided at the continence center. When nursing care is delivered using Orem's theory, continuity of self-care is the natural outgrowth. ■

References

- Agency for Health Care Policy and Research. (1996). *Urinary incontinence in adults: Acute and chronic management. Clinical practice guideline No. 2*. Washington, DC: U.S. Department of Health and Human Services.
- Branch, L.G., Walker, L.A., Wetle, T.T., DuBeau, C.E., & Resnick, N.M. (1994). Urinary incontinence knowledge among community-dwelling people 65 years of age and older. *Journal of the American Geriatric Society, 42*, 1257-1262.
- Bernier, F. (2001). In J.M. Black, J.H. Hawks, & A.M. Keene (Eds.), *Medical-surgical nursing: Clinical management for positive outcomes* (6th ed.) (pp. 801-873). Philadelphia: W.B. Saunders.
- Bernier, F., & Davila, G.W. (1995).



Continuing Education

Applying Orem's Self-Care Deficit Theory of Nursing To Continence Care: Part 2

Francie Bernier

The flavor of Orem's Self-Care Deficit Theory is rarely enjoyed and experienced during a nurse's early years of practice. With so much to learn, so much to understand, and so many new thought processes, the abstract theoretical concepts from theory-based nursing practice are one more challenge for the nursing student. As with broccoli, a child may turn up a nose with the first taste, but after experimenting with broccoli and other vegetables, the taste of broccoli becomes a favorite.

Changing thinking patterns to a theory-based practice comes with nursing experience and nursing logic, bringing together nurses in one voice and making the client's care unidirectional, while creating a logical method of practice. It allows for all nurses participating in the client's care to use a nursing model to offer nursing care. As many nurses report, "It just makes sense."

Theory-based nursing practice provides a framework for initiating the research process. It

Theory based nursing practice provides a framework for initiation of the research process. Orem's Self-Care Deficit Theory of Nursing clearly relates and can be easily applied to continence care. Orem's Theory guides nursing practice with theoretical concepts and goal setting providing a foundation upon which nurses can question the practice and expand the avenue for nursing research.

Broccoli Is to Orem. . .

"Broccoli again!" the young boy whines.
"You know I just can't eat it!
"It looks like little trees, you know,
"And boys can't stand to see it!"

"What does she mean?" the child-nurse whines.
"This 'Orem-ese' is awful.
"Why can't she just speak English, now,
"Her words are simply frightful."

I pass the broccoli, meat, and spuds.
He piles it on with vigor.
"How is that broccoli, son?" I ask.
A teenage shrug and snicker.

The patient sighs, the young nurse smiles,
As both must work together.
"I'll help you do self-care, today.
"We'll learn from one another."

"Please pass the broccoli, meat, and spuds."
A fine man he's become.
"I love the stuff you cook for me."
He gobbles every crumb.

"His deficits could overwhelm
"His wife, his self-care agent.
"Let's look at requisites, demands,
"And self-care that's dependent."

"Look, my son, they're little trees.
"They'll help you grow like Daddy.
"So hurry, eat your meat and spuds,
"And eat your broccoli gladly."

"I'll help her do these things herself,
"And do some others for her.
"She'll soon be home and on her own,
"I'll ease her toward the latter."

Broccoli becomes a part of life,
To devour and to savor.
Orem is long internalized,
She's done me quite a favor.

— Jane Schade Henderson

Francie Bernier, MSN, RN, C, is Certified in Ambulatory Women's Health Care by the National Certification Corporation, is currently employed as the Clinical Education Specialist for InCare's PRS Division of Hollister, Libertyville, IL, and is a Doctoral Student, University of Virginia.

Note: CE Objectives and Evaluation Form appear on page 391.



Figure 1.
Assessment Using Orem's Self-Care Deficit Theory of Nursing

I. Client Profile

A. Personal Characteristics

L.R. is a 30-year-old Caucasian, English-speaking female. She is a teacher but is not currently working as she is staying home to raise her two children, ages 4 and 2. She is active in her church groups and participates at various activities with her children. L.R. completed her master's degree in education. Just prior to having children, she taught third grade. She enjoys being active with her children, reading, and meditation.

B. Current Health Orientation

L.R. states she is in excellent health. However, since the birth of her last baby, she has noticed she is experiencing urine loss with exertional activities. Her goals are related to decreasing these symptoms to prevent worsening of the symptoms as she progresses through the life cycle.

C. Family Characteristics

L.R. is married and has two normal, healthy, living children. Her parents are living and both are healthy at 68 years of age. She has one brother who is married and without current medical problems.

D. Environmental Characteristics

L.R. lives with her husband and children in the suburbs. She feels safe in her neighborhood. Her shopping areas, schools, and health care facilities are nearby.

II. Universal Self-Care Requisites

A. Air

L.R. and all household members do not smoke. She lives in a metropolitan area where ozone alerts occur periodically.

B. General Health Habits

1. L.R. practices good hygiene, health habits, and dental care. She visits her physician and dentist when appropriate. Her vital signs are all within normal limits. T-97.2, P-84, R-18, BP 104/68. LR drinks one to two caffeinated beverages a day. She drinks one glass of orange juice per day and rarely drinks milk. She drinks water all other times.
2. Review of systems:
 - a. *Skin*: No rashes, scaling, lesions, growths, or tumors.
 - b. *Hair*: Short curly hair. Denies any changes or hair loss.
 - c. *Nails*: Nail beds are clean and pink in color with good capillary refill. Denies any changes in appearance.
 - d. *Breasts*: Denies any pain, lumps, or nipple discharge. Breasts are symmetrical with fibrocystic changes. Reports monthly self-breast examinations. Has not had a baseline mammogram. No family history of breast cancer.
 - e. *Respiratory*: Denies any changes in smell or sensitivity to smells. Denies shortness of breath, dyspnea, and chronic cough. There is no history of asthma. Lungs are clear to auscultation and percussion.
 - f. *Cardiovascular system*: Denies palpitations, heart murmur, varicose veins, or hypertension. Denies any personal or family history of heart disease. Physical examination reveals a regular rate and rhythm without murmur.
 - g. *Peripheral vascular system*: No temperature changes, edema, or varicosities. Pedal pulses are strong bilaterally.
 - h. *Integument*: No evidence of dehydration. Skin has good turgor. There is no evidence of edema or excessive dryness. She denies complaints of excessive sweating or polydipsia. There is no need for parenteral fluids.

C. Food

1. Health habits: Denies any special needs for food preparation or dietary modifications (cultural, medical, or religious). 24-hour diet recall: ate bowl of cereal for breakfast, salad for lunch, chicken, green beans, and potato for dinner. She is not a picky eater and does not eat a lot of red meats. She is responsible for the meal preparation. She denies any change in her weight and does not have any problems with digestion. Her only medications are a multivitamin and calcium. Ht. 5'4" Wt-118.



Figure 1. (continued)
Assessment Using Orem's Self-Care Deficit Theory of Nursing

2. Review of systems:
 - a. *Mouth*: Teeth in excellent condition. Two fillings in back molars noted. Denies problems with chewing. No lesions or erythema noted.
 - b. *Throat*: No c/o dysphagia. No lesions or erythema noted.
 - c. *Gastrointestinal*: No problems with nausea, vomiting or indigestion, polyphagia or pain. Bowel sounds are present, abdomen nontender to deep palpation, no rebound tenderness.
- D. Elimination**
1. Health habits: Bowel movements every day or every other day. Denies use of laxatives or stool softeners. Complains of urine loss associated with exertional activities without urgency. Voids 7 to 9 times per day with no nocturia. No complaints of flatus or fecal incontinence symptoms.
 2. Review of systems:
 - a. *Bladder*: Denies polyuria, nocturia, or oliguria. Complains of urinary incontinence associated with activities such as jumping rope, coughing, and with increasing symptoms before menses. Denies signs and symptoms of cystitis, urgency, or pain. Voids 7 to 9 times per day.
 - b. *Bowel*: Denies hemorrhoids, diarrhea, or constipation, fecal or flatus incontinence.
 - c. *Genitalia*: No complaints of irritation, itching, or vaginal discharge consistent with infection. No history of STDs. Color pink with good vascular and estrogen supply.
- E. Activity and Rest**
1. Health habits: L.R. enjoys participating in sports. She requires 6 to 8 hours of sleep. She is active and participates in sports, despite UI. Denies using alcohol or drugs to induce sleep.
 2. Review of systems:
 - a. *Musculoskeletal*: Good muscle strength and full range of motion of all extremities. Pelvic floor assessment reveals a weakened pelvic floor. Able to recruit the pelvic floor muscle, but is unable to sustain the contraction for greater than 2 to 3 seconds. Anal sphincter tone excellent.
 - b. *Neurological*: No complaints of numbness or tingling in any extremities. No complaints of heat or cold intolerance; extremities are warm to the touch and there are no unusual tremors. No complaints of headaches, loss of memory, or loss of consciousness. DTRs present and normal in all four extremities.
- F. Solitude and Social Interaction**
1. Health habits: Satisfied with sexual activity of 1 to 2 times per week. Takes birth control pills. Sees her family and extended family frequently and socializes with friends. She is with her children most of her time and states she rarely has time alone. However, she occasionally takes a day off and leaves the children with her husband or sister-in-law. She has not given up her normal activities due to her symptoms of incontinence.
 2. Review of systems:
 - a. *Ears*: No decreased hearing or pain, no tinnitus.
 - b. *Eyes*: Wears soft contact lenses. Denies blurred vision or night blindness. Complains of dry eyes late in the evening and uses eye drops that help.
 - c. *Reproductive*: Menarche age 12, 28-day cycles with very light flow since on birth control pills. Denies problems with PMS or menstrual cramps. Gravida 2 Para 2. Vaginal deliveries X 2 with mid-line episiotomy scars.
- G. Hazards of Human Life, Human Functioning, and Human Well-Being**
- Wears a seat belt. Has never smoked or used street drugs; drinks alcohol 0-1 times per week. Denies any history of physical abuse and advocates gun control.
- H. Normalcy**
- Promotion of human functioning and development within social groups in accord with human potential, known limitations, and the human desire to be normal.
1. Health habits: Has yearly GYN examination and dental examinations 2 times per year. Has health insurance through her husband. Does self-breast examinations. Feels she communicates well with her husband, family, and friends. Manages her stress by exercise, meditation, and discussion.



Figure 1. (continued)
Assessment Using Orem's Self-Care Deficit Theory of Nursing

2. Self-concept/image: L.R. is not presently working and is pleased with the decision to stay home. She feels good about it as she enjoys being home with her children. Is considering home schooling her children. She has never had any problems with depression. However, she is worried about the potential social problems and increasing symptoms of urinary incontinence as she ages. She goes to a Methodist church frequently.

III. Developmental Self-Care Requisites

L.R. is functioning normally for her developmental stage (early adulthood, ages 18 to 30).

IV. Past Health Deviation Self-Care Requisites

- A. Seeking appropriate medical assistance:** L.R. has regular physical examinations. Her recent complaint of UI is upsetting to her.
- B. Attending to pathological states:** L.R. recognizes the need for medical intervention to treat her problem with UI. She wants to address the problem now to prevent the symptoms from becoming worse.
- C. Carrying out medically prescribed measures:** L.R. did Kegel exercises as prescribed by her gynecologist. However, when her exercise regimen failed to help her gain control of her incontinence, she found a physician who offers continence care without surgery.
- D. Attending to deleterious effects of medical care measures:** L.R. realizes her incontinence symptomatology will increase if she does not address the problem now.
- E. Modifying one's self-concept:** L.R. has no complaints or evidence of depression associated with her complaints of UI.
- F. Learning to live with the effects of pathological conditions:** Realizes incontinence is not a life-threatening condition. However, she realizes that the long-term effects of urinary incontinence can affect her sense of well-being and may alter her quality of life.

V. Present Health Deviation Self-Care Requisites

- A. Seeking appropriate medical assistance:** L.R. has set up six appointments to address her problem with UI.
- B. Attending to pathological states:** L.R. desires prevention of her symptoms from increasing.
- C. Carrying out medically prescribed measures:** Has attempted Kegel exercises in the past.
- D. Attending to deleterious effects of medical care measures:** None noted.
- E. Modifying one's self-concept:** N/A
- F. Learning to live with the effects of pathological conditions:** L.R. accepts the diagnosis of urinary incontinence and reality of addressing the condition before symptoms get worse. Has chosen not to undergo a surgical intervention at this young age.

guides nursing practice with theoretical concepts and goal setting, providing a foundation upon which nurses can question the practice and expand the avenue for nursing research. Theory-based practice is timeless. However, the constant changes brought about by research can expand the theory to make it more useful in current practice.

Using Orem's Theory to Direct Continence Care

Orem's theory clearly relates and can be easily applied to continence care. The following is a case study (see Figure 1) using all three of Orem's theories: self-

care, self-care deficit, and nursing system. The case study is intended as a comprehensive teaching tool that would not necessarily be used in its entirety in every practice situation. The usefulness of Orem's theory lies in its unique ability to provide a framework upon which the nurse creates a logical method to guide assessment, determine the nursing intervention, and deliver the nursing care to the client.

Using Orem's Theory

Theory-based practice facilitates the application of nursing practice in "one voice," guiding the nursing role within the health care setting. Using a theo-

ry-based practice keeps the nurse thinking as a nurse, directs the nursing care by the nurse, and creates a common ground of discussion for all nursing care

When the continence nurse uses Orem's theory to evaluate and assess L.R., her patient, the nurse finds that L.R.'s main concern is her loss of bladder control and that she is seeking information and care (see Figure 2). The medical condition is stress urinary incontinence. The need for nursing is to provide L.R. with a plan and information to address the bladder dysfunction. The goal of treatment is to encourage L.R. to improve or cure her symptoms while preventing her symp-



Figure 2.
Nursing Plan of Care

Diagnosis	
Nursing Diagnosis #1: Knowledge deficit related to nonsurgical treatment of urinary incontinence.	Self-Care Deficit: Elimination: Seeking information related to urinary incontinence.
Nursing System: Supportive Educative	
Nursing Diagnosis #2: Altered patterns of urinary elimination.	
Nursing System: Supportive Educative	Self-Care Deficit: Elimination: Urinary incontinence associated with exertional activities.
Nursing Diagnosis #3: Potential for depression with increasing symptomatology associated with the aging process.	
Nursing System: Supportive Educative	Self-Care Deficit: Normalcy associated with self-concept/imaging.
Goals	
1. Increased knowledge base to the causes and types of urinary incontinence.	
2. Increased awareness as to the nonsurgical care of urinary incontinence.	
3. Increase knowledge as to the use of pelvic floor muscle and other behavioral interventions to decrease symptomatology.	
Plan	
Client Responsibilities	Nursing Responsibilities
1. Listen to explanations of causes, types, and treatment of urinary incontinence.	1. Provide comfortable environment for education process.
2. Utilize the information gained to decrease potential for depression.	2. Encourage client to express feelings and provide education to improve potential quality of life issues.
3. Keep bladder diaries.	3. Encourage client to complete the diaries by informing her about the importance of the document. The nurse should also interpret the diary weekly.
4. Do prescribed pelvic floor exercises at home and during activities that cause UI.	4. Encourage pelvic floor exercises per client. Monitor weekly sessions, looking for improvement and changes in status.
5. Return to office for followup session as prescribed.	5. Set up appointments and followup as needed.
Evaluation	
1. Within the first week, L.R. should be able to restate the causes, types, and treatment of urinary incontinence.	
2. Within 4 weeks a decrease in the symptoms should be noted by increased use of the pelvic floor muscle and increased knowledge of the activities that trigger urinary incontinence.	
3. Encourage L.R. to monitor symptoms and call for appointments to return to office if at any time symptoms return or changes in urogenital health occurs.	

toms from worsening. Education is a key component of L.R.'s care.

Using the theory of self-care to review universal self-care requisites for L.R., the continence nurse can correlate the symptoms of urinary stress incontinence to the eight universal self-care requisites.

1. *The maintenance of sufficient intake of air.* L.R.'s assessment of her respiratory status reveals no evidence of deficits.
2. *The maintenance of sufficient intake of water.* L.R. reports an adequate intake of water. Her first bladder diary

will reveal her fluid intake. The continence nurse will review the diary, evaluate the type of fluids L.R. ingests, and look for any relationship of bladder dysfunction to symptoms. Review of the diary provides opportunity to identify the relationship of

bladder irritants to incontinence.

3. *The maintenance of a sufficient intake of food.* This requisite is met. L.R.'s weight is within normal limits. However, during her continence evaluation, the nurse would stay alert to needed suggestions in dietary alteration to help maintain bladder health.
4. *The provision of care associated with elimination processes and excrement.* L.R.'s self-care deficit is stress UI. She complains of urine loss not associated with voiding attempts. Her urine loss is associated with her bladder's inability to contain urine during specific activities.
5. *The maintenance of balance between activity and rest.* L.R. is not complaining of symptoms of nocturia or problems with nocturia associated with these symptoms.
6. *The maintenance of balance between solitude and social interaction.* During the assessment L.R. reveals her problem associated with incontinence does not affect her activity level.
7. *The prevention of human hazards to human life, human functioning, and human well-being.* L.R. expresses no relationship to this requisite.
8. *The promotion of human functioning and development within social groups in accord with human potential, known human limitations, and human desire to be normal.* **Normalcy** is used in the sense of that which is essentially human, and that which is in accord with the genetic and constitutional characteristics and the talents of individuals (Orem, 1991). L.R. is seeking information and interventions to return her continence status to normal.

Figure 3.
Keeping Orem Simple

Theory of Self-Care: Nursing Interview

Assess Self-Care Requisites = Evaluate Therapeutic Self-Care Demands

- Universal Self-Care Requisites (all met except the provision of care associated with elimination processes and excrement)
- Developmental Self-Care Requisites (all met)
- Health Deviation Self-Care Requisites (all met except bladder control)

Theory of Self-Care Deficit: Identify Self-Care Agency

- Inadequate Self-Care Deficit (legitimate need for nursing to overcome stress urinary incontinence)

Theory of Nursing System: Identify Nursing Diagnosis

- Decide on the Type of Nursing System and Determine Goals
 - Wholly Compensatory
 - Partly Compensatory
 - Supportive-Educative (appropriate nursing system for L.R.)

The developmental self-care requisites relate to L.R.'s developmental process throughout her life cycle (Chinn & Kramer, 1995). L.R. demonstrates that she is functioning as a responsible adult while caring for herself and her family. She is able to describe her family, social, and personnel life comfortably. She appears to be comfortable with her decision to pursue improvement in her health care.

Continence nurses use the theory of self-care deficit to develop a plan of care. L.R. is seeking health-related knowledge about her incontinence. Requesting information, education, and care to meet the therapeutic self-care demand (action needed to overcome self-care deficits) is a deliberate action and not instinctive. Her nursing plan will be directed toward assisting her to learn Kegel exercises, developing strength in the pelvic floor muscle, and recognizing the behaviors and activities that precipitate her incontinence. The plan will include pelvic floor rehabilitation, electrical stimulation, and dietary changes if indicated (see Figures 2 & 3).

Health-deviation self-care requisites relate to self-care that prevents defects and deviations from normal structure and integrity and those that control the extension and effects of these defects (Chinn & Kramer, 1995). L.R. recognizes that her problems with bladder control must be addressed. Concerns of worsening symptoms as she ages have led her to seek care and find a solution.

The theory of nursing system is the unifying theory. This theory answers three questions: "What do nurses do when they nurse?" "What is the product made by nurses?" and "What results are sought by nurses?" Because L.R. is in need of a supportive educative level of nursing care, the care plan would be directed at having the client take responsibility and participate in the rehabilitation process of her continence status. This is accomplished by providing the educational knowledge in a supportive environment and reinforcing the need for her complete participation in the process.



Conclusion

The independent professional practice of nursing is distinguished from other health-related disciplines in that it strives to care for the entire client. The nursing profession works in collaboration with other allied health care professionals to improve the health care for the presenting client and improve the method of health care delivery. However, the method of practice is still not well defined by nurses. Orem's theory helps nurses apply professional definition and application to nursing practice.

The inclusion of Orem's Self-Care Deficit Theory of Nursing supports a consistent method of nursing practice. It serves as a practical guide for the application of continence services and provides a consistent framework that encourages strong client responsibility for recovery and maintenance. It is useful in defining a systematic assessment, treatment, and evaluation of incontinence and serves as a pragmatic nursing application of theory to practice. ■

References

- Chinn, P.L., & Kramer, M.K. (1995). *Theory and nursing: Integrated knowledge development* (5th ed.). St. Louis: Mosby.
- Orem, D.E. (1991). *Nursing: Concepts of practice* (4th ed.) (p. 126). St. Louis: Mosby-Year Book, Inc.

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- Multimodality pelvic physiotherapy treatment of urinary incontinence in adult women. *International Urogynecology Journal*, 6, 187-194.
- Bernier, F., & Jenkins, P. (1997). The use of vaginal estrogen in the treatment of urogenital dysfunction. *Urologic Nursing*, 17(3), 92-95.
- Burgio, K.L., Matthews, K.A., & Engel, B.T. (1991). Prevalence, incidence and correlates of urinary incontinence in healthy, middle age women. *Journal of Urology*, 146, 1225-1229.
- Chinn, P.L., & Kramer M.K. (1999). *Theory and nursing: Integrated knowledge development* (5th ed.) (pp. 219-220). St. Louis: Mosby.
- Dennis, C.M. (1997). *Self-care deficit theory: Concepts and applications*. St. Louis: Mosby.
- Firlit, S.L. (1994). The nursing theory-nursing practice and connection. In J. McClosky & H.K. Grace (Eds.), *Current issues in nursing* (4th ed.) (pp. 76-81). St. Louis: Mosby.
- Harrison, G.L., & Memel D.S. (1994). Urinary incontinence in women: Its prevalence and its management in health promotion clinic. *British Journal of Genetic Practice*, 44(381), 149-152.
- Hartweg, D.L. (1991). *Dorothea Orem: Self-care deficit theory*. London: Sage Publications.
- Helene Fuld Health Trust. (1988). *The nursing theorist, portraits of excellence: Dorothea Orem* (VHS videocassette). Oakland, CA: Studio III.
- Kegel, A. (1948). Progressive resistance exercise in the functional restoration of the perineal muscles. *American Journal of Obstetrics and Gynecology*, 56, 238-248.
- Marriner-Tomey, A. (1994). Introduction to analysis of nursing theories. In A. Marriner-Tomey (Ed.), *Nursing theorist and their work* (3rd ed.) (pp. 3-16). St. Louis: Mosby.
- Morse, W., & Werner, J.S. (1988). Individualization of patient care using Orem's theory. *Cancer Nursing*, 11(3), 195-202.
- Newman, D.K. (1997). How much society pays for the treatment of urinary incontinence. *Ostomy/Wound Management*, 43(1), 18-25.
- Orem, D.E. (1956). *Hospital nursing service, an analysis*. Indianapolis: The Division of Hospital and Institutional Services, Indiana State Board of Health.
- Orem, D.E. (1959). *Guides to developing curricula for the education of practical nurses*. Washington, DC: Government Printing Office. U.S. Department of Health, Education, and Welfare, Office of Education.
- Orem, D.E. (1987). Orem's general theory of nursing. In R. Parse (Ed.), *Nursing science: Major paradigms, theories, and critiques* (pp. 67-89). Philadelphia: W.B. Saunders.
- Orem, D.E. (1991). *Nursing: Concepts of practice* (4th ed.). St. Louis: Mosby-Year Book, Inc.
- Orem, D.E., Taylor, S.G., & Renpenning, K.M. (2001). *Nursing concepts of practice* (6th ed.). St. Louis: Mosby.
- Vasquez, M.A. (1992). From theory to practice: Orem's self-care nursing modes and ambulatory care. *Journal of Post-Anesthesia Nursing*, 7(4), 251-255.

