rem’s self-care deficit nursing theory (Orem 2001) is widely used and accepted by nurses (Taylor 2002) and is one of the most frequently used theories in general nursing practice (Alligood and Marriner-Tomey 2002). This paper attempts to evaluate the theory as a means to address the unique needs of people with intellectual disabilities. Fawcett’s (1995) template for critically analysing conceptual models is used. Fawcett (1995) noted that the concepts and propositions of this theory could also be considered at the level of abstraction and generality of conceptual models, and referred to it as Orem’s self-care framework. This author (Fawcett 2000) acknowledged that this framework is widely recognised as a conceptual model. In discussion and practical application it is also referred to as ‘the self-care model’ (Pearson et al. 2000). This term will be used throughout this discussion.

Prior to commencing this appraisal the authors held the belief that the self-care model (Orem 2001) was too complex to be applied successfully to the needs of those with intellectual disabilities. This initial view was potentially in response to its relative under use in intellectual disability settings in the UK and Ireland, together with negative perceptions of the use of other conceptual models of nursing borrowed from the general nursing domain.

This paper aims to examine the potential of Orem’s (2001) self-care model to meet the needs of people with varying degrees of intellectual disabilities and additional physical care needs, in hospital, community and residential settings. Cognisance is taken of contemporary frameworks for the analysis and critique of models of nursing, in particular those offered by Fawcett (1995) and McKenna (1999). The benefits and deficits of Orem’s self-care model are examined. The philosophical similarities between Orem’s self-care model and current concepts of care for people with intellectual disabilities will be highlighted.

The terms intellectual disabilities/learning disabilities and mental handicap will be used interchangeably in this paper to refer to the same client group. The term intellectual disabilities/mental handicap and learning disability will be used to describe a client care group who receive nursing interventions from nurses who are registered within the mental handicap division of the register with An Bord Altranais (the nursing regulatory body in the Republic of Ireland).

Background

It is important to provide a background to the use of conceptual models of nursing within intellectual disability nursing in Ireland prior to embarking on an appraisal of Orem’s (2001) self-care model. Intellectual disability/mental handicap nursing is in its infancy compared with other nursing disciplines. Mental handicap nursing is reported to have commenced in Ireland in 1957 (Sheerin 2000). Although widely applied in other nursing disciplines, application of conceptual models of nursing within this sector represents a challenge. Contemporary...
setting predominates.

Although many espouse widespread application of conceptual models of nursing, which often originate from a generalist nurse perspective, this might contradict the holistic philosophy of care for people with intellectual disabilities that pervades the overall direction of care for the intellectual disabilities sector across a number of countries (Wolfensberger and Thomas 1983) and social role valorisation (SRV) (Wolfensberger and Murphy 1980). The philosophical parity warrants further discussion.

Origins

It is interesting to note that Orem's (2001) self-care deficit nursing theory (2001) was developed as a means to articulate the key aspects of Orem's self-care model of nursing care, which has much in common with widely held philosophical frameworks for the delivery of care in the intellectual disabilities sector since the 1970s (Murphy 2000). It was developed to articulate ideas that had previously been expressed in a fragmented manner and, therefore, in an arbitrary way (Nirje 1969, O'Brien and Tyne 1981, Wolfensberger 1972). This philosophical development within nursing, and its ability to contribute to advancement of nursing interdisciplinarily, is consistent with the ideology of normalcy which is consistent with the philosophical development within healthcare settings outside of the UK (Raven 1988), although recognition and evidence of its impact is still limited. The integration of the self-care model shares the philosophical framework of Orem's model in relation to philosophical parity, its use, its influence on knowledge development within nursing, and its ability to withstand scrutiny. McKenna (1999) and Fawcett (1995) generally agree on the issues that should be addressed in an attempt to analyse or critique a nursing model.

Raven's (1988) view that normalisation (Nirje 1969, O'Brien and Tyne 1981, Wolfensberger 1972) is consistent with the overall direction of care for the intellectual disabilities sector, and the philosophical development from an interdisciplinary manner, thus making it inconsistent with the predominant basis for the delivery of care (O'Brien 1987). It is in this context that the conceptual model (Roper-Logan-Tierney activities of daily living (1996) to be compared with the self-care model adheres to Fawcett's (1995) general agreement on the issues that should be addressed in an attempt to analyse or critique a nursing model.

Negative views of conceptual models in the intellectual disabilities field were developing new philosophical frameworks for the delivery of care such as questioning how conceptual models in mental health settings were being used. Nurses in Murphy (1997) discussed Orem's (1991) self-care deficit theory (Orem 2001) to be inappropriate in mental health settings. The reasons for the lack of uptake of conceptual models of nursing: schemes of work and beliefs of those nurses using it (Fawcett 1995). The mental health settings also revealed in two Irish studies (McKenna 1999) suggests that several nurses using it (Fawcett 1995). The environment within intellectual disability care are for the integration of learning disabilities. The lack of cited work is unfortunate because there are many anecdotal examples of how Orem's (2001) self-care model shares the philosophical framework of Orem's model in relation to philosophical parity, its use, its influence on knowledge development within nursing, and its ability to withstand scrutiny. McKenna (1999) and Fawcett (1995) generally agree on the issues that should be addressed in an attempt to analyse or critique a nursing model.

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Philosophical parity

In an intellectual disability context, Orem’s (2001) conceptualisation of universal self-care prerequisite relating to normalcy sits well with the philosophical underpinnings of contemporary care for people with an intellectual disability. This is commonly referred to as the philosophy of normalisation or social role valorisation (Nirje 1969, O’Brien and Tyne 1981, Wolfensberger, 1972, 1983, Wolfensberger and Thomas 1983). Figure 1 summarises some of the important congruencies between Orem’s self-care model and contemporary philosophies in learning disability nursing practice.

The eight universal self-care prerequisites proposed by Orem (1991) suggest the need to ‘promote human functioning and functioning within social groups in accord with human potential, known human limitations, and human desires to be normal’. In Orem’s (1991) view ‘normalcy is seen as that which is essentially human and that which is in accord with the genetic and constitutional characteristics of individuals’.

Orem’s (2001) eight self-care prerequisites may be considered consistent with O’Brien and Tyne’s (1981) description of normalisation as ‘the use of means which are valued in our society in order to develop and support personal behaviours, experiences and characteristics which are likewise valued’. Philosophically, Orem, Wolfensberger, Nirje, and O’Brien would appear to share common ground on the issue of normalcy/normalisation. Raven (1988) recognised the latter and examined the applicability of the self-care model to the care of people with intellectual disabilities in Australia.

Human rights

The self-care model would also appear to share commonly held assumptions regarding the rights of people with learning disabilities on at least one human rights issue. Orem (1991), cited in (Fawcett 1995), suggests that ‘adult persons have the right and responsibility to care for themselves to maintain rational life and health’. It is widely perceived that the role of the nurse within the intellectual disability context is to support the individual in this right and responsibility.

Table 1: Orem’s (2001) Self-care Model of Nursing: key attributes

<table>
<thead>
<tr>
<th>Self-care</th>
<th>Self-care agency</th>
<th>Self-care deficit</th>
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<tbody>
<tr>
<td>Self-care</td>
<td>Refers to the activities that individuals do to themselves/environments that adjust functioning in the interest of sustaining life, maintaining or restoring integrated functioning under stable or changing environmental conditions. Self care aims to maintain or bring about a condition of wellbeing.</td>
<td>Refers to ability of individuals to: determine requirements for regulating functioning, judge/decide what to do and how to perform care measures to meet self-care requisites.</td>
</tr>
<tr>
<td>Universal self-care requisites associated with life processes and maintenance of the integrity of human structure and function.</td>
<td>Self-care requisites associated with human developmental processes and conditions and events that occur during various stages during the life cycle as well as events that may adversely affect development.</td>
<td>Health deviation self-care requisites associated with genetic and constitutional defects and human structural and functional deviations and their effects, as well as with medical and diagnostic and treatment measures prescribed or performed by physicians.</td>
</tr>
<tr>
<td>Therapeutic self-care demand</td>
<td>Nursing agency</td>
<td>Self-care deficit</td>
</tr>
<tr>
<td>Self-care deficit</td>
<td>Refers to demands on individuals to meet:</td>
<td>A complex attribute of nurses developed through specialised education and training in theoretical and practical nursing sciences and through their development of the art of nursing in reality situations.</td>
</tr>
<tr>
<td>A dynamic action system produced by nurses as they engage in diagnostic, prescriptive and regulatory operations of nursing. There are three types of nursing system:</td>
<td>This system is selected when an individual cannot or should not perform any self-care actions.</td>
<td>This system is selected when an individual can and should perform all self-care actions.</td>
</tr>
<tr>
<td>This system is selected when an individual can perform some, but not all, self-care actions.</td>
<td>Supportive Educative nursing system</td>
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practice & research

Intellectual disability context is to enable and empower people with an intellectual disability to achieve such a right. Orem's (2001) presupposition that human beings have the potential to develop the skills necessary for self care is congruent with another contemporary philosophy of care for people with an intellectual disability, social role valorisation (Wolfensberger 1983, Wolfensberger and Thomas 1983). Wolfensberger and Thomas (1983) suggest that social role valorisation involves an attempt 'to create an existence for disabled people which is as close to normal living conditions as possible making available patterns and conditions of everyday life which are as close as possible to the norms and patterns of mainstream society'.

Environmental issues
In 1995, Fawcett suggested that Orem (1991) had underscored the contribution of environmental factors in relation to an individual's development. It is possible, however, that Fawcett (1995) misinterpreted Orem's (1991) conceptualisation of the environmental issues. Orem (1991) views environmental factors as having a dynamic interplay between physical and psychosocial matters and that it is only in this context that the environment can play a role in the care of and needs of individuals.

This interpretation fits nicely with the intellectual disability context. The interaction between psychosocial, physical and environmental factors is crucial to understanding the needs of individuals with an intellectual disability who present with challenging behaviours and is widely espoused in the literature (Durand 1990, Emerson et al 1987, Mansell 1992, Zarkowska and Clements 1994).

Furthermore, Zarkowska and Clements (1994) share Orem's (1991) concept of the dynamic interplay between social, physical, environmental and psychological issues in relation to the adjustment of personal behaviours. They suggest that it is through the manipulation of the environmental settings, triggers, human actions and responses that an individual can be motivated to adjust personal behaviours.

Instead of underscoring the role of the environment in explaining components of her model of nursing care, Orem (1991) demonstrates an acute awareness of the dynamic interplay between many complex factors which can contribute to healthy or unhealthy states. In addition, Orem (1991) suggests that a developmental environment should be seen as a place where an individual could be motivated to establish appropriate goals and to adjust his or her behaviour to achieve such goals.

Such developmental environments and environmental manipulations form the very essence of care for people with intellectual disabilities in certain contexts. Durand (1990), Mansell (1992) and Emerson et al (1987) have written extensively on the need to adapt environments to bring about change in quality of life, reduction of challenging behaviour and general improvements in health for people with intellectual disabilities.

Table 2. Orem's (2001) three key theories

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<td>People can benefit from nursing because they are subject to health-related or self-derived limitations that render them incapable of continuous self-care or that result in ineffective or incomplete care.</td>
<td>Self care is a learned behaviour that purposely regulates human structural integrity, functioning and human development.</td>
<td>Nursing systems formed when nurses use their abilities to prescribe, design and provide nursing for legitimate patients by performing discreet actions and systems of actions that regulate the value of or the exercise of individuals capabilities to engage in self care and meet the self-care requisites of the individual therapeutically.</td>
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Fig. 1. Key similarities between Orem's (2001) model of nursing and contemporary philosophies in learning disabilities nursing practice

<table>
<thead>
<tr>
<th>chronological origins</th>
<th>philosophical parity</th>
<th>educational utility</th>
<th>social utility</th>
<th>environmental issues</th>
<th>human rights</th>
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<tr>
<td>Orem's model</td>
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Orem's (2001) three key theories

- Theory of self-care deficit
- Theory of self care
- Theory of nursing systems

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Fig. 1. Key similarities between Orem's (2001) model of nursing and contemporary philosophies in learning disabilities nursing practice
LEARNING DISABILITY PRACTICE
views the act of nursing as an attempt to meet the client's self-care needs with much more sophistication than would be possible using more traditional, simplistic approaches.

The use of Orem's (2001) comprehensive self-care model enables practitioners to look at a client's care in the context of a continuum of care – which might mean total absence of medical intervention, where major health needs are being met by a tertiary care agency; or total care, where a client may have minimal health needs, but there may be major problems in communication or other daily activities. Orem's (2001) self-care model has much to offer people with intellectual disabilities.

Orem's (2001) model for the first time, the care of a client with moderate intellectual disabilities had improved immeasurably. This paper has highlighted the overall contribution of nurses who will specifically work in the intellectual disability sector due to the development of nurse education curricula within Ireland, where many nursing curricula made to nursing internationally, education, and training is in its infancy, although there is some interest at practice level and some attempts to make the system is working well, for a variety of reasons.

In an anecdotal report by a nurse using Orem's model, she stated that the client was developing their own goals may have difficulty grasping this language, given that those with severe to profound disabilities may have less. While application was reported in Australia and New Zealand (Wolfensberger 1972). Raven's (1988) work examining the applicability of Orem's (2001) comprehensive self-care model is extremely complex both in the language used and the framework's construction. However, there is no dispute that philosophically the model is very much aligned to contemporary philosophies relating to the intellectual/learning disability context also offers an interesting template to teach students about the similarities between the self-care model (Orem 1995) to an intellectual, education, and training context. Anecdotally, it has reported benefits in the special education context. Orem's (2001) model fits from using this framework in a nurse education context. Orem's (2001) model has particular application in the education context. Orem's (2001) model has particular application in the education context. Orem's (2001) model has particular application in the education context. Orem's (2001) model has particular application in the education context.
Exploring Orem’s self-care model in learning disability nursing:

Practical application paper: part 2
This paper explores the use of Orem's self-care model of nursing in a community setting for a person with an intellectual disability (see case study).

The use of theo-

Fawcett's views regarding the need for a

nursing's professional status profile rather

role of theory development in raising

theorists have become preoccupied with the

areas of knowledge outside of the profession.

Similarly, Heath (1998) highlighted that many

knowledge base for nursing in favour of a

nursing practice through the use of nursing

and includes the following requisites (activi-

ties he or she has to provide it. A nursing diag-

nosis is then made, after which a nursing care

plan is designed containing specific goals and

Evaluation of goals will...
Case study

Sara (not her real name) is a 34-year-old woman with a mild intellectual disability who lives in the community, sharing a home with two housemates of a similar age. Sara was diagnosed with asthma ten years ago. Asthma is a chronic inflammatory disorder of the airways that causes frequent episodes of coughing, wheezing, chest tightness and difficult breathing. It is controlled by inhaler usage and environmental adaptation. Due to the sudden change of routine, Sara found the life adjustments difficult which resulted in frequent visits to the accident and emergency department, with exacerbation of symptoms. Sara had an obvious knowledge deficit and had to be taught how to control her asthma attacks by using breathing exercises and quick relief medications (such as Salbutamol). She also required education about the benefit and need for long-term preventative medications and about the condition and the correct use of inhaler technique. Sara was taught these facts before coming into care some five years ago, however, over the past three years her control of her asthma had deteriorated to such a degree that she was admitted to hospital via the local accident and emergency department on three occasions.

Sara works locally in a factory and recent demands to work longer hours were causing her to become stressed. The result was that she was going to work in the morning with sometimes just a cup of coffee and no breakfast. Sara smokes and the number of cigarettes she was smoking increased, possibly due to this stress. Some of the other knock-on effects of her longer working day were: not having time to relax and rest, being too tired to take her inhalers, taking irregular and imbalanced meals and neglecting any form of social activity and household chores. Her housemates remained quite supportive and often reminded her to care of herself. Up until then, Sara had been her own self-care agent, only requiring intervention on occasions. Her family lives abroad and has no direct contact with her care. Her housemates are good observers and inform her of changes they have noted. Sara realised that she required assistance to meet her self-care deficits therefore nursing intervention was warranted. The following step in nursing process was investigated using Orem's model of self-care.
Care plan for Sara

Assessment:
Assessing and planning the care for Sara involved the investigation and accumulation of facts regarding Sara's self-care ability and her self-care demands.

The assessment was carried out in the form of an interview at Sara's home. Sara's housemates were present for part of the assessment; they can play a vital role in helping Sara to re-establish her own self-care agency and are also influential in environmental decisions that may affect Sara, such as keeping pets, continuing changes to their routine and general effects on them. The environment was conducive to allow for a relaxed atmosphere and a tactful approach was used. Parts of the interview were recorded verbatim (with Sara's consent) to establish what she understood about her health situation. The assessment focused on two of three self-care categories.

It was felt that the following categories were applicable in identifying Sara's current self-care demands/deficit. Universal self-care and health deviation self care (Pearson et al. 1996).

This part of the nursing process determines Sara's usual pattern of carrying out self care and what her current difficulties are. Also obtained were baseline data, nursing observations, medical history and current medications. Problems were identified (figure 1) which formed the basis for the subsequent care plan.

Formulation of the care plan:
After completing Sara's assessment it was agreed that a need for self-care demand existed in the following areas: Poor control of her asthma, avoiding/preventing the triggers that exacerbate her asthma, smoking, diet, rest and relaxation. This part of the nursing process is where practical judgments are made to address the issue of what can be done now and in the future (Cavanagh 1991). A decision for a supportive-educative nursing system was made. This was agreed to be the best approach in view of Sara's high ability in the past to manage her own self-care needs. To re-establish self care and meet her self-care demands, the following was outlined to establish goals:

I to reduce self-care demand to a level which Sara is capable of meeting;
I to enable Sara to increase her ability to meet self-care demand;
I to enable Sara's supporters (housemates) to give independent care when self-care is impossible or (initiate someone who can).

The objective of Orem's model is to eliminate self-care deficits. The self-care demands were transferred onto the nursing care plan documentation. Problems were listed, followed by the goals that Sara would strive to achieve. The nursing actions and type of nursing actions to be applied were outlined. Daily recordings were made in the care plan progress notes. Sara was asked to keep a diary to record how she felt she was progressing. This could be used when reviewing the care plan so that Sara could give feedback on her progress. When evaluating the care plan an audit of how Sara used resources would also be made. The care plan would then be modified according to progress.

Evaluation of the use of Orem's model in practice
Consequent evaluation of the use of the model in this case (Cormack and Reynolds 1992) found that the language used in the model was very medically orientated, using terms such as patient and diagnosis, which didn't necessarily apply to learning disability practice. However, the scope of practice was clearly delineated as the nursing needs of Sara were clearly identified and as an approach it was specific to nurses and nursing. This framework appeared to be valid, as making a nursing diagnosis and identifying appropriate nursing interventions was achieved. It appeared reliable as it can be applied to any area within the field of intellectual disability. Orem's model is currently used in some practice settings in Ireland.
### Table 1: Components of Self-Care

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Universal Self-care Requisites</td>
<td></td>
</tr>
<tr>
<td>Normalcy</td>
<td>Prevention of hazards; adequate nutrition; sleep, rest; social interaction; balance between solitude and group interaction; balance between activity and rest.</td>
</tr>
<tr>
<td>Sufficient Intake of Food</td>
<td>Sufficient intake of food, vitamins, and calcium.</td>
</tr>
<tr>
<td>Sufficient Intake of Water</td>
<td>Sufficient intake of water.</td>
</tr>
<tr>
<td>Sufficient Intake of Air</td>
<td>Sufficient intake of air. Needs to have regular breaks, not smoke, and not eat spicy foods.</td>
</tr>
<tr>
<td>Bowel Pattern</td>
<td>Requires balanced diet, more vitamins and calcium.</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>Requires a plan for emergency situations, such as a plan for when to call for help.</td>
</tr>
</tbody>
</table>

### Analysis and Evaluation

The care for Sara was described using Orem's (2001) self-care model of nursing. It proved a useful framework in this practice setting because Sara was able to understand and use it to manage her chronic obstructive pulmonary disease (COPD). The model allowed for identification of nursing interventional areas and established why a particular set of responses to health problems as it was previously promoting self-care. It complied with ethical standards in nursing as it benefited professionally the service. It allowed for identification of nursing intervention areas and dogma: finding a place for practical utility of models used by nurses.

### Conclusion

The authors recommend that Orem's (2001) model has potential for use in other learning disability settings and has been found to be useful in this community-based residential centre. Further research is needed to explore the potential of Orem's model in other settings, such as hospitals and community-based residential centres.