Self-Care Deficit Theory Case Study

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Introduction

Dorothea Orem's Self-Care Deficit Nursing Theory provides a useful framework for planning care when a person can perform some health activities independently but needs nursing assistance in other areas. The original case identifies Mr. Juan Duran as an adult with poor vision and names Jenny as the nurse responsible for assessment and care planning. It correctly emphasizes self-care agency, therapeutic self-care demand, universal requisites, health-deviation needs, and the nursing methods of doing for, guiding, supporting, teaching, and creating a developmental environment. The case can be strengthened by moving from a list of needs to a patient-specific clinical process. Poor vision does not automatically make Mr. Duran dependent, and age should not be treated as incapacity. Jenny must assess what he can safely do, what barriers exist, which resources are available, and what goals matter to him. Orem's theory is most ethical when it increases agency rather than replacing it (Orem, 2001).

For a closely related comparison, see Self Care Deficit and Peaceful End of Life Nursing Theories.

The theoretical foundation is discussed further in Orem's Self-Care Theory.

Case Overview

Mr. Duran is an adult whose impaired vision may affect medication use, food preparation, mobility, reading labels, managing appointments, and identifying environmental hazards. The original scenario does not provide his age, diagnosis, living arrangement, language, cognition, income, or treatment plan. Jenny should not invent these facts. Her first task is to gather them and identify whether the vision problem is stable, correctable, progressive, or associated with an urgent condition. She must also determine whether Mr. Duran has other health needs that influence self-care, such as diabetes, hypertension, weakness, pain, or limited access to transportation (D'Souza et al., 2017; Moura et al., 2015).

Orem's View of the Person

Orem describes people as agents capable of deliberate action to maintain life, health, development, and wellbeing. Self-care includes learned activities performed by individuals on their own behalf. This view protects Mr. Duran from being reduced to a passive recipient. The nurse begins with capability and preference rather than a deficit label. Even if he cannot read a printed medication label, he may

organize his routine accurately through memory, tactile markers, audio tools, or family support. Nursing care should identify the least restrictive method that allows safe participation.

Self-Care Agency

Self-care agency is the person's ability to know, decide, and act. Jenny should assess physical strength, dexterity, vision, hearing, cognition, motivation, health literacy, emotional condition, cultural practices, and access to tools. Capacity can vary by task. Mr. Duran may independently eat, bathe, and communicate while needing help with insulin measurement or travel. Self-care agency is also influenced by time, fatigue, environment, money, and support. A person who appears unable in one setting may perform well after the environment is adapted.

Therapeutic Self-Care Demand

Therapeutic self-care demand is the total set of actions required to meet current self-care requisites. Jenny must define the actual demand from Mr. Duran's condition and treatment. If he takes medication, the demand includes correct identification, dose, timing, storage, and monitoring. If visual impairment increases fall risk, the demand includes safe movement and environmental organization. The demand should be individualized and reviewed as his condition changes. A generic list of food, air, water, rest, elimination, social interaction, and hazard prevention becomes clinically useful only when translated into observable tasks.

Universal Self-Care Requisites

Universal requisites include adequate air, water, nutrition, elimination, activity and rest, solitude and social interaction, hazard prevention, and promotion of normal functioning. Jenny should ask whether Mr. Duran can obtain and prepare food, recognize spoilage, access drinking water, use the bathroom safely, sleep comfortably, and maintain social contact. Visual impairment may influence each area differently. She should not assume that poor vision causes poor nutrition or isolation; she should assess evidence. If a problem exists, nursing action should target the barrier rather than take over the entire activity.

Developmental Self-Care Requisites

Developmental requisites arise from life transitions and conditions that affect growth or adaptation. The original essay mentions Erikson's integrity-versus-despair stage, but this stage applies to later adulthood and should not be assigned without knowing Mr. Duran's age. Jenny can instead assess how visual change affects identity, work, family roles, independence, confidence, and future plans. A person newly losing vision may experience grief and fear, while someone with long-standing

impairment may possess well-developed strategies. Developmental support should fit the individual's experience.

Health-Deviation Requisites

Health-deviation requisites arise from illness, injury, diagnosis, or treatment. They include seeking appropriate care, understanding the condition, following treatment where chosen, monitoring effects, adapting self-concept, and living with limitations. Jenny should determine whether Mr. Duran has received an eye examination, whether corrective lenses or treatment are available, and whether he understands warning signs. Sudden vision loss, flashes, severe eye pain, neurologic symptoms, or acute change may require urgent medical evaluation. Nursing theory should never delay necessary diagnosis.

Identifying the Self-Care Deficit

A self-care deficit exists when therapeutic demand exceeds self-care agency. Jenny should compare task by task. If Mr. Duran can select meals but cannot read cooking controls, the deficit concerns safe appliance use—not nutrition as a whole. If he knows his medicines but cannot distinguish bottles, the deficit concerns accessible identification. This precision prevents excessive dependence. The assessment should also identify strengths, existing adaptations, and support people. A deficit is not a permanent identity; it can change through education, recovery, technology, or environmental modification.

Nursing System Selection

Orem describes wholly compensatory, partly compensatory, and supportive-educative systems. A wholly compensatory system is appropriate when the patient cannot perform required actions and the nurse must act. A partly compensatory system divides activities between patient and nurse. A supportive-educative system is used when the patient can learn and perform but needs teaching, guidance, or support. Mr. Duran's poor vision alone does not justify wholly compensatory care. He will likely need a combination, with the goal of maximizing supportive-educative and partly compensatory approaches whenever safe.

Assessment of Vision and Function

Jenny should document the nature and duration of visual impairment, use of glasses or devices, ability to see contrast and depth, and function under different lighting. Functional questions are more informative than a diagnosis alone: Can he read medication labels? Identify food? Navigate stairs? Recognize faces? Use a phone? Manage money? She should assess falls, near misses, driving, and

home layout. Referral to ophthalmology, optometry, occupational therapy, low-vision rehabilitation, or social services may be appropriate.

Medication Safety

Medication management is a likely risk area. Jenny can reconcile all prescriptions, over-the-counter products, and supplements; remove duplicates; and simplify schedules with the prescriber or pharmacist where possible. Accessible methods include large-print labels, high contrast, tactile markers, talking devices, blister packaging, and alarms. Color alone should not be the only coding method because visual perception may vary. Mr. Duran should demonstrate the process through teach-back. Family assistance should be included only with his consent and without assuming that relatives are always available or safe.

Nutrition and Hydration

Jenny should assess food access, appetite, ability to shop and cook, swallowing, dental health, and cultural preferences. Visual impairment may increase risk when using knives, heat, or expiration labels. Adaptations can include organized storage, tactile markers, contrasting cutting boards, safer appliances, meal delivery, or occupational-therapy training. The care plan should avoid replacing cooking if Mr. Duran wants to retain it. Nutritional goals must reflect his diagnoses rather than a generic “healthy diet.”

Mobility and Fall Prevention

Home hazards may include loose rugs, poor lighting, clutter, unmarked steps, and frequently moved objects. Jenny can recommend consistent furniture placement, contrast strips, handrails, accessible switches, and clear pathways. She should review footwear, balance, medications causing dizziness, and need for mobility training. Environmental change should occur with Mr. Duran, not around him without permission. Removing familiar objects unexpectedly can increase rather than reduce risk.

Activity, Rest, and Participation

Maintaining activity supports health and independence. Jenny should ask what exercise and daily roles Mr. Duran values and whether fear of falling has reduced participation. A safe plan may involve guided walking, strength and balance activity, accessible community programs, or physical therapy. Rest should also be assessed because pain, anxiety, nocturia, or medication may disrupt sleep. The goal is balanced activity rather than simply restricting movement to prevent injury.

Communication and Health Literacy

Written instructions should be available in accessible formats such as large print, audio, electronic text compatible with screen readers, or Braille if used. Jenny should speak directly to Mr. Duran rather than to a companion and identify herself when entering. She should describe procedures before touching or moving objects. Teach-back confirms understanding without testing intelligence. Language interpretation should be provided when needed. Accessibility is part of safe communication, not an optional courtesy.

Social Interaction and Emotional Health

Visual loss can affect confidence, work, relationships, and social participation, but it does not inevitably cause depression or dependence. Jenny should ask about mood, loneliness, coping, and meaningful relationships. Referral may be appropriate for counseling, peer support, rehabilitation services, or community groups. Solitude can be chosen and healthy; isolation is a problem when unwanted or harmful. The care plan should reflect Mr. Duran's preferences rather than impose an ideal amount of social contact.

Environmental and Resource Assessment

Orem's theory recognizes conditioning factors that influence self-care. Jenny should assess housing, transportation, insurance, income, device access, family support, and community services. Recommending an expensive device is not a viable plan when it is unaffordable. She may connect Mr. Duran with low-vision programs, disability services, transportation, pharmacy delivery, or benefits. Institutional care should not be assumed necessary merely because the patient has difficulty reaching items. Home modifications and training may preserve independence.

Patient-Centered Goals

Goals should be specific, measurable, achievable, relevant, and time-bound. Examples may include: Mr. Duran will correctly identify and explain his medication schedule using an accessible system before discharge; he will demonstrate a safe route through the home; he will identify two symptoms requiring urgent evaluation; and he will select one support service he is willing to use. Goals must be negotiated. A technically ideal plan that he rejects will not promote self-care.

Interventions Through Orem's Five Methods

Jenny may act for Mr. Duran when an immediate task cannot be performed safely; guide him through decisions; support his efforts and confidence; provide an environment that facilitates development; and teach knowledge and skills. These methods should be combined deliberately. For example, she might initially prepare a medication while teaching an accessible method, then observe him performing it independently. The transition from doing to supporting is a sign of progress when clinically appropriate.

Evaluation

Evaluation asks whether the intervention improved agency and met the therapeutic demand. Jenny should observe performance, review incidents, ask about confidence, and reassess barriers. Completion of education is not enough. If Mr. Duran cannot use the system at home, the plan has failed regardless of documentation. New deficits may appear after a treatment change. Follow-up should therefore include adaptation and coordination across care settings.

Comparison With Roy's Adaptation Model

Roy's Adaptation Model would focus more explicitly on responses to internal and external stimuli across physiological function, self-concept, role function, and interdependence. Jenny might assess how vision loss affects adaptation in each mode and identify stimuli contributing to ineffective responses. Orem focuses more directly on the gap between required self-care and ability. Neither model automatically produces better care. Orem is especially useful for defining tasks and levels of nursing assistance, while Roy may provide a broader analysis of adaptation. The nurse can use theory flexibly without forcing the patient into abstract categories (Shah et al., 2015).

Ethical Considerations

Promoting self-care must not become blaming the patient when poverty, disability, inaccessible systems, or illness limits action. Independence should not be treated as the only valued outcome; interdependence is normal. Jenny should respect informed refusal, privacy, culture, and risk tolerance. She must also distinguish capacity from sensory impairment. Poor vision does not mean poor decision-making. The ethical aim is supported autonomy and safety, not maximum independence at any cost.

Conclusion

Orem's Self-Care Deficit Nursing Theory offers a structured way to assess Mr. Duran's poor vision without defining him by it. Jenny should identify his universal, developmental, and health-deviation requisites; evaluate task-specific self-care agency; calculate therapeutic demand; and determine where a genuine deficit exists. Nursing systems can then range from temporary compensation to supportive education, with accessible communication, medication safety, environmental adaptation, mobility, nutrition, emotional support, and referrals integrated into the plan. The quality of care will be judged by whether Mr. Duran can participate safely in goals that matter to him. Orem's theory is most effective when nursing action expands the person's control and removes environmental barriers rather than replacing abilities that remain intact.

References

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