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IDA JEAN ORLANDO

A Nursing Process Theory

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Assumptions of the Theory

Each nursing theory contains assumptions that are explicit or implied. Assumptions are premises accepted by the theorist as given and true, self-evident, and unquestioned (Barnum, 1990). They "are the taken-for-granted statements of the theory....They may or may not represent the shared beliefs of the discipline" (Meleis, 1991, p.13). Assumptions are important because "they describe that state of being out of which the nursing theory grows. Underlying assumptions are the starting points of the . . . [theorist's] reasoning" (Barnum, 1990, p.20). In evaluating a theory's assumptions a nurse should consider whether they reflect the real world of nursing and whether the theory is logically consistent with its assumptions. According to Marriner-Tomey (1989), in order to accept as true the theory about the phenomenon one must accept the assumptions as true.

Orlando developed her theory in the late 1950s before the nursing profession began to study theory development systematically. Therefore, Orlando, like most of the early nurse theorists, did not explicitly identify the theory's concepts, assumptions, and propositions systematically. Nonetheless, her theory contains assumptions about the nursing profession, nurses, patients, and the nature of nurse-patient interaction. The following implied assumptions are presented along with Orlando's thoughts related to them.

Assumptions About Nursing

Assumption 1

Nursing is a distinct profession separate from other disciplines. Orlando (1987) asserts that nurses are independent professionals by virtue of their license to practice nursing. Her view that doctor's orders are for the patient, not the nurse, conveys the thrust of her conviction of this assumption (Pelletier, 1967). She believes that nursing's failure to articulate a function distinct from medicine, and other professions, has kept nursing on a dependent path. As a result, health administrators, medical authorities, and health policies continue to push nursing down a dependent path that has served non-nursing interests (Orlando, 1985, 1987). Only a radical independent path would cause health-care policy makers to consider fully the importance of professional nursing services (Orlando & Dugan, 1989). This distinction would help nurses, as a collective body, to develop the independent organization and delivery of services within the competitive health-care system (Orlando & Dugan, 1989). A distinct professional function provides the independent authority and autonomy needed to achieve this distinctiveness.

Assumption 2

Professional Nursing has a distinct function and product (outcome). Nursing's failure to identify a distinct function has thwarted the development of a theoretical framework upon which to base professional nursing practice and the training of professional nurses (Orlando, 1972). It also has undermined the profession's ability to build a coherent knowledge base (Orlando & Dugan, 1989). The distinct function should characterize every activity of every nurse while practicing nursing; therefore, it must be identifiable in each nurse-patient contact (Pelletier, 1976). The function justifies nursing's work as a profession and remains constant regardless of the patient's age, diagnosis, medical care status, or whether cared for at home or in an institution or agency (Orlando, 1972). The focus of professional nursing is the patient's immediate experience. Orlando (1987) believes nursing might lose its intrinsic character and go down the dependent path if nursing

does not collectively clearly articulate its unique function.

Orlando thinks the lack of a distinct function has inhibited nursing's demonstration of the product (outcome) of that function through practice and research, as well as interfered in the development of the content required to achieve the product of the distinct function (Pelletier, 1976). A distinct product would clarify what form the result would take after the nurse fulfills the function. This distinct product is something the patient cannot produce alone or get from anyone else who is not trained to practice professional nursing (Pelletier, 1976). Implicit in this assumption is that effective practice can be empirically identified.

Assumption 3

There is a difference between lay and professional nursing. Orlando (1983) thinks the nursing profession should provide the public with the distinction between lay and professional nursing. According to Orlando (1961) any person nurses another when she or he carries the burden of responsibility for those things that the person cannot do alone. Orlando and Dugan (1989) write that lay nursing is a transmitted social behavior found in all cultures and includes encouragement, nurturance, nourishment, protection, and curative care. This assistance can be provided to the self or to another by almost anybody. The activity is routine, repetitive, or custodial in nature. When these efforts fail people suffer distress and are helpless because they are unaware of and unable to identify the cause of the distress. "In contrast to 'lay' nursing, professional nursing is required when the 'causes' of the individual's inability 'to nurse' the self (or another as with family members) are NOT known or clearly understood by the individual(s) or the nurse. That is, not known *before* the nurse's professional investigation is conducted" (Pelletier, 1980, pp.4-5).

A professional nurse identifies both the cause of the distress and the individual help required to relieve the distress, and designs the activity to meet the need for help. The effect of the activity, the alleviation of distress, is noted in the patient's verbal and nonverbal behavior (Orlando & Dugan, 1989). The distinction between lay and professional nursing would clarify nursing's societal responsibility.

Assumption 4

Nursing is aligned with medicine. In Orlando's early work the nurse's access to the patient was through medicine. Although she states that traditionally nursing has been aligned with medicine, Orlando consistently emphasizes the difference in the two professions' responsibility to the patient. Physicians place patients under the nurse's care when patients cannot meet their own needs for help or because they need help in following the prescribed treatment or diagnostic plan (Orlando, 1961). Medicine is responsible for the prevention and treatment of disease, whereas nursing is responsible for offering help to patients for their physical and mental comfort while they are under medical treatment or supervision (Orlando, 1961). In her later writings Orlando clearly states that nursing is practiced wherever a person is in need of its service. This service is provided to people both sick and well, with or without a diagnosed disease, and takes place within or outside institutions (Orlando, 1972, 1987).

Assumptions About Patients

Assumption 1

Patients' needs for help are unique. Because patients are unique the help a nurse provides must be specifically geared to each patient's immediate needs for help (Orlando, 1961). Orlando developed specific guidelines for nurses to use to uncover the meaning of a patient's unique experience.

Assumption 2

Patients have an initial inability to communicate their needs for help. According to Orlando (1961) nurses must realize that patients cannot clearly state the nature and meaning of their distress or need without the nurse's help or without having a previously established helpful relationship (Orlando, 1961). Without this recognition patients' distress will not be identified. Consequently this delay may seriously threaten the patient's condition or exacerbate his or her

discomfort (Orlando, 1961). Considering patients' initial inability to communicate clearly, nurses should assume that patients' behavior is evidence of distress or an unmet need for help.

Assumption 3

When patients cannot meet their own needs they become distressed (Orlando, 1961). When patients become distressed they are dependent on the nurse for help. If patients are able to meet their own needs and follow prescribed activities unaided, they do not require the nurse's help. Therefore, nurses must be able to validate whether or not patients require their help at a given time (Orlando, 1961).

Assumption 4

The patient's behavior is meaningful. Although the behavior has a specific meaning to the patient this meaning is not self-evident. On the surface a patient's problem may look simple and the nurse may think she or he can apply some knowledge from another field to solve the problem. However, what becomes apparent from Orlando's (1961) theory is that the meaning of the patient's behavior is rarely what it appears; thus arbitrary solutions are seldom helpful. Consequently the nurse, after observing a patient's behavior, realizes that she or he does not understand the meaning without further exploration with the patient (Orlando, 1961).

Assumption 5

Patients are able and willing to communicate verbally (and nonverbally when unable to communicate verbally). Implicit in the theory is that it is most useful with patients who are able and willing to communicate verbally. Although it can be used with babies and comatose or unconscious patients it does rely heavily on verbal communications. If patients are unable to speak or are unconscious, nurses could enlist family or significant others to participate on the patient's behalf or rely on their own observations of nonverbal vocal behavior and/or nonverbal physiological manifestations in carrying out a deliberative nursing process (Schmieding, 1986).

Assumptions About Nurses

Assumption 1

The nurse's reaction to each patient is unique. According to Orlando (1961, 1972) each nurse's immediate reaction is based on how the nurse experiences her or his participation in the nurse-patient situation. The nurse never knows in advance what her or his reaction to the patient will be. Orlando notes that in each situation the nurse has to find out more about her or his own reaction and action in order to understand its particular meaning to the patient (Orlando, 1961).

Assumption 2

Nurses are responsible for helping patients avoid or alleviate distress. Because they are responsible to alleviate patients' distress or to help patients avoid distress nurses must focus on eliminating things that interfere with the patient's mental and physical comfort. Conversely, nurses should not add to the patient's distress (Orlando, 1961).

Assumption 3

The nurse's mind is the major tool for helping patients. Similar to Burr, Hill, Nye, and Reiss (1979), Orlando regards the nurse's mind as the chief vehicle for converting mental processes, perceived from an immediate situation, into action. What occurs in the mind is in large part a function of what occurs in the interaction. The nurse's mind, therefore, is the intervening variable between the nurse's unique perception and its conversion into action. Orlando (1961) notes that what a nurse automatically perceives or thinks is not as important as what the nurse does. What the nurse says or does is an outcome of the nurse's reaction in the situation. Thus, the nurse's behavior is influenced by the meaning the nurse attaches to the thought she or he has in the mind. Therefore, the nurse's mind, and its content, is the nurse's major tool. Orlando describes how the nurse should use her or his reaction in an exploratory way to find the meaning of the patient's behavior (Orlando, 1961). Orlando assumes that nurses are

logical thinkers who can convert the content of their minds into actions that ultimately will benefit the patient.

Assumption 4

The nurse's use of automatic responses prevents the responsibility of nursing from being fulfilled. When a nurse acts without deliberations with the patient, the action often is not helpful because the nurse does not consider the patient's perception. Automatic personal responses are based on assumptions and are rarely reliable for decision making or action. Because the nurse's automatic response does not include the patient, communications between patient and nurse become unclear or stop (Orlando, 1961). The patient's distress or sense of helplessness continues because the nurse's action is based on reasons other than the patient's immediate need for help (Orlando, 1961).

Assumption 5

A nurse's practice is improved through self-reflection. The nurse's words and actions are the exclusive mode through which the patient is served. Therefore, the focus of improvement is on what nurses say and do and how these practices influence the process of care. As nurses comprehend how their practice helped or did not help the patient, this understanding comprises the material out of which nurses develop and improve their knowledge and skill in practice (Orlando, 1961). Self-reflection, as a method to improve a practitioner's practice, is supported by action science as developed by Argyris and Schön (1978).

Assumptions About the Nurse-Patient Situation

Assumption 1

The nurse-patient situation is a dynamic whole. Because the patient and the nurse are people, they interact and a process occurs between

them. In this process, what the nurse says and does affects the patient and what the patient says and does affects the nurse (Orlando, 1961). This process is unique for each situation. Orlando (1961) notes that when the nurse expresses her or his perceptions or thoughts as questions or wonderings it enables the patient to express the meaning the patient has of the nurse's expression. When nurses explore the meaning of the patient's behavior the patient is more willing to express her or his concerns. Once patients have been helped and trust the nurse, their communications are more spontaneous and explicit (Orlando, 1961).

Assumption 2

The phenomenon of the nurse-patient encounter represents a major source of nursing knowledge. The nurse's perception of a patient's behavior, and her or his subsequent thoughts and feelings, are objective and subjective data acquired through the nurse's direct experience with the patient. Although they require investigation, these data represent the knowledge base out of which the patient's plan of care will be developed.

Accepting these assumptions is prerequisite to the theory's acceptance. These assumptions are the foundation for the formulations of the interrelated concepts that constitute Orlando's theory.

*The Theorist's Propositions
and Implied Research*

"Propositions are statements of relationships between concepts in the theoretical system" (Kim, 1983, p. 11). "Until one has propositional statements about the relationship between the concepts one does not have a usable theory" (Burr et al., 1979, p. 52). Propositions state the theory's concepts in an associational or causal way that indicates that the relationship can be measured. Thus propositions provide a means for developing hypotheses so the theory can be tested through research. Without research, the theory's influence on nursing practice can only be assumed. It is only through research that these assumptions can be confirmed or refuted. It is through research that a theory can be further developed or refined.

Orlando did not formulate explicit propositions of her theory; however, propositional statements can be derived from her concepts. Following each proposition, research implied by the proposition is suggested.

Proposition 1: There is a relationship between the *patient's presenting behavior* and the presence of patient distress (*an immediate need for help*).

When patients have an unmet need for help they become distressed (Orlando, 1961). This distress is manifested through their

behavior. Behaviors can be conveyed to the nurse through verbal and nonverbal communications.

A research study could be undertaken to categorize the following types of verbal communication to the nurse: questions, complaints, and requests. Nurses trained in the use of Orlando's deliberative nursing process would explore the meaning to the patient of the verbal communications and categorize results into types of distress or no distress. Although the patient's distress is unique, knowledge about the type of behavior that is most often used by patients to communicate certain types of distress, and their associated need for help, would be a helpful resource to nurses for exploration of similar situations in the future. Also, these findings would be useful for developing further research, and for educational purposes.

Proposition 2: *There is a relationship between a nurse's use of Orlando's distinct nursing function and the nurse's ability to recognize the need for inquiry (deliberative nursing process) into the meaning of the patient's presenting behavior.*

Dewey (1938) and Kuhn (1970) both believe that the use of an organizing principle (such as Orlando's function of nursing) allows a person to recognize a situation as problematic. Early recognition of a patient's immediate need for help is important because the longer the patient experiences distress, the greater the distress becomes and the more obscure the patient's behavior (Orlando, 1961). The more obscure the behavior, the more difficult it is for the nurse to find out what the patient is distressed about. According to Orlando (1961) the treatment and prevention of a disease proceeds best when patients are not distressed.

Research could be designed to examine differences in nurse responses in patient encounters between nurses who use "finding out and meeting the patient's immediate need for help" and nurses who use a different theory and/or no nursing theory. Implied in this research is the relationship between the nurse's immediate reaction to a patient's verbal request and the use of all or part of the immediate reaction in the nurse's response.

Proposition 3: *The more competent the nurse is in labeling her or his perceptions, thoughts, and feelings (immediate reaction), the more apt*

she or he is to find out (*deliberative nursing process*) the nature of the patient's distress.

According to Orlando (1961), although it is difficult to separate the items of the immediate reaction, it is important to do so because it helps the nurse understand how the items influence each other. If the nurse does not understand the basis of her or his process of action it is difficult for the nurse to use the immediate reaction effectively in exploration of the patient's behavior. Orlando (1961) believes the exploration of any part of the nurse's reaction is immediately helpful in determining the patient's need for help.

A research study that includes the education of nurses in the use of Orlando's theory could be designed to compare nurses' identification of patient distress and associated need for help between nurses who can accurately separate their immediate reaction with nurses unable to do so. A secondary research component in this study could be to identify types of patient behavior that are more likely associated with the nurse's ability or inability to accurately separate the items of her or his immediate reaction.

Proposition 4: *If the nurse explores her or his immediate reaction with the patient the patient's distress is lessened (improvement).*

The major aim of Orlando's (1961) theory is to bring about improvement in the patient's verbal and nonverbal behavior, thus improving the nursing care of patients. If the patient's immediate needs for help are not found out and met, the patient's condition remains the same or worsens. A patient's condition might be seriously threatened if the distress is not relieved. After the nurse's action, the nurse is able to determine immediately whether the distress was relieved by observing changes in the patient's verbal and nonverbal behavior. Research that compares patient outcomes when nurses explore and when they do not explore the patient's presenting behavior could be used to test the theory.

In addition to research on the effects of improvement in the patient's immediate behavior, other indicators reflecting improvement might be studied. For example, experimental research could compare randomly assigned patients who have deliberative nursing care with those who have automatic nursing care by measuring

patient levels of anxiety, depression, or helplessness after each shift. This study would measure the immediate influence of nursing on patients. A variety of standardized instruments are available to measure these concepts. Patient distress also could be operationalized as increased dependence, which could be measured with standardized instruments.

Proposition 5: The nurse's use of the *deliberative nursing process* will be less costly than the nurse's use of *automatic personal responses* (a secondary concept of the theory).

Because automatic actions are based on conclusions arrived at independently of the patient they most often are not helpful, as they do not consider the patient's perception of the situation. Because the nurse arbitrarily applies a solution to what she or he thinks the patient's problem is, that solution often is ineffective and therefore costly in terms of the nurse's time, materials, and drugs. It also may prolong the patient's hospitalization or use of ambulatory services. Recently, reducing health-care costs has been a major national goal. Therefore the nurse's use of a deliberative nursing process might be both effective and efficient.

One research question would be, "Are nurses who use a deliberative nursing process approach to explore the patient's behavior more likely to reduce costs than those who use automatic personal actions?" The study could measure such costs as length of stay or health-care visits, use of analgesics and hypnotics, and nursing contact hours.

Proposition 6: Patients experiencing repeated *improvement* as the result of *deliberative nursing* will have positive cumulative effects.

Orlando (1961) often refers to the cumulative effects of repeated patient improvement as the result of deliberative nursing. She notes that although improvement is always relative to the patient's condition at the start of the nurse-patient contact, these repeated improvements may positively contribute to the patient's improved self-care. At another time she notes that improvement is related to the length of the nurse-patient contact and to what they accomplish in each contact. Even though the changes might be small they may have cumulative value (Orlando, 1961).

Research could be designed to measure the degree of self-care competence in colostomy care on discharge in two groups of patients, one receiving deliberative nursing and the other nondeliberative nursing care. A research question for obstetrical nursing is, "Do primiparous women feel more confident about self- and newborn care at discharge when they have received deliberative nursing care versus nondeliberative nursing care?" Also, a researcher could compare patients' sense of self-care confidence immediately prior to discharge in cohorts of patients receiving deliberative and nondeliberative care.

Orlando's propositions provide a way to study systematically the elements of her theory. These proposed research studies would provide information to further assess the theory's internal validity as well as to determine how the nurse's use of the theory influences the outcome of the patient's condition.

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