Orlando’s Deliberative Nursing Process Theory
A Practice Application in an Extended Care Facility

When nurses undertake actions based on this validation process, the immediate needs of the patient are met, resulting in the ultimate goal of nursing—patient improvement.

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ABSTRACT

Ida J. Orlando was one of the first nursing theorists to write about the nursing process based on her own research. Her Deliberative Nursing Process Theory focuses on the interaction between the nurse and patient, perception validation, and the use of the nursing process to produce positive outcomes or patient improvement. Orlando’s key focus was to define the function of nursing. This author’s purpose is to acquaint nurses with Orlando’s theory and to encourage the use of the deliberative process to bring about patient improvement. This article provides an analysis of Orlando’s theory and a demonstration of its successful use in clinical practice in an extended care setting.

Although Ida J. Orlando’s (1961) Deliberative Nursing Process Theory may not be as well known or studied as the theories of Rogers, King, Roy, or Orem, she made major contributions to nursing research and theory (Fawcett, 1993; Schumacher, Fisher, Tomey, Mills, & Sauter, 1998). As a research associate at Yale, Orlando conducted a study on nursing situations and the resulting outcomes. The findings from her study led to the development of her theory. Orlando believed that nursing is a distinct, autonomous profession responsible for ascertaining that a patient’s needs are met either by direct or indirect means. Flynn and Heffron (1988) credit Orlando with being one of the first theorists to publish topics on the nursing process. Her writings on the nursing process also represented an early example of nursing research about nursing practice (Flynn & Heffron, 1988; Schmieding, 1993). This author’s purpose is to acquaint nurses with Orlando’s work, with a description and analysis of her theory, and to demonstrate the use of the theory in an extended care facility.

DESCRIPTION AND ANALYSIS OF MODEL

In the 1950s, Orlando conducted a study to determine what constituted nursing by conducting research in a practice setting (Schumacher et al., 1998). According to Schumacher et al. (1998), Orlando later stated, in personal correspondence, that the original motivation for her study was a search for facts about nursing’s purpose. In her study, Orlando (1961) examined various nursing situations to investigate what happened during a nurse–patient interaction, and to determine the outcome of that interaction. She wrote,

The purpose of nursing is to supply the help a patient requires in order for his needs to be met (Orlando, 1961, p. 8).

After keeping meticulous notes for 3 years, she spent another year analyzing the data. From her verbatim notes, she described the process a nurse follows to change a patient’s behavior to produce a positive outcome. She placed her emphasis on the procedure a nurse uses in validating observations, perceptions, and feelings with a patient. It was her assertion that a nurse participates in a certain process with a patient in all nursing situations (Flynn & Heffron, 1988; Fawcett, 1993; Schumacher et al., 1998). Flynn and Heffron call Orlando’s theory unique because it represented a belief based on personal research and was documented by verbatim notes.

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The significance of Orlando's writings, according to Fawcett (1993), is that her theory helped define the professional role of the nurse and supplied a clearer understanding of the nurse-patient relationship. Her theory focuses on delivery of care through the nursing process. It does not explain specifically how to provide care (Schumacher et al., 1998).

Orlando (1961; 1990) said there are three elements present in any nursing encounter:

- The behavior of the patient.
- The reaction of the nurse.
- The nursing action undertaken to benefit the patient.

The nurse observes the behavior of the patient and makes certain assumptions (reaction of the nurse). Then the nurse communicates these assumptions or perceptions to the patient to determine if these perceptions are correct (validation). It was Orlando's proposition that, if the nurse undertakes action based on the validation process, the immediate needs of the patient for help are met. The result is patient improvement. Improvement, according to Orlando (1990), is the goal of the nursing process.

When a patient is in distress, Orlando said it is the result of unmet needs for help. The nurse observes this distress, makes observations, and validates these perceptions with the patient. Patient behavior requires assessment at the time it occurs.

Identical behaviors at different times by the same patient may mean different things, according to Orlando. Any behavior of the patient, regardless of the form in which it appears, may represent a plea for help. The nurse does not assume the reaction to the patient is correct, helpful, or appropriate until the validity of the perception is checked with the patient (Orlando, 1961).

Fawcett (1993) asserts, in her evaluation of Orlando's theory, that nursing's four metaparadigm concepts are not clearly identified in the theory. She said Orlando was very explicit about individuals and nursing, but alluded to health only briefly as a state of well-being, and considered the environment to be
only the immediate situation. Olsen and Hanchett (1997), however, believe Orlando’s model does contain definitions of nursing’s four metaparadigm concepts. They say that individuals behave in both verbal and nonverbal ways. People become distressed when unable to meet their needs.

Nursing is an interaction with people who have an immediate need for help—the subsequent relief of distress. Stress relief provides improvement, leading to a sense of well-being. The criterion for determining improvement is the cessation of any stressful behavior. For example, a patient may ring frequently for the nurse. When the nurse responds, the patient has a list of tasks for the nurse to do. On observation, assessment, and validation of perceptions with the patient, the nurse affirms the cause of the behavior is really loneliness in a strange environment.

Health is the result of a patient’s needs being met. Environment is part of any nurse–patient interaction, because it is involved in all nursing situations. To help a patient, it may be necessary for a nurse to take action related to the environment. For example, the nurse may need to teach a family about the dangers of lead-based paint in the house.

Orlando’s theory was used at Yale University as the foundation for the Graduate Program in Mental Health and Psychiatric (Schumacher et al., 1998). It was also the foundation for the nursing program at McLean Hospital in Belmont, Massachusetts where Orlando served as a Clinical Nursing Consultant from 1962 to 1972.

Haggerty (1987) used Orlando’s theory as the foundation for her study of nursing students’ immediate responses to distressed patients. Seventy-five senior students from an associate degree and a bachelor’s degree program participated in the study. The purpose was to determine if the type of educational program or the actual distress of the patients influenced the students’ responses to the distress of the patients. Participants watched videotapes of patients exhibiting pain and emotional distress and then answered research questions based on Orlando’s concepts. Nurse experts established research validity.

The eight response categories were scored according to their agreement with Orlando’s concepts. In 42% of the interactions, the nurses did not attempt to identify the nature and extent of the patient’s distress. The study indicated that the type of degree program was not related to the students’ responses to the distressed patients.

Haggerty said that nurses have to be able to differentiate between observations and inferences, otherwise they may base their practice on incorrect assumptions. Based on her research, Haggerty recommended that Orlando’s model be used to teach nursing students how to interact with patients. The presenting behavior of the patient may not accurately reflect the actual need of the patient. Haggerty agreed with Orlando that the emotional needs of a patient may present as somatic complaints.

Hampe (1975) used Orlando’s concept about helping people in distress by applying it to grieving families in a hospital setting. In her qualitative study, 27 spouses of terminally ill patients were interviewed to determine if their needs were identified and met by the nursing staff. Based on Orlando’s concept of meeting needs, Hampe found that the nursing staff often avoided and evaded the spouses’ questions. She asserted that changes in nurse’s priorities were necessary. Nurses must be available to meet the emotional needs of families and the patients.

Anderson, Mertz, and Leonard (1965) and Wolfer and Visintainer (1975) used Orlando’s theory in studying the elimination of patient distress during the admission process. Both of these studies supported the hypothesis that deliberative nursing actions during the admission process helped to reduce stress for patients and families. They concluded that nurses who take the time to explore verbal and nonverbal responses are able to provide patient satisfaction during and after a hospital stay.

Schmieding (1984; 1988) used Orlando’s theory to study situations in nursing administration. By analyzing responses to situations determined to be automatic, as opposed to deliberative, according to Orlando’s definition, she concluded that automatic responses did not always solve the issue presented by a staff member or a patient. Automatic responses often resulted in unsatisfactory outcomes in her opinion. As the director of nursing at Boston City Hospital, she implemented Orlando’s theory by educating nurses about its concepts and how to apply them. She explored with her staff the difference between automatic and deliberative responses to patients, families, physicians, and other staff. It was Schmieding's conclusion that when nurses correctly understood the function of nursing, as defined by Orlando, they took more initiative in problem solving and implementing conflict resolution.

Schumacher et al. (1998) note that despite the wide use of Orlando’s theory in nursing research, scant evidence of practice application is found in the nursing literature. In 1972, Peichin concluded that nurses who use Orlando’s theory in clinical practice developed a more trusting relationship with their patients. By using Orlando’s theory in nursing practice, one can develop better relationships with patients and resolve conflicts in a practice setting, especially in the care of older adults confined to nursing homes or extended care facilities. An example of a successful practice application in such a setting follows.
APPLICATION OF THE MODEL

A nursing problem developed on the subacute unit of the extended care facility. The nursing staff asked the supervisor to help find a solution. Two older adults on one wing, Anna and Grace (names have been changed for anonymity) were creating havoc for the staff and other patients during the night. They were constantly calling out loudly for the staff, or ringing the call bells. The staff responded quickly, but immediately after the staff left their rooms, the women would call out again. The other patients on the wing complained they were unable to sleep because of the excessive noise these two patients were making during the night. The staff was frustrated, trying to cope with their behaviors.

Anna, one of the women causing the problem, had a diagnosis of end-stage, chronic, obstructive pulmonary disease and renal failure. She frequently removed her nasal oxygen cannula, then got out of bed and fell. Sometimes she crawled into bed with her roommate, much to that individual’s distress. She spent much of the night calling out for her husband or the nurse. During the day, she complained to her family that no one came to take care of her at night.

Grace, the other patient causing a problem, had sustained a fractured hip. She cried all night, keeping her roommate awake. She also rang her call bell constantly, usually ringing immediately after the staff left the room. Grace asked for pain medication every time any staff member entered the room.

After meeting with the staff about the situation, the supervisor identified the problem as distress because of unmet needs. Orlando’s Deliberative Nursing Process Theory model was chosen by the nurse supervisor for the practice application because the idea of validation in dealing with patients who are in distress met her philosophical values. First, an extra nursing assistant was assigned exclusively to that wing. The supervisor explained to the staff the plan and their roles. Then, the supervisor assumed nursing responsibility for these two patients.

She observed their behavior, made notes, verified her perceptions with them, and planned a nursing action. Every morning before the end of the shift, a quick staff conference was called to discuss the progress of the plan. Orlando (1961; 1990) said needs are often unmet because a patient’s communication is inadequate; therefore, it is the function of the nurse to find out what the needs are. She said the ultimate aim of the nurse is to bring about improvement. Orlando (1990) wrote,

> The nurse achieves her purpose by initiating a process that ascertains the patient’s immediate need, and helps meet the need directly or indirectly” (p 9).

She said the presenting behavior of the patient, regardless of the form in which it appears, represents a plea for help. It is necessary to remember that the nurse’s perceptions of a patient’s behavior may or may not be correct from the patient’s point of view. It is the responsibility of the nurse, according to Orlando, to take the initiative to help the patient express the meaning of the distressful behavior. Then, the nurse needs to help the patient explore the distress so it is relieved.

After careful observation of Anna’s behavior, and perception validation with her, the supervisor found that Anna was afraid of dying alone in the dark. The reason she removed the oxygen cannula was to get out of bed and be with other people. This was also the reason she got into bed with her roommate, and kept calling out.

The supervisor explained to Anna that the lack of oxygen made her confused and contributed to her falls. She agreed to keep the oxygen on and call for help before getting out of bed. A nightlight placed next to her bed was left on all night. She developed a trust in the aide and supervisor. She knew they understood her fears, and would answer her call bell quickly. Anna did eventually die, but the nursing process was successful. Prior to her death, she was able to sleep most of the night; she had no more falls. She used her call bell when she needed help. The goal of improvement was achieved.

In Grace’s case, after observing her behavior and perception verification of her thoughts, the supervisor found that Grace was afraid that her family was not going to take her home. She thought they were going to sell her house, and place her in a nursing home for the rest of her life. During the night, when Grace was alone, she was unable to control her fears, so she sought relief by seeking pain medication. The more fearful she became, the more she cried.

The nursing actions involved changing her pain medication to another type of analgesic, and scheduling a family conference with the social worker to discuss Grace’s fear of not being able to return to her home. Because of circumstances beyond the control of her family, Grace’s future remains uncertain, but she sleeps better, does not constantly ring for the nurse, and does disturb her roommate. She understands that the staff will help her in any way that they can.

Orlando (1990) said activities conducted in a disciplined nursing process help the patient because the nurse understands the meaning of the presenting behavior and plans actions to meet the patient’s needs. The nurse will know if the actions undertaken on behalf of the patient help when the behavior improves or ceases.

This practice application used the four nursing metaparadigms in the following way:

- Person (two women patients in distress).
- Environment (the nursing unit during the night shift).
Nursing (nursing interaction and process on behalf of the two women).
- Health (the patients needs were met).

One of the disadvantages of using this theory is the need for staff education. Although Schmieding (1984) and Fawcett (1993) agree with Orlando that nurses need special training to learn the process discipline, this author was able to apply the theory, and teach it to the night staff, after extensive self-directed reading. The process discipline is the technique of learning not to automatically respond to presenting behavior, but to respond after deliberation. By staying focused on nursing's function and applying knowledge learned from dealing with Anna and Grace, staff have been able to apply that knowledge to other patients.

Orlando's theory provides a valuable method of dealing with and resolving stressful behavior. It can also be used in dealing with person-to-person encounters in other situations to avoid conflict. For example, Schmieding (1984) said that when nurses understand the function of nursing is to help the patient, they can control the process of decision-making related to nursing care. She says decisions need to be made on the basis of how patient care is affected. It is her assertion that nurses have been taught to believe that anything affecting the patient is their responsibility.

The nurse can determine if an activity is within the scope of nursing responsibility by asking, "Does it or does it not help the nurse find out and meet the patient's immediate needs for help?" (Schmieding, p. 761). If the answer is not, then the nurse must determine who is responsible for the activity. Schmieding said this makes it possible for nurses to stop automatically complying with every request, and return nonnursing activities to the department to which they belong. This is not the same as saying, "It is not my job." However, it permits the nurse to say, "If I do that, I won't be able to do my job, which is to observe the patient, and find out and meet the patient's need for help. Can you understand why I can't do it?" (Schmieding, p. 761). Thus, Orlando's theory can be used to clarify the professional nurse's role because the focus is on meeting the needs of the patient.

It is important to acquaint nurses with Orlando's theory because the use of this theory allows a nurse to develop interventions that will specifically help patients in distress with improvement as the outcome goal. Orlando's key focus is on the nursing process. Her theory helps to clarify and define the nurse's role in the health care environment.

Currently, there are many changes in health care. Managed care, mergers of health care corporations, and changes in payment systems have all affected the lives of health care workers and patients. Nursing needs to remain focused on the central issue, that is patient satisfaction and improvement. Nurses need to take the leadership role as creators of a climate of trust, especially for older patients and their families in the long-term care setting.

Despite scant evidence of practice application in the literature, the theory was applied successfully and with ease in patient interventions when their behavior was stressful to themselves and others. Based on personal experience, this author recommends that other nurses use Orlando's theory in long-term care settings as a means of dealing with distressful behavior. Further research should be conducted on applying the theory to nursing situations in different settings to provide nurses with research-based evidence for their clinical practice.

REFERENCES