Supplemental Study Guide For CRRN Test Prep
CRRN Study Guide

Dear Test Taker:

Congratulations on embarking on an amazing journey toward self development in rehabilitation nursing! Whether this is your first time testing or second or third, this guide is designed to help you study key terms more effectively.

The CRRN exam can be a piece of cake for you with the right preparation and materials. Please read this guide carefully. There are many important tips to help you increase your knowledge and be a more effective test taker.

   Establish a study plan
   Choose resources/materials from which to study

   How to Formulate a Study Plan

Think about how you previously studied in school. Think about how you prepared for the NCLEX.

   Do you study better at the last minute?
   Do you study better in advance?
   Talk to your co-workers about how they studied and if it was effective
   Write down in a planner or on a calendar exactly when you will study and where

See Test Taking Strategies power point

Other Resources

Association of Rehab Nurses  *The Specialty Practice of Rehab Nursing: A Core Curriculum* (6th ed) Glenview, IL

This study guide corresponds to the sections of the Kessler CRRN Course by topic where applicable.
Overview of Rehab/Legislative Terms

1. Policy Agenda
   • The preferences of federal and state governments include cost containment, access to care and quality of care. Practitioners prefer income maintenance, professional autonomy and malpractice reform. Profitability, administrative simplification and bad debt reduction are preferred by provider organizations and technology producers prefer regulatory environment issues and research funding.

2. Legal Issues/Laws
   A. The Americans with Disabilities Act is a landmark piece of legislation providing all Americans with disabilities equal opportunity and access in employment and services to that offered to the general public.
   B. The Surface Transportation Act provided tax incentives for the removal of barriers for those not previously required to do so.
   C. The Individuals with Disabilities Education Act established education as a right for all children 5 to 17 years.
   D. Patient Self Determination Act: Requires that all people receiving medical care be given written information about their right to make decisions regarding end of life issues.
   F. The Rehabilitation Act of 1973 impacted both social and health-related areas of life, addressing employment, education and the use of public facilities, including transportation.
   G. The 1975 Education for all Handicapped Children Act was a series of amendments to the Education of the Handicapped Act and provided appropriate public education and protection for the rights of children receiving educational services.
   H. The Developmental Disabilities Act and Bills of Rights provided funds for developmental disabilities programs and special projects. The Individuals with Disabilities Education Act added transition, assistive technology, rehabilitation counseling and social work to the services provided.
   I. The 1978 amendments created comprehensive services for independent living and the 1984 amendments modified the definition of severe disability to include those 16 years or older.
   J. The Individuals with Disabilities Education Act (IDEA), passed in 1990, was an amendment to earlier legislation that added transition services, assistive technology, rehabilitation counseling and social work to the services that may be provided to children with disabilities. It also emphasized 'people first' language.
Overview of Rehab/Legislative Terms (cont’d)

Legislation at A Glance

<table>
<thead>
<tr>
<th>1970</th>
<th>Education for All Handicapped</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Defined handicapped children and established a specific category for children with learning disabilities</td>
</tr>
</tbody>
</table>

Led to

1975

Developmental Disabilities Act and Bill of Rights

• Bolstered public school education for this population and provided protection for the rights of children r/t Educational services

• Reinforced rights and added funds to support the program and other special populations

Rehab Act of 1978

• Created a comprehensive plan for services for independent living

• This act amended the 1973 act and provided grants to states for vocational rehab, employment placement and independent living centers as demonstration projects
### Legislation at A Glance (cont’d)

<table>
<thead>
<tr>
<th>Act</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Security (1980)</strong></td>
<td>• Extended trial work periods for the disabled enabling them to retain social security benefits</td>
</tr>
<tr>
<td></td>
<td>• Placed gainfully employed disabled in a special benefit category</td>
</tr>
<tr>
<td><strong>Surface Transportation Act</strong></td>
<td>• Encouraged removal of architectural barriers in the transportation industry</td>
</tr>
<tr>
<td><strong>IDEA (1983)</strong></td>
<td>• Ensured access to educational opportunities for children with disabilities</td>
</tr>
<tr>
<td><strong>Vocational Ed Act (1984)</strong></td>
<td>• Required states to provide funds for people with disabilities to have access to available vocational educational opportunities</td>
</tr>
<tr>
<td><strong>Rehab Amendments 1984</strong></td>
<td>• Modified the definition of “severely disabled” and places a lower age limit at 16 years</td>
</tr>
<tr>
<td></td>
<td>• Extended provisions of the 1973 Rehab Act</td>
</tr>
<tr>
<td><strong>In 1986</strong></td>
<td>• Expanded to emphasize Native Americans</td>
</tr>
<tr>
<td></td>
<td>• Expanded the influence of the National Council of Handicapped</td>
</tr>
<tr>
<td></td>
<td>• Decreased the Federal share</td>
</tr>
</tbody>
</table>

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Legislation at A Glance (cont’d)

**ADA of 1990**
- Employment without discrimination; accessibility & accommodations
- Public Service – access to all state and local services
- Public rail accessibility

**Balanced Budget Act 1997**
- Mandated new Medicare PPS for SNF’s; Home Care, Inpatient Rehab Facilities and LTACH’s

**1999**
- Refined post acute care payments

**Deficit Reduction Act (DRA) of 2005**
- Mandated that CMS develop a standardized patient assessment and implement a demonstration project for post acute care payment reform
Overview of Rehab/Legislative Terms (cont’d)

3. Financial Terms r/t rehab
A. Break-even analysis is a tool that focuses specifically on the quantity of patients needed for the financial viability of a program.
B. In marginal cost analysis, decisions about change are not based on average costs but on marginal costs. Once costs have been adjusted for the impact of inflation, the fixed and variable costs can be determined by regression analysis.
C. Cost-benefit analysis measures the relative costs and benefits of a project.
D. Regulation-based cost containment strategies include supply-side costs (restrictions on supply of physicians), price controls and utilization controls (peer review organizations).
E. Competition-based cost containment strategies include demand-side incentives (cost sharing), supply-side regulation (antitrust), payer-driven competition, and utilization controls (managed care).
F. The resource-based relative value scale is based on the time, skills and intensity it takes to provide the service. It was implemented in 1992 as part of the 1989 Omnibus Budget Rehabilitation Act. Prior to 1992, reimbursement was on a fee-for-service basis.
   Prospective reimbursement uses pre-established criteria to determine the amount of reimbursement in advance. Cost-plus reimbursement was the traditional method for establishing per diem rates for institutions.
G. Under fee-for-service payment, the financial risk is borne by the health plan that pays providers for all covered services.
H. Under prospective payment, health plans shift part of the financial risk to hospitals by paying a fixed amount based on admission diagnosis.
I. Capitation involves a fixed monthly payment. All three methods of payment may include cost sharing using deductibles and copayments.
J. The network model allows referrals to a wider range of physicians and services than other health care delivery models.
K. In the group model, the HMO contracts exclusively with a group of physicians and separately with hospitals.
L. The IPA, the fastest growing model, enters into a contractual relationship with solo or group practitioners while the staff model type of HMO employs its own practitioners who are salaried.
M. Cost identification analysis is a thorough identification of the direct and indirect costs involved in a service.
N. Cost-benefit analysis is the determination of whether the dollar value of the service outweighs its costs and the cost effectiveness analysis determines the dollar cost per unit of outcome.
O. Cost-utility analysis is appropriate when the outcome of interest can best be expressed in terms of changes in the quality of life.
P. Discounts from normal charges given to large payers for health care services are called contractual allowances.
Q. The contribution margin is the amount by which the price exceeds the variable cost. If the margin is positive, the organization benefits by that amount.
R. When some patients are assigned more costs than they create and others less, it is called cross-subsidization.
S. Cost reimbursement is the revenue based on the organization receiving payment for costs incurred.
Rights
A. Some rights have been seen as so important that they have become legal rights. Legal rights are created through legislative statutes, judicial review, etc. and may be positive or negative rights.
B. Positive or welfare rights call for provision of goods or services. Laws that protect negative rights require others to refrain from interfering with just claims. Examples of positive rights include the right to public education, licensed driver's right to use of public roads, and indigent right to health care.
C. Examples of negative rights include freedom of religion, equal opportunity in employment, right to bear arms, and no taxation without representation.

Moral Theories
A. The deontological model assumes that rightness or wrongness does not depend on the consequence but is inherent in the act.
B. The utilitarian model is based on the assumption that actions lead to maximizing the overall good.
C. The intuitionist model assumes that all points of view are considered and good or bad is determined by moral intuition. There are no universal laws in the personalized model rather individuals choose when to make compromises.
## Neuropathophysiology

<table>
<thead>
<tr>
<th>Hypothalamus</th>
<th>Medulla</th>
<th>Basal Ganglia</th>
<th>Thalamus</th>
</tr>
</thead>
</table>
| - Secretion of ADH  
- Satiety Center  
- Regulation of vegetative functions via control of the autonomic nervous system | - Contains centers that work with hypothalamus to control body temperature  
- Contains respirator center  
- Cranial nerves originate here  
- Contains vasodilation and vasopressor centers  
- Contains swallowing and vomiting centers | - Smoothes out movement & makes postural adjustments  
- Injury to this area will result in bradykenesia & rigidity | - Initial recognition of sensory info, pain, touch, pressure  
- Relay station for sensory info, routing to correct area of brain  
- Differentiates pleasant from unpleasant |

<table>
<thead>
<tr>
<th>Internal Capsule</th>
<th>Pons</th>
<th>RAS</th>
<th>Limbic System</th>
</tr>
</thead>
</table>
| - All motor fibers converge here | - Contains the apneustic center and pneumotaxic center  
- Occulocephalic and occulovestibular reflex | - Active in controlling LOC  
- Selective attention | - Affects motivation & attention  
- Important for storage of memory  
- Helps maintain biorhythms  
- Injury to this area may result in hyperarousal  
- Important in the role of primitive behavior |
### Neuropathophysiology (cont’d)

#### Upper Motor Neuron

- Connects the brain with the anterior horn of the spinal cord and, in turn, the lower motor neuron.

- Damage causes lesion of the Brain or Spinal Cord that damages tracts & blocks signals to and from the brain
  - Corticospinal tract is the upper motor neuron
  - Any injury to a tract from the brain to T12-L1 (end of spinal cord) is considered an upper motor neuron lesion
  - Clinical picture – spasticity, retention of muscle mass, loss of voluntary control or weakness

#### Lower Motor Neuron

- Lesion of spinal nerve(s) that damages the connection between the spinal cord and the muscle tissue
  - Transmit messages from the anterior horn to the peripheral muscles—necessary for reflex to occur
  - Damage will result in flaccid paralysis, absent or hyporeflexia, and muscle atrophy
  - Damage to the spinal cord at L2 or below is defined as a **lower motor neuron injury**
### CRANIAL NERVE

<table>
<thead>
<tr>
<th>CRANIAL NERVE</th>
<th>NORMAL FUNCTION</th>
<th>DYSFUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Olfactory</td>
<td>Smell</td>
<td>Unilateral or bilateral anosmia</td>
</tr>
<tr>
<td>II. Optic</td>
<td>Vision</td>
<td>Optic atrophy, papilledema, amblyopia, field defects</td>
</tr>
<tr>
<td>III. Occulomotor</td>
<td>Eyelid and eyeball movement</td>
<td>Diplopia, ptosis of lid, dilated pupil, inability to focus on close objects</td>
</tr>
<tr>
<td>IV. Trochlear</td>
<td>Innervates superior oblique, Turns eye downward laterally</td>
<td>Convergent strabismus, diplopia</td>
</tr>
<tr>
<td>V. Trigeminal</td>
<td>Chewing, Face &amp; mouth touch &amp; pain, Taste</td>
<td>Tic doulourex, loss of facial sensation, decreased ability to chew, loss of corneal reflect, decreased blinking</td>
</tr>
<tr>
<td>VI. Abducens</td>
<td>Turns eye laterally</td>
<td>Diplopia, strabismus</td>
</tr>
<tr>
<td>VII. Facial</td>
<td>Controls most facial expressions, Secretions of tears &amp; saliva, Taste</td>
<td>Bell’s palsey, decreased ability to distinguish tastes</td>
</tr>
<tr>
<td>VIII. Vestibulocochlear</td>
<td>Hearing, Equilibrium sensation</td>
<td>Tinnitus, vertigo, deafness</td>
</tr>
<tr>
<td>IX. Glossopharyngeal</td>
<td>Taste, Senses carotid blood pressure</td>
<td>Loss of “gag” reflex, loss of taste, difficulty swallowing</td>
</tr>
<tr>
<td>X. Vagus</td>
<td>Senses aortic blood pressure, Slows heart rate, Stimulates digestive organs, Taste</td>
<td>Loss of voice, impaired voice, difficulty swallowing</td>
</tr>
<tr>
<td>XI. Accessory</td>
<td>Controls trapezius &amp; sternocleidomastoid, Controls swallowing movements</td>
<td>Difficulty with speech and swallowing, inability to protrude tongue</td>
</tr>
<tr>
<td>XII. Hypoglossal</td>
<td>Controls Tongue movements</td>
<td>Difficulty with speech and swallowing, inability to protrude tongue</td>
</tr>
</tbody>
</table>

**Mnemonic to help memorize the cranial nerves:**

*On Old Olympic Towering Tops A Finn And German Viewed Some Hops*
# Issues in Bowel Management

## BOWEL PROGRAM CHEAT SHEET

### UMN-SCI
- T12 and above
- **Reflexic bowel**
  1. Warm liquid 30 minutes before to take advantage of gastro colic reflex
  2. Manually remove stool in rectal vault
  3. Perform digital stimulation for one minute
  4. Use topical anesthetic if patient had autonomic dysreflexia
  5. Repeat digital stem 3-4 times, q 10 minutes
  6. If no response, do suppository

### LMN – SCI
- At or below T12-L1
- **Flaccid or areflexic bowel**
  1. Hot liquids wait 30 minutes
  2. Patients performs a gentle Valsalva maneuver
  3. Perform disimpaction either side lying or on the commode
  4. Sit on commode to facilitate evacuation
  5. Modify diet to create a firm stool
# Issues in Bowel Management

## Neurogenic Bowel Types

<table>
<thead>
<tr>
<th>Uninhibited Neurogenic Bowel</th>
<th>Motor Paralytic Bowel</th>
<th>Sensory Paralytic Bowel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seen in cortical, subcortical lesions above C1 as seen in Stroke, MS, certain types of brain tumors</td>
<td>Damage to anterior horn cells of S2, S3, S4 ventral roots</td>
<td>Occurs with damage to the dorsal roots of S2, S3, S4 or dorsal horns of spinal cord</td>
</tr>
<tr>
<td>Sensory impulses travel through the sacral reflex arc to the brain but the brain is unable to interpret the impulses to defecate.</td>
<td>Due to polio, intervertebral disk disease, trauma or tumor</td>
<td>Causes can be diabetes or tabes dorsalis</td>
</tr>
<tr>
<td>Involuntary elimination occurs when the sacral defecation arc is activated</td>
<td>Saddle sensation is intact but bulbocavernous and anal reflex are absent</td>
<td>Saddle sensation is diminished or absent</td>
</tr>
<tr>
<td>Incontinence is accompanied by a sense of urgency and occurs close to gastrocolic reflex</td>
<td>Incontinence is rare except in widespread disease</td>
<td>Bulbocavernous and anal reflex are WNL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incontinence is rare</td>
</tr>
</tbody>
</table>

## Reflex Neurogenic Bowel

- Automatic bowel function
- Occurs with SCI lesions above T12 to L1 that involve the upper motor neurons and sensory tracts but spare the lower motor neurons
- This is seen in tetraplegia, high thoracic para and M.S.
- It is also seen in pernicious anemia
- Bowel sensation and saddle sensation are decreased or absent
- Bulbocavernous reflex and anal reflex are increased
- No voluntary control
- S2-S4 intact so person can get a stimulus response reaction and BM

## Autonomous Neurogenic Bowel

= Flaccid or Nonreflex

- Occurs with SCI lesions at or below T12-L1
- Lower motor neuron associated with paraplegia, spina bifida, tumor, intervertebral disc disease
- Sensation is diminished to absent as is the bulbocavernous and anal reflex
- Frequent fecal incontinence because of no tone in the sphincter so leakage of stool with transfers and the valsalva maneuver
## Issues In Bladder Management

### Neurogenic Bladder

<table>
<thead>
<tr>
<th>Uninhibited Neurogenic</th>
<th>Sensory Paralytic</th>
<th>Motor Paralytic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location of injury</strong></td>
<td>Location – Damage to dorsal horn at level of sacral arc or damage to dorsal roots S2-S4</td>
<td>Location – anterior horn cells or S2-S4 ventral roots</td>
</tr>
<tr>
<td>- cortex, brainstem, pons and subcortical areas</td>
<td>- Possible cause – childbirth neuropathy secondary to diabetes mellitus, tabes dorsalis, pelvic survey or trauma, peripheral vascular disease</td>
<td>- Possible cause – Poliomyelitis, herniated disk, pelvic trauma</td>
</tr>
<tr>
<td>- newborn infant, stroke, brain injury, brain tumor, MS, encephalopathy, dementia, Alzheimer’s</td>
<td>- S/S – able to void completely but lacks awareness of need to void, infrequent voiding secondary to lack of sensory awareness, large volume voids with low residual volumes</td>
<td>- S/S – Normal sensation with difficulty passing urine, dribbling with abdominal pressure, incomplete emptying with high residual volumes</td>
</tr>
<tr>
<td><strong>Possible cause</strong></td>
<td>- Possible cause – child birth neuropathy secondary to diabetes mellitus, tabes dorsalis, pelvic survey or trauma, peripheral vascular disease</td>
<td></td>
</tr>
<tr>
<td>- newborn infant, stroke, brain injury, brain tumor, MS, encephalopathy, dementia, Alzheimer’s</td>
<td>- S/S – able to void completely but lacks awareness of need to void, infrequent voiding secondary to lack of sensory awareness, large volume voids with low residual volumes</td>
<td></td>
</tr>
<tr>
<td><strong>S/S</strong></td>
<td>- S/S – able to void completely but lacks awareness of need to void, infrequent voiding secondary to lack of sensory awareness, large volume voids with low residual volumes</td>
<td></td>
</tr>
<tr>
<td>Lack of awareness, frequency, urgency, nocturia, decreased bladder capacity with low residual volumes</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reflex Neurogenic

- Location of injury – SCI above T12-L1 or level of sacral reflex arc
- Possible cause – SCI above T12-S1, MS, Spinal cord tumor
- S/S – Some to no awareness of voiding, unpredictable voiding, voiding occurs in response to reflex – stroking, tapping, pulling at public hairs
- Adequacy of voiding dependent upon degree of detrusor/sphincter, dysynergy
- Frequently high post void residuals

### Autonomous/Areflexic Neurogenic Bladder

- Location – Sacral reflex arc
- Possible causes – all SCI during period of spinal shock, SCI damage to sacral arc, polio, vascular occlusion to spinal cord, spina bifida, myelomeningocele, postoperative radical pelvic surgery or radiation, herniated lumbar disk
- S/S – Absent voiding reflex although may have sensation of fullness, dribbling with abdominal pressure, high residual volumes
**STUDY TIP:**

*Be sure to take regular breaks to stretch and or get something to eat.*

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*Take a break*
## Stroke Aphasia

<table>
<thead>
<tr>
<th>Receptive/Fluent/Wernike’s Aphasia</th>
<th>Global Aphasia</th>
<th>Expressive/Broca’s/Nonfluent Aphasia</th>
<th>Transcortical Dysphasia</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Superior temporal gyrus</td>
<td>- Frontal-temporal dominant lobes</td>
<td>- Frontal lobe</td>
<td>- Occurs with lesions of anterior/posterior presylvian fissure</td>
</tr>
<tr>
<td>- Able to produce language but it does not make sense</td>
<td>- Anterior and posterior speech areas are extensively impaired</td>
<td>- Motor aspects of speech</td>
<td>- Has ability to repeat and recite</td>
</tr>
<tr>
<td>- Impaired in naming, reading, writing</td>
<td>- Exhibits comprehension and speaking problems</td>
<td>- Inability to form or finding words</td>
<td>- Inability to read and write</td>
</tr>
<tr>
<td>- Able to produce verbal language that is meaningless</td>
<td>- Impaired reading, `naming &amp; writing</td>
<td>- Difficulty writing thoughts into symbols (not the physical aspect, but translating)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- May have intact autonomic speech but only for singing songs, etc.</td>
<td>- Impaired ability to read letters, numbers or written material</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Slow, effortful speech</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Verbal comprehension intact</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- May have intact autonomic speech</td>
<td></td>
</tr>
</tbody>
</table>

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*Image: Traditional cortical language areas, inferred from the results of strokes.*
**Anterior Cerebral Artery**  
-Supplies the medial surfaces and upper area of the frontal and parietal lobes  
-S/S confusion, labile emotions, urinary incontinence, loss of coordination, weakness/numbness on affected side, paralysis of contralateral foot/leg, impaired mobility, sensation greater in LE than UE, impaired sensory function

**Middle Cerebral Artery**  
-Supplies part of frontal lobe and lateral surface of temporal and parietal lobes  
-S/S – altered level of responsiveness, alterations in communication including aphasia, dysphasia, reading difficulty, inability to write, visual field deficits, alteration in cognition, mobility and sensation including contralateral sensory deficit and hemiparesis more severe in upper extremities

**Posterior Cerebral Artery**  
-Supplies medial and inferior temporal lobes, medial occipital lobes, thalamus, posterior hypothalamus and visual receptive area  
-S/S – hemiplegia, receptive aphasia, sensory impairment, dyslexia, visual field deficits and coma
**Brain Injury**  
**Function of Lobes**  
(See Core curriculum Chapter 5)

<table>
<thead>
<tr>
<th>Frontal Lobe</th>
<th>Parietal Lobe</th>
<th>Occipital Lobe</th>
</tr>
</thead>
</table>
| - Logical thinking  
- Executive functioning  
- Future planning  
- Abstract thinking  
- Screening out unnecessary stimuli  
- Locations of memorized patterns of movement  
- Initiates voluntary movement  
- Seat of personality  
- Speech motor area in L hemisphere  
- Concentration  
- Complicated math problems  
- Complex problem solving  | - Recognition of objects  
- Body awareness  
- Reception of sensory impulses  
- Interpretation of the sensation of touch, temperature, pressure and pain  
- Spatial relations  | - Interpretation of visual information  
- Recognition of the meaning of written words  |

<table>
<thead>
<tr>
<th>Temporal Lobe</th>
<th>Cerebellum</th>
<th>Brain Stem</th>
</tr>
</thead>
</table>
| - Recognition of tones, loudness and qualities of sound  
- Interpretation of the meanings of spoken words  
- Storage of short term memory  | - Modifies speed, force and accuracy of movement  
- Interpretation of balance  
- Control of the amount of muscle tone  
- Voluntary muscle coordination  | - Includes mid brain, pons and medulla oblongata  
- Includes cell bodies of CN 3 –12  
- Midbrain contains substantia nigra & red nucleus  
- Injury to midbrain associated with decorticate posturing (abnormal flexion)  
- Pons contains apneustic center |
### Theory

<table>
<thead>
<tr>
<th>THEORIST</th>
<th>MODEL/THEORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orem, Dorothea</td>
<td>Pt. is a <em>biological, symbolic, and social</em> unit. Emphasis is on <em>self-care</em>. Health defined as “<em>INTERGRATED wholeness of mind and body</em>”. Nurse assesses pt. and provides help, references/resources for pt. to evaluate options.</td>
</tr>
</tbody>
</table>
| Kubler-Ross, Elizabeth | Any major *life loss or death*, can be seen as presenting with **five stages of Grief**: DABDA  
1. Denial  
2. Anger  
3. Bargaining  
4. Depression  
5. Acceptance  
Nurse assesses pt. and provides help, references/resources for pt. to evaluate options.                                                                                                                                                                                   |
| King, Imogene          | Pt. is an “*open system*”, interacting with the environment. Pt. has *intrinsic* worth, and *capable* the majority of times, in *making decisions*. Pt. can *obtain goals* resulting from *interactions between pt. and nurse*. Pt.’s family/significant other *must* be included as part the REHAB team. Pt. adjusts to life experiences, and stress, using prior coping and/or newly taught skills. |
| Hall, Lydia             | Pt. *achieves maximum potential* through *learning*; health is a *learned behavior*. Nursing centers around *CARE, CORE, CURE*. Nurse is a *nurturer and teacher*.                                                                                                                                                                                              |
| Roy, Sister Callista   | Pt. must *ADAPT* to the *changing needs* in a *changing environment*. Nurses addresses *physiological needs, self concept, role mastery and interdependence*.                                                                                                                                                                                                                       |
| Fawcett, Jacqueline     | Identified 4 concepts as *Foundation for Nursing Theories*:  
*Person, Environment, Health, Nursing*  
**PRIMARY Prevention**- Activities to reduce the probability of disease development;  
**SECONDARY Prevention**- Early detection and disease treatment;  
**TERTIARY Prevention**- Monitoring processes and Rehabilitative activities.                                                                                                                                                                                                                          |
| Selye, Hans             | Classic Stress Theory—“*FIGHT or FLIGHT*” response                                                                                                                                                                                                                                                                                                   |
| Bandura, Albert         | Self-Efficacy “*belief in one’s capabilities to organize and perform tasks*”  
Belief of pt. *that they will succeed in a particular situation*                                                                                                                                                                                                                                                                                     |
| Kobasa, Suzanne         | Hardiness is built based on Stressful Life Events                                                                                                                                                                                                                                                                                                   |
# Theory

<table>
<thead>
<tr>
<th>THEORIST</th>
<th>MODEL/THEORY</th>
</tr>
</thead>
</table>
| Lewin, Kurt       | “Change Theory” - behavior is a function of both personality and environment, with the interaction between the two dynamic change.  
Three states of change are:  
**Unfreezing** - movement from steady state to unsteady state and amenable to change  
- Status quo questioned.  
**Movement** to a Higher Level **Behavior**  
- Problem Assessed and diagnosed; options, GOALS established; Evaluation done  
**ReFreezing**  
- Integration, stabilization of new learning  
- New responses are integrated into lifestyle and relationships; Change is complete |
| Newman, Betty     | Health care systems model in which the person is viewed as an **OPEN SYSTEM** in **INTERACTION** with the environment.                                                                                     |
| Rosenstock & Becker | **HEALTH BELIEF MODEL**  
Health value depends on perceived susceptibility to a disease level; perceived seriousness of the disease; perceived barriers to promote action; and perceived benefits of taking action toward health. |
| PLISSIT (Annon, 1976) | **MODEL FOR SEXUAL COUNSELING**  
1. **Permission** - Allow questions 2. **Limited Information** - Provide info and ask if pt. comfortable discussing  
3. **Specific Suggestions** to resolve problem 4. **Intensive Therapy** (expert referral)  
Used initially as a tool to assess older pts. sexuality concerns. |
| Knowles, Malcolm | Theorist during 1960-70’s. Is considered “one of the founding fathers of the adult learning theory”. Andragogy Concept meaning “the art and science of helping adults learn.” Knowles felt adults over the age of 18 learn much differently than children.

SIX basic premises of KNOWLES THEORY:

1) NEED to KNOW-adults need to know the reason for learning(Objectives and Goals written)
2) EXPERIENCE- adults draw from their past experiences in life and work to aid their education( relate new ideas to past activity)
3) SELF Concept- adults need to be responsible for their decisions on education, involvement in planning and evaluation of their instruction.( evaluation of instruction-eval., summaries after CEU; self eval checklists or a pre-learning activity inventory of skills)
4) READINESS- the learning readiness of adults is closely related to the assumption of new social roles (family caregiver/self caregiver)
5). ORIENTATION- as an adult learns new knowledge, he/she wants to apply that knowledge immediately in problem solving(return demonstrations/repeat demonstrations
6) Motivation- self or “internally desires “ to learn new skills, data

MUCH OF NURSING EDUCATION IS BASED ON KNOWLES THEORY. Knowles theory has been said to be a theory of Teaching, rather than of Learning.
Considerations for the GERIATRIC CLIENT
GERIATRIC CLIENT ASSESSMENT

1. Perform an assessment of the client to determine any obvious medical/sensory/cognitive deficits.
2. Include culture, education levels, economic, social status (single, married, no family or friend network) in assessment.
3. Be certain that any assistive or supportive devices needed by the client are at hand and in use (glasses, hearing aids).
Geriatric Clients

SENSORY CHANGES

• **VISION**-ageing eyes require 25% more LIGHT to read.
  – GLARE is also a problem to discriminate printed materials, adjust blinds, drapes as necessary to reduce glare or relocate.
  – COLORS of PRINTED DATA should be **BLACK TEXT** on **WHITE BACKGROUNDS** and avoid glossy paper, and blue and green color ink as those all make visualization difficult.
  – Have a **MAGNIFYING GLASS** or **MAGNIFYING PAGE VIEWER** available.
  – **LIGHT SOURCE**-have a high intensity light shine on the material to be read or surface to be worked on.

• **HEARING**-high frequency hearing loss is common.
  – Phonetically similar sounds eg: ”s, t, f, g” are commonly NOT heard.
  – **Reduce** background noise. **Lower** your voice when speaking.
  – down across from the client at **same eye level, speaking slowly**, but not over exaggerating words.
  – **Repeat** or clarify **message** if client does not seem to comprehend.
  – Make certain that **hearing assistive devices** are **working** and are **worn**.
  – Adjust **speaker volumes of any AV materials** as necessary.
  – Check client’s ears for excessive wax build up and have it removed ,if found.

• **TIMING**-allow **MORE TIME** for educational **PRESENTATION**.
  – It may require several **repetitions** of **MAJOR POINTS** or re-statements of points.
  – **PRESENT MAJOR POINTS FIRST**, clarify, using Examples.

• **MOTOR SKILLS**-repetition of **ONE STEP** at a time
  – allow **mastery of that step** prior to proceeding to another step
  – Allow for **Associations** between other types of motor skills
  – **Tasks** (for example say-“similar to putting tooth paste on your toothbrush”).

• **REVIEW**- summarize major points
  – **CLARIFY** with associations of daily tasks.

• **REPEAT/RETURN DEMONSTRATION**
  – must be done to ascertain if motor skill memory has occurred.
STUDY TIP:
Daily Affirmation
I will pass the CRRN Exam with Ease