# Concept 02: Functional Ability
# Giddens: Concepts for Nursing Practice, 2nd Edition

**MULTIPLE CHOICE**

1. The nurse is assessing a patient's functional ability. Which patient **best** demonstrates the definition of functional ability?
   a. Considers self as a healthy individual; uses cane for stability
   b. College educated; travels frequently; can balance a checkbook
   c. Works out daily, reads well, cooks, and cleans house on the weekends
   d. Healthy individual, volunteers at church, works part time, takes care of family and house

   ANS: D
   Functional ability refers to the individual's ability to perform the normal daily activities required to meet basic needs; fulfill usual roles in the family, workplace, and community; and maintain health and well-being. The other options are good; however, healthy individual, church volunteer, part time worker, and the patient who takes care of the family and house fully meets the criteria for functional ability.

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   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Basic Care and Comfort

2. The nurse is assessing a patient's functional performance. What assessment parameters will be **most** important in this assessment?
   a. Continence assessment, gait assessment, feeding assessment, dressing assessment, transfer assessment
   b. Height, weight, body mass index (BMI), vital signs assessment
   c. Sleep assessment, energy assessment, memory assessment, concentration assessment
   d. Health and well-being, amount of community volunteer time, working outside the home, and ability to care for family and house

   ANS: A
   Functional impairment, disability, or handicap refers to varying degrees of an individual's inability to perform the tasks required to complete normal life activities without assistance. Height, weight, BMI, and vital signs are part of a physical assessment. Sleep, energy, memory, and concentration are part of a depression screening. Healthy, volunteering, working, and caring for family and house are functional abilities, not performance.

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   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential

3. The nurse is assessing a patient with a mobility dysfunction and wants to gain insight into the patient's functional ability. What question would be the **most** appropriate?
   a. "Are you able to shop for yourself?"
   b. "Do you use a cane, walker, or wheelchair to ambulate?"
   c. "Do you know what today's date is?"
   d. "Were you sad or depressed more than once in the last 3 days?"

ANS: B
"Do you use a cane, walker, or wheelchair to ambulate?" will assist the nurse in determining the patient's ability to perform self-care activities. A nutritional health risk assessment is not the functional assessment. Knowing the date is part of a mental status exam. Assessing sadness is a question to ask in the depression screening.

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OBJ: NCLEX® Client Needs Category: Physiological Integrity: Physiological Adaptation

4. The nurse is developing an interdisciplinary plan of care using the Roper-Logan-Tierney Model of Nursing for a patient who is currently unconscious. Which interventions would be most critical to developing a plan of care for this patient?
   a. Eating and drinking, personal cleansing and dressing, working and playing
   b. Toileting, transferring, dressing, and bathing activities
   c. Sleeping, expressing sexuality, socializing with peers
   d. Maintaining a safe environment, breathing, maintaining temperature

   ANS: D
   The most critical aspects of care for an unconscious patient are safe environment, breathing, and temperature. Eating and drinking are contraindicated in unconscious patients. Toileting, transferring, dressing, and bathing activities are BADLs. Sleeping, expressing sexuality, and socializing with peers are a part of the Roper-Logan-Tierney Model of Nursing; however, these are not the most critical for developing the plan of care in an unconscious patient.

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   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Physiological Adaptation

5. The home care nurse is trying to determine the necessary services for a 65-year-old patient who was admitted to the home care service after left knee replacement. Which tool is the **best** for the nurse to utilize?
   a. Minimum Data Set (MDS)
   b. Functional Status Scale (FSS)
   c. 24-Hour Functional Ability Questionnaire (24hFAQ)
   d. The Edmonton Functional Assessment Tool

   ANS: C
   The 24hFAQ assesses the postoperative patient in the home setting. The MDS is for nursing home patients. The FSS is for children. The Edmonton is for cancer patients.

   REF: Page 16 OBJ: NCLEX® Client Needs Category: Health Promotion and Maintenance

6. The nurse is assessing a patient's functional abilities and asks the patient, "How would you rate your ability to prepare a balanced meal?" "How would you rate your ability to balance a checkbook?" "How would you rate your ability to keep track of your appointments?" Which tool would be indicated for the best results of this patient's perception of their abilities?
   a. Functional Activities Questionnaire (FAQ)™
   b. Mini Mental Status Exam (MMSE)
   c. 24hFAQ
   d. Performance-based functional measurement

   ANS: A

The FAQ is an example of a self-report tool which provides information about the patient's perception of functional ability. The MMSE assesses cognitive impairment. The 24hFAQ is used to assess functional ability in postoperative patients. Performance-based tools involve actual observation of a standardized task, completion of which is judged by objective criteria.

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**MULTIPLE RESPONSE**

1. A 65-year-old female patient has been admitted to the medical/surgical unit. The nurse is assessing the patient's risk for falls so that falls prevention can be implemented if necessary. Select all the risk factors that apply from this patient's history and physical. (*Select all that apply*.)
   a. Being a woman
   b. Taking more than six medications
   c. Having hypertension
   d. Having cataracts
   e. Muscle strength 3/5 bilaterally
   f. Incontinence

   ANS: B, D, E, F
   Adverse effects of medications can contribute to falls. Cataracts impair vision, which is a risk factor for falls. Poor muscle strength is a risk factor for falls. Incontinence of urine or stool increases risk for falls. Men have a higher risk for falls. Hypertension itself does not contribute to falls. Taking medications to treat hypertension that may lead to hypotension and dizziness is a fall risk. Dizziness does contribute to falls.

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   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential

**MATCHING**

Match the activities listed with the appropriate functional level of ability:
a. for instrumental activities of daily living (IADLs)
b. for basic activities of daily living (BADLs)

1. Uses a cane
2. Bathes daily
3. Takes medications as prescribed
4. Dresses self
5. Balances the checkbook
6. Cleans the house

1. ANS: B REF: Page 14|Page 15
   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential
2. ANS: B REF: Page 14|Page 15
   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential
3. ANS: A REF: Page 14|Page 15
   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential
4. ANS: B REF: Page 14|Page 15

OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential

5. ANS: A REF: Page 14|Page 15
   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential
6. ANS: A REF: Page 14|Page 15
   OBJ: NCLEX® Client Needs Category: Physiological Integrity: Reduction of Risk Potential