Ackley & Ladwig's Nursing Problems & Care Planning Handbook An Evidence - Based Approach 14th edition Makic Test Bank

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Activity InTolerance

Q1: A postoperative client will be getting out of bed and walking to the chair for the first time since surgery. Which intervention by the nurse is best?

A. Pre-medicate the client for pain prior to the activity. (Correct)

B. Take the client's vital signs prior to beginning the activity.

C. Call the provider and request a physical therapy consultation.

D. Encourage the client to do as much as possible him- or herself.

Rationale: Pain often limits a client's activity and/or willingness to participate in activity. Pre-medicating the client beforehand will allow the client to be active while remaining as comfortable as possible. Baseline vital signs might be an important assessment, but is not as important as providing pain control. There is no indication for the client to require physical therapy. Simply encouraging the client will not help if the client's pain level prevents participation. DIF: Cognitive Level: Application/Applying TOP: Nursing Process: Implementation MSC: Physiological Integrity: Pharmacological and Parenteral Therapies

Q2: A nurse is ambulating a client in the hallway. The client begins to act confused and seems weaker than earlier. Which action by the nurse takes priority?

A. Stop ambulating the client and have someone bring a wheelchair. (Correct)

B. Return the client to bed immediately, ambulating slowly.

C. Have the client rest, then resume ambulating at a slower pace.

D. Encourage the client to take slow deep breaths while returning to bed.

Rationale: This patient may be experiencing cardiac decompensation and should stop all activity immediately to reduce the risk of a fall. The nurse should remain with the client and have someone else bring a wheelchair so the client can be returned to bed. The other activities are not appropriate as they will place more stress on the client's heart. DIF: Cognitive Level: Application/Applying TOP: Nursing Process: Implementation MSC: Physiological Integrity: Physiological Adaptation

Q3: A client has been on bed rest for several weeks and now has orders to begin increasing activity as tolerated. The client is concerned about tolerating more activity. Which action by the nurse is best?

A. Teach the client about the benefits of increased activity.

B. Assist the client in setting realistic short-term activity goals. (Correct)

C. Discuss all the potential complications of remaining bedfast.

D. Call the provider and request a physical therapy consultation.

Rationale: Clients who have helped set goals are more likely to participate in activities that help reach that goal. For a client who is apprehensive about increasing activity, mutually agreeing on short-term goals could help encourage the client to try the activities. Teaching the client about the benefits of activity and about the complications of immobility are certainly important, but may not convince a client to participate. A physical therapy consultation is not indicated in this situation. DIF: Cognitive Level: Application/Applying TOP: Nursing Process: Planning MSC: Physiological

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Integrity: Reduction of Risk Potential

Q4: A client with chronic obstructive pulmonary disease (COPD) wants to increase activity but complains of extreme weakness with each attempt at ambulating. Which action by the nurse is best?

A. Arrange a dietary consult. (Correct)

B. Place oxygen on the client.

C. Limit the client's activity.

D. Encourage walking shorter distances.

Rationale: Malnutrition can lead to increased weakness due to loss of lean body mass. Clients with COPD often struggle with maintaining adequate nutrition. The client may need oxygen depending on the client's oxygen saturation levels; however, placing oxygen may not improve the ability to ambulate. The nurse would need to assess this. The client should be encouraged to be as active as tolerated. Walking shorter distances may be a good option once the client's nutritional status has been addressed and oxygen provided as needed. DIF: Cognitive Level: Application/Applying TOP: Nursing Process: Implementation MSC: Safe Effective Care Environment: Management of Care

Q5: A hospitalized older client needs to increase activity, but is unsteady and complains of dizziness with activity. Which initial action by the nurse is most important?

A. Evaluate the client's medications. (Correct)

B. Ask the client if he or she is afraid of falling.

C. Perform lower extremity strength testing.

D. Reassure the client that someone will help with ambulation.

Rationale: Many medications can lead to decreased functional ability, particularly beta-blockers, lipid-lowering agents, some anti-psychotics, and other anti-hypertensives. The nurse should assess the client's medications for any medication that could be contributing to this concern. Asking if the client is afraid of falling is important to determine fall risk but less important than evaluation of medications that may be causing the dizziness with activity. Lower extremity strength testing may be needed, but is not causing the dizziness. Reassuring the client does not provide any solution to the problem. DIF: Cognitive Level: Application/Applying TOP: Nursing Process: Assessment MSC: Physiological Integrity: Pharmacological and Parenteral Therapies

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