Test your Knowledge

1. A Speech-Language Pathologist ordered a thickened liquid diet for a client diagnosed with dysphagia. Which food items would you find on the client’s tray? Select all that apply.

1. Oatmeal.
2. Yogurt.
3. Coffee.
4. Broth.
5. Hummus.

2. Which meal assistance techniques would you use when assisting a client who has dysphagia? Select all that apply.

1. Encourage the client to drink water between bites of food.
2. Encourage the client to take a ½ teaspoonful of food with each bite.
3. Use utensils adapted with a large handle.
4. Encourage the client to swallow twice before eating the next spoonful.
5. Ensure the client is sitting upright with their head slightly tilted forward.
6. Use the clock face method to identify food location.
7. Encourage the client to swallow by gently touching client’s chin.

3. You need to assist a client who is two months post cerebrovascular accident (CVA), with left-sided weakness and dysphagia. Which side of the client’s mouth should you place the food?

Right side or the Left side

Reflect on: Which side has stronger muscles for chewing?

4. Which are the following signs of dysphagia? Select all that apply.

1. Coughing while eating.
2. Ability to clear throat.
3. Food pocketing in the cheek.
4. Gurgling or change in voice.
5. Drooling during a meal.

5. What priority action should the nurse take when witnessing a client with dysphagia begin to choke during meal?

1. Provide four back blows between the scapula.
2. Assess for pocketing of food in between coughing.
3. Run to get additional assistance for the client.
4. Call for help and encourage the client to clear their airway by coughing.

6. What observations would the nurse make that would indicate possible aspiration for a client with dysphagia? **Select all that apply.**

1. The client requires three complete swallows between each mouthful of food.
2. The client coughs before or after swallowing a mouthful of food.
3. The client has a wet or gurgly voice after swallowing.
4. The client's chin is tucked down while swallowing food.
5. The client drools while eating.

7. Why is it important to assess for pocketing when a client has dysphagia? **Select all that apply.**

1. Pocketed food can be aspirated.
2. Assessing for pocketing can ensure that the entire airway is cleared of food.
3. Food that is pocketed needs to be removed.
4. Pocketing indicates the client needs a drink of water between mouthfuls.
5. Assessing for pocketing allows the nurse to check for dental caries.

8. Identify the equipment required by the nurse to assess a client for pocketing. Select all the apply.

1. Gloves.
2. Stethoscope.
3. Tongue Depressor.
4. Penlight.

9. A client has right-sided weakness in their arm and leg. The client is right-handed. During breakfast, you noticed the client’s arm becomes lethargic and the client begins to struggle raising their arm to their mouth. The client still has half of their breakfast to eat, including yogurt and oatmeal. What should the nurse do first?

1. Offer to feed the client.
2. Encourage the client to eat with their non-dominant hand.
3. Begin to use the hand under hand technique with the client.
4. Encourage the client to rest.

10. Which strategy reduces the risk of gastroesophageal reflux?

* 1. Drink water between each bite.
	2. Swallow at least twice between mouthfuls.
	3. Tilt chin down while eating.
	4. Remain sitting upright for 30 minutes after a meal.

11. Which meal assistance strategies should the nurse implement throughout mealtime with clients? Select all that apply.

1. Encourage the client to talk throughout the meal.
2. Sit within the client’s line of vision.
3. Provide prompting, encouragement and direction as needed.
4. Prepare the next spoonful before client finishes swallowing.
5. Inform the client that they should sit upright for 30 minutes after their meal.

12. Prioritize the following interventions if a client begins to choke. Drag and drop the words in priority sequence.

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| --- |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

The options:

* Call for help.
* Assess for pocketing.
* Assess lungs for aspiration.
* Tell the client that you will stay with them.
* Encourage the client to cough and clear throat.