ASSIST COMPETENCY ASSESSMENT: RESPONSE FORM

ASSIST – ACUTE SCREENING OF SWALLOW IN STROKE/TIA COMPETENCY ASSESSMENT

NAME:

POSITION:

FACILITY:

DATE:

Step 1: Ensure you have completed an introductory ASSIST training workshop before proceeding with this competency assessment. Please see your Speech Pathologist or Nurse Unit Manager if you have not yet attended this training.

Step 2: Ensure you have a copy of the ASSIST screening tool at hand as you answer these questions.

Step 3: Play ASSIST Competency Assessment PDF/DVD now.

	SCORE
1. What pre-feeding skills are required before screening can commence? a) Able to maintain adequate alertness ☐ b) Able to maintain upright sitting posture ☐ c) Able to hold head erect ☐ d) All of the above ☐	/1
Are these sitting positions adequate for screening? **2.** Position one: Yes ☐ No ☐ **3.** Position two: Yes ☐ No ☐ **4.** Position three: Yes ☐ No ☐	/3
Do these patients have 'facial weakness/droop'? **5.** Patient one: Yes ☐ No ☐ **6.** Patient two: Yes ☐ No ☐ **7.** Patient three: Yes ☐ No ☐ **8.** Patient four: Yes ☐ No ☐ **9.** Patient five: Yes ☐ No ☐	/5
Do these patients have slurred speech? **10.** Patient one: Yes ☐ No ☐ **11.** Patient two: Yes ☐ No ☐ **12.** Patient three: Yes ☐ No ☐	/3
13. Why is it important to check a patient's ability to cough? _____ _____ _____ _____	/1
Do these patients have a hoarse voice? **14.** Patient one: Yes ☐ No ☐ **15.** Patient two: Yes ☐ No ☐ **16.** Patient three: Yes ☐ No ☐	/3

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17. Why would this patient 'fail' the screen? a) Not able to maintain adequate alertness ☐ b) Not wearing dentures ☐ c) Slurred speech & drooling saliva ☐ d) None of the above – OK to proceed ☐	/1
18. Would you progress to testing this patient with a sip of water? Yes ☐ No ☐	/1
19. Would you progress to testing this patient with a cup of water? Yes ☐ No ☐	/1
20. Observe the nurse testing the patient with a sip of water. Should the nurse continue with screening? Yes ☐ No ☐	/1
Read the following scenario. The stroke unit nurse is getting handover from the ED nurse about a new admission. Name 5 risk factors for dysphagia this patient is likely to exhibit. **21.**_____ **22.**_____ **23.**_____ **24.**_____ **25.**_____	/5
26. Observe the nurse testing the patient with a sip of water. What should the nurse do now? a) STOP here ☐ b) Give the patient another sip of water ☐ c) Proceed to give the patient a full cup of water ☐	/1
27. What is meant by Nil By Mouth? a) Oral medications may be given with a sip of water ☐ b) Oral fluids are allowed but not food or medications ☐ c) No medication, food or fluid to be given orally ☐	/1
Name 3 indicators of swallowing difficulty for a patient who has commenced an oral diet **28.**_____ **29.**_____ **30.**_____	/3
TOTAL SCORE	**/30**