Clinical Guidelines for Stroke Management

A quick guide for nursing

This summary is based on the National Stroke Foundation Clinical Guidelines for Stroke Management 2010 which have been approved by the NHMRC and endorsed by the Royal College of Nursing, Australia.

It presents a sub-set of recommendations from the Clinical Guidelines for Stroke Management considered by an advisory panel to be of most relevance to nursing care. The summary has been designed to raise awareness of stroke clinical practice from a nursing perspective. While this summary focuses on nursing care, stroke care is most effective when all members of the multidisciplinary team are involved.

Important caveats to the recommendations are included in the preamble to each section in the main document. Readers are referred back to the main document for details regarding these caveats along with the specific research which underpins the recommendations and the designated NHMRC levels of evidence for each recommendation (refer Table 1).

In general, where the evidence is clear and trusted, or where there is consensus on the basis of clinical experience and expert opinion (Good practice point), the word ‘should’ has been used to indicate that the intervention should be routinely carried out. Where the evidence is less clear or where there was significant variation in opinion, the word ‘can’ has been used. Individual patient factors should always be taken into account when considering different intervention options.

Please note that this is a summary only and as a result, those individual recommendations not considered entirely relevant to nursing have been omitted within the topics.

This document is a general guide to appropriate practice, to be followed subject to the clinician’s judgment and the patient’s preference in each individual case. The guidelines are designed to provide information to assist decision-making and are based on the best evidence available at the time of development. Copies of the summary and the Clinical Guidelines for Stroke Management can be downloaded through the National Stroke Foundation website: www.strokefoundation.com.au.

Key points
- Nurses are vital members of the multidisciplinary stroke care team in acute, rehabilitation and community care settings.
- Nurses have important roles in all aspects of stroke care, such as:
  - Rapid assessment of the stroke patient to facilitate appropriate diagnostic and early interventions (e.g. thrombolysis, aspirin) (refer Section 2.2)
  - Monitoring and responding to routine aspects of acute care (BP, temperature and glucose control) essential to prevent or detect stroke complications (refer Section 3.0)
  - Ensuring early/timely completion of screening and assessments, such as for stroke severity (refer Section 2.1), swallowing deficits before administration of food, drink or oral medication (refer Section 5.2), nutrition and hydration status (refer Section 6.1), communication and mood (refer Section 5.4, Section 6.7)
  - Coordinating and reinforcing lifestyle and other secondary prevention measures (refer Section 4.0)
  - Working with other members of the team to maximise the amount of active intervention/practice, where possible (refer Section 5.1)
  - Ensuring all assessments and preparations are completed for patients and carers to ensure safe discharge from hospital (refer Sections 1.2, 1.4, 1.5)
  - Ensuring access to specialist palliative care/palliative care pathways, as appropriate (refer Section 1.14).
TABLE 1 Grading recommendations

<table>
<thead>
<tr>
<th>GRADE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
</tr>
<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation but care should be taken in its application</td>
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<tr>
<td>D</td>
<td>Body of evidence is weak and recommendation must be applied with caution</td>
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<tr>
<td></td>
<td><strong>Good practice point (GPP)</strong> Recommended best practice based on clinical experience and expert opinion</td>
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SECTION 1 Organisation of services

1.1 Stroke unit care

| a) | All people with stroke should be admitted to hospital and be treated in a stroke unit with a multidisciplinary team. | A 5 |
| b) | All people with stroke should be admitted directly to a stroke unit (preferably within three hours of stroke onset). | C 37 |
| c) | Smaller hospitals should consider stroke services that adhere as closely as possible to the criteria for stroke unit care. Where possible, patients should receive care on geographically discrete units. | B 5, 41 |
| d) | If people with suspected stroke present to non-stroke unit hospitals, transfer protocols should be developed and used to guide urgent transfers to the nearest stroke unit hospital. | C 35, 36 |

1.2 Ongoing inpatient rehabilitation

| a) | To ensure all stroke patients receive early, active rehabilitation by a dedicated stroke team, health systems should have comprehensive services which include and link the fundamentals of acute and rehabilitation care. | B 5, 38 |
| b) | Patients should be transferred to a stroke rehabilitation unit if ongoing inpatient rehabilitation is required. | B 5, 38 |
| c) | If a stroke rehabilitation unit is not available, patients who require ongoing inpatient rehabilitation should be transferred to a conventional rehabilitation unit where staff have stroke-specific expertise. | B 38 |
| d) | All patients, including those with severe stroke, who are not receiving palliative care should be assessed by the specialist rehabilitation team prior to discharge from hospital regarding their suitability for ongoing rehabilitation. | GPP |

1.3 Inpatient stroke care co-ordinator

An inpatient stroke care coordinator should be used to coordinate services and assist in discharge planning. | GPP |

1.4 Safe transfer of care from hospital to community

| a) | Prior to hospital discharge, all patients should be assessed to determine the need for a home visit, which may be carried out to ensure safety and provision of appropriate aids, support and community services. | C 59 |
| b) | To ensure a safe discharge occurs, hospital services should ensure the following are completed prior to discharge: |
|   | • patients and families/carers have the opportunity to identify and discuss their post-discharge needs (e.g. physical, emotional, social, recreational, financial and community support) with relevant members of the multidisciplinary team | GPP |
|   | • general practitioners, primary healthcare teams and community services are informed before or at the time of discharge | GPP |
• all medications, equipment and support services necessary for a safe discharge are organised  
• any continuing specialist treatment required is organised  
• a documented post-discharge care plan is developed in collaboration with the patient and family and a copy provided to them. This may include relevant community services, self-management strategies (e.g. information on medications and compliance advice, goals and therapy to continue at home), stroke support services, any further rehabilitation or outpatient appointments, and an appropriate contact number for any queries.

c) A locally developed protocol may assist in implementation of a safe discharge process.  
d) A discharge planner may be used to coordinate a comprehensive discharge program for stroke survivors.

1.5 Carer training

Relevant members of the multidisciplinary team should provide specific and tailored training for carers/family before the stroke survivor is discharged home. This should include training, as necessary, in personal care techniques, communication strategies, physical handling techniques, ongoing prevention and other specific stroke-related problems, safe swallowing and appropriate dietary modifications, and management of behaviours and psychosocial issues.

1.6 Community rehabilitation and follow-up services

a) Contact with and education by trained staff should be offered to all stroke survivors and families/carers after discharge.  
b) Stroke survivors can be managed using a case management model after discharge. If used, case managers should be able to recognise and manage depression, and help to coordinate appropriate interventions via a medical practitioner.  
c) Stroke survivors should have regular and ongoing review by a member of a stroke team, including at least one specialist medical review. The first review should occur within three months, then again at six and 12 months post discharge.  
d) Stroke survivors and their carers/families should be provided with the contact information for the specialist stroke service and a contact person (in the hospital or community) for any post-discharge queries for at least the first year following discharge.

1.7 Standardised assessment

Clinicians should use validated and reliable assessment tools or measures that meet the needs of the patient to guide clinical decision-making.

1.8 Goal setting

a) Stroke survivor and their families/carers who are involved in the recovery process should have their wishes and expectations established and acknowledged.  
b) Stroke survivor and their families/carers should be given the opportunity to participate in the process of setting goals unless they choose not to or are unable to participate.  
c) Health professionals should collaboratively set goals for patient care. Goals should be prescribed, specific and challenging. They should be recorded, reviewed and updated regularly.  
d) Stroke survivors should be offered training in self-management skills that include active problem-solving and individual goal setting.
1.9 Team meetings
The multidisciplinary stroke team should meet regularly (at least weekly) to discuss assessment of new patients, review patient management and goals, and plan for discharge.

1.10 Information and education
a) All stroke survivors and their families/carers should be offered information tailored to meet their needs using relevant language and communication formats.

b) Information should be provided at different stages in the recovery process.

c) Stroke survivors and their families/carers should be provided with routine, follow-up opportunities for clarification or reinforcement of the information provided.

1.11 Family meetings
The stroke team should meet regularly with the patient and their family/carer to involve them in management, goal setting and planning for discharge.

1.12 Counselling
Counselling services should be available to all stroke survivors and their families/carers and can take the form of:

- an active educational counselling approach
- information supplemented by family counselling
- a problem-solving counselling approach.

1.13 Respite care
Stroke survivors and their carers/families should have access to respite care options. The respite care may be provided in their own home or in an institution.

1.14 Palliative care
a) An accurate assessment of prognosis or imminent death should be made for patients with severe stroke or those who are deteriorating.

b) Stroke patients and their families/carers should have access to specialist palliative care teams as needed and receive care consistent with the principles and philosophies of palliative care.

c) A pathway for stroke palliative care can be used to support stroke patients and their families/carers and improve care for people dying after stroke.

1.15 Stroke service improvement
All stroke services should be involved in quality improvement activities that include regular audit and feedback (‘regular’ is considered at least every two years).

SECTION 2 Early assessment and diagnosis

2.1 Rapid assessment in the emergency department
a) Initial diagnosis should be reviewed by a clinician experienced in the evaluation of stroke.

b) Emergency department staff should use a validated stroke screening tool to assist in rapid accurate assessment for all people with stroke.

c) Stroke severity should be assessed and recorded on admission by a trained clinician using a validated tool (e.g. NIHSS or SSS).
SECTION 3 Acute medical and surgical management

3.1 Thrombolysis

a) Intravenous rt-PA in acute ischaemic stroke should only be undertaken in patients satisfying specific inclusion and exclusion criteria. A 12

b) Intravenous rt-PA should be given as early as possible in carefully selected patients with acute ischaemic stroke as the effect size of thrombolysis is time-dependent. Where possible, therapy should commence in the first few hours but may be used up to 4.5 hours after stroke onset. A 12, 223

c) Intravenous rt-PA should only be given under the authority of a physician trained and experienced in acute stroke management. B 12

d) Thrombolysis should only be undertaken in a hospital setting with appropriate infrastructure, facilities and network support including:
   • access to a multidisciplinary acute care team with expert knowledge of stroke management who are trained in delivery and monitoring of patients receiving thrombolytic therapy GPP
   • pathways and protocols available to guide medical, nursing and allied health acute phase management, in particular acute blood pressure management C 224, 227 234
   • immediate access to imaging facilities and staff trained to interpret images. GPP

e) A minimum set of de-identified data from all patients treated with thrombolysis should be recorded in a central register to allow monitoring, review, comparison and benchmarking of key outcomes measures over time. C 225

f) The commencement of aspirin for patients who have received thrombolysis should be delayed for 24 hours (usually after a follow-up scan has excluded significant bleeding). GPP

3.2 Antithrombotic therapy

Aspirin orally or via a nasogastric tube or suppository (for those with dysphagia) should be given as soon as possible after the onset of stroke symptoms (i.e. within 48 hours) if CT/MRI scans excludes haemorrhage. The first dose should be at least 150 to 300 mg. Dosage thereafter can be reduced (e.g. 100 mg daily). A 246

3.3 Acute phase blood pressure lowering therapy

a) In ischaemic stroke, if blood pressure is more than 220/120 mmHg, antihypertensive therapy can be started or increased, but blood pressure should be cautiously reduced (e.g. by no more than 10–20%) and the patient monitored for signs of neurological deterioration. GPP

b) Pre-existing antihypertensive therapy can be continued (orally or via nasogastric tube) provided there is no symptomatic hypotension or other reason to withhold treatment. GPP

3.4 Physiological monitoring

Patients should have their neurological status (e.g. Glasgow Coma Scale), vital signs (including pulse, blood pressure, temperature, oxygen saturation and glucose levels) and respiratory pattern monitored and documented regularly during the acute phase, the frequency of such observations being determined by the patient’s status. C 277–80

3.5 Oxygen Therapy

a) Patients who are hypoxic (i.e. <95% oxygen saturation) should be given supplemental oxygen. GPP

b) The routine use of supplemental oxygen is not recommended in acute stroke patients who are not hypoxic. C 282

3.6 Glycaemic control

a) On admission, all patients should have their blood glucose level monitored and appropriate glycaemic therapy instituted to ensure euglycaemia, especially if the patient is diabetic. GPP

b) An early intensive approach to the maintenance of euglycaemia is currently NOT recommended. B 296
### 3.7 Pyrexia
Antipyretic therapy, comprising regular paracetamol and/or physical cooling measures, should be used routinely where fever occurs.  

### 3.8 Seizure management
Anti-convulsant medication should be used for people with recurrent seizures after stroke.

### SECTION 4 Secondary prevention

#### 4.1 Lifestyle modification

a) Every stroke patient should be assessed and informed of their risk factors for a further stroke and possible strategies to modify identified risk factors. The risk factors and interventions include:

- stopping smoking: nicotine replacement therapy, bupropion or nortriptyline therapy, nicotine receptor partial agonist therapy and/or behavioural therapy
- improving diet: a diet low in fat (especially saturated fat) and sodium but high in fruit and vegetables
- increasing regular exercise
- avoiding excessive alcohol (i.e. no more than two standard drinks per day).

b) Interventions should be individualised and delivered using behavioural techniques such as educational or motivational counselling.

#### 4.2 Adherence to pharmacotherapy

Interventions to promote adherence with medication regimes are often complex and should include combinations of the following:

- reminders, self-monitoring, reinforcement, counselling, family therapy, telephone follow-up, supportive care and dose administration aids
- information and education in hospital and in the community.

#### 4.3 Blood pressure lowering

All stroke and TIA patients, whether normotensive or hypertensive, should receive blood pressure lowering therapy, unless contraindicated by symptomatic hypotension.

#### 4.4 Antiplatelet therapy

Long-term antiplatelet therapy should be prescribed to all people with ischaemic stroke or TIA who are not prescribed anticoagulation therapy.

#### 4.5 Anticoagulation therapy

a) Anticoagulation therapy for secondary prevention for people with ischaemic stroke or TIA from presumed arterial origin should not be routinely used.

b) Anticoagulation therapy for long-term secondary prevention should be used in people with ischaemic stroke or TIA who have atrial fibrillation or cardioembolic stroke.

#### 4.6 Cholesterol lowering

a) Therapy with a statin should be used for all patients with ischaemic stroke or TIA.

b) Statins should NOT be used routinely for haemorrhagic stroke.

#### 4.7 Diabetes management

Patients with glucose intolerance or diabetes should be managed in line with national guidelines for diabetes.
SECTION 5 Rehabilitation

5.1 Amount, intensity and timing of rehabilitation

5.1.1 Amount and intensity of rehabilitation

a) Rehabilitation should be structured to provide as much practice as possible within the first six months after stroke. A 470

b) For patients undergoing active rehabilitation, as much physical therapy (physiotherapy and occupational therapy) should be provided as possible with a minimum of one hour active practice per day at least five days a week. GPP

c) Patients should be encouraged by staff members, with the help of their family and/or friends if appropriate, to continue to practice skills they learn in therapy sessions throughout the remainder of the day. GPP

5.1.2 Timing of rehabilitation

 Patients should be mobilised and upper limb training should commence as early and as frequently as possible. B 482

5.2 Sensorimotor impairment

5.2.1 Dysphagia

a) Patients should be screened for swallowing deficits before being given food, drink or oral medications. Personnel specifically trained in swallowing screening using a validated tool should undertake screening. B 494, 495

b) Swallowing should be screened for as soon as possible but at least within 24 hours of admission. GPP

c) The gag reflex is not a valid screen for dysphagia and should not be used as a screening tool. B 496, 497

d) Patients who fail the swallowing screening should be referred to a speech pathologist for a comprehensive assessment. This may include instrumental examination e.g. VMBS and/or FEES. Special consideration should be given to assessing and managing appropriate hydration. These assessments can also be used for monitoring during rehabilitation. GPP

e) Dysphagic patients on modified diets should have their intake and tolerance to diet monitored. The need for continued modified diet should be regularly reviewed. B 479

f) Patients with persistent weight loss and recurrent chest infections should be urgently reviewed. GPP

g) All staff and carers involved in feeding patients should receive appropriate training in feeding and swallowing techniques. GPP

5.2.2 Visual field loss

Stroke survivors who appear to have difficulty with recognising objects or people should be screened using specific assessment tools, and if a visual deficit is found, referred for comprehensive assessment by relevant health professionals. GPP

5.3 Activities of daily living (ADL)

a) Patients with difficulties in performance of daily activities should be assessed by a trained clinician. A 98, 602

b) Staff members and the stroke survivor and their carer/family should be advised regarding techniques and equipment to maximise outcomes relating to performance of daily activities and sensorimotor, perceptual and cognitive capacities. GPP

c) People faced with difficulties in community transport and mobility should set individualised goals and undertake tailored strategies, help to resume driving, aids and equipment, and written information about local transport options/alternatives. B 604
5.4 Communication

5.4.1 Aphasia

a) All patients should be screened for communication deficits using a screening tool that is valid and reliable. C 608

b) All written information on health, aphasia, social and community supports should be available in an aphasia-friendly format. D 615, 616

c) People with chronic and persisting aphasia should have their mood monitored. GPP

d) Environmental barriers facing people with aphasia should be addressed through training communication partners, raising awareness of, and educating about, aphasia in order to reduce negative attitudes, and promoting access and inclusion by providing aphasia-friendly formats or other environmental adaptations. People with aphasia from culturally and linguistically diverse backgrounds may need special attention, for example, from trained healthcare interpreters. GPP

e) The impact of aphasia on functional activities, participation and quality of life, including the impact upon relationships, vocation and leisure, should be assessed and addressed as appropriate from early post-onset and over time for those chronically affected. GPP

SECTION 6 Managing complications

6.1 Nutrition and hydration

a) All stroke patients should have their hydration status assessed, monitored and managed. Appropriate fluid supplementation should be used to treat or prevent dehydration. B 666, 667, 669, 673, 681

b) All patients with stroke should be screened for malnutrition. B 670, 686

c) Patients who are at risk of malnutrition, including those with dysphagia, should be referred to a dietitian for assessment and ongoing management. GPP

d) Screening and assessment of nutritional status should include the use of validated nutritional assessment tools or measures. B 675

e) Nutritional supplementation should be offered to people whose nutritional status is poor or deteriorating. A 682

f) Nasogastric tube feeding is the preferred method during the first month post stroke for people who do not recover a functional swallow. B 687

g) Food intake should be monitored for all people with acute stroke. GPP

6.2 Poor oral hygiene

a) All patients, particularly those with swallowing difficulties, should have assistance and/or education to maintain good oral and dental (including dentures) hygiene. GPP

b) Staff or carers responsible for the care of patients disabled by stroke (in hospital, in residential care and in home care settings) can be trained in assessment and management of oral hygiene. C 691
### 6.3 Subluxation
For people with severe weakness who are at risk of developing a subluxed shoulder, management should include education and training for the patient, family/carer and clinical staff on how to correctly handle and position the affected upper limb. GPP

### 6.4 Shoulder pain
For people with severe weakness who are at risk of developing shoulder pain, management may include interventions to educate staff, carers and people with stroke about preventing trauma. GPP

### 6.5 Fatigue

a) Therapy for stroke survivors with fatigue should be organised for periods of the day when they are most alert. GPP

b) Stroke survivors and their families/carers should be provided with information and education about fatigue; including potential management strategies such as exercise, establishing good sleep patterns and avoidance of sedating drugs and too much alcohol. GPP

### 6.6 Incontinence

#### 6.6.1 Urinary incontinence

a) All stroke survivors with suspected urinary continence difficulties should be assessed by trained personnel using a structured functional assessment. B 780, 781

b) A portable bladder ultrasound scan should be used to assist in diagnosis and management of urinary incontinence. B 780

c) Stroke survivors with confirmed continence difficulties should have a continence management plan formulated, documented, implemented and monitored. C 781

d) The use of indwelling catheters should be avoided as an initial management strategy except in acute urinary retention. GPP

e) A community continence management plan should be developed with the stroke survivor and family/carer prior to discharge and should include information on accessing continence resources and appropriate review in the community. GPP

f) If incontinence persists the stroke survivor should be re-assessed and referred for specialist review. GPP

g) For people with urge incontinence:
   - anticholinergic drugs can be trialled B 783, 784
   - a prompted or scheduled voiding regime program/ bladder retraining should be trialled. GPP
   - if continence is unachievable, containment aids can assist with social continence. GPP
h) For people with urinary retention:
   • The routine use of indwelling catheters is NOT recommended. However if urinary retention is severe, intermittent catheterisation should be used to assist bladder emptying during hospitalisation. If retention continues, intermittent catheterisation is preferable to indwelling catheterisation.
   GPP
   • If using intermittent catheterisation, a closed sterile catheterisation technique should be used in hospital.
   C 791
   • Where management of chronic retention requires catheterisation, consideration should be given to the choice of appropriate route, urethral or suprapubic.
   GPP
   • If a stroke survivor is discharged with either intermittent or indwelling catheterisation they and their family/carer will require education about management, where to access supplies and who to contact in case of problems.
   GPP

i) For people with functional incontinence, a whole-team approach is recommended.
   GPP

6.6.2 Faecal incontinence

a) All stroke survivors with suspected faecal continence difficulties should be assessed by trained personnel using a structured functional assessment.
   B 793

b) For those with constipation or faecal incontinence, a full assessment (including a rectal examination) should be carried out and appropriate management of constipation, faecal overflow or bowel incontinence established and targeted education provided.
   B 793

c) Bowel habit retraining using type and timing of diet and exploiting the gastro-colic reflex should be used for people who have bowel dysfunction.
   C 794

d) If continence is unachievable, containment aids can assist with social continence.
   GPP

e) Education and careful discharge planning and preparation is required for any patient discharged with bowel incontinence.
   GPP

6.7 Mood disturbance

All patients should be screened for depression using a validated tool.
   GPP

6.8 DVT/PE

a) Early mobilisation and adequate hydration should be encouraged in all acute stroke patients to help prevent DVT and PE.
   GPP

b) Antithrombotic therapy is NOT recommended for the prevention of DVT/PE in haemorrhagic stroke patients.
   GPP

c) Thigh-length antithrombotic stockings are NOT recommended for the prevention of DVT/PE post stroke.
   B 831

6.9 Pressure care

a) All stroke survivors at risk (e.g. stroke severity, reduced mobility, diabetes, incontinence and nutritional status) should have a pressure injury risk assessment and regular evaluation completed by trained personnel.
   GPP

b) All stroke survivors assessed as high risk should be provided with appropriate pressure-relieving aids and strategies, including a pressure-relieving mattress as an alternative to a standard hospital mattress.
   B 852
6.10 Falls

a) Falls risk assessment should be undertaken using a valid tool on admission to hospital. A management plan should be initiated for all those identified as at risk of falls.  GPP

b) Multifactorial interventions in the community, including an individually prescribed exercise program, should be provided for people who are at risk of falling.  B 61

SECTION 7 Community participation and long-term recovery

7.1 Self-management

a) Stroke survivors who are cognitively able should be made aware of the availability of generic self-management programs before discharge from hospital and be supported to access such programs once they have returned to the community.  C 863, 867

b) Stroke-specific programs for self-management should be provided for those who require more specialised programs.  GPP

c) A collaboratively developed self-management care plan can be used to harness and optimise self-management skills.  GPP

7.2 Driving

a) All patients admitted to hospital should be asked if they intend to drive again.  GPP

b) Any patient who does wish to drive should be given information about driving after stroke and be assessed for fitness to return to driving using the national guidelines (Assessing Fitness To Drive) and relevant state guidelines. Patients should be informed that they are required to report their condition to the relevant driver licence authority and notify their car insurance company before returning to driving.  GPP

c) Stroke survivors should not return to driving for at least one month post event. A follow-up assessment (normally undertaken by a GP or specialist) should be conducted prior to driving to assess suitability. Patients with TIA should be instructed not to drive for two weeks.  GPP

d) If a person is deemed medically fit but is required to undertake further testing, they should be referred for an occupational therapy driving assessment. Relevant health professionals should discuss the results of the test and provide a written record of the decision to the patient as well as informing the GP.  GPP

7.3 Leisure

Targeted occupational therapy programs can be used to increase participation in leisure activities.  A 603

7.4 Return to work

Stroke survivors who wish to work should be offered assessment (i.e. to establish their cognitive, language and physical abilities relative to their work demands), assistance to resume or take up work, or referral to a supported employment service.  GPP

7.5 Sexuality

a) Stroke survivors and their partners should be offered:
   • the opportunity to discuss issues relating to sexuality with an appropriate health professional  GPP
   • written information addressing issues relating to sexuality post-stroke.  GPP

b) Any interventions should address psychosocial aspects as well as physical function.  GPP
7.6 Support

7.6.1 Peer support

Stroke survivors and family/carers should be given information about the availability and potential benefits of a local stroke support group and/or other sources of peer support before leaving hospital and when back in the community.

GPP

7.6.2 Carer support

Carers should be provided with tailored information and support during all stages of the recovery process. This includes (but is not limited to) information provision and opportunities to talk with relevant health professionals about the stroke, stroke team members and their roles, test or assessment results, intervention plans, discharge planning, community services and appropriate contact details.

C 125,903

Where it is the wish of the stroke patient (and their family/carer), carers should be actively involved in the recovery process by assisting with goal setting, therapy sessions, discharge planning and long-term activities.

GPP

Carers should be provided with information about the availability and potential benefits of local stroke support groups and services, at or before the person’s return to the community.

C 903-905, 907

Carers should be offered support services after the person’s return to the community. Such services can use a problem-solving or educational-counselling approach.

C 126, 904, 906

Assistance should be provided for families/carers to manage stroke survivors who have behavioural problems.

GPP

The following expert working group members are acknowledged for their assistance in developing this summary – Ms Louise-Ann Jordan, Prof Sandy Middleton, Prof Lin Perry and Ms Trish Spreadborough.

About the National Stroke Foundation

The National Stroke Foundation is a not-for-profit organisation that works with the public, government, health professionals, patients, carers, families and stroke survivors to reduce the impact of stroke on the Australian community.

Our challenge is to save 110 000 Australians from death and disability due to stroke over 10 years.

We will achieve this by:

• educating the public about the risk factors and signs of stroke and promoting healthy lifestyles
• working with all stakeholders to develop and implement policy on the prevention and management of stroke
• encouraging the development of comprehensive and coordinated services for all stroke survivors and their families
• encouraging and facilitating stroke research.

StrokeLine

The National Stroke Foundation’s 1800 787 653 StrokeLine provides information about stroke prevention, recovery and support. Our qualified health professionals offer comprehensive information and help.

The toll free service is open business hours EST across Australia, a message service is available outside these hours.

References are available from: www.strokefoundation.com.au. This document is a general guide to appropriate practice, to be followed subject to the clinician’s judgement and the patient’s preference in each individual case. The guidelines are designed to provide information to assist decision-making and are based on the best evidence available at the time of development. Copies of the document can be downloaded through the National Stroke Foundation website: www.strokefoundation.com.au.