Australian Commission on **Safety and Quality** in Health Care | **Clinical Care Standards**

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Consultation on the draft revised *Stroke Clinical Care Standard* Targeted consultation template

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Consultation feedback is requested by 5pm AEDT Tuesday 28 October 2025

Are the revised quality statements and supporting information for patients, clinicians and healthcare services appropriate?

Please specify any suggestions and/or concerns including the quality statement and line number if possible.

Stroke Foundation welcomes the expanded focus of the document with greater emphasis on early rehabilitation and follow-up. We also welcome the changes to include intracerebral haemorrhage (ICH), and the focus on telehealth and stroke unit care. We also obviously support close collaboration with and reference to the *Living Clinical Guidelines for Stroke Management* (the Living Guidelines) throughout.

- We do however note that all statements (possibly with the exception of the new Follow-up assessment and review standard) relate to recommendations outlined in the Living Guidelines, but only the Time-critical therapy standard specifically mentions the Guidelines (line 72/73). We recommend a clearly stated overarching principle that all statements align to the Living Guidelines (noting this is mentioned on p11, line 234/235, already, but could be strengthened).
- For Statement 1 – Early assessment and transport to hospital, consider adding 'pre-notification' in line 69 as an essential element for good pre-hospital care, as outlined by the second recommendation in the pre-hospital section (Ambulance services should pre-notify the hospital of a suspected stroke case where the patient may be eligible for reperfusion therapies. (Chowdhury et al. 2021) E.g. "When acute stroke is suspected the service will immediately transport the patient to a stroke-capable hospital, supported by telestroke consultation as required, and pre-notify the hospital prior to arrival if the suspected stroke case may be eligible for reperfusion therapies".
- We approve the wording of the other proposed statements.
- We strongly recommend the addition of stroke coordinator to the list of members of the specialist stroke team for Statement 3 – Stroke unit care (line 674-676). This role is fundamental to coordinating care, is listed as a recommendation for stroke unit certification and is in the Acute Stroke Services Framework. We also strongly recommend strengthening the wording around stroke unit certification and suggest modifying line 723-725 as follows: "Services that participate in formal stroke unit certification programs have been found to perform better on all acute processes of care. (reference Nationally Certified Stroke Centers Outperform Self-Attested Stroke Centers in the Florida Stroke Registry | Stroke) The Australian Stroke Coalition has a voluntary system for stroke unit certification in Australian hospitals, which healthcare services are strongly encouraged ~~can choose~~ to participate in."
- While we recognise the text (p36) related to Statement 7 is essentially the same, we feel that the way patients and clinicians work together should be reflected using the terminology 'co-designed' or 'jointly designed'. Line 1019 could be changed to "…and jointly develop an ongoing care plan with you to guide your care after you leave hospital." The language still implies that the hospital team will do for/to the patient, rather than a much more active co-design process which is recommended. Similarly, line 1032 could be changed to "While patients are in hospital, jointly develop a written individualised care …." Line 1047 needs to specifically mention the care plan is for the patient to take home with them. Ie. "Communicate the care plan to patients, their families and support people, ensure they adequately understand the information provided, and ensure they take their copy of the care plan. Also provide a copy to their GP …."
- We suggest changing Line 1055 to "…before they leave the hospital, in collaboration ~~discussion~~ with the patient…" (discussion doesn't adequately portray the need for two-way input). A final

comment after line 1072 needs to state, 'A copy of the care plan should be provided to the patient and family to take with them.'

- We support the proposed new Statement 8 – Follow-up assessment and review, noting it will be important to ensure systems are in place to facilitate a multidisciplinary approach. It is critical that follow-up is undertaken by more than one health professional (i.e. not just a doctor or a nurse). In many centres, following up of all patients is not current practice and will be a challenge to implement, despite its importance.

Will the revised indicators be useful to support local clinical quality improvement activities? Please explain any changes you suggest to the proposed indicators.

While we understand the need for flexibility, we strongly question the third dot point on p13 (line 258-259), where 'other measures' could be used instead of proposed indicators. While unlikely, there has been two decades of effort from the stroke community to build agreed indicators and definitions, to ensure comparability between data collection. We feel this point could cause confusion if it was taken out of context. At a minimum, we propose deleting the words ".., or instead of, …" on line 259. We need to ensure all services see it as their responsibility to adhere to these nationally agreed statements.

- We agree with indicators for Quality Statements 1, 2, 3, 5, 7 and 8.
- For indicator 4d, we approve in principle, but this may need to be tested as it is a new indicator. There may be times where the patient is discharged within 3-5 days – would their rehabilitation needs have changed within a few days? Is there a recommended timeframe that needs to pass before reassessment is recommended e.g. 3 days? What definition is accepted for the term 'multidisciplinary team'? What if just doctor and physio assessed them (which wouldn't be classed as MDT)? Would it need to be a minimum number of team members or all team members?
- Also, assessment is just the first step, but does not determine if any referral is provided. Would it be more appropriate to have the indicator "Proportion of patients with a stroke who were referred for ongoing rehabilitation prior to discharge to the community" with inclusion/exclusion criteria specifying where this is appropriate?
- For indicator 6a, this indicator is different to all others in the Standard, in that it assesses an organisational level process, whereas all the other indicators are patient level processes (which is what 6b covers). We question the value of this indicator, and the feasibility of collecting it and using the data to meaningfully drive quality improvement. We recommend the information on line 998-1002 be included in indicator 6b, and the Commission and Steering Group consider removing indicator 6a.
- For indicator 6b, we note this has two components (information and practical training). The definitions will need to work through ensuring both are met, or give guidance as to exclusions for denominators, e.g. what if the carer wasn't deemed to need training? (recent previous admission where this was provided, no problems with daily needs etc).

Are the cultural safety and equity considerations appropriate? Please provide suggestions.

Stroke Foundation strongly supports greater information on cultural safety and equity and approves of the additional information throughout; however, we suggest further comment on broader equity considerations should be noted, even if briefly (e.g. other vulnerable populations, non-English speaking people, rural and remote people, possible gender imbalance in care, older aged people etc.).

Are the recommended resources useful? Are there additional or alternative resources you would recommend supporting implementation of the quality statements?
For example, any related initiatives the Commission should be aware.

- We are grateful the Commission has included resources that Stroke Foundation provides throughout, but particularly on p34. We also have a dedicated website for young survivors of stroke which could be added: Home - Young Stroke
- Regarding the references to My Stroke Journey on p37/38, as highlighted on p37 this resource is useful, but does not replace a care plan resource itself. We suggest that p38, line 1079 -1084, be modified slightly to "The Stroke Foundation resource *My Stroke Journey* addresses ~~covers all~~ the ~~essential~~ elements of a care plan and includes pages for clinicians and patients to complete together. *My Stroke Journey* is intended to be provided by hospital clinicians and discussed with patients, and their families/support people, in the first few days after their stroke, and to stay with patients in their transition from hospital to home. This resource is used by clinicians to deliver stroke education, explain treatment and care, secondary prevention education, and help plan for discharge home.

Please provide any further comments

Further emphasis on jointly developed (with the clinical team and survivor of stroke and their family) rehabilitation goals should be included (p29 and p37/38). There is currently little or no mention, or guidance, about patient-centered goal-setting to set meaningful goals in stroke rehabilitation (e.g. reference to Principles for goal setting | Australian Government Department of Health, Disability and Ageing).

Other suggestions:

- Line 208, please use capitals for 'Nurse Practitioners', as this is a legally protected title.
- Line 241 (Table 2), the definition of patient seems confusing. As it currently reads "When the word 'patient' is used in this standard, it may include the person's carer, family member, support person, or substitute decision maker" - are they not covered by 'support people' below? Suggest reviewing this definition.
- Line 483, add "can they lift both arms equally?" (we are reviewing this information and below ourselves).
- Line 484, add "is their speech slurred? Do they understand you? Can they speak?
- Line 495, add "Tools in most cases should screen for stroke severity indicating a possible large vessel occlusion (LVO), with local protocols to guide which hospital to transport the patient to for possible surgery."
- Line 518, add "..time critical therapies (see Box 1). Ambulances may have agreed bypass protocols to comprehensive stroke services in the case of suspected patient with LVO."
- Line 567-569, we recognise there has been debate about consent with reperfusion, but this wording is inconsistent throughout. All treatments really require discussion and informed consent, and we think it is not helpful to overly state the point here, We suggest, "Your healthcare team will discuss the options with you and your family or support people. ~~and seek consent whenever possible, bearing in mind that these treatments are an emergency therapy and may be required without delay.~~ The treatment you receive will be based on your type of stroke, clinical condition and history and your wishes, and will be based on national evidence-based recommendations."
- Line 584, consider changing 'will' to 'may'.
- Line 589, consider adding text "time-critical therapy. If reperfusion is considered, multimodal imaging (CTA/CTP) should be used when possible, to identity candidates for endovascular thrombectomy or surgical treatments. Take into consideration…"
- Line 710, suggest removing "managed immediately ~~as recommended and~~ within one hour." Some hospital protocols have different 'recommended' thresholds or timeframes.
- Line 796, 'Nurse Practitioner' should be in capitals.
- Line 883, consider adding "with stroke, and their family/support people, are educated…"

References

Chowdhury SZ, Baskar PS, Bhaskar S. 2021. Effect of prehospital workflow optimization on treatment delays and clinical outcomes in acute ischemic stroke: A systematic review and meta-analysis. Acad Emerg Med. 28(7):781–801.