

Clinical Guidelines for Stroke Management 2017

Summary – Speech Pathology

This summary is a quick reference to the recommendations in the *Clinical Guidelines for Stroke Management 2017* most relevant to speech pathology.

Speech pathologists study, diagnose and treat communication disorders, including difficulties with speaking, listening, understanding language, reading, writing, social skills, fluency and using voice. They work with people who have difficulty communicating because of stroke. Speech pathologists also work with people who experience difficulties swallowing food and drink safely.

While this summary focuses on these aspects of care, stroke care is the most effective when all members of an interdisciplinary team are involved. For the comprehensive set of recommendations that covers the whole continuum of stroke care, please refer to further information on InformMe <https://informme.org.au/en/Guidelines/Clinical-Guidelines-for-Stroke-Management-2017>.

The *Clinical Guidelines for Stroke Management 2017* is an update of the previous clinical guidelines published in 2010 and is based on the best evidence available. The new Clinical Guidelines use an internationally recognised guideline development approach called GRADE (Grading of Recommendations Assessment, Development and Evaluation) and an innovative guideline development and publishing platform known as MAGICapp (Making Grade the Irresistible Choice). GRADE ensures a systematic process in developing recommendations, which are based on the balance of benefits and harms, quality of evidence, patient values, and resource considerations. MAGICapp enables transparent display of this process and access to additional practical information for recommendation implementation.

Recommendations

Each recommendation is given a strength based on GRADE. GRADE methodology includes four factors to guide the development of a recommendation and determine the strength of that recommendation:

- The balance between desirable and undesirable consequences
- Confidence in the estimates of effect (quality of evidence)
- Confidence in values and preferences and their variability (clinical and consumer preferences)
- Resource use (cost and implementation considerations).

The GRADE process uses only two categories for the strength of recommendations, based on how confident the guideline developers are in that the “desirable effects of an intervention outweigh undesirable effects [...] across the range of patients for whom the recommendation is intended” (GRADE Handbook):

- **Strong recommendations:** where guideline developers are certain that the evidence supports a clear balance towards either desirable or undesirable effects; or
- **Weak recommendations:** where guideline developers are not as certain about the balance between desirable and undesirable effects as the evidence base isn't as robust.

These strong or weak recommendations can either be for or against an intervention. If the recommendation is AGAINST an intervention this means it is recommended NOT to do that intervention.

Consensus-based recommendations: statements have been developed based on consensus and expert opinion (guided by any underlying or indirect evidence) for topics where there is either a lack of evidence or insufficient quality of evidence on which to base a recommendation but it was felt that advice should be made.

Practice points: for questions outside the search strategy (i.e. where no systematic literature search was conducted), additional considerations are provided.

Key points

- A speech pathologist is an important member of the interdisciplinary stroke care team. Speech pathologists work with someone after a stroke to improve their communication abilities and/or swallow.
- Recent evidence has resulted in several changes in the 2017 recommendations, for example, all stroke survivors should be screened for communication deficits using a screening tool that is valid and reliable, and those stroke survivors with suspected communication difficulties should receive formal, comprehensive assessment by a specialist clinician to determine the nature and type of the communication impairment.
- Impairments (such as sensorimotor and cognition) and activities (such as physical activity and activities of daily living) should be assessed and rehabilitation commenced promptly (within 24-48 hours of admission), using interventions proven effective for the patient's conditions. Any stroke patient with identified rehabilitation needs should be referred to a rehabilitation service.
- Management of secondary complications resulting from primary impairments should commence in the acute phase, as well as being considered during sub-acute and long-term care. This includes prevention, early detection, and reduction strategies.
- Stroke survivors and their carers should be offered information, education, support and training throughout all phases of post-stroke recovery in order to enable safe discharge and successful reintegration into the community.

Recommendations are presented for the 2010 and 2017 versions to note changes easily, and are also presented in Chapter order for easier reference to the relevant section of the full Clinical Guidelines.

2010 Clinical Guidelines	2017 Clinical Guidelines
Chapter 4: Acute medical and surgical management	Chapter 3 of 8: Acute medical and surgical management
	Stroke unit care
	<p>Strong recommendation New</p> <p>All acute stroke services should implement standardised protocols to manage fever, glucose and swallowing difficulties in stroke patients.</p>
	Assessment for rehabilitation
	<p>Info Box Practice points New</p> <ul style="list-style-type: none"> • Every stroke patient should have their rehabilitation needs assessed within 24–48 hours of admission to the stroke unit by members of the interdisciplinary team, using the Assessment for Rehabilitation Tool. • Any stroke patient with identified rehabilitation needs should be referred to a rehabilitation service. • Rehabilitation service providers should document whether a stroke patient has rehabilitation needs and whether appropriate rehabilitation services are available to meet these needs.
Dysphagia	Dysphagia
Patients should be screened for swallowing deficits before being given food, drink or oral medications.	<p>Practice statement Consensus-based recommendation New</p> <p>People with acute stroke should have their swallowing screened within four hours of arrival at hospital and before being given any oral food, fluid or medication.</p>
Swallowing should be screened for as soon as possible but at least within 24 hours of admission.	

<p>Personnel specifically trained in swallowing screening using a validated tool should undertake screening.</p>	<p>Weak recommendation Updated People with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional.</p>
<p>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 &/or FEES. Special consideration should be given to assessing and managing appropriate hydration. These assessments can also be used for monitoring during rehabilitation.</p>	<p>Weak recommendation Updated All stroke patients who have failed swallow screening or who deteriorate should have a comprehensive assessment of swallowing performed by a speech pathologist.</p>
<p>Compensatory strategies such as positioning, therapeutic manoeuvres or modification of food and fluids to facilitate safe swallowing should be provided for people with dysphagia based on specific impairments identified during comprehensive swallow assessment.</p>	<p>Strong recommendation Updated For stroke survivors with swallowing difficulties, behavioural approaches such as swallowing exercises, environmental modifications, safe swallowing advice, and appropriate dietary modifications should be used early.</p>
	<p>Weak recommendation AGAINST New For stroke survivors with dysphagia, non-invasive brain stimulation should only be provided within a research framework.</p>
	<p>Weak recommendation AGAINST New For patients with stroke, acupuncture should not be used for treatment of dysphagia in routine practice other than as part of a research study.</p>
<p>One or more of the following methods can be provided to facilitate resolution of dysphagia:</p> <ul style="list-style-type: none"> • therapy targeting specific muscle groups (e.g. ‘Shaker’ therapy) • thermo-tactile stimulation 	<p>Weak recommendation AGAINST Updated For stroke survivors with dysphagia, surface neuromuscular electrical stimulation should only be delivered by clinicians experienced in this</p>

<ul style="list-style-type: none"> • electrical stimulation if it is delivered by clinicians experienced with this intervention, applied according to published parameters and employing a research or quality framework. 	<p>intervention, and be applied according to published parameters in a research framework.</p>
	<p>Weak recommendation AGAINST New For stroke survivors with dysphagia, pharyngeal electrical stimulation is not routinely recommended.</p>
<p>Dysphagic patients on modified diets should have their intake and tolerance to diet monitored. The need for continued modified diet should be regularly reviewed.</p>	<p>Practice statement Consensus-based recommendations Updated</p> <ul style="list-style-type: none"> • Until a safe swallowing method is established for oral intake, patients with dysphagia should have their nutrition and hydration assessed and managed with early consideration of alternative non-oral routes. • Patients with dysphagia on texture-modified diets and/or fluids should have their intake and tolerance to the modified diet monitored regularly due to the increased risk of malnutrition and dehydration. • Patients with dysphagia should be offered regular therapy that includes skill and strength training in direct therapy (with food/fluids) and indirect motor therapy which capitalises on the principles of neural plasticity to improve swallowing skills. • Patients with persistent weight loss, dehydration and/or recurrent chest infections should be urgently reviewed. • All staff and carers involved in feeding patients should receive appropriate training in feeding and swallowing techniques. • All staff should be appropriately trained in the maintenance of oral hygiene, including daily brushing of teeth and/or dentures and care of gums.
<p>Patients with persistent weight loss and recurrent chest infections should be urgently reviewed.</p>	
<p>All staff and carers involved in feeding patients should receive appropriate training in feeding and swallowing techniques.</p>	
<p>The gag reflex is not a valid screen for dysphagia and should NOT be used as a screening tool.</p>	<p>-</p>

Chapter 6: Rehabilitation	Chapter 5 of 8: Rehabilitation
	Early supported discharge services
	<p>Strong recommendation Updated</p> <p>Where appropriate stroke services are available, early supported discharge services should be offered to stroke patients with mild to moderate disability.</p>
	Home-based rehabilitation
	<p>Weak recommendation Updated</p> <p>Home-based rehabilitation may be considered as a preferred model for delivering rehabilitation in the community. Where home rehabilitation is unavailable, stroke patients requiring rehabilitation should receive centre-based care.</p>
	Goal setting
	<p>Strong recommendation Updated</p> <ul style="list-style-type: none"> • Health professionals should initiate the process of setting goals, and involve stroke survivors and their families and carers throughout the process. Goals for recovery should be client-centred, clearly communicated and documented so that both the stroke survivor (and their families/carers) and other members of the rehabilitation team are aware of goals set. • Goals should be set in collaboration with the stroke survivor and their family/carer (unless they choose not to participate) and should be well-defined, specific and challenging. They should be reviewed and updated regularly.

	Communication
	Assessment of communication deficits
All patients should be screened for communication deficits using a screening tool that is valid and reliable.	Info Box Practice points New <ul style="list-style-type: none"> • All stroke survivors should be screened for communication deficits using a screening tool that is valid and reliable. • Those stroke survivors with suspected communication difficulties should receive formal, comprehensive assessment by a specialist clinician to determine the nature and type of the communication impairment.
Those patients with suspected communication difficulties should receive formal, comprehensive assessment by a specialist clinician.	
Aphasia	Aphasia
Treatment for aphasia should be offered as early as tolerated.	Info Box Practice point New Treatment for aphasia should be offered as early as tolerated.
	Strong recommendation Updated For stroke survivors with aphasia, speech and language therapy should be provided to improve functional communication.
For patients undergoing active rehabilitation, as much therapy for dysphagia or communication difficulties should be provided as they can tolerate.	Weak recommendation Updated For stroke survivors with aphasia, intensive aphasia therapy (at least 45 minutes of direct language therapy for five days a week) may be used in the first few months after stroke.
	Weak recommendation AGAINST New Brain stimulation (transcranial direct current stimulation or repetitive transcranial magnetic stimulation), with or without traditional aphasia therapy, should not be used in routine practice for improving speech and language function and only used as part of a research framework.

<p>Where a patient is found to have aphasia, the clinician should:</p> <ul style="list-style-type: none"> • document the provisional diagnosis • explain and discuss the nature of the impairment with the patient, family/carers and treating team, and discuss and teach strategies or techniques which may enhance communication • in collaboration with the patient and family/carer, identify goals for therapy and develop and initiate a tailored intervention plan. The goals and plans should be reassessed at appropriate intervals over time. 	<p>Info Box Practice points New</p> <p>Where a stroke patient is found to have aphasia, the clinician should:</p> <ul style="list-style-type: none"> • Document the provisional diagnosis. • Explain and discuss the nature of the impairment with the patient, family/carers and treating team, and discuss and teach strategies or techniques which may enhance communication. • Identify goals for therapy, and develop and initiate a tailored intervention plan, in collaboration with the patient and family/carer. • Reassess the goals and plans at appropriate intervals over time. • Use alternative means of communication (such as gesture, drawing, writing, use of augmentative and alternative communication devices) as appropriate. <p>All written information on health, aphasia, social and community supports (such as that available from the Australian Aphasia Association or local agencies) should be available in an aphasia-friendly format.</p>
<p>Alternative means of communication (such as gesture, drawing, writing, use of augmentative and alternative communication devices) should be used as appropriate.</p>	
<p>All written information on health, aphasia, social and community supports (such as that available from the Australian Aphasia Association or local agencies) should be available in an aphasia-friendly format.</p>	
<p>People with chronic and persisting aphasia should have their mood monitored.</p>	<p>Info Box Practice points New</p> <ul style="list-style-type: none"> • Stroke survivors with chronic and persisting aphasia should have their mood monitored. • Environmental barriers facing people with aphasia should be addressed through training communication partners, raising awareness of and educating about aphasia 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 from trained healthcare interpreters.
<p>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.</p>	

<p>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.</p>	<ul style="list-style-type: none"> • 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.
<p>Interventions should be individually tailored but can include:</p> <ul style="list-style-type: none"> • treatment of aspects of language (including phonological and semantic deficits, sentence level processing, reading and writing) following models derived from cognitive neuropsychology • constraint-induced language therapy • the use of gesture • supported conversation techniques • delivery of therapy programs via computer. 	<p>-</p>
<p>The routine use of piracetam is NOT recommended.</p>	<p>-</p>
<p>Group therapy and conversation groups can be used for people with aphasia and should be available in the longer term for those with chronic and persisting aphasia.</p>	<p>-</p>
<p>Dysarthria</p>	<p>Dysarthria</p>
<p>Interventions for the treatment of dysarthria can include:</p> <ul style="list-style-type: none"> • biofeedback or a voice amplifier to change intensity and increase loudness • intensive therapy aiming to increase loudness (e.g. Lee Silverman Voice Treatment) • the use of strategies such as decreased rate, over-articulation or gesture • oral musculature exercises. 	<p>Weak recommendation Updated</p> <p>For stroke survivors with dysarthria, individually tailored interventions provided by a speech and language pathologist or a trained communication partner may be provided.</p>

	<p>Weak recommendation AGAINST Updated</p> <p>For stroke survivors with dysarthria, non-speech oromotor exercises have not been shown to provide additional benefit to behavioural speech practice and are not recommended.</p>
Patients with unclear or unintelligible speech should be assessed to determine the nature and cause of the speech impairment.	-
People with severe dysarthria can benefit from using augmentative and alternative communication devices in everyday activities.	-
Dyspraxia of speech	Apraxia of speech
<p>Interventions for speech motor skills should be individually tailored and can target articulatory placement and transitioning, speech rate and rhythm, increasing length and complexity of words and sentences, and prosody including lexical, phrasal, and contrastive stress production.</p> <p>In addition, therapy can incorporate:</p> <ul style="list-style-type: none"> • integral stimulation approach with modelling, visual cueing, and articulatory placement cueing • principles of motor learning to structure practice sessions (e.g. order in which motor skills are practised during a session, degree of variation and complexity of behaviours practised, intensity of practice sessions) and delivery of feedback on performance and accuracy • PROMPT therapy. 	<p>Weak recommendation Updated</p> <p>For stroke survivors with apraxia of speech, individually tailored interventions incorporating articulatory-kinematic and rate/rhythm approaches may be used.</p> <p>In addition, therapy may incorporate:</p> <ul style="list-style-type: none"> • Use of modelling and visual cueing. • Principles of motor learning to structure practice sessions. • Prompts for Restructuring Oral Muscular Phonetic Targets (PROMPT) therapy. • Self-administered computer programs that use multimodal sensory stimulation. • For functional activities, the use of augmentative and alternative communication modalities such as gesture or speech-generating devices is recommended.
The use of augmentative and alternative communication modalities such as gesture or speech-generating devices is recommended for functional activities.	

Patients with suspected dyspraxia of speech should receive comprehensive assessment.	-
Cognitive communication deficits	Cognitive communication disorder in right hemisphere stroke
Stroke patients with cognitive involvement who have difficulties in communication should have a comprehensive assessment, a management plan developed and family education, support and counselling as required.	<p>Practice statement <u>Consensus-based recommendations</u></p> <p>Stroke survivors with cognitive involvement who have difficulties in communication should have input from a suitably trained health professional including:</p> <ul style="list-style-type: none"> • a comprehensive assessment, • development of a management plan, and • family education, support and counselling as required. <p>Management may include:</p> <ul style="list-style-type: none"> • Motoric-imitative, cognitive-linguistic treatments to improve use of emotional tone in speech production. • Semantic-based treatment connecting literal and metaphorical senses to improve comprehension of conversational and metaphoric concept.
Cognition	Cognition and perception
Assessment of cognition	Assessment of cognition
All patients should be screened for cognitive and perceptual deficits using validated and reliable screening tools.	<p>Info Box <u>Practice points</u></p> <ul style="list-style-type: none"> • All stroke survivors should be screened for cognitive and perceptual deficits by a trained person (e.g. neuropsychologist, occupational therapist or speech pathologist) using validated and reliable screening tools, ideally prior to discharge from hospital. • Stroke survivors identified during screening as having cognitive deficits should be referred for comprehensive clinical neuropsychological investigations.
Patients identified during screening as having cognitive deficits should be referred for comprehensive clinical neuropsychological investigations.	

<h3>Executive functions</h3>	<h3>Executive function</h3>
<p>Patients considered to have problems associated with executive functioning deficits should be formally assessed using reliable and valid tools that include measures of behavioural symptoms.</p>	<p>Info Box Practice points</p> <ul style="list-style-type: none"> • Stroke survivors considered to have problems associated with executive functioning deficits should be formally assessed by a suitably qualified and trained person, using reliable and valid tools that include measures of behavioural symptoms. • For stroke survivors with impaired executive functioning, the way in which information is provided should be tailored to accommodate/compensate for the particular area of dysfunction.
<p>In stroke survivors with impaired executive functioning, the way in which information is provided should be considered.</p>	
<p>External cues, such as a pager, can be used to initiate everyday activities in stroke survivors with impaired executive functioning.</p>	<p>Weak recommendation Updated</p> <p>For stroke survivors with cognitive impairment, meta-cognitive strategy and/or cognitive training may be provided.</p>
<h3>Chapter 7: Managing complications</h3>	<h3>Chapter 6 of 8: Managing complications</h3>
	<h3>Nutrition and hydration - Early feeding</h3>
<p>Nasogastric tube feeding is the preferred method during the first month post-stroke for people who do not recover a functional swallow.</p>	<p>Weak recommendation Updated</p> <ul style="list-style-type: none"> • For stroke patients who do not recover a functional swallow, nasogastric tube feeding is the preferred method of feeding in the short term. • For stroke patients, there is no preference with regard to continuous pump (meaning using a pump for greater than or equal to 16hrs out of 24hrs for less than or equal to 80ml/hr) feeding versus intermittent bolus feeding (meaning 250-400mls/hr for 4-5times/day) therefore practical issues, cost and patient preferences should guide practice.

Poor oral hygiene	Oral hygiene
All patients, particularly those with swallowing difficulties, should have assistance and/or education to maintain good oral and dental (including dentures) hygiene.	<p>Strong recommendation</p> <p>All stroke patients, particularly those with swallowing difficulties, should have assistance and/or education to maintain good oral and dental (including dentures) hygiene.</p>
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.	<p>Strong recommendation</p> <p>Staff and carers of stroke patients (in hospital, in residential care and home settings) should be trained in assessment and management of oral hygiene.</p>
	<p>Weak recommendation New</p> <p>For stroke patients, chlorhexidine in combination with oral hygiene instruction, and/or assisted brushing may be used to decrease dental plaque and gingiva bleeding. Caution should be taken, however, for patients with dysphagia.</p>
Fatigue	Fatigue
Therapy for stroke survivors with fatigue should be organised for periods of the day when they are most alert.	<p>Practice statement Consensus-based recommendations Updated</p> <ul style="list-style-type: none"> • Therapy for stroke survivors with fatigue should be organised for periods of the day when they are most alert. • Stroke survivors and their families/carers should be provided with information and education about fatigue. • Potential modifying factors for fatigue should be considered including avoiding sedating drugs and alcohol, screening for sleep-related breathing disorders and depression. • While there is insufficient evidence to guide practice, possible interventions could include exercise and improving sleep hygiene.
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 excessive alcohol.	

	Chapter 7 of 8: Discharge planning and transfer of care
	Information and education
	<p>Strong recommendation New</p> <ul style="list-style-type: none"> • All stroke survivors and their families/carers should be offered information tailored to meet their individual needs using relevant language and communication formats. • Information should be provided at different stages in the recovery process. • An approach of active engagement with stroke survivors and their families/carers should be used allowing for the provision of material, opportunities for follow-up, clarification, and reinforcement.
	Discharge care plans
	<p>Strong recommendation New</p> <p>Comprehensive discharge care plans that address the specific needs of the stroke survivor should be developed in conjunction with the stroke survivor and carer prior to discharge.</p>
	<p>Info Box Practice point New</p> <p>Discharge planning should commence as soon as possible after the stroke patient has been admitted to hospital.</p>
	<p>Practice statement Consensus-based recommendations</p> <p>To ensure a safe discharge process occurs, hospital services should ensure the following steps are completed prior to discharge:</p>

	<ul style="list-style-type: none"> • Stroke survivors and families/carers have the opportunity to identify and discuss their post-discharge needs (physical, emotional, social, recreational, financial and community support) with relevant members of the multidisciplinary team. • General practitioners, primary healthcare teams and community services are informed before or at the time of discharge. • All medications, equipment and support services necessary for a safe discharge are organised. • Any necessary continuing specialist treatment required has been organised. • A documented post-discharge care plan is developed in collaboration with the stroke survivor and family and a copy provided to them. This discharge planning process may involve relevant community services, self-management strategies (i.e. 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 post-discharge queries. • A locally developed protocol or standardised tool may assist in implementation of a safe and comprehensive discharge process.
	<p>Patient and carer needs</p>
	<p>Practice statement <u>Consensus-based recommendation</u> Hospital services should ensure that stroke survivors and their families/carers have the opportunity to identify and discuss their post-discharge needs (including physical, emotional, social, recreational, financial and community support) with relevant members of the interdisciplinary team.</p>

	<p>Carer training</p> <p>Weak recommendation</p> <p>Relevant members of the interdisciplinary team should provide specific and tailored training for carers/family before the stroke survivor is discharged home. This training should include, as necessary, personal care techniques, communication strategies, physical handling techniques, information about ongoing prevention and other specific stroke-related problems, safe swallowing and appropriate dietary modifications, and management of behaviours and psychosocial issues.</p>
<p>Chapter 8: Community participation and long-term recovery</p>	<p>Chapter 8 of 8: Community participation and long-term care</p>
<p>Self-management</p> <p>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.</p> <p>Stroke-specific programs for self-management should be provided for those who require more specialised programs.</p> <p>A collaboratively developed self-management care plan can be used to harness and optimise self-management skills.</p>	<p>Self-management</p> <p>Weak recommendation New</p> <ul style="list-style-type: none"> • Stroke survivors who are cognitively able and their carers 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. • Stroke-specific self-management programs may be provided for those who require more specialised programs. • A collaboratively developed self-management care plan may be used to harness and optimise self-management skills.

Any interventions should address psychosocial aspects as well as physical function.	
Support	Support
Peer support	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.	Weak recommendation Stroke survivors and their families/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.
Carer support	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.	Strong recommendation Carers of stroke survivors should be provided with tailored information and support during all stages of the recovery process. This support 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. Support and information provision for carers should occur prior to discharge from hospital and/or in the home and can be delivered face-to-face, via telephone or computer.
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.	Practice statement Consensus-based recommendations Updated <ul style="list-style-type: none"> • Carers should receive psychosocial support throughout the stroke recovery continuum to ensure carer wellbeing and the sustainability of the care arrangement. Carers should be supported to explore and develop problem solving strategies, coping strategies and stress

<p>Where it is the wish of the person with stroke, carers should be actively involved in the recovery process by assisting with goal setting, therapy sessions, discharge planning, and long-term activities.</p>	<p>management techniques. The care arrangement has a significant impact on the relationship between caregiver and stroke survivor so psychosocial support should also be targeted towards protecting relationships within the stroke survivors support network.</p>
<p>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.</p>	<ul style="list-style-type: none"> • Where it is the wish of the stroke survivor, carers should be actively involved in the recovery process by assisting with goal setting, therapy sessions, discharge planning, and long-term activities. • 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.
<p>Assistance should be provided for families/carers to manage stroke survivors who have behavioural problems.</p>	<ul style="list-style-type: none"> • Assistance should be provided for families/carers to manage stroke survivors who have behavioural problems.

For access to the full Clinical Guidelines and further information refer to InformMe <https://informme.org.au/en/Guidelines/Clinical-Guidelines-for-Stroke-Management-2017>.