

Clinical Guidelines for Stroke Management 2017

Summary – Social Work

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

Social workers provide support, counselling and information to stroke survivors and their families/carers regarding options for optimising physical, emotional, social and spiritual wellbeing. They also assist in organising community resources and support, as well as appropriate moves to residential care facilities.

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 social worker is an important member of the interdisciplinary stroke care team. Social workers help to manage the emotional, social and financial impact of stroke. They can help plan for life after stroke.
- Recent evidence has resulted in several changes in the 2017 recommendations, for example, 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.
- 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 3: Early assessment and diagnosis	Chapter 2 of 8: Early assessment and diagnosis
	Palliative care
	<p>Strong recommendation</p> <p>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.</p>
	<p>Practice statement Consensus-based recommendations</p> <ul style="list-style-type: none"> • For patients with severe stroke who are deteriorating, a considered assessment of prognosis or imminent death should be made. • 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.
Chapter 5: Secondary prevention	Chapter 4 of 8: Secondary prevention
Lifestyle modification	Lifestyle modification
<p>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:</p> <ul style="list-style-type: none"> • 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 	<p>Info Box Practice point Updated</p> <p>All people with stroke or TIA (except those receiving palliative care) should be assessed and informed of their risk factors for recurrent stroke and strategies to modify identified risk factors. This should occur as soon as possible and prior to discharge from hospital.</p>

<ul style="list-style-type: none"> • increasing regular exercise • avoiding excessive alcohol (i.e. no more than two standard drinks per day). 	
<p>Interventions should be individualised and delivered using behavioural techniques such as educational or motivational counselling.</p>	
<h2>Chapter 6: Rehabilitation</h2>	<h2>Chapter 5 of 8: Rehabilitation</h2>
	<h3>Early supported discharge services</h3>
	<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>
	<h3>Home-based rehabilitation</h3>
	<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>
	<h3>Goal setting</h3>
	<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

	<p>their families/carers) and other members of the rehabilitation team are aware of goals set.</p> <ul style="list-style-type: none"> • 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.
Chapter 7: Managing complications	Chapter 6 of 8: Managing complications
Fatigue	Fatigue
<p>Therapy for stroke survivors with fatigue should be organised for periods of the day when they are most alert.</p>	<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.
<p>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.</p>	
<p>If continence is unachievable, containment aids can assist with social continence.</p>	

Mood disturbance	Mood disturbance
Identification	Mood assessment
All patients should be screened for depression using a validated tool.	Info Box Practice points Updated <ul style="list-style-type: none"> • Stroke survivors with suspected altered mood (e.g. depression, anxiety, emotional lability) should be assessed by trained personnel using a standardised and validated scale. • Diagnosis should only be made following clinical interview.
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	Chapter 7 of 8: Discharge planning and transfer of care
	Information and education
	Strong recommendation New <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
	Strong recommendation New 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.
	Info Box Practice point New Discharge planning should commence as soon as possible after the stroke patient has been admitted to hospital.
	Practice statement Consensus-based recommendation A discharge planner may be used to coordinate a comprehensive discharge program for stroke survivors.
	Practice statement Consensus-based recommendations To ensure a safe discharge process occurs, hospital services should ensure the following steps are completed prior to discharge: <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

	<p>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.</p> <ul style="list-style-type: none"> • A locally developed protocol or standardised tool may assist in implementation of a safe and comprehensive discharge process.
	Patient and carer needs
	<p>Practice statement <u>Consensus-based recommendation</u></p> <p>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>
	Home assessment
	<p>Practice statement <u>Consensus-based recommendation</u></p> <p>Prior to hospital discharge, all stroke survivors 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.</p>
	Carer training
	<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,</p>

	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.
Chapter 8: Community participation and long-term recovery	Chapter 8 of 8: Community participation and long-term care
Self-management	Self-management
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.	Weak recommendation New <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.
Stroke-specific programs for self-management should be provided for those who require more specialised programs.	
A collaboratively developed self-management care plan can be used to harness and optimise self-management skills.	
Driving	Driving
All patients admitted to hospital should be asked if they intend to drive again.	Practice statement Consensus-based recommendations Updated <ul style="list-style-type: none"> All stroke survivors or people who have had a transient ischaemic attack should be asked if they wish to resume driving.

<p>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.</p>	<ul style="list-style-type: none"> • Any person wishing to drive again after a stroke or TIA should be provided with information about how stroke may affect his/her driving and the requirements and processes for returning to driving. Information should be consistent with the Austroads standards and any relevant state guidelines.
<p>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.</p>	<ul style="list-style-type: none"> • For private licenses, stroke survivors should be instructed not to return to driving for a minimum of four weeks post stroke. People who have had a TIA should be instructed not to drive for two weeks. For commercial licenses, stroke survivors should be instructed not to return to driving for a minimum of 3 months post stroke. People who have had a TIA should be instructed not to drive for four weeks.
<p>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.</p>	<ul style="list-style-type: none"> • A follow-up assessment should be conducted by an appropriate specialist to determine medical fitness prior to return to driving. • If a stroke survivor is deemed medically fit but has residual motor, sensory or cognitive changes that may influence driving, they should be referred for an occupational therapy driving assessment. This may include clinic based assessments to determine on-road assessment requirements (for example modifications, type of vehicle, timing), on-road assessment and rehabilitation recommendations.
<p>Leisure</p>	<p>Leisure</p>
<p>Targeted occupational therapy programs can be used to increase participation in leisure activities.</p>	<p>Weak recommendation For stroke survivors, targeted occupational therapy programs including leisure therapy may be used to increase participation in leisure activities.</p>
<p>Return to work</p>	<p>Return to work</p>
<p>Stroke survivors who wish to work should be offered assessment (i.e. to establish their cognitive, language and physical abilities relative to their</p>	<p>Weak recommendation</p>

<p>work demands), assistance to resume or take up work, or referral to a supported employment service.</p>	<ul style="list-style-type: none"> • All stroke survivors should be asked about their employment (paid and unpaid) prior to their stroke and if they wish to return to work. • For stroke survivors who wish to return to work, assessment should be offered to establish abilities relative to work demands. In addition, assistance to resume or take up work including worksite visits and workplace interventions, or referral to a supported employment service should be offered.
<p>Sexuality</p>	<p>Sexuality</p>
<p>Stroke survivors and their partners should be offered:</p> <ul style="list-style-type: none"> • the opportunity to discuss issues relating to sexuality with an appropriate health professional • written information addressing issues relating to sexuality post stroke. 	<p>Practice statement <u>Consensus-based recommendations</u></p> <p>Stroke survivors and their partners should be offered:</p> <ul style="list-style-type: none"> • the opportunity to discuss issues relating to sexual intimacy with an appropriate health professional; <i>and</i> • written information addressing issues relating to sexual intimacy and sexual dysfunction post stroke.
<p>Any interventions should address psychosocial aspects as well as physical function.</p>	<p>Any interventions should address psychosocial as well as physical function.</p>
<p>Support</p>	<p>Support</p>
<p>Peer support</p>	<p>Peer support</p>
<p>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.</p>	<p>Weak recommendation</p> <p>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.</p>

Carer support	Carer support
<p>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.</p>	<p>Strong recommendation</p> <p>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.</p>
<p>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.</p>	<p>Practice statement <u>Consensus-based recommendations</u> Updated</p> <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 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. • 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.
<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>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>	

<p>Assistance should be provided for families/carers to manage stroke survivors who have behavioural problems.</p>	<ul style="list-style-type: none">• 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.• Assistance should be provided for families/carers to manage stroke survivors who have behavioural problems.
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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>.