

Clinical Guidelines for Stroke Management 2017

10 things to know about the
Clinical Guidelines

For healthcare professionals

10 things to know about the Clinical Guidelines

For healthcare professionals

The *Clinical Guidelines for Stroke Management 2017* updates and supersedes the *Clinical Guidelines for Stroke Management 2010*.

The Clinical Guidelines have been updated in accordance with the *2011 NHMRC Standards for clinical practice guidelines* and therefore recommendations are based on the best evidence available. The Clinical Guidelines cover the whole continuum of stroke care from pre-hospital to acute care, to rehabilitation and on to community reintegration.

Review of the Clinical Guidelines used an internationally recognised guideline development approach, known as GRADE (**G**radings of **R**ecommendations **A**ssessment, **D**evelopment and **E**valuation), and an innovative guideline development and publishing platform, known as MAGICapp (**M**aking **G**rade the **I**rresistible **C**hoice). GRADE ensures a systematic process is used to develop recommendations that are based on the balance of benefits and harms, patient values, and resource considerations. MAGICapp enables transparent display of this process and access to additional practical information useful for Clinical Guideline recommendation implementation.

Key points:

- › All patients with suspected stroke or TIA should be managed as a time-critical medical emergency and receive urgent medical assessment. Investigations of underlying causes of stroke should be started early to enable commencement of secondary prevention therapies.
- › In the acute phase of care, all stroke patients should be treated in a stroke unit with an interdisciplinary team, and their temperature, blood sugar levels and swallowing function should be managed appropriately. Eligible patients should receive thrombolysis or endovascular thrombectomy. Other medical interventions and surgeries should be carefully considered according to the patient's condition.
- › Impairments (including sensorimotor, cognition and communication) should be assessed promptly and rehabilitation activities (including physical activity and activities of daily living) commenced early using interventions that are proven to be effective for the patient's condition.

- › Management of secondary complications should commence in the acute phase, as well as being considered during post-acute care and long-term care. These include prevention strategies, or reduction strategies when prevention is unsuccessful.
- › Discharge planning must involve stroke survivors, their family/carers, the healthcare team members, and community service providers. The care plan should include tailored information and resources, and should consider the need for a home assessment and carer training and needs assessment.
- › Participation and reintegration into the community is often an overlooked aspect. Stroke survivors should be involved in discussions regarding self-management programs, driving, rehabilitation, leisure therapies, community mobility, return to work options, sexual intimacy, and ongoing support.
- › Evidence published since the previous guidelines has led to a number of major changes in the new Clinical Guideline recommendations:
 - › In TIA patients, the use of ABCD² risk score in isolation to determine the urgency of investigation was found to potentially delay recognition of other high-risk indicators and should be avoided.
 - › Endovascular thrombectomy is now standard care for patients with large vessel occlusion and system changes to make this treatment accessible are required.
 - › Commencing intensive out of bed activities within 24 hours of stroke onset is not recommended, however all stroke patients should commence mobilisation (out of bed activity) within 48 hours of stroke onset, unless otherwise contraindicated.
 - › Blood pressure in patients with intracerebral haemorrhage should be lowered to SBP of 140 mmHg, but not substantially below that target.
 - › The minimum amount of scheduled rehabilitation therapy for stroke survivors is now 3 hours a day with at least 2 hours of active task practice during this time; a three-fold increase from the previous guidelines.
- › New topics included in these Clinical Guidelines include cardiac investigation, cervical artery dissection and venous sinus thrombosis.
- › Physiological monitoring, seizure management, central post stroke pain, agnosia, behavioural change, pressure care, sleep apnoea and complementary and alternative therapy have not been included in these Clinical Guidelines. These topics may be updated in future iterations.
- › Topics relating to organisation of stroke services are not included in these Clinical Guidelines. Please refer to the [National Acute and Rehabilitation Stroke Services Frameworks](#) for this information.