

Clinical Guidelines for Stroke Management

Summary – Speech Pathology

This summary is a quick reference to the recommendations in the Clinical Guidelines for Stroke Management 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 specific recommendations, 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/Guidelines/Clinical-Guidelines-for-Stroke-Management>.

The Stroke Foundation in partnership with Cochrane Australia is testing a model of continually reviewing and updating recommendations for the Clinical Guidelines for Stroke Management in response to new evidence on a monthly basis. For changes to recommendations based on new research evidence, please refer to further information on InformMe <https://informme.org.au/Guidelines/Living-guidelines-for-stroke-management>

The Clinical Guidelines uses an internationally recognised guideline development approach called GRADE (Grading of Recommendations Assessment, Development and Evaluation) and an innovative guidelines development and publishing platform known as MAGICapp (MAKING Grade the Irresistible Choice). GRADE ensures a systematic process in developing recommendation, 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 recommendation, based on how confidence the guideline developers are in that the “desirable effects of an intervention outweigh undesirable effect [...] 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.

Recommendations are presented as at June 2025 with a note if it has changed in the last two years and are also presented in Chapter order for easier reference to the relevant section of the full Clinical Guidelines.

For the full list of references, please refer to the individual MAGICapp chapters through InformMe <https://informme.org.au/Guidelines/Clinical-Guidelines-for-Stroke-Management>.

Chapter 3 of 8: Acute medical and surgical management

Stroke unit care

Strong recommendation

All stroke patients should be admitted to hospital and be treated in a stroke unit with an interdisciplinary team. (Langhorne 2020)

Info box

Practice points

- All stroke patients should be admitted directly to a stroke unit (preferably within three hours of stroke onset).
- For patients with suspected stroke presenting to non-stroke unit hospitals, transfer protocols should be developed and used to guide urgent transfers to the nearest stroke unit hospital.
- Where transfer is not feasible, smaller isolated hospitals should manage stroke services in a manner that adheres as closely as possible to the criteria for stroke unit care. Where possible, stroke patients should receive care in geographically discrete units.

Strong recommendation

All acute stroke services should implement standardised protocols to manage fever, glucose and swallowing difficulties in stroke patients. (Middleton et al. 2011)

Assessment for rehabilitation

Info box

Practice points

- 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 an appropriate process or tool e.g. the [Assessment for Rehabilitation Tool](#) (Australian Stroke Coalition Working Group 2012).
- 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

Strong recommendation

People with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional. (Poorjavad et al. 2014; Benfield et al. 2020)

Practice statement

Consensus-based recommendations

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. (Bray et al. 2016; Ouyang et al. 2020)

Strong recommendation

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. (Geeganage et al. 2012)

Weak recommendation **AGAINST**

For stroke survivors with dysphagia, non-invasive brain stimulation should only be provided within a research framework. (Pisegna et al. 2016)

Weak recommendation **AGAINST**

For patients with stroke, acupuncture should not be used for treatment of dysphagia in routine practice other than as part of a research study. (Long et al. 2012)

Weak recommendation **AGAINST**

For stroke survivors with dysphagia, surface neuromuscular electrical stimulation should only be delivered by clinicians experienced in this intervention, and be applied according to published parameters in a research framework. (Chen et al. 2016)

Weak recommendation **AGAINST**

For stroke survivors with dysphagia, pharyngeal electrical stimulation is not routinely recommended. (Bath et al. 2016; Scutt et al. 2015)

Practice statement

Consensus-based recommendations

- 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.

Please also refer to the topic Early Nutrition in [Managing Complications](#).

Chapter 5 of 8: Rehabilitation

Early supported discharge services

Strong recommendation

Where appropriate home-based coordinated stroke services are available (see Practical information section), early supported discharge services should be offered to stroke patients with mild to moderate disability. (Langhorne et al. 2017)

Home-based rehabilitation

Weak recommendation

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. (Rasmussen et al. 2016; Hillier et al. 2010)

Goal setting

Strong recommendation

- 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. (Sugavanam et al. 2013; Taylor et al. 2012)
- 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. (Sugavanam et al. 2013; Taylor et al. 2012)

Communication difficulties

Assessment of communication deficits

Info box

Practice points

- 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.

Aphasia

Info box

Practice points

Treatment for aphasia should be offered as early as tolerated.

Strong recommendation

For stroke survivors with aphasia, speech and language therapy should be provided to improve functional communication, reading comprehension, auditory comprehension, general expressive language and written language. (RELEASE Collaboration 2021; Brady et al. 2016)

Strong recommendation

For stroke survivors with aphasia, early aphasia therapy, starting within the first 4 weeks post stroke should be provided to maximise language recovery (RELEASE Collaboration 2021)

Weak recommendation

For stroke survivors in the acute phase (up to six weeks post stroke onset), language therapy sessions (direct time on task) ranging between 30-45 minutes, two-three days per week may be provided from stroke onset to week 6 post stroke, with additional therapy sessions during this acute phase being unlikely to yield any further benefit to language recovery (Godecke et al. 2020; RELEASE Collaboration 2021)

Weak recommendation

For stroke survivors with chronic aphasia (>6 months post stroke onset), intensive aphasia therapy (at least 10 hours/week of therapist led, individual or group therapy for 3 weeks, together with 5 hours or more, per week of self-managed training) may be used to improve aphasia. (Breitenstein et al. 2017)

Weak recommendation AGAINST

Brain stimulation (transcranial direct current stimulation or repetitive transcranial magnetic stimulation), with or without traditional aphasia therapy, is not recommended in routine practice for improving speech and language function in chronic patients with aphasia and only used as part of a research framework. (Elsner et al. 2019; Ding et al. 2022)

Strong recommendation

Communication partner training should be provided to health professionals or volunteers who interact with people with aphasia after stroke. (Simmons-Mackie et al. 2016; Finch et al. 2017; Power et al. 2020)

Weak recommendation

Communication partner training may be provided to carers or family members of people with aphasia after stroke. (Simmons-Mackie et al. 2010; Simmons-Mackie et al. 2016)

Info box

Practice points

Where a stroke patient is found to have aphasia, the clinician should:

- 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.

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.

Info box

Practice point

- 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.
- 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.

Apraxia of speech

Weak recommendation

For stroke survivors with apraxia of speech, individually tailored interventions incorporating articulatory-kinematic and rate/rhythm approaches may be used. (Ballard et al. 2015)

In addition, therapy may incorporate (Ballard et al. 2015):

- 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.

Dysarthria

Weak recommendation

For stroke survivors with dysarthria, interventions tailored to the individual which include speech production tasks that target connected speech may be provided, which may include for example strategies to reduce speaking rate, emphasize articulatory placement or increased loudness (e.g., LSVT®LOUD) (Mitchell et al. 2017; Finch et al. 2020)

Cognitive communication deficits

Practice statement

Consensus-based recommendations

Stroke survivors with difficulties in communication following right hemisphere damage should have input from a suitably trained health professional including:

- a comprehensive assessment,
- development of a management plan, and
- family education, support and counselling as required. (Lehman Blake et al. 2013; Ferre et al. 2011)

Management may include:

- Motoric-imitative, cognitive-linguistic treatments to improve use of emotional tone in speech production. (Rosenbek et al. 2006)
- Semantic-based treatment connecting literal and metaphorical senses to improve comprehension of conversational and metaphoric concept. (Lungren et al. 2011)

Cognition and perception difficulties

Assessment of cognition

Info box

Practice points

- 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.

Executive function

Info box

Practice points

- 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.

Weak recommendation

For stroke survivors with cognitive impairment, meta-cognitive strategy and/or cognitive training may be provided. (Zucchella et al. 2014; Skidmore et al. 2015)

Telehealth in rehabilitation

Weak recommendation

Telehealth services may be used as an alternative approach to delivering rehabilitation, especially for patients who cannot access specialist rehabilitation in the community. It may also be used as an adjunct to in-person therapy. Delivering of specific interventions via telehealth should only be considered for those that have demonstrated benefits. (Laver et al. 2020)

Chapter 6 of 8: Managing complications

Nutrition and hydration

Early feeding

Strong recommendation

All stroke patients should be screened for malnutrition at admission and on an ongoing basis (at least weekly) while in hospital. (Dennis et al. 2005)

Strong recommendation

For stroke patients whose nutrition status is poor or deteriorating, nutrition supplementation should be offered. (Geeganage et al. 2012; Dennis et al. 2005)

Weak recommendation

- For stroke patients who do not recover a functional swallow, nasogastric tube feeding is the preferred method of feeding in the short term. (Geeganage et al. 2012; Gomes et al. 2015; Dennis et al. 2005)
- 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. (Lee et al. 2010)

Weak recommendation

For stroke patients who are adequately nourished, routine oral nutrition supplements are not recommended. (Geeganage et al. 2012; Dennis et al. 2005)

Info box

Practice points

- For patients with acute stroke food and fluid intake should be monitored.
- Stroke patients who are at risk of malnutrition, including those with dysphagia, should be referred to an Accredited Practising Dietitian for assessment and ongoing management.

Oral hygiene

Strong recommendation

All stroke patients, particularly those with swallowing difficulties, should have assistance and/or education to maintain good oral and dental (including dentures) hygiene. (Campbell et al. 2020)

Strong recommendation

Staff and carers of stroke patients (in hospital, in residential care and home settings) should be trained in assessment and management of oral hygiene. (Campbell et al. 2020)

Weak recommendation

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. (Lam et al. 2013; Yuan et al. 2020)

Fatigue

Practice statement

Consensus-based recommendations

- 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, education and strategies to assist in managing 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 cognitive behavioural therapy (focusing on fatigue and sleep with advice on regular exercise), exercise and improving sleep hygiene.

Mood disturbance

Mood assessment

Info box

Practice points

- Stroke survivors with suspected altered mood (e.g. depression, anxiety, emotionalism) should be assessed by trained personnel using a standardised and validated scale for use in people with stroke.
- Diagnosis should only be made following clinical interview.

Chapter 7 of 8: Discharge planning and transfer of care

Information and education

Strong recommendation

- All stroke survivors and their families/carers should be offered information tailored to meet their individual needs using relevant language and communication formats. (Crocker et al. 2021)
- Information should be provided at different stages in the recovery process. (Crocker et al. 2021)
- 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. (Crocker et al. 2021)

Info box

Practice points

- Stroke survivors and their families/carers should be educated in the FAST stroke recognition message to maximise early presentation to hospital in case of recurrent stroke.
- The need for education, information and behaviour change to address long-term secondary stroke prevention should be emphasized (refer to [Secondary Prevention](#)).

Discharge care plans

Strong recommendation

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. (Johnston et al. 2010; Goncalves-Bradley et al. 2016)

Info box

Practice point

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:

- 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. This tool should be aphasia and cognition friendly.

Patient and carer needs

Practice statement

Consensus-based recommendation

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.

Carer training

Weak recommendation

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. (Forster et al. 2013)

Chapter 8 of 8: Community participation and long-term care

Self-management

Strong recommendation **New**

Self-management interventions that are directed by the stroke survivor, should be offered within the first four months of discharge into community living. The strongest evidence base exists for the 'Take Charge After Stroke' intervention. (Fu et al. 2020)

Weak recommendation

- 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.

(Fryer et al 2016; Oh et al. 2022)

Support

Peer support

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. (Kruithof et al. 2013)

Carer support

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. (Legg et al. 2011; Eames et al. 2013)

Weak recommendation New

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 (Minshall et al. 2019; Chen et al. 2014).

Practice statement

Consensus-based recommendations

- 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.
- 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/Guidelines/Clinical-Guidelines-for-Stroke-Management>.