Public consultation feedback and response Stroke Living Guidelines Updates

January 12 – February 28, 2023

Author	Organisation	Topic	Feedback	Actions taken
Amanda Clayton (individual) 09.02.23	Lived Experience Advisory Group for Childhood Stroke Project, Stroke Foundation	Driving	Just a little feedback with the driving guidelines, are we able to include information for young adults learning to drive. I currently sit on the Lived Experience Advisory Group for the Childhood Stroke Project | Stroke Foundation - Australia and currently struggle to find any information on Learning to drive, not just returning to drive. Information that could help is, what is needed to become eligible and in what order? Are there extra hours required? Do you need to book a specific instructor for the test?	Noted. There is very little evidence or information on Learning to Drive available. A little has been found on the AustRoad Standard and it has been added to the consensus-based recommendation.
Sinead O'Halloran (individual) 21.02.23	AT&R Middlemore Hospital, NZ	Driving	1.) Stroke survivors without visual field deficit and/or acceptable visual acuity (refer to relevant section in standards) should be instructed not to return to driving for a period of time. - I feel this statement reads a bit unclearly as 'without visual field deficit' and without 'acceptable visual acuity' are two very different presentations with one being visually impaired and one not. 2.) Any person with stroke or TIA discharged from hospital or seen in a TIA clinic should be screened/assessed for any ongoing neurological deficits that could impact driving. Cognitive, physical and behavioural assessment findings should be documented. Where no persisting deficits are identified, the person may recommence driving on their current license after the minimum exclusion period without license restriction or further review. - Does this indicate that the person does not require medical clearance from their GP to return to driving? In New Zealand, we recommend medical clearance from GP (or similar) following the minimum stand down period even when full neurological/functional recovery has been achieved. The previous driving guidelines align with this practise by stating 'A follow-up assessment should be conducted by an appropriate specialist to determine medical fitness prior to return to driving. (Austroads standards 2016 [24])'	1) Changed the wording of the statement to be clearer. 2) Difference in recommendations is noted and reflected in the text. The changes were to add "in Australia" and a statement specific to NZ.

Susan Pearce AM (on behalf of Ellen Rawstron) (group) 21.02.23	NSW Health (Agency for clinical innovation)	Driving	Ms Ellen Rawstron, Acting Chief Executive, Agency for Clinical Innovation, has advised that the Stroke Network has reviewed the proposed changes in the driving section of the guidelines. The subject matter experts within the network expressed support for the proposed changes.	Noted. No change required.
Mark Pugin & Kim Hawe (individual) 21.02.23	Driver Safety Team at Waka Kotahi (NZ transport agency)	Driving	We both really appreciate the opportunity to see the guidance you have prepared, and were really impressed with the comprehensive advice that is provided to take into account the whole person and all the aspects of their life that can be affected by a stroke. The guidance and information on driving was completely on target from our perspective also, and there are no suggested alterations from our viewpoint.	Noted. No change required.
Skye Jacobi (group) 22.02.23	Government of South Australia Health Department for Health and Wellbeing	Driving	The System Design and Planning branch has provided the information to the Stroke Community of Practice (SCoP) seeking feedback and below are the responses received: 1. The guideline needs to define what "treating clinicians" mean as it could be interpreted. The treating stroke specialists assume the intent is to redivert the task to treating General Practitioners. 2. The first bullet point in "For private licence holders:" section should be rephrased to read "Stroke survivors without physical, including sensory deficits, cognitive and visual field defects and/or acceptable visual acuity should be instructed not to return to drive". As it currently reads, it would mean that if someone has no visual defects, they can return to drive after four weeks regardless of other possible defects including motor, sensory, cognitive, behavioural, visuospatial etc and it's the same case with commercial licence. The following questions were also raised: 3. What is the recommendation for patients with more than one stroke/TIA? Shoudl they have longer non-driving period, as supposed to the current four weeks non-driving rule after each stroke? This is because those who have had more than one stroke would mean that their medical condition has not been/or cannot be optimised better due to the multiple episodes. 4. When is it appropriate to advice patients not to drive at all? The Stroke Community of Practice were also provided the opportunity to submit their feedback directly via the online portal.	1. Changed the wording to clarify who is the clinician. 2. Changed as suggested 3. Patients with more than one stroke/TIA will need to be assessed following each stroke/TIA for the deficits that could impact driving. 4. The advice is intended to guide when to return to driving. If these conditions are not met then that would indicate RTD is not appropriate at all.

Fiona Landgren (group) 27.02.23	Project Health and Austroads	Driving	1. Given that the Australian and NZ management approaches are quite different, is the term 'consensus based' a bit confusing? 2. Suggested 5 headings for the content (eg suggested "fitness to drive assessment" as a new heading to separate from the concept of the minimum driving period) 3. Suggested rearrangment of content: Maybe all the info about non-driving periods goes in one place. Maybe this ("Health services where stroke survivors receive rehabilitation...") goes first as the pathway would ideally cover the rest of the recommendations below? 4. Suggested the addition of "These minimum non-driving periods are determined by the relevant jurisdiction as follows and are the result of local consensus" or something like this to indicate that the non-driving periods are determined by licensing authorities not by this consensus statement. 5. Suggest change to license holder (previously private vehicle driver) 6. for "Stroke survivors without visual field deficit and/or acceptable visual acuity (refer to relevant section in standards) should be instructed not to return to driving for a period of time", it's not really clear what happens to people with visual field deficit - as distinct from those without 7. For "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", this would apply equally to commercial drivers so maybe a separate heading in the document about the role of OT driver assessment and also consistent terminology - practical driver assessment versus OT driver assessment. 8. Private vehicle drivers are subject to conditional licences as well but only mentioned below for commercial	1. Consensus based recommendations are named due to the fact that we have not found research to make an 'evidence-based recommendation'. While we recognise not everyone will agree this has been developed collaboratively with Australian and New Zealand stakeholders and we feel it reflects general consensus. 2. Two headings have been added (non-driving periods and fitness to drive assessment) and content re-arranged accordingly. 3. Changed as suggested. 4. We have tried to be clear these are firmly based on the underlying national standards and referenced accordingly. We feel no further change is needed. 5. Change not required, already "license holder" 6. This is covered in the non-driving section where 'Stroke survivors should refrain from recommencing driving until... stroke deficits precluding safe driving (if present) have resolved". 7. Added as suggested to commercial drivers section. Inconsistent terminology adjusted. 8. A sentence on conditional licences has been added to private license holders.
Brenda Booth (Individual) 27.02.23	Lived experience, Australian Stroke Coalition	Driving	I think it is spot on.	Noted. No change required.

Olivia Sexton (on behalf of Rebecca Cross) (group) 01.03.23 (requested extension)	ACT Health Directorate and Canberra Health Services	Driving	• Austroads provide recommendations for driving resumption for most medical conditions in a single document. Having separate guidelines for Transient Ischemic Attack (TIA)/stroke would create confusion. If every society/ foundation starts publishing separate guidelines, it will be difficult for clinicians (and patients) to follow them. • Austroads recommendations do not mandate clinician review for private license holders prior to resumption of driving for patients without significant impairment. The proposed recommendation for needing medical clearance for all or most of TIA/stroke patients are more onerous than what Austroads recommends and would mean patients would need additional clinic appointments with a specialist, which could potentially strain the ambulatory services and disadvantage patients waiting to be seen for other neurological conditions. • It is more feasible to adhere to Austroads guidelines as many TIA/stroke patents also suffer from other conditions such as seizures which are not covered by these updated guidelines.	Thank you for your valuable comments. We absolutely agree about not wanting to create separate guidance -our intention has been to reflect the national recommendations as the source, but to provide further context and operationalise these for stroke patients given the Austroad standards can't go into detail for all patient groups. Regarding your second point -we agree that follow up for those without significant impairment is not warranted in this update of the standards and we believe our current wording reflects that. The key issue is that we believe the standards do mandate medical clearance at some point after stroke before returning to drive which is likely to be much earlier in the recovery (ie. often at or prior to hospital discharge) and this is important guidance to provide as there is uncertainty in the clinical community about this and especially to help define what 'significant impairment' may mean.

March 27 – May 5, 2023

Author	Organisation	Topic/s	Feedback	Actions taken
Tessa Jones (on behalf of Dr Robyn Lawrence) (group) 08.05.23	SA Health	Neurointervention, Oxygen therapy and Central post-stroke pain	The System Design and Planning branch within DHW has forwarded the information to the leaders of stroke care across South Australia via the Stroke Community of Practice (SCoP), seeking feedback on the Guidelines. The branch received a response from Prof Timothy Kleinig, Chair, SCoP advising that he has previously provided his feedback regarding the update through his involvement as part of the committee of Stroke Foundation Guidelines and he fully supports the updated guidelines. The SCoP were also provided the opportunity and appropriate links to submit their feedback directly via the online portal.	Noted. No change required.
Emma Brown (on behalf of Dr Marco Briceno) (group) 08.05.23	NT Health	Neurointervention, Oxygen therapy and Central post-stroke pain	NT Health has circulated the Stroke Foundation's draft changes to relevant clinicians within NT Health and preliminary feedback to the recommended changes has been positive. NT Health will forward relevant feedback to guidelines@strokefoundation.org.au as it becomes available.	Noted. No change required.
Maria Travers (on behalf of Rebecca Cross) (group) 25.05.23 (requested extension)	ACT Health Directorate and Canberra Health Services	Neurointervention, Oxygen therapy and Central post-stroke pain	We have consulted internally with our Office for Professional Leadership and Education (OPLE), which has noted that the: - guidelines are clearly written and reflect current best practise principles with strong supporting evidence; and - alignment of the guidelines with the Australian Stroke Clinical Registry data sets will be important. OPLE has also suggested that it would also be important to capture other stakeholders that are a crucial part of the patient assessment workflow. For example: - Calvary Public Hospital Bruce Emergency Department - Private hospitals for referral pathways and workflows - ACT ambulance – an important stakeholder in prehospital assessment and diagnosis of stroke; noting that ACT ambulance is currently considering the implementation and outcomes of the recent Victorian trial of portable ultrasound in ambulances for diagnosis and treatment of stroke - Feedback and input from allied health professionals about pain management in both pharmacological and non-pharmacological interventions should also be considered.	Noted. No change required. The public consultation information is currently being distributed widely, including to the Australian Stroke Coalition which includes all the national stroke organisations, state stroke networks or representatives, peak bodies and professional organisations, and associated organisations.