Clinical Guidelines for Stroke Management

Summary – Social Work

This summary is a quick reference to the recommendations in the Clinical Guidelines for Stroke Management 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 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

Palliation

Strong recommendation

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. (Gade et al. 2008)

Practice statement

Consensus-based recommendations

- 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 4 of 8: Secondary prevention

Lifestyle modifications

Info box

Practice points

All patients 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.

Weak recommendation

Interventions addressing secondary stroke risk factors may be used for all people with stroke and TIA. Such interventions should include multiple components including individual (support and counselling) and organisational approaches (regular reviews by relevant health care professionals) and include exercise training as a component. (Bridgwood et al. 2020; Liljehult et al. 2020; Wang et al. 2019; Deijle et al. 2017)

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.

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)

Chapter 6 of 8: Managing complications

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.

Home assessments

Practice statement

Consensus-based recommendation

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.

Carrer 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)

Driving

Practice statement Updated

Consensus-based recommendations

- All stroke survivors or people who have had a transient ischaemic attack (TIA) who were driving prior to their stroke should be asked if they wish to resume driving.

- Any person wishing to resume driving after a stroke or TIA should be provided with information about how stroke-related impairments may affect their driving and the requirements and processes for returning to driving. Information should be consistent with the Austroads/Waka Kotahi New Zealand Transport Agency standards and any relevant state guidelines.
- For stroke survivors wishing to drive for the first time, the medical and other clinical team members should discuss the feasibility of driving and provide advice as to further steps in line with national standards and any relevant state guidelines.
- Health services where stroke survivors receive care should develop an appropriate site-specific post-stroke fitness to drive pathway in accordance with local legal requirements and resources, and ensure assessments and advice is communicated to the general practitioner.

Non-driving periods

- Stroke survivors should refrain from recommencing driving until both the mandated period of non-driving has elapsed and stroke deficits precluding safe driving (if present) have resolved, as confirmed by their treating doctors (in conjunction with other non-medical clinician/s). Minimum non-driving periods determined by the relevant national standards must be followed. Please note for fitness to drive purposes in Australia TIA is defined as cerebral ischaemic symptoms resolving within 24 hours, irrespective of MRI evidence of infarction.
- For private license holders:
  - In Australia the minimum timeframe is four weeks post stroke (mandated) and two weeks after a TIA (advisory only).(Austroads standards 2022).
  - In New Zealand the minimum timeframe is one month for a single event (stroke or TIA) and three months for those with recurrent or frequent events (if no further recurrence has occurred within this timeframe).(New Zealand Transport Agency 2014)
- For commercial license holders:
  - In Australia the minimum timeframe is three months post stroke (mandated) and four weeks after a TIA (advisory only). (Austroads standards 2022)
  - In New Zealand this generally means permanent stand down after stroke for commercial driving, but this may be appealed in special circumstances. The timeframe after TIA is six months and additional criteria apply (New Zealand Transport Agency 2014).

Fitness to drive assessments

- 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 influence driving safely. Visual, cognitive, physical and behavioural assessment findings should be documented.
- Stroke survivors without physical/sensory or cognitive impairments, and who meet the vision standards for driving (refer to relevant section in standards) should be instructed not to return to driving for a period of time.
- For private license holders:
  - In Australia, 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. In New Zealand, a follow-up assessment should be

conducted by an appropriate specialist to determine medical fitness prior to return to driving. (New Zealand Transport Agency 2014)

  - If after the minimum exclusion period the treating clinician is uncertain whether persisting motor, sensory or cognitive changes preclude safe driving, an occupational therapy specialist driving assessment should occur.
  - A conditional license may be required depending on the nature of the deficits (for example vehicle modifications, local area driving only).
- For commercial license holders:
  - In Australia, where no deficits which may impact driving are identified, a conditional license may be considered by the driver licensing authority after at least three months and subject to annual review, taking into account information provided by an appropriate specialist. After three months, if the treating clinician is uncertain whether persisting motor, sensory or cognitive changes preclude safe driving, an occupational therapy specialist driving assessment should occur.
- Stroke survivors who have physical/sensory or cognitive impairments that may impact driving, or who do not meet the vision standards for driving (refer to relevant section in standards), should be instructed not to return to driving and the medical and other clinical team members should discuss and provide advice as to further steps in line with national standards and any relevant state guidelines.
  - If further driving assessment is deemed necessary 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, provided by a driver assessor occupational therapist.

Weak recommendation

For stroke survivors needing driving rehabilitation, driving simulation may be used. Health professionals using driving simulation need to receive training and education to deliver intervention effectively and appropriately, and mitigate driving simulator sickness. (George et al. 2014; Classen et al. 2014)

Practice statement

Consensus-based recommendation

On-road driving rehabilitation may be provided by health professionals specifically trained in driving rehabilitation.

Leisure

Weak recommendation

For stroke survivors, targeted occupational therapy programs including leisure therapy may be used to increase participation in leisure activities. (Dorstyn et al. 2014; Walker et al. 2004)

Return to work

Weak recommendation

- 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. (Ntsiea et al. 2015)

Sexuality

Practice statement

Consensus-based recommendations

Stroke survivors and their partners should be offered:

- the opportunity to discuss sexuality and intimacy with an appropriate health professional; *and*
- written information addressing issues relating to sexual intimacy and sexual dysfunction post stroke.

Any discussion or written information should address psychosocial as well as physical function.

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.