

Clinical Guidelines for Stroke Management

Summary – Nursing

This summary is a quick reference to the recommendations in the Clinical Guidelines for Stroke Management most relevant to nursing.

Nurses are an integral member of the interdisciplinary team across the whole stroke care continuum and many of these recommendations can be nurse-initiated working in conjunction as part of the team. Other recommendations may be primarily initiated by other team members but require critical input from nurses. The extent of nurses' contribution to implementing individual recommendations will vary depending on how your stroke service is resourced, how care is organised and individual nurses' scope of practice.

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 1 of 8: Pre-hospital care

Pre-hospital care

Strong recommendation

All stroke patients potentially eligible for reperfusion therapies should have an ambulance dispatched as an immediate response and be managed as a time critical emergency. (Berglund et al. 2012)

Strong recommendation

- a. Ambulance services should preferentially transfer suspected stroke patients to a hospital capable of delivering reperfusion therapies as well as stroke unit care. (Chowdhury et al. 2021)
- b. Ambulance services should pre-notify the hospital of a suspected stroke case where the patient may be eligible for reperfusion therapies. (Chowdhury et al. 2021)

Info Box

Practice Point

- General practitioners are encouraged to educate reception staff in the FAST stroke recognition message and to redirect any calls about suspected acute stroke to 000.
- Regular stroke education may improve patient identification by clinicians. (Oostema et al. 2019; Chowdhury et al. 2021)

Strong recommendation

For patients in major cities with suspected stroke who are potentially eligible for reperfusion therapies, pre-hospital treatment in a mobile stroke unit is recommended. (Turc et al. 2022)

Chapter 2 of 8: Early assessment and diagnosis

Transient ischaemic attack

Strong recommendation

- All patients with suspected transient ischaemic attack (TIA), i.e. focal neurological symptoms due to focal ischaemia that have fully resolved, should have urgent clinical assessment. (Lavalley et al. 2007; Rothwell et al. 2007) (*Refer to the 'Practical Information' section for further useful information*)
- Patients with symptoms that are present or fluctuating at time of initial assessment should be treated as having a stroke and be immediately referred for emergency department and stroke specialist assessment, investigation and reperfusion therapy where appropriate. (Lavalley et al. 2007; Rothwell et al. 2007)
- In pre-hospital settings, high risk indicators (e.g. crescendo TIA, current or suspected AF, current use of anticoagulants, carotid stenosis or high ABCD² score) can be used to identify patients for urgent specialist assessment. (Lavalley et al. 2007; Rothwell et al. 2007)

Strong recommendation

When TIA patients present to primary care, the use of TIA electronic decision support, when available, is recommended to improve diagnostic and triage decisions. (Ranta et al. 2015)

Weak recommendation **AGAINST**

In TIA patients, use of the ABCD² risk score in isolation to determine the urgency of investigation may delay recognition of atrial fibrillation and symptomatic carotid stenosis in some patients and should be avoided. (Wardlaw et al. 2015)

Strong recommendation

All TIA patients with anterior circulation symptoms should undergo early carotid imaging with CT angiography (aortic arch to cerebral vertex), carotid Doppler ultrasound or MR angiography. Carotid imaging should preferably be done during the initial assessment but should not be delayed more than 2 days (see [Imaging](#)).

Weak recommendation

Patients with TIA should routinely undergo brain imaging to exclude stroke mimics and intracranial haemorrhage. MRI, when available, is recommended to improve diagnostic accuracy (see [Imaging](#)).

Strong recommendation

Patients with suspected TIA should commence secondary prevention therapy urgently (see [Secondary Prevention](#)).

Strong recommendation

- All patients with TIA should be investigated for atrial fibrillation with ECG during initial assessment and referred for possible prolonged cardiac monitoring as required (see [Cardiac Investigations](#)).
- TIA patients with atrial fibrillation should commence anticoagulation therapy early after brain imaging has excluded haemorrhage, unless contraindicated (see [Anticoagulant therapy](#) in [Secondary Prevention](#)).

Practice statement

Consensus-based recommendations

- All patients and their family/carers should receive information about TIA, screening for diabetes, tailored advice on lifestyle modification strategies (smoking cessation, exercise, diabetes optimisation if relevant – see [Secondary prevention](#)), return to driving (see [Driving](#) in [Community participation and long-term care](#)) and the recognition of signs of stroke and when to seek emergency care.
- All health services should develop and use a local TIA pathway covering primary care, emergency and stroke specialist teams to ensure patients with suspected TIA are managed as rapidly and comprehensively as possible within locally available resources.

Assessment of suspected stroke

Strong recommendation

All suspected stroke patients who have been pre-notified to the stroke or ED team, and who may be candidates for reperfusion therapy, should be met at arrival and assessed by the stroke team or other experienced personnel. (Meretoja et al. 2012; Meretoja et al. 2013)

Weak recommendation

The use of clinical screening tools to identify stroke by ED staff is recommended where an expert stroke team is unable to immediately assess a patient. (Zhelev et al. 2019)

Info box

Practice points

- Initial diagnosis should be reviewed by a clinician experienced in the evaluation of stroke.
- Stroke severity should be assessed and recorded on admission by a trained clinician using a validated tool (e.g. NIHSS).
- A blood glucose reading should be taken to improve specificity (hypoglycaemia can present as a 'stroke mimic').

Investigations

Imaging

Brain imaging

Strong recommendation

All patients with suspected stroke who are candidates for reperfusion therapies should undergo brain imaging immediately. All other suspected stroke patients should have an urgent brain CT or MRI ('urgent' being immediately where facilities are available and preferably within 60 minutes). (Brazzelli et al. 2009)

Weak recommendation

In patients with suspected stroke and TIA, MRI is more sensitive and specific than non-contrast CT and is the preferred modality when diagnostic confirmation is required. (Brazzelli et al. 2009)

Practice statement

Consensus-based recommendations

Either CT or MRI are acceptable acute imaging options but these need to be immediately accessible to avoid delaying reperfusion therapies.

Strong recommendation

If using CT to identify hyperdense thrombus, thin slice (< 2 mm) non-contrast CT should be used rather than the standard 5 mm slices to improve diagnostic sensitivity for vessel occlusion. (Mair et al. 2015)

Weak recommendation

CT perfusion imaging may be used in addition to routine imaging to improve diagnostic and prognostic accuracy. (Biesbroek et al. 2012)

Info box

Practice points

- If a patient with stroke develops neurological deterioration, immediate clinical assessment and further brain imaging (CT or MRI) should be considered.
- Routine brain imaging approximately 24 hours after reperfusion therapies have been administered is recommended to identify haemorrhagic transformation and delineate the extent of infarction, both of which are important when making decisions about antithrombotic therapy and DVT prophylaxis.

Imaging

Vascular imaging

Strong recommendation

- All patients who would potentially be candidates for endovascular thrombectomy should have vascular imaging from aortic arch to cerebral vertex (CTA or MRA) to establish the presence of vascular occlusion as a target for thrombectomy and to assess proximal vascular access. (Goyal et al. 2016; Broderick et al. 2013)
- All other patients with carotid territory symptoms who would potentially be candidates for carotid re-vascularisation should have early vascular imaging to identify stenosis in the ipsilateral carotid artery. CT angiography (if not already performed as part of assessment for reperfusion therapies), Doppler ultrasound or contrast-enhanced MR angiography are all reasonable options depending on local experience and availability. (Netuka et al. 2016; Chappell et al. 2009; Nonent et al. 2011; Anzidei et al. 2012)

Info box

Practice points

In ischaemic stroke and TIA patients, routinely imaging the entire vasculature from aortic arch to cerebral vertex with CTA or MRA is encouraged to improve diagnosis, recognition of stroke aetiology and assessment of prognosis.

The administration of intravenous iodinated contrast for CT angiography/perfusion, when clinically indicated, should not be delayed by concerns regarding renal function. Post-hydration with intravenous 0.9% saline is advisable. (RANZCR guidelines 2016; Ang et al. 2015).

Info box

Practice points

Vascular imaging should not be performed for syncope or other non-focal neurological presentations.

Cardiac investigations

Weak recommendation

Initial ECG monitoring should be undertaken for all patients with stroke. The duration and mode of monitoring should be guided by individual patient factors but would generally be recommended for at least the first 24 hours. (Kurka et al. 2015)

Strong recommendation

For patients with embolic stroke of uncertain source, longer term ECG monitoring (external or implantable) should be used. (Afzal et al. 2015)

Weak recommendation

Further cardiac investigations should be performed where clarification of stroke aetiology is required after initial investigations. In patients with ischaemic stroke, echocardiography should be considered based on individual patient factors. Transoesophageal echocardiography is more sensitive for suspected valvular, left atrial and aortic arch pathology. (Holmes et al. 2014; Shah et al. 2021)

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 et al. 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.

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.

Reperfusion therapy

Intravenous thrombolysis

Strong recommendation

For patients with potentially disabling ischaemic stroke within 4.5 hours of onset who meet specific eligibility criteria, intravenous thrombolysis should be administered as early as possible after stroke onset (Wardlaw et al. 2014; Emberson et al. 2014)

Strong recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

For patients with potentially disabling ischaemic stroke who do not have clinical or brain imaging contraindications, intravenous tenecteplase (0.25mg/kg, maximum 25mg) should be

administered up to 4.5 hours of onset. If tenecteplase is not available then alteplase (0.9mg/kg, maximum 90mg) should be given. (Palaodimou et al 2024; Meng et al 2024; Muir et al 2024; Parsons et al 2024; Campbell et al 2018; Ma et al 2024; Emberson et al 2014)

Weak recommendation

For patients with potentially disabling ischaemic stroke without large vessel occlusion who meet specific clinical and brain imaging eligibility criteria, tenecteplase may be used as an alternative to alteplase within 4.5 hours of onset. (Huang et al. 2016; Menon et al. 2022; Wang et al. 2023)

Strong recommendation

When using intravenous alteplase, a dose of 0.9 mg/kg, maximum of 90 mg should be administered. (Wardlaw et al. 2014; Emberson et al. 2014; Anderson et al. 2016)

Strong recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

For patients with potentially disabling ischaemic stroke who meet perfusion mismatch criteria in addition to standard clinical criteria, tenecteplase (0.25 mg/kg) or intravenous alteplase (dose of 0.9 mg/kg) should be administered up to 9 hours after the time the patient was last known to be well, or from the midpoint of sleep for patients who wake with stroke symptoms, unless the patient has a large vessel occlusion and immediate access to endovascular therapy. (Campbell et al 2019; Palaodimou et al 2024; Xiong et al 2024.)

Weak recommendation

For patients with potentially disabling ischaemic stroke of unknown onset time who meet MRI FLAIR-diffusion mismatch criteria in addition to standard clinical criteria, intravenous alteplase (dose of 0.9 mg/kg, maximum of 90 mg) may be administered (Thomalla et al. 2019).

Weak recommendation New Draft submitted to NHMRC for approval – JUNE 2025

For patients with potentially disabling ischaemic stroke who meet perfusion mismatch criteria in addition to standard clinical criteria, intravenous tenecteplase may be administered from 9 to 24 hours after stroke onset or when the patient was last known to be well, the patient has large vessel occlusion and immediate access to endovascular therapy. (Palaodimou et al 2024; Xiong et al 2024)

Weak recommendation AGAINST New Draft submitted to NHMRC for approval – JUNE 2025

For patients with nondisabling ischaemic stroke, intravenous alteplase or tenecteplase should not be administered. (Coutts et al 2024; Chen et al 2023; Khatri et al 2018)

Practice statement New Draft submitted to NHMRC for approval – JUNE 2025

Consensus-based recommendations

For ischaemic stroke patients who received dabigatran pre-stroke, intravenous thrombolysis can be administered after dabigatran reversal.

Practice statement

Consensus-based recommendations

Thrombolysis should be undertaken in a setting with appropriate infrastructure, facilities and network support (e.g. via telemedicine) including:

- access to an interdisciplinary acute care team with expert knowledge of stroke management, who are trained in delivery of thrombolysis and monitoring of patients receiving thrombolytic therapy
- a streamlined acute stroke assessment workflow (including ambulance pre-notification, code stroke team response and direct transport from triage to CT scan) to minimise treatment delays, and protocols available to guide medical, nursing and allied health acute phase management
- immediate access to imaging facilities and staff trained to interpret images
- routine data collected in a central register to allow monitoring, benchmarking and improvements of patient outcomes over time for those treated with reperfusion.

The patient and caregivers should be involved in the decision to give thrombolysis whenever possible and this discussion of risk and benefit documented in the medical record. However, as a time-critical emergency therapy, thrombolysis should not be delayed if the patient does not have the capacity to consent and there are no legal representatives present. Clinicians should follow local health department policies regarding consent for emergency treatment in patients who are unable to consent for themselves.

Endovascular Therapy

Strong recommendation Updated

For patients with a disabling clinical deficit due to ischaemic stroke caused by a large vessel occlusion in the internal carotid artery, proximal middle cerebral artery (M1 and proximal or dominant M2 segments), basilar artery occlusion, or with tandem occlusion of both the cervical carotid and intracranial large arteries, endovascular thrombectomy should be undertaken when the procedure can be commenced within 24 hours of stroke onset, taking into account individual patient factors. Such factors include: extent and location of brain injury, pre-morbid function, frailty, comorbidities, and patient's and/or family's wishes. (Goyal et al. 2016; Albers et al. 2018; Nogueira et al. 2018; Tao et al. 2022; Jovin et al. 2022; Yoshimura et al. 2022; Sarraj et al. 2023; Huo et al. 2023)

Strong recommendation Updated

Eligible stroke patients should receive intravenous thrombolysis while concurrently arranging endovascular thrombectomy, with neither treatment delaying the other. (Goyal et al. 2016; Majoie et al. 2023)

Practice statement **Updated**

Consensus-based recommendations

Patients presenting beyond 24h after they were last seen to be well may be considered for endovascular thrombectomy if imaging suggests the presence of salvageable brain tissue.

Endovascular thrombectomy should be performed by an experienced neurointerventionist with recognised training in the procedure (Conjoint Committee for Recognition of Training in Interventional Neuroradiology CCINR.org.au).

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)

Weak recommendation

All stroke patients who have failed swallow screening or who deteriorate should have a comprehensive assessment of swallowing performed by a speech pathologist. (Kertscher et al. 2014; O'Horo et al. 2015)

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](#).

Acute antithrombotic therapy

Strong recommendation

Patients with ischaemic stroke who are not receiving reperfusion therapy should receive antiplatelet therapy as soon as brain imaging has excluded haemorrhage. (Sandercock et al. 2014)

Strong recommendation AGAINST

Acute antiplatelet therapy should not be given within 24 hours of thrombolysis administration with the exception of patients who require stent implantation as part of acute stroke therapy. (Zinkstok et al. 2012)

Strong recommendation AGAINST

Routine use of anticoagulation in patients without cardioembolism (e.g. atrial fibrillation) following TIA/stroke is not recommended. (Wang et al. 2023)

Strong recommendation

Aspirin plus clopidogrel should be commenced within 24 hours and used in the short term (first three weeks) in patients with minor ischaemic stroke or high-risk TIA to prevent stroke recurrence. (Hao et al. 2018)

Weak recommendation

Aspirin plus ticagrelor commenced within 24 hours may be used in the short term (first 30 days) in patients with minor ischaemic stroke or high-risk TIA to prevent stroke recurrence. (Johnston et al. 2020)

Acute blood pressure lowering therapy

Strong recommendation AGAINST Updated Draft submitted to NHMRC for approval – JUNE 2025

Intensive blood pressure lowering in the acute phase of care to a target SBP of < 140 mmHg is not recommended for patients with **ischaemic** stroke. (Chen and Zhu 2024)

Strong recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

In patients with **acute intracerebral haemorrhage**, early blood pressure lowering should be undertaken with a target systolic blood pressure of 130 to 140 mmHg within one hour of commencing treatment. (Wang et al 2024; Ma et al 2023; Li et al 2024)

Weak recommendation

Pre-existing antihypertensive medication may be withheld until patients are neurologically stable and treatment can be given safely. (Bath and Krishnan 2014)

Practice statement

Consensus-based recommendations

- All acute stroke patients should have their blood pressure closely monitored in the first 48 hours after stroke onset.
- Patients with acute ischaemic stroke eligible for treatment with intravenous thrombolysis should have their blood pressure reduced to below 185/110 mmHg before treatment and in the first 24 hours after treatment.
- Patients with acute ischaemic stroke with blood pressure > 220/120 mmHg should have their blood pressure cautiously reduced (e.g. by no more than 20%) over the first 24 hours.

Intracerebral haemorrhage (ICH) management

Medical interventions

Weak recommendation

- For stroke patients with warfarin-related intracerebral haemorrhage, prothrombin complex concentrate should be urgently administered in preference to standard fresh frozen plasma to reverse coagulopathy. (Steiner et al. 2016)
- Intravenous vitamin K (5–10 mg) should be used in addition to prothrombin complex to reverse warfarin but is insufficient as a sole treatment. (Steiner et al. 2016)

Weak recommendation

Stroke patients with intracerebral haemorrhage related to direct oral anticoagulants should urgently receive a specific reversal agent where available. (Pollack et al. 2016; Connolly et al. 2016)

Strong recommendation **AGAINST**

For stroke patients with intracerebral haemorrhage previously receiving antiplatelet therapy, platelet transfusion should not be administered. (Baharoglu et al. 2016)

Strong recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

In patients with **acute intracerebral haemorrhage**, early blood pressure lowering should be undertaken with a target systolic blood pressure of 130 to 140 mmHg within one hour of commencing treatment. (Wang et al 2024; Ma et al 2023; Li et al 2024) (see [Acute blood pressure lowering therapy](#)).

Weak recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

For stroke patients with intracerebral haemorrhage, a care bundle approach to acute management may be used. (Ma et al 2023)

Oxygen therapy

Weak recommendation **AGAINST**

For acute stroke and Transient Ischaemic Attack (TIA) patients who have SpO₂ >92% on room air, the routine use of supplemental oxygen is not recommended. (Chu et al 2018; Ding et al 2018)

Weak recommendation AGAINST

For acute ischaemic stroke patients, hyperbaric oxygen therapy is not recommended. (Bennett et al. 2014; Li et al. 2024)

Practice statement Updated

Consensus-based recommendations

If supplemental oxygen is required (SpO₂ <92% on room air) a target oxygen saturation of 92-96% is reasonable, or 88-92% if the patient is at risk of hypercapnic respiratory failure. (Barnett et al. 2022)

Brain cytoprotection

Practice statement

Consensus-based recommendations

For stroke patients, putative brain cytoprotective agents, including hypothermic cooling, are not recommended outside the context of research.

Practice statement

Consensus-based recommendations

Patients with acute ischaemic stroke who were receiving statins prior to admission can continue statin treatment.

Glycaemic therapy

Strong recommendation

All stroke patients should have their blood glucose level monitored for the first 72 hours following admission, and appropriate glycaemic therapy instituted to treat hyperglycaemia (glucose levels greater than 10 mmol/L), regardless of their diabetic status. (Middleton et al. 2011)

Strong recommendation AGAINST

For stroke patients, an intensive approach to the maintenance of tight glycaemic control (between 4.0–7.5 mmol/L) is not recommended. (Bellolio et al. 2014; Wu et al. 2024)

Pyrexia management

Strong recommendation

All stroke patients should have their temperature monitored at least four times a day for 72 hours. (Middleton et al. 2011)

Weak recommendation

Stroke patients with fever ≥ 37.5 °C may be treated with paracetamol as an antipyretic therapy. (Chen et al. 2018; Middleton et al. 2011)

Acute stroke telehealth services

Strong recommendation

In hospitals without onsite 24/7 stroke medical specialist availability, telestroke systems should be used to assist in patient assessment and decision making regarding acute thrombolytic therapy and possible transfer for endovascular therapy. This system should include the ability for stroke medical specialists to access remote brain imaging scans and preferably include the use of videoconferencing facilities or, if not possible, ensure the diagnosis and management discussions between local clinicians/family/patient occurs via a telephone consultation. (Lazarus et al. 2020; Bladin et al. 2020)

Head position

Weak recommendation

Patients with acute stroke, while in bed and not receiving nasogastric feeding, may be managed in any position during the first 24 hours after hospital admission. (Anderson et al. 2017)

Chapter 4 of 8: Secondary prevention

Adherence to pharmacotherapy

Weak recommendation

Interventions to promote adherence with medication regimens may be provided to all patients with stroke. Such regimens may include combinations of the following:

- reminders, self-monitoring, reinforcement, counselling, motivational interviewing, family therapy, telephone follow-up, supportive care and dose administration aids (Lawrence et al. 2015; Mahtani et al. 2011; Nieuwlaat et al. 2014; Haynes et al. 2008)
- development of self-management skills and modification of dysfunctional beliefs about medication (O'Carroll et al. 2014; Kronish et al. 2014)
- information and education in hospital and in the community (Lawrence et al. 2015; Mahtani et al. 2011; Nieuwlaat et al. 2014).

Blood pressure lowering therapy

Acute blood pressure management

Practice statement

Consensus-based recommendations

- All patients with acute stroke should have their blood pressure closely monitored in the first 48 hours after stroke onset.
- Patients with acute ischaemic stroke eligible for treatment with intravenous thrombolysis should have their blood pressure reduced to below 185/110 mmHg before treatment and in the first 24 hours after treatment.
- Patients with acute ischaemic stroke with blood pressure >220/120/mmHg should have their blood pressure cautiously reduced (e.g. by no more than 20%) over the first 24 hours.

Strong recommendation **AGAINST** Updated Draft submitted to NHMRC for approval – JUNE 2025

Intensive blood pressure lowering in the acute phase of care to a target SBP of < 140 mmHg is not recommended for patients with **ischaemic** stroke. (Chen and Zhu 2024)

Strong recommendation Updated Draft submitted to NHMRC for approval – JUNE 2025

In patients with **acute intracerebral haemorrhage**, early blood pressure lowering should be undertaken with a target systolic blood pressure of 130 to 140 mmHg within one hour of commencing treatment. (Wang et al 2024; Ma et al 2023; Li et al 2024)

Weak recommendation

Pre-existing antihypertensive agents may be withheld until patients are neurologically stable and treatment can be given safely. (Bath and Krishnan 2014)

Long term blood pressure management

Strong recommendation

- All patients with stroke or TIA, with a clinic blood pressure of >140/90mmHg should have long term blood pressure lowering therapy initiated or intensified. (Zonneveld et al. 2018; Ettehad et al. 2016)
- Blood pressure lowering therapy should be initiated or intensified before discharge for those with stroke or TIA, or soon after TIA if the patient is not admitted. (Zonneveld et al. 2018; Ettehad et al. 2016)

- Any of the following drug classes are acceptable as blood pressure lowering therapy; angiotensin-converting-enzyme inhibitor, angiotensin II receptor antagonists, calcium channel blocker, thiazide diuretics. Beta-blockers should not be used as first-line agents unless the patient has ischaemic heart disease. (Zonneveld et al. 2018; Mukete et al. 2015)

Weak recommendation

- In patients with a systolic blood pressure of 120-140mmHg who are not on treatment, initiation of antihypertensive treatment is reasonable, with best evidence for dual (ACEI/diuretic) therapy. (Ettehad et al. 2016; Kitagawa et al. 2019; Katsanos et al. 2017)
- The ideal long term blood pressure target is not well established. A target of <130mmHg systolic may achieve greater benefit than a target of 140mmHg systolic, especially in patients with stroke due to small vessel disease, provided there are no adverse effects from excessive blood pressure lowering. (Kitagawa et al. 2019; Ettehad et al. 2016)

Management of atrial fibrillation

Strong recommendation

- For patients with ischaemic stroke or TIA, with atrial fibrillation (both paroxysmal and permanent), oral anticoagulation is recommended for long-term secondary prevention. (Saxena et al 2004; Saxena and Koudstaal 2004; Ruff et al. 2014)
- Direct oral anticoagulants (DOACs) should be initiated in preference to warfarin for patients with non-valvular atrial fibrillation and adequate renal function. (Ruff et al. 2014)
- For patients with valvular atrial fibrillation or inadequate renal function, warfarin (target INR 2.5, range 2.0-3.0) should be used. Patients with mechanical heart valves or other indications for anticoagulation should be prescribed warfarin. (Tawfik et al. 2016)

Weak recommendation Updated

For patients with ischaemic stroke without significant haemorrhagic transformation, direct oral anticoagulant therapy can commence or recommence within 48 hours of minor-moderate stroke and from day 6-7 for major stroke (Fischer et al. 2023).

Info box

Practice points

- Concurrent antiplatelet therapy should not be used for patients who are anticoagulated for atrial fibrillation unless there is clear indication (e.g. recent coronary stent). Addition of antiplatelet for stable coronary artery disease in the absence of stents should not be used.
- For patients with TIA, anticoagulant therapy should begin once CT or MRI has excluded intracranial haemorrhage as the cause of the current event.

Weak recommendation

For patients with ischaemic stroke due to atrial fibrillation and a genuine contraindication to long-term anticoagulation, percutaneous left atrial appendage occlusion may be a reasonable treatment to reduce recurrent stroke risk. (Osmancik et al. 2020)

Antiplatelet therapy

Strong recommendation

Long-term antiplatelet therapy (low-dose aspirin, clopidogrel or combined low-dose aspirin and modified release dipyridamole) should be prescribed to all patients with ischaemic stroke or TIA who are not prescribed anticoagulation therapy, taking into consideration patient co-morbidities. (Rothwell et al 2016; Niu et al 2016; Greving et al 2019)

Strong recommendation

All ischaemic stroke and TIA patients should have antiplatelet therapy commenced as soon as possible once brain imaging has excluded haemorrhage unless thrombolysis has been administered, in which case antiplatelet therapy can commence after 24-hour brain imaging has excluded major haemorrhagic transformation. (see [Antithrombotic therapy](#) in [Acute medical and surgical management](#))

Strong recommendation

Aspirin plus clopidogrel should be commenced within 24 hours and used in the short term (first three weeks) in patients with minor ischaemic stroke or high-risk TIA to prevent stroke recurrence. (Hao et al. 2018) (see [Antithrombotic therapy](#) in [Acute medical and surgical management](#))

Strong recommendation **AGAINST**

The combination of aspirin plus clopidogrel should not be used for the long-term secondary prevention of cerebrovascular disease in people who do not have acute coronary disease or recent coronary stent. (Zhang et al. 2015; Greving et al. 2019)

Strong recommendation **AGAINST**

Antiplatelet agents should not be used for stroke prevention in patients with atrial fibrillation. (Connolly et al. 2011)

Weak recommendation

In patients with spontaneous (or primary) intracerebral haemorrhage who were previously prescribed antithrombotic therapy for secondary prevention of cardiovascular and/or cerebrovascular disease, restarting antiplatelet therapy after the acute phase may be considered, although the optimal timing is undetermined (see practical information). (RESTART Collaboration 2019)

Cholesterol lowering therapy

Strong recommendation

All patients with ischaemic stroke or TIA with possible atherosclerotic contribution and reasonable life expectancy should be prescribed a high-potency statin, regardless of baseline lipid levels. (Manktelow et al. 2009; Tramacer et al. 2019)

Strong recommendation

In patients with ischaemic stroke, cholesterol lowering therapy should target LDL cholesterol < 1.8 mmol/L for secondary prevention of atherosclerotic cardiovascular disease. (Amarenco et al. 2020; Lee et al. 2022)

Weak recommendation AGAINST

Statins should not be used routinely for intracerebral haemorrhage. (Manktelow et al. 2009; Amarenco et al. 2006)

Weak recommendation AGAINST

Fibrates should not be used routinely for the secondary prevention of stroke. (Zhou et al. 2013; Wang et al. 2015)

Diabetes management

Info box

Practice point

Patients with glucose intolerance or diabetes should be managed in line with [Diabetes Australia Best Practice Guidelines](#).

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)

Diet

Practice statement

Consensus-based recommendations

All patients with stroke or TIA should be supported to follow a Mediterranean or similar style diet (high intake of plant-based foods such as fruit, vegetables, whole grain cereals, legumes and nuts, moderate intake of low fat dairy products, and low intake of processed and red meat and sugary foods, as well as olive oil as the main added dietary fat) to reduce the risk of recurrent stroke. (English et al. 2021; Sebastian et al. 2024)

Info box

Practice points

All patients with stroke should be referred to an Accredited Practising Dietitian who can provide individualised dietary advice.

Physical activity

Info box

Practice points

Patients with stroke or TIA should be advised and supported to undertake appropriate, regular physical activity as outlined in one of the following existing guidelines:

- [Australia's Physical Activity & Sedentary Behaviour Guidelines for Adults \(18-64 years\)](#) (Commonwealth of Australia 2014) OR
- [Physical Activity Recommendations for Older Australians \(65 years and older\)](#) (Commonwealth of Australia 2005).

Obesity

Info box

Practice points

Patients with stroke or TIA who are overweight or obese should be offered advice and support to aid weight loss.

Smoking

Info box

Practice points

Patients with stroke or TIA who smoke should be advised to stop and assisted to quit in line with existing guidelines, such as [Supporting smoking cessation: a guide for health professionals](#). (RACGP 2019)

Alcohol

Info box

Practice points

People with stroke or TIA should be advised to avoid excessive alcohol consumption (>4 standard drinks per day) in line with the [Australian Guidelines to Reduce Health Risks from Drinking Alcohol](#). (NHMRC 2020)

Chapter 5 of 8: Rehabilitation

Commencement of rehabilitation

Strong recommendation **AGAINST**

For stroke patients, starting intensive out-of-bed activities within 24 hours of stroke onset is not recommended. (Rethnam et al. 2020, Langhorne et al. 2018, Bernhardt et al. 2015)

Strong recommendation

All stroke patients should commence mobilisation (out-of-bed activity) within 48 hours of stroke onset unless otherwise contraindicated (e.g. receiving end-of-life care). (Bernhardt et al. 2015; Lynch et al. 2014)

Weak recommendation

For patients with mild and moderate stroke, frequent, short sessions of out-of-bed activity should be provided, but the optimal timing within the 48-hour post-stroke time period is unclear. (Bernhardt et al. 2015)

Amount of rehabilitation

Strong recommendation

- For stroke survivors, rehabilitation should be structured to provide as much scheduled therapy (occupational therapy and physiotherapy) as possible. (Lohse et al. 2014; Schneider et al. 2016; Veerbeek et al. 2014)
- For stroke survivors, group circuit class therapy should be used to increase scheduled therapy time. (English et al. 2015)

Practice statement

Consensus-based recommendations

Stroke survivors should be encouraged to continue with active task practice outside of scheduled therapy sessions. This could include strategies such as:

- self-directed, independent practice;
- semi-supervised and assisted practice involving family/friends, as appropriate.

Weak recommendation

A minimum of three hours a day of scheduled therapy (occupational therapy and physiotherapy) is recommended, ensuring at least two hours of active task practice occurs during this time. (Lohse et al. 2014; Schneider et al. 2016)

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)

Sensorimotor impairments

Weakness

Strong recommendation

For stroke survivors with reduced strength in their arms or legs, progressive resistance training should be provided to improve strength. (Dorsch et al. 2018)

Weak recommendation

- For stroke survivors with arm weakness repetitive practice using assistive technology, constraint induced movement therapy (CIMT), and robotics may be used to improve arm strength. (de Sousa et al. 2018)
- For stroke survivors with leg weakness task specific training, repetitive practice using cycling or electrical stimulation may be used to improve leg strength. (de Sousa et al. 2018)

Loss of sensation

Weak recommendation

For stroke survivors with sensory loss of the upper limb, sensory-specific training may be provided. (de Diego et al. 2013; Carey et al. 2011; Doyle et al. 2010)

Loss of cardiorespiratory fitness

Strong recommendation

For stroke survivors, rehabilitation should include individually-tailored exercise interventions to improve cardiorespiratory fitness. (Saunders et al. 2020)

Practice statement

Consensus-based recommendations

- All stroke survivors should commence cardiorespiratory training during their inpatient stay.
- Stroke survivors should be encouraged to participate in ongoing regular physical activity regardless of their level of disability.

Visual field loss

Practice statement

Consensus-based recommendations

- All stroke survivors should have an:
 - assessment of visual acuity while wearing the appropriate glasses, to check their ability to read newspaper text and see distant objects clearly;
 - examination for the presence of visual field deficit (e.g. hemianopia) and eye movement disorders (e.g. strabismus and motility deficit).

Activity limitations

Sitting

Strong recommendation

For stroke survivors who have difficulty sitting, practising reaching beyond arm's length while sitting with supervision/assistance should be undertaken. (Veerbeek et al. 2014)

Standing up from sitting

Strong recommendation

For stroke survivors who have difficulty in standing up from a chair, practice of standing up should be undertaken. (Pollock et al. 2014; French et al. 2016)

Standing

Strong recommendation

For stroke survivors who have difficulty with standing, activities that challenge balance should be provided (French et al. 2016; van Duijnhoven et al. 2016; Hugues et al. 2019).

Weak recommendation

For stroke survivors who have difficulty with standing balance, one or more of the following interventions may be used in addition to practicing tasks that challenge balance:

- Virtual reality training, which may include treadmill training, motion capture or force sensing devices (e.g. Wii Balance Boards) (Zhang et al. 2021; Laver et al. 2017)
- Visual or auditory feedback e.g. force platform biofeedback (Veerbeek et al. 2014; Stanton et al. 2017)
- Electromechanically assisted gait or standing training (Zheng et al. 2019)

Walking

Strong recommendation

Stroke survivors with difficulty walking should be given the opportunity to undertake tailored repetitive practice of walking (or components of walking) as much as possible. (French et al. 2016)

The following modalities may be used:

- Circuit class therapy (with a focus on overground walking practice) (Veerbeek et al. 2014);
- Treadmill training with or without body weight support (Mehrholz et al. 2014; Nascimento et al. 2021).

Weak recommendation

For stroke survivors with difficulty walking, one or more of the following interventions may be used in addition to those listed above:

- Virtual reality training. (Corbetta et al. 2015)
- Electromechanically assisted gait training. (Mehrholz et al. 2013)
- Biofeedback. (Stanton et al. 2017)
- Cueing of cadence. (Nascimento et al. 2015)
- Electrical stimulation. (Howlett et al. 2015)

Weak recommendation

For stroke survivors, individually fitted lower limb orthoses may be used to minimise limitations in walking ability. Improvement in walking will only occur while the orthosis is being worn. (Daryabor et al. 2021; Wada et al. 2021)

Arm activity

Strong recommendation

For stroke survivors with some active wrist and finger extension, intensive constraint-induced movement therapy (minimum 2 hours of active therapy per day for 2 weeks, plus restraint for at least 6 hours a day) should be provided to improve arm and hand use. (Corbetta et al. 2015)

Weak recommendation

For stroke survivors with at least some voluntary movement of the arm and hand, repetitive task-specific training may be used to improve arm and hand function. (French et al. 2016)

Weak recommendation

For stroke survivors with mild to severe arm weakness, mechanically assisted arm training (e.g. robotics) may be used to improve upper limb function. (Mehrholtz et al. 2018)

Weak recommendation

Virtual reality and interactive games may be used to improve upper limb function. (Laver et al. 2017; Aminov et al. 2018)

Weak recommendation

For stroke survivors with mild to severe arm or hand weakness, electrical stimulation in conjunction with motor training may be used to improve upper limb function. (Howlett et al. 2015; Yang et al. 2019)

Weak recommendation

For stroke survivors with mild to moderate weakness of their arm, mental practice in conjunction with active motor training may be used to improve arm function. (Barcley-Goddard et al. 2020; Borges et al. 2018)

Weak recommendation

For stroke survivors with mild to moderate weakness, mirror therapy may be used as an adjunct to routine therapy to improve arm function after stroke. (Thieme et al. 2018)

Strong recommendation AGAINST

Hand and wrist orthoses (splints) should not be used as part of routine practice as they have no effect on function, pain or range of movement. (Tyson et al. 2011)

Weak recommendation AGAINST

Brain stimulation (transcranial direct stimulation or repetitive transcranial magnetic stimulation) should not be used in routine practice for improving arm function, and only used as part of a research framework. (Elsner et al. 2020; van Lieshout et al. 2019; Hao et al. 2013)

Participation restrictions

Activities of daily living

Strong recommendation

- Community-dwelling stroke survivors who have difficulties performing daily activities should be assessed by a trained clinician. (Legg et al. 2017)
- Community-dwelling stroke survivors with confirmed difficulties in personal or extended activities of daily living should have specific therapy from a trained clinician (e.g. task-specific practice and training in the use of appropriate aids) to address these issues. (Legg et al. 2017)

Weak recommendation

For stroke survivors, virtual reality technology may be used to improve activities of daily living outcomes in addition to usual therapy. (Laver et al. 2017)

Weak recommendation **AGAINST**

For older stroke survivors living in a nursing home, routine occupational therapy is not recommended to improve ADL function. (Sackley et al. 2015)

Weak recommendation **AGAINST**

Acupuncture is not routinely recommended to improve activities of daily living. (Yang et al. 2016)

Strong recommendation **AGAINST**

Administration of amphetamines to improve activities of daily living is not recommended. (Martinsson et al. 2007)

Weak recommendation **AGAINST**

Selective serotonin reuptake inhibitors should not be used to reduce disability. (Legg et al. 2021)

Weak recommendation **AGAINST**

Brain stimulation (transcranial direct stimulation or repetitive transcranial magnetic stimulation) should not be used in routine practice to improve activities of daily living and only used as part of a research framework. (Elsner et al. 2020; Hao et al. 2013)

Communication difficulties

Assessment of communication deficits

Info box

Practice point

- 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 point

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 points

- 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.

Perception

Practice statement

Consensus-based recommendations

- Stroke survivors with identified perceptual difficulties should have a formal perceptual (i.e. neurological and neuropsychological) assessment.
- Stroke survivors with an identified perceptual impairment and their carer should receive:
 - verbal and written information about the impairment;
 - an assessment and adaptation of their environment to reduce potential risk and promote independence;
 - practical advice/strategies to reduce risk (e.g. trips, falls, limb injury) and promote independence;
 - intervention to address the perceptual difficulties, ideally within the context of a clinical trial.

Attention and concentration

Practice statement

Consensus-based recommendations

For stroke survivors with attentional impairments or those who appear easily distracted or unable to concentrate, a formal neuropsychological or cognitive assessment should be performed.

Weak recommendation

For stroke survivors with attention and concentration deficits, cognitive rehabilitation may be used. (Loetscher et al. 2019; Rogers et al. 2018; Virk et al. 2016)

Weak recommendation

For stroke survivors with attention and concentration deficits, exercise training and leisure activities may be provided. (Liu-Ambrose et al. 2015)

Memory

Weak recommendation

For stroke survivors with memory deficits, cognitive rehabilitation may be used to improve memory function in the short term. Memory rehabilitation strategies may include internal (mental) strategies (e.g. association, mental rehearsal, rhymes) and external compensatory aids (e.g. notebooks, diaries, calendars, alarms, audio recordings, photos, mobile phones). (das Nair et al. 2016; Withiel et al. 2019)

Practice statement

Consensus-based recommendations

Any stroke survivor found to have memory impairment causing difficulties in rehabilitation or adaptive functioning should:

- be referred to a suitably qualified healthcare professional for a more comprehensive neuropsychological and functional assessment of their memory abilities and needs;
- have their nursing and therapy sessions tailored to use techniques that capitalise on preserved memory abilities and existing memory strategies (both internal and external);
- be comprehensively trained on how to use internal strategies (e.g. association, mental rehearsal, rhymes) and external strategies (e.g. notebooks, diaries, audio recordings, smartphone apps and alarms);
- have therapy delivered in an environment as similar to the stroke survivor's usual environment as possible to encourage generalisation.

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)

Limb apraxia

Info box

Practice point

Stroke survivors who have suspected difficulties executing tasks but who have adequate limb movement and sensation should be screened for apraxia.

Weak recommendation

For stroke survivors with limb apraxia, interventions such as gesture training, strategy training and/or errorless learning may be provided. (Lindsten-McQueen et al. 2014)

Neglect

Info box

Practice point

Any stroke survivor with suspected or actual neglect or impairment of spatial awareness should have a full assessment using validated tools.

Weak recommendation

For stroke survivors with symptoms of unilateral neglect, cognitive rehabilitation (e.g. computerised scanning training, pen and paper tasks, visual scanning training, eye patching, mental practice) may be provided. (Bowen et al. 2013)

Weak recommendation

For stroke survivors with symptoms of unilateral neglect, mirror therapy may be used to improve arm function and ADL performance. (Thieme et al. 2018)

Practice statement

Consensus-based recommendations

Stroke survivors with impaired attention to one side should be:

- given a clear explanation of the impairment;
- taught compensatory strategies systematically, such as visual scanning to reduce the impact of neglect on activities such as reading, eating and walking;
- given cues to draw attention to the affected side during therapy and nursing procedures;
- monitored to ensure that they do not eat too little through missing food on one side of the plate.

Weak recommendation AGAINST

Non-invasive brain stimulation should not be used in routine clinical practice to decrease unilateral neglect, but may be used within a research framework. (Salazar et al. 2018; Kwon et al. 2018; Fan et al. 2018)

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 hydration

Strong recommendation

- All stroke patients should have their hydration status assessed, monitored, and managed throughout their hospital admission.
- Where fluid support is required, crystalloid solution should be used in preference to colloid solutions as the first option to treat or prevent dehydration. (Visvanathan et al. 2015)

Early feeding

Strong recommendation

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

Weak recommendation

- For patients with stroke 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 patients with stroke, 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 patients with stroke 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. (Chipps et al 2014; Lam et al 2013; Brady et al 2006)

Strong recommendation

Staff and carers of patients with stroke (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 patients with stroke, 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)

Spasticity

Weak recommendation

For stroke survivors with **upper** limb spasticity, Botulinum Toxin A in addition to rehabilitation therapy may be used to reduce spasticity, but is unlikely to improve activity or motor function. (Foley et al. 2013; Gracies et al. 2014)

Weak recommendation

For stroke survivors with **lower** limb spasticity, Botulinum Toxin A in addition to rehabilitation therapy may be used to reduce spasticity but is unlikely to improve motor function or walking. (Wu et al. 2016; McIntyre et al. 2012; Olvey et al. 2010)

Weak recommendation **AGAINST**

For stroke survivors with spasticity, acupuncture should not be used for treatment of spasticity in routine practice other than as part of a research study. (Lim et al. 2015)

Weak recommendation

For stroke survivors with spasticity, adjunct therapies to Botulinum Toxin A, such as electrical stimulation, casting and taping, may be used. (Stein et al. 2015; Mills et al. 2016; Santamato et al. 2015)

Weak recommendation AGAINST

For stroke survivors, the routine use of stretch to reduce spasticity is not recommended. (Harvey et al. 2017)

Contracture

Strong recommendation AGAINST

For stroke survivors at risk of developing contracture who are receiving comprehensive, active therapy the routine use of splints or stretch of the arm or leg muscles is not recommended. (Harvey et al. 2017)

Practice statement

Consensus-based recommendations

- For stroke survivors, serial casting may be trialled to reduce severe, persistent contracture when conventional therapy has failed.
- For stroke survivors at risk of developing contracture or who have developed contracture, active motor training or electrical stimulation to elicit muscle activity should be provided.

Subluxation

Weak recommendation

For stroke survivors at risk of shoulder subluxation, electrical stimulation may be used in the first six months after stroke to prevent or reduce subluxation. (Vafadar et al. 2015; Lee et al. 2017)

Weak recommendation AGAINST

For stroke survivors at risk of shoulder subluxation, shoulder strapping is not recommended to prevent or reduce subluxation. (Appel et al. 2014)

Practice statement

Consensus-based recommendations

For stroke survivors at risk of shoulder subluxation, firm support devices (e.g. devices such as a laptray) may be used. A sling maybe used when standing or walking.

Practice statement

Consensus-based recommendations

To prevent complications related to shoulder subluxation, education and training about correct manual handling and positioning should be provided to the stroke survivor, their family/carer and health professionals, and particularly nursing and allied health staff.

Pain

Shoulder pain

Weak recommendation

For stroke survivors with shoulder pain, shoulder strapping may be used to reduce pain. (Appel et al. 2014)

Weak recommendation

For stroke survivors with shoulder pain, electrical stimulation may be used to manage pain. (Qiu et al. 2019)

Weak recommendation

For stroke survivors with shoulder pain, shoulder injections (either sub acromial steroid injections for patients with rotator cuff syndrome, or methylprednisolone and bupivacaine for suprascapular nerve block) may be used to reduce pain. (Adey-Wakeling et al. 2013; Rah et al. 2012)

Weak recommendation

For stroke survivors with shoulder pain and upper limb spasticity, Botulinum Toxin A may be used to reduce pain. (Singh et al. 2010)

Weak recommendation

For stroke survivors with shoulder pain, acupuncture in addition to comprehensive rehabilitation may be used to reduce pain. (Liu et al. 2019)

Practice statement

Consensus-based recommendations

For stroke survivors with severe weakness who are at risk of developing shoulder pain, management may include:

- shoulder strapping;
- education of staff, carers and stroke survivors about preventing trauma;
- active motor training to improve function.

Info box

Practice point

For stroke survivors who develop shoulder pain, management should be based on evidence-based interventions for acute musculoskeletal pain.

Central post-stroke pain

Practice statement **Updated**

Consensus-based recommendations

For stroke survivors with central post-stroke pain tricyclic antidepressant or antiepileptic medication may be trialed to reduce pain. Any trial of medications to reduce pain needs to be undertaken with caution with planned follow up to minimise risks. Any non-pharmacological interventions trialed are strongly encouraged to be used within a research framework.

Swelling of the extremities

Consensus-based recommendations

For stroke survivors with severe weakness who are at risk of developing swelling of the extremities, management may include the following

- passive mobilisation;
- elevation of the limb when resting.

Practice statement

Consensus-based recommendations

For stroke survivors who have swelling of the hands or feet management may include the following:

- passive mobilisation;
- elevation of the limb when resting.

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.

Incontinence

Urinary incontinence

Weak recommendation

- All stroke survivors with suspected urinary continence difficulties should be assessed by trained personnel using a structured functional assessment. (Martin et al. 2006)
- For stroke survivors, a portable bladder ultrasound scan should be used to assist in diagnosis and management of urinary incontinence. (Martin et al. 2006)

Weak recommendation

- Stroke patients in hospital with confirmed continence difficulties, should have a structured continence management plan formulated, documented, implemented and monitored. (Wikander et al. 1998)
- If incontinence persists the stroke survivor should be re-assessed and referred for specialist review once in the community. (Thomas et al. 2019)

Weak recommendation

For stroke survivors with urge incontinence:

- anticholinergic drugs can be tried (Nabi et al. 2006; Abrams et al. 2017);
- a prompted or scheduled voiding regime program/ bladder retraining can be trialled (Thomas et al. 2015; Thomas et al. 2019; Abrams et al. 2017);
- if continence is unachievable, containment aids can assist with social continence.

Practice statement

Consensus-based recommendations

For stroke patients with urinary retention:

- The routine use of indwelling catheters is not recommended. However if urinary retention is severe, intermittent catheterisation should be used to assist bladder emptying during hospitalisation. If retention continues, intermittent catheterisation is preferable to indwelling catheterisation.
- If using intermittent catheterisation, a closed sterile catheterisation technique should be used in hospital.
- Where management of chronic retention requires catheterisation, consideration should be given to the choice of appropriate route, urethral or suprapubic.
- If a stroke survivor is discharged with either intermittent or indwelling catheterisation, they and their family/carer will require education about management, where to access supplies and who to contact in case of problems.

Practice statement

Consensus-based recommendations

For stroke survivors with functional incontinence, a whole-team approach is recommended.

Practice statement

Consensus-based recommendations

For stroke survivors, the use of indwelling catheters should be avoided as an initial management strategy except in acute urinary retention.

Faecal incontinence

Weak recommendation

- All stroke survivors with suspected faecal continence difficulties should be assessed by trained personnel using a structured functional assessment. (Harari et al. 2004)
- For stroke survivors with constipation or faecal incontinence, a full assessment (including a rectal examination) should be carried out and appropriate management of constipation, faecal overflow or bowel incontinence established and targeted education provided. (Harari et al. 2004)

Weak recommendation

For stroke survivors with bowel dysfunction, bowel habit retraining using type and timing of diet and exploiting the gastro-colic reflex should be used. (Venn et al. 1992; Munchiando et al. 1993)

Practice statement

Consensus-based recommendations

For stroke survivors with bowel dysfunction:

- Education and careful discharge planning should be provided.
- Use of short-term laxatives may be trialled.
- Increase frequency of mobilisation (walking and out of bed activity) to reduce constipation.
- Use of the bathroom rather than use of bed pans should be encouraged.
- Use of containment aids to assist with social continence where continence is unachievable.

Mood disturbance

Mood assessment

Info box

Practice points

- 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.

Treatment for Emotionalism

Weak recommendation

For stroke survivors with emotionalism, antidepressant medication such as selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressants may be used. (Allida et al. 2022)

Prevention of depression

Weak recommendation

For stroke survivors, antidepressant medication may be used to prevent depression. (Allida et al. 2020)

Weak recommendation

For stroke survivors, psychological strategies (e.g. problem solving, motivational interviewing) may be used to prevent depression. (Allida et al. 2020)

Treatment of depression

Weak recommendation

For stroke survivors with depression, antidepressants, which includes SSRIs should be considered. There is no clear evidence that particular antidepressants produce greater effects than others and will vary according to the benefit and risk profile of the individual. (Allida et al. 2023)

Weak recommendation

For stroke survivors with depression or depressive symptoms, psychological therapy may be provided. (Allida et al. 2023)

Weak recommendation

For stroke survivors with depression or depressive symptoms, structured exercise programs, particularly resistance training or programs of high intensity, may be used. (Eng et al. 2014; Saunders et al. 2020)

Weak recommendation

For stroke survivors with depression or depressive symptoms, acupuncture may be used. (Zhang et al. 2010)

Weak recommendation

For stroke survivors with depression, non-invasive brain stimulation (repetitive transcranial magnetic stimulation [rTMS]) may be used. (Allida et al. 2023)

Treatment of anxiety

Practice statement

Consensus-based recommendations

For people with anxiety after stroke, psychological therapy and/or relaxation strategies, such as yoga may be trialed to reduce levels of anxiety. The addition of pharmacotherapy should be very carefully considered taking into account higher risk of harms.

Personality and behaviour

Practice statement

Consensus-based recommendations

- Behavioural changes after stroke can impact on a person's ability to engage in meaningful activities and also their quality of life. Therefore, the impact of any behavioural changes on relationships, employment and leisure should be assessed and addressed across the lifespan.
- Stroke survivors and their families/carers should be given access to individually tailored interventions for personality and behavioural changes. This may include positive behaviour support programs, anger-management therapy and rehabilitation training and support in management of complex and challenging behaviour.

Deep venous thrombosis or pulmonary embolism

Weak recommendation

For acute ischaemic stroke patients who are immobile, low molecular weight heparin in prophylactic doses may be used in the absence of contraindications. (Sandercock et al. 2015; Sherman et al. 2007)

Weak recommendation

For acute stroke patients who are immobile, the use of intermittent pneumatic compression may be used, either as an alternative to low molecular weight heparin or in those with a contraindication to pharmacological DVT prophylaxis (including patients with intracerebral haemorrhage or within 24 hours of thrombolysis). (Dennis et al. 2013)

Strong recommendation **AGAINST**

Antithrombotic stockings are not recommended for the prevention of DVT or PE post stroke. (Naccarato et al. 2010)

Info box

Practice points

- For stroke patients, pharmacological prophylaxis should not be used in the first 24 hours after thrombolysis until brain imaging has excluded significant haemorrhagic transformation.
- For acute stroke patients, early mobilisation and adequate hydration should be encouraged to help prevent DVT and PE.
- For stroke patients receiving intermittent pneumatic compression, skin integrity should be assessed daily.
- For patients with intracerebral haemorrhage, pharmacological prophylaxis may be considered after 48-72 hours and once haematoma growth has stabilised, although evidence is limited.

Falls

Practice statement

Consensus-based recommendations

- For stroke patients, a falls risk assessment, including fear of falling, should be undertaken on admission to hospital. A management plan should be initiated for all patients identified as at risk of falls.
- For stroke survivors at high risk of falls, a comprehensive home assessment for the purposes of reducing falling hazards should be carried out by a qualified health professional. Appropriate home modifications (as determined by a health professional) for example installation of grab rails and ramps may further reduce falls risk.

Weak recommendation

For stroke survivors who are at risk of falling, multifactorial interventions in the community, including an individually prescribed exercise program and advice on safety, should be provided. (Denissen et al. 2019; Gillespie et al. 2012)

Pressure injury

Info box

Practice points

Staff and carers of patients with stroke at risk of pressure injuries (in hospital, in residential care and home settings) should be trained to assess skin, provide appropriate pressure area care, and treat pressure injuries consistent with existing guidelines such as the [International Guidelines for the Prevention and Treatment of Pressure Ulcers/Injuries](#). (EPUAP, NPIAP and PPPIA 2019)

Sleep Disorders

Info Box **New**

Practice point

If obstructive sleep apnoea or other sleep disorders have previously been diagnosed, patients with stroke should be encouraged to continue with their usual treatment while in hospital and monitor for any changes.

Info Box **New**

Practice point

If a sleep disorder is suspected, then appropriate investigations should be undertaken and referral to a specialist made.

Weak recommendation **New**

Stroke patients diagnosed with sleep-disordered breathing (e.g. obstructive sleep apnoea) can be prescribed continuous positive airway pressure (CPAP) treatment. (Toh et al. 2023; Fu et al. 2023).

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.

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)

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.

Community mobility and outdoor travel

Weak recommendation

Stroke survivors who have difficulty with outdoor mobility in the community should set individualised goals and get assistance with adaptive equipment, information and referral on to other agencies. Escorted walking practice may be of benefit to some individuals and if provided, should occur in a variety of community settings and environments, and may also incorporate virtual reality training that mimics community walking. (Barclay et al. 2015; Logan et al. 2014)

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>.