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National clinical guideline for stroke

Prepared by the Intercollegiate Stroke Working Party

Fifth Edition 2016

Royal College of Physicians | Sentinel Stroke National Audit Programme (SSNAP)

Rehabilitation: What's new?

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Plan

1. Focus and structure
2. Content, a few key recommendations
3. What hasn’t changed, but really should

Let’s start with some clarity...

- What does the ICSWP mean by rehabilitation?
- When should it happen?

‘A process aimed at enabling people with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels’

Rehab is not JUST therapy
Rehab is not just for Christmas

What's new for rehabilitation?

Structure, emphasis, completeness, reducing inequalities:

Focus - patient-centred, pathway, care home residents

Positioning - 'rehabilitation' moved from chap 6 to chap 4

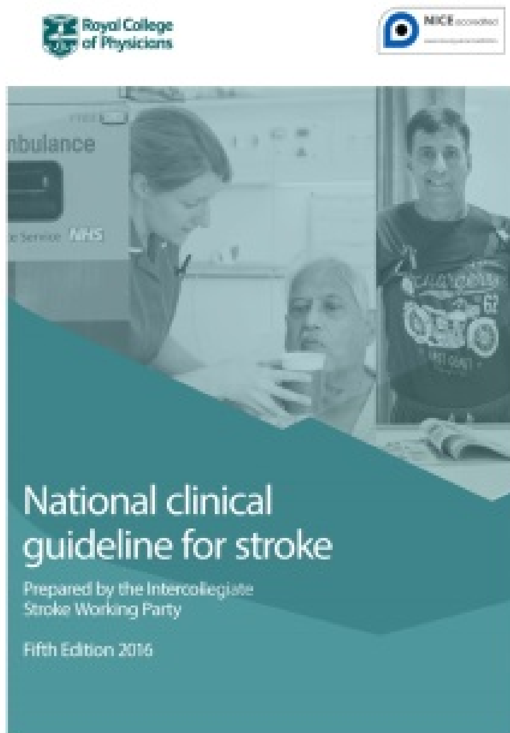
Chap 4 - problem-based, A-Z from ADLs to Vision
- from 46 to 17 topics, from 44 to 35 pages

Completeness of topics -

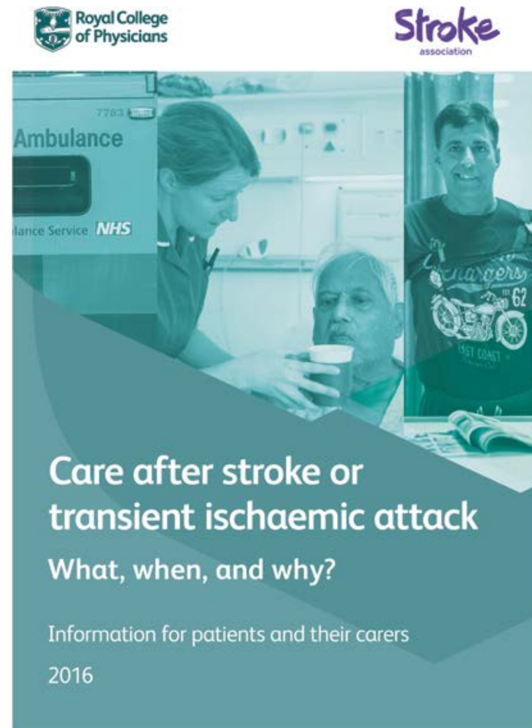
- Introduction
- Evidence to recommendations
- Recommendations
- Sources
- Implications (collective)

A suite of guideline documents

Full guideline



Easy read



Concise guideline

Some of the concise guidelines

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Key recommendations for stroke 2016

This concise guide contains 30 key recommendations identified by the Intercollegiate Stroke Working Party, which, if followed, will enhance the quality of stroke care. They have been extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the guideline at strokeaudit.org/guideline. This concise guide should not be read in isolation, and members of the stroke multidisciplinary team should consider the guideline in full.

Overall structure of stroke services

6.1.1A Commissioning organisations should ensure that their commissioning portfolio includes the whole stroke pathway from prevention (including neurovascular services) through acute care, early rehabilitation, secondary prevention, early supported discharge, community rehabilitation, systematic follow-up, palliative care and long-term support.

Commissioning acute stroke services

6.2.1B Commissioners should commission acute stroke services in accordance with the recommendations in this guideline to provide:

> urgent brain imaging for patients with suspected acute stroke;

> treatment with alteplase for patients with acute ischaemic stroke;

> an endovascular service for patients with acute ischaemic stroke;

> a neuroscience service to admit, investigate and manage patients referred with subarachnoid haemorrhage, both surgically and with interventional radiology;

> a neuroscience service delivering neurosurgical interventions for intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus;

> direct admission of patients with acute stroke to a hyperacute stroke unit providing active management of physiological status and homeostasis within 4 hours of arrival at hospital;

> an acute neurovascular service for the diagnosis and treatment of people with suspected TIA;

> an acute vascular surgical service to investigate and manage patients with TIA and non-disabling stroke due to carotid artery stenosis.

Commissioning rehabilitation services

6.4.1A Commissioners should commission stroke rehabilitation services in accordance with the recommendations in this guideline to provide:

> an inpatient stroke unit capable of providing stroke rehabilitation for all people with stroke admitted to hospital;

> a specialist early supported discharge service to enable people with stroke to receive rehabilitation at home or in a care home;

> specialist rehabilitation services capable of meeting the specific health, social and vocational needs of people with stroke of all ages;

> services capable of delivering specialist rehabilitation in out-patient and community settings in liaison with in-patient services.

Overall organisation of acute stroke services

2.2.1A Community medical services and ambulance services (including call handlers and primary care reception staff) should be trained to recognise people with symptoms indicating an acute stroke as an emergency requiring transfer to a hyperacute stroke centre.

Specialist stroke services

2.3.1B People with suspected acute stroke (including when occurring in people already in hospital)

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Orthoptics concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for orthoptists. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, orthoptists should consider the guideline in full.

Specialised stroke services

2.3.1D Acute stroke services should have management protocols for the admission pathway including links with the ambulance service, emergency stroke treatments, acute imaging, neurological and physiological monitoring, swallowing assessment, hydration and nutrition, vascular surgical referrals, rehabilitation, end-of-life (palliative) care, secondary prevention, the prevention and management of complications, communication with people with stroke and their family/carers and discharge planning.

2.3.1J Acute stroke services should have an education programme for all staff providing acute stroke care (including ambulance services and the emergency department as appropriate) and should provide training for healthcare professionals in the specialty of stroke.

Resources

2.4.1A People with stroke should be treated on a specialist stroke unit throughout their hospital stay unless their stroke is not the predominant clinical problem.

2.4.1J A stroke rehabilitation unit should have a single multi-disciplinary team including specialists in:

> medicine;

> nursing;

> physiotherapy;

> occupational therapy;

> speech and language therapy;

> dietetics;

> clinical psychology/neuropsychology;

> social work;

> orthoptics;

> with easy access to pharmacy, orthotics, specialist seating, assistive technology and information, advice and support for people with stroke and their family/carers.

Transfers of care - discharge from hospital

2.7.1K People with stroke, including those living in care homes, should continue to have access to specialist services after leaving hospital, and should be provided with information about how to contact them.

Rehabilitation approach - goal setting

2.10.1A People with stroke should be actively involved in their rehabilitation through:

> having their feelings, wishes and expectations for recovery understood and acknowledged;

> participating in the process of goal setting unless they choose not to, or are unable to because of the severity of their cognitive or linguistic impairments;

> being given help to understand the process of goal setting, and to define and articulate their personal goals.

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Occupational therapy concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for occupational therapists. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, occupational therapists should consider the guideline in full.

Transfers of care from hospital to home

2.7.1H Before the transfer home of a person with stroke who is dependent in any activities, the person's home environment should be assessed by a visit with an occupational therapist. If a home visit is not considered appropriate they should be offered an access visit or an interview about the home environment including photographs or videos taken by family/carers.

Rehabilitation approach - intensity of therapy

2.11.1A People with stroke should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

2.11.1C Multi-disciplinary stroke teams should incorporate the practising of functional skills gained in therapy into the person's daily routine in a consistent manner, and the care environment should support people with stroke to practise their activities as much as possible.

2.11.1D Healthcare staff who support people with stroke to practise their activities should do so under the guidance of a qualified therapist.

Psychological care - organization and delivery

2.12.1E Services for people with stroke should provide screening for mood and cognitive disturbance within six weeks of stroke (in the acute phase of rehabilitation and at the transfer of care into post-acute services) and at six and 12 months using validated tools and observations over time.

Early mobilisation

3.12.1B Patients with difficulty moving early after stroke who are medically stable should be offered frequent, short daily mobilisations (sitting out of bed, standing or walking) by appropriately trained staff with access to appropriate equipment, typically beginning between 24 and 48 hours of stroke onset. Mobilisation within 24 hours of onset should only be for patients who require little or no assistance to mobilise.

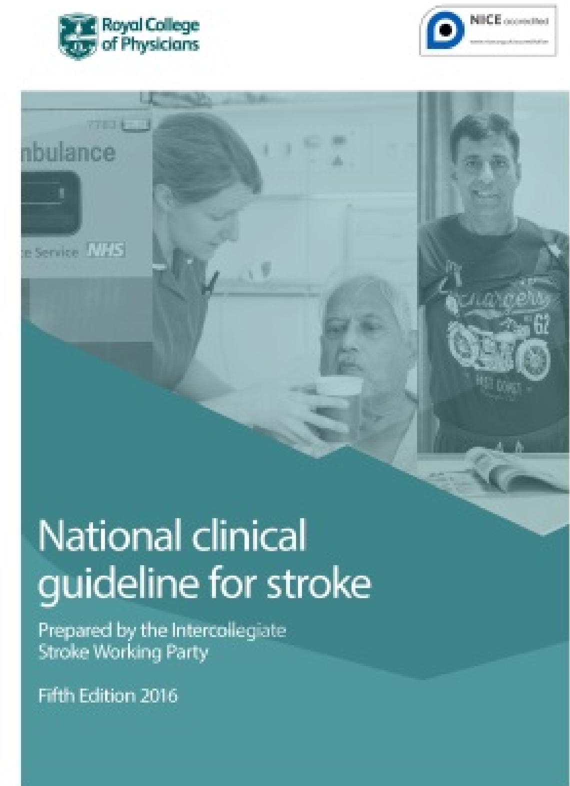
Activities of daily living

4.1.1.1A People with stroke should be formally assessed for their safety and independence in all relevant personal activities of daily living by a clinician with the appropriate expertise, and the findings should be recorded using a standardised assessment tool.

4.1.1.1B People with limitations of personal activities of daily living after stroke should be referred to an occupational therapist with experience in neurological disability, be assessed within 72 hours of referral, and be offered treatment for identified problems (e.g. feeding, toileting) by the

What's new in 2016 – 9 topics

1. thrombectomy
2. imaging
3. blood pressure in ICH
4. minor & TIA management
5. **psychology**
6. **early mobilisation**
7. **end of life care**
8. **gait training for people unable to walk**
9. BP targets for 2° stroke prevention



Rehabilitation in the 30 key recommendations

1) Commissioning rehab 6.4.1A
2) Overall service 6.1.1A ✓
3) Transfers of care 2.7.1A & K ✓
4) **Work and leisure 4.1.4.1B** ✓
5) **Aphasia assessment 4.4.1.1A** ✓
6) Life after stroke, reviews 5.9.1.1A ✓
7) Hydration and nutrition 4.7.1F ✓
8) Care homes 2.17.1A ✓
9) **H/ASU resources 2.4.1B** ✓
10) **Org psychological care 2.12.1A** ✓
11) **Early mobilisation 3.12.1B** ✓
12) **Rehab – intensity 2.11.1A** ✓

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Specialist stroke services

2.3.1B People with suspected acute stroke (including when occurring in people already in hospital)

New rehabilitation recommendations chapter 2

Resources

2.4.1B A hyperacute and/or acute stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations in **Table 2.1**.

- Addition of orthoptists to MDT 2.4.1 J
- Two additions to Table 2.1

New in chapter 2

Table 2.1 Recommended staffing levels for stroke units

	PT WTE/5 bed	OT WTE/5 bed	SLT WTE/5 bed	Psy WTE/5 beds	Diet WTE/5 bed	Nurs WTE/1 bed	Cons physic
HASU	0.73	0.68	0.34	**0.2**	**0.15**	2.9	24/7, min 6 rota
ASU	0.84	0.81	0.40	**0.2**	**0.15**	1.35	5 days ward rounds

Implications - "require a considerable increase in the provision of some specialties in stroke services, especially clinical/neuro-psychology…".

New in chapter 2

Psychological care – organisation and delivery

2.12.1A Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the multi-disciplinary team.

New in chapter 3

2012 Early mobilisation 4.15.1B

People with acute stroke should be mobilised within 24 hours of stroke onset, unless medically unstable, by an appropriately trained healthcare professional with access to appropriate equipment.

2016 Early mobilisation 3.12.1B

Patients with difficulty moving early after stroke who are medically stable should be offered frequent, short daily mobilisations (sitting out of bed, standing or walking) by appropriately trained staff with access to appropriate equipment, typically beginning between 24 and 48 hours of stroke onset. Mobilisation within 24 hours of onset should only be for patients who require little or no assistance to mobilise.

What’s NOT new, but should be

- general cognition “**little** research”
- apraxia “**absence** of new evidence”
- attention & memory “**only 1** of sufficient quality”
- executive function & neglect “**insufficient**”
- perception “**uncertainty**”
- anxiety, depression & distress “**more needed**”
- Emotionalism “ **not changed**”

What's NOT new, but should be

- Not just psychology - Also evidence gaps in communication, continence, driving, fatigue, mental capacity, pain, sex, work, carers, self management, life after stroke………
- Need plan of action – growing capacity & collaborative culture
- Need (sensible) NIHR commissioned calls

What's new in rehabilitation?

The short answer – a lot

The good news

- great teamwork ➔ patient-centred focus *Thank you*
- great teamwork ➔ consensus
- high quality evidence ➔ definite recommendations

The bad news

- evidence may be difficult to accept
- worrying absence of activity in some topics