Royal College of Physicians

Concise guide for stroke 2012

This concise guide includes 28 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*, fourth edition, 2012, which contains over 300 recommendations covering almost every aspect of stroke management. The key recommendations are given below with their number (eg 2.1.1) and letter (eg A, B), so that they can be found in the main guideline.

2.1.1A Commissioning organisations should ensure that their commissioning portfolio encompasses the whole stroke pathway from prevention through acute care, early rehabilitation and initiation of secondary prevention on to palliation, later rehabilitation in the community and long-term support.

2.2.1A Ambulance services, including call handlers, should be commissioned to respond to every patient presenting with a possible acute stroke as a medical emergency.

2.2.1B Acute services should be commissioned to provide:

- imaging of all patients in the next slot or within 1 hour if required to plan urgent treatment (eg thrombolysis), and always within 12 hours
- thrombolysis in accordance with recommendations in the *National clinical guideline for stroke*, fourth edition, 2012
- active management of physiological status and homeostasis
- completion of all investigations and treatments to reduce risk of stroke for transient ischaemic attacks and minor strokes within 1 week or within 24 hours for high-risk cases
- an acute vascular surgical service to investigate and manage people with neurovascular episodes in ways and in timescales recommended in the *National clinical guideline for stroke*, 2012
- a neuroscience service to admit, investigate and manage all patients referred with potential subarachnoid haemorrhage, both surgically and with interventional radiology
- a neuroscience service delivering neurosurgical interventions as recommended for major intracerebral haemorrhage, malignant cerebral oedema, and hydrocephalus.

2.3.1A Commissioners should ensure that every provider specifically enacts all the secondary prevention measures recommended, and this should be the subject of regular audit or monitoring by commissioners.

2.4.1A Commissioning organisations should commission:

- an inpatient stroke unit capable of delivering stroke rehabilitation as recommended in the *National clinical guideline for stroke*, fourth edition, 2012 for all people with stroke admitted to hospital
- early supported discharge to deliver specialist rehabilitation at home or in a care home
- rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages
- services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services, as recommended in the *National clinical guideline for stroke*, fourth edition, 2012.

3.1.1C All hospitals receiving acute medical admissions that include patients with potential stroke should have arrangements to admit them directly to a specialist acute stroke unit (onsite or at a neighbouring hospital) to monitor and regulate basic physiological functions such as blood glucose, oxygenation, and blood pressure.

3.2.1B Patients with suspected stroke should be admitted directly to a specialist acute stroke unit and assessed for thrombolysis, receiving it if clinically indicated.

3.2.1C Patients with stroke should be assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

3.2.1F Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment should be treated in a specialist stroke rehabilitation unit, which should fulfil the following criteria:

> it should be a geographically identified unit
> it should have a coordinated multidisciplinary team that meets at least once a week for the interchange of information about individual patients
> the staff should have specialist expertise in stroke and rehabilitation
> educational programmes and information are provided for staff, patients and carers
> it has agreed management protocols for common problems, based on available evidence.

3.7.1A All transfers between different teams and between different organisations should:

> occur at the appropriate time, without delay
> not require the patient to provide complex information already given
> ensure that all relevant information is transferred, especially concerning medication
> maintain a set of patient-centred goals
> transfer any decisions made concerning 'best interest decisions' about medical care.

3.8.1E Provide early supported discharge to patients who are able to transfer independently or with the assistance of one person. Early supported discharge should be considered a specialist stroke service and consist of the same intensity and skillmix as available in hospital, without delay in delivery.

3.10.1A The views of stroke patients and their carers should be considered when evaluating a service; one method that should be used is to ask about their experiences and which specific aspects of a service need improvement.

3.14.1A Patients with stroke should be offered a minimum of 45 minutes of each appropriate therapy that is required, for a minimum of 5 days per week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it.

4.2.1A All patients whose acute symptoms and signs resolve within 24 hours (ie TIA) should be seen by a specialist in neurovascular disease (eg in a specialist neurovascular clinic or an acute stroke unit).

4.5.1A Brain imaging should be performed immediately (ideally the next imaging slot and definitely within 1 hour of admission, whichever is sooner) for people with acute stroke if any of the following apply:

> indications for thrombolysis or early anticoagulation
> on anticoagulant treatment
> a known bleeding tendency

> a depressed level of consciousness (Glasgow Coma Score below 13)
> unexplained progressive or fluctuating symptoms
> papilloedema, neck stiffness or fever
> severe headache at onset of stroke symptoms.

4.6.1A Any patient, regardless of age or stroke severity, where treatment can be started within 3 hours of known symptom onset and who has been shown not to have an intracerebral haemorrhage or other contraindications should be considered for treatment using alteplase.

4.6.1B Between 3 and 4.5 hours of known symptom onset, patients under 80 years who have been shown not to have an intracerebral haemorrhage or other contraindication, should be considered for treatment with alteplase.

4.13.1A All patients should be assessed within a maximum of 4 hours of admission for their:

> ability to swallow, using a validated swallow screening test (eg 50 ml water swallow) administered by an appropriately trained person
> immediate needs in relation to positioning, mobilisation, moving and handling
> bladder control
> risk of developing skin pressure ulcers
> capacity to understand and follow instructions
> capacity to communicate their needs and wishes
> nutritional status and hydration
> ability to hear, and need for hearing aids
> ability to see, and need for glasses.

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.

5.4.1A All patients with stroke or TIA should have their blood pressure checked. Treatment should be initiated and/or increased as is necessary or tolerated to consistently achieve a clinic blood pressure below 130/80, except for patients with severe bilateral carotid stenosis, for whom a systolic blood pressure target of 130–150 is appropriate.

5.5.1A For patients with ischaemic stroke or TIA in sinus rhythm, clopidogrel should be the standard antithrombotic treatment:

> clopidogrel should be used at a dose of 75 mg daily.

6.21.1A Until a safe swallowing method has been established, all patients with identified swallowing difficulties should:

> be considered for alternative fluids with immediate effect
> have a comprehensive assessment of their swallowing function undertaken by a specialist in dysphagia
> be considered for nasogastric tube feeding within 24 hours
> be referred for specialist nutritional assessment, advice and monitoring
> receive adequate hydration, nutrition and medication by alternative means
> be considered for the additional use of a nasal bridle if the nasogastric tube needs frequent replacement, using locally agreed protocols.

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6.24.1B Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should:

- have any identified causes of incontinence treated
- have an active plan of management documented
- be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment first
- only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place.

6.34.1A Services should adopt a comprehensive approach to the delivery of psychological care after stroke, which should be delivered by using a 'stepped care' model from the acute stage to long-term management (see chapter 7 in the *National clinical guideline for stroke*, fourth edition, 2012).

7.1.1C Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if:

- new problems, not present when last seen by the specialist service, are present
- the patient's physical state or social environment has changed.

7.4.1A Patients and their carers should have their individual practical and emotional support needs identified:

- before they leave hospital
- when rehabilitation ends or at their 6-month review
- annually thereafter.

7.5.1B All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.

7.6.1B The carer(s) of every person with a stroke should be involved with the management process from the outset, specifically:

- as an additional source of important information about the patient both clinically and socially
- being given accurate information about the stroke, its nature and prognosis, and what to do in the event of a further stroke or other problems, for example post-stroke epilepsy
- being given emotional and practical support.

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