Simply Stroke *for Doctors and Nurses*

20 questions for physicians and nurses caring for patients in stroke rehabilitation

1. Are all your stroke patients assessed for rehabilitation?
- All stroke patients should be screened, then assessed and treated as required, for cognitive, sensorimotor and communication difficulties
- Patients should start rehabilitation as soon as they are able and be encouraged to practice skills

2. Do all of your patients have a swallowing screening as soon as possible, within 24 hours?
- Patients who fail the screening should be referred to a SLT for assessment
- The need for a modified diet should be regularly reviewed
- Dysphagic patients with weight loss and recurrent chest infections should be urgently reviewed
- Everyone involved in feeding patients should be trained in appropriate techniques

3. Do you assess falls risk for all patients?
- Develop a management plan with physiotherapists

4. Do you screen all your patients for sensory symptoms and visual deficits?
- All patients should be screened for lost or altered sensation, including hypersensitivity
- Patients who report or appear to have visual deficits should be comprehensively assessed

5. Do you screen your patients for central post-stroke pain?
- Patients with unresolved central pain should be trialled with tricyclic antidepressants or anticonvulsants, and after a few weeks should be referred to a specialist pain team

6. Are all of your patients screened for communication and speech deficits with a valid screening tool?
- All patients with suspected deficits should be comprehensively assessed by a SLT
- Information should be provided in an aphasia-friendly format
- Mood should be monitored in patients with aphasia

7. Do you screen all patients for cognitive and perceptual deficits?
- When screening identifies cognitive or perceptual deficits, patients should be comprehensively assessed for attention, memory, executive functions, apraxia, agnosia, and neglect

8. Are all of your patients comprehensively assessed for activities of daily living?
- Patients should be assessed for difficulties in personal or extended activities of daily living by a trained clinician, and specific therapy provided to address any difficulties

9. Do your patients practice sitting and standing up?
- Sitting and standing up practice with supervision/assistance should be provided

10. Do you encourage all of your patients with upper limb deficits to use the limb as much as possible?
- Recovery of upper limb function is important for regaining independence

11. Do you monitor your patients for shoulder pain?
- Shoulder pain can be managed with shoulder strapping and education of patients, carers and staff to prevent trauma
- Ultrasound is NOT recommended

12. Do you screen all your patients for mood disorders?
- Patients with suspected altered mood (depression, anxiety, emotional lability) should be assessed by trained personnel using standardised and validated scales
- Strategies such as problem solving and motivation interviewing can be used to prevent and manage depression after stroke
- Antidepressants for depression or emotional lability

13. Do you provide oral hygiene assistance and education to all patients?

- All patients should have assistance and education for good oral and dental hygiene
- Staff and carers can be trained in the assessment and management of oral hygiene

14. Do you monitor hydration and nutrition for all patients?

- All patients at risk of malnutrition should be referred to a dietitian
- If swallowing is inadequate, nasogastric feeding is the preferred method during the first month

15. Do you assess urinary continence in all patients with suspected difficulties?

- For patients with urge urinary incontinence:
  - scheduled voiding, bladder retraining and anticholinergic drugs can be trialled
  - social continence can be assisted with continence aids
- For patients with urinary retention:
  - the use of indwelling catheters should be avoided as an initial management strategy except in acute urinary retention
  - the routine use of indwelling catheters is not recommended, intermittent catheterization is preferred to assist bladder emptying
  - sterile techniques should be used for intermittent catheterisation in hospital
  - for chronic retention, urethral or suprapubic routes should be considered
  - patients/carers should be educated for management of catheterization after discharge
- For patients with functional urinary incontinence:
  - a whole-team approach is recommended
  - improving mobility and reducing delirium can help

16. Do you assess faecal continence in all patients with suspected difficulties?

- For patients with constipation or bowel incontinence:
  - a full assessment including rectal examination should be carried out
  - bowel habit retraining using diet, habits and the gastro-colic reflex can be used
  - containment aids can assist with social continence
  - education and careful planning are required for any patient being discharged with bowel incontinence

17. Do you monitor all patients for spasticity, contracture, subluxation and swelling?

- Moderate to severe spasticity can be treated with Botulinum toxin A in conjunction with physical therapy and electrical stimulation in conjunction with EMG biofeedback
- Interventions to decrease spasticity should NOT be provided unless moderate to severe
- For contracture, range of motion can be increased with electrical stimulation and casting
- For people in active rehabilitation, prolonged lengthened positioning is NOT recommended
- Patients, carers and staff should be trained in shoulder care and support to prevent subluxation
- Swelling of the extremities can be managed with dynamic pressure garments for the upper limb, electrical stimulation, elevation with or without continuous passive motion

18. Do you monitor your patients for deep vein thrombosis and pulmonary embolism?

- Early mobilization and adequate hydration
- Anti-platelet therapy for ischaemic stroke patients
- Low molecular weight heparin can be used with caution for selected ischaemic stroke patients
- Thigh-length antithrombotic stockings are NOT recommended
- Antithrombotic therapy should NOT be used in patients with intracerebral haemorrhage

19. Do you assess the risk of pressure ulcers for all patients with reduced mobility?

- Appropriate aids and strategies, including a pressure-relieving mattress

20. Do you monitor all patients for sleep apnoea?

- Continuous positive airway pressure (CPAP) or oral devices