Based on the New Zealand Clinical Guidelines for Stroke Management 2010

Simply Stroke *for Physiotherapists and Occupational Therapists*

10 questions for therapists 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

2. Do you assess and monitor falls risk for all patients?

- Develop a management plan including individually prescribed exercise programmes

3. 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 difficulty with vision and/or perception should be comprehensively assessed
- Information about sensory symptoms should be shared with the patient, family, and staff, for safety and the use of compensatory strategies
- Sensory-specific training can be provided to patients with sensory loss

4. 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
- Therapy sessions should be tailored to capitalize on preserved memory abilities and delivered in a context similar to the patient's usual environment to encourage generalisation
- Patients with apraxia should be taught strategies to improve activities of daily living
- Patients with agnosia should be taught strategies for optimising safety and function
- Patients with unilateral neglect can be treated with attentional cues, visual scanning training, structured feedback, half-field eye patching

5. Do all patients in active rehabilitation have at least one hour of active practice per day, at least 5 days per week?

- Task-specific circuit class training can be used to increase therapy dose
- Patients should be encouraged to continue to practice skills throughout the day

6. Do your patients practice sitting and standing up?

- Sitting and standing up practice with supervision/assistance should be provided as required

7. Do you assess walking for all of your patients?

- Lower limb weakness can be addressed with progressive resistance exercise, EMG biofeedback, and electrical stimulation
- Tailored, repetitive practice of walking or its components should be provided as much as possible
- Adjuvants include cueing of cadence, treadmill, robotics, biofeedback, virtual reality
- Ankle-foot orthoses can be used for persistent foot drop, and should be individually fitted

8. Do you encourage all of your patients with upper limb deficits to use the limb as much as possible?

- Upper limb weakness can be addressed with progressive resistance exercise, EMG biofeedback, and electrical stimulation
- Tailored, repetitive task-specific training should be provided as much as possible
- Adjuvants include constraint-induced movement therapy, robotics, mental practice, mirror therapy, bilateral training

9. Are all of your patients comprehensively assessed for activities of daily living?

- Task-specific practice and trained use of appropriate aids can be used
- Staff and family should be advised on techniques and equipment to assist with ADLs
- Escorted outdoor journeys and tailored strategies should be provided to patients with difficulties in community transport and mobility

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

- 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
- Overhead pulley exercise should NOT be used to maintain shoulder range of motion
- Patients, carers and staff should be trained in shoulder care and support to prevent subluxation
- Shoulder pain can be managed with shoulder strapping and education of patients, carers and staff to prevent trauma
- Ultrasound is NOT recommended for shoulder pain
- Swelling of the extremities can be managed with dynamic pressure garments for the upper limb, electrical stimulation, elevation with or without continuous passive motion