National clinical guidelines for stroke
Impact on occupational therapy practice

Background

The National Clinical Guidelines for Stroke (NCGS) were developed by the Intercollegiate Working Party for Stroke and co-ordinated by the Clinical Effectiveness and Evaluation Unit of the Royal College of Physicians (RCP). The aim was to improve the management of stroke care at a national level, following a report by the RCP which demonstrated that stroke services were disorganised, haphazard and poor.

The intercollegiate working party encompassed representatives of most health care professions and included patients and their families. Jan Harrison, Dr Caroline Ellis-Hill and Dr Marion Walker represented the College of Occupational Therapists.

Designed primarily for practising clinicians and other health care professionals involved in the diagnosis and management of patients with stroke, the Guidelines are intended to assist them in making decisions for each patient by using current evidence based practice.

The NCGS includes sections on: service organisation, approaches to rehabilitation, carers and families, acute (specific, medical) diagnosis, acute (medical/surgical) interventions, early disability assessment and management, rehabilitation interventions, transfer back to the community, long-term patient management and service evaluation. Most common clinical problems for which there is evidence at some level are covered.

Each guideline has the level of evidence and grade of recommendation, as follows:

Level of evidence	Type of evidence	Grade of recommendation
Ia	Meta-analysis of randomised controlled trials (RCTs)	A
Ib	At least one RCT	A
IIa	At least one well designed, controlled study but without randomisation	B
IIb	At least one well designed, quasi-experimental study	B
III	At least one well designed, non-experimental descriptive study (eg comparative studies, correlation studies, case studies)	B
IV	Expert committee reports, opinions and/or experience of respected authorities	C

The NCGS is a dynamic document, which it is intended will be updated every six months on the Internet (www.rcplondon.ac.uk) and re-published in a new edition every two years.

National Association of Neurological Occupational Therapists

Royal College of Physicians

The Stroke Clinical Forum of the National Association of Neurological Occupational Therapists (NANOT) (a specialist section of the College of Occupational Therapists) is assisting Dr Marion Walker in the continuous search for evidence for these guidelines and the development of further guidelines.

Guidelines with direct implications for occupational therapy practice

The following guidelines, extracted from the NCGS, represent those that have direct implications for occupational therapy practice. However, NANOT recommends that all occupational therapists read the NCGS in their entirety.

Approaches to rehabilitation

Use of assessments/measures

a) Clinicians should use assessments or measures appropriate to their needs (ie to help make a clinical decision) (C)

b) Where possible and available, clinicians should use assessments or measures that have been studied in terms of validity (appropriateness for the purpose) and reliability (extent of variability) (C)

c) Routine assessments should be minimised, and each considered critically (C)

d) Patients should be reassessed at appropriate intervals (C)

Teamwork

a) All members of the healthcare team should work together with the patient and family, using an agreed therapeutic approach (B)

b) Nurses should be an integral part of the rehabilitation team (C)

c) All staff should be trained to place patients in positions that reduce the risk of complications such as contractures, respiratory complications and pressure sores (B)

d) All staff should be trained in the recognition and basic management of communication and cognitive problems (C)

Goal setting

a) Goals should be meaningful, challenging but achievable (B), and there should be both short- and long-term goals (C)

b) Goal setting should involve the patient (B), and the family if appropriate (C)

c) Goals should be set at the team level as well as at the level of an individual clinician (C)

d) Judging progress against goals set (goal attainment scaling) may be helpful (B)

Underlying approach to therapy

a) Any of the current exercise therapies should be practised within a neurological framework to improve patient function (A)

Intensity/duration of therapy

a) Patients should see a therapist each working day if possible (B)

b) While they need therapy, patients should receive as much as can be given and they find tolerable (A)

c) Patients should be given as much opportunity as possible to practise skills (A)

Carers and families

a) The needs of the family to be given information, to be involved in taking decisions and making plans, and to be given support, must be considered from the outset (C)

b) Stroke services must be alert to the likely stress on carers, specifically recognising the stress associated with 'hidden' impairments such as cognitive loss, urinary incontinence, and irritability (B)

c) Information should be given to families on the nature of stroke and its manifestations, and on relevant local and national services (A)

d) Family support workers should be involved to help reduce carer distress (A)

Early disability assessment and management

Multidisciplinary general assessment: rehabilitation referral

a) A multidisciplinary assessment using a formal procedure or protocol should be undertaken and documented in the notes within 5 working days of admission (A). The protocol should include assessment of:

   i. Consciousness level, using a validated clinical method, on admission (C)

   ii. Swallowing, using a validated clinical method, to be undertaken within 24 hours by appropriately trained personnel (C)

   iii. The risk of developing pressure sores, undertaken on admission (C)

   iv. Nutritional status, using a validated method, to be undertaken within 48 hours by appropriately trained personnel (B)

   v. Cognitive impairment, using a validated clinical method, within 48 hours of regaining consciousness (C)

   vi. The patient's needs in relation to moving and handling, within 48 hours of admission (C)

b) All patients should be referred to a specialist rehabilitation team as soon as possible, preferably within 7 days of admission (C)

c) Healthcare workers should consider their knowledge, training, competence, health and physical capabilities before every manual handling procedure, taking into account the setting and the available equipment (C)

Prevention of complications: positioning

a) Staff should position patients to minimise the risk of complications such as contractures, respiratory complications, shoulder pain and pressure sores (C)

Rehabilitation interventions

Psychological impairment: mood disturbance; depression, emotionalism and anxiety

a) Patients should be given information, advice and the opportunity to talk about the impact of illness upon their lives (B)

b) Patients' psychosocial needs should be assessed (C)

c) Patients should be screened for depression and anxiety within the first month of stroke, and their mood kept under review. In those patients who can respond to it, a standardised questionnaire may be used for screening, but any clinical diagnosis should be confirmed by clinical interview (C)

d) Emotionalism after stroke should be confirmed by a few simple questions at clinical interview (B)

e) Any patient diagnosed with one form of mood disorder should be assessed for the others (B)

f) Patients with severe, persistent or troublesome tearfulness (emotionalism) should be given anti-depressant drug treatment, monitoring the frequency of crying to check effectiveness (A)

g) Patients in whom a depressive disorder has been diagnosed should be considered for a trial of antidepressant medication (A)

h) Mood disorder that is causing persistent distress or worsening disability should be managed by or with advice from an experienced clinical psychologist or psychiatrist (C)

Psychological impairment: cognitive impairment

a) Every stroke rehabilitation service should have ready rapid access to expert neuropsychological expertise to assess patients (C)

b) Patients with persistent visual neglect or visual field defects should be offered specific retraining strategies (A)

Motor impairment: improving motor control (conventional)

a) A physiotherapist with expertise in neuro-disability should co-ordinate therapy to improve movement performance of patients with stroke (C)

Functional rehabilitation interventions: activities of daily living

a) All patients with difficulties in activities of daily living should be assessed by an occupational therapist with specialist knowledge in neurological disability (A)

b) Patients showing unexplained persistent difficulties in ADL should be assessed specifically for perceptual impairments (B)

c) Patients with difficulties in ADL should be treated by a specialist multidisciplinary team (A)

d) All patients must be given opportunities to practise personal ADL and, as appropriate, relevant domestic and community activities (C)

e) Patients should be offered advice on, and treatment aimed to achieve, employment or wanted leisure activities as appropriate (C)

Functional rehabilitation interventions: equipment and adaptations (personal aids)

a) The need for special equipment should be assessed on an individual basis; once provided, equipment should be evaluated on a regular basis (B)

b) Patients should be supplied as soon as possible with all aids and equipment needed (A)

c) All patients should have easy quick access to any equipment that might increase their independence (C)

d) Decisions must take into account the patient's (and, if necessary, the family's) views and expectations (C)

e) Ankle-foot orthoses are of benefit to some patients (B)

f) If an ankle-foot orthosis is supplied, it should be individually fitted (C)

g) A walking stick may increase standing stability in patients with severe disability (B)

Functional rehabilitation interventions: equipment and adaptations (appliances)

a) Every patient who is at home or leaving hospital should be assessed fully to determine whether equipment or adaptations can increase safety or independence (A)

b) Prescription of equipment and adaptations should be based on careful assessment of the patient and the physical and social environment in which it is to be used (B)

c) All equipment supplied should have proven reliability and safety (C)

d) The patient and/or caregiver should be thoroughly trained in the safe and effective use of any equipment supplied (C)

e) The suitability and use of equipment should be reviewed over time as needs will change (B)

f) All patients should be given a contact number for future advice or help with equipment provided (C)

Transfer back to the community: discharge planning

a) Early hospital discharge should only be considered if there is a specialist stroke rehabilitation team in the community and if the patient is able to transfer safely from bed to chair (A)

b) Early hospital discharge to generic (non-specialist) community services should not be undertaken (A)

c) Carers should receive all necessary equipment and training in moving and handling, in order to position and transfer the patient safely in the home environment (B)

d) Hospital services should have a protocol and local guidelines for discharge (A), to check that, before discharge occurs:

   i. Patients and families are prepared and fully involved (C)

   ii. General practitioners and primary healthcare teams, and community social services departments, are all informed (C)

   iii. All necessary equipment and support services are in place (C)

   iv. Any continuing treatment required should be provided without delay by a specialist service in the community, day hospital or outpatients (A)

   v. Patients are given information about, and offered contact with appropriate local statutory and voluntary agencies (C)

Long-term patient management

Further rehabilitation after discharge

a) Any patient with disability at 6 months or later after stroke should be assessed for a period of further targeted rehabilitation to be given where appropriate (A)

Post-discharge social function

a) Patients and their carers should have their individual psychosocial and support needs reviewed on a regular basis (C)

b) Health and social services professionals should ensure that patients and their families have information about the statutory and voluntary organisations offering services specific to these needs (C)

c) Patients who used to drive before their stroke must be given accurate up-to-date advice on their responsibilities (C)

d) Patients who wish to drive should be assessed for any absolute contraindications, then for their cognitive ability to drive safely, their motor ability to control a car, and their need for any adaptations (C)

Audit tool

An occupational therapy module will be included as part of a package for auditing these guidelines, and will be available from the RCP later in 2001.

Source

Intercollegiate Working Party for Stroke. *National Clinical Guidelines for Stroke*. London: Royal College of Physicians; 2000.

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