



Speech and language 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 speech and language therapists. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, speech and language therapists should consider the guideline in full.

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.

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.

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

People with stroke in care homes

2.17.1A People with stroke living in care homes should be offered assessment and treatment from community stroke rehabilitation services to identify activities and adaptations that might

improve quality of life.

2.17.1B Staff caring for people with stroke in care homes should have training in the physical, cognitive/communication, psychological and social effects of stroke and the management of common activity limitations.

Acute stroke care

3.10.1E Patients with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

3.10.1G Patients with swallowing difficulties after acute stroke should only be given food, fluids and medications in a form that can be swallowed without aspiration.

Work and leisure

4.1.4.1B People who wish to return to work after stroke (paid or unpaid employment) should:

- > have their work requirements established with their employer (provided the person with stroke agrees);
- > be assessed cognitively, linguistically and practically to establish their potential for return;
- > be advised on the most suitable time and way to return to work, if return is feasible;
- > be referred through the job centre to a specialist in employment for people with disability if extra

support or advice is needed;

> be referred to a specialist vocational rehabilitation team if the job centre specialist is unable to provide the necessary rehabilitation.

Cognitive impairment

4.3.1.1C People with communication impairment after stroke should receive a cognitive assessment using valid assessments in conjunction with a speech and language therapist. Specialist advice should be sought if there is uncertainty about the interpretation of cognitive test results.

Aphasia

4.4.1.1A People with communication problems after stroke should be assessed by a speech and language therapist to diagnose the problem and to explain the nature and implications to the person, their family/carers and the multidisciplinary team. Reassessment in the first four months should only be undertaken if the results will affect decision-making or are required for mental capacity assessment.

4.4.1.1B In the first four months after stroke, people with aphasia should be given the opportunity to practise their language and communication with a speech and language therapist or other communication partner as frequently as tolerated.

4.4.1.1C After the first four months, people with communication problems after stroke should be reviewed to determine their suitability for further treatment with the aim of increasing participation in communication and social activities. This may involve using an assistant or volunteer, family member or communication partner guided by the speech and language therapist, computer-based practice or other impairment-based or functional treatment.

4.4.1.1D People with communication problems after stroke should be considered for assistive technology and communication aids by an appropriately trained, experienced clinician.

4.4.1.1E People with aphasia after stroke whose first language is not English should be assessed

and provided with information about aphasia and communication practice in their preferred language.

4.4.1.1F The carers and family of a person with communication problems after stroke, and health and social care staff, should receive information and training from a speech and language therapist which should enable communication partners to optimise engagement in rehabilitation, and promote autonomy and social participation.

4.4.1.1G People with persistent communication problems after stroke that limit their social activities should be offered information about local or national groups for people with aphasia, and referred as appropriate.

Dysarthria

4.4.2.1A People with unclear or unintelligible speech after stroke should be assessed by a speech and language therapist to diagnose the problem and to explain the nature and implications to the person, their family/carers and the multidisciplinary team.

4.4.2.1B People with dysarthria after stroke which limits communication should:

- > be trained in techniques to improve the clarity of their speech;
- > be assessed for compensatory and augmentative communication techniques (e.g. letter board, communication aids) if speech remains unintelligible.

4.4.2.1C The communication partners (e.g. family/carers, staff) of a person with severe dysarthria after stroke should be trained in how to assist the person in their communication.

Mouth care

4.11.1A People with stroke, especially those who have difficulty swallowing or are tube fed, should have mouth care at least 3 times a day including:

- > brushing of teeth and cleaning of gums with a suitable cleaning agent (toothpaste and/or chlorhexidine dental gel), for which an electric toothbrush should be considered;

- > removal of excess secretions;
- > application of lip balm.

4.11.1B People with stroke who have dentures should have their dentures:

- > put in during the day;
- > cleaned regularly using a toothbrush, toothpaste and/or chlorhexidine dental gel;
- > checked and replaced if ill-fitting, damaged or lost.

4.11.1C People in hospital or living in a care home after stroke should receive mouth care from staff who have been trained in:

- > assessment of oral hygiene;
- > selection and use of appropriate oral hygiene equipment and cleaning agents;
- > provision of oral care routines;
- > awareness and recognition of swallowing difficulties.

Swallowing

4.16.1A People with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

4.16.1B Until a safe swallowing method is established, people with swallowing difficulty after acute stroke should:

- > be immediately considered for alternative fluids;
- > have a comprehensive specialist assessment of their swallowing;
- > be considered for nasogastric tube feeding within 24 hours;
- > be referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- > receive adequate hydration, nutrition and medication by alternative means.

4.16.1C Patients with swallowing difficulty after acute stroke should only be given food, fluids and medications in a form that can be swallowed without aspiration.

4.16.1D People with stroke with suspected aspiration or who require tube feeding or dietary modification should be considered for instrumental assessment (videofluoroscopy or fibre-optic endoscopic evaluation of swallowing).

4.16.1E People with stroke who require instrumental assessment of swallowing (videofluoroscopy or fibre-optic endoscopic evaluation of swallowing) should only receive this:

- > in conjunction with a specialist in dysphagia management;
- > to investigate the nature and causes of aspiration;
- > to direct an active treatment/rehabilitation programme for swallowing difficulties.

4.16.1F People with swallowing difficulty after stroke should be considered for swallowing rehabilitation by a specialist in dysphagia management. This should include one or more of:

- > compensatory strategies such as postural changes (e.g. chin tuck) or swallowing manoeuvres (e.g. supraglottic swallow);
- > restorative strategies to improve oropharyngeal motor function (e.g. Shaker headlifting exercises);
- > sensory modification, such as altering the taste and temperature of foods or carbonation of fluids;
- > texture modification of food and/or fluids.

4.16.1G People with stroke who require modified food or fluid consistency should have these provided in line with nationally agreed descriptors.

4.16.1H People with difficulties self-feeding after stroke should be assessed and provided with the appropriate equipment and assistance (including physical help and verbal encouragement) to promote independent and safe feeding.

4.16.1I People with swallowing difficulty after stroke should be provided with written guidance for all staff/carers to use when feeding or providing fluids.

4.16.1J People with stroke should be considered for gastrostomy feeding if they:

- > need but are unable to tolerate nasogastric tube feeding;
- > are unable to swallow adequate food and fluids orally by four weeks from the onset of stroke;
- > are at high long-term risk of malnutrition.

4.16.1K People with stroke who are discharged from specialist treatment with continuing problems with swallowing food or fluids safely should be trained, or have family/carers trained, in the management of their swallowing difficulty and be regularly reassessed.

4.16.1L People with stroke receiving end-of-life (palliative) care should not have burdensome restrictions imposed on oral food and/or fluid intake if those restrictions would exacerbate suffering.

Life after stroke - further rehabilitation

5.9.1.1A People with stroke, including those living in a care home, should be offered a structured health and social care review at six months and 1 year after the stroke, and then annually. The review should consider whether further interventions are needed, and the person should be referred for further specialist assessment if:

- > new problems are present;
- > the person's physical or psychological condition, or social environment has changed.

5.9.1.1B People with stroke should be offered further therapy if goals for specific functions and activities can be identified and agreed and the potential for change is likely.

5.9.1.1C People with stroke should be provided with the contact details of a named healthcare professional (e.g. a stroke co-ordinator) who can provide further information and advice.

5.9.1.1D People with stroke should be helped to develop their own self-management plan.

End-of-life (palliative) care

2.15.1C Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should be taken in the best interests of the person and whenever possible should take their prior expressed wishes into account.

2.15.1D End-of-life (palliative) care for people with stroke should include an explicit decision not to impose burdensome restrictions that may exacerbate suffering. In particular, this may involve a decision, taken together with the person with stroke, those close to them and/or a palliative care specialist, to allow oral food and/or fluids despite a risk of aspiration.

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