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Orthoptics 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 orthoptists. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, orthoptists should consider the guideline in full.

Specialised stroke services

2.3.1D Acute stroke services should have management protocols for the admission pathway including links with the ambulance service, emergency stroke treatments, acute imaging, neurological and physiological monitoring, swallowing assessment, hydration and nutrition, vascular surgical referrals, rehabilitation, end-of-life (palliative) care, secondary prevention, the prevention and management of complications, communication with people with stroke and their family/carers and discharge planning.

2.3.1J Acute stroke services should have an education programme for all staff providing acute stroke care (including ambulance services and the emergency department as appropriate) and should provide training for healthcare professionals in the specialty of stroke.

Resources

2.4.1A People with stroke should be treated on a specialist stroke unit throughout their hospital stay unless their stroke is not the predominant clinical problem.

2.4.1J A stroke rehabilitation unit should have a single multi-disciplinary team including specialists in:

- medicine;
- nursing;
- physiotherapy;
- occupational therapy;
- speech and language therapy;
- dietetics;
- clinical psychology/neuropsychology;
- social work;
- orthoptics;
- with easy access to pharmacy, orthotics, specialist seating, assistive technology and information, advice and support for people with stroke and their family/carers.

Transfers of care - discharge from hospital

2.7.1K People with stroke, including those living in care homes, should continue to have access to specialist services after leaving hospital, and should be provided with information about how to contact them.

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.

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.

Independence in daily living

4.1.1.1A People with stroke should be formally assessed for their safety and independence in all relevant personal activities of daily living by a clinician with the appropriate expertise, and the findings should be recorded using a standardised assessment tool.

Driving

4.1.3.1A People who have had an acute stroke or TIA should be asked about driving before they leave the hospital or specialist outpatient clinic.

4.1.3.1B People with stroke who wish to drive should:

> be advised of the exclusion period from driving and their responsibility to notify the DVLA if they have any persisting disability which may affect their eligibility;

> be asked about or examined for any absolute bars to driving e.g. epileptic seizure (excluding seizure within 24 hours of stroke onset), significant visual field defects, reduced visual acuity or double vision;

> be offered an assessment of the impairments that may affect their eligibility, including their cognitive, visual and physical abilities;

> receive a written record of the findings and conclusions, copied to their general practitioner.

4.1.3.C People with persisting cognitive, language or motor disability after stroke who wish to return to driving should be referred for on-road screening and evaluation.

Work and leisure

4.1.4.1A People with stroke should be asked about their pre-stroke work and leisure activities.

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.

4.1.4.1C Vocational rehabilitation programmes for people after stroke should include:

> assessment of potential problems in returning to work, based on the work role and demands from both the employee's and employer's perspectives;

> an action plan for how problems may be overcome;

> interventions specifically designed for the individual which may include: vocational counselling and coaching, emotional support, adaptation of the working environment, strategies to compensate for functional limitations in mobility and arm function, and fatigue management;

> clear communication between primary and secondary care teams and including the person with stroke, to aid benefit claims or to support a return to work.

Perception

4.3.6.1A People who appear to have perceptual difficulties after stroke should have a perceptual assessment using standardised measures.

4.3.6.1B People with agnosia after stroke should:

> have the impairment explained to them, their family/carers and the multidisciplinary team;

> have their environment assessed and adapted to reduce potential risks and promote independence;

> be offered a perceptual intervention, such as functional training, sensory stimulation, strategy training and/or task repetition, ideally in the context of a clinical trial.

Spatial awareness

4.3.7.1A People with stroke affecting the non-dominant cerebral hemisphere should be considered at risk of impaired awareness on the contralateral side and should be assessed for this using standardised measures.

4.3.7.1C People with impaired awareness to one side after stroke should:

> have the impairment explained to them, their family/carers and the multidisciplinary team;

> be trained in compensatory strategies to reduce the impact on their activities;

> be given cues to draw attention to the affected side during therapy and nursing activities;

> be monitored to ensure that they do not eat too little through missing food on one side of the plate;

> be offered interventions aimed at reducing the functional impact of the reduced awareness (e.g. visual scanning training, limb activation, sensory stimulation, eye patching, prism wearing, prism adaptation training, mirror therapy, galvanic vestibular stimulation, transcranial magnetic stimulation), ideally in the context of a clinical trial.

Falls and fear of falling

4.9.3.1A People with stroke should be offered falls risk assessment and management as part of their stroke rehabilitation, including training for them and their family/carers in how to get up after a fall.

Vision

4.17.1A People with stroke should be:

> assessed for visual acuity whilst wearing the appropriate glasses to check their ability to read newspaper text and see distant objects clearly;

> examined for the presence of visual field deficit (e.g. hemianopia) and eye movement disorders (e.g. strabismus and motility deficit).

4.17.1B People with altered vision, visual field defects or eye movement disorders after stroke should receive information, support and advice from an orthoptist and/or an ophthalmologist.

4.17.1C People with visual loss due to retinal artery occlusion should be jointly managed by an ophthalmologist and a stroke physician.

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.

Overall structure of services

6.1.1A Commissioning organisations should ensure that their commissioning portfolio includes the whole stroke pathway from prevention (including neurovascular services) through acute care, early rehabilitation, secondary prevention, early supported discharge, community rehabilitation, systematic follow-up, palliative care and long-term support.

6.1.1E Commissioners should require that all those caring for people with stroke have the knowledge, skills and attitudes to provide safe, compassionate and effective care, especially for vulnerable people with restricted mobility, sensory loss, impaired communication and cognition and neuropsychological problems.

Commisioning rehabilitation services

6.4.1A Commissioners should commission stroke rehabilitation services in accordance with the recommendations in this guideline to provide:

> an inpatient stroke unit capable of providing stroke rehabilitation for all people with stroke admitted to hospital;

> a specialist early supported discharge service to enable people with stroke to receive rehabilitation at home or in a care home;

> specialist rehabilitation services capable of meeting the specific health, social and vocational needs of people with stroke of all ages;

> services capable of delivering specialist rehabilitation in out-patient and community settings in liaison with in-patient services.

Psychological care - organisation and delivery

2.12.1A Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the multi-disciplinary team.

Carers

2.16.1C The primary carer(s) of a person with stroke should be offered an educational programme which:

> explains the nature, consequences and prognosis of stroke and what to do in the event of a further stroke or other problems e.g. post-stroke epilepsy;

> teaches them how to provide care and support;

> gives them opportunities to practise giving care;

> provides advice on secondary prevention, including lifestyle changes.

Management of TIA - treatment and vascular prevention

3.3.1A Patients with non-disabling stroke or TIA should receive treatment for secondary prevention introduced as soon as the diagnosis is confirmed, including:

> discussion of individual lifestyle factors (smoking, alcohol excess, diet, exercise);

> clopidogrel 300 mg loading dose followed by 75 mg daily;

> high intensity statin therapy with atorvastatin 20-80 mg daily;

> blood pressure-lowering therapy with a thiazide-like diuretic, long-acting calcium channel blocker or angiotensin-converting enzyme inhibitor.

Early mobilisation

3.12.1A Patients with difficulty moving after stroke should be assessed as soon as possible within the first 24 hours of onset by an appropriately trained healthcare professional to determine the most appropriate and safe methods of transfer and mobilisation.

Social integration, community integration and participation

5.9.2.1C People with stroke whose social behaviour is causing distress to themselves or others should be assessed by an appropriately trained healthcare professional to determine the underlying cause and advise on management. Following the assessment:

> the nature of the problem and its cause should be explained to family/carers, other people in social contact and the rehabilitation team;

> the person should be helped to learn the best way to interact without causing distress;

> those involved in social interactions should be trained in how to respond to inappropriate or distressing behaviour;

> psychosocial management approaches should be considered;

> antipsychotic medicines may be indicated if other causes have been excluded and the person is at risk of harm to themselves or others. The balance of risk and benefit from antipsychotic medication should be carefully considered. Treatment should be started with a low dose and increased slowly according to symptoms, and should be short-term (e.g. one week) or intermittent and withdrawn slowly.

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Setting higher standards

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