strokefoundation

Stop stroke. Save lives. End suffering.

Occupational therapy

Concise guidelines
Stroke rehabilitation and recovery

This summary is designed to provide a quick overview of the recommendations relevant to occupational therapists from the full *Clinical Guidelines for Stroke Rehabilitation and Recovery*. Important caveats to the recommendations are included in the preamble to each section in the main document. Readers are referred back to the main document for details regarding these caveats along with the specific research which underpins the recommendations and the designated NHMRC levels of evidence for each recommendation. In general the use of the term 'should' or 'may' has been used to indicate the strength of a recommendation, that is, 'should' is used to indicate a stronger recommendation whereas the use of 'could' reflects a weaker recommendation. These guidelines cover care ***after*** the first seven days. They should be used in conjunction with the *National Clinical Guidelines for Acute Stroke Management* which refers to the first seven days of care.

Discharge planning, transfer of care and integrated community care

2.1: Family and team meetings

The stroke team should meet regularly with the person with stroke and the family to involve them in management, goal setting and planning for discharge.

2.2: Pre-discharge needs assessment

a) Before discharge, people with stroke and their carers should have the opportunity to identify and discuss their post-discharge needs (eg. physical, emotional, social and financial) with the interdisciplinary team.

b) Before discharge (or home trial) from inpatient care and, where appropriate, a home assessment should be carried out to ensure safety and community access. Optimal independence will be facilitated through home modification and adaptive equipment, as required.

2.3: Care plans

People with stroke, their carers, the general practitioner, and community care providers should be involved with the interdisciplinary team in the development of a care plan that outlines care in the community after discharge, including the development of self-management strategies, provision of equipment and support services, and outpatient appointments.

2.4: Carer training

Therapists should provide specific training for carers before the patient's discharge home. This should include training, as necessary, in personal care techniques, physical handling techniques, ongoing prevention and other specific stroke-related problems.

2.5: Liaison with community providers

The stroke survivor's general practitioner, other primary health professionals and community service providers should be involved in, and informed about, the discharge plans and agreed post-discharge management, as early as possible prior to discharge.

2.6: Post-discharge follow-up

b) Stroke survivors and their families should be followed up by a relevant member of the team after their discharge from a formal rehabilitation program.

2.7: General information and education

All stroke survivors and their families should be provided with timely, up-to-date information in conjunction with opportunities to learn via education from members of the interdisciplinary team and other appropriate community service providers. Simple information provision alone is not effective.

Management of the consequences of stroke

3.1 Sensorimotor impairments

3.1.2: Sensation

One or more of the following interventions for increasing tactile and kinaesthetic sensation may be provided for people who have sensory impairments:

- sensory-specific training
- sensory-related training
- cutaneous electrical stimulation in conjunction with conventional therapy

3.1.3: Spasticity

a) One or more of the following interventions may be provided for people who have moderate to severe spasticity (ie, spasticity that interferes with a stroke survivor's activity or personal care):

- dynamic splinting
- vibration
- stretch
- electromyographic biofeedback

b) Interventions to decrease spasticity should not be routinely provided for people who have mild to moderate spasticity (ie, spasticity that does not interfere with a stroke survivor's activity or personal care).

3.1.4: Contracture

a) For people at risk of developing contractures, management may include prolonged positioning of muscles in a maximum lengthened position to maintain range of motion.

b) For people who have contractures, management may include the following interventions to increase range of motion:

- electrical stimulation
- casting

3.1.7: Swelling of the extremities

a) For people who are immobile, management may include the following interventions to prevent swelling in the hand and foot:

- electrical stimulation
- continuous passive motion in elevation
- pressure garments

b) For people who have swollen extremities, management may include the following interventions to reduce swelling of the hand and foot:

- electrical stimulation
- continuous passive motion in elevation

3.2 Physical activity

3.2.5: Upper limb activity

One or more of the following interventions should be provided for people with difficulty using their upper limb:

- task-specific training
- joint position biofeedback in conjunction with conventional therapy
- robot-assisted reaching
- constraint-induced movement therapy

3.2.6: Amount of practice

a) Rehabilitation should be structured to provide as much practice as possible within the first six months after stroke.

b) Group therapy involving task-specific training or video self-modelling may be used to increase the amount of practice in rehabilitation.

3.3 Activities of daily living (ADL)

a) People who have difficulty with ADL should receive occupational therapy or multidisciplinary interventions targeting ADL.

b) Until clinical safety is proven, administration of amphetamines to improve ADL is not recommended.

3.4 Cognitive capacities

3.4.1: Attention and concentration

Cognitive therapy may be used in rehabilitation of attention and concentration deficits.

3.4.2: Memory

External cues may be used to help prompt memory in people with memory difficulties.

3.4.3: Executive functions

External cues, such as a pager, may be used to initiate everyday activities in people with impaired executive functioning.

3.5 Visuospatial/perceptual capacities

3.5.1: Visual function

a) Prism glasses may be used to improve visual function in people with homonymous hemianopia but there is no evidence of benefit in ADL function.

b) Computer-based visual restitution training may be used to improve visual function in people with visual field deficits.

3.5.3: Neglect

People with unilateral spatial neglect may benefit from cognitive rehabilitation (for example, scanning training).

3.5.4: Apraxia

Strategy training in conjunction with conventional therapy to improve ADL may help people with apraxia in the short term (<5 months) to improve planning and task execution.

Living with stroke

4.1 Activity and participation in the community

4.1.1: Self-management

a) People with stroke who do not have cognitive impairment should be made aware of the availability of generic self-management programs before discharge from hospital and be supported to access such programs once they have returned to the community.

b) Stroke-specific programs for self-management may be provided to people who require more specialised programs.

c) A collaboratively developed self-management care plan may be used to harness and optimise self-management skills.

4.1.2: ADL and exercise

a) People living in the community who have difficulties with ADL should have access, as appropriate, to therapy services to improve, or prevent deterioration in, ADL.

b) People who are living in the community more than 6 months after their stroke should have access to interventions to improve fitness and mobility.

c) People living in the community should be provided with information (eg, alternative transport options, resuming driving, ADL and exercise opportunities/services) to facilitate increased outdoor journeys and therefore greater participation within the community. The information provided should also be supplemented by other simple strategies (eg, encouragement, use of appropriate aids/ appliances, approaches to overcoming fear) by an appropriate health professional.

d) General practitioners should refer to allied health professionals where necessary when undertaking routine medical review of people with stroke.

4.1.3: Driving

a) People with stroke who wish to return to driving may be offered a visual attention retraining program or traditional perceptual training.

b) The National Guidelines for Driving (Austroads) and relevant state guidelines should be followed for all issues relating to driving following a stroke.

c) People with stroke who wish to return to driving should be offered an opportunity to undertake an occupational therapy driving assessment, unless there are medical contraindications.

4.1.4: Leisure

Targeted occupational therapy may be used to increase participation in leisure activities.

4.1.5: Return to work

People with stroke who wish to work should be offered assessment and assistance to resume or take up work.

4.1.6: Sexuality

People with stroke and their carers should be offered:

- the opportunity to discuss issues relating to sexuality with an appropriate health professional
- written information addressing issues relating to sexuality post stroke
- any interventions should address psychosocial aspects as well as physical function

This summary is based on the *Clinical Guidelines for Stroke Rehabilitation and Recovery*, National Stroke Foundation, 2005.

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