



strokefoundation

Stop stroke. Save lives. End suffering.

Speech pathology

Concise guidelines

Stroke rehabilitation and recovery

This summary is designed to provide a quick overview of the recommendations relevant to speech pathologists 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

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.

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 person's discharge home. This should include training, as necessary, in communication strategies, safe swallowing and modified diet.

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.

2.7: 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

3.4 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.

3.6 Communication

3.6.1: Aphasia

a) Interventions for people with aphasia may include:

- ▣ treatment of phonological and semantic deficits following models derived from cognitive neuropsychology
- ▣ constraint-induced therapy
- ▣ the use of gesture

b) The following techniques may be used to enhance therapy for people with aphasia:

- ▣ use of volunteers (including family or staff) trained in supported conversation techniques
- ▣ computer-based therapy programs

c) People with aphasia may be considered for group therapy.

d) Until clinical safety is proven and any benefits clearly outweigh any harms, the routine use of the following interventions for aphasia are **not** recommended:

- ▣ Piracetam
- ▣ other pharmacological interventions

e) Aphasia therapy should be commenced as early as possible following a stroke.

f) People with aphasia may benefit from intensive intervention by a speech pathologist.

g) People with severe aphasia may benefit from augmentative and alternative communication devices used in functional activities.

3.6.2: Dyspraxia of speech

a) Interventions for the treatment of dyspraxia of speech may include modelling, visual cueing, integral stimulation and articulatory placement cueing.

b) People with severe apraxia of speech may benefit from augmentative and alternative communication devices used in functional activities.

3.6.3: Dysarthria

a) Interventions for the treatment of dysarthria may include:

- ▣ biofeedback or a voice amplifier to change intensity and increase loudness
- ▣ a palatal lift to compensate for velopharyngeal incompetency
- ▣ the use of strategies such as decreased rate, overarticulation or gesture
- ▣ oral musculature exercises

b) People with severe dysarthria may benefit from augmentative and alternative communication devices used in functional activities.

3.7: Dysphagia

a) Compensatory strategies such as positioning, therapeutic manoeuvres or modification of food and fluids to facilitate safe swallowing may be provided for people with dysphagia.

b) One or more of the following methods may be provided to facilitate resolution of dysphagia:

- ▣ “shaker” therapy targeting specific muscle groups
- ▣ thermo-tactile stimulation
- ▣ electrical stimulation

This summary is based on the *Clinical Guidelines for Stroke Rehabilitation and Recovery*, National Stroke Foundation 2005, which have been endorsed by Speech Pathology Australia.



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Speech Pathology Australia



Giving people a say in life

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