Royal College of Physicians

NICE accredited
www.nice.org.uk/accreditation

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

Transfers of care from hospital to home

2.7.1H Before the transfer home of a person with stroke who is dependent in any activities, the person's home environment should be assessed by a visit with an occupational therapist. If a home visit is not considered appropriate they should be offered an access visit or an interview about the home environment including photographs or videos taken by family/carers.

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.

2.11.1C Multi-disciplinary stroke teams should incorporate the practising of functional skills gained in therapy into the person's daily routine in a consistent manner, and the care environment should support people with stroke to practise their activities as much as possible.

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

Psychological care - organization and delivery

2.12.1E Services for people with stroke should provide screening for mood and cognitive disturbance within six weeks of stroke (in the acute phase of rehabilitation and at the transfer of care into post-acute services) and at six and 12 months using validated tools and observations over time.

Early mobilisation

3.12.1B Patients with difficulty moving early after stroke who are medically stable should be offered frequent, short daily mobilisations (sitting out of bed, standing or walking) by appropriately trained staff with access to appropriate equipment, typically beginning between 24 and 48 hours of stroke onset. Mobilisation within 24 hours of onset should only be for patients who require little or no assistance to mobilise.

Activities of 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.

4.1.1.1B People with limitations of personal activities of daily living after stroke should be referred to an occupational therapist with experience in neurological disability, be assessed within 72 hours of referral, and be offered treatment for identified problems (e.g. feeding, toileting) by the

occupational therapist, who should also involve other members of the specialist multidisciplinary team.

4.1.1.1C People with stroke should be offered, as needed, specific treatments that include:

> dressing practice for people with residual problems with dressing;

> as many opportunities as appropriate to practice self-care;

> assessment, provision and training in the use of equipment and adaptations that increase safe independence;

> training of family/carers in how to help the person with stroke.

Extended activities of daily living

4.1.2.1A People whose activities have been limited by stroke should be:

> assessed by an occupational therapist with expertise in neurological disability;

> trained in how to achieve activities safely and given as many opportunities to practise as reasonable under supervision, provided that the activities are potentially achievable;

> provided and trained in how to use any adaptations or equipment needed to perform activities safely.

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.

4.1.3.1C 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.

4.1.4.1D People with stroke who wish to return to or take up a leisure activity should have their cognitive and practical skills assessed, and receive support to pursue their activity.

Arm function

See also 4.2 B, C and D

4.2.1A People with stroke with potential or actual arm movement should be given every opportunity to practice functional activities. Practice should be characterised by movements that are of high intensity, repetitive and are task-specific. These activities may be bilateral or unilateral depending on the task.

4.2.1E People without movement in the affected arm after a stroke should be trained in how to care for their affected arm and monitored for any change.

Cognition

4.3.1A People with stroke should be considered to have at least some cognitive impairment in the early phase. Routine screening should be undertaken to identify the person's level of functioning, using standardised measures.

4.3.1B Any person with stroke who is not progressing as expected in rehabilitation should receive a detailed assessment to determine whether cognitive impairments are responsible, with the results explained to the person, their family and the multidisciplinary team.

4.3.1E People with acute cognitive problems after stroke whose care is being transferred from hospital should receive an assessment for any safety risks from persisting cognitive impairments. Risks should be communicated to their primary care team together with any mental capacity issues that might affect their decision-making.

4.3.1F People with stroke returning to cognitively demanding activities such as driving or work should have their cognition fully assessed.

4.3.1G People with continuing cognitive difficulties after stroke should be considered for comprehensive interventions aimed at developing compensatory behaviours and learning adaptive skills.

Apraxia

4.3.2A People with difficulty executing tasks after stroke despite adequate limb movement should be assessed for the presence of apraxia using standardised measures.

Attention and concentration

See also 4.3.3 B and C

4.3.3A People who appear easily distracted or unable to concentrate after stroke should have their attentional abilities assessed using standardised measures.

Executive functioning

See also 4.3.4 B and C

4.3.4A P People with stroke who appear to have adequate skills to perform complex activities but fail to initiate, organise or inhibit behaviour should be assessed for the dysexecutive syndrome using standardised measures.

Memory

See also 4.3.5 B

4.3.5A People with stroke who report memory problems and those considered to have problems with learning and remembering should have their memory assessed using standardised measures.

Perception

See also 4.3.6 B

4.3.6A People who appear to have perceptual difficulties after stroke should have a perceptual assessment using standardised measures.

Spatial awareness

See also 4.3.7 C

4.3.7A 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.

4.3.7B When assessing problems with spatial awareness in people with stroke, clinicians should use a standardised test battery in preference to a single subtest, and the effect on functional tasks such as dressing and mobility should be included.

Fatigue

See also 4.6 B

4.6A People with stroke who are medically stable but who report fatigue should be offered an assessment for mental and physical factors that may be contributing, particularly when engagement with rehabilitation or quality of life is affected.

Falls and fears of falling

4.9.3A 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.

Anxiety, depression and psychological distress

See also 4.10.1.1 B and C

4.10.1.1A People with stroke with one mood disorder (e.g. depression) should be assessed for others (e.g. anxiety).

Shoulder pain and subluxation

4.12.3.1A People with functional loss in their arm after stroke should have the risk of shoulder pain reduced by:

> careful positioning of the arm, with the weight of the limb supported;

> ensuring that family/carers handle the affected arm correctly, avoiding mechanical stress and excessive range of movement;

> avoiding the use of overhead arm slings and pulleys.

4.12.3.1B People with arm weakness after stroke should be asked regularly about shoulder pain.

Sensation

See also 4.13 B

4.13.1A People with stroke should be screened for altered sensation and if present, assessed for sensory impairments using standardised measures.

Sex

4.14.1A People with stroke should be asked, soon after discharge and at their 6-month and annual reviews, whether they have any concerns about sex. Partners should also have an opportunity to raise any problems.

Spasticity and contracture management

4.15A People with motor weakness after stroke should be assessed for spasticity as a cause of pain, as a factor limiting activities or care, and as a risk factor for the development of contractures.

4.15.1H People with stroke should not be routinely offered splinting for the arm and hand.

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).

Social integration and participation

5.9.2.1A As part of their self-management plan, people with stroke should be supported to identify social and leisure activities that they wish to participate in, taking into account their cognitive and practical skills. Healthcare professionals should:

> advise the person with stroke and their family/carers about the benefits of participating in social and leisure activities;

> identify and help to overcome any barriers to participation (e.g. low self-confidence or lack of transport).

Further rehabilitation

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.

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

11 St Andrews Place,
Regent's Park
London NW1 4LE
Tel: +44 (0)20 3075 1378
Email: stroke@rcplondon.ac.uk

www.rcplondon.ac.uk

Royal College of Physicians

Setting higher standards

Compiled by Mrs Karen Clements and Prof Avril Drummond on behalf of the Intercollegiate Stroke Working Party