



## Complete Summary

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### GUIDELINE TITLE

Management of patients with stroke. Rehabilitation, prevention and management of complications, and discharge planning. A national clinical guideline.

### BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with stroke. Rehabilitation, prevention and management of complications, and discharge planning. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Nov. 48 p. (SIGN publication; no. 64). [168 references]

## COMPLETE SUMMARY CONTENT

SCOPE  
METHODOLOGY - including Rating Scheme and Cost Analysis  
RECOMMENDATIONS  
EVIDENCE SUPPORTING THE RECOMMENDATIONS  
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS  
QUALIFYING STATEMENTS  
IMPLEMENTATION OF THE GUIDELINE  
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY

## SCOPE

### DISEASE/CONDITION(S)

Stroke

### GUIDELINE CATEGORY

Management  
Prevention  
Rehabilitation

### CLINICAL SPECIALTY

Cardiology  
Family Practice  
Geriatrics  
Internal Medicine

Neurology  
Physical Medicine and Rehabilitation

#### INTENDED USERS

Advanced Practice Nurses  
Health Care Providers  
Hospitals  
Nurses  
Occupational Therapists  
Pharmacists  
Physical Therapists  
Physician Assistants  
Physicians  
Speech-Language Pathologists

#### GUIDELINE OBJECTIVE(S)

- To present evidence-based recommendations for the management of patients with stroke
- To assist individual clinicians, primary care teams, hospital departments, and hospitals to optimize their management of stroke patients
- To focus on general management, rehabilitation, the prevention and management of complications and discharge planning, with an emphasis on the first 12 months after stroke

#### TARGET POPULATION

Patients with stroke

#### INTERVENTIONS AND PRACTICES CONSIDERED

##### Organisation of Services

1. Hospital care--admit or remain at home
2. Early supported discharge and post-discharge support
3. Rehabilitation for patients in the home

##### General Rehabilitation Principles

1. Core multidisciplinary team membership and communication
2. Education and training of staff
3. Early mobilisation
4. Information provision for patients and carers
5. Carer support and stroke family worker support
6. Rehabilitation for people living at home within one year of stroke or more than one year after stroke

##### Specific Management and Prevention Strategies

1. Intensity of therapy

2. Therapies to address motor impairment (e.g., task-specific training, treadmill training, biofeedback, use of ankle foot orthoses, electrical stimulation)
3. Speech and language therapy
4. Cognitive screening and assessment
5. Assessment of nutrition and swallowing status
6. Recognition, investigation, and treatment of common infections
7. Assessment for urinary and fecal incontinence and use of urinary catheterization
8. Management and prevention of hemiplegic shoulder pain
9. Prevention and treatment of pressure ulcers
10. Therapeutic positioning (considered but not recommended)
11. Screening for and treatment of mood disturbances (e.g., use of antidepressants)
12. Risk assessment and preventive treatment for venous thromboembolism (use of aspirin, heparin, graduated compression stockings)
13. Assessment for ability to drive and appropriate referrals
14. Counseling on sexuality
15. Dealing with ethical dilemmas in post-stroke care (e.g., use of cardiopulmonary resuscitation, feeding, use of antibiotics, policies for methicillin-resistant *Staphylococcus aureus*)

#### Discharge Planning and Transfer Care

1. Planning and formulating specific policies for pre-discharge, discharge, and post-discharge
2. Providing ongoing support to patients and caregivers

#### MAJOR OUTCOMES CONSIDERED

- Overall physical and functional outcomes (patient improvement or deterioration)
- Risk of death, dependency, and long-term care in an institution at one year
- Hospital admission rates, length of hospital stay
- Incidence of complications, such as chest or urinary tract infection, deep vein thrombosis or pulmonary embolism

## METHODOLOGY

#### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

#### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The majority of the questions addressed in this guideline were answered by evidence identified from a series of Cochrane Reviews. These reviews were supplemented by searches of the Cochrane Stroke Group's specialized trials register, carried out by members of the guideline development group. Details are available from the Scottish Intercollegiate Guidelines Network (SIGN) Executive.

#### NUMBER OF SOURCE DOCUMENTS

Not stated

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++ High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++ High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g., case reports, case series

4 Expert opinion

## METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses  
Systematic Review

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Scottish Intercollegiate Guidelines Network (SIGN) carries out comprehensive systematic reviews of the literature using customized search strategies applied to a number of electronic databases and the Internet. This is often an iterative process whereby the guideline development group will carry out a search for existing guidelines and systematic reviews in the first instance and, after the results of this search have been evaluated, the questions driving the search may be redefined and focused before proceeding to identify lower levels of evidence.

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. SIGN has

developed checklists to aid guideline developers to critically evaluate the methodology of different types of study design. The result of this assessment will affect the level of evidence allocated to the paper, which in turn will influence the grade of recommendation it supports.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]). Available from the [SIGN Web site](#).

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The process for synthesizing the evidence base to form graded guideline recommendations is illustrated in the companion document titled "SIGN 50: A Guideline Developer's Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN website.

Evidence tables should be compiled, summarizing all the validated studies identified from the systematic literature review relating to each key question. These evidence tables form an important part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

In order to address how the guideline developer was able to arrive at their recommendations given the evidence they had to base them on, SIGN has introduced the concept of considered judgement.

Under the heading of considered judgement, guideline development groups are expected to summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- Generalisability of study findings
- Applicability to the target population of the guideline
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources need to treat them.)

Guideline development groups are provided with a pro forma in which to record the main points from their considered judgement. Once they have considered these issues, the group are asked to summarise their view of the evidence and assign a level of evidence to it, before going on to derive a graded recommendation.

The assignment of a level of evidence should involve all those on a particular guideline development group or subgroup involved with reviewing the evidence in relation to each specific question. The allocation of the associated grade of

recommendation should involve participation of all members of the guideline development group. Where the guideline development group is unable to agree a unanimous recommendation, the difference of opinion should be formally recorded and the reason for dissent noted.

The recommendation grading system is intended to place greater weight on the quality of the evidence supporting each recommendation, and to emphasise that the body of evidence should be considered as a whole, and not rely on a single study to support each recommendation. It is also intended to allow more weight to be given to recommendations supported by good quality observational studies where randomised controlled trials (RCTs) are not available for practical or ethical reasons. Through the considered judgement process guideline developers are also able to downgrade a recommendation where they think the evidence is not generalisable, not directly applicable to the target population, or for other reasons is perceived as being weaker than a simple evaluation of the methodology would suggest.

On occasion, there is an important practical point that the guideline developer may wish to emphasise but for which there is not, nor is their likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as "good practice points." It must be emphasized that these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

#### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

Grade A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or randomized controlled trial rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rate as 2++

Grade D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

External Peer Review  
Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development, at which the guideline development group present their draft recommendations for the first time. The national open meeting for this guideline was held on 14 May 2001 and was attended by 180 representatives of all the key specialties relevant to the guideline. The draft guideline was also available on the SIGN web site for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the guideline.

The guideline draft was commented on by expert external reviewers, whose submissions were carefully considered by the guideline development group and, where appropriate, incorporated into the final version. As a final quality control check, the guideline was reviewed by an Editorial Group comprising the relevant specialty representatives on SIGN Council.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The grades or recommendations (A-D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

#### Organisation of Services

A- Patients admitted to hospital because of acute stroke should be treated in a multidisciplinary stroke unit.

B- Where rehabilitation in stroke rehabilitation units is not possible, rehabilitation should be provided in a generic rehabilitation ward.

D- Trusts should consider appointment of a stroke liaison nurse/co-ordinator.

B- Stroke patients who are dependent in activities of daily living should receive hospital-based care in organised stroke units.

A- Early supported discharge services provided by a well resourced, co-ordinated specialist multidisciplinary team are an acceptable alternative to more prolonged hospital stroke unit care and can reduce the length of hospital stay for selected patients.

#### General Rehabilitation Principles

B- The core multidisciplinary team should consist of appropriate levels of nursing, medical, physiotherapy, occupational therapy, speech and language therapy, and social work staff.

B- Patients and carers should have an early active involvement in the rehabilitation process.

B- Stroke unit teams should conduct at least one formal multidisciplinary meeting per week at which patient problems are identified, rehabilitation goals set, progress monitored and discharge is planned.

B- Members of the multidisciplinary stroke team should undertake a continuing programme of specialist training and education.

B- Stroke patients should be mobilised as early as possible after stroke.

D-Stroke patients and their carers should be offered information about stroke and rehabilitation.

A- Stroke patients living at home, within one year of stroke onset, should be considered for specialist therapy-based rehabilitation services.

B- The provision of stroke family care workers by charities, voluntary groups, social services and Health Boards should be considered as part of a strategy of improving the care of families affected by stroke.

#### Specific Management and Prevention Strategies

B- Task-specific training can be used in order to improve performance of selected tasks.

B- Carefully selected non-ambulant patients, late after severe stroke, may benefit from treadmill training.

B- Patients with co-existing pathologies affecting cardiovascular fitness may benefit from training using a treadmill that offers partial body weight support.

B- Electromyographic (EMG) biofeedback need not be used routinely in the rehabilitation of function and movement following stroke.

B- Although ankle foot orthoses may help some patients with foot drop, they should not be used routinely without proper assessment prior to use and follow-up to establish their effectiveness in the individual.

B- Electrical stimulation (ES) should be considered for use in improving muscle force, strength and function in selected patients. Electrical stimulation must not be assumed to have sustained effects.

B- Aphasic stroke patients should be referred for speech and language therapy. Where the patient is sufficiently well and motivated, aim for minimum of two hours per week.

D- Patients with dysarthria should be referred to an appropriate speech and language therapy service for assessment and management.

D- The presence or absence of incontinence of urine should be documented for all patients after a stroke.

B- Central Post Stroke Pain may respond to the use of tricyclic antidepressants, particularly amitriptyline.

C- The management and prevention of hemiplegic shoulder pain is an integral part of good quality physical care provided within the multidisciplinary environment of the stroke unit.

B- Hip protectors are recommended in men and women at high risk of hip fracture (particularly older people in care homes) although problems with compliance should be recognised.

D- Hospital managers should ensure that nursing expertise, staffing and equipment levels are sufficient to prevent pressure ulcers.

D- Hospitals should have up to date policies on risk assessment, pressure ulcer prevention and treatment.

C- Stroke patients should not routinely receive antidepressant drugs to prevent depression.

B- Stroke patients with diagnosed depression should be offered a course of treatment with antidepressant drug therapy.

B- Drug treatments may be used to treat emotionalism in stroke patients.

A- Aspirin (initial starting dose 150-300mg/day and 75mg/day or more thereafter) should be given to all patients with acute ischaemic stroke in the first two weeks following stroke onset to help prevent deep vein thrombosis and pulmonary embolism (provided there are no known contraindications to aspirin

therapy). Aspirin can be given by nasogastric tube or rectally (using 300mg/day suppositories) for those who are unable to swallow.

D- Two weeks following acute ischaemic stroke, clinicians should reassess the patient's risk for deep vein thrombosis (DVT) and consider starting additional prophylactic medical treatment (e.g. heparin).

D- Physical methods (e.g. graduated elastic compression stockings) are preferred for patients recovering from haemorrhagic stroke.

C- Selected use of graduated elastic compression stockings may be justified for some high risk stroke patients.

D- If there is doubt about a patient's ability to drive, patients should be referred to the local Disabled Drivers' Assessment Centre (details available from the Driver and Vehicle Licensing Agency).

D- Hospitals (or stroke units) should have a local cardiopulmonary resuscitation policy.

#### Discharge Planning and Transfer of Care

D- Pre-discharge home visits should be available for patients that require them.

#### Roles of the Multidisciplinary Team

B- Stroke patients should be treated 24 hours a day by nurses specialising in stroke and based in a stroke unit.

B- A minimum nursing level of 10 whole time equivalents per 10 beds is recommended.

D- Consultants with an interest in stroke, after adequate training and with appropriate continuing professional development, should be available to co-ordinate every stroke service or unit.

D- If the patient is to be admitted, the general practitioner (GP) should communicate with the hospital staff the basis of the diagnosis, the premorbid condition of the patient, any relevant social factors and past medical history.

D- For successful discharge, the general practitioners and community staff should receive adequate information from the hospital prior to discharge.

D- All patients who have difficulties with movement following stroke should have access to a physiotherapist specialising in stroke. Physiotherapy treatment should be based on an assessment of each patient's unique problems.

D- Speech and language therapists should be involved in stroke management at all stages in the recovery process and should liaise closely with all related healthcare professionals, with outside agencies, both statutory and voluntary, with the individual who has suffered a stroke and with his/her carers.

D- All patients who have problems with activities of daily living following stroke should have access to an occupational therapist with specific knowledge and expertise in neurological care. Occupational therapy treatment should be based on an assessment of each patient's unique problems.

D- A social worker should be a member of the multidisciplinary team and should have a key role in the discharge planning process.

D- Each multidisciplinary stroke team should have access to a clinical psychologist and psychiatrist.

#### Definitions:

A. At least one meta-analysis, systematic review of randomised controlled trials (RCTs), or RCT rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B. A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C. A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D. Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

#### Levels of Evidence

1++ High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++ High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3 Non-analytic studies, e.g., case reports, case series

4 Expert opinion

#### CLINICAL ALGORITHM(S)

None provided

### EVIDENCE SUPPORTING THE RECOMMENDATIONS

#### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

### BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

#### POTENTIAL BENEFITS

- Improved physical and functional outcomes
  - Evidence from clinical trials suggests that early rehabilitation intervention leads to improved physical and functional outcomes.
  - An overview of stroke units compared with management on general wards has shown that there is an improved outcome following admission to hospital with a reduction in risk of death, dependency and long-term care in an institution at one year.
  - The benefits of a stroke unit were seen in units that admitted patients directly from the community or took over their care within two weeks of admission to hospital. The evidence of benefit is most clear for units, which can provide several weeks of rehabilitation if required.
  - Domiciliary therapy and attendance at day hospital are associated with further functional improvements. Home-care services have been shown to lead to reduced hospital stay and improvement in long-term outcome.
  - Occupational therapists treat people who have impairments, restricted activity levels and limited ability to participate as a result of injury or illness, in order to achieve the highest level of independence possible.
  - Speech and language treatment is aimed at maximizing communication and reducing linguistic or motor speech difficulties resulting from stroke.
  - In a study of global aphasia where subjects were randomised to intensive therapy (daily sessions) and regular therapy (three sessions per week), more patients in the intensive group achieved significant improvement.
  - Low dose aspirin has been shown to be safe and effective in preventing deep vein thrombosis (DVT) and pulmonary embolism.

## POTENTIAL HARMS

While the benefits may be similar to those seen in the perioperative periods, the risks of graduated elastic compression stockings are potentially greater due to an increased prevalence of peripheral vascular disease and potential discomfort for patients who are very immobile.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to changes as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available. However, it is advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) Trust and is an essential part of clinical governance. It is acknowledged that every Trust cannot implement every guideline immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Key points of audit and recommendations for further research are identified in the original guideline. Please see the "Implementation and Audit" section of the original guideline document for further details.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness  
Staying Healthy

#### IOM DOMAIN

Effectiveness  
Patient-centeredness

### IDENTIFYING INFORMATION AND AVAILABILITY

#### BIBLIOGRAPHIC SOURCE(S)

Scottish Intercollegiate Guidelines Network (SIGN). Management of patients with stroke. Rehabilitation, prevention and management of complications, and discharge planning. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Nov. 48 p. (SIGN publication; no. 64). [168 references]

#### ADAPTATION

Not applicable: The guideline was not adapted from another source.

#### DATE RELEASED

1998 Apr (revised 2002 Nov)

#### GUIDELINE DEVELOPER(S)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

#### SOURCE(S) OF FUNDING

Scottish Executive Health Department

#### GUIDELINE COMMITTEE

Not stated

#### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group: Dr Richard Lindley (Chairman); Mr John Brown; Mr Campbell Chalmers; Mrs Ursula Corker; Mrs Marion Dawson; Dr Ali El-Ghorr; Professor Peter Langhorne; Ms Lynn Legg; Mrs Flora MacGillivray; Ms Therese Jackson; Dr Catherine Mackenzie; Dr Ron MacWalter; Dr Jacqueline McDonald; Dr Grant McHattie; Dr Alex Pollock; Mr Cameron Sellars; Mr Mark Smith (Secretary); Dr Jacqueline Taylor; Dr Deborah Tinson; Mr Ian Wellwood

#### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Scottish Intercollegiate Guidelines Network (SIGN) guideline development groups are required to complete a declaration of interests, both personal and non-personal. A personal interest involves payment to the individual concerned, e.g., consultancies or other fee-paid work commissioned by or shareholdings in the pharmaceutical industry; a non-personal interest involves payment which benefits any group, unit or department for which the individual is responsible, e.g., endowed fellowships or other pharmaceutical industry support. SIGN guideline group members should be able to act as independently of external commercial influences as possible, therefore, individuals who declare considerable personal interests may be asked to withdraw from the group. Details of the declarations of interest of any guideline development group member(s) are available from the SIGN executive.

#### GUIDELINE STATUS

This is the current release of the guideline.

Any amendments to the guideline in the interim period will be noted on the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

#### GUIDELINE AVAILABILITY

Electronic copies: Available in portable document format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

#### AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Quick reference guide: Management of patients with stroke: rehabilitation, prevention and management of complications, and discharge planning, Scottish Intercollegiate Guidelines Network, 2002. 2 p. Available in portable document format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001 Feb. (SIGN publication; no. 50). Electronic copies available from the [SIGN Web site](#).
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research & Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Electronic copies available from the [SIGN Web site](#).
- A background paper on the legal implications of guidelines. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network.

#### PATIENT RESOURCES

The following is available:

- Patient issues. Management of patients with stroke. Rehabilitation, prevention and management of complications, and discharge planning. A national clinical

guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Nov. p. 30-2. (SIGN publication; no. 64).

Electronic copies: Available in portable document format (PDF) from the [Scottish Intercollegiate Guidelines Network \(SIGN\) Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

#### NGC STATUS

This summary was completed by ECRI on February 6, 2002. The information was verified by the guideline developer as of April 9, 2002. This summary was updated by ECRI on April 28, 2003. The updated information was verified by the guideline developer on June 3, 2003.

#### COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions. Please refer to the guideline developer's Web site, [www.sign.ac.uk](http://www.sign.ac.uk), for further details.

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