

Stroke Clinical Care Standard 2026 – Quality statements

1. Early assessment and urgent transport to hospital

A person with suspected stroke is assessed at first clinical contact using a validated stroke screening tool, such as the [F.A.S.T. \(Face, Arms, Speech and Time\)](#) test. When acute stroke is suspected, the person is transported immediately to a hospital capable of providing appropriate time-critical therapy. The hospital is pre-notified to enable rapid access to care.

2. Time-critical therapy

A patient with acute stroke receives time-critical therapy urgently and in accordance with the [Living Clinical Guidelines for Stroke Management](#). A patient with ischaemic stroke suitable for reperfusion therapy receives timely thrombolysis and/or endovascular thrombectomy. A patient with intracerebral haemorrhage receives urgent blood-pressure-lowering therapy and/or anticoagulation reversal where appropriate

3. Stroke unit care

A patient with stroke is promptly transferred to a stroke unit, as defined in the [National Acute Stroke Services Framework](#). The patient receives early, protocolised care to prevent complications and maximise recovery.

4. Rehabilitation

A patient's initial rehabilitation needs are assessed by a multidisciplinary team as early as possible and within 48 hours of hospital admission for stroke. Individualised, guideline-recommended rehabilitation begins as soon as clinically appropriate during the admission. Rehabilitation needs are continually assessed and documented. Arrangements for ongoing rehabilitation are made before discharge.

5. Minimising risk of another stroke

While in hospital, a patient undergoes a comprehensive assessment to determine the probable cause of their stroke. This assessment informs their ongoing care, including individualised treatment and education to promote healthy living and reduce their risk of another stroke

6. Practical assistance for families and support people

The family and support people of a patient with stroke are provided with information and practical assistance so that they can safely and confidently support the patient to manage their daily needs.

7. Individualised care plan

Before leaving hospital, a patient with stroke and their family or support people are involved in the development of an individualised care plan that describes the ongoing care required. This care plan is given to the patient, their general practice and their ongoing rehabilitation team at the time of discharge.

8. Follow-up assessment and review

A patient who has had a stroke receives a follow-up assessment and review, with appropriate multidisciplinary team input, within six months of their stroke diagnosis. This is arranged before discharge.

