Australian Commission on **Safety and Quality** in Health Care

Clinical Care Standards

Stroke

Clinical Care Standard

June 2026

safetyandquality.gov.au

The Australian Commission on Safety and Quality in Health Care pays respect to the Gadigal people as the Traditional Custodians of Country where the Commission's office is located. We extend that respect to all Aboriginal and Torres Strait Islander peoples, and their deep time connections to land, water and sky.

We recognise that knowledge about healthy Country, community and culture has been developed by Aboriginal and Torres Strait Islander peoples over tens of thousands of years and has been shared for generations. We are committed to partnering with and learning from Aboriginal and Torres Strait Islander peoples through the work that we do.

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Please note that there is the potential for minor revisions of this document. Please check www.safetyandquality.gov.au for any amendments.

The *Stroke Clinical Care Standard* has been endorsed by the following organisations:

Contents

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.

Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this Clinical Care Standard. These indicators are intended to support local quality improvement activities.

Quality statement 1. Early assessment and urgent transport to hospital

Indicator 1a: Proportion of patients with a suspected stroke who were assessed by ambulance services using a validated stroke screening tool.

Applicable for: ambulance services.

Indicator 1b: Median time from first clinical contact to arrival at a hospital capable of providing appropriate time-critical stroke therapy for patients with a suspected stroke.

Applicable for: ambulance services.

Quality statement 2. Time-critical therapy

Indicator 2a: Proportion of patients with an ischaemic stroke who received intravenous thrombolytic therapy.

Applicable for: acute hospitals.

Indicator 2b: Median time from arrival at hospital to treatment with an intravenous thrombolytic agent for patients with an ischaemic stroke.

Applicable for: acute hospitals.

Indicator 2c: Proportion of patients with an ischaemic stroke who received endovascular thrombectomy.

Applicable for: acute hospitals with endovascular capabilities.

Indicator 2d: Proportion of patients with an ischaemic stroke who were transferred for endovascular thrombectomy.

Applicable for: acute hospitals without endovascular capabilities.

Indicator 2e: Median time from arrival at hospital to departure for patients with an ischaemic stroke transferred for endovascular thrombectomy.

Applicable for: acute hospitals without endovascular capabilities.

Indicator 2f: Median time from arrival at hospital to endovascular thrombectomy for patients with an ischaemic stroke who had endovascular thrombectomy.

Applicable for: acute hospitals with endovascular capabilities.

Indicator 2g: Median time from arrival at hospital to initiation of blood-pressure-lowering therapy for patients with an acute intracerebral haemorrhage and elevated systolic blood pressure on presentation.

Applicable for: acute hospitals.

Indicator 2h: Median time from arrival at hospital to initiation of anticoagulation reversal for patients with an acute intracerebral haemorrhage taking an anticoagulant.

Applicable for: acute hospitals.

Quality statement 3. Stroke unit care

Indicator 3a: Proportion of patients with a stroke who had documented treatment in a stroke unit.

Applicable for: acute hospitals.

Indicator 3b: Median time from arrival at hospital to admission to a stroke unit for patients with a stroke.

Applicable for: acute hospitals with a stroke unit.

Indicator 3c: Evidence of local arrangements to ensure patients with a stroke receive early protocolised care in accordance with the current Living Clinical Guidelines for Stroke Management or evidence-based, locally endorsed guidelines.

The local arrangements should specify:

- protocols for monitoring and prompt management of pyrexia, hyperglycaemia and swallowing difficulties
- escalation pathways for pyrexia, hyperglycaemia, and swallowing difficulties
- protocols for screening for communication difficulties and further assessment as required
- protocols to ensure appropriate venous thromboembolism prophylaxis
- processes to ensure relevant staff are trained in the use of the validated tools used at the service to screen for swallowing and communication difficulties
- processes to support implementation and monitoring of the local arrangements.

Applicable for: acute hospitals.

Indicator 3d: Proportion of patients with a stroke who had a swallow screen or assessment completed before they were given any food, fluids or oral medication.

Applicable for: acute hospitals.

Quality statement 4. Rehabilitation

Indicator 4a: Proportion of patients with a stroke seen by a physiotherapist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

Indicator 4b: Proportion of patients with a stroke seen by a speech pathologist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

Indicator 4c: Proportion of patients with a stroke seen by an occupational therapist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

Indicator 4d: Proportion of patients with a stroke whose ongoing rehabilitation needs were assessed by a multidisciplinary team and documented before discharge to the community.

Applicable for: acute and sub-acute hospitals.

Indicator 4e: Proportion of patients with a stroke who were referred for ongoing rehabilitation before discharge from hospital.

Applicable for: acute and sub-acute hospitals.

Quality statement 5. Minimising risk of another stroke

Indicator 5a: Proportion of patients with a stroke prescribed an antihypertensive medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

Indicator 5b: Proportion of patients with an ischaemic stroke prescribed a lipid-lowering medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

Indicator 5c: Proportion of patients with an ischaemic stroke and atrial fibrillation prescribed an oral anticoagulant medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

Quality statement 6. Practical assistance for families and support people

Indicator 6a: Proportion of patients with a stroke where at least one family member or support person received information and practical assistance to support the patient with their new daily needs before discharge to the community.

Applicable for: acute and sub-acute hospitals.

Quality statement 7. Individualised care plan

Indicator 7a: Proportion of patients with a stroke who had an individualised care plan on discharge to the community.

Applicable for: acute and sub-acute hospitals.

Quality statement 8. Follow-up assessment and review

Indicator 8a: Proportion of patients with a stroke who participated in a follow-up review within six months of the diagnosis of their stroke.

Applicable for: acute and sub-acute hospitals.

More information

The definitions required to collect and calculate these indicator data are specified online at the Australian Institute of Health and Welfare's Metadata Online Registry (METEOR): meteor.aihw.gov.au/content/817660.

Also see the Using indicators section for more information.

Updates

This revised Clinical Care Standard incorporates changes in the relevant evidence-based guidelines since 2019. The scope and goal have been revised to incorporate the expanded focus areas described below.

Key updates in the current version include:

- change of title, previously the ‘Acute Stroke Clinical Care Standard’, to include aspects of care extending beyond the acute and hyperacute phase
- addition of cultural safety and equity considerations
- broader inclusion of stroke telehealth in hyperacute and acute stroke care
- greater emphasis on ambulance services and pre-hospital notification systems
- inclusion of time-critical care for intracerebral haemorrhage (ICH)
- greater emphasis on rehabilitation, including assessment of needs, initiation in hospital and planning arrangements for ongoing care post discharge
- amendments to improve timely access to stroke unit care and early, protocolised care
- a new quality statement about follow-up.

Key updates to the indicators include:

- the addition of indicators to measure
  - provision of time-critical care
  - delivery of stroke unit care
  - multidisciplinary assessment to identify rehabilitation needs
  - referral for ongoing rehabilitation
  - participation in a follow-up review
- the retiring of four indicators
- revisions to several indicators.

See Appendix: Updates in the 2026 Standard for a detailed list of amendments.

Clinical Care Standards

A Clinical Care Standard describes the care that patients should be offered by clinicians and healthcare services for a specific clinical condition, treatment, procedure or clinical pathway, regardless of where people are treated in Australia. Clinical Care Standards aim to address unwarranted variation in health care or patient outcomes by increasing evidence-based health care for priority aspects of care.

Clinical Care Standards include:

- quality statements that describe the expected standard for key components of patient care
- explanations of what each quality statement means for
  - people receiving care, to ensure that they know what care may be offered and can make informed decisions in partnership with their clinician
  - clinicians, to support decisions about appropriate care
  - healthcare services, to inform them of the policies, procedures and organisational factors that can enable delivery of high-quality care
- indicators to support local quality improvement, allowing clinicians and healthcare services to monitor the care described in the Standard.

Clinical Care Standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission). By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

Applying Clinical Care Standards

While implementation of the *Stroke Clinical Care Standard* is not mandated, healthcare services assessed to the National Safety and Quality Health Service (NSQHS)[1] Standards are expected to identify relevant Clinical Care Standards and implement those that will reduce risk to patients, improve quality, and address local areas of unwarranted variation in process or outcomes or from best practice, according to their local quality improvement priorities.

The Commission's Fact sheet: Applicability of Clinical Care Standards[2] provides more information about assessment to the NSQHS Standards, compliance and the role of indicators.[2]

More information about applicable healthcare settings is provided below.

National Safety and Quality Standards

Clinical Care Standards support quality improvement and can be used in any setting where they may help achieve high-quality care. Information about the role of Clinical Care Standards for healthcare services providing care consistent with the National Safety and Quality Health Service (NSQHS) Standards[1] and the National Safety and Quality Primary and Community Healthcare Standards (Primary and Community Healthcare Standards)[3] can be found online.

General principles of care

Clinical Care Standards should be implemented as part of an overall approach to improving safety, quality, and appropriateness of care. Some principles and key actions are described in other Commission standards and guidance and are not reproduced here. These include:

- effective clinical governance
- person-centred care and partnering with consumers
- shared decision making and informed consent
- environmental sustainability and climate resilience
- cultural safety and equity (see also Cultural safety and equity on page 13).

For more information

- NSQHS Standards[1]
- Primary and Community Healthcare Standards[3]
- Fact sheet: Applicability of Clinical Care Standards[2]
- User Guide for Reviewing Clinical Variation
- Clinical Care Standards
- Joint Statement on Climate Change and Health.[4]

About the Stroke Clinical Care Standard

Goal

The goal of this Clinical Care Standard is to improve the assessment, management and transitions of care for patients with stroke to increase their likelihood of survival and recovery while reducing their risk of another stroke.

Scope

The *Stroke Clinical Care Standard* relates to the care that adult patients should receive when they have, or are suspected of having, an ischaemic stroke or intracerebral haemorrhage. This includes patients who have a stroke while in hospital. It covers the care provided from pre-hospital emergency service contact through hospital admission and discharge to the community.

What is not covered

The Standard does not cover:

- transient ischaemic attack (TIA)
- subarachnoid, extradural or subdural haemorrhage
- intracerebral haemorrhage secondary to a structural abnormality in the brain (such as an arteriovenous malformation, intracranial aneurysm, tumour, trauma, or previous cerebral infarction)
- the care of children with stroke.

This Standard does not offer specific guidance on end-of-life or palliative care for patients who have had a stroke. See the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.[5]

Healthcare settings

This Clinical Care Standard applies to care provided in:

- pre-hospital emergency settings, primarily ambulance services
- hospital settings, including public and private hospitals, rehabilitation services and outpatient clinics
- some primary care settings.

Not all quality statements within this Standard will be applicable to every healthcare service. Healthcare services should consider their individual circumstances when determining how to apply each statement.

When implementing this Clinical Care Standard, healthcare services should consider:

- the context in which care is provided
- local variation
- their individual quality improvement priorities.

In inner regional, outer regional, remote and very remote settings, different strategies may be needed to implement the Standard. For example, the use of:

- telehealth consultations
- multidisciplinary teams – including general practitioners (GPs), nurses, and allied health (where clinically appropriate)
- hub-and-spoke models integrating larger and smaller health services and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

Multidisciplinary care for stroke

During a hospital admission and following discharge from hospital, patients are likely to need specific types of care provided by various clinicians. Multidisciplinary (or interdisciplinary[6]) care refers to comprehensive care provided by different clinicians who work collaboratively to address as many of a patient's needs as possible.[7] Planning, coordination and regular communication between clinicians are essential components of multidisciplinary care.

A coordinated multidisciplinary team approach is essential for improving outcomes for patients with stroke. In the stroke unit, care should be provided by a dedicated interprofessional team with members who have expertise in stroke and/or rehabilitation and meet regularly to discuss the patient's care. This team should include:

- nurses
- medical practitioners (such as neurologists and rehabilitation physicians)
- allied health professionals (including physiotherapists, occupational therapists, speech pathologists, social workers, dietitians) and Aboriginal and Torres Strait Islander Liaison Officers
- a stroke coordinator.[8]

In the community, the patient's GP may coordinate their multidisciplinary care and involve community rehabilitation providers.

Evidence

The key Australian evidence source that underpins the *Stroke Clinical Care Standard* is the Stroke Foundation's Living Clinical Guidelines for Stroke Management.[6]

See the Commission's Stroke Clinical Care Standard webpage for a full list of the evidence sources that support this Clinical Care Standard.

Supporting resources

See the Commission's Stroke Clinical Care Standard webpage for supporting documents, including the following:

- Guide for consumers
- Information for clinicians
- Information for healthcare services
- Links to other resources, templates and information.

Using indicators

Measurement is a key part of quality improvement. The indicators in this Clinical Care Standard allow clinicians and healthcare services to monitor and improve the care they provide as part of local quality improvement activities.

Before using the indicators, refer to each indicator's specifications as described in METEOR: Metadata Online Registry. These define the data elements and computation descriptions to calculate the indicators and describe the applicable healthcare settings in which the indicators are suitable for collection.

When using the indicators, note that:

- indicators are listed with the related quality statement
- the Commission does not set benchmarks for Clinical Care Standards indicators
- services may use other relevant measures that relate to their needs and the needs of their patients in addition to, or instead of, these indicators.

See the Commission's website for more information on measuring quality, including patient-reported outcome measures (PROMs) and patient experience measures.

Tools to support data collection for clinical quality improvement

Clinical quality registries support health services to monitor variation in care to improve patient outcomes, and can support implementation of Clinical Care Standards. The Australian Stroke Clinical Registry (AuSCR) collects data on processes of care and outcomes for patients admitted with acute stroke. Several of the indicators in the *Stroke Clinical Care Standard* are captured in AuSCR.

Additional resources available to support clinical quality improvement in stroke include the:

- National Stroke Targets 30/60/90
- Adaptive Health Data Platform (AHDaPt), formerly known as the Australian Stroke Data Tool (AuSDaT)
- New South Wales Realising Improvements in Stroke (RISE) program.

Cultural safety and equity

Person-centred care recognises and respects differences in individual needs, beliefs and cultures. The Commission:

- is committed to supporting healthcare services to provide culturally safe and equitable health care to all Australians
- acknowledges that discrimination and inequity are significant barriers to achieving high-quality health outcomes for some patients from culturally and linguistically diverse communities.

Culturally safe service provision and environments are those in which places, people, policies, and practices foster mutual respect, shared decision making, and an understanding of different cultural, linguistic, and spiritual perspectives. Cultural safety is supported by organisations and individuals that recognise cultural power imbalances and actively address them by:

- ensuring access to and use of interpreter services or cultural translators when a patient requests them
- providing visual or written information in a language that the patient, their family and carers will understand
- providing cultural competency training for all staff
- encouraging clinicians to examine their own beliefs and attitudes when treating and communicating with culturally diverse patients[9]
- identifying variation in healthcare provision or outcomes for specific patient populations, including those based on ethnicity, and responding accordingly.[10]

Cultural safety and equity for Aboriginal and Torres Strait Islander peoples

Health outcomes for Aboriginal and Torres Strait Islander peoples can be improved by addressing systemic racism and other root causes that reduce access to care. Historical and current contributing factors include a lack of culturally safe care, culturally inappropriate health education, and sociocultural determinants such as differences in employment opportunities.

The recommendations for improving cultural safety and equity in this Clinical Care Standard focus on increasing access to health care by overcoming cultural power imbalances. Their ultimate goal is to improve health outcomes for Aboriginal and Torres Strait Islander peoples.[11]

Cultural safety and equity recommendations in this document have been developed in consultation with Aboriginal and Torres Strait Islander individuals, clinicians and representative health service organisations. However, it is recognised that cultural safety is determined by the Aboriginal and Torres Strait Islander individuals, families and communities experiencing the care.[12]

Recommendations

When implementing this Clinical Care Standard, cultural safety can be improved through embedding an organisational approach such as described in the recommendations below. In addition, specific considerations for cultural safety for people who have had a stroke are provided throughout this Standard.

When providing care for Aboriginal and Torres Strait Islander peoples, particular consideration should be given to the following recommendations.

Building culturally safe systems

- Ensure systems and processes support people to self-report their Aboriginal and Torres Strait Islander status and record self-identification.
- Ensure all staff engage regularly in cultural safety training.
- Disaggregate data by Aboriginal and Torres Strait Islander status when using the indicators included in this Standard. This will support identification of access and outcome issues so that improvements can be made.
- Implement the six actions for Aboriginal and Torres Strait Islander Health from the National Safety and Quality Health Service (NSQHS) Standards.[9]

Flexible and connected service delivery

- Provide flexible service delivery to optimise attendance and help develop trust with Aboriginal and Torres Strait Islander individuals and communities.
- Establish robust communication channels and referral pathways with primary healthcare providers, including Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).
- Where possible, provide outreach services close to home, on Country or in collaboration with ACCHOs or other community healthcare providers.

Communication and person-centred care

- Take a collaborative approach to ensure that interventions are suitably tailored to the individual's personal needs and preferences for care.
- Encourage the inclusion of support people, family and kin and the person's trusted healthcare provider (such as their ACCHO) in all aspects of care, including decision making and plans for treatment and management.
- Engage culturally appropriate interpreter services and cultural translators when this will assist the patient.
- Involve Aboriginal and Torres Strait Islander Health Workers or Aboriginal and Torres Strait Islander Health Practitioners as part of a patient's multidisciplinary team and involve Aboriginal and Torres Strait Islander Liaison Officers in hospital settings.
- Use culturally and linguistically appropriate materials to aid in communication and discussion, accounting for varying levels of health literacy.

Related resources

- *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander health* – a guide to help improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people based on the National Safety and Quality Health Service Standards[9]
- *National Agreement on Closing the Gap* – an agreement built around four priority reforms for transforming the way governments work with, and for, Aboriginal and Torres Strait Islander peoples to improve outcomes
- *Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health* – a framework that commits the Australian Government and all states and territories to embed cultural respect principles into their health systems[11]
- Clinical Yarning – a patient-centred framework to improve communication in Aboriginal health care[13]
- Communicating Positively: A Guide to Appropriate Aboriginal Terminology – a guide developed by NSW Health to use when working with Aboriginal people and communities, and when developing policy and programs[14]
- Plain English Health Dictionary – a resource developed by the Northern Territory Government as a resource for Aboriginal Interpreter Services[15]

Stroke resources for Aboriginal and Torres Strait Islander peoples

- First Nations Peoples and Stroke – stories and resources by the Stroke Foundation, including Our Stroke Journey and a F.A.S.T. Poster for First Nations peoples.
- Stroke: Written by the Mob – a series of short videos by people from the Peel and Mehi Aboriginal community, predominantly Gamilaraay/Kamilaroi Aboriginal communities, describing their experiences of stroke. Project funded by the Hunter New England Local Health District and NSW Agency for Clinical Innovation.

Stroke

Stroke remains a leading cause of death and disability in Australia, with profound impacts on individuals, families, and the healthcare system. Stroke occurs when a blood vessel supplying blood to the brain suddenly becomes blocked (ischaemic stroke) or ruptures and begins to bleed (intracerebral haemorrhage).[16] In 2023, there were an estimated 45,785 stroke events in Australia, including 34,793 first-ever strokes, which equates to one stroke every 11 minutes.[17] The lifetime costs associated with strokes that occurred in 2023 exceeded $15 billion, which equates to almost $350,000 per person.[17] In 2022, stroke was the underlying cause of 8,400 deaths in Australia.[16]

Timely thrombolysis rates lag in Australia

The urgency of stroke care is underscored by the principle that ‘time is brain’, with every minute of delayed treatment increasing the risk of irreversible brain damage. Rapid recognition, diagnosis, and treatment are essential to improving survival and functional outcomes. Reperfusion therapies, including thrombolysis and endovascular thrombectomy, have significantly improved the potential for recovery when administered promptly to eligible patients with ischaemic stroke.

Despite improvements in care, timely thrombolysis rates in Australia lag behind those in the United States and United Kingdom.[18] Only 55% of Australian patients with an acute stroke reach hospital within the critical 4.5-hour window for thrombolysis treatment.[19]

While ischaemic stroke accounts for approximately 80% of cases, evidence is increasing for the role of time-critical treatment for improving outcomes in intracerebral haemorrhage.

Stroke care is optimised in dedicated stroke units

One-quarter of Australians with an acute stroke do not receive care in a dedicated stroke unit during their hospital stay. This is despite strong evidence that people who receive care in a stroke unit are more likely to be treated in line with clinical guidelines, care plans and protocols, compared to those treated outside a stroke unit.[18] A large controlled trial conducted in stroke units examined the impact of a multidisciplinary, nurse-initiated treatment protocol for the management of fever, hyperglycaemia, and swallowing dysfunction. A significant reduction in death and dependency at 90 days and significant improvements in physical health were demonstrated with use of the protocol.[20]

More can be done to improve quality of life after a stroke

It is estimated that there were 440,481 people with a history of stroke living in Australia in 2023.[17] Rehabilitation is proven to reduce disability and improve quality of life, yet many Australians still do not access the support needed to regain independence.[22]

Communication difficulties caused by stroke can pose a clinical safety risk. People with aphasia (a language impairment that affects speaking, understanding, reading and writing) represent a significant proportion (27%–46%) of stroke survivors. Yet there are profound inequities in the care received by people with aphasia. Stroke survivors with aphasia are less likely to be involved in their care planning, receive stroke risk factor education (despite higher baseline risk factors), or an assessment for rehabilitation (despite being more likely to have rehabilitation needs identified).[23]

Regional differences in stroke care

Regional Australians are 17% more likely to have a stroke than those in metropolitan areas.[21] However, they have less access to specialised services, including stroke units, thrombolysis, and rehabilitation.[18] In 2024, median door-to-needle time for hospitals participating in AuSCR* was 29 minutes slower in regional hospitals than in metropolitan hospitals (89 minutes versus 60 minutes, respectively).[19] Many people with stroke who live outside metropolitan areas are discharged without a care plan or adequate follow-up, and formal rehabilitation is often unavailable.[24] These disparities are compounded by workforce shortages, geographic isolation, and limited infrastructure. While telehealth and digital health solutions show promise in bridging some gaps, their implementation remains uneven. Addressing these inequities is essential to ensure all Australians, regardless of location, receive high-quality stroke care and support.

Aboriginal and Torres Strait Islander peoples

Culturally safe stroke care supports recovery and wellbeing. It respects the values, traditions, and lived experiences of Aboriginal and Torres Strait Islander peoples and recognises their connections to Country, family, and community.

Compared to non-Indigenous people, Aboriginal and Torres Strait Islander peoples are:[16]

- more likely to suffer a stroke at a younger age
- twice as likely to be hospitalised for stroke
- more likely to have risk factors such as diabetes, high blood pressure, smoking, high cholesterol, and atrial fibrillation.

* Note these data do not include adult hospital data from NSW.[19]

Quality statements

Quality statement 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.

Purpose

To reduce the time to assessment for people with suspected stroke, including pre-hospital arrangements to ensure early diagnosis and access to time-critical therapy.

What the quality statement means

For patients

If you or another person has any of the signs below, call 000 for an ambulance immediately. **F.A.S.T.** is an easy way to remember the main signs of stroke and the response needed:

- **F**ace – check their face. Has their mouth drooped?
- **A**rms – can they lift both arms equally?
- **S**peech – is their speech slurred? Do they understand you? Can they speak?
- **T**ime – is critical. If you see any of these signs, call 000 straight away.

If the ambulance or emergency services think you may be having a stroke, they will arrange for you to get to a hospital as fast as possible for early, accurate diagnosis and time-critical therapy. This may mean going to a hospital that is able to treat stroke, even if it is not the closest hospital to you.

For clinicians

Using validated screening tools at first clinical contact in the community, pre-hospital or hospital setting can quickly identify suspected stroke and enable rapid access to time-critical treatment in the hyperacute phase. A validated screening tool, such as F.A.S.T., can identify stroke with high sensitivity, and can be used by all clinicians and first responders (including those in community settings such as general practice).[25] Note that F.A.S.T. is a useful tool for identifying stroke, particularly for non-clinicians. However, other tools may have greater accuracy in detecting acute ischaemic stroke (see Related resources).

Once a patient is suspected of having an acute (clinical signs less than 24 hours) stroke, expedite primary emergency transport (usually by ambulance) to a hospital capable of providing time-critical stroke therapy. Features of stroke services capable of providing time-critical therapy appropriate

to the patient's needs are described in the National Acute Stroke Services Framework, and include rapid assessment, access to computed tomography (CT) and hyperacute therapy such as thrombolysis.[8]

Pre-hospital clinicians, including ambulance services, should use pre-notification systems and bypass to access hospitals capable of providing appropriate time-critical stroke therapies (including thrombolysis) when required. Further assessment of stroke severity (such as the likely presence of large vessel occlusion), and suitability for time-critical care may be necessary to identify the most appropriate destination hospital. Alert the hospital to the patient's clinical condition and provide adequate patient identifiers to facilitate timely admission and imaging. Follow local recommended protocols to help prepare the patient for rapid treatment, which may include documenting symptom discovery, last known 'well' time, time of ambulance arrival on scene and medication history, as well as insertion of an intravenous cannulation.

Hospital-based teams should prepare for patient arrival when pre-notified, by obtaining medical records and a best possible medication history, contacting next of kin for more details, activating a 'Code Stroke' alert system, and facilitating access to CT imaging for urgent assessment.

All clinicians should be aware of local stroke network and referral pathways, including how to access the telestroke service to support decision making about where to transport or transfer the patient. Exceptions include patients for whom transfer would not be consistent with their goals of care or advanced care plan, such as palliative care patients.

For healthcare services

Ensure that protocols support the use of a validated screening tool, such as F.A.S.T., to enable the appropriate triage and transport of people with suspected stroke to an appropriate hospital as described in the National Acute Stroke Services Framework. The National Acute Stroke Services Framework describes capabilities of appropriate stroke services such as for rapid assessment, on-site CT imaging and protocols for providing timely hyperacute therapy such as thrombolysis.[8]

Note that F.A.S.T. is a useful tool to identify stroke, including for non-clinicians, however other tools may have greater accuracy in detecting acute ischaemic stroke (see Related resources).

Ambulance and retrieval services should use screening tools to identify patients with suspected stroke and ensure that they are treated as a time-critical emergency. This includes priority dispatch of ambulances and transport of patients directly to hospitals capable of providing appropriate time-critical stroke therapies.[6,26] Ambulances should have agreed bypass protocols to transport people to a Comprehensive Stroke Centre in the case of patients with suspected large vessel occlusion.

Emergency departments can use screening tools to trigger urgent assessment of patients who arrive at hospital independently.[6,27] More detailed stroke severity scales (for example, National Institutes of Health Stroke Scale [NIHSS]) may be used in hospital but are not recommended in the pre-hospital setting.[6,28]

Healthcare services without on-site medical stroke specialists should ensure that clinicians are aware of the local stroke network and referral pathways, which should include access to telestroke to support decision making.[6,8,26]

Hospitals capable of providing time-critical stroke therapies should have effective protocols in place to respond to pre-notification of patients with suspected stroke to enable rapid assessment and treatment. This includes activating 'Code Stroke' alert systems, facilitating access to CT imaging for urgent assessment[8], obtaining medical records and a best possible medication history, and contacting next of kin for more details.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Explain the rationale for assessment, tests, transport, and interventions to the patient, their family and their support people in a culturally safe way.

Recognise and address individuals' potential barriers to care by, for example, providing culturally appropriate stroke awareness and recognition information to the community and suitable ways to access rapid care. This is especially important for people whose access to services and infrastructure is limited.

Recognise and respond to any concerns associated with diagnosis and treatment, including the potential need for hospitalisation off Country. Where clinically safe, prioritise care on Country and minimise unnecessary transfers. If transfer is required, plan early for return to Country to support wellbeing. Ask for consent to transport to hospital, which may involve consulting the patient's family and community members.

Ensure processes for ambulance and hospital intake provide an opportunity for patients to self-identify and for services to capture and act on identification data.

Related resources

Validated stroke screening tools include (in alphabetical order):

- BE-FAST – Balance, Eyes, Face, Arms, Speech, Time[29]
- CRESST – Canberra pREhospital Stroke Screening Tool[30]
- F.A.S.T. – Face, Arms, Speech, Time[31]
- MASS – Melbourne Ambulance Stroke Screen[32]
- ROSIER – Recognition of Stroke in the Emergency Room.[33]

Other validated tools used in the assessment of stroke include (in alphabetical order):

- ACT-FAST – for identification of large vessel occlusion[34]
- HUNTER-8 or NIHSS-8 – for quantifying the impairment caused by stroke[35-37]
- Modified Rankin Scale or mRS – for measuring premorbid function[38]
- RACE – Rapid Arterial Occlusion Evaluation (large vessel occlusion identification tool).[37]

Indicators for local monitoring

Indicator 1a: Proportion of patients with a suspected stroke who were assessed by ambulance services using a validated stroke screening tool.

Applicable for: ambulance services.

METEOR link: meteor.aihw.gov.au/content/817898

Indicator 1b: Median time from first clinical contact to arrival at a hospital capable of providing appropriate time-critical stroke therapy for patients with a suspected stroke.

Applicable for: ambulance services.

METEOR link: meteor.aihw.gov.au/content/817964

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure that a patient with stroke receives clinically appropriate time-critical therapy as soon as possible following brain imaging to increase their likelihood of survival and reduce subsequent disability.

What the quality statement means

For patients

There are two types of stroke: those that occur when a blood clot blocks a blood vessel, and those caused by bleeding in the brain.

A brain scan will be done urgently to look for signs of a stroke and to work out the type of stroke. A computed tomography (CT) scan and magnetic resonance imaging (MRI) are different types of scans that take pictures of your brain and can show areas of damage and swelling. After the scans, your healthcare team will discuss treatment options with you and your family or support people. The treatment you receive will be based on your type of stroke, your clinical condition and history, and your wishes, and will follow national evidence-based recommendations.

Stroke caused by a blood clot (ischaemic stroke)

If a stroke is caused by a blood clot blocking a blood vessel, treatment to restore blood flow in the brain should be urgently considered. If your clinicians think this treatment could help, it should be offered as soon as possible after a stroke to prevent brain cells from dying (‘time is brain’).

The treatment may involve medicines to dissolve the blood clot (thrombolysis) or surgery to remove the blood clot (endovascular thrombectomy). These treatments are not suitable for everyone with a stroke caused by a blood clot. They cannot be used if it has been a long time since your stroke. They must not be used if the stroke is caused by bleeding in the brain.

Stroke caused by bleeding in the brain (intracerebral haemorrhage)

If a stroke is caused by bleeding in the brain, treatment should be urgently considered. If your healthcare team thinks treatment could help, it should be offered as soon as possible.

If your blood pressure is high, you will be given medicines to lower your blood pressure. This may help stop the bleeding in the brain from spreading and may prevent any brain injury from getting worse.

If you were taking a blood thinning medicine before your stroke, a medicine may be given to reverse the effects of the blood thinning medication and prevent more bleeding.

Other urgent treatments or surgery may also be recommended, according to individual needs and the cause of the stroke.

For clinicians

Urgently assess the patient and arrange vascular imaging, such as a CT scan or MRI, to determine whether the patient may benefit from time-critical therapy. Consider the patient's comorbidities, circumstances and preferences, and discuss the potential benefits and risks of treatment options with the patient and their family or carer. If time-critical therapy is not provided, document the reason in the patient's medical record.

Ischaemic stroke

Consider reperfusion treatment for all patients with ischaemic stroke. As clinically indicated, offer thrombolysis and/or endovascular thrombectomy within the timeframes recommended in the current Living Clinical Guidelines for Stroke Management.[6]

To enable appropriate reperfusion, use multimodal imaging (Non-Contrast CT [NCCT], and both CT angiogram and CT perfusion) when possible, to identify candidates for endovascular thrombectomy or surgical treatments. If you refer a patient to a Comprehensive Stroke Centre for an endovascular thrombectomy, ensure a prompt and coordinated transfer of care, in consultation with the receiving team, so the patient arrives at the service without delay. As part of this transfer, ensure all imaging (including any CT angiogram) is transferred to the treating hospital rapidly to facilitate treatment on arrival.

In hospitals that do not provide 24-hour, on-site access to stroke specialists, use telestroke systems to assist with patient assessment and decision making regarding acute thrombolytic therapy and possible transfer for endovascular thrombectomy.

Intracerebral haemorrhage

If an intracerebral haemorrhage is identified after imaging, and if clinically indicated, promptly initiate control of blood pressure and reversal of coagulopathy within the targets and timeframes recommended in the current Living Clinical Guidelines for Stroke Management.[6]

Other neurosurgical interventions may be time-critical for some patients. Arrange urgent vascular imaging (such as CT angiography, magnetic resonance angiography or digital subtraction angiography) to identify patients who may need specific specialist treatment, such as management of bleeds secondary to vascular malformations. Refer for neurosurgical consultation using your local stroke network and referral pathway.

For healthcare services

Ensure clinicians know of and use the Living Clinical Guidelines for Stroke Management[6] when managing suspected stroke.

Have systems, protocols and processes in place to offer time-critical imaging and treatment for stroke in line with your organisation's stroke capability and within the targets and timeframes recommended in the Living Clinical Guidelines for Stroke Management.[6,8] Protocols should include pathways for time-critical therapy for both ischaemic stroke and intracerebral haemorrhage.

Healthcare services that transfer patients to a Comprehensive Stroke Centre for endovascular thrombectomy must establish protocols to ensure timely and coordinated transfer of care, so that patients arrive at the service without delay and are able to receive the procedure as soon as clinically appropriate. Ensure all imaging (including CT angiogram) is transferred to the treating hospital rapidly to facilitate treatment on arrival.

Ensure there are local referral pathways for neurosurgical consultation for patients with intracerebral haemorrhage or who may require neurosurgical interventions.

Monitor achievement of recommended timeframes and address barriers.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide the person with access to Aboriginal and Torres Strait Islander Liaison Officers or other relevant workers and clinicians who can discuss potential concerns about urgent treatment, such as reperfusion therapy, either in the patient's language or in a way that is culturally safe for the person.

Related resources

- The Australian and New Zealand Living Clinical Guidelines for Stroke Management[6]
- Stroke and transient ischaemic attack (published 2025 Dec). In: Therapeutic Guidelines. Melbourne: Therapeutic Guidelines Limited; accessed Jan 2026. www.tg.org.au
- In palliative and end-of-life care, management may differ and should align with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[5]

Indicators for local monitoring

Intravenous thrombolytic therapy

Indicator 2a: Proportion of patients with an ischaemic stroke who received intravenous thrombolytic therapy.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817906

Indicator 2b: Median time from arrival at hospital to treatment with an intravenous thrombolytic agent for patients with an ischaemic stroke.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817909

Endovascular thrombectomy

Indicator 2c: Proportion of patients with an ischaemic stroke who received endovascular thrombectomy.

Applicable for: acute hospitals with endovascular capabilities.

METEOR link: meteor.aihw.gov.au/content/817911

Indicator 2d: Proportion of patients with an ischaemic stroke who were transferred for endovascular thrombectomy.

Applicable for: acute hospitals without endovascular capabilities.

METEOR link: meteor.aihw.gov.au/content/817913

Indicator 2e: Median time from arrival at hospital to departure for patients with an ischaemic stroke transferred for endovascular thrombectomy.

Applicable for: acute hospitals without endovascular capabilities.

METEOR link: meteor.aihw.gov.au/content/817917

Indicator 2f: Median time from arrival at hospital to endovascular thrombectomy for patients with an ischaemic stroke who had endovascular thrombectomy.

Applicable for: acute hospitals with endovascular capabilities.

METEOR link: meteor.aihw.gov.au/content/817929

Continued next page

Indicators for local monitoring

Acute intracerebral haemorrhage management

Indicator 2g: Median time from arrival at hospital to initiation of blood-pressure-lowering therapy for patients with an acute intracerebral haemorrhage and elevated systolic blood pressure on presentation.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817921

Indicator 2h: Median time from arrival at hospital to initiation of anticoagulation reversal for patients with an acute intracerebral haemorrhage taking an anticoagulant.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817931

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure that patients with stroke receive multidisciplinary, protocolised care in a stroke unit to reduce death, prevent complications and maximise recovery.

What the quality statement means

For patients

A stroke unit is a special hospital ward for patients with stroke. Being treated in a stroke unit by a team of health professionals who specialise in stroke care will increase your chances of a good recovery. Your specialised team may include doctors, nurses, occupational therapists, physiotherapists, speech pathologists, dietitians, social workers, pharmacists, and a stroke coordinator.

You should be offered treatment in a specialised stroke unit whenever possible. The ambulance should take you directly to a hospital with a stroke unit or your hospital should transfer you to one if necessary. You (and your family or support people) should be given the opportunity to discuss your wishes regarding transfer to a place that provides stroke unit care.

If there is no stroke unit in your area, and transfer is not feasible, you may receive care in the nearest hospital that provides recommended stroke care without a stroke unit. For example, the healthcare team may have regular videocalls with stroke health professionals at another hospital (telehealth) rather than face-to-face visits on-site. This may allow you to receive specialist care closer to your home.

Your healthcare team will offer the best care for you, based on national or local recommendations. Soon after you arrive at hospital, your healthcare team will check your ability to swallow to make sure you can drink, eat and take medicines safely. If you have trouble swallowing, a speech pathologist will develop a plan with you and your family or support people. Your healthcare team will regularly check your blood sugar levels and body temperature and treat them when necessary.

For clinicians

Ensure that patients with stroke are promptly transferred to a stroke unit, as defined in the National Acute Stroke Services Framework.[8] Stroke unit care is organised care within a specific ward in a hospital. It is provided by a multidisciplinary team who specialise in stroke management, coordinating diagnostic work-up and treatment, early mobilisation and rehabilitation and secondary prevention. This team works with the patient and family during the inpatient stay. Care quality is recorded and guided by established protocols.[8] People with stroke who receive care in a dedicated stroke unit are more likely to be alive, living at home, and independently looking after themselves one year after their stroke.[39]

Intensive care units (ICUs), high dependency units (HDUs) or similar locations are appropriate alternatives to stroke unit care for patients requiring critical care management.

If there is no stroke unit at the healthcare service, patients should receive guideline-recommended care and protocols in the nearest similar unit able to meet the requirements for stroke unit care. This may include management on the ward where the patient is located, with access to a telestroke service and allied health assessment.

Follow local protocols, in line with the recommendations in the current Living Clinical Guidelines for Stroke Management[6] to ensure patients with stroke receive early care to minimise or prevent complications and maximise recovery. This should include:[6,8]

- screening for swallowing difficulties within four hours of arrival to hospital using a validated screening tool before giving patients food, fluids or oral medications
- monitoring and prompt management of pyrexia and hyperglycaemia for the first 72 hours
- screening for communication difficulties
- ensuring appropriate venous thromboembolism (VTE) prophylaxis
- following escalation pathways within the above protocols (such as review by a speech pathologist if swallowing or communication difficulties are identified), and notifying medical officers if the patient has body temperature or glucose levels outside the recommended parameters
- other recommended protocols for care of patients after stroke as described in the National Acute Stroke Services Framework[8] and the Living Clinical Guidelines for Stroke Management[6].

All clinicians should use supportive communication techniques with patients who have communication difficulties. This improves patient consent processes, patients' ability to express their needs and preferences, and patient engagement with care.[6]

For healthcare services

Ensure that systems and infrastructure are in place for patients with stroke to be treated by a multidisciplinary team in a stroke unit as soon as possible. Ensure that these comply with the recommendations to enable best practice care outlined in the National Acute Stroke Services Framework.[8] The Australian Stroke Coalition has a system for stroke unit certification in Australian hospitals, which healthcare services can participate in.

ICUs, HDUs or similar locations are appropriate alternatives to stroke unit care for patients requiring critical care management.

If there is no stroke unit at the healthcare service, ensure patients receive guideline-recommended care and protocols in the nearest similar unit able to meet the requirements for stroke unit care. This may include management on the ward where the patient is located, with access to a telestroke service and allied health assessment.

Ensure local protocols align with the current Living Clinical Guidelines for Stroke Management.[6] Protocols should include:

- screening for and management of swallowing difficulties
- monitoring and prompt early management of pyrexia and hyperglycaemia for the first 72 hours of care
- screening for communication difficulties
- ensuring appropriate VTE prophylaxis
- escalation pathways for patients with temperature and glucose outside recommended parameters or with swallowing or communication difficulties identified on screening
- other recommended protocols for stroke unit care.[6]

Ensure relevant staff are trained to use validated screening tools to screen for swallowing and communication difficulties.

Related resources

- FeSS (Fever, Sugar and Swallowing) clinical treatment protocols and implementation strategy (bundle of care for monitoring and managing pyrexia, hyperglycaemia and swallowing difficulties)[20]
- Venous Thromboembolism Prevention Clinical Care Standard (for VTE prophylaxis)
- Aphasia screening tools from the Australian Aphasia Rehabilitation Pathway, including validity and reliability data to guide the choice of a screening tool for non-speech pathologists
- The Aphasia Rapid Test (used to screen for communication difficulties) and resources developed and endorsed by the Queensland Aphasia Research Centre[40]

Indicators for local monitoring

Indicator 3a: Proportion of patients with a stroke who had documented treatment in a stroke unit.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817933

Indicator 3b: Median time from arrival at hospital to admission to a stroke unit for patients with a stroke.

Applicable for: acute hospitals with a stroke unit.

METEOR link: meteor.aihw.gov.au/content/817935

Indicator 3c: Evidence of local arrangements to ensure patients with a stroke receive early protocolised care in accordance with the current Living Clinical Guidelines for Stroke Management or evidence-based, locally endorsed guidelines.

The local arrangements should specify:

- protocols for monitoring and prompt management of pyrexia, hyperglycaemia and swallowing difficulties
- escalation pathways for pyrexia, hyperglycaemia, and swallowing difficulties
- protocols for screening for communication difficulties and further assessment as required
- protocols to ensure appropriate venous thromboembolism prophylaxis
- processes to ensure relevant staff are trained in the use of the validated tools used at the service to screen for swallowing and communication difficulties
- processes to support implementation and monitoring of the local arrangements.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817937

Indicator 3d: Proportion of patients with a stroke who had a swallow screen or assessment completed before they were given any food, fluids or oral medication.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817939

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To minimise impairments and improve functional outcomes for patients after stroke through proactive assessment, initiation and planning for rehabilitation according to the patient's needs.

What the quality statement means

For patients

If you have had a stroke, you will very likely benefit from rehabilitation to help you manage its impact on your everyday life. Rehabilitation covers many different things, and your needs may be different to another stroke survivor's. For example:

- you may need help re-learning how to eat, drink, walk, communicate or carry out your other usual daily activities
- you may need support to manage the emotional and psychological impact of any changes caused by the stroke
- some people have trouble with memory, self-identity, sexuality, paying attention and problem-solving, which can make day-to-day activities harder.

Your rehabilitation needs will be assessed as early as possible after your stroke (and within the first two days of your arrival to hospital), so that your rehabilitation can start as soon as it is safe to do so. The initial assessment will involve your family or support people and a healthcare team tailored to your specific needs (which may include doctors, nurses, occupational therapists, physiotherapists, speech pathologists, pharmacists, psychologists and social workers). Your healthcare team will share the findings of your assessment with you and your family or support people.

Rehabilitation should be started as soon as your healthcare team deem it safe and be targeted according to your needs.

While you are in hospital, your needs for ongoing rehabilitation will be assessed and documented in your medical record. Your healthcare team will discuss their recommendations with you and your family or support people. Your healthcare team will make arrangements for your ongoing rehabilitation, which may take place in hospital or at home through a home-based service, at a clinic or via telehealth. You will be given the contact details of your stroke support services, care navigator or rehabilitation team in case you have any questions about the arrangements after you leave hospital.

For clinicians

As soon as possible and within 48 hours of admission, a multidisciplinary team should use a validated tool* to assess patient deficits, current impairment, activity limitations, and rehabilitation needs. Different aspects of the rehabilitation assessment may involve clinicians from different fields. These should include, but not be limited to, medical (including rehabilitation medicine), nursing, occupational therapy, physiotherapy, speech pathology, dietetics, and clinical psychology. Document the outcome of the rehabilitation needs assessment in the patient's medical record.

Review and discuss the patient's rehabilitation needs with a rehabilitation physician or other clinician with expertise in the recovery of functional independence. Discuss the results of the rehabilitation needs assessment with the patient and their family or support people, together with the multidisciplinary team, to help determine initial rehabilitation needs and begin planning.

Start individualised rehabilitation in hospital as soon as clinically appropriate and follow the recommendations in the Living Clinical Guidelines for Stroke Management.[6] Alternative arrangements may apply if the patient is unable or unwilling to participate in rehabilitation, or rehabilitation is not consistent with their goals of care.

Note: Intensive early mobilisation within 24 hours of stroke onset is not recommended.[6,41]

While the patient is in hospital, record functional status using a validated tool such as the Functional Independence Measure (FIM), modified Rankin Scale (mRS), Barthel Index, or Functional Autonomy Measurement System (SMAF).

Throughout the hospital admission, the multidisciplinary team should continually re-assess the patient's rehabilitation needs, especially before discharge. Consider changes in the patient's mood and cognition such as difficulty with concentration, memory loss, and language issues. Document these assessments in the patient's medical record and discuss ongoing care requirements (and the options for providing these) with patients, their families and support people. Use this information as part of a shared decision making approach to determine the most appropriate care setting for ongoing rehabilitation, such as inpatient rehabilitation, home-based therapy services, outpatient rehabilitation or telehealth.

Once the discharge destination is decided, ensure all necessary arrangements are in place before the patient is discharged from hospital. These should include providing a rehabilitation plan, confirming a bed in a rehabilitation unit or completing all referrals to community services for patients being discharged to a private residence or an aged care facility.

* See the Australian Stroke Coalition's Assessment for rehabilitation: Pathway and Decision-Making Tool.

For healthcare services

Ensure that policies and procedures are in place for a multidisciplinary team to assess and document the initial rehabilitation needs of patients with stroke within 48 hours of admission to hospital, using a validated assessment tool to guide planning and early initiation of rehabilitation. Ensure clinicians record and discuss patient deficits, current impairment, activity limitations, rehabilitation needs, and functional status. Also ensure that the multidisciplinary team discusses findings with patients and their families or support people.

Ensure a multidisciplinary team, including medical, nursing and allied health professionals, is available (face-to-face or via telehealth) to:

- commence early and timely rehabilitation in line with the Living Clinical Guidelines for Stroke Management[6]
- re-assess rehabilitation needs (including mood and cognition)
- make plans and arrangements for ongoing rehabilitation before discharge together with patients and their families or support people.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Develop streamlined referral pathways back to the community, particularly for those from regional, rural or remote communities who have received care away from home. Liaise with primary care clinics, including Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs), to ensure arrangements are in place for travel and for safe transition back to the community, including arrangements for ongoing rehabilitation as needed.

Related resources

- The Australian Stroke Coalition's Assessment for Rehabilitation: Pathway and Decision-Making Tool is used to assess and assist with decision making regarding patients' rehabilitation needs
- Validated tools used to measure functional status include those listed below:
  - Functional Independence Measure (FIM)[42]
  - Modified Rankin Scale (mRS)[38]
  - Barthel Index[43]
  - Functional Autonomy Measurement System (SMAF)[44]
- The Rehabilitation Stroke Services Framework[45] outlines the principles, essential elements, models of care and staffing recommendations for stroke services. It also provides guidance about systems for effective integration of stroke survivors into the community after they leave hospital. This Framework discusses workforce and resource requirements as well as requirements regarding data collection and quality improvement activities
- Principles for goal setting – an Australian Government resource for developing person-centred goals

Indicators for local monitoring

Indicator 4a: Proportion of patients with a stroke seen by a physiotherapist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817941

Indicator 4b: Proportion of patients with a stroke seen by a speech pathologist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817943

Indicator 4c: Proportion of patients with a stroke seen by an occupational therapist within 48 hours of admission to hospital.

Applicable for: acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817945

Indicator 4d: Proportion of patients with a stroke whose ongoing rehabilitation needs were assessed by a multidisciplinary team and documented before discharge to the community.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817947

Indicator 4e: Proportion of patients with a stroke who were referred for ongoing rehabilitation before discharge from hospital.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817949

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure that patients with stroke undergo assessment and investigations to determine the probable cause of the stroke, start appropriate secondary prevention treatment, and receive education on how to reduce their risk of another stroke.

What the quality statement means

For patients

Your healthcare team may recommend follow-up tests to work out the reason for your stroke. Some tests may be done in hospital and some may be done after you are discharged.

People who have had a stroke are at high risk of having another stroke. Your healthcare team will offer you treatment and advice on how to reduce this risk. For example, they might recommend monitoring and managing blood pressure and diabetes. You may be prescribed medicines for high blood pressure, diabetes, high cholesterol, or blood-thinning medicines, which you will need to keep taking after leaving hospital.

Your healthcare team may also recommend changes to your lifestyle to reduce your risk of another stroke. This might mean quitting smoking if you smoke or vape, limiting alcohol consumption, eating healthy foods, maintaining a healthy weight, keeping physically active, and avoiding the use of recreational drugs.

You will be given written information and advice to help you understand what you can do to help prevent another stroke.

For clinicians

Communicate with the patient's general practice team to gather information about previous treatments and investigations undertaken, which may inform their ongoing treatment. For example, their previous response to relevant medicines and results of cardiac monitoring.

Offer testing and assessment to investigate the mechanism of the patient's stroke to enable targeted therapies that can minimise the risk of recurrence (for example, cardiac assessment and monitoring to screen for atrial fibrillation). When assessment is not appropriate during the acute admission, refer or arrange for the assessments to be completed promptly after hospital discharge.

Prescribe appropriate medicines for secondary prevention, including anticoagulants for atrial fibrillation and antiplatelet, antihypertensive and lipid-lowering medicines, where indicated and in line with current guidelines. Other measures may include time-limited surgical interventions (for example, carotid endarterectomy) or closure of a patent foramen ovale in younger patients.

Assess the patient's risk of recurrent stroke and modifiable risk factors. As part of a multidisciplinary team, provide patients with stroke and their families or support people with education and information about reducing their risk of another stroke in a way they can understand. Discuss risk factors such as uncontrolled hypertension or diabetes, smoking, poor diet, insufficient physical activity and excessive alcohol or recreational drug use, and provide written information.

For healthcare services

Ensure that processes are in place to investigate the mechanism of the patient's stroke during hospital admission and arrange any recommended follow-up investigations before discharge to enable appropriate follow-up care. Support appropriate communication with patients' usual general practice teams to obtain relevant history.

Ensure that systems are in place for preventive therapies to be prescribed or recommended in line with current guidelines and documented before patients with stroke are discharged.

Ensure that processes are in place for multidisciplinary input to assess the risk of recurrence and educate patients about reducing their risk of another stroke. Ensure that written information about reducing stroke risk is available and suitable to the patient population.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide information in a way that reflects the literacy, language, and cultural needs of the individual patient. Information should be provided in a way that builds understanding, engagement, and empowerment to manage and reduce their ongoing risk of another stroke.

Include family, kin, community members or trusted healthcare providers in discussions, if the patient desires this. Allow time to build rapport and trust and for explanation and questions. Consider the need for multiple encounters and methods of communication, and for appropriate handover to the person's usual health service in the community.

Written and audiovisual material for Aboriginal and Torres Strait Islander people should be developed in partnership with the community and people with expertise in Aboriginal and Torres Strait Islander health.

Indicators for local monitoring

Indicator 5a: Proportion of patients with a stroke prescribed an antihypertensive medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817951

Indicator 5b: Proportion of patients with an ischaemic stroke prescribed a lipid-lowering medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817953

Indicator 5c: Proportion of patients with an ischaemic stroke and atrial fibrillation prescribed an oral anticoagulant medicine on discharge from hospital.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817955

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To equip the families and support people of patients with stroke with the skills and knowledge to help them support the patient's daily needs, in addition to any supportive care or home-based services.

What the quality statement means

For patients, families and support people

Family members and support people are often critical in the support and care of a person with stroke, whether they live independently or in an aged care home. Some people will need extra services or support that cannot be provided by family or existing support people.

If there are significant changes to the person's capabilities or level of independence after their stroke, this can take a toll on family and support people.

Your family and support people will be offered information and practical assistance to help support you with your daily needs after discharge, and as your needs change over time. This may include support with the following areas.

Care and daily support

- Personal care techniques
- Safe physical handling and transfers
- Use of aids and assistive devices
- Managing swallowing and dietary needs
- Managing fatigue and day-to-day activities

Communication, thinking and behaviour

- Communication difficulties, including communication partner training where needed
- Changes in thinking skills, such as memory, attention, and concentration
- Emotional wellbeing and mood changes
- Challenging behaviours, including irritability, impulsivity, or personality changes

Living in the community and care transitions

- Returning to and participating in community life (for both the person with stroke and their support people)
- Transitions of care, including respite and residential aged care options

Support services and practical matters

- Accessing carer respite services
- Carer financial support
- Access to the National Disability Insurance Scheme (NDIS) or My Aged Care
- Health and financial decision-making responsibilities

Information and support may be provided by medical, nursing, allied health staff, or a social worker. You will also receive contact details for support services and other helpful information.

For clinicians

Patients with stroke often experience changes in their ability to safely carry out their daily activities. They may need much more support from family and others than before their stroke. Offer information and practical guidance to families and support people to help them support the patient with any new care needs after discharge. Documenting all care given in the 24-hour period before discharge can help in identifying the patient's support needs when they are discharged to a private residence or a residential aged care facility.

Practical assistance includes advice, guidance and training for families and support people on how to safely support the patient with their new daily needs. Below are examples of the areas in which a patient may need support, and the types of assistance clinicians can offer to family and support people.

- Physical care: Personal care techniques, the use of new assistive equipment, modification of food and drink to ensure safe swallowing, and safe mobilisation and transfer.
- Communication and cognition: Communication partner training, and strategies to manage changes in memory, concentration, and behaviour.
- Psychosocial wellbeing: Fatigue management, emotional support, carer self-care, and strategies for both the patient and carer to return to community life.
- System navigation: Support to access respite, carer financial aid, NDIS or My Aged Care, guidance on health and financial decision-making responsibilities, and the contact details of support services.

A range of clinicians may offer assistance and advice, including social workers, occupational therapists, physiotherapists, speech pathologists, dietitians, nurses, pharmacists, psychologists, and doctors.

If a patient is assessed as able to manage independently but does not have an identified carer or support person, offer the patient information, support and advice (in a way they can understand) to help them safely and confidently manage their daily needs.

For healthcare services

Ensure that processes and resources are in place to provide information and assistance to the family and support people of patients with stroke before their discharge. This should enable them to safely and confidently manage the patient's changed care needs. This should not replace arrangements for appropriate home-based services.

All patients, families and support people should receive:

- information about new individual patient care needs
- practical assistance to meet these needs (including personal care techniques, support with communication, use of new assistive equipment, modification of food and drink, mobilisation, safe transfers, and changes in behaviour)
- information and support to access carer financial support, NDIS or My Aged Care, and guidance on health and financial decision-making responsibilities
- details on how to access support services (for example, respite care).

Also offer information and practical support to patients who do not have family or support people to assist them on discharge but are considered able to live independently after a stroke. Ensure that systems are in place for these patients to receive information, advice, and support (in a way that they can understand and access) so they can safely and confidently manage their daily needs.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide culturally appropriate and co-designed information resources (in local language as appropriate) and the opportunity to have questions answered by a trusted health professional.

Related resources

The Stroke Foundation has developed many resources to assist stroke survivors, their carers and health professionals in the process of discharge planning and transfer of care:

- My Stroke Journey – an information pack to give to stroke survivors and their carers before hospital discharge[46]
- *Aphasia Handbook* – an information guide for people with aphasia and their families, carers and friends, which should accompany the resource 'My Stroke Journey' for all patients who have aphasia
- StrokeLine – a free telephone support service providing information and advice on stroke prevention, treatment and recovery, staffed by health professionals. Call 1800 787 653 or email strokeline@strokefoundation.org.au
- EnableMe – a free web-based resource providing information, a community forum and a tool to track personal goals for recovery
- Young Stroke – an initiative aimed at delivering information and resources for younger survivors of stroke aged 18 to 65 years old, their partners, families, friends and carers
- i-REBOUND After Stroke – a patient-centred education resource
- For more information, see: strokefoundation.org.au/what-we-do/for-survivors-and-carers.

See also Carer Gateway – an Australian Government program providing free services and support for carers.

Indicator for local monitoring

Indicator 6a: Proportion of patients with a stroke where at least one family member or support person received information and practical assistance to support the patient with their new daily needs before discharge to the community.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817957

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Quality statement 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.

Purpose

To improve communication at transitions of care (following discharge from hospital) between patients, families, support people, clinicians and care providers. This ensures ongoing and appropriate patient care, improves quality of life and reduces disability.

What the quality statement means

For patients

Before you are ready to leave hospital, your doctors, nurses and other members of your healthcare team will discuss your recovery with you and your family or support people and jointly develop an ongoing care plan with you to guide your care after you leave hospital.

The care plan will set out in writing:

- your ongoing rehabilitation needs, goals and plan
- changes to your medicines (which may include a detailed list of your medicines and information provided by a pharmacist)
- any lifestyle changes you are advised to make
- information and practical assistance to support your daily needs (including when you may go back to driving a vehicle and any equipment, assistive technologies, home modifications, communication support or other additional support you may need)
- follow-up appointments and contact details for the healthcare team that will look after you after discharge, such as your general practice or rehabilitation provider, and any follow-ups at the hospital.

You and your regular general practice will get a copy of this care plan, as will your rehabilitation or aged care provider if you have one. Your care plan will change over time as your condition changes.

For clinicians

While patients are in hospital, jointly develop a written individualised care plan with them and their family or support people to ensure appropriate follow-up and ongoing care when they leave hospital.

The individualised care plan should include:

- results from relevant rehabilitation assessments, ongoing rehabilitation needs and goals, and a plan to achieve these (see Quality statement 4)
- secondary prevention recommendations discussed, such as medicines and lifestyle modifications (see Quality statement 5), and, where possible, a medication list and education provided by a pharmacist
- information discussed and practical assistance for managing daily activities, advice on when the person may resume driving a vehicle, and contact details for support services available in the community (see Quality statement 6)
- details of referrals and follow-up appointments, including
  - scheduled appointments for any pending investigations and for ongoing care
  - when to go to their general practice for follow-up, which may include ongoing prescriptions for medicines or referrals for pending investigations and services
  - who to contact for follow-up, including for emerging or unmet rehabilitation needs post-discharge[45]
  - a follow-up review appointment within six months of diagnosis (see Quality statement 8).

Give a copy of the care plan to patients and their families or support people. Ensure they understand the information provided and that they take a copy of the care plan before discharge. Also provide a copy to their general practice and, where appropriate, their ongoing rehabilitation team (such as a rehabilitation physician and allied health professionals) or aged care provider before or at the time of discharge.

Stroke Foundation's My Stroke Journey is a useful planning resource that can be given to patients before they leave hospital after a stroke.[46] This information should be summarised and contextualised in the care plan provided to other health professionals.

For healthcare services

Ensure that processes and resources are in place for clinicians to develop an individualised care plan for patients with stroke before they leave the hospital, in collaboration with the patient and their family or support people. Ensure that systems allow for the individualised care plan to be provided at the time of discharge in a format appropriate to the patient's general practice and, where appropriate, their ongoing rehabilitation team or aged care provider.

Care plans for patients with stroke must follow a consistent format that includes:

- results from relevant rehabilitation assessments, ongoing rehabilitation needs and goals, and a plan to achieve these (see Quality statement 4)
- secondary prevention recommendations discussed, such as medicines and lifestyle modifications (see Quality statement 5)
- information discussed and practical assistance for managing daily activities, advice on when the person may resume driving a vehicle, and contact details for support services available in the community (see Quality statement 6)
- details of referrals and follow-up appointments.

The patient must receive a copy of the individualised care plan to take with them before being discharged.

Ensure that clinicians make referrals and appointments and that these are communicated to patients and their families or support people, general practice and, where appropriate, their rehabilitation team and aged care providers. Referrals and arrangements should be made for:

- any pending investigations
- the patient's general practice
- the patient's rehabilitation team (if they will be receiving home-based therapy services, outpatient rehabilitation or telerehabilitation)
- a follow-up appointment within six months of diagnosis with appropriate multidisciplinary team input (see Quality statement 8).

Ensure that appropriate systems are in place to support the discharge process and appropriate follow-up care. This includes establishing links with primary health, community health and rehabilitation services to enable potential review by specialist rehabilitation services or periodic intensive rehabilitation when significant changes are identified on regular patient review post-discharge.[45]

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Provide documentation, including results, follow-up appointments and future management, to the patient's general practice, primary healthcare service or Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ACCHO) in a timely fashion.

Give the patient the individualised care plan and discuss it with them and their family or support people in a culturally appropriate way. See the Stroke Foundation's *Our Stroke Journey*.

Related resources

Stroke Foundation's *My Stroke Journey* covers all the essential elements of a care plan and includes pages for clinicians and patients to complete together. The Stroke Foundation resource *My Stroke Journey* is intended to be provided by hospital clinicians and discussed with patients, and their families or support people, in the first few days after their stroke, and to stay with patients in their transition from hospital to home. This resource is used by clinicians to deliver stroke education, explain treatment and care, deliver secondary prevention education, and inform the development of an individualised, comprehensive discharge care plan that can be shared with the patient and their GP. For more information, see My Stroke Journey.[46]

Indicator for local monitoring

Indicator 7a: Proportion of patients with a stroke who had an individualised care plan on discharge to the community.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817959

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Quality statement 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.

Purpose

To ensure that patients with stroke receive follow-up to assess their progress, optimise their recovery and function, and minimise their risk of another stroke.

What the quality statement means

For patients

Before you leave the hospital, your healthcare team will arrange a follow-up review for you (and your family or support people if applicable) in the first six months after your stroke. This is an important opportunity to check on your recovery, see how you are managing at home, and update your care plan with you and your family or support people.

During this follow-up review, your healthcare team may talk to you about your:

- health and recovery – including progress towards your rehabilitation goals, your medicines, lifestyle changes, and the results of any tests
- daily life – including returning to driving or work, any equipment you might need, communication or swallowing issues, and assessments of your vision and continence
- wellbeing and support – including your mood, memory and thinking, fatigue management, personal relationships (including sexuality and intimacy), identity and role changes, and any further therapy or community support you may need.

For clinicians

Ensure that patients who have had a stroke receive a comprehensive follow-up assessment and review, booked before discharge from hospital. This appointment should be within six months of the person's stroke diagnosis and include relevant family members or support people. It may be face-to-face or via telehealth and may not necessarily be the first or only follow-up with a healthcare provider.

The patient's needs at discharge should determine the appropriate clinician (or clinicians) to conduct the assessment and review, and its timing. It should be conducted by clinicians with relevant skills and expertise – which may include members of a multidisciplinary stroke team, acute stroke service outpatient clinic or rehabilitation service – who can access additional multidisciplinary input as required at the time of follow-up.

At the follow-up review, assess the patient's self-management and update the patient's individualised care plan by addressing the following domains as appropriate.

- Medical and secondary prevention: Review medication adherence and indication, patient progress with lifestyle modifications, and any pending investigation results.
- Rehabilitation: Re-assess rehabilitation needs against the patient's goals and progress. Record functional status at follow-up using a validated tool such as the Functional Independence Measure (FIM), modified Rankin Scale (mRS), Barthel Index, and Functional Autonomy Measurement System (SMAF). Review the choice of rehabilitation pathway to ensure rehabilitation continues to meet the patient's needs.
- Functional status: Assess cognition, vision, fitness to drive, continence and equipment needs.
- Psychosocial and vocational: Re-assess mood and, if appropriate, sexual dysfunction. Review or develop a return-to-work plan, which may include returning to voluntary work, community roles or ongoing carer responsibilities for partners, parents, children or grandchildren. Assess the person's engagement in community life and reintegration.
- Care coordination: Review the effectiveness of existing referrals and assess the need for further appointments with allied health, rehabilitation, or other community support services.

Give the patient, their GP and their ongoing rehabilitation team an updated care plan at the end of the appointment (see Quality statement 7).

For healthcare services

Have systems and resources in place to arrange for patients to receive a comprehensive follow-up appointment within six months of their stroke diagnosis and with the most appropriate multidisciplinary team for their needs. This may be the acute stroke or rehabilitation service.

The follow-up appointment may be face-to-face or via telehealth and should address, as required, the following domains:

- medical and secondary prevention (including a review of medication, lifestyle modifications, and any pending investigation results)
- re-assessment of rehabilitation needs, goal and progress
- functional status (assessed and recorded using a validated tool)
- psychosocial and vocational needs
- return-to-work plan
- care coordination (including a review of the effectiveness of existing referrals and identifying the need for further appointments with allied health, rehabilitation, or other community support services).

Ensure that processes are in place for communicating the updated care plan to patients, their general practice and their rehabilitation team at the end of the appointment.

Cultural safety and equity for Aboriginal and Torres Strait Islander people

Liaise with primary care clinics, including Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs), to ensure travel arrangements are in place to support attendance at follow-up appointments. Find alternative ways to contact patients if they do not have regular access to a phone, email or postage delivery service to receive information about follow-up appointments.

Ensure that communication and materials are culturally and linguistically appropriate for the patient to support participation in stroke management and rehabilitation.

Indicator for local monitoring

Indicator 8a: Proportion of patients with a stroke who participated in a follow-up review within six months of the diagnosis of their stroke.

Applicable for: acute and sub-acute hospitals.

METEOR link: meteor.aihw.gov.au/content/817961

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Appendix: Updates in the 2026 Standard

Section	Action	Description
Overall	Amended	Title changed from *Acute Stroke Clinical Care Standard* to *Stroke Clinical Care Standard*, reflecting the inclusion of care beyond the acute and hyperacute phases and the addition of new components of care, including cultural safety, rehabilitation and follow-up care.
Scope	Amended	Updated to include pre-hospital care, time-critical care for intracerebral haemorrhage (ICH) and an enhanced emphasis on components related to rehabilitation and transitions of care. Healthcare settings to which the Standard applies have been specified to include pre-hospital emergency settings, hospital-based rehabilitation services, outpatient clinics and some primary care settings.
Cultural safety and equity	New	Added new recommendations to support cultural safety and equity particularly for Aboriginal and Torres Strait Islander peoples both as general principles of care and for specific quality statements (as described below).
Quality statement 1	Amended	Renamed ‘Early assessment and urgent transport to hospital’. Updated to strengthen pre-hospital assessment and emphasise validated tools, early transport to time-critical care, and use of pre-notification systems. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 2	Amended	Updated to include explicit requirements for time-critical therapy for ICH and revised guidance for thrombolysis and thrombectomy. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 3	Amended	Strengthened to require early, protocolised care, updated escalation pathways, and training of staff in the use of validated screening tools.

Section	Action	Description
Quality statement 4	Amended	Renamed ‘Rehabilitation’. Updated to emphasise early multidisciplinary assessment, early initiation of rehabilitation, and improved integration with discharge planning, reflecting expanded rehabilitation focus. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 5	Amended	Updated to improve clarity regarding assessment for the mechanism of stroke, strengthened focus on secondary prevention education, and ensuring timely follow-up investigations. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 6	Amended	Renamed ‘Practical assistance for families and support people’. Updated to expand expectations for information and practical support provided to families and carers, strengthening alignment with discharge planning and continuity of care. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 7	Amended	Renamed ‘Individualised care plan’. Updated to strengthen requirements for multidisciplinary input, clearer documentation of rehabilitation needs, and ensuring timely communication of care plans to primary and community providers. Amended to include cultural safety and equity considerations for clinicians and healthcare services.
Quality statement 8	New	A new quality statement titled ‘Follow-up assessment and review’ added, requiring a comprehensive follow-up assessment within six months of diagnosis, arranged before discharge.
Indicator 1b	New	Median time from first clinical contact to arrival at a hospital capable of providing appropriate time-critical stroke therapy for patients with a suspected stroke.
Indicator 2d	New	Proportion of patients with an ischaemic stroke who were transferred for endovascular thrombectomy.
Indicator 2e	New	Median time from arrival at hospital to departure for patients with an ischaemic stroke transferred for endovascular thrombectomy.
Indicator 2g	New	Median time from arrival at hospital to initiation of blood-pressure-lowering therapy for patients with an acute intracerebral haemorrhage and elevated systolic blood pressure on presentation.
Indicator 2h	New	Median time from arrival at hospital to initiation of anticoagulation reversal for patients with an acute intracerebral haemorrhage taking an anticoagulant.

Section	Action	Description
Indicator 3c	New	Evidence of local arrangements to ensure patients with a stroke receive early protocolised care in accordance with the current Living Clinical Guidelines for Stroke Management or evidence-based, locally endorsed guidelines.
Indicator 3d	New	Proportion of patients with a stroke who had a swallow screen or assessment completed before they were given any food, fluids or oral medication.
Indicator 4b	New	Proportion of patients with a stroke seen by a speech pathologist within 48 hours of admission to hospital.
Indicator 4c	New	Proportion of patients with a stroke seen by an occupational therapist within 48 hours of admission to hospital.
Indicator 4e	New	Proportion of patients with a stroke who were referred for ongoing rehabilitation before discharge from hospital.
Indicator 8a	New	Proportion of patients with a stroke who participated in a follow-up review within six months of the diagnosis of their stroke.
Indicator 1a	Amended	Editorial changes to improve clarity.
Indicator 2a	Amended	Editorial changes to reflect current terminology.
Indicator 2b (previously 2c)	Amended	Amended to measure the median time from arrival at hospital to treatment with an intravenous thrombolytic agent.
Indicator 2c (previously 2b)	Amended	Editorial changes to improve clarity.
Indicator 2f (previously 2d)	Amended	Editorial changes to improve clarity.
Indicator 3a	Amended	Editorial changes to improve clarity.
Indicator 3b	Amended	Amended to measure the median time from arrival at hospital to admission to a stroke unit for patients with a stroke.
Indicator 4a	Amended	Amended to measure whether a patient was seen by a physiotherapist within 48 hours of admission to hospital.
Indicator 4d (previously 4b)	Amended	Amended to measure whether a patient was assessed by a multidisciplinary team to identify their ongoing rehabilitation needs before discharge to the community.
Indicator 5a	Amended	Amended to measure prescription of an antihypertensive medicine on discharge from hospital.
Indicator 5b	Amended	Amended to measure prescription of a lipid-lowering medicine on discharge from hospital.
Indicator 5c	Amended	Amended to measure prescription of an oral anticoagulant medicine on discharge from hospital.

Section	Action	Description
Indicator 6a	Amended	Amended to measure whether a patient's family member or support person received information and practical assistance to support the patient with their new daily needs before discharge to the community.
Indicator 7a	Amended	Amended to measure whether a patient had an individualised care plan on discharge to the community.
2019 Indicator 5d	Retired	Proportion of patients with a final diagnosis of ischaemic stroke on antithrombotic medications on separation from hospital.
2019 Indicator 5e	Retired	Proportion of patients with a final diagnosis of acute stroke who have documented evidence of advice on risk factor modification prior to separation from hospital.
2019 Indicator 6a	Retired	Proportion of patients with a final diagnosis of acute stroke whose carer(s) received a formal needs assessment prior to separation from hospital.

Glossary

Refer also to the Commission's glossary for terms used in this Standard.

Term	Definition
acute stroke	Rapidly developing (within 24 hours) clinical signs of neurological dysfunction of presumed vascular origin, due to ischaemia or intracerebral haemorrhage.
atrial fibrillation	A condition in which the heart beats irregularly. The heartbeat is outside its usual rhythm and is often faster than normal.
Australian Stroke Clinical Registry (AuSCR)	A national clinical quality registry that systematically monitors and reports on the quality of acute stroke care and patient outcomes across Australian hospitals.
care plan	A document that describes agreed goals of care and outlines planned medical, nursing and allied health activities for a patient.[2]
clinicians	All types of healthcare providers who deliver direct clinical care to patients. Clinicians include doctors, nurses, pharmacists, Aboriginal and Torres Strait Islander Health Workers, Aboriginal and Torres Strait Islander Health Practitioners and allied health professionals.
diagnosis	The identification of a condition, disease or injury made by evaluating the symptoms and signs presented by a patient.
end of life	The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.
endovascular thrombectomy	A minimally invasive procedure performed via angiogram, in which a catheter passes up into the brain to remove the clot in the blocked blood vessel.[6] Endovascular thrombectomy is also known as mechanical clot retrieval or endovascular clot retrieval.
Face, Arms, Speech and Time (F.A.S.T.) test	A test used to screen for the diagnosis of stroke or transient ischaemic attack.[28]

Term	Definition
first clinical contact	The time when the person with stroke symptoms first encounters a clinician. This can be in the community, pre-hospital or hospital setting.
haemorrhagic stroke	A type of stroke caused by bleeding into or around the brain.[28,47] See **intracerebral haemorrhage**.
healthcare record	A record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. Information in a healthcare record can be sourced from multiple healthcare organisations.
healthcare services	Healthcare services are those responsible for leading and governing the service. They are the organisations responsible for implementing clinical governance, administration and financial management of one or more service units providing health care to patients. Health care is delivered in a wide range of settings. Services may vary in size and organisational structure from single healthcare providers to complex organisations.
hospital	Public and private acute and psychiatric hospitals, freestanding day hospital facilities, and alcohol and drug treatment centres. Includes hospitals specialising in dentistry, ophthalmology, and other acute medical or surgical care. May also include hospitals run by the Australian Defence Force and correctional authorities, and those in Australia's offshore territories. Excludes outpatient clinics and emergency departments.
individualised care plan	*See* **care plan**.
intracerebral haemorrhage	A type of stroke in which an artery inside the brain bursts and bleeds into the brain itself.[47]
ischaemic stroke	A type of stroke caused by the blood supply being blocked, usually by a blood clot. Clots that cause strokes usually form either in the heart or in one of the large vessels that supplies blood to the brain. The clot then travels up and blocks a blood vessel in the brain.[48]
medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.
Metadata Online Registry (METEOR)	METEOR is Australia's web-based repository for national metadata standards for health, housing and community services statistics and information. Hosted by the Australian Institute of Health and Welfare (AIHW), METEOR provides users with a suite of features and tools, including online access to a wide range of nationally endorsed data and indicator definitions. The AIHW METEOR website contains more information about this indicator set and the definitions needed to collect and calculate indicator data. Links are provided with the relevant quality statements.

Term	Definition
multidisciplinary care (for stroke)	Comprehensive care provided by different clinicians with expertise in stroke (for example, neurologists, rehabilitation physicians, radiologists, general practitioners, clinical nurse specialists, nurse practitioners, care navigators or coordinators, physiotherapists, occupational therapists, speech pathologists, pharmacists, psychologists, social workers, and other allied health professionals) from one or more organisations, who work collectively with the aim of addressing as many of a patient's needs as possible.[7] A coordinated multidisciplinary team approach is essential for improving the care delivered to patients with stroke. Multidisciplinary care of patients can improve health outcomes and offers more efficient use of health resources. Planning, coordination and regular communication between clinicians are essential components of multidisciplinary care. Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.)[1]
multidisciplinary team	A team that includes clinicians from multiple disciplines who work together to deliver comprehensive care that addresses as many of a patient's needs as possible. The team may operate under one organisational umbrella or may be brought together as a unique team from several organisations. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.
patient	The person receiving care. When the word 'patient' is used in this Standard, it may include the person's carer, family member, support person, or substitute decision maker. Only the patient or their substitute decision maker, such as a legal guardian, can give consent for care. However, carers, families and support people who are not substitute decision makers may also support the patient in their decision making and actively participate in their care. These people should be given information and be included in discussions when the patient wishes.
person-centred care	Health care that respects the patient, their family and their carers, and responds to the person's preferences, needs and values. Person-centred care is equitable, culturally safe and free from racism and all other forms of discrimination.
rehabilitation	A set of interventions designed to optimise functioning and reduce disability in individuals with health conditions, in interaction with their environment.[49]
risk factor	A characteristic, condition or behaviour that increases the likelihood of disease, injury or loss of wellbeing.
stroke	A sudden interruption in regular blood flow to the brain causing damage to brain structures, loss of body functions, disability or death. Stroke is a serious medical emergency. There are two types of stroke: ischaemic stroke and haemorrhagic stroke.[17]
stroke unit	Co-located beds within a geographically defined unit that is staffed by a dedicated, multidisciplinary team that specialises in stroke management, meets once a week to discuss a patient's care, and receives regular programs of staff education and training related to stroke. As defined in the National Acute Stroke Services Framework.[8]

Term	Definition
support people	Anyone accompanying or providing support to another person in relation to their health. This could include the person's partner, immediate family members, friends, Aboriginal and Torres Strait Islander Liaison Officer, and people who are paid to provide support.
telehealth	Health services delivered using information and communication technologies, such as videoconferencing or phone calls.
thrombectomy	The removal of a blood clot from a blood vessel.[28]
thrombolysis, thrombolytic therapy	The use of medicines to break up a blood clot. An example of a thrombolysis medicine is tenecteplase.[28]
validated screening tool	A tool that has been shown to accurately and rapidly help identify people with a certain medical condition. Examples of stroke screening tools include the: • Face, Arms, Speech, Time (F.A.S.T.) test[31] • Melbourne Ambulance Stroke Screen (MASS)[32] • Recognition of Stroke in the Emergency Room (ROSIER) scale.[25] See the Related resources section in Quality statement 1 for more.

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