The goal of the Acute Stroke Clinical Care Standard is to improve the early assessment and management of patients with stroke to increase their chance of surviving the stroke, to maximise their recovery and to reduce their risk of another stroke.

Clinicians and health services can use this Clinical Care Standard to support the delivery of high quality care.

UNDER THIS CLINICAL CARE STANDARD

A person with suspected stroke is immediately assessed at first contact using a validated stroke screening tool, such as the F.A.S.T. (Face, Arm, Speech and Time) test.

**FACE:** Check their face. Has their mouth drooped?

**ARMS:** Can they lift both arms?

**SPEECH:** Is their speech slurred? Do they understand you?

**TIME:** Time is critical. If you see any of these signs call 000 straight away.

A patient with ischaemic stroke for whom reperfusion treatment is clinically appropriate, and after brain imaging excludes haemorrhage, is offered a reperfusion treatment in accordance with the settings and time frames recommended in the Clinical guidelines for stroke management.

A patient with stroke is offered treatment in a stroke unit as defined in the Acute stroke services framework.

A patient’s rehabilitation needs and goals are assessed by staff trained in rehabilitation within 24–48 hours of admission to the stroke unit. Rehabilitation is started as soon as possible, depending on the patient’s clinical condition and their preferences.

A patient with stroke, while in hospital, starts treatment and education to reduce their risk of another stroke.

A carer of a patient with stroke is given practical training and support to enable them to provide care, support and assistance to a patient with stroke.

Before a patient with stroke leaves the hospital, they are involved in the development of an individualised care plan that describes the ongoing care that the patient will require after they leave hospital. The plan includes rehabilitation goals, lifestyle modifications and medicines needed to manage risk factors, any equipment they need, follow-up appointments, and contact details for ongoing support services available in the community. This plan is provided to the patient before they leave hospital, and to their general practitioner or ongoing clinical provider within 48 hours of discharge.