What's new and what does this mean for dietetics?

Cara Lewis, Stroke Dietitian, BDA representative ICSWP, NCG Topic Group lead

Dr Rebecca Fisher, National Stroke Programme Manager, Clinical Policy Unit, NHS England, Associate Director, King’s College London Stroke Programme, NCG Editor
Aims for today

• To share main relevant updates from the new guideline

• To consider the implications for dietetic practice and nutritional care, including how updates can be implemented
What are you most looking forward to hearing about?

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#3652 512
Main dietetic related updates

1. Staffing levels updated

2. Consideration of and decision making around EDAR

3. Detail and clarification around a range of elements of care

4. Importance of training and communication
   • eg mouth care, gastrostomy care
The Guideline Process

- Limited update: 59 research questions
- UK and Ireland
- Management, in adults, of stroke, TIA and SAH
- 4 chapters
- 538 recommendations
- Strength of recommendations: strong “should” or conditional “may”
- Unchanged text is marked [2016]
- 13 Topic Groups appraised evidence
- 6 BDA Members, across 3 topic groups
- 7 questions, 103 papers, directly related to nutritional care
The Guideline Process: Organisation Structure

Guideline Development Group (GDG)

Guideline editors

- Topic group leads: Dietetics, nutrition, hydration and language recovery, Vision and upper limb
- Topic group leads: Hyper acute care, ICH management, Thrombectomy, TIA management
- Long Term Management (LTM) topic group leads: LTM 1, LTM 2
- Topic group leads: Motor recovery, Psychology and patient-directed therapy, Rehabilitation potential, Cognitive screening

Processes supported by the stroke guideline team

Full terms of reference are found here

www.strokeguideline.org
The Guideline Process – seven steps

The following steps are followed to ensure a thorough and rigorous process for updating the guideline. Details of each step follow.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Development of scope</td>
<td>Establish research questions, assign questions to topic groups, appoint topic group leads and members</td>
</tr>
<tr>
<td>Searching the scientific literature</td>
<td>Convert questions (PICO) to search strategies, perform searches</td>
</tr>
<tr>
<td>Selection of studies for inclusion</td>
<td>Review abstracts and select papers for full evidence review</td>
</tr>
<tr>
<td>Assessment of the quality of evidence</td>
<td>Complete evidence tables, convene topic group evidence review meetings</td>
</tr>
<tr>
<td>Moving from evidence to recommendations</td>
<td>Assess evidence, draft recommendations, evidence to recommendations and implications, submit to GDG for review and sign off</td>
</tr>
<tr>
<td>Health economic considerations</td>
<td>Review specific papers for cost implications</td>
</tr>
<tr>
<td>External peer review and public consultation</td>
<td>Identify organisations and invite them to participate in peer review, review and respond to comments</td>
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</tbody>
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Questions grouped together (one or two per topic group) and addressed in an evidence review cycle (approx. 10 weeks) culminating in submission of proposed amendments to the GDG.

Cycle repeated as necessary until all questions have been addressed and all amendments reviewed by the GDG.

See next page for example process for one question.
Update 1: Staffing, what is new?

- Registered staff
- Non-clinical time
- Non-face-to-face clinical activity (environmental visits, family contact and equipment ordering)
- Unregistered support workers and rehabilitation assistants under the supervision of registered staff
Update 1: Staffing, what is new?

A multidisciplinary service providing early supported discharge and community stroke rehabilitation should adopt a minimum core team structure matching the recommendations in Table 2.8 and below.

**Table 2.8 Recommended levels of staffing for multidisciplinary services providing early supported discharge and community stroke rehabilitation**

<table>
<thead>
<tr>
<th>Discipline</th>
<th>WTE per 100 referrals to service p.a.</th>
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</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>1.0</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1.0</td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td>0.4</td>
</tr>
<tr>
<td>Social worker</td>
<td>Up to 0.5 and at least 0.5 WTE per team recommended locally</td>
</tr>
<tr>
<td>Rehabilitation assistant/assistant practitioners</td>
<td>1.0</td>
</tr>
<tr>
<td>Clinical psychology/neuropsychology</td>
<td>0.2-0.4*</td>
</tr>
<tr>
<td>Nursing</td>
<td>Up to 1.2 and at least 1 full time nurse per team</td>
</tr>
<tr>
<td>Medicine</td>
<td>0.1</td>
</tr>
</tbody>
</table>

*This reflects the time that a team member should be co-located within the MDT and could include additional skill mix, e.g. assistant psychologist.

The service should also include:
- Appropriate administration and management (including data management) support;
- Timely access to psychological and neuropsychological services (e.g. Improving Access to Psychological Therapies [IAPT] and community mental health services with stroke-specific training and appropriate supervision, psychology or neuropsychology departments), return to work and vocational rehabilitation services, dietetics, pharmacy, orthotics, orthoptics, spasticity services, specialist seating, assistive technology and information, pain management, advice and support for people with stroke and their family/careers. [2023]
Update 1: Staffing, what is new?

Effectiveness of Stroke Early Supported Discharge
Analysis From a National Stroke Registry
Rebecca J. Fisher, PhD, Adrian Byrne, PhD, Niki Chouliara, PhD, Sarah Lewis, PhD, Liz Paley, MSc, Alex Hoffman, MSc, Anthony Radd, MD, Thompson Robinson, MD, Peter Langhorne, PhD, and Marion F. Walker, PhD

Early supported discharge services for people with acute stroke
Peter Langhorne, Satu Baylan, Early Supported Discharge Trialists
Authors’ declarations of interest
Version published: 13 July 2017  Version history
Dietetic related research questions

Rehab and Recovery:
1. For nutritionally vulnerable stroke patients, does nutrition support or mealtime interventions, result in improved outcomes?
2. For acute stroke patients receiving nutrition via a nasoenteric feeding tube, does a nasal bridle, mittens or other restraining device improve outcomes compared with not using any device?
3. For patients after a stroke with an unsafe swallow, does eating and drinking with acknowledged risks or approaches that support this, improve outcomes, care or patient experience?
4. What are the most effective treatments for dysphagia after stroke?
5. What is the best method to improve oral health after stroke?
Dietetic related research questions

Long Term Management
1. How should eating and drinking be managed towards the end of life after a stroke?
2. What is the best way to make decisions about artificial feeding and hydration after stroke?

Lipid Management
1. What lipid-lowering treatments should be used in people who cannot tolerate statins, or in whom statins do not sufficiently lower cholesterol, after stroke or TIA?
2. How low should LDL-C be lowered in secondary vascular prevention after stroke and TIA?

Organisation of Stroke Services
1. What is the appropriate staffing and skill mix for an inpatient stroke service?
2. What staffing levels in post-acute care deliver the best outcomes for people with stroke
Update 2: EDAR

• Swallowing section

• Evidence review:
  • 1 paper + 2 guidance documents noted (RCP, RCSLT)

• New recommendation – informed by guidance:
  • EDAR should be considered, and characteristics of a robust decision making process noted:
    • Person centered
    • Involve the person and their family/carer and members of MDT
    • Include a swallowing assessment
    • Include steps to minimise risk
Update 2: EDAR

• Swallowing

For people with dysphagia after stroke the option to eat and drink orally despite acknowledged risks should be considered. This decision-making process should be person-centred and taken together with the person with stroke, their family/carers and the multidisciplinary team. It should include a swallowing assessment and steps to minimise risk. [2023]

People with stroke who are discharged from specialist treatment with continuing problems with swallowing food or fluids safely should be trained, or have family/carers trained, in the management of their swallowing and be regularly reassessed. [2023]

People with stroke receiving end-of-life (palliative) care should not have burdensome restrictions on oral food or fluids if those restrictions would exacerbate suffering. In particular, following assessment this may involve a decision, taken together with the person with stroke, their family/carers and the multidisciplinary team, to allow oral food or fluids despite risks including aspiration and choking. [2023]
Update 2: EDAR

• End of Life care

• Evidence review
  • 9 papers + 3 guidance documents

• Commentary:
  • EDAR referenced, describing characteristics of a decision making process

• Recommendations:
  • Consider prior wishes regarding EDAR
Update 3: Hydration and Nutrition - Detail and clarification

- Evidence review
  - 3 research questions considered: nutrition support, NGT retention, EDAR
  - 27 papers appraised

- Lack of evidence to significantly change recommendations re nutrition support and NGT retention (NB: see evidence to recommendations section)

- New recommendations:

  G. People with stroke who require food or fluid of a modified consistency should:
  - be referred to a dietitian for specialist nutritional assessment, advice and monitoring;
  - have the texture of modified food or fluids prescribed using internationally agreed descriptors;
  - be referred to a pharmacist to review the formulation and administration of medication. [2023]

  L. The carers and family of those with a gastrostomy tube should receive training, equipment and ongoing support from a specialist team, e.g. a home enteral feeding team. [2023]
Update 3: Hydration and Nutrition - Detail and clarification

• Recommendations where detail has been added:
  • Use of standardized approach for screening hydration and nutritional status
  • “Assessment” for NGT within 24hr of admission
  • Reference to IDDSI
  • Detail around considerations for gastrostomy: including trial of retention methods, shared decision making
  • Consideration of environmental and postural factors
  • On discharge from stroke services, individual should have a documented care plan including monitoring

• Evidence to recommendations:
  • Nutritional composition of nutrition support (Yoshimura et al. 2019) – area of future research
  • NGT retention methods – lack of evidence of acceptability and effectiveness
  • Practical environmental strategies to aid intake – lack of evidence
Update 3: Mouth care - Detail and clarification

• Evidence review:
  • 1 research question
  • 10 papers reviewed including Cochrane Systematic review – Campbell et al 2020

• New recommendation:
  People with stroke and their family/carers should receive information and training in mouth care and maintaining good oral hygiene before transfer of their care from hospital. This information should be clearly communicated within and across care settings, e.g. within a care plan which includes regular dental reviews. [2023]

• Recommendations where detail has been added:
  • Frequency of mouth care ≥ x3/day v mechanical removal of plaque ≥ x2/day
  • Additional guidance around use of toothpaste, chlorhexidine gel, toothbrush
  • Additional detail around care of dentures and referral to dental professional if ill fitting/replacement required
Update 3: Mouth care - Detail and clarification

• Evidence to recommendations:
  • Cochrane review (Campbell et al 2020):
    • Compared effectiveness of oral health care interventions
    • Informed some updates to recommendations
    • Identified oral health care as a research priority, with a need for agreed outcome measures

• Consensus around importance of:
  • Locally agreed roles/responsibilities and
  • A care plan for oral health
Update 3: Swallowing – Detail and clarification

• Evidence Review
  • Abundant evidence investigating treatments for dysphagia: 56 papers (!)

• Recommendations where detail has been added:
  • SLT mentioned as a professional for swallow assessments and swallow rehabilitation
  • Differentiation between compensatory strategies and swallow rehabilitation
  • Reference to IDDSI, pharmacy input and decision making around EDAR.

• Recommendations also added for non invasive stimulation treatments for dysphagia.
Update 3: End of life care – Detail and clarification

• Evidence review
  • 2 research questions
  • 9 papers + 3 guidance documents

• Recommendations where detail has been added:

  C Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should, whenever possible, take the person's prior expressed wishes and preferences into account and should be taken in the best interests of that person. When withdrawing artificial nutrition and hydration, a recognised nutrition and hydration decision-making process should be considered. [2023]

  D End-of-life (palliative) care for people with stroke should include an explicit decision not to have burdensome restrictions that may exacerbate suffering. In particular, following assessment this may involve a decision, taken together with the person with stroke, their family/carer, and the multidisciplinary team, to allow oral food or fluids despite risks including aspiration and choking. [2023]

• Materials may support decision making processes:
  • Including BMA guidance
Update 4: Training and communication

• Importance of training noted regarding:
  • Gastrostomy care – training for family/carers
  • Mouth care – training for staff and family/carers

• Importance of communication noted regarding:
  • Patient’s wishes around EDAR
  • A mouth care plan across care settings
  • On discharge from stroke services, where a nutritional care plan, including monitoring should be in place
Guideline wide updates

1. **More** eligible patient groups for reperfusion therapy with ‘advanced imaging’
   - Thrombolysis up to 9 hours and wake-up stroke
   - Basilar artery thrombosis up to 12 hours
   - Thrombectomy with established infarction and salvageable brain tissue up to 24 hours

2. **More** aggressive secondary prevention
   - A new, lower target of LDL below 1.8mmol/L (non-HDL below 2.5 mmol/L)
   - Lower target BP for IS and ICH (lower than NICE):
     - Clinic BP below 130/80, home BP below 125/75
     - Encourage home or ambulatory measurement to guide self-management

3. **More** intensive rehab in hospital and at home
Key updates for rehab and recovery

- **Rehabilitation potential**
  - People should be considered to have potential to benefit from rehabilitation at any point after their stroke

- **Increase in intensity and dose of therapy:**
  - For motor recovery:
    - Daily therapy for up to 3 hours/day, and
    - Daily activity for up to 6 hours/day
  - For language recovery:
    - Use of assisted technology and telerehabilitation (to supplement other therapy)
    - Therapy offered for as long as individuals continue to make gains
    - May consider comprehensive aphasia programmes from 3 months after stroke if tolerated.

- **Motor recovery:**
  - Offered cardiorespiratory training or mixed training once medically stable
Key updates for rehab and recovery

• Psychological Care
  • Routine screening for delirium
  • Consider screening for apathy alongside cognitive and mood disorders

• Fatigue
  • Assess and review periodically for post-stroke fatigue

• Holistic reviews
  • Comprehensive reviews for all patients at 6 months and annually thereafter
Key updates for long term management

- **Physical activity:**
  - Cardiorespiratory or mixed training for fitness
  - Equipment and facilities should be made available
  - Outside statutory health services
e.g. fitness trainers
  - Collaboration with cardiac and pulmonary rehabilitation

- **Further Rehabilitation**
  - Reviews beyond 6 months to identify further needs
  - Interventions offered if further goals can be identified and agreed
  - People with stroke should be supported with their own self-management plan
What are the implications for dietitians?

• Make the most of resources at https://www.strokeguideline.org/

• Opportunity to support the case for change, implementation and evaluation

• Opportunity to address gaps in evidence

• Opportunity to build evidence to drive improvements in nutritional care.
What are the next steps?

1. What is one thing you will do in response to the new guideline?

2. What do the updates mean for you locally?

3. What do the updates mean for us nationally?

4. What support can we leverage?
   • Local and national networks – dietetics, stroke and beyond
   • Stroke guideline contributors group – watch this space!
   • BDA Neurosciences Group Stroke Working Party and BDA Neurosciences Specialist Group
     • To join the BDA NSG SWP – contact Cara Lewis and Eleanor (Elle) Williams.
Conclusions: main dietetic related updates

1. Staffing levels updated

2. Consideration of and decision making around EDAR

3. Detail and clarification around a range of elements of care

4. Importance of training and communication
   • eg mouth care, gastrostomy care

5. What will you do next?
Thank you and Questions

• Thank you:

Editor:
• Dr Rebecca Fisher

Topic Group co Lead:
• Prof Sue Pownall

Prof Martin James
Guideline team

BDA Members:
• Dr Tom Butler
• Sam Francis
• Becky Hosking
• Preet Kainth
• Cara Lewis
• Kim Mueller
• Sarah Pickup
• Elle Williams (Consultation response)