

Nutrition (secondary prevention)

5.8.3.1A People with stroke or TIA should be advised to eat an optimum diet that includes:

- > five or more portions of fruit and vegetables per day from a variety of sources;
- > two portions of oily fish per week (salmon, trout, herring, pilchards, sardines, fresh tuna).

5.8.3.1B People with stroke or TIA should be advised to reduce and replace saturated fats in their diet with polyunsaturated or monounsaturated fats by:

- > using low-fat dairy products;
- > replacing butter, ghee and lard with products based on vegetable and plant oils;
- > limiting red meat intake, especially fatty cuts and processed meat.

5.8.3.1C People with stroke or TIA who are overweight or obese should be offered advice and support to aid weight loss including adopting a healthy diet, limiting alcohol intake to 2 units a day or less and taking regular exercise. Targeting weight reduction in isolation is not recommended.

5.8.3.1D People with stroke or TIA should be advised to reduce their salt intake by:

- > not adding salt to food at the table;
- > using little or no salt in cooking;
- > avoiding high-salt foods, e.g. processed meat such as ham and salami, cheese, stock cubes, pre-prepared soups and savoury snacks such as crisps and salted nuts.

5.8.3.1E People with stroke or TIA who drink alcohol should be advised to limit their intake to 14 units a week, spread over at least three days.

5.8.3.1F Unless advised to do so for other medical conditions, people with stroke or TIA should not routinely supplement their diet with:

- > B vitamins or folate;
- > vitamins A, C, E or selenium;
- > calcium with or without vitamin D.



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Nutrition and dietetics concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for dietitians. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, dietitians should consider the guideline in full.

Specialist stroke services

2.3.1C Acute stroke services should provide specialist multi-disciplinary care for diagnosis, hyperacute and acute treatments, normalisation of homeostasis, early rehabilitation, prevention of complications and secondary prevention.

2.3.1D Acute stroke services should have management protocols for the admission pathway including links with the ambulance service, emergency stroke treatments, acute imaging, neurological and physiological monitoring, swallowing assessment, hydration and nutrition, vascular surgical referrals, rehabilitation, end-of-life (palliative) care, secondary prevention, the prevention and management of complications, communication with people with stroke and their family/carers and discharge planning.

Resources

2.4.1B A hyperacute and/or acute stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations in Table 2.1.

2.4.1J A stroke rehabilitation unit should have a single multi-disciplinary team including specialists in dietetics.

Transfers of care from hospital to home

2.7.1C A stroke early supported discharge team should be organised as a single multi-disciplinary

team including specialists with easy access to dietetics.

End-of-life (palliative) care

2.15.1C Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should be taken in the best interests of the person and whenever possible should take their prior expressed wishes into account.

2.15.1D End-of-life (palliative) care for people with stroke should include an explicit decision not to impose burdensome restrictions that may exacerbate suffering. In particular, this may involve a decision, taken together with the person with stroke, those close to them and/or a palliative care specialist, to allow oral food and/or fluids despite a risk of aspiration.

Management of TIA

3.3.1A Patients with non-disabling stroke or TIA should receive treatment for secondary prevention introduced as soon as the diagnosis is confirmed, including discussion of individual lifestyle factors (smoking, alcohol excess, diet, exercise).

3.3.1E Patients with TIA or an acute non-disabling stroke with stable neurological symptoms who have symptomatic severe carotid stenosis of 50–99% (NAS CET method) should receive optimal medical treatment: control of blood pressure, antiplatelet treatment, cholesterol reduction through diet and drugs, and lifestyle advice including smoking cessation.

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Setting higher standards

Acute stroke care

3.10.1B Patients with acute stroke should have their clinical status monitored closely, including hydration and nutrition

3.10.1D Patients with acute stroke should have their hydration assessed using multiple methods within four hours of arrival at hospital, and should be reviewed regularly and managed so that normal hydration is maintained.

3.10.1E Patients with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

3.10.1F Until a safe swallowing method is established, patients with dysphagia after acute stroke should:

- > be immediately considered for alternative fluids;
- > have a comprehensive specialist assessment of their swallowing;
- > be considered for nasogastric tube feeding within 24 hours;
- > be referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- > receive adequate hydration, nutrition and medication by alternative means.

3.10.1G Patients with swallowing difficulties after acute stroke should only be given food, fluids and medications in a form that can be swallowed without aspiration.

Continence

4.5.1E People with stroke with constipation should be offered advice on diet, fluid intake and exercise.

Hydration and nutrition

4.7.1A Patients with acute stroke should have their hydration assessed using multiple methods within four hours of arrival at hospital, and should be reviewed regularly and managed so that normal hydration is maintained.

4.7.1B Patients with acute stroke should be screened for the risk of malnutrition on admission and at least weekly thereafter. Screening should be conducted by trained staff using a structured tool.

4.7.1C Patients with acute stroke who are adequately nourished on admission and are able to meet their nutritional needs orally should not routinely receive oral nutritional supplements.

4.7.1D Patients with acute stroke who are at risk of malnutrition or who require tube feeding or dietary modification should be referred to a dietitian for specialist nutritional assessment, advice and monitoring.

4.3.1E Patients with stroke who are at risk of malnutrition should be offered nutritional support. This may include oral nutritional supplements, specialist dietary advice and/or tube feeding in accordance with their expressed wishes or, if the patient lacks mental capacity, in their best interests.

4.7.1F Patients with stroke who are unable to maintain adequate nutrition and fluids orally should be:

- > referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- > be considered for nasogastric tube feeding within 24 hours of admission;
- > assessed for a nasal bridle if the nasogastric tube needs frequent replacement, using locally agreed protocols;
- > assessed for gastrostomy if they are unable to tolerate a nasogastric tube with nasal bridle.

4.7.1H People with stroke should be considered for gastrostomy feeding if they:

- > need but are unable to tolerate nasogastric tube feeding;
- > are unable to swallow adequate food and fluids orally by four weeks from the onset of stroke;
- > are at high long-term risk of malnutrition.

4.7.1I People with difficulties self-feeding after stroke should be assessed and provided with the appropriate equipment and assistance (including physical help and verbal encouragement) to promote independent and safe feeding.

4.7.1J People with stroke discharged from specialist care services with continuing problems meeting their nutritional needs should have their dietary intake and nutritional status monitored regularly.

4.7.1K People with stroke receiving end-of-life (palliative) care should not have burdensome restrictions imposed on oral food and/or fluid intake if those restrictions would exacerbate suffering.

Falls and fear of falling

4.9.3D People with stroke with symptoms of vitamin D deficiency, or those who are considered to be at high risk (e.g. housebound), should be offered calcium and vitamin D supplementation.

Swallowing

4.16.1A People with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

4.16.1B Until a safe swallowing method is established, people with swallowing difficulty after acute stroke should:

- > be immediately considered for alternative fluids;
- > have a comprehensive specialist assessment of their swallowing;
- > be considered for nasogastric tube feeding within 24 hours;
- > be referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- > receive adequate hydration, nutrition and medication by alternative means.

4.16.1C Patients with swallowing difficulty after acute stroke should only be given food, fluids and medications in a form that can be swallowed without aspiration.

4.16.1D People with stroke with suspected aspiration or who require tube feeding or dietary modification should be considered for instrumental assessment (videofluoroscopy or fibre-optic endoscopic evaluation of swallowing).

4.16.1G People with stroke who require modified food or fluid consistency should have these provided in line with nationally agreed descriptors.

4.16.1H People with difficulties self-feeding after stroke should be assessed and provided with the appropriate equipment and assistance (including physical help and verbal encouragement) to promote independent and safe feeding.

4.16.1I People with swallowing difficulty after stroke should be provided with written guidance for all staff/carers to use when feeding or providing fluids.

4.16.1J People with stroke should be considered for gastrostomy feeding if they:

- > need but are unable to tolerate nasogastric tube feeding;
- > are unable to swallow adequate food and fluids orally by four weeks from the onset of stroke;
- > are at high long-term risk of malnutrition.

4.16.1K 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 difficulty and be regularly reassessed.

A comprehensive and personalised approach

5.1.1A People with ischaemic stroke or TIA should be offered advice on lifestyle factors that may modify lipid levels, including diet, physical activity, weight, alcohol and smoking.

Lipid modification

5.5.1A People with ischaemic stroke or TIA should be offered advice on lifestyle factors that may modify lipid levels, including diet, physical activity, weight, alcohol and smoking.