









Background:

- Currently a myriad of cognitive tools used acutely
? Optimal tool
? Who ? When
- Clinicians look to guidelines to inform the care/improve practice from evidence-based medicine
- Appraise CPGs in adult stroke & synthesis recommendations in clinically useful way

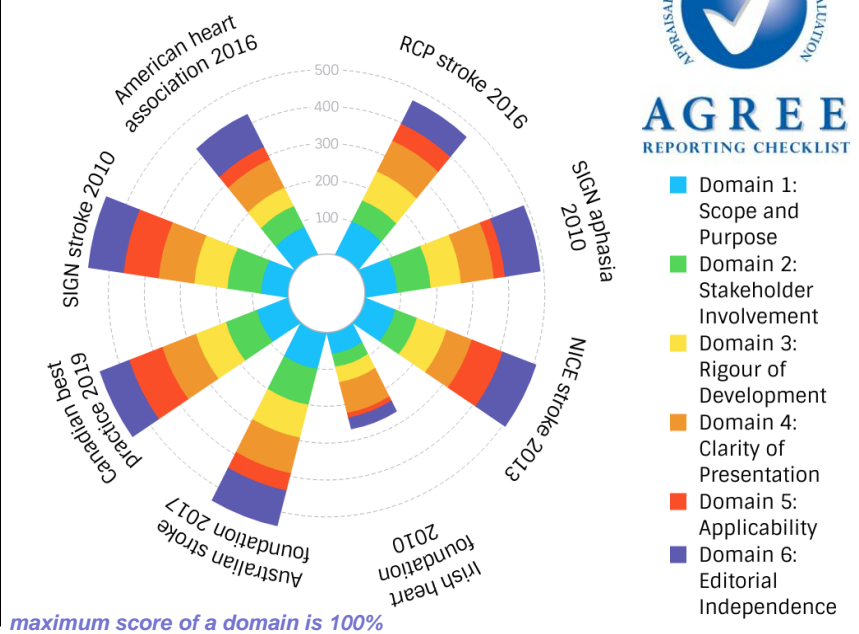
CPGs identified

							
Royal College Physicians, UK 2016	SIGN, Scotland 2010	SIGN, Scotland (aphasia) 2010	Australian Stroke Foundation 2017	Canadian stroke 2019	NICE, UK 2013	Irish Heart Foundation 2010	AHA/ASA association 2016

Method (with 2 individuals):

- Literature search & extraction of relevant CPGs
- Excerpt characteristics/recommendations & evidence base of those CPGs
- AGREE (a validated quality method) score CPGs validated quality method) with intraclass correlation coefficient to ensure reliability
- Synthesis tables of CPG recommendations

AGREE scored CPGs



Synthesised Recommendation results:

- Cognitive screening should be routine almost unanimously in CPGs as was presumption of impairment post stroke
- Large degree heterogeneity between CPGs

Conclusion:

- Key clinical questions vague/not addressed what tool, by who & when, how to communicate outcome
- Lack of primary research
- Common all CPGs using RCTs with an intervention v gold standard as metric ? Applicable
- Cannot correlate AGREE score with CPG quality this must still be done subjectively

Synthesised recommendations of CPGs

