APPROACHES TO MAXIMIZING THE POTENTIAL FOR RECOVERY IN THE ACUTE CARE PHASE		
Topic	**Intervention**	**Implication**
Medication management Certain classes of drugs (ie, anticholinergics, sedative/hypnotics, opioid analgesics, anticonvulsants) may impair neurorecovery; use of others (ie, serotonergic agents) may facilitate recovery.[10]	When feasible, avoid medications that may impair neuroplasticity and functional recovery.[11] Consider initiating medications beneficial to recovery process.[12] Educate patients on safe and sustainable medication use.	Promote neurorecovery, minimize adverse and side effects; promote safety, independence and self-sufficiency for patient and caregivers after discharge.
Nutritional Status Malnutrition is common in patients with stroke, and dysphagia contributes to malnutrition risk that is ssociated with extended hospital stay, poorer functional outcome, and increased mortality rates 3-6 months after stroke.[13]	Early nutrition/dietary consultation to evaluate and treat malnutrition. Early dysphagia screening to evaluate risk for aspiration, and enteral nutrition through a nasogastric tube, when risk persists for more than 48 to 72 hours.[14] Screening: thiamine (B1), pyridoxine (B6), folate (B9), cyanocobalamin (B12), and vitamin D levels.[15]	Prevention of complications resulting from energy-protein deficit.[6,16] Facilitation of myelin synthesis, optimizing neural functioning.[15] Promotes vascular health via reduction of serum homocysteine levels.[17]
Insomnia Adequate sleep is vital for neural recovery, energy, and focus and insomnia may be premorbid or secondary to the stroke. Associated with worse recovery outcomes.[18]	Early implementation of a sleep log and treatment appropriate pharmacotherapeutics (eg, melatonin, trazodone, mirtazapine).[7] When feasible, avoid use of antiphyscotics, anticholinergics, benzodiazepine, opioid analgesics or zolpidem, which may impair cognition, reduce and/or reverse neuroplasticity.[19]	Early screening and treatment of insomnia may enhance neuronal plasticity, enhance spontaneous neurobiological recovery, and improve motivation and participation in therapy.[5]
Obstructive Sleep Apnea A common premorbid or acquired sleep disorder in stroke patients. Associated with decreased recovery and increased risk of recurrent stroke and mortality.[20]	Overnight oximetry may help identify patients at risk by alerting nocturnal apneic or hypoxemic events.[8]	Early screening and treatment of hypoxemic events and apnea facilitates adequate cerebral oxygenation, and improves sleep quality, alertness and focus during therapy.[8]
Delirium Post stroke delirium is associated with higher mortality, prolonged hospitalizations, and poor functional outcome.[21]	Early screening and treatment, particularly in patients with predisposing factors such as old age, dementia, visual impairment, history of excessive alcohol use, polypharmacy, malnutrition, renal impairment, and dehydration.[22]	Early recognition and prevention of delirium may improve outcomes in stroke patients.[21]
Depression/Mood Disorders Premorbid clinical depression and other mood and adjustment disorders may be exacerbated or worsen, after a stroke—with adverse effects on cognitive recovery, physical recovery, and mortality.[23]	Early screening for mood, adjustment disorders, and apathy (Nine-item Patient Health Questionnaire (PHQ9), or 15-item Geriatric Depression Scale [GD-15]). Discuss initiation of an antidepressant, or neurostimulant (dopaminergic or cholinergic agents).[24-26]	Early effective treatment of depression and mood disorder may improve motivation and positively influence rehabilitation outcome of stroke patients.[27]

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