NHS
Hertfordshire Community
NHS Trust

Secondary Stroke Prevention

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Outstanding services
ealthier communities

Aims

- To raise awareness of secondary stroke prevention education for patients and the challenges.
- To take a realistic view point of how this can incorporated in our current workplace and stroke pathways.
- To give an overview and insight into the ACP Trainee pathway for nurses

Advanced Clinical Practitioner

The new role of Advanced Clinical Practitioner (ACP) has been introduced to the unit.

Advanced clinical practice is defined as ‘the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experiences and improve outcomes’ (Health Education England, 2017).

Multi-professional Framework of Practice

Four pillars which underpin this practice:

- Clinical Practice
- Leadership and Management
- Education
- Research

Advanced Practice - Website Content - multi-professionalframeworkforadvancedclinicalpracticeinengland (1).pdf - All Documents (sharepoint.com)

Practice Development Project

Quality Improvement is the framework used to methodically improve healthcare provision (Wolfe et al., 2021).

There is a high risk of a patient going on to have another stroke after an initial event due to ongoing modifiable risk factors. As such, there needs to be clear strategies for secondary prevention planning that incorporates medication, surgical and lifestyle factors (Hall et al., 2022).

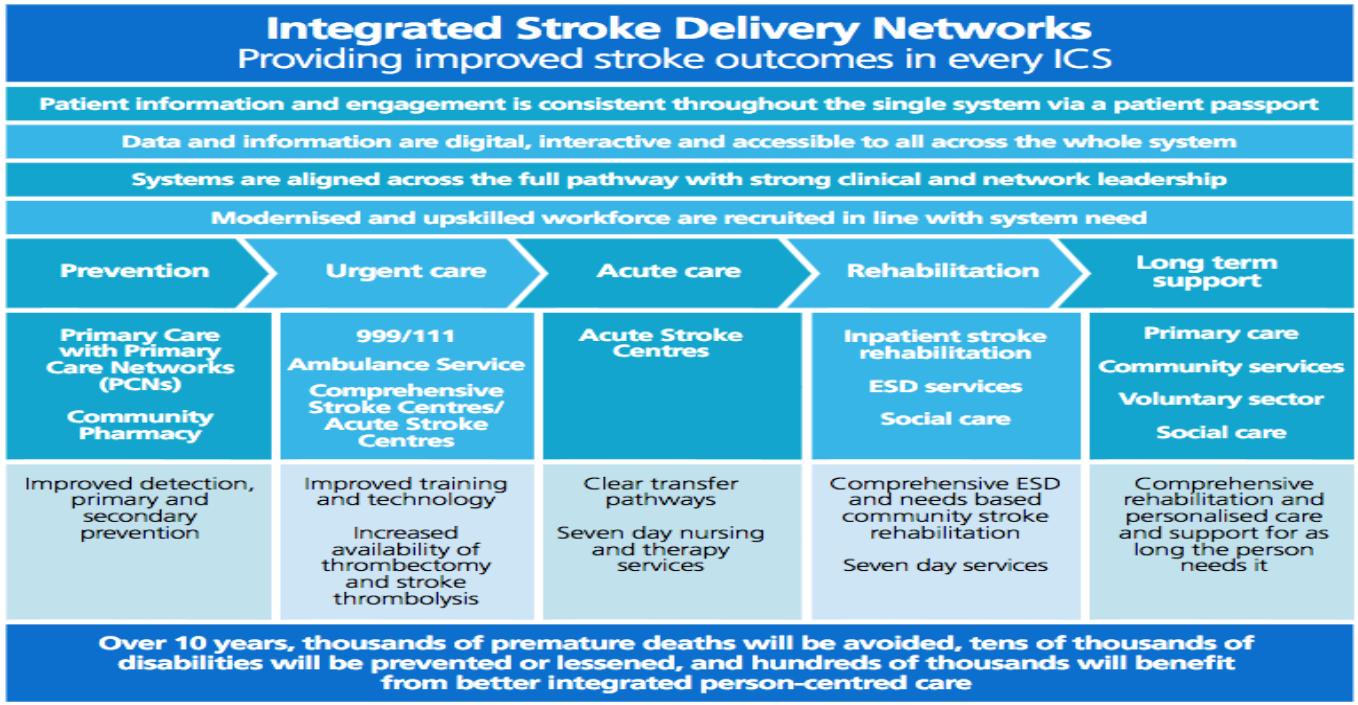
Current Data and Guidelines

- Following a TIA or Stroke the risk of recurrent cardiovascular event at 10 years is 39.2% (Hall et al 2022)
- The Global Burden of Disease (GBD) 2013 study identified that modifiable risk factors cause 90% of stroke burden. Managing these risk factors could reduce 75% of this stroke burden (Pandian et al 2018)
- Modifiable risk factors include hypertension, poor diet, smoking, inactivity, dyslipidaemia and Atrial Fibrillation.
- Stroke has been made a clinical priority in the NHS long term plan and ISDNs have been developed to bring service providers together to enhance local stroke services.

The National Stroke Service Model - Integrated Stroke Delivery Networks (ISDN)

ISDN's draw on clinical priorities set out from the NHS Long Term Plan over the next decade (NHS, 2021). Stroke is a clinical priority and ISDNs have been developed in all areas in England to bring service providers together to enhance stroke pathways (NHS, 2021).

Figure 1: ISDN infographic



Action Plan for Stroke 2018-2030

- The Action Plan for Stroke in Europe 2018-2030 also seeks to address secondary prevention.
- It calls for the address of lifestyle factors alongside prevention such as medication and surgical interventions. The current stroke model is often medics to provide assessment and medication for patients to take to reduce secondary risk and therapists to provide therapy for enable a patients recovery.
- In a review of guidelines and pathways across Europe there was a consistent gap in messaging and action in secondary prevention.
- Modelling suggests lifestyle changes such as diet and exercise alongside medication adherence could see a 80% reduction in recurrent vascular events.

New National Stroke Guidelines April 2023

Key changes in rehabilitation and secondary prevention:

- People with stroke should be considered to have the potential to benefit from rehabilitation at any point after their stroke.
- People with stroke should be routinely screened for delirium
- People with stroke should be assessed and periodically reviewed for post-stroke fatigue, including for factors that might precipitate or exacerbate fatigue (e.g. depression and anxiety, sleep disorders, pain) and these factors should be addressed accordingly. Appropriate time points for review are at discharge from hospital and then at regular intervals, including at 6 months and annually thereafter

Contents - National Clinical Guideline for Stroke (strokeguideline.org)

What's new:

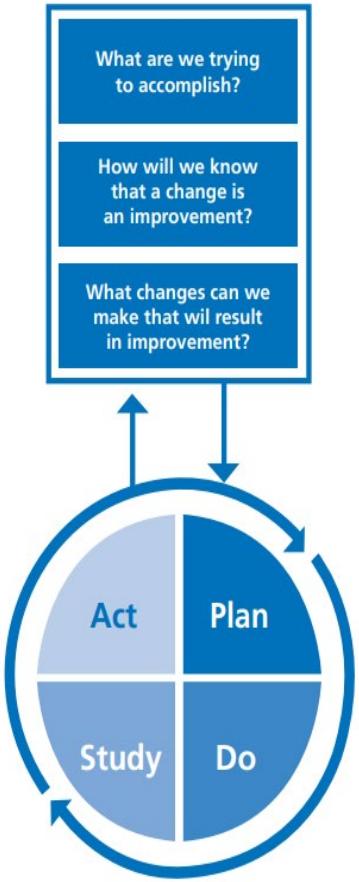
- Home blood pressure monitoring should be considered for guiding the management of BP-lowering treatment, with a typical home systolic BP target below 125 mmHg
- Lipid-lowering treatment for people with ischaemic stroke or TIA and evidence of atherosclerosis should aim to reduce fasting LDL-cholesterol below 1.8 mmol/L (equivalent to a non-HDL-cholesterol below 2.5 mmol/L in a non-fasting sample).
- People who have an intracerebral haemorrhage whilst taking an antithrombotic medication to prevent vascular occlusive events may be considered for restarting antiplatelet treatment
- People with ischaemic stroke and atrial fibrillation or flutter should be considered for anticoagulation within 5 days of onset for mild stroke and may be considered for anticoagulation from 5-14 days of onset for moderate to severe stroke. Wherever possible people in the latter category should be offered participation in a trial of the timing of initiation of anticoagulation after stroke.

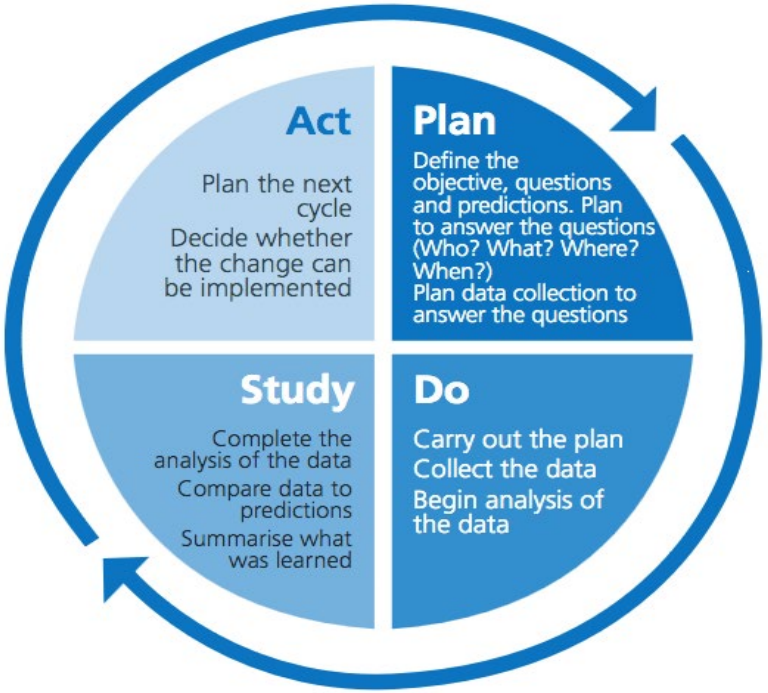
A sum of our parts

Perform Quality Improvement projects.

- Take it slow – PDSA cycles – Quality Improvement takes time.
- Find opportunities to increase health education to patients.
- Information giving – consistent over the pathway.
- Join online resources (My Stroke Guide)
- Take the next step – help a patient text the stop smoking line.
- Include the family – next stage professionals.

PDSA Cycles (NHS England & NHS Improvement 2017).





Aim of project

What are we trying to accomplish?

Embedding the new ACP role to cover all elements of stroke rehabilitation and care.

For the ACP role to be fluid to evolve with quality improvements identified for the unit.

How will we know that a change is an improvement?

Any change must result in a clear indication that patients are receiving more information about their stroke risk factors.

What changes can we make that will result in improvement?

Using the skills of the ACP four pillars of practice to lead an improvement in sharing clinical information with patients in an appropriate context.

Before intervention

- Few nurses attending meetings
- No secondary prevention information given to patients – signposted to GP or follow up with stroke consultant.
- Staff had limited time to give secondary stroke information
- Not all professions rated it as high importance
- Nursing staff wanted more education and structure built into their role to support with this.

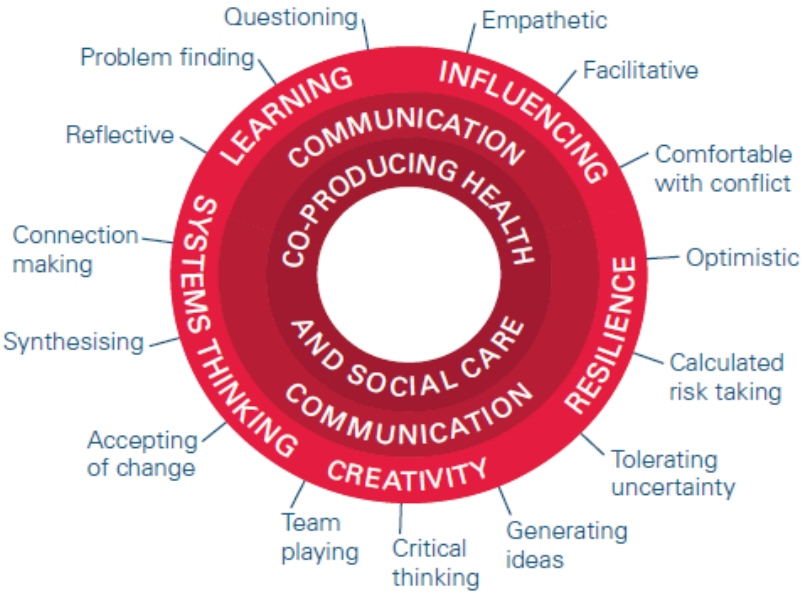
After intervention

- ACP attending planning meetings
- Spreading an emphasis to all professions to attend
- Supporting nurses in attendance and what topics to cover with patients
- Audit showed all patients had information given about secondary stroke prevention. Detailing their modified risk factors and prevention tools.
- As time progressed other professions placing emphasis on secondary stroke prevention and how this impacts a patients recovery.
- MDT working evident – diabetes management example.

Conclusion

- There is currently no clear guidance and focus on secondary stroke prevention.
- It is clearly an area that should be a clinical priority to help aid our patients recovery from stroke.
- Together in each of our roles we can seek to expose our patients to continuous secondary prevention focus to work towards reducing secondary stroke incidence.
- NICE – Make Every Contact Count.

Figure 1: The habits of improvers



Source: *The habits of an improver: Thinking about learning for improvement in health care*. The Health Foundation; 2015.

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