Barns Medical Practice Service Specification Secondary Prevention of Stroke or Transient Ischaemic Attack (TIA)

Review date 1st January 2023

Introduction

Primary care teams are responsible for initial referral of possible stroke or TIA patients assessment, for delivery of effective secondary prevention and management of longer term problems associated with stroke.

Diagnosis

The diagnosis of a TIA is based entirely on a careful history supplemented by a reliable eyewitness account if possible.

A TIA is an acute focal neurological deficit with loss of function of sudden onset such as:

- Limb weakness or sensory change resulting in hemiplegia or hemisensory loss
- Speech disturbance resulting in dysphasia or dysarthria
- Visual disturbance e.g amaurosis fugax or visual field scotoma

The patient will typically have a clear recollection of the event and be able to describe it clearly. Impairment of consciousness or confusion does not occur.

The symptoms are most easily recognised if they present as **FAST**

- **F**acial weakness
- **A**rm and/or leg weakness
- **S**peech disturbance
- **T**ime is brain – call 999

Not all symptoms need necessarily be present. Most attacks last under an hour and usually less than 15 minutes. Focal deficit lasting longer than an hour should be considered as a stroke and be admitted to hospital.

The principal significance of a TIA is the risk of early recurrent vascular events especially a stroke. About 15% of strokes are preceded by a TIA and 50% will occur within the first 24 hours.

The **ABCD2 score** is useful in determining a patient's vascular risk after a TIA and indicates the likelihood of a stroke within the following 48 hours.

Higher scores >4 mean increased likelihood of stroke within the following 48 hours. These patients should be admitted unless they can be seen at the TIA clinic within 48 hours. Scores ≥ 4 have approximately a 10% risk of a stroke within the next 48 hours.

Age >60 years		1 point
Blood Pressure systolic BP ≥140mmHg OR diastolic BP ≥ 90mmHg		1 point
Clinical features (choose one)		
	• Unilateral weakness	2 points
	• Speech disturbance only	1 point
Duration of symptoms	>60 minutes	2 points
	10-60 minutes	1 point
	<10 minutes	0 points
Diabetes		1 point

Pathway for Stroke or TIA patients presenting in primary care or A&E

The following should be considered for admission to the Acute Stroke Unit:

- New onset persisting (>1hr) FAST symptoms suggesting stroke
- TIA patients on warfarin/NOAC
- Crescendo TIAs (>2 in the past 2 weeks)
- Transient FAST symptoms lasting <= 1 hour (TIA) in the last 48 hours in higher risk patient ABCD =/>4

Other patients should be referred to the Rapid Access TIA Clinic

- Amaurosis Fugax/sudden onset visual field scotomas
- TIA in lower risk patients (ABCD2<4)
- TIA symptoms lasting < 1 hour seen more than 48 hours after the event

- ➢ Give aspirin 300mg a day or clopidogrel 75mg a day if aspirin intolerant until seen.
- ➢ Continue with pre-existing anti-hypertensive therapy

- If the patient is significantly hypertensive (>140/85mmHg) or (>130/80mmHg with diabetes) consider introduction of anti-hypertensives, preferably ACE inhibitors
- Stop all NSAIDS, HRT, COCP
- Advise patient not to drive.
- All patients with visual symptoms should be either vetted by an optometrist as the TIA clinic has no facilities/expertise to carry out eye examinations
- Please check blood tests including cholesterol and glucose
- If patients over 60 years with visual symptoms please ensure ESR and CRP are done before the clinic appointment
- Give the patient the TIA clinic information sheet

TIA Clinic- 24 hour phone line

Crosshouse 01563 827 188

Ayr 01292 617148

Every patient who has had a stroke or TIA and in whom secondary prevention is appropriate should be investigated for risk factors as soon as possible and certainly within 1 week of onset.

For patients who have had an ischaemic stroke or TIA, the following risk factors should also be checked for:

- atrial fibrillation and other arrhythmias
- carotid artery stenosis (only for people likely to benefit from surgery)
- structural and functional cardiac disease.

Regular Review

There are many potential interventions to reduce risk. Ensuring identification and reduction of all risk factors, including aspects of lifestyle, will lead to more effective secondary prevention of stroke and other vascular events.

Patients should have their risk factors reviewed and monitored regularly in primary care, at a minimum on a yearly basis.

All patients receiving medication for secondary prevention should:

- be given information about the reason for the medication, how and when to take it and any possible common side effects

- receive verbal and written information about their medicines in a format appropriate to their needs and abilities
- have compliance aids such as large-print labels and non-childproof tops provided, dosette boxes according to their level of manual dexterity, cognitive impairment and personal preference and compatibility with safety in the home environment
- be aware of how to obtain further supplies of medication
- have a regular review of their medication
- have their capacity (eg cognition, manual dexterity, ability to swallow) to take full responsibility for self-medication assessed by the multidisciplinary team prior to discharge as part of their rehabilitation

Lifestyle measures

Smoking cessation should be promoted in the initial prevention plan using individualised programmes which may include pharmacological agents and/or psychological support.
Exercise
:
Exercise programmes should be tailored to the individual following appropriate assessment, starting with low-intensity physical activity and gradually increasing to moderate levels.

diet
eat five or more portions of fruit and vegetables , increase oily fish and reduce salt,fat and red meat in diet

alcohol encourage to keep within recognised safe drinking limits of no more than three units per day for men and two units per day for women and have at least two alcohol-free days a week

Blood pressure

Blood-pressure lowering treatment should be initiated after stroke or TIA prior to hospital discharge or at 2 weeks, whichever is the soonest, or at the first clinic visit for non-admitted patients. Thereafter, treatment should be monitored frequently and increased as necessary to achieve target blood pressure as quickly as tolerated and safe in primary care. Patients who do not achieve target blood pressure should be referred for a specialist opinion.

antihrombotic therapy

For patients with ischaemic stroke or TIA in sinus rhythm, clopidogrel 75 mg daily should be the standard antithrombotic treatment:

Lipid-lowering therapy

A statin should be considered in all patients who have had an ischaemic stroke or TIA regardless of cholesterol. Simvastatin 40mg at night is the drug of choice (dose reduced to 20mg in renal impairment or when co prescribed with interacting drugs such as amlodipine, amiodarone or verapamil. The use of atorvastatin may be required if cholesterol levels remain high as per NHS Ayrshire and Arran Lipid Guidelines.

Anticoagulation

Anticoagulation will be initiated in secondary care for people with ischaemic stroke or TIA and paroxysmal persistent or permanent AF or Atrial Flutter once intracranial bleeding and other contraindications such as uncontrolled hypertension are excluded.

Treatment in people with TIA will start immediately on diagnosis once imaging has excluded haemorrhage.
Treatment is deferred for variable periods in people with non disabling ischaemic stroke depending on specific circumstances but starts within 14 days of onset
Treatment is deferred until at least 14 days from onset in people with disabling ischaemic stroke. In the interim aspirin 300mf daily will be used.
Anticoagulation for people with TIA or stroke should be with adjusted dose of warfarin (target INR 2.5 range 2-3) or a NOAC edoxaban for people with non valvular AF.
Anticoagulation should not be used in people with stroke or TIA in sinus rhythm unless other indications such as a cardiac source of embolism, cerebral venous thrombosis or arterial dissection are present.
Do not prescribe antiplatelet therapy as an alternative to anticoagulation in people with cardioembolic stroke and a contraindication such as undiagnosed bleeding. Identify modifiable risk factors using a tool such as has-bled and attempt to reduce bleeding risk
Antithrombotic treatment in people with recurrent TIA or stroke should be the same as for those with a single event.

annual review

1st Visit

The following information will be recorded

- date of diagnosis
- family history of stroke
- smoking status and smoking cessation advice

- blood pressure
- record any previous vascular investigations eg MRI, CAT scan, carotid Doppler, ECHO
- height/weight
- alcohol consumption
- level of physical activity
- drug therapy and compliance
- depression questions via Vision template

Annual Review

- BP >140/85, procedure as per hypertension protocol should be followed (consideration should be given to those who have BP > 130/80 in patients with diabetes or CKD)
- smoking status and advice regarding cessation
- alcohol
- urinalysis
- weight, BMI
- random blood glucose, lipids, U&Es, FBC(CK and LFTs if on statin)
- depression questions via Vision template

Lifestyle advice as above - diet/smoking/alcohol/exercise

offer flu vaccine annually and pneumococcal vaccination if required

Medication

Discuss therapy and concordance

Rehabilitation

Resources for Staff and or Patients

Taken from National Clinical Guidelines for Stroke - fourth edition

published in September 2012 by the Royal College of Physicians Intercollegiate Stroke Working Party

Practice specific information – see service specification

Internet information

http://www.patient.co.uk/health/stroke-leaflet

http://www.nhs.uk/conditions/transient-ischaemic-attack/pages/introduction.aspx

http://sign.ac.uk/guidelines/fulltext/108/index.html

http://www.stroke.org/understand-stroke/what-stroke/what-tia

Staff involved and training required

Stroke rehabilitation should be managed by the multi-disciplinary team. Recommendations for the contribution of each discipline of the team should be based upon the individual needs of the patient. Appropriate referral should be made by the Surgery if the patient's consultant has not done so. Annual review usually occurs within the surgery and a screening visit is carried out by the Health Care Assistants (HCA0 (see appendix 1). Review of the screening visit includes input from General Practitioners, and Registered General Nurses (RGNs).

Advertising of service to patients

Via website

APPENDIX1

Stroke/TIA Annual Review Management Protocol by Health Care Assistants

DATE CREATED 06/12/2018

REVIEW DATE 06/12/2020

PURPOSE OF PROTOCOL

To enable suitably trained Health Care Assistants working for or on behalf of BARNS MEDICAL PRACTICE who have undertaken relevant training (as outlined below), to regularly review a patient how has previously had a stroke or Transient Ischemic Attack (TIA) as a duty delegated by the General Practitioner or a registered nurse. The results of the screening visit are then examined / assessed by a GP or nurse with a special interest in the condition and any changes to management will be communicated following the initial visit and often by telephone.

AIM

To monitor patients who have previously sustained a stroke/TIA annually.

To report and act on changes in overall condition

To offer continuing health promotion advice and prevent further complications

AUTHORITY TO PROCEED

In accordance with HCA code of conduct (Scottish Gov., 2009) and with the training and skills listed below.

TRAINING + SKILLS

- Completion of HCA induction training course on the management of stroke/TIA and its complications.
- Completion of period of supervised practice and completion of assessment of competence
- Training and competence in the correct procedure for onward referral or management of any concerning features on the day of review.
- Appropriate anatomy and physiology knowledge
- Access to and knowledge of relevant guidance/ protocols re. stroke
- Demonstration of competence in relation to this delegated duty within the PDP and appraisal

ELIGIBILITY CRITERIA

INCLUSION/EXCLUSIONS

All patients who have sustained a stroke/TIA and have been stabilised on treatment and are attending for annual review or regular monitoring as invited by BARNS MEDICAL PRACTICE . This protocol does not include management of the patient in the 1st 3 months following a stroke.

ADMINISTRATION PROTOCOL

1. Patients will be advised to attend for annual checks once stabilised on medication.
2. Computer search will be run after 15 months to ascertain those who have not been seen.
3. These patients will receive 3 letters to attend for review.
4. Opportunistic monitoring will be ongoing in response to computer triggers at other consultations where possible.

CLINIC PROTOCOL

1. A 10-minute appointment will be offered.
2. Consultation will be carried out in privacy of a consulting room.
3. Computerised notes will be made available.
4. The LTCRv Stroke/TIA Template will be completed annually.

Assessment

- Smoking status, refer to smoking cessation clinic if smoker
- Diet (weight, height, BMI), low fat diet
- Exercise
- Medications
- Alcohol consumption
- Discuss salt intake
- Offer lifestyle advice and record

Vital signs

- Blood pressure < 140/80
- Pulse

Blood monitoring

U+Es, glucose, lipids, TFT (if no results in last year), LFT if on statin.

Urine testing

Specimen blood, protein and ACR sent annually

Outcome

1. If well controlled including BP review annually and a telephone consultation is planned with the practice nurse to deliver this information.
2. If BP not well controlled or any other complications – to be seen by GP and appointment is arranged.

Record Keeping

The Long Term Condition Review Template, within the Vision computerised record will be completed with regard to Stroke /TIA

Audit

Health Care Assistants will be expected to participate in audit in relation to patient outcomes and the development of this role.

Management of Significant Event

Any significant event which occurs during a stroke /TIA consultation must be reported to the Practice Manager / General Practitioner or the Registered Nurse / Manager and the incident reported via the Barns Medical Practice significant event document.

REFERENCES

SIGN Management of Stroke http://sign.ac.uk/guidelines/fulltext/108/index.html [online] last accessed 18/2/15

SIGN Booklet for patients and carers http://sign.ac.uk/pdf/pat108.pdf [online] last accessed 18/2/15