ESO EUROPEAN STROKE ORGANISATION

STROKE ACTION PLAN EUROPE 2018 – 2030

SAFE STROKE ALLIANCE FOR EUROPE

Stroke Action Plan for Europe National Coordinator meeting: Workshops report

20-22 March, 2023
Pullman Old Town Riga, Latvia

Organising committee:

Professor Hanne Christensen, Chair of SAP-E Steering committee
Dr Francesca Romana Pezzella, Co-Chair of SAP-E Steering committee
Arlene Wilkie, Co-Chair of SAP-E Steering committee
Dr Melinda Roaldsen, SAP-E Chief Operations Officer

National coordinators from following countries were present in person:

North region

Peter Vogele, Denmark
Rubina Ahmed, Sarah Belson , Englan, Northern Ireland, Wales, Scotland
Jattinder Khaira, England
Janika Korv, Estonia
Thorir Steingrimsson, Iceland
Peter Kelly, Ireland
Aleksandras Vilionskis, Lithuania
Fiona Quigg, Northern Ireland
Grethe Lunde, Norway
Mia Von Euler, Sweden
Bert Vrijhoef, The Netherlands

South region

Dmitar Maslarov, Dmitar Taskov, Dorina Dobreva, Bulgaria
Ervin Jancic , Croatia
Harriet Proios, Greece
Simona Sacco, Italy
Fisnik Jashari, Kosovo
Maria Mallia, Malta
Elena Simeonovska Joveva, Gordana Dimeska, Elena Lichkova, North Macedonia
Zeljko Zivoanovic, Ivan Milojevic, Serbia

East region

Nune Yeghiazaryan, Armenia
Robert Mikulik, Ales Tomek, Czech Republic
Andras Folyovich, Hungary
Stanislav Groppa, Moldova
Adam Kobayashi, Anna Czlonkowska, Poland
Cristina Tiu, Romania
Vladimir Nosal, Zuzana Gdovinova, Slovakia

West region

Sigrid Schwarz, Austria
Sylvie De Raedt, Belgium
Elsa Azevedo, Ana Nunes, Gustavo Santo, Catarina Fonseca, Portugal

The purpose of this report is to provide the Stroke Action Plan for Europe (SAP-E) National Coordinators, the SAP-E steering committee, ESO EC and SAFE board an overview of the workshops that were carried out by the SAP-E national coordinator at the meeting in Riga in March 2023.

1. SAP-E and future ahead - setting time limit goals for 2026

In this session, the group broke out into four regional groups: countries were divided into four geographical groups of North, South, East and West.

Each group, in rotation, was asked to brainstorm on four topics for 20 minutes: organisation and timing of acute stroke care, subacute care, early mobilisation and secondary prevention, and life after stroke.

Each group was specifically asked to discuss what are the acceptable time limits for care in each topic and to set and agree upon new goals to be reached by 2026.

Overall, the discussions clearly demonstrated the differences in health care systems, staffing, organisation of stroke care, not to mention resources in the countries. Some even felt that setting targets for stroke unit care was not possible from their perspective.

Note: the paper is a report of the discussions of the workshops and the time limits reported are not to be used as guidance for National Coordinators in the advocacy work.

a. Acute stroke care

In this session each regional group was asked to discuss minimum standards for acute care that should be received.

Summary from this group session:

Door to needle	45 min	
Door to groin	Mothership model	60 min
	Drip-and-ship model	120 min
Door to imaging	15 min	
Door to NIHSS	10 min	
Door to blood work-up	10 min	
OAC related ICH reversal	50% Exclude 50% 60 min	

b. Stroke unit care

In this session each regional group was asked to discuss minimum standards for care that should be received within the stroke unit.
Summary from this group session:

	North	South	East	West
Admission to stroke unit care	Door to stroke unit care < 4 hours	-		Door to stroke unit ASAP & < 3 hours

Swallowing Screening	ASAP before any meal or drink & < 6 hours	-	Before the first meal/drink	ASAP before any meal or drink & < 12 hours
Aspirin bolus	< 1 hour after imaging	-	ASAP and < 24 hours after onset	ASAP & < 6 hours after door
BP reduction in ICH		-		< 1hour
Non-aggressive mobilisation	< 12 hours after admission	-		
Prevention of VTE		-		

c. Secondary prevention

In this session each regional group was asked to discuss minimum standards for when secondary prevention initiatives should be initiated.

Summary from this group session:

Intervention	North	South	East	West
Antiplatelets	≤ 2 H	≤ 24 h	≤ 24 h	24 to 36 h depending on IVT
	"Not later than" is not acceptable	≤ 24 h	≤ 24 h	+ statins
Work-up for AFib	48 h monitoring from admittance	≤ 48 h	Monitoring for 72h – If neg. ext. work-up within 14 days	48 h
	Continue extensive workup immediately	Organizational barriers	Monitoring for 72h – If neg. ext. work-up within 14 days	48 h
Work-up for carotid stenosis	Disagreement between 24-72 h CTA should be done in all	≤ 48 h	≤ 24 h	72 h
Lifestyle advice	Clinical history, individualised advice asap and in all transition phases	100%	100% at discharge at least	On discharge
		During hospitalisation and feedback at discharge	Cultural bias	
			Longterm patient coaching	
Screening and assessment	Disagreement between	24-72 h	≤ 48 h	

	24- 48 h		Is cognitive screening included ?	
Initiate therapy	Screening + 24 h	72 h	≤ 48 h	
Early supported discharge	24- 48 h	Cultural and organisational barriers	4 days/ discussion about what we mean by early supported discharge	

d. Life after stroke

For this topic – all four groups shared ideas on the best care that should be expected after a stroke.
Summary from this group session:

1. Plans on care and further rehabilitation after stroke – on discharge

- Everyone should have a personalised care plan – a holistic plan which includes who is responsible for what the stroke survivor needs; and that this plan changes depending on the transitions between services and the needs of the individual.
- Everyone should receive this care plan on discharge from rehab care following a stroke from a key worker from within a multidisciplinary team.
- General signposting information should be given to each stroke survivor, along with the care plan.
- Every carer should receive a personalised plan including training if they are delivering the long-term care plan.

Barriers to this: This is available in the UK, Sweden, Austria, Denmark and possibly Malta. It is not available in other European countries. There are no guidelines, it is not in national stroke plans. It is not compulsory and it is not reimbursed.

Solution: it was suggested by the SAP-E national coordinators that ESO-SAFE develop a European wide agreed care plan and information sheet template that can be used and adapted by European countries based on the existing Post-Stroke Check list.

2 - Initiation of out-patient rehabilitation in the communities should happen 5-10 days after discharge. To enable this, practical minimum guidelines are needed.

3 - Follow up should happen at 3 months using the Post Stroke Check List. It should be carried out by a someone from a hospital or GP or trained nurse as part of a multi-disciplinary team. The personalised care plan should be updated at this point.

4 - A second follow up should happen at 6 months to check status (including complications and loss of functioning) and ensure possibility of referral to relevant interventions such as a family doctor, a GP or a trained community nurse.

5 - An annual follow up should happen with the Post Stroke Check List and the personalised care plan must be updated based on the changing needs of the individual. This could be carries out by a ,a.GP or trained community nurse for example.

Barrier to this: the SAP-E national coordinators felt the current post stroke check list created by the WSO was not being used universally throughout Europe.

Solution: the SAP-E national coordinators suggested that ESO-SAFE develop a care plan and information sheet template that can be used and adapted by European countries based on the existing Post-Stroke Check list.

6 - Every person who has had a stroke should have access to life after stroke information including social/welfare system information, self-management, peer to peer, vocational and financial support, psychological support within six months of discharge. Ideally the individual would be referred to a local SSO.

Barrier: many countries do not have welfare systems or strong SSOs to provide this support nationally

Solution: SAP-E national coordinators to work with local physicians and allied health professionals in partnership with stroke survivors and carers to work to grow and strengthen SSOs in their countries as well as advocating for this to be included in the national stroke plans.

7 - A new point was raised by the SAP-E national coordinators. They asked for guidance on the minimum standards that should be expected for those stroke survivors that remain long term in institutions.

Solution: This issue should be addressed in the updated version of the SAP-E

2. 1.What are the important life after stroke issues

In regional groups, the national coordinators were asked to brainstorm on most important LAS interventions on individual level, as well as on country level and how to facilitate these transition of stroke patients from hospital to primary sector.

Medical needs	**Intervention**
• Secondary prevention (including comorbidities – diabetes, high blood pressure) • Adherence to treatment • Communication (speech, their communication, cognition) • Movement (mobility, spasticity) • Pain • Vision • Mood (anxiety, masking) • Memory • Dysphasia • Nutrition • Fatigue Vertigo	• A multidisciplinary team – case manager, physician, speech and language, occupational therapy, psychological support, physiotherapy, movement advice, SSO Who will deliver • 3 monthly, 6 monthly, annual reviews/follow up and adaptation of plans • Ongoing rehabilitation programme • Assistive technologies • Peer support • Education and information • Medicine information

Societal needs	Intervention
• Driving • Isolation/loneliness • Return to work/occupational activity • Intimacy, sex, co-habiting, relationships • Travel • Leisure activities/physical exercise • Communication/aphasia • Diet • Emotions management • Financial security • Legal support • Support for carers and family • Home adaptations • Accessible public places • Stigma and discrimination	• Societal multidisciplinary team – stroke coordinator/case manager, physician (neurologist, psychiatrist), GP/ family/community doctor, allied health professionals (nurse, speech therapist, occupational therapist, physiotherapist, dietician, psychologist), social/welfare, stroke support organisation, This team will provide: • Holistic support • Self-management support • Peer to peer support/connection/education • Follow up/ongoing reviews and adapting care plans • Vocational training/employee guidance • Support on their rights – finance, legal, healthcare, legal guardian • Public education

In summary,

The first in person meeting of the SAP-E National Coordinators was of enormous importance and success. As well as providing essential opportunities for networking and sharing experiences and motivating each other, the National Coordinators discussed standards of stroke care in Europe. These rich discussions highlighted the differences across Europe and the great work that is being done to address and improve stroke prevention and treatment and care of all those affected by stroke.