Atrial fibrillation (AF) is a common heart rhythm disorder whereby deranged electrical impulses in the atria prevent effective atrial contractions, allowing blood to pool with the potential formation of emboli. Approximately 1–2% of the general population is affected. Symptoms may include palpitations, shortness of breath, fatigue and lethargy but people may be asymptomatic or unaware that they have the condition.

While the condition itself is not life-threatening, AF-related ischaemic stroke is of particular concern and evidence suggests that stroke risk remains constant whether the individual has prolonged, permanent or paroxysmal AF (Friberg et al, 2010). One in five strokes is attributed to this arrhythmia and these are more likely to be fatal than other causes of stroke, with survivors more severely disabled (Camm et al, 2010). Assessment of stroke risk in people with AF was previously calculated using CHADS2 to identify risk factors associated with a higher incidence of stroke (Camm et al, 2010).

However, this evolved into a more sensitive instrument, the CHA2DS2-VASc (Lip et al, 2010; Olesen et al, 2011) to inform stroke risk calculation and thus support prescribing decisions regarding the need for anticoagulation. The acronym and scoring system are explained in Table 1.

A score of one or more in the CHADS2 or ≥2 in the CHA2DS2-VASc means that thromboprophylaxis is indicated. Use of tools to assist with assessment of bleeding risk such as the HAS-BLED score (Pisters et al, 2010) is also recommended to further inform the risk/benefit ratio for both patients and prescribing clinicians (Camm et al, 2010).

Therefore, the focus of assessment and treatment for individuals with AF is not only aimed at controlling or relieving symptoms, but also at reducing stroke risk through identification of individuals who would benefit from thromboprophylaxis. Evidence regarding what is considered most effective in this regard has previously supported use of aspirin (National Institute for Health and Care Excellence (NICE), 2006; Camm et al, 2010).

However, evidence for benefits of aspirin, either alone or in combination with other antiplatelet agents, to reduce stroke risk is weak—yet, its potential to increase risk of bleeding is similar to that of anticoagulants (Camm et al, 2012). Thus revised European guidelines in 2012 strongly recommended use of anticoagulants, with aspirin use reserved only for people who refused these (Camm et al, 2012). While previously warfarin was the only anticoagulant available, requiring frequent blood testing to monitor individual clotting levels threatening concordance, the development of novel non-vitamin-K antagonist anticoagulants provides a more acceptable, yet still cost-effective alternative (NICE, 2014a). However, as these medications are relatively new additions to national prescribing formulary and currently only licensed for use in patients with non-valvular AF, familiarity and confidence regarding their use may take some time to develop.

In light of the potential to reduce the risk of stroke if AF is detected and anticoagulation commenced, significant work has been undertaken in the UK to improve knowledge and awareness of both assessment and treatment. GRASP-AF is an audit tool developed to assist primary care practices in identifying patients diagnosed with AF via their practice records (NHS Improving Quality (NHSIQ), 2012). The tool is designed to ensure that practices are compliant with requirements of the Quality

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**Abstract**

Prescribing evidence-based medications and keeping up-to-date with new evidence is a requirement for both medical and non-medical prescribers (Nursing and Midwifery Council (NMC), 2006). In considering how new evidence is incorporated into practice, it is clear that there can be a considerable lag before new, authorised and recommended treatments are assimilated. The following case study illustrates the potential for conflicting advice that can arise as a result of inconsistent guidance and lack of awareness of updated evidence for treatment of specific conditions. Further, benefits of shared decision making between patients and clinicians and their potential application between clinicians in such situations is highlighted. The importance of specialist nurses in facilitating both education and access to new evidence is identified, as is the need for effective and timely communication to secure judicious implementation of changes in policy and practice.

**Key words**
- Atrial fibrillation
- Guidelines
- Specialist nurses
- Stroke risk assessment

if there might be a rhythm disturbance. His pulse was regular in clinic and his electrocardiogram (ECG) showed sinus rhythm. To investigate further, the author arranged for an ambulatory cardiac monitor to assess for any arrhythmias.

When the results of this were analysed, episodes of paroxysmal AF were demonstrated. In applying the CHA2DS2-VASc scoring system (Lip, 2011), he scored two—one point for hypertension and one for his age (range 65–74). Thus he met primary stroke prevention criteria for anticoagulation, which was explained to him via a letter that was copied to his GP requesting that this was commenced. Mr Bloggs telephoned a week or so after the letter was sent to say that after discussion with his GP, they had decided that he only really needed aspirin as, according to his CHADS2 score of one (for hypertension), he was only at low risk of stroke.

As a result of current specialist knowledge, it was possible to effectively explain to Mr Bloggs why aspirin was no longer recommended and identify how the evidence that he and his GP were employing had been updated. Further, owing to an awareness of the existence of conflicting guidance for GPs, it was possible to identify precisely where the error in information occurred. Mr Bloggs was grateful for further explanations but requested that a further letter be written to him and his GP including additional information to guide the prescription of anticoagulation.

Discussion

It is not usual practice in all cardiac centres to bring patients back to secondary care when results of investigations are reported unless any ensuing treatment requires initiation within a secondary care setting. However, as can be seen from the case study of Mr Bloggs, this can mean that there is insufficient opportunity to engage in an open dialogue with patients regarding proposed treatment options and an over-reliance on primary care clinicians to provide this.

The term ‘shared decision making’ (SDM) is used to describe clinical decisions arising from discussions between clinicians and patients regarding proposed treatment. Key components of SDM are identified as providing (Elwyn et al, 2012):

- Information
- Opportunities to explore and deliberate options with patients
- Support for patients to make an informed choice regarding the option that best suits them.

However, within this example, it seems that correspondence and collaboration with Mr Bloggs’ GP may also have benefitted from the SDM approach. The decision reached by Mr Bloggs and his GP after receiving recommendations based on an investigating clinician’s analysis suggests that insufficient evidence had been provided to support the rationale to either Mr Bloggs or his GP. Good communication and ensuring evidence-based practice are key standards within the NMC (2006) standards for prescribing.
As AF is such a common condition and there had been local educational efforts aimed at updating GPs' knowledge and awareness of assessment and treatment, a more cooperative response was anticipated from this GP. However, such educational efforts may not reach all GPs. Therefore, any guideline is only effective if clinicians are aware of and implement its content, which can cause both delays in treatment initiation and inappropriate prescribing practice. In England, GPs' practice is guided by the QOF (NHS Employers, 2013), which is apparently not quickly responsive to changes in evidence.

If GPs are aware of updated evidence, they may choose to incorporate this as a principle of 'best practice', yet their 'performance' in relation to the QOF would be penalised if they do. Therefore, in order to ensure that primary care clinicians are kept abreast of specialist practice developments, it seems that a two-pronged approach may be indicated.

From a policy perspective, it is essential that there is timely communication between relevant policy development bodies and practice governing bodies such as NICE, NHS England and specialty guideline development groups to ensure such conflicting guidance does not jeopardise safe prescribing. From a personal responsibility perspective, this issue has been discussed within local cardiology clinical forums. An agreed development is that, specifically where such potential conflicts have been identified, a one-page printed overview of the updated clinical guidance will be provided with references for further reading by primary care clinicians if desired.

However, there remains the potential for guidance from specialists to be ignored unless there is a willingness among non-specialist clinicians to engage and a shared understanding of what constitutes best practice. Barriers to implementation of specialist guidelines in primary care settings are also not limited to AF (Grol, 2001; Chenot et al, 2008). In anticipation of potential barriers to implementation of the new NICE (2014b) AF guidelines, an implementation collaborative consensus document was developed as part of the implementation programme focusing on the exclusion of aspirin from treatment options and supporting novel non-vitamin-K antagonist anticoagulants (NICE, 2014a). This brings together the evidence for anticoagulation in non-valvular AF and adopts a 'frequently asked questions' approach to how information is presented. Education and raise awareness to an extent, it will be difficult to ensure that such approaches reach every relevant clinician or that those clinicians will feel confident to change their practice. Shared decision making models may help to ensure that both individual patients and their primary care clinicians are provided with information and opportunities to explore potential treatment options through direct discussion with a specialist clinician. Through this collaborative approach, it is anticipated that patients will feel supported in their treatment choices and non-specialist clinicians will feel supported in implementing recommendations from clinical guidelines.

**References**


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**Table 1. Original CHADS2 tool with the development to CHA2DS2VASC scoring**

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure/left ventricular dysfunction</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>Age ≥ 75</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
</tr>
<tr>
<td>Stroke/TIA/thrombo-embolism</td>
<td>2</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>1</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>1</td>
</tr>
<tr>
<td>Ex category (female)</td>
<td>1</td>
</tr>
</tbody>
</table>

*Source: adapted from Lip, 2011*
Specialist nurses can play a key role in supporting patients and non-specialist clinicians to understand evidence to support treatment decisions. Always proof read and check spellings carefully. ( BJCN) is a clinical and professional review journal for nurses who wish to be fully informed of developments in the specialty of cardiac nursing. It aims to provide the highest standards of clinical reviews and to offer a forum for the exchange of knowledge and experience from which patients will benefit.

We welcome submissions from both first time and experienced authors. The supportive review process often provides inexperienced authors with constructive advice on how to improve their articles. Articles published in the journal normally fall into the following categories: clinical, care study, drug focus, practical procedures, research and development and career focus. There will also be book reviews, comment pieces and letters.

**Key Points**

- Assessment of stroke risk is a crucial part of treatment for atrial fibrillation
- Treatment guidelines may lag behind a fast-developing evidence base
- Shared decision-making models may also apply between clinicians, rather than only between clinicians and patients
- Specialist nurses can play a key role in supporting patients and non-specialist clinicians to understand evidence to support treatment decisions

**Introduction**

*British Journal of Cardiac Nursing* (BJCN) is a clinical and professional review journal for nurses who wish to be fully informed of developments in the specialty of cardiac nursing. It aims to provide the highest standards of clinical reviews and to offer a forum for the exchange of knowledge and experience from which patients will benefit.

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Here are some general points to keep in mind when writing an article for the journal. BJCN aims to present all articles, including original research, in an easy-to-read informative style. Simplicity is key, so please avoid jargon. Consider the key take home message from your article. It may be helpful to distil the essence of your article into four or five key points before you start and use these to guide your writing. Be very clear about what your article adds to the literature. If this is obvious, your article is more likely to be accepted. A key aim of BJCN is to be of practical use to its readers, so take care to outline the implications for practice. Read other articles from BJCN for ideas on style and layout. Organize your article in a logical manner. Subheadings, pictures and boxes all help break up the text for readers and help maintain interest in the article. If you have not written for publication before, it can be helpful to take advice from colleagues. Always proof read and check spellings carefully.

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All articles should be submitted online at: http://www.epress.ac.uk/bjcardn/webforms/author.php. Documents should be double-spaced (including references) and formatted for A4 paper and all pages should be numbered. For purposes of confidentiality, author identification should appear only on the title page. You will receive an email stating that your article has arrived and has been sent for review. All clinical and research articles should include an abstract of between 100 and 150 words, key words, and 5–6 key points, i.e. phrases that summarize the major themes of your article. Conflict of interest: Please declare any conflicts of interest, i.e. any possible interests, financial or otherwise, which may embarrass the author or the journal if highlighted at a later date.

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