Position statement on the 2023 NICE head injury guidelines regarding asymptomatic patients on anticoagulation or antiplatelet treatment

This position statement is endorsed and supported by the following organisations: Association of Ambulance Chief Executives (AACE), Royal College of Emergency Medicine (RCEM), British Geriatrics Society (BGS), Society of British Neurological Surgeons (SBNS), and UK Hospital at Home Society.

Aim

The aim of this position statement is to enable health care professionals to make safe and appropriate decisions about which patients taking anticoagulation or antiplatelet treatment need to go to hospital and receive a CT scan after sustaining a head injury, based on interpretation of the NICE Head injury: assessment and early management (NG232) guideline.

NICE guidance (NG232)

The guideline makes two important recommendations regarding the assessment and early management of head injury in patients who are on anticoagulation:

> *1.2.4 Community health services (GPs, ambulance crews, NHS walk-in or minor injury centres, dental practitioners) and inpatient units without an emergency department should refer people who have sustained a head injury to a hospital emergency department, using the ambulance service if necessary, if there are any of these risk factors*.
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> "Current anticoagulant and antiplatelet treatment" are listed as a risk factor.

It should be noted that aspirin monotherapy alone is not an indication for referral.

> 1.5.13 *For people who have sustained a head injury and have no other indications for a CT head scan, but are on anticoagulant treatment (including vitamin K antagonists, direct-acting oral anticoagulants, heparin and low molecular weight heparins) or antiplatelet treatment (excluding aspirin monotherapy),* ***consider*** *doing a CT head scan: within 8 hours of the injury (for example, if it is difficult to do a risk assessment or the patient may not return to the emergency department if they have signs of deterioration) or within the hour if they present more than 8 hours after the injury.*

A small proportion of patients taking anticoagulant or antiplatelet medication with asymptomatic head injury will have an intracranial haemorrhage which is only detectable on CT scan. Regardless of a patient's eligibility for neurosurgery, detecting a bleed in these patients provides an opportunity to assess their current prescription and temporarily or permanently stop anticoagulant or antiplatelet use to avoid deterioration.

The guideline recommends that health care practitioners should ‘consider’ doing a CT scan. Currently some patients are not being taken to hospital or receiving a CT scan where the benefits do not outweigh the risks for the individual patient.

Adopting a patient centred approach

As detailed in the NICE guideline Shared decision making (NG197), patients have the right to be involved in discussions about the risks and benefits and to make informed decisions about their care.

Shared decision-making should put the patient at the centre of decisions. What matters most to the patient with asymptomatic head injury must be prioritised when making the decision to consider transport to hospital or perform a CT scan.

An Advance Care Plan or DNAR may not always be applicable for conditions which are reversible and/or treatable. However, some patients may have, with their families and carers, made clear Advance Care Plans stating what they wish to happen in the event of a fall and possible head injury or that they do not want hospital admission under any circumstances.

For older patients and patients with frailty who are commencing or currently taking anticoagulant or antiplatelet medication, it is recommended that advance care planning should include the patient’s wishes if they were to sustain a symptomatic or asymptomatic head injury.

Staying in their own home rather than being transferred to hospital or having a CT scan may be more of a priority to the patient than the detection of a potential intracranial haemorrhage and should be given equal consideration.

Where appropriate, discussions should take place with the patient and their relative/carer about the risks and benefits and the patient choice of whether to go to hospital. Patients must have capacity to make the decision not to be conveyed. If the patient does not have capacity due to a long-term condition (not the acute head injury) then their relative / carer, if they have legal decision-making power for health, can be consulted and act on behalf of the patient.

If there is no Advance Care Plan specific to the patient who lacks capacity, and they are expressing a wish to not be conveyed to hospital after sustaining a head injury then the attending healthcare practitioner will need to access support from senior clinical decision-makers, where appropriate (see below).

Patients who are not being conveyed to hospital must be suitably supervised and the carer provided with clear instructions of what to do if they deteriorate.

It is also essential that the risk and benefits of ongoing anticoagulant or antiplatelet use are reviewed in each individual patient based on the clinical indications for anticoagulation, the risk of the current head injury, and the risk of future falls. In the majority of patients, a temporary pause of anticoagulation use will be necessary. This may involve accessing senior clinical support (see below).

Decision support

Ambulance services

Ambulance services employ various grades of registered and non-registered health care professionals, both working front line and in control room settings.

Depending on the clinical grade, scope of practice and experience, ambulance clinicians will need access to clinical decision support for decisions relating to patients who have sustained head injuries and take anticoagulants and/or antiplatelets, if there is no clear patient benefit from attending the emergency department and a decision is being made to not convey a patient to hospital.

A well governed and regulated system for this decision support will need to be locally determined and may or may not already exist. Where these are not currently available, 24/7 decision-support should be prioritised in the development of future services to improve patient centered care and unnecessary use of NHS resources.

Decision support may be provided by health care professionals in ambulance control/clinical assessment service, the local hospital, or community teams (via telephone, online or face to face). Some areas have access to frailty hospital at home services, urgent community response teams, or a senior member of the geriatric medicine team at a hospital.

Where there is no clear advance care plan or senior decision-making support is not available it is recognised that, due to the complexity and risk level of decision-making, ambulance service clinicians will likely need to recommend transport to the hospital emergency department.

It should also be noted that there may be other reasons that patients with asymptomatic head injury require transfer to hospital. These include concerns around a medical cause for the head injury, another traumatic injury or safeguarding concerns around care provision.

Emergency departments

Emergency Department clinicians should have access to the Emergency Medicine Consultant and senior clinicians covering geriatric services for decision-making support.

Other locations

This guidance is applicable and transferable to other community-based health care professionals working in community walk in centres, urgent treatment centres or minor injury units who should seek senior decision making from the patients GP or remote support hubs to assist in decision making about the need to convey the patient to hospital and how to convey them. Where the patient is fully alert and mobile with minimal aid then an ambulance may not be required, and the patient can be conveyed to hospital by car or taxi.

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