NICE National Institute for Health and Care Excellence

SL example: 18-21

NICE Shared Learning Collection submission template

Name and contact details:

Name:

Job title: Arrhythmia Clinical Nurse Specialist

Organisation name: University Hospital of North Midlands

Email address:

UK Region: West Midlands

Type of organisation: Acute Trust

Sector: Secondary Care

Willing to share contact details and the content on the NICE website YES

Title of submission: (avoid generic titles like 'implementing NICE guidance')

Atrial Fibrillation (AF) Holistic Care Pathway

Description: Please briefly describe the project. The description should make reference to how the relevant NICE guidance/Quality Standard relates to your work together with any particular recommendations or quality statements within them that have been implemented.

An arrhythmia Clinical Nurse Specialist qualified in Health Assessment and Prescribing attached to an Electrophysiologist consultant reviews referred AF patients in clinic. There is a protected 35-40 minute appointment for a new patient to allow a full explanation of their condition and treatment pathway. A lot of work goes on prior to the clinic appointment to facilitate best practice and holistic care, reflecting the NICE principles of 'patient centred care'. and 'Personalised package of care and information' (1.2)

Dos the submission specifically refer to the implementation of NICE guidance?

Yes

Does the submission relate to the general implementation of NICE guidance?

No

FOI ref 705-1920

Specific NICE guidance:

The reference number of the NICE guidance: CG180

Atrial fibrillation: management
Clinical guideline [CG180] Published date: June 2014 Last updated: August 2014

Sponsorship:

Is the submission sponsored in any way by a different organisation or company to that of the organisation submitting the example? If so please provide brief details of funding received and its source. **([illegible]00 characters maximum)**

No

Your submission

Aim and objectives: What were you trying to achieve? How do the aims and objectives relate to NICE guidance / Quality Standards? **(2500 characters maximum, including spaces)**

The NICE guidance for AF sets out a template for care of the AF patient that has been incorporated and expanded on in local practice.

An Arrhythmia Clinical Nurse Specialist was tasked with specialising in an area of arrhythmia care and AF was chosen as an area where gains could potentially be made. Over a six year period various measures were gradually introduced to enhance the care of the AF patient. The current AF holistic care pathway reflects the recommendations within the NICE guidelines and includes additional content.

Multiple conferences were attended over the years and good examples of best practice were chosen and incorporated locally. Examples include-

Anticoagulation assessment with better uptake of DOAC.

Address comorbidities/lifestyle factors.

Develop a good support system.

Screen for Obstructive Sleep Apnoea.

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Reasons for implementing your project: *What was happening before the project started and why was the change needed? Have you carried out a baseline assessment? What opportunities for improving efficiency, saving costs or increasing productivity did you identify? How did you involve patients/stakeholders? What is the size/catchment area of your organisation and any relevant local population demographics?* **(2500 characters maximum, including spaces)**

The care of AF patients was shared between multiple cardiologists and there was variability in management strategies. There was no point of contact once a patient was discharged and there was variation in follow up and support literature provided. Some specific areas were identified where an arrhythmia Clinical Nurse Specialist might provide care under a more unified programme.

There was a realisation that AF related stroke was a major problem globally and locally and any measures that could be found to help combat this consequence were sought as advocated by NICE (1.5). The potential benefits of the DOACs were recognised and clearly they should be advocated. Education on all the pros and cons of each was sought. Patients suffering stroke while awaiting anticoagulation was recognised as a scenario that should be avoided. Patients turning up to clinic with previously identified AF and not anticoagulated was a similar area of concern.

NICE guidance does not focus to a great extent on comorbidities and lifestyle but these are known to be a major factor in the management of AF. Many patients seemingly had poor knowledge and effort in those areas.

NICE advocates a support system for AF patients (1.2). Before the holistic pathway was created patients might have received some literature ad hoc but no contact phone number or other support.

There is a strong and not always well publicised link between AF and Obstructive Sleep Apnoea. Screening for Obstructive Sleep Apnoea was minimal.

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How did you implement the project: *What steps did you use to put NICE guidance into practice? What problems did you face and how did you design your approach to overcome these? (for example - access to resources, gaining buy-in from stakeholders). If your project incurred costs please elaborate on how much and what the source of funding was.* **(2500 characters maximum, including spaces)**

Education sessions with outside speakers to give AF/anticoagulation talks to Emergency Portal meetings were organised. Speakers and training courses were offered to the Non-medical prescriber group and a recruited team of AF link nurses. Funding was secured via anticoagulation pharmacy firms (without influence on content). The hospital emergency and medical clinical guidelines were updated to reflect the use of DOACs. An anticoagulation poster was designed and widely distributed and displayed throughout the Trust (Appendix 2). Anticoagulation was assessed in clinic using CHA2DS2-VASc and HASBLED as per NICE guidance (1.4) with assessment of TTR with warfarin (1.5) and renal function using the Cockcroft Gault formula and conversion if taking antiplatelet. As recommended by NICE there is access to Left Atrial Appendage Occlusion assessment for those unsuitable for anticoagulation (1.5.19).

To tackle lifestyle factors/comorbidities, at an early stage, all AF referrals are copied to cardiac rehabilitation. Relevant literature is posted out to patients and the offer to attend drop in education classes with talks from consultants/nurses/physiologists/nutritionists is made (The Heart Support Group). After attendance at arrhythmia clinic and the heart rhythm optimised with rate and rhythm control including access to ablation as indicated in NICE guidance (1.6.19). An invite is made to attend cardiac rehabilitation supervised exercise programme in local gyms and encouragement given to keep up regular exercise afterwards. Alternatively instruction on a home exercise programme is offered.

Bariatric surgery is discussed where appropriate and a referral recommended to the local speciality.

All patients get the arrhythmia nurse office phone number. Literature on AF, anticoagulation and any planned procedures derived from a variety of reliable sources are proffered. Literature from the British Heart Foundation and AF Association offer access to further support networks. A closed Facebook support group was developed and linked the existing Cardiac Rehabilitation Facebook group, wider support being advocated by NICE (1.2). Access has been arranged for referral to Cognitive Behavioural Therapy when indicated (NICE 2.1)

A very low threshold was used for referring the AF patient for Obstructive Sleep Apnoea assessment. An increased waiting list for Obstructive Sleep Apnoea testing was addressed again with the help of the Cardiac Rehabilitation team with education in the process of assessment and referral for Obstructive Sleep Apnoea so that it happens earlier while waiting for AF clinic.

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Key findings: *Did your project meet the initial aims and objectives? What were the main results? These can either be short or longer term results (Please illustrate results quantitatively and qualitatively where you are able to). What cost savings and increases in efficiency and productivity didyour work make? Did it prevent illness or unnecessary treatment / admissions? What did it mean for staff* **(2500 characters maximum, including spaces)**

It is very rare now for a patient to attend clinic without anticoagulation already having been assessed. Everything that can be done to reduce AF related stroke is a massive benefit to the healthcare economy and wellbeing of the individual and family. The Sentinel Stroke National Audit Programme data continually informs on our improving stroke prevention performance and work continues with other projects also contributing in this area.

It is well documented that dealing effectively with comorbidities/lifestyle is more effective than medical/surgical remedies in the treatment of AF. A holistic pathway for the local management of AF patients with cost neutral measures involving the Multidisciplinary Team and getting patients involved in the self-management of their condition at an early stage means that when they attend clinic there is more time to concentrate on rate and rhythm management and this is easier to do with less intervention. The work done with the Cardiac Rehabilitation Team prior to the clinic visit has allowed each clinic slot to be shortened and an extra clinic slot allocated to reduce waiting times and increase revenue. There would be a potential further cost saving generated as there would likely be less expensive interventions with electrical cardioversion, antiarrhythmic medication and ablation by tackling comorbidities/lifestyle earlier.

A good support system means that there is less likelihood of emergency admission or repeat A+E attendance when just advice is needed. The Facebook group helps to answer frequent questions that come up with issues including AF and holiday insurance that have been asked and answered frequently before and can be done better via peer support. There would potentially be a cost saving with fewer emergency admissions and readmissions with a well-managed and supported patient.

Hundreds of AF patients have been identified and assessed for Obstructive Sleep Apnoea. Many are now established on Continuous Positive Airways Pressure systems and likely would need less intensive measures in the future management of their AF in terms of medication, electrical cardioversion and ablation. An abstract on Obstructive Sleep Apnoea and AF was presented by the team this year at the Heart Rhythm Congress meeting in Birmingham and published in 'E P Europace'. **Is sleep apnoea unrecognised in patients with atrial fibrillation?**

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EP Europace, Volume 20, Issue suppl_4, October 2018, Pages iv7–iv8,https://doi.org/10.1093/europace/euy198.008

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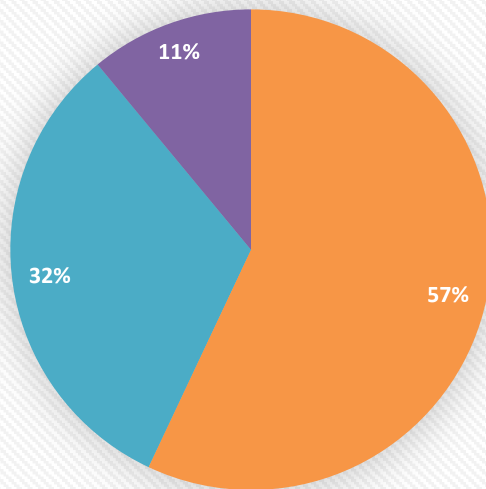
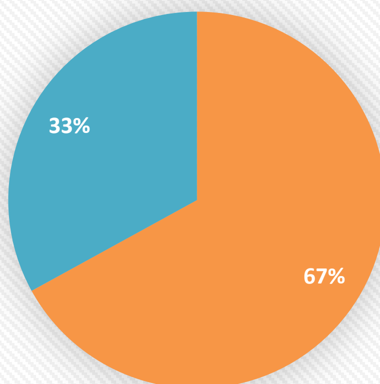
Appendix 1

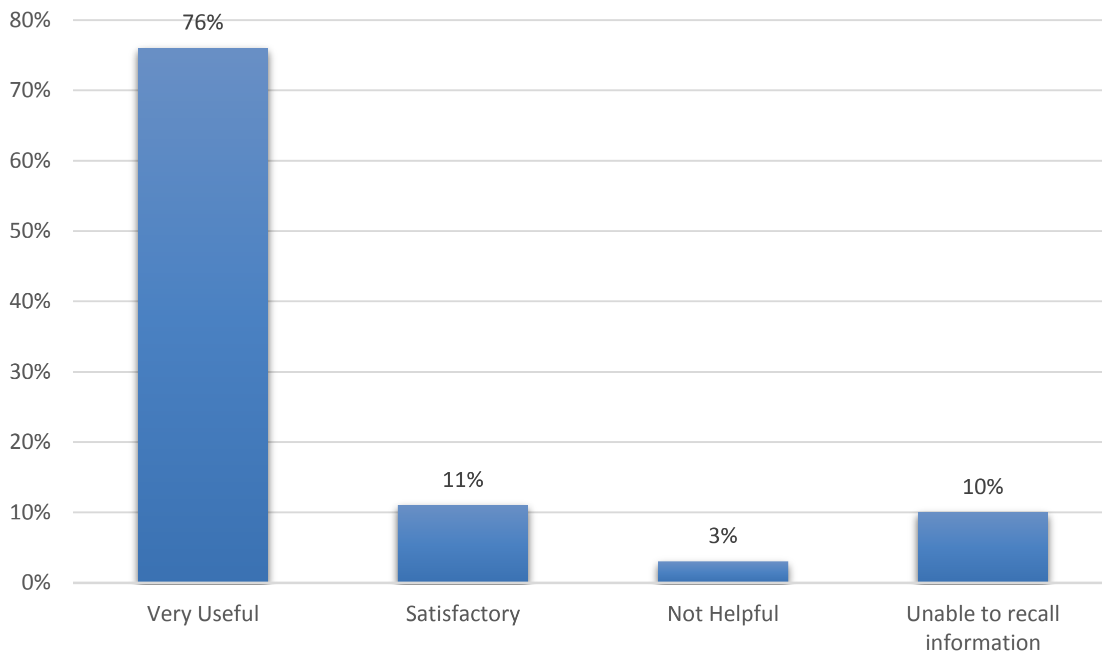
Cardiac Rehabilitation AF Patients Service Audit

The data is drawn from the April 2018 - March 2019 database, though we only started sending AF tailored information packs out around June 2018

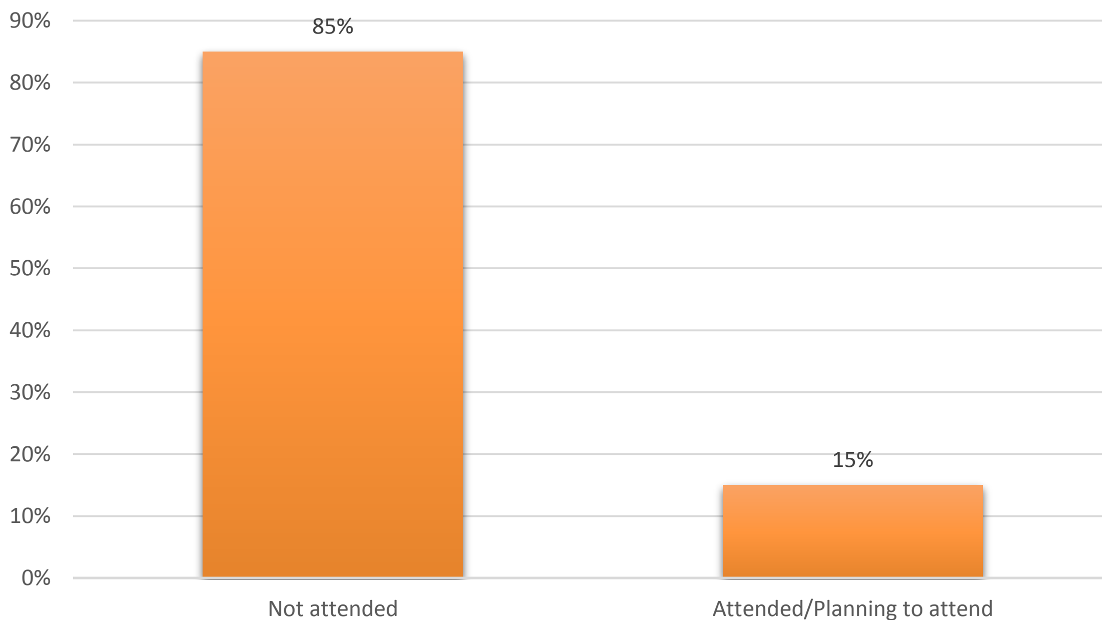
Total number of AF referrals = 334







Patient Telephone Audit: Usefulness of Information pack
80%
70%
60%
50%
40%
30%
20%
10%
0%
76%
11%
3%
10%
Very Useful
Satisfactory
Not Helpful
Unable to recall information



Patient Telephone Audit: Uptake of Heart Support Group
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
85%
15%
Not attended
Attended/Planning to attend

DO NOT WAIT ANTICOAGULATE! Appendix 2 Anticoagulation poster

Does your patient have paroxysmal or persistent atrial fibrillation or flutter?

Have they been assessed for anticoagulation?

Asprin monotherapy is not recommended for the management of AF.

These rhythms are associated with strokes of significantly higher morbidity and mortality than non-AF related strokes.

Assess the stroke risk using the CHADSVASc scoring system (online medical guidelines).

•If **$CHA_2DS_2VASc = 1$ consider** anticoagulation (excluding 1 for female sex alone).

•If **$CHA_2DS_2VASc \geq 2$ offer** anticoagulation.

We use '**consider**' to reflect a recommendation for which the evidence of benefit is less certain. We use '**offer**' to reflect a strong recommendation where there is clear evidence of benefit (NICE).

Assess the bleeding risk using the HASBLED scoring system (online medical guidelines).

Document your findings. **If you do not anticoagulate, document the reason.**

If you need advice contact Staffordshire Thrombosis and Anticoagulation Centre (STAC) on ****** OR STAC Registrar, pager 15458 or stroke AF team on ****** or arrhythmia nurse team on ******.

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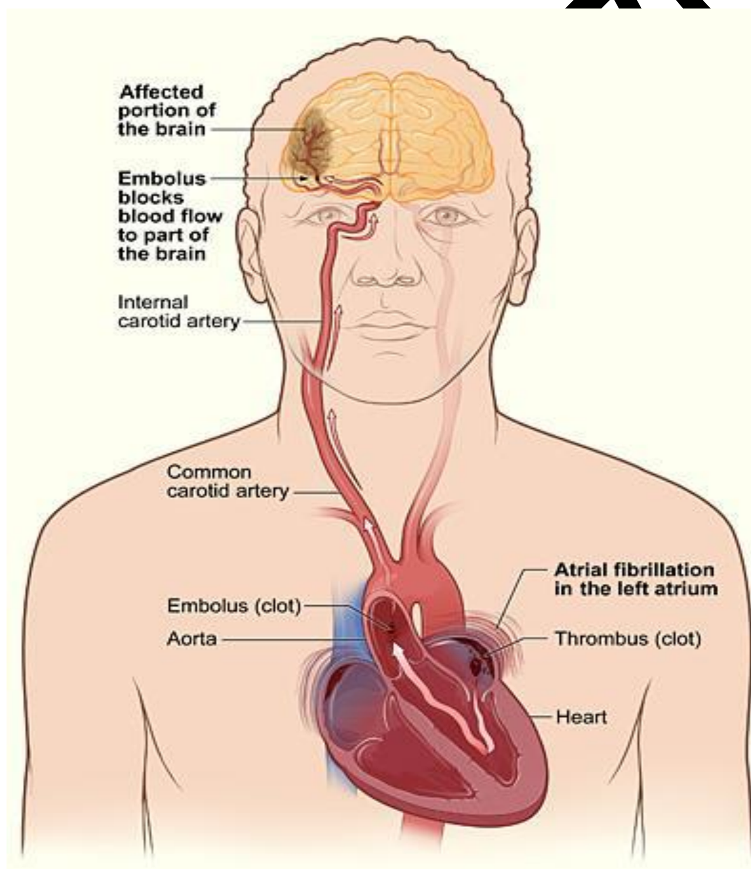

Despite receiving only 15% of the cardiac output, the brain is the destination for most clots (>80%) that embolise from the heart.

AF in old age (>75 yrs) is a strong indication, NOT A CONTRAINDICATION for anticoagulation. If you send your patient away with a direct/newer oral anticoagulant (DOAC/NOAC), their stroke protection starts within a few hours.

Before you commence a DOAC the patient should have FBC, INR, LFT and U&E. The dose is dependent on creatinine clearance (Cockcroft and Gault equation, online calculation tools are available). Should be monitored regularly for renal function (STAC will do if referred) and advised to seek immediate help for bleeding issues.

If you do not assess for anticoagulation the patient may suffer a stroke while waiting.

Anticoagulate with edoxaban, rivaroxaban, apixaban, dabigatran or warfarin-see medical guidelines.

DO NOT WAIT ANTICOAGULATE!

Key learning points: *What is your key learning? If you did it again, how would you do it differently? What pointers would you give to help someone from another organisation facing similar challenges? What might be successful and what should they avoid?* **(2000 characters maximum, including spaces)**

Everything that has been learned over the last six years and gradually implemented could be done at an early stage by anyone setting up new Clinical Nurse Specialist AF clinics today if they have similar services locally to access. It is important to identify and engage key people who are keen and enthusiastic to help.

Attending specialist conferences was particularly helpful. There was usually information picked up that could be implemented locally.

Determination is needed to push through on issues that need to be addressed and just keep trying different avenues if one seems closed off. Publicise what you are doing as I know I am guilty of working in isolation to an extent and not sharing best practice enough. Case studies for areas of best practise have been submitted on various forums this year and we were 'Highly Commended' for the British Heart Foundation Champion award this year for AF services.

Do not reinvent the wheel. Please feel free to contact our centre and we will gladly share any content that may be helpful.

Where did you hear about the Shared Learning Database/Awards?

Other (please specify)

BHF staff

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