ACHD is required to differentiate low risk from high risk patients. The role of NOACs in this group of patients is unclear and needs further evidence. 1 patient had a stroke on a NOAC despite being compliant.

Stable IHD/Prevention/Hypertension/Lipids

76 PROPHYLAXIS OF VENOUS THROMBOEMBOLISM: ENSURING APPROPRIATE PRESCRIBING AND RELIABLE DATA COLLECTION

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Background Venous thromboembolism (VTE) is the most common preventable cause of death with safe and effective prevention measures available. Inpatients at high risk for VTE often fail to be provided prophylaxis despite clear guidelines and this mismatch between VTE prophylaxis and thromboembolic risk is a major issue for clinicians. We sought to clarify compliance of practice with the NICE quality standard and to assess accuracy of the Commissioning for Quality and Innovation (CQUIN) VTE form.

Methods A point prevalence study was performed involving a comprehensive review of 100 consecutive patients at Barnet Hospital. We assessed compliance against the NICE guideline 92 by ensuring appropriate assessment of VTE and bleeding risk, clarifying that those where the VTE risk outweighs the bleeding risk are offered prophylaxis. We also assessed the accuracy of VTE risk assessment form completion using validated bleeding risk (HASBLED) and VTE risk (Wells) scores. We implemented technical improvements in the VTE risk assessment form; medical education through mandatory completion of VTE eLearning modules; and involvement of the MDT through grand round discussions. Following implementation, a reaudit of 50 patients was performed.

Results In 100 patients assessed, mean age was 71 years, 55 were male, with mean weight 74.8kg; see Table 1. Based on the drug chart, VTE prophylaxis was appropriately offered in 69% of patients; see Figure 1. The VTE risk assessment form was accurately completed in 57% for VTE risk status, in 69% for bleeding risk, and in 69% for VTE prophylaxis prescribed. After implementations, the reaudit revealed VTE prophylaxis was appropriate in 88%, VTE risk assessment form was accurate in 78% for VTE risk status, 90% for bleeding risk, and 89% for VTE prophylaxis prescribed. The section of the drug chart devoted to VTE risk assessment was poorly utilised; 21% in the initial audit and 18% in the reaudit.

Conclusion Whilst single centre and modest in size, this robust, complete audit demonstrated compliance with VTE prophylaxis guidelines was poor, for both risk assessment and appropriate prescribing. Technical improvements to the VTE form, educating trainees and involving the MDT significantly improved compliance with guidelines. Future work is required to overcome accuracy issues of form completion ensuring patients receive optimal care.

Abstract 76 Table 1 Characteristics of the participants by initial audit and reaudit

Baseline Characteristic	Initial Audit	Reaudit
N	100	50
Mean Age (years) ± SD	71 ± 18	72 ± 19
Male (%)	55	36
Body Weight (kg)	74.8	72.9
Atrial Fibrillation(%)	18	20
Heart Failur (e%)	12	18
Hypertension(%)	47	26
Diabetes (%)	25	10
Chronic Kidney Disease%	18	16

SD, standard deviation

77 IMPACT OF CARDIOVASCULAR COMORBIDITIES ON MORTALITY AMONGST PSYCHIATRIC PATIENTS IN THE UNITED KINGDOM

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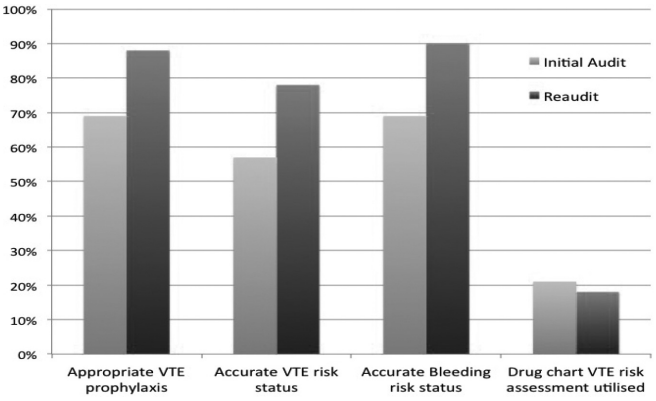
Introduction Cardiovascular disease is increasingly being associated with novel risk factors including psychiatric diseases. Although a high prevalence of cardiovascular comorbidities has been demonstrated in psychiatric patients, the impact of these on mortality are yet to be studied.

Objectives We aimed to investigate the prevalence of cardiovascular comorbidities and their contribution to mortality amongst psychiatric patient in North England, UK.

Methods Anonymous information on adult psychiatric patients was obtained from hospitals in North England, UK between 1st January 2000 and 31st March 2013. This data was analysed according to the ACALM (Algorithm for Comorbidities, Associations, Length of stay and Mortality) study protocol. ICD-10 and OPCS-4 codes were used to trace patients coded for psychiatric disease, demographics, prevalence of cardiovascular comorbidities and mortality data. Mortality of psychiatric patients with and without cardiovascular comorbidities were



Abstract 76 Figure 1

compared by logistic regression. P values <0.05 were taken as statistically significant.

Results Amongst 929552 patients admitted during the study period, 80172 had a diagnosis of psychiatric disease. Mean age of psychiatric patients was 53.9 years, 50.8% were male and 84.0% were Caucasian. 22679 (28.3%) psychiatric patients died. Logistic regression showed mortality was increased significantly by comorbid diagnoses of ischaemic heart disease (OR 1.221), atrial fibrillation (OR 1.357), cerebrovascular disease (OR 1.657), heart failure (OR 2.555), ischaemic stroke (OR 1.386), myocardial infarction (OR 1.234), peripheral vascular disease (OR 1.581), type 1 diabetes (OR 1.836) and type 2 diabetes (OR 1.171). Conversely mortality was significantly reduced in psychiatric patients with comorbid hypertension (OR 0.630), hyperlipidaemia (OR 0.416) and angina (OR 0.779).

Conclusion We have demonstrated that cardiovascular comorbidities are highly prevalent amongst psychiatric patients and contribute significantly to mortality. We also demonstrate that diagnoses of some cardiovascular risk factors (hypertension and hyperlipidaemia, but not diabetes) has a protective effect on mortality, probably due to effective monitoring and management of risk factors. Improved management of cardiovascular risk amongst psychiatric patients could prevent mortality in this at-risk group.

78 IMPACT OF ETHNICITY ON MORTALITY AMONGST TOBACCO ABUSERS IN THE UNITED KINGDOM

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Introduction Tobacco smoking contributes significantly to the global health burden and its negative impact on cardiovascular morbidity and mortality in particular have been well documented. Smoking is affected by sociodemographic factors though with rates varying according to sex, social class and ethnicity. However, the impact of ethnicity on mortality amongst hospitalised tobacco abusers is yet to be studied.

Objectives We aimed to investigate the impact of ethnicity on mortality of hospitalised patients with a comorbid diagnosis of tobacco abuse. We did this using a large database of patients admitted with comorbid tobacco abuse to hospitals in the North of England between 2000–2013.

Methods Anonymous information on adult tobacco abusers was obtained for hospitals in North West England between 1st January 2000 and 31st March 2013. This data was analysed according to the ACALM (Algorithm for Comorbidities, Associations, Length of stay and Mortality) study protocol. ICD-10 and OPCS-4 codes were used to trace patients coded for tobacco abuse, patient demographics and mortality data.

Abstract 77 Table 1 Demonstrates the crude unadjusted and the adjusted mortality rates for psychiatric patients according to cardiovascular comorbidity

Cardiovascular Comorbidity	Prevalence n (%)	Crude mortality n (%)	Odds ratio (95% confidence intervals)
Hypertension	17 216 (21.5%)	6724 (39.1%)	0.630 (0.602- 0.660) ***
Chronic Kidney Disease	1 678 (2.1%)	1 021 (60.8%)	1.004 (0.896-1.125)
Atrial Fibrillation	5 861 (7.3%)	3 871 (66.0%)	1.357 (1.268-1.451) ***
Ischaemic Heart Disease	8 484 (10.6%)	4 207 (49.6%)	1.221 (1.128-1.322) ***
Cerebrovascular Disease	4 347 (5.4%)	2 808 (64.6%)	1.657 (1.430-1.920) ***
Peripheral Vascular Disease	1 233 (1.5%)	710 (57.6%)	1.581 (1.382-1.807) ***
Type 1 Diabetes	1 005 (1.3%)	328 (32.6%)	1.836 (1.559-2.162) ***
Heart Failure	4 003 (5.0%)	2 864 (71.5%)	2.555 (2.350-2.778) ***
Ischaemic Stroke	3 323 (4.1%)	2 260 (68.0%)	1.386 (1.173-1.639) ***
Myocardial Infarction	1 940 (2.4%)	969 (49.9%)	1.234 (1.104-1.379) ***
Type 2 Diabetes	7 324 (9.1%)	3 151 (43.0%)	1.171 (1.102-1.245) ***
Angina	4 511 (5.6%)	1 928 (42.7%)	0.779 (0.704-0.863) ***

p < 0.05* p<0.01* p<0.001