100 further procedures, followed by roll out of the program to other nursing staff.

Results During training (RAA) cannulation was successful on 1st attempt in 42 out of 50 (success rate allowing for two attempts 84%), with no complications recorded. Successful access by a more experienced operator N = 7, failed (RAA) N = 1. The following 100 were performed independently on unselected patients (success rate 81%; (1st pass 70)), with no complications, need for alternate access routes, N = 1.

The following table details the success rate and patient comfort score recorded during 104 procedures performed by a nurse specialist and trainee registrars.

Patient parameters contributing to FRANCE-2 score	Values
Age ≥90 years	7.0% (n=13)
BMI <18.5	1.6% (n=3)
New York Heart Association Class IV	7.5% (n=14)
Acute pulmonary oedema ≥2 in past year	6.4% (n=12)
Systolic pulmonary artery pressure ≥60mmHg	5.9% (n=11)
Critical pre-operative state	4.3% (n=8)
Respiratory insufficiency	43.9% (n=82)
Dialysis	1.1% (n=2)
Transfemoral approach	93% (n=174)

Abstract 65 Table 1

Conclusion Nurse-led (RAA) is safe and feasible and has the potential to improve catheter laboratory efficiency, patient satisfaction, standardise procedure training and improve staff retention.

Our next steps will be to train more nurses in radial access and progress to nurse led angiography.

Conflict of Interest None

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CLINICAL OUTCOMES FOLLOWING ELECTIVE PERCUTANEOUS CORONARY INTERVENTION (PCI) AND SAME DAY DISCHARGE (SDD): A RETROSPECTIVE COHORT STUDY

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10.1136/heartjnl-2019-BCS.64

Introduction In 2016, 100,483 patients in the United Kingdom underwent PCI (1). PCI is a guideline recommended treatment for coronary artery disease (2). Contemporary techniques and pharmacotherapy strategies have improved the safety of PCI, thus reducing risk of major adverse cardiovascular events (MACE) and the requirement for overnight stay in elective cases. Published data have demonstrated that the majority of post-procedural complications occur within the initial 6 hours, and that patients can be safely discharged after a period of observation (3). Implementation of these recommendations

Abstract 66 Table 1

	NUH (n=306)	BCIS (n=26,245)
Death	0.32% (n=1)	0.17%
MI	0.32% (n=1)	0.04%
Stroke	0%	0.04%
CABG	0%	0.03%
Revascularisation	0.65% (n=2)	0.10%
SDD (%)	55	26

into clinical practice has the potential to provide significant healthcare cost savings.

Objectives This study aimed to evaluate the clinical outcomes of patients undergoing elective PCI at a tertiary cardiac centre, determine rates of elective SDD PCI, and identify potential areas for service improvement.

Methods Elective PCI procedures over a 12-month period (October 2016 – September 2017) were electronically retrieved from our trust's TOMCAT cardiovascular information system. Incidence of MACE at 30 days after PCI was recorded following review of procedure reports, discharge summaries and hospital re-admission data. NHS numbers were used as unique identifiers to ensure robust data collection. Our data was subsequently compared with the British Cardiovascular Intervention Society (BCIS) 2016 audit results.

Results 306 patients underwent elective PCI during the study period. 1.3% incidence of MACE was recorded (death 0.32% [n=1]; MI 0.32% [n=1]; urgent revascularisation 0.65% [n=2]; stroke [n=0]; emergency CABG [n=0]). 55% (168/306) of elective PCI was performed as a SDD. 34 patients were admitted overnight, despite undergoing uncomplicated single-vessel PCI. Applying published criteria, SDD would have been appropriate in this group.

Conclusion This study demonstrates that elective PCI at our centre is safe and results in low rates of MACE, with clinical outcomes comparable to national audit data. 55% of elective PCI at our centre is SDD, considerably higher than BCIS figures. Patients suitable for SDD were identified and will be the focus of future pathway and service improvement.

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Conflict of Interest None