Methods We conducted a baseline audit of 28 consecutive days of discharge letters against four process measures to establish the frequency and quality of documentation of discharge driving advice for patients discharged from our cardiac care unit. Subsequently, we implemented a quality improvement project (QIP) with prospective patient-centred primary outcome measures. Over six plan-do-study-act (PDSA) cycles, we iteratively designed a standard operating procedure (SOP) for consultant-led discharge driving advice, supported by patient and staff posters, whiteboard magnets and nursing checklists, and a smartphone ‘app’. Following the QIP, we audited a second period of 28 consecutive days of discharge letters against the same four process measures to assess lasting change.

Results Baseline audit established that, of 115 consecutive patients, 74 had a diagnosis that could affect their driving eligibility. Of these, one (1.4%) had appropriate documentation of discharge driving advice. Qualitative data collected prospectively throughout the QIP showed positive patient experience and accurate patient understanding as new operating procedures were implemented. Repeat audit of 124 consecutive patients following intervention identified 81 patients who had a diagnosis that could affect their driving eligibility, of whom 36 (44.4%) had appropriate documentation of discharge driving advice.

Conclusion Discharge driving advice is relevant to most cardiologist inpatient admissions, and yet was rarely documented. A simple SOP for consultant-led discharge driving advice was developed using PDSA methodology, which was well-received by patients and, following re-audit, demonstrated a lasting improvement in documented advice.

Conflict of Interest None to declare.

93 REAL WORLD PATIENTS WITH AF AND A HEART FAILURE ADMISSION HAVE DOUBLE THE MORTALITY RATE OF THAT SEEN IN THE APAF-CRT MORTALITY TRIAL

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Background Atrioventricular node ablation with cardiac resynchronisation therapy (CRT) reduced mortality and heart failure hospitalisations (HFH) in the APAF CRT mortality trial. They enrolled patients with severely symptomatic AF, HFH in the previous year, and a narrow QRS. However, trial populations are often not representative of the real-world experience. We wanted to know how our real-world patients compare with the APAF trial population?

Methods Hospital records were interrogated for patients admitted with a HFH and AF from April 2018 to December 2019 in a single centre.

Results 303 patients were identified. Mean age 82 ± 9.5, CHA2DS2-VASC score 5 ± 1.6 and Charlson Comorbidity Index (CCI) 6 ± 2.1. When compared with the trial population, real world patients were older (82 y vs 73 y p = <0.0001), had more strokes (18% vs 8% p = 0.01) and more coronary disease (43% vs 30% p = 0.01). They had less paroxysmal atrial fibrillation (30% vs 40% p = 0.04), fewer attempts at catheter ablation (1.3% vs 10% p = <0.0001) and less hypertension (59% vs 73% p = 0.004) (figure 1). Applying the trial inclusion criteria, 122 (40%) patients would have fulfilled the APAF entry criteria (figure 2). 60 of those patients died, which is double that seen in the control arm of the trial (49% vs 23% p=0.006). Median survival from discharge was 211 (204–683) days. A relative risk reduction of 74% in mortality, as seen in the trial, would have resulted in 44 fewer deaths.

Of the 122 patients, 42 (34%) patients had 158 subsequent heart failure hospitalisations, with a median length of stay of 11 days, totalling 2826 bed days. Applying a relative risk reduction in HFH of 23% to our cohort would have resulted in 10 patients not experiencing a further HFH over the 21-month period, saving 89–935 bed days. However, real world patients had more comorbidities. Mean CCI was 7±1.9 and 20% also had severe valve disease. A further 70 (23%) patients had a left bundle branch block >120 ms and 46 (38%) had a device. These patients might also be expected to benefit from an ablate and pace approach but were not included in the trial. Of these, 80 (69%) died and 43 patients had 76 HFH. If the same benefit was seen in these patients, there would be a further 59 fewer deaths and 10 patients not experiencing a further HFH.

Conclusion 40% of all patients admitted with HF and AF to our centre met APAF trial criteria. Almost half of total bed-days were used in patients eligible for trial inclusion (47%). However, real-world patients were older with associated comorbidity and frailty, which could explain the significantly higher mortality rate observed in our cohort. The excluded broad QRS and device patients might also benefit from an ablate and pace approach, particularly as they had an even higher mortality rate (69%) and further studies are needed in these patients. Adopting an ablate and pace strategy in this large patient group will increase the demand on electrophysiology and complex device implant services.

Conflict of Interest Nil

94 CLINICAL RESPONSE TO INCIDENT AF IN A TERTIARY HOSPITAL IS DELAYED AND CONSEQUENTIAL

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Atrial fibrillation (AF) is common in hospitalized patients, occurring in c.10% of unselected inpatients. In a vulnerable hospital patient, the development and persistence of AF can precipitate acute hemodynamic decompensation and result in complications including stroke and heart failure. Early management of AF to anticoagulate, rate control or restore sinus rhythm, and manage underlying precipitants mitigates these