The day my heart skipped a beat

Safe, consistent and effective management of Atrial Fibrillation in the Emergency Department
Objectives

• The problems
• The team
• The interventions
• Results
• Learning
The Patient
The Problem

**AF and stroke risk**

- Increased risk of strokes by up to 5x
- Only half of those who should take OACs are
- 7,000 strokes and 2,000 premature deaths could be avoided with OAC

*Prof Mark Baker. NICE - Director of Clinical Practice*

In SGH ED we see 50 patients per month with new onset AF. Only 35% were being risk stratified for stoke.
The Problem

- SGH ED Admits 65% of patients with New AF
- Ottowa ED admits 3.2% of patients with New AF managed with the ‘Ottowa Aggressive Protocol’
The Problem

Confusing array of management strategies

- NICE Guidance
- ESC Guidance
- AHA Guidance
- Personal opinion
The Team

• Dr Ramamoorthy
  • Credibility within ED

• Dr Yue
  • Cardiology cons
  • Ensures buy in from in the inpatient team

• Me

• Dr Quartermaine, Dr Cartwright.

• Nathan Twinning

• Nichola Howerth
Methodology

Process mapping
Aims

• 90% of patients to be stroke risk stratified/anticoagulated by Oct 2016

• To discharge more than 50% of patients presenting with New AF by Oct 2016
Interventions

1. ED guideline, education, facilitation of safe discharge

2. Pitstop interventions

3. Pharmacy interventions
Intervention

Guideline and Education

- A pragmatic combination of ESC & NICE guidelines

- Locally agreed

- Facilitation of safe discharge and follow up

- Trialled and amended several times

- Inclusion in SHO induction, Nursing teaching, SpR teaching and Senior team meeting.
Intervention

Pit-Stop

- Identify patients with new AF early
- Early review to decide rate vs rhythm
- Early initiation of treatment
- Correct investigations on arrival in ED

AF

NEW ATRIAL FIBRILLATION

RED FLAGS
- HR>110, Shock, Syncope, Chest pain
- Underlying sepsis
- PE

IMMEDIATE MANAGEMENT
- Senior review
  - Clexane 1.5mg/kg
  - Treat underlying cause e.g. Sepsis, PE
  - Rhythm control – move to Resus
  - Rate control – give first dose ASAP

BLOODS
- FBC, U&E, VBG, CRP, LFT, TFT, Mg, Clotting
- Cultures if signs of infection

REMEMBER:
- CXR
- AF Pathway in ‘ED Guidelines’ folder on desktop
Intervention

- Stocking relevant medications in ED:
  - Flecainide
  - Verapamil
  - TTO Bisoprolol
  - TTO Apixaban
Anticoagulated/Risk Stratified for Stroke
4 Hr Target:
AF Patient Breach Rate vs. Departmental Breach Rate

- AF patients
- Departmental
Lessons

• Define an Aim early on that is simple and measurable

• Measures

‘If you can’t measure something, you can’t understand it. If you can’t understand it, you can’t control it. If you can’t control it you can’t improve it’

• Measurable measures essential!
• Understand the limitations of process measures.
• Remember balancing measures.
Lessons

• First follower theory
  • Recruit key people into the team.
  • Target individuals with influence (and ideally permanent contracts!)
  • A project needs initial momentum and then should generate its own energy.
Conclusion

• The management of AF is complex.

• It is possible to change the way AF is managed in ED to provide safe, consistent and effective management.