Table 1

NICE (QS93). Quality Improvement statements on atrial fibrillation[11]

Statement	Authors' comments
1 Adults with non-valvular atrial fibrillation and a CHA_2DS_2-VASc stroke risk score ≥ 2 are offered anticoagulation	Even those with a score of 1 should have the risks and benefits discussed as ESC guidelines encourage treatment in this group. Written protocols required Valvular AF describes those with rheumatic mitral valve stenosis and metallic heart valve replacements. All such patients should be prescribed warfarin
2 Adults with atrial fibrillation are not prescribed aspirin as monotherapy for stroke prevention	Aspirin does not prevent AF-related strokes. In patients with stable, chronic coronary disease (no stent or acute coronary syndrome in past 12 months) aspirin can be stopped if warfarin, apixaban or rivaroxaban started
3 Adults with atrial fibrillation who are prescribed anticoagulation discuss the options with their healthcare professional at least once a year	Patients on NOACs need renal function monitoring. It is important to check time in the therapeutic range for warfarin patients and compliance with those on NOACs
4 Adults with atrial fibrillation taking a vitamin K antagonist who have poor anticoagulation control have their anticoagulation reassessed	NOACs are increasingly becoming the anticoagulant of choice. They are superior to warfarin, particularly if < 65% of INRs are within the desired therapeutic range, with both a lower incidence of ischaemic stroke and intracranial haemorrhage. Other markers of poor control include: 2 INR values > 5, 1 INR value > 8 or 2 INR values < 1.5 within the past 6 months
5 Adults with atrial fibrillation whose treatment fails to control their symptoms are referred for specialised management within 4 weeks	Primarily aimed at alleviating symptoms and avoiding tachycardia cardiomyopathy and heart failure in susceptible individuals
6 Adults with atrial fibrillation on long-term vitamin K antagonist therapy are supported to self-manage with a coagulometer	Enabling patients to self-manage their coagulation using a coagulometer can help to optimise their treatment. As well as reducing the frequency of hospital or clinic visits, it can improve outcomes such as risk of stroke and bleeding. May be less relevant with increasing uptake of NOACs