

**Abstract 146 Table 2** Journey of a patient seen in Ambulatory Care in terms of hours of staff time spent looking after them

Each visit	
Booked in	5 minutes
Seen by Doctor and bloods taken	20 minutes
Furosemide infusion	2 hours
Discharge summary	15 minutes
<b>Total time</b>	<b>2 hours 40minutes</b>

in demonstrating a real-world benefit could be attributed to small numbers of patients and short timeframes to evaluate impact.

The results also help convey an important safety aspect of using the CASI tool showing a 1.9-fold (95% CI: 1.25 - 2.89; p-value=0.007) increase in the number of emergency admissions for heart failure compared to prior to induction of CASI in the registered users (figure 2). This demonstrates an important triage system embedded in the NHS test bed work in being able to not just send patients to ambulatory care but also filter out patients that need more urgent review.

**Conclusion** It is important to appreciate the importance of an ambulatory heart failure service in freeing up NHS beds. Evaluating the NHS Test Bed project over a longer timeframe with large numbers of patients to reach statistical significance will be of vital importance to prepare for the future surges of the COVID-19 pandemic.

**Conflict of Interest** None

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**147 DAILY WEIGHT AND FLUID BALANCE ASSESSMENT IN PATIENTS ADMITTED WITH ACUTE HEART FAILURE**

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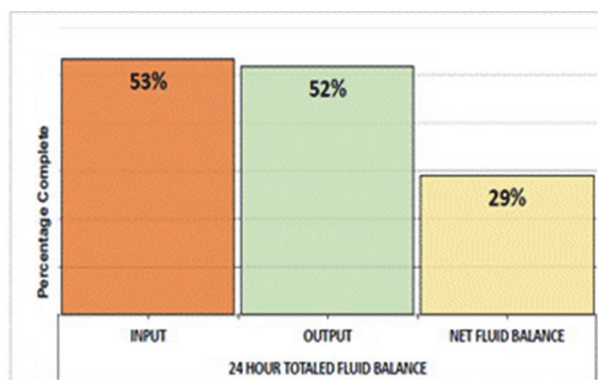
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**Introduction** Associated with high morbidity and mortality, congestive heart failure (CHF) is a common consequence of numerous cardiac diseases. Close monitoring of fluid balance and daily weights in patients admitted with acute heart failure (AHF) plays a crucial role in its management and allows the therapeutic efficacy of diuretic therapy to be maximized. It's recommended by ESC guidelines that patients hospitalized due to acute heart failure should be weighed daily and have an accurate fluid balance chart completed.

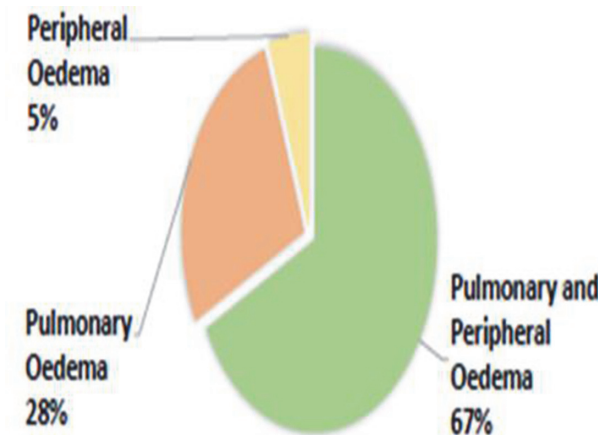
**Purpose** To collect information on the demographic of the patients admitted, type of heart failure and underlying cause. To measure the compliance for daily weight and fluid balance assessment in patients admitted with AHF and receiving IV diuretic therapy.

**Method** Retrospective analysis of data on 94 patients who were admitted over 6 months period to the cardiology ward of a district general hospital with AHF and requiring intravenous diuretic therapy.

**Results** Average age for admissions was 76.5 year old (54% male, 46% female), and average length of admission was 4.9 days. Table 1 shows the number of patients of Heart failure with reduced ejection fraction (HFrEF) or Heart failure with



**Abstract 147 Figure 1** Completion of fluid balance charts (N = 69)



**Abstract 147 Figure 2**

**Abstract 147 Table 1**

	HFrEF or HFmrEF	HFpEF
Ischaemic heart disease	17 (29%)	5 (6%)
Atrial fibrillation	8 (9%)	11 (13%)
Other arrhythmia	0	1 (1%)
Aortic valve disease	5 (6%)	5 (6%)
Mitral valve disease	2 (2%)	1 (1%)
Mixed valve disease	2 (2%)	1 (1%)
Dilated cardiomyopathy	10 (11%)	0
Hypertrophic obstructive Cardiomyopathy	0	1 (1%)
Non-compaction cardiomyopathy	1 (1%)	0
No clear cause	13 (15%)	11 (13%)
<b>Total</b>	<b>58 (67%)</b>	<b>29 (33%)</b>

mid-range ejection fraction (HFmrEF) Vs. Heart failure with preserved ejection fraction (HFpEF) and the underlying cause of heart failure. 42% of patients had a daily weight charts, and weight was recorded for 67% of the cumulative days in hospital. 52% of patients had fluid balance charts, and were totaled on 29% of admission days (figure 1).

There were symptoms and signs of pulmonary oedema in 28% of patients, while 5% of patients had only signs of peripheral oedema, and 67% had symptoms and signs of both pulmonary and peripheral oedema (figure 2).

**Conclusions** Two thirds of patients admitted with AHF and requiring IV diuretics have reduced LV ejection fraction, ischemic heart disease is the most common underlying cause of heart failure among this population. Despite guidelines recommendations, close monitoring of weight and fluid balance in patients hospitalized due to acute heart failure, is not being documented as much as desired.

**Conflict of Interest** None

#### 148 ROLE OF THE DAY CARE UNIT IN THE OPTIMAL MANAGEMENT OF HEART FAILURE PATIENTS

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We set up our ambulatory care unit and heart failure (HF) lounge to improve management of heart failure (HF) patients; reduce A&E attendances and hospital admissions; optimise medicine administration; facilitate discharge from our wards and promote an holistic approach. We kept the lounge running as a 'green' zone through the Covid pandemic in 2020.

**Methods** The programme used a combination of quality improvement and Lean methodology working with staff and patients to create new pathways The service processes were reviewed and referral pathways aligned to support community to specialist referral and redesign of service was completed. The team monitored quality outcomes such as patients access to specialist review, medication review and patient experience of the service, also identifying patterns of attendance and admission pre and post attendance to the lounge.

**Results** The evaluation of the programme, centred on the experience of staff and patients, has shown improved information sharing between primary and secondary care staff; the patients described the care as efficient, enabling them to remain in their own home, with effective continuity of care. In 2020, despite the pandemic, the ACU was kept as a 'green' zone and 521 patients attended; - 87% of patients referred from community services did not have to attend A&E; - 100% of patients received a Specialist Review; - 100% of patients received a full medication review and optimisation; - there was a reduction in A&E attendance following attendance to the lounge of 90%. - There was a reduction in bed days of 310, with a cost reduction of £231,649.

**Conclusion** The ACU Heart lounge has proven that the day case concept can be extremely useful in managing complex chronic disease like heart failure, benefiting patients and service providers, even in circumstances of the continuing Covid19 pandemic.

**Conflict of Interest** None

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#### IMPACT OF COVID-19 PANDEMIC ON GLOBAL CONTRIBUTIONS TO THE EUROPEAN HEART FAILURE CONGRESS: DO WE NEED MORE DIVERSITY?

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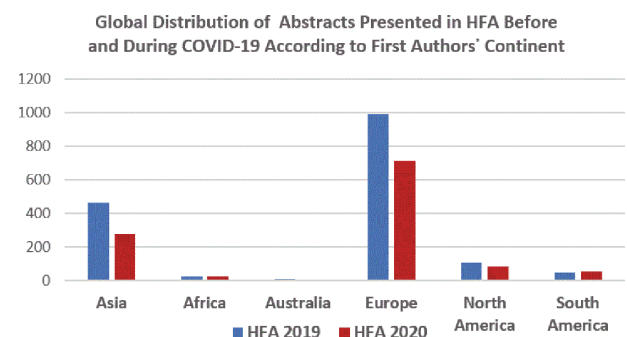
**Background** Highly impact international conferences play a critical role in advancing career, academic thrive and global networking. After COVID-19 era, virtual science contributes remarkably to increase networking and professional collaboration across the globe. Up to our knowledge there is no data regarding global contributions to cardiology conferences in general and how COVID-19 might impact the landscape of these contributions in particular, especially in the context of contributions from low- and middle-income countries (LIC and MIC).

**Purpose** Current analysis aimed to determine the global diversity in abstracts presented at European Heart Failure congress according to the continent and world bank class of the country of the first author.

**Methods** Cross sectional analysis of the European Heart Failure congress abstracts published in the (European Journal of Heart Failure) in 2019 and 2020 which represented the before and during COVID-19 era respectively. The analysis was done according to the continent and world economic classification of the first authors' country.

**Results** Total n. of abstracts analysed were 2779 with 17.6% decline rate during pandemic contributions (1634 in 2019 vs 1145 in 2020). Europe followed by Asia had the highest total abstract contributions; 1701 and 740 abstracts respectively. Europe contributions proportion increased during pandemic (60.52% in 2019 to 62.18% in 2020) while Asia contributions proportion declined during pandemic (28.33% in 2019 vs 24.19% in 2020),  $p=0.03$ , see **figure 1**. Russia had the highest number of contributions (11.68% in 2019 vs 12.22% in 2020), this is followed by Spain (7.34% in 2019 vs 11.35% in 2020) and Portugal (5.87% in 2019 vs 11.44% in 2020). A total of 1899 (68.33%) abstracts were from high-income countries (HIC) vs 880 (31.67%) from MIC and none from LIC in the sum of both years. Contributions from MIC increased during COVID-19 era from 30.23% in 2019 to 33.71% in 2020, while contributions from HIC declined from 69.76% in 2019 to 66.28% during COVID-19 era in 2020,  $p=0.052$ , see **figure 1**.

**Conclusions** About third of contributions to European Heart Failure congress were from MIC and none from LIC, however, there is modest increase of contributions from MIC



Abstract 149 Figure 1