and 94% had access to a private location. 76% of patients reported that they were able to access their appointment without limitations in comparison to in-person consultations, although some reported a decreased personal connection with their physician. Satisfaction scores reflected this positive outlook (90/100 for patients and 75/100 for physicians), although patients reported that they would prefer virtual consultations less than 50% of the time outside the pandemic. Information was collected from patients on what aspects could be improved on the virtual service.

Conclusion and Implications Virtual clinics could be increasingly implemented in modern Cardiology. Telemedicine could provide a high-quality service with reduced cost and increased accessibility, particularly for patients in rural areas. In addition, virtual care at scale could allow in-person visits to be prioritised for patients who would truly benefit from their use, while reducing the risk of transmissible infections including COVID-19 and others.

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INITIAL EXPERIENCE AND VALIDATION OF A NOVEL TOOL TO ASSESS PATIENT EXPERIENCE IN THE CATHETERIZATION LABORATORY (PATCATH) IN PATIENTS UNDERGOING CORONARY ANGIOGRAPHY OR ANGIOPLASTY IN A SINGLE HIGH-VOLUME CENTRE

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Introduction Patient-reported experience metric (PREM) questionnaires are important tools to evaluate the experience of patients in their interaction with healthcare systems but have not been widely used in patients undergoing cardiovascular procedures. Validated PREM tools may identify areas of

Abstract 59 Figure 1 Patient responses

improvement surrounding patient encounters and be useful in assessing response to change over time.

Methods Recently a novel tool was developed by the Patient Initiative Committee of the European Association of Percutaneous Intervention (EAPCI), in association with the European Society of Cardiology Patient Forum, designed to capture patient experience in the catheterization laboratory. The questionnaire is divided into 3 domains assessing experience before, during and after coronary angiography or angioplasty (figure 1, Panels A-C). Responses were recorded on a scale of strongly agree, agree, disagree, or strongly disagree. This tool was administered to consecutive patients undergoing coronary angiography or angioplasty as a day case or an inpatient procedure at a single centre. The questionnaire was administered in an anonymized manner prior to hospital discharge in a pilot study conducted over a defined time period. Age group and gender were voluntarily self-reported.

Results A total of 100 valid responses were received over the study period in November-December 2020. The majority of subjects were male (73%); 5% of subjects were less than 45 years old, 43% were between 45-65 years, 31% were between 66-74 years and 21% were >75 years old. Patient responses indicated a high degree of satisfaction with the experience before the procedure: 98.6% of patients strongly agreed or agreed with statements assessing positive experience, reflecting a level of knowledge of why the procedure was recommended and perceived level of support (figure 1, Panel A). Similarly, patient responses indicated a high degree of satisfaction with the experience during the procedure: 98.5% strongly agreed or agreed with statements assessing positive experience of comfort/safety, communication and understanding (figure 1, Panel B). After the procedure 59.3% strongly agreed or agreed with statements assessing positive experience: with lower levels of positive experience for questions related to understanding regarding lifestyle changes (60%), rehabilitation program participation (46%), medication prescription (58%) and treatment duration (53%) (figure 1, Panel C).

Conclusion The results of our survey indicate that a novel PREM tool designed to evaluate patient experience of coronary angiography or angioplasty, is feasible to administer and is generally well understood by patients. Lower rates of positive response in the questionnaire domain related to experience after the procedure may be related to lower levels of positive experience or deficiencies of the tool in relation to the experience under survey. This should be evaluated by further testing in additional cohorts across multiple sites.

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IS IT WORTH IT? THE IMPACT OF AN ADDITIONAL INPATIENT-DEDICATED ACUTE CATH LAB ON INPATIENT TIME AND COST OF HOSPITALIZATION AT A NATIONAL PPCI CENTRE

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Introduction Modern day catheterisation laboratories must cater both for elective outpatient cases and acute inpatient presentations. With the limited resources of our health

system under significant strain in the setting of a global pandemic, economic factors must invariably be considered in order to provide adequate care to meet the requirements the largest possible proportion of our population. We sought to assess the impact on hospital costs and patient flow of opening a second laboratory (the 'Acute Lab') for acute inpatient cases at University Hospital Limerick, a nationally designated 24/7 primary percutaneous coronary intervention (PPCI) centre.

Methods We carried out a single-centre retrospective analysis of inpatients who underwent procedures in the Acute Lab over a 12-week period from August-November 2020. The Acute Lab was open 3 days per week (Monday/Wednesday/Friday) from 08:00-13:00. Data collection included patient admission routes, wards/locations, referring diagnoses and procedural details, as well as hospital costs and number of admission days pre- and post-procedure [figure 1]. Cost estimates for inpatient stays and various procedures were gathered with input from the hospital finance department.

Results 171 patients underwent procedures in the Acute Lab over our study period (mean of 4.75 cases/day). Mean age was 64.71 ($\pm$ 13.09) years. 101 patients were male. The vast majority of patients were admitted via ED/AMU and were admitted under the cardiology or general medical services. 38.01% of patients were referred with acute coronary syndrome and 66.67% had positive cardiac biomarker (high sensitivity troponin). 21.64% of patients underwent PCI and

Abstract 60 Figure 1 Referring diagnosis

Abstract 60 Figure 2 Procedures