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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10.1136/heartjnl-2021-ICS.60

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

TIME OF DISCHARGES POST-CATH LAB PROCEDURE

Abstract 60 Figure 3 Discharges

12.28% underwent permanent pacemaker implantation [figure 2]. 67.25% of patients were discharged either same-day (33.33%) or one day (33.92%) post-procedure [figure 3]. The additional cost of opening the second cath lab (primarily staffing costs encompassing nursing, physiologist, radiography and cleaning staff) was approximately €1626 per day (08:00-13:00 only), or €342 per patient (based on a mean of 4.75 cases/day). One hospital admission day to a general ward in UHL costs €890, with a CCU admission priced even higher. If each of the 115 patients who were discharged within 24 hours of their procedure needed just one further day of admission, this would cost the hospital an additional €63,020 (over 12 weeks), or €252,080 per annum. If the increased costs of CCU bed days and delays >24 hours were taken into account, this number would be expected to be higher again. The actual cost of each procedure was not included in this cost analysis as these fixed costs would be required irrespective of when the procedure was actually carried out.

Conclusions The opening of a second cath lab in our tertiary centre helped to improve patient flow, reduce waiting times for procedures, reduce admission lengths and reduce cost to the hospital. These are all important factors as our health service struggles to come to terms with the economic and organisational impact of the COVID-19 pandemic.

61 TO DETERMINE THE CHANGE IN EXERTIONAL CAPACITY WHILE WEARING A VARIABLE NUMBER OF SURGICAL FACE MASKS WHILE UNDERGOING AN EXERCISE TOLERANCE TEST

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10.1136/heartjnl-2021-ICS.61

Introduction In August 2020 HIQA published a review on the community wearing of facemasks as a preventative measure against Covid-19. WHO reports that studies involving exercise and wearing of facemasks suggested limited detrimental effects to healthy persons, however there is some concern for those with respiratory disorders, thus recommending 'people should not wear masks during vigorous intensity physical activity because masks may reduce the ability to breathe comfortably'. Ireland has followed this guidance introducing social distancing and ventilation measures in exercise arenas. In contrast, guidance given by the CDC in USA advises wearing of a face-mask in the gym at all times. Shaw et al., reported no effect

of various types of facemasks on performance (incl. perceived exertion) using a cycle ergometer. Another study reports athletes presenting with 'hypoxic and hypercapnic breathing'.

Aim To analyse if varying thicknesses of surgical masks (one, three or five-thick) would alter the exertional capacity of fit healthy participants while performing an exercise tolerance test.

Methods Ethical approval was granted by the UCC's Clinical Research Committee. Healthy fit male participants were recruited via convenience sampling, a poster advertisement was placed on Mercy University Hospital noticeboard. Six suitable participants were accepted in order of contact made with the researcher. Those with confirmed/suspected COVID-19 in the previous 14 days of first test were excluded. The primary outcome was to reject the null hypothesis that 'there is no difference between exertional capacity and varying mask thickness'. Secondary outcomes included SpO2 measurements throughout exercise. The same Cardiac GE treadmill was used for each fitness test and data was obtained from this system and recorded manually on charts, data was anonymised. Statistical analysis using an ANOVA test was carried out with SPSS software. A P-value of <0.05 was accepted as statistically significant. Mean and standard deviation of each of the participants maximum exertional capacity was calculated for the three different mask thickness types. This was single-blinded to the participant, with the surgical mask

Abstract 61 Figure 1 Time to maximum exertion of each participant when exercising with one, three or five masks