often daily weights are documented in AHF inpatients. We also wanted to explore whether prescribing daily weights is associated with higher documentation rates. Method: A retrospective analysis of 55 inpatients referred to the AHF specialist team between 1st November and 31st December 2021 was performed. Patients were required to fit stringent inclusion and exclusion criteria. For each patient, we recorded the total length of stay in days and the number of daily weights documented. As part of the secondary analysis, we hypothesised that patients with ‘daily weights’ written on the drug chart would have higher documentation rates. Therefore, we also recorded if patients had ‘daily weights’ or similar prescribed. Documentation rates were compared, between patients prescribed daily weights on the drug chart and those who were not, with an unpaired T-test. Results: There were 32 patients who met our criteria. On average, weights were recorded only 46% of admission days [Figure 1]. Prescribing ‘daily weights’ was associated with significantly higher documentation rates (83% vs 46%, p<0.05), however only 25% of patients had these prescribed [Figure 2]. Daily weights may not always be prioritised in busy departments, can be missed in handovers and when patients are moved downstream. Prescribing ‘daily weights’ acts as an automated reminder to healthcare staff to measure and monitor this parameter, with the added benefit of allowing easy comparison of diuretic dose and effect.

Conclusion: This audit highlights the problem of inconsistent measurement and recording of daily weights. There is large scope for improving this and we have identified a novel method for addressing this. These findings will form the basis of our quality improvement project.

Conflict of Interest: None

134 UTILISATION OF SODIUM GLUCOSE TRANSPORT PROTEIN 2 (SGLT2) INHIBITOR IN PATIENTS WITH CARDIAC RESYNCHRONISATION THERAPY (CRT) DEVICE: A UK DISTRICT GENERAL HOSPITAL PERSPECTIVE

Ronald Manorekang, Nathan Price, Iyad Ahmed, Chris Hayes. The York and Scarborough Teaching Hospitals NHS Foundation Trust, Wigginton Road, York, YO31 8HE, United Kingdom; York and Scarborough teaching hospitals NHS foundations trust

Introduction: SGLT2 inhibitors are proven to reduce mortality and hospitalisation in heart failure patients. Dapagliflozin is the first one to be approved in the UK in February 2021 for its use in patients with heart failure. Empagliflozin is currently being reviewed to be added on the list. In local clinical practice, we rarely see patients being prescribed this medication despite its known advantages. Method: We reviewed our cohort

Abstract 133 Table 1

<table>
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<th>Type</th>
<th>SGLT2i</th>
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<th>CRTD</th>
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Chi-Squared Tests

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<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>6.315</td>
<td>1</td>
<td>0.012</td>
</tr>
</tbody>
</table>

Abstract 133 Figure 1

How often were daily weights recorded?

- Measured, 46%
- Not measured, 54%

Abstract 133 Figure 2

Does prescribing “daily weights” improve documentation?

- How often patient weighed during admission (100% = every day, 0% - not once)
- How often were daily weights recorded (n=32)
of patients with CRT device who are still known to our local cardiac physiologist team, whether they are taking SGLT2 inhibitors as per January 2022.

**Results** There are 330 patients on our bi-ventricular pacing cohort. More patients are documented to have CRT-D (n=217, 66%) than CRT-P (n=113, 34%). Average age for CRT-D patients is younger (74±9) compared to CRT-P (80±11). There are 283 patients (74%) who are still in active follow up. Of these, 21 (7%) patients are currently taking SGLT2 inhibitor. More patients are being prescribed SGLT2 inhibitor on the CRT-D group (n=19, 6.7%) compared to just 2 patients (0.7%) on the CRT-P cohort (p = 0.01). Majority of patients (n=17) are on dapagliflozin in contrast to empagliflozin (n=3).

**Conclusion** One year after SGLT2 inhibitor approval to be used in the UK, its utilisation in our cohort is still low, especially in those with CRT-P device.

**Conflict of Interest** None

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**Abstract 135**

**ARE WE AVOIDING THE AMERICAN HEART ASSOCIATION LIST OF MEDICATIONS WHICH CAN CAUSE OR WORSEN HEART FAILURE? A RETROSPECTIVE ANALYSIS ON ACUTE HEART FAILURE ADMISSIONS**

Theofanis Nizamis, Emma Langan, Akhlaque Uddin. Chesterfield Royal Hospital NHS Foundation Trust, Calow, Chesterfield, Derbyshire, Chesterfield, DBY 545BL, United Kingdom; Nottingham University Hospitals NHS Trust

Background and Introduction Heart failure is a complex clinical syndrome in which the heart fails to meet the metabolic demands of the body. It is multifactorial in aetiology and its burden - health, social and economic, is increasing. The multifactorial aetiology of heart failure consists also of medications that can either provoke it or worsen it. The American Heart Association (AHA) has published a list of such medications divided into different categories, based on their action.

**Purpose** The AHA medications list is lengthy and the impact of these medications on heart failure is not yet fully understood. Nevertheless, its existence and significance are still unknown to a high proportion of the medical community. We aim to raise awareness about medications that can cause or worsen heart failure syndrome and their potential but also to highlight the need to ensure that the patients have been prescribed the prognostic HF drugs.

**Methods** 110 patients admitted with a primary diagnosis of heart failure in Nottingham University Hospitals in February 2020, had their electronic records reviewed retrospectively. We assessed the following parameters: Age, Sex, Background, whether the heart failure decompensation was new or old, the length of stay, AHA medications on admission and discharge, prognostic medications on discharge, and several blood results such as Hb, BNP, creatinine, MCV. We performed statistic evaluations on the above parameters.

**Results** The patients’ average age was 78.5 years (SD: +/- 13) and the average stay in hospital was 10 days (SD: +/- 9). 57% were female (n=62 patients) and 43% male (n=48 patients). More than half of these patients (55%) had hypertension and 41% had ischemic heart disease. It is noteworthy that from the total cases 70% were decompensation of known heart failure and 30% were new diagnoses of HF. The percentage of the patients on AHA list drugs on admission was 37% and 32% were still discharged on AHA drugs. 79% of the patients were discharged on prognostic medications. 21% were not discharged on any prognostic medications, 34% were discharged on either b-blocker, ACEI or ARB only and 45% were discharged on full prognostic regimes such as ACEIs/ARBs, MRAs+ b-blocker. 15 patients were excluded due to death, multiple intolerances, HFpEF and fast-track discharges. 37% of the patients did not have their BNP checked. The mean Hb and MCV were 122 and 92 respectively.

**Conclusion** The vast majority of the heart failure admissions were due to decompensation, so this is an opportunity to focus on how to prevent readmissions, by optimizing the medical management and arranging outpatient follow-up appointments for symptoms monitoring. Furthermore, over 1/3 of the patients were admitted on AHA drugs and still, 32% of these patients were discharged on them. Awareness should be raised about those medications and we should grow a culture of medical optimisation. For instance, an automatically generated alert when completing electronic discharge letters about AHA drugs will prevent discharges on these medications. Nevertheless, it should be highlighted that the BNP check is very important in assessing the severity of the patients’ presentation, which will guide further management. We have now introduced the Heart Failure 5 bundle to promote optimal management of heart failure patients, using keywords, so that they can be easily retained by the medical team. This bundle also endorses a holistic approach, aiming to take into account all the parameters which will lead to the provision of excellent care.

**Conflict of Interest** None