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