This CPS has been endorsed for use by WACHS and is to be applied to the WACHS clinical practice context until it is transitioned completely to a WACHS CPS.

Purpose

To establish minimum practice standards for Chest Pain and Acute Coronary Syndrome (ACS) Management of the adult hospitalised patient throughout WA Country Health Service (WACHS). This Clinical Practice Standard (CPS) is to be used in conjunction with specific site instructions / requirements.

Further information relating to specialty areas including Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WNHS) and Mental Health Services can be found via healthpoint.hdwa.health.wa.gov.au.

Scope

All medical, nursing, midwifery and allied health staff employed within SMHS and WACHS. All health care professionals to work within their scope of practice appropriate to their level of training and responsibility. Further information can be found via healthpoint.hdwa.health.gov.au.

Mandatory Requirements specific to this CPS

Refer to the Guidelines for the Management of Acute Coronary Syndromes
Heart Foundation Website: www.heartfoundation.org.au

Operational Directive (OD)/ Information Circular (IC) Search: www.health.wa.gov.au

1. Consideration of the patients' pre morbid conditions and any local factors that may affect the assessment must be completed and documented. Ascertain pre-hospital treatments given to patient and document.
2. All patients with chest pain will be assessed at presentation to the Emergency Department (ED) or as an inpatient.
3. On initial presentation to the ED, the patient is to have a nursing triage score of 1 or 2 by a triage competent Nurse, and be cardiac monitored as per the National Australasian Triage Scale on assessment.
4. Staff will implement the required interventions, re-assess and document the patient's condition at intervals determined by the Medical Officer (MO), based upon their clinical status.
5. MO and shift coordinator are to be promptly informed of all patients with chest pain and any changes in their condition.
6. Resuscitation equipment to be available in areas as per site based policies.
7. A 12 lead ECG to be performed at onset of each episode of chest pain/ischaemic symptom(s) and repeat as clinically appropriate or as directed by MO or Nurse Practitioner (NP).

8. MO to review ECG within 10 minutes (as practicable) (Only Doctors of registrar or consultant level may sign ECGs). Rural and remote WACHS sites should seek early consultation with tertiary level service for interpretation and advice on ECGs.
9. Oxygen therapy should only be used if the patient is hypoxic and should be titrated to the lowest concentration that meets the oxygenation goals. This should be an oxygen saturation of 88-92% for patients with or at risk of hypercapnoeic respiratory failure and 94 – 98% for all other patients. In patients receiving ongoing oxygen therapy this should be appropriately prescribed by the MO.
10. Refer to site specific transport policies for transfer of patients if required.
11. Nursing staff may administer Intravenous (IV) sodium chloride 0.9% (5-30mL) without prescription to maintain venous access patency and flushing, prior to and post prescribed medication. Consider compatible diluents if required.
12. If patient high risk non ST elevation acute coronary syndrome (NSTEACS), prepare for Coronary Care Transfer (CCT), Coronary Care Unit (CCU) or appropriate site specific department admission as requested by ED/CCU physician. On transfer patient must be attached to a defibrillator, have O2, suction, air viva and resuscitation medications available (transport box). Transfers do not need a doctor and / or nurse, as paramedics have the required skills for most inter hospital transfers. In WACHS regional areas where ambulances are operated by volunteers, a doctor and/or nurse escort will be required.

General Information

Acute Coronary Syndromes (ACS) is used to collectively describe acute myocardial infarction (heart attack) and unstable angina (chest pain occurring at rest as a new onset of pain with exertion, or angina that is more frequent, longer in duration or lower in threshold than before) [1].

- Acute myocardial infarction occurs when an atherosclerotic plaque ruptures, triggering a complex cascade of events that result in thrombi partially or completely occluding the coronary vasculature, compromised coronary blood flow and subsequent injury and/or death of myocardial tissue [2].
- Angina occurs when a plaque or blood clot results in narrowing of the blood vessel. This may happen as a precursor to a myocardial infarction or remain stable for a long time [1].

Acute Coronary Syndrome (ACS) includes patients with unstable angina, Non ST Segment Elevation Acute Coronary Syndrome (NSTEACS) to ST Segment Elevation Myocardial Infarction (STEMI).

Recognition

• Pain or discomfort • Dyspnoea (shortness of breath) • Weakness • Nausea or Vomiting	• Palpitations • Syncope (loss of consciousness) • Light headedness • Cardiac arrest [3]

Equipment Required

- Choice of equipment must be appropriate for the age and/or size of the patient
- Equipment must be serviced and calibrated in accordance with manufacturer's recommendations to ensure reliability and accuracy
- Site Specific Forms

• Electrocardiograph Monitor (ECG)	• Cardiac Monitor
• Sphygmomanometer	• Oxygen Saturation Monitor

Staffing Requirements

- Staff are required to maintain the minimum level of competency that is required for their role.
- Staffing levels to be undertaken safely and are appropriate for the clinical condition of the patient.

Patient Monitoring

Individualised management plan to be documented in the patients' health records as soon as is practicable. At a minimum the plan must consider:

- Diagnosis
- Presence of comorbidities and treatment
- Protocol requirements
- Any restriction to intervention associated with advanced health directives (AHD) or the like

Procedural Guideline

Key points prior to commencing any procedure

- Consider cultural, ethical and communication requirements
- Explain the procedure/s to the patient, family and/or carer and gain appropriate consent
- Ensure choice of equipment is appropriate for the age, size and condition of the patient
- Review patient history and diagnosis for clinical conditions, medications and psychosocial factors that could influence observations
- Refer to previous observation parameters if available for comparison
- Maintain standard safety precautions for infection control

Assessment of Acute Coronary Syndrome

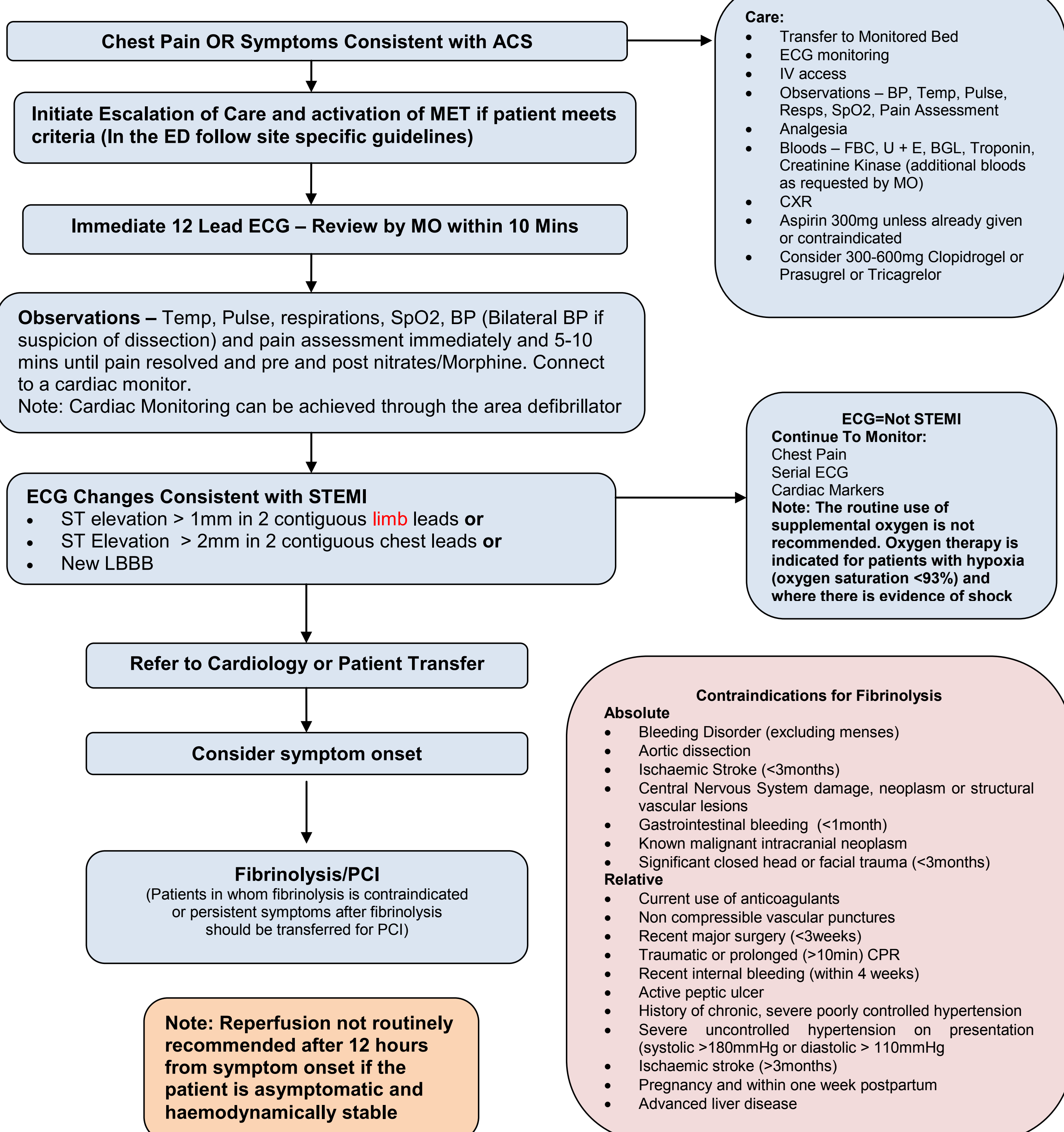
All patients complaining of chest pain/discomfort should be suspected of having ACS until proven otherwise.

Rapid assessment and management is required to ensure optimum outcomes and pathways assist in determining if a patient is High, Intermediate or Low Risk. The following is to be completed within 10 minutes in accordance with the Australian College of Emergency Medicine (ACEM) guidelines and Heart Foundation Guidelines for the Management of Acute Coronary Syndromes [4 1 5].

Refer to Appendix 1 – Acronyms used in this CPS

Initiate Escalation of Care Process and activation of WACHS Clinical Escalation of Acute Physiological Deterioration Including Medical Emergency Response Policy if patient meets criteria (in the Emergency Department follow site specific guidelines)

Acute Coronary Syndrome (ACS) Assessment/Treatment Algorithm[6]



Note: Some medications and blood tests recommended may not be available in smaller WACHS sites.

Troponin Assessment and Time Pathway[6]

Re – Evaluate and Risk Stratify

- Clinical History
- Examination
- ECG
- CXR
- Investigations to diagnose cause
- Evaluate clinical likelihood of ACS

↓

Test all patients with sensitive Troponin assay (coefficient of variation ≤ 10% at decision limit). Clinicians need to be aware that assays may differ between sites and therefore should be familiar with the cut off and characteristics of the particular assay at the given site.

↓

At Presentation

- **Negative (<99th percentile)** → **3 hours after presentation and > 6 hours after the onset of symptoms**: Repeat Troponin
  - **Negative** → **MI unlikely**
  - **Positive >99th percentile or > 50% increase** → **MI likely**
- **Positive (>99th percentile)** → **6 hours after presentation**: **Repeat troponin to evaluate cause of troponin elevation**
  - **Significant change to troponin level** → **MI likely**
  - **No change to troponin level** → **Not early MI**

MI unlikely :

- uneventful observation period
- Continuous cardiac monitoring for 6 hours post pain
- MO to consider further functional or anatomical testing for coronary artery disease based upon clinical features and risk factors

MI likely:

- Refer to Cardiology Immediately
- Start Aggressive Medical Management
- Admit/transfer to appropriate site specific department as applicable
- Refer for Angiography
- PCI or CABG

Not early MI:

- Consider late MI or other cause of chronic troponin elevation e.g. sepsis pulmonary embolus. Clinical management to be directed at other evident conditions
- Consider patient transfer to tertiary site if applicable

High-Risk NSTEACS

- Repetitive or prolonged (>10 mins) ongoing chest pain
- Elevation of at least 1 cardiac biomarker (troponin)
- Persistent or dynamic ST depression >0.5mm or new T wave inversion >2mm
- Transient ST segment elevation (>0.5mm) in more than 2 contiguous leads
- Haemodynamic compromise: systolic blood pressure <90mmHg, cool peripheries, diaphoresis, killip class >1 and or new onset mitral regurgitation
- Sustained ventricular tachycardia
- Syncope
- LV systolic dysfunction (EF <40%)
- Prior PCI within 6 months or prior CABG surgery
- Presence of known diabetes (with typical symptoms of ACS)
- Chronic kidney disease – GFR <60 mL/min (with typical symptoms of ACS)

Intermediate Risk NSTEACS

Presentation with clinical features consistent with ACS and any of:

- Chest Pain or discomfort within the past 48hrs that occurred at rest or was repetitive or prolonged (but currently resolved)
- Age > 65 years
- Known CHD: Prior MI with LVEF > 40% or known coronary lesion > 50% stenosed
- No high risk ECG changes
- Two or more of known hypertension, family history, active smoking or hyperlipidemia
- Presence of known diabetes (with atypical symptoms of ACS)
- Prior aspirin use **AND NOT** meeting the criteria for high risk NSTEACS

Low-risk NSTEACS

Presentation with clinical features consistent with ACS without intermediate or high risk features e.g.:

- Onset of angina symptoms within the last month **or**
- Worsening in severity or frequency of angina **or**
- Lowering in angina threshold

12 Lead Electrocardiograph (ECG)

Aim to perform 12 Lead ECG within 5 - 10 minutes of onset of chest pain or at the earliest possible opportunity after first contact with a healthcare practitioner as a patient may require to go to the Cardiac Catheter Lab for treatment [7]. The ECG is a crucial component of risk assessment and planning of treatment as it differentiates between the types of ACS. Patients presenting with NSTEACS are subsequently diagnosed as either unstable angina or non ST elevation myocardial infarction (NSTEMI).

The 12 Lead ECG along with patient history, examination and cardiac enzyme biomarkers e.g. cardiac specific troponin (released when the myocardium sustains injury), provides information about the site and extent of myocardial ischaemia or damage. Identification of patients with STEMI is essential in determining whether the patient may need emergency reperfusion, either:

- Thrombolytic therapy, to dissolve the occluding thrombus or
- Percutaneous Coronary Intervention (PCI) to open a blocked coronary artery [2 8].

If delivered within the first few hours after onset of chest pain, reperfusion therapy can provide reduction in necrosis of cardiac tissue (myonecrosis), which in turn significantly improves prognosis [1]. Individuals with NSTEACS do not require emergency reperfusion but risk must be assessed to determine the most appropriate treatment and its timing [4 1].

Document on ECG:

- If chest pain present
- Pain Score (1-10)
- Date and Time (Check automatic print out is correct)
- Label ECG or type information into ECG (for electronic storage if available to site) including:
  - Patient name, date of birth +/- unit medical record number (UMRN)

Ensure:

- ECG reviewed and signed within 10 minutes (as practicable) by senior MO. After hours, some sites may not have a senior MO and in these instances a MO at the site may review. Rural and remote WACHS sites should seek early consultation with tertiary level service for interpretation and advice on ECGs.
- ECG transmitted/faxed if no MO on duty as appropriate to area/site.
- Consideration to perform V4 ® if inferior changes observed on 12 lead ECG.
- Reassure and explain all aspects of care to the patient.

Pain

Immediately report tearing, crushing or ripping type pain to the MO or NP

Consider if the pain is:

- Continuous and/or very prolonged [8]
- Sharp, dull, stabbing, crushing, heavy, burning [4]
- Unrelated to activity [8]
- Reproduced on deep inspiration or coughing [4 8]
- Associated with symptoms e.g. dizziness, palpitations, tingling or difficulty swallowing [4]
- Increased with changes in position
- Reproduced with chest wall palpation
- Associated with dyspnea, cyanosis, nausea and diaphoresis
- Associated with precipitating factors e.g. anxiety, food, physical or emotional exertion, change in haemodynamic parameters e.g. atrial fibrillation. Determine if any treatments or other factors changed the level of pain. A history of physical or emotional stress before symptom onset increases likelihood of an ACS. Factors which increase myocardial oxygen demand can precipitate ischaemic chest pain.

Severe pain of any source may provoke some of the clinical signs such as sweating, pallor and tachycardia which commonly accompany ACS [4]. In some cases the patient cannot qualify the nature of the discomfort but places his or her fist in the centre of the chest (the 'Levine Sign'). Compare to previous episodes/history of chest pain (if appropriate).

Ascertain and document the time that pain commenced and duration of pain. Duration of pain is important in determining the risk stratification for the patient involved. Prolonged or unrelieved chest pain may be indicative of a myocardial infarction rather than unstable angina. Score pain using the numerical rating scale between 0-10 (0 = pain free, 10= worst pain possible) where possible or consider using alternative tool. This will enable continuity of pain evaluation and facilitates clinical decision making.

Differential Diagnosis of Chest Pain

• Aortic dissection (e.g. tearing pain) • Endocarditis • Pericarditis • Muscle skeletal disease • Pneumothorax • Pancreatitis • Oesophageal Rupture (Boerhaave's Disease)	• Gastric Oesophageal Reflux Disease • Pulmonary embolus • Shingles • Bronchitis or pneumonia • Anxiety, panic or stress • Cholecystitis [9]

L.O.C.A.T.E.

Assess nature and location of suspected or confirmed ACS chest pain using the L.O.C.A.T.E. criteria. Assess for the most life threatening cause before considering conditions with less risk.

Location	• Exact location e.g. chest, neck, back or arm • Does the pain radiate and if so where? • Use anatomical landmarks to describe the exact location e.g. 5th intercostal space mid clavicular line
Onset and Duration	• What was the exact time of the chest pain onset? • Was it gradual or acute? • When does it occur? • What was the patient doing at the time? • How long did it last? • Does it change or move? • Does it increase or decrease in intensity?
Character	• Ask the character of the pain. Note they may need help with descriptive words e.g. sharp, stabbing, dull, aching, burning, pressure, heaviness, tightness, cramping • Document the patients pain score (0-10) both now and also when the pain started
Associated Symptoms	• Ask and observe for symptoms e.g. nausea, vomiting, sweating, dizziness, oedema, shortness of breath, palpitations, fatigue. • Check for symptoms of muscular-skeletal pain • Check for vague symptoms, especially in females such as sleep pattern changes
Treatment	What has the patient tried to do to relieve the pain both now and in the past? E.g. • GTN spray/tablets • Antacids, H2 antagonist • Rest, stopped activity • Stretching/meditation/relaxation exercise • Breathing techniques • Heat or ice pack Did it work?
Eliminate /Aggravate	• What eliminates the pain? E.g. Rest, medication, stopping the activity or any of the previous treatments (above) • What aggravates or instigates the pain? E.g. Movement, deep respirations or coughing, eating • Does food alleviate or aggravate the pain? • Is the pain changed by leaning forward?

Physiological Observations

Perform and document physiological observations-bilateral blood pressure, temperature, oxygen saturations, bilateral peripheral pulses, respirations, peripheral perfusion, capillary refill and presence of peripheral oedema.

- Perform bilateral manual blood pressure, initially and with changes in the nature of the chest pain.
- A difference between right and left systolic blood pressure of > 20mmHg to be reported to MO. Asymmetry of blood pressures may indicate aortic dissection.

Imaging Technique

Computerised Tomography (CT) angiography, Medical Resonance Imaging (MRI) or nuclear cardiography to be considered by MO as they may provide valuable short and long term prognostic information about the incidence of future major cardiac events [7]. CT Aortagram may be performed to rule out aortic dissection.

Management of ACS Chest Pain

Note: Some medications and blood tests recommended may not be available in smaller WACHS sites.

Oxygen Therapy

Hyperoxia is known to cause coronary vasoconstriction and may reduce coronary blood flow. In the absence of hypoxia, the benefit of oxygen therapy is uncertain and in some cases oxygen therapy may be harmful [10].

Oxygen therapy should only be used if the patient is hypoxic and should be titrated to the lowest concentration that meets the oxygenation goals. This should be an oxygen saturation of 88-92% for patients with or at risk of hypercapnoeic respiratory failure and 94 – 98% for all other patients. Patients commenced on acute oxygen therapy should be assessed promptly, carefully and regularly.

- Once patient stable, oxygen is to be reviewed and prescribed on site specific documentation by MO.
- Nursing Staff to ensure that all nurse initiated supplemental oxygen is documented in the patient's notes.

Biochemistry and Intravenous Cannula Insertion

Nursing Staff to liaise with MO/NP regarding Intravenous Cannula insertion and Biochemistry.
Suggested Biochemistry:

- Full Blood Count (FBC).
- Urea and Electrolytes (U+Es).

- Blood Glucose Level (BGL).
- Cardiac Enzymes (CE)*, Troponin- I or T are very sensitive and specific for myocardial injury, as well as predictive of short term risk for myocardial infarction or death.
- Creatinine Kinase. Can be used to indicate the level of damage and when to ambulate patient post cardiac event.
- Magnesium. Level may indicate the need for replacement to prevent the occurrence of arrhythmias.

If clinically required, additional bloods may include: Liver Function Test (LFT), CRP, INR, Serum Lipid Level etc, as requested by MO.
[2,8 9,11]

Common Pharmacological Interventions in the Management of ACS Chest Pain

- All medications to be prescribed by MO prior to administration.

Medications may include:

Nitrate Therapy

Beneficial haemodynamic effects of GTN include improved myocardial oxygen delivery and reduction in myocardial oxygen demand. Therapeutic effect is apparent within 1-2 minutes of IV administration [12 13]. Caution in patients with aortic stenosis or high sensitivity to this drug.

- Glyceryl Trinitrate (GTN) IV, oral, sub lingual or transdermal.
- GTN can have a hypotensive effect due to vasodilation. Consult with MO if patients systolic blood pressure (BP) falls >20mmHg below pre infusion BP and or a fall of systolic BP below 90mmHg.

Anti-Platelet Therapy

- Aspirin is recommended early (if not contraindicated) as an anti-platelet agent to reduce mortality in acute myocardial infarction and prevent re-infarction.
- Clopidogrel (platelet aggregation inhibitor) has been shown to reduce the incidence of recurrent ischaemic event post Myocardial Infarction [12 13].

Anti–thrombin Therapy

- IV or subcutaneous unfractionated Heparin (UFH) or low molecular weight heparin (LMWH). However, in all situations these agents should not be switched from LMWH or vice versa, as this has been shown to have an increased bleeding risk [14 12 13].
- In patient with ongoing chest pain with NSTEMI may be commenced on IV Tirofiban (glycoprotein IIb/IIIa). In patients on IV Heparin observe for signs of Heparin Induced Thrombocytopenia (HITs), which is usually indicated with a low platelet count. This does not always occur at the beginning of commencing an infusion and may be seen 2-3 days later.

Beta Blocker Therapy

- Current evidence does not advise the routine use of IV beta blockers in the pre hospital or during initial assessment in the ED [13]. However, with severe hypertension or tachycardia when no contraindications exist it may be useful in specific settings [13]. Caution in severe asthmatic and in patients with inferior MI as they are prone to second and third degree blocks.

Opioid Analgesia

Administer in titrated doses to control symptoms but avoid sedation and respiratory depression [12] [13]. E.g. Morphine sulphate (or Fentanyl).

ACE Inhibitors

- Current evidence suggests ACE inhibitors and angiotensin receptor blocker agents reduce mortality in patients with acute myocardial infarction. However, this does not extend to support the routine initiation of these in the pre hospital or ED setting [13].

Lipid Lowering Therapy

- Statins should be considered early after the onset of ACS unless contraindicated [13].

Frequency of Observations

Nursing Staff to:

- Continue patient observations (BP, HR, pain score, SpO2) and record them:
  - 5-10 minutely if the patient has pain, until the pain is resolved.
  - 30 minutely if no pain, until the 6 hour Troponin T result is known.
  - Hourly after the 6 hour Troponin T result is negative. If positive continue 30 minutely until the next troponin or until a definitive plan or change in treatment indicating otherwise.
  - 5-10 minutely if any change in condition or after last administration of narcotics/ vasodilators. If the patient condition and observations are stable then perform physiological observations again 30 minutes later.
  - As advised by MO/NP.
- Ensure continuous cardiac monitoring where available as advised by MO or as clinically indicated.
- Repeat ECG if at any time the patient complains of pain. 12 lead ECG to be repeated 10/60 with ongoing chest pain [11].
- **Monitor, reassure, treat** and **evaluate** treatment until chest pain is relieved and as clinically indicated.
- Liaise with MO/NP regarding plan of care, monitoring plan and ongoing treatment.
- Perform 12 lead ECG once pain has resolved, to ensure resolution of any changes [11].
- Provide reassurance and rationale for all care provided as informing patient of care may reduce anxiety and therefore reduces the workload on the heart.
- Ensure call bell is within patient reach.

Ask patient to:

- Remain resting in bed.
- Inform Nursing staff immediately of any chest pain or other symptoms e.g. heaviness, pressure, arm pain etc.

MO to determine appropriate treatments e.g. emergency primary PCI, thrombolytic therapy and or medical management so as to relieve symptoms, limit myocardial damage and reduce the risk of cardiac arrest.

Ensure that the patient rests in bed/trolley. Patients may prefer to sit up as in some instances lying flat may provoke or worsen the pain [12].

Should the patient complain of recurrent pain, the **Nurse** will:

- Immediately inform the MO and Shift Coordinator.
- Perform a 12 lead ECG and repeat when the patient becomes pain free.
- Obtain and record physiological observations.
- Document all care in the patient notes.
- Patients who are hypotensive and / or tachycardic at any stage should be immediately. reported to the Senior MO.

To rapidly assess eligibility for reperfusion strategy the **MO** to be informed if:

- Reported chest pain is not relieved 10/60 after treatment administered.
- If the pain increases in severity.
- A change in clinical condition/pain presentation.

Post ACS Management

Patient Education

- Explain nature of illness and ways to reduce further incidents e.g. Advice on lifestyle changes to reduce the risk of further coronary heart disease events.
- Educate patient regarding pharmacological therapies and the effects of medications used to manage ACS.
- How to manage ACS and when to seek further advice.
- Information pamphlets related to ACS.
- Discuss follow up with General Practitioner. Ensure discharge summary with reconciled medication list is accurate.
- Ensure referral to cardiac rehabilitation program where available e.g. Cardiac Coaching patients on Achieving Cardiovascular Health **(COACH)**. Education, counseling and psychological interventions in addition to exercise training, improve a patients sense of wellbeing. Refer to the Heart Foundation Website: www.heartfoundation.org.au.
- MO to communicate planned management and ongoing care of the patient as relevant.

Documentation

Failure to accurately and legibly record, and understand what is recorded, in patient health records contribute to a decrease in the quality and safety of patient care.

Refer to WACHS Documentation Clinical Practice Standard.

Document all findings in the site specific forms and patient notes:

- Clinical assessment of patient
- Investigations and interventions
- Responses to interventions
- Actions initiated for medical review of patient
- Pharmacological management
- Pain treatment outcomes
- Information on patient education provided

Clinical Handover

Clinical Handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to any person or professional group on a temporary or permanent basis.

Information exchange should adhere to the WA Health Clinical Handover Policy. iSoBAR is the minimum data set that must be used in all clinical handovers initiated by WA Department of Health employees [15].

Compliance Monitoring

Compliance with this CPS must be monitored and reported to relevant site governance committees. Evaluation, audit and feedback processes must be in place to monitor compliance. Audits should occur as part of the sites organisational audit program or through quality improvement activities in individual clinical areas.

A standardised audit tool should be used throughout the organisation so that data can be collated centrally. Data obtained from auditing and evaluating service should be communicated to the clinical workforce.

Compliance can be monitored by auditing documentation and process, reviewing trends though the Clinical Incident Management Systems and investigations as required such as Root Cause Analysis [16].

Appendix 1 Acronyms

ACS	Acute Coronary Syndrome
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CCU	Coronary Care Unit
CHD	Coronary Heart Disease
ECG	Electrocardiogram
ICU	Intensive Care Unit
LBBB	Left Bundle Branch Block
MI	Myocardial Infarction
NSTEACS	non ST elevation acute coronary syndrome
NSTEMI	non ST elevation myocardial infarction
PCI	Percutaneous Coronary Intervention
STEMI	ST segment elevation myocardial infarction

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Armadale Health Service, (AHS), Emergency Department Clinical Guidelines, Chest Pain/ACS Guideline, 2011
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Fremantle Hospital and Health Service (FHHS), Chest Pain Assessment Service, 2012
King, B - Cardiology Senior Registrar (SR), FHHS

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Wilson, K - SQuIRE AMI Project Team, FHHS

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SQuIRe AMI Project Team, Endorsed – Cardiovascular Medicine and Emergency Medicine, FHHS

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Fremantle Hospital Cardiologist, Endorsed – Nursing Practice Committee, FHHS
Lukins, N - SQuIRE AMI Project Team, FHHS

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Hendriks, R - Head of Department Cardiovascular Department, FHHS

Rockingham Peel Group (RPG), Clinical Practice Manual Chest Pain – Assessment and Management Emergency Department (Clinical Guideline) 2009
Clinical Nurse Specialist (CNS) Emergency Department (ED), Endorsed – Clinical Practice Committee
Registered Nurse ED, Endorsed – Clinical Practice Committee, RPG

RPG, Clinical Practice Manual Patients Presenting to the Emergency Department with Suspected Cardiac Chest Pain Emergency Department (Procedure), 2008
ED Director Chest Pain, Endorsed - Clinical Practice Committee, RPG

South Metropolitan Health Service (SMHS) Nursing Practice Standard for Chest Pain: Suspected and Confirmed Acute Coronary Syndrome (ACS) Management 2012
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Legislation

Acts Amendment (Consent to Medical Treatment) Act 2008
Carers Recognition Act 2004
Civil Liability Act 2002
Disability Services Act 1993
Equal Opportunity Act 1984, Equal Opportunity Regulations 1986
Guardianship and Administration Act 1990
Health Practitioner Regulation National Law (WA) Act 2010
Mental Health Act 1996
Occupational Health and Safety Regulations 1996
Occupational Health Safety and Welfare Act 1984
Poisons Act 1964, Poisons Regulations 1965, Poisons Amendment Regulations 2010
Public Sector Management Act 1994
State Administrative Tribunal Act 2004, State Administrative Tribunal Regulations 2004
State Records Act 2000 - The children and community Services Amendment (Reporting Sexual Abuse of Children) Act 2008
The Children and Community Services Amendment Bill 2010

Standards

EQuIPNational www.achs.org.au/
National Standards for Mental Health Services (NSHMS)

WA Department of Health Policies (Operational Directives)

healthpoint.hdwa.health.wa.gov.au
www.health.wa.gov.au
Admission, Readmission, Discharge and Transfer (ARDT) Policy for WA Health Services (OD 0540/14)
Clinical and Related Waste Management – Clinical Wastes 2009 (OD 0259/09)
Clinical Deterioration Policy (OD 0501/14)
Clinical Handover Policy, 2014 (OD 0484/14)
Clinical Incident Management Policy, 2013 (OD 0421/14)
Consent to Treatment Policy for the Western Australian health system, 2011 (OD 0324/11)
Correct Patient, Correct Site and Correct Procedure Policy and Guideline for WA Health Services 2nd Edition 2006 (OD 0004/06)
Guidelines for nurses performing triage in emergency at non tertiary hospitals 2011 (OD 334/11)
Guidelines for nurses performing triage in emergency at non tertiary hospitals 2011 (OD 334/11)
Guidelines for Referral of patients for medical review by medical officers or emergency nurse practitioners from triage at non tertiary hospitals 2011 (OD 0333/11)
Guidelines for Referral of patients for medical review by medical officers or emergency nurse practitioners from triage at non tertiary hospitals 2011 (OD 0333/11)
Hand Hygiene in Western Australian Hospitals 2013 (OD 0429/13)
Implementation of the Anticoagulation Medication Chart (WAAMC) 2014 (OD 0522/14)
The Policy for Credentialing and Scope of Clinical Practice for Medical Practitioners 2nd Edition 2009 (OD 0177/09)
Use of Acute Oxygen Therapy in Western Australian Hospitals (OD 0397/12)
Use of Acute Oxygen Therapy in Western Australian Hospitals 2011 OD 0325/11
Western Australian Patient Identification Policy 2014 (OD 0486/14)

SMHS Policies

healthpoint.hdwa.health.wa.gov.au
Bariatric Management
Consumer and Carer Participation
Consumer and Carer Participation in Mental Health
Falls Prevention Guidelines Code
Health Record Documentation Policy and Standards
Infection Control Policy
Mandatory Training Governance Policy
Multicultural Policy
OSH: Manual Handling
Single Use/Single Patient Use Medical Devices
12 Lead ECG CPS

Related WACHS Policy Documents

Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy

Infection Prevention and Control Policy

Medication Administration Policy

MR1B WACHS Emergency Chest Pain Kit

Risk Assessment for Admission of the Heavier Patient Policy

Risk Assessment for Admission of the Heavier Patient Site Assessment Form

Standardised Logos

EQuIPNational www.achs.org.au/ [17,18]

	Governance for Safety and Quality in Health Service Organisations
	Partnering with Consumers
	Preventing and Controlling Healthcare Associated Infections
	Medication Safety
	Patient Identification and Procedure Matching
	Clinical Handover

WA Department of Health iSoBAR - Guide to Handover Content and Structure

i	IDENTIFY	Introduce yourself and your patient
S	SITUATION	Describe the reason for handing over
o	OBSERVATIONS	Include vital signs and assessments
B	BACKGROUND	Pertinent patient information
A	AGREE A PLAN	Given the situation, what needs to happen
R	READ BACK	Clarify shared understanding

	Blood and Blood Products
	Preventing and Managing Pressure Injuries
	Recognising and Responding to Clinical Deterioration in Health Care
	Preventing Falls and Harm from Falls
	Service Delivery
	Provision of Care
	Workforce Planning and Management
	Information Management
	Corporate Systems and Safety
	Hand Hygiene Moment Required
	Documentation Required for Episode of Care

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