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Royal Cornwall Hospitals NHS Trust

Administration of Thrombolysis for ST Elevation Myocardial Infarction Policy

V4.0

May 2023

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. Acute ST segment elevation myocardial infarction (STEMI) is defined as the combination of signs and symptoms compatible with acute myocardial ischemia-chest pain/pressure/short of breath/being clammy/nauseous, which lasts for >15 minutes, combined with specific ECG changes (comprising of 1 mm or more of ST segment elevation in two or more contiguous limb leads or 2mm or more of ST segment elevation in two or more consecutive chest leads. Patients presenting with new or assumed new left bundle branch block, in combination with a clinical presentation consistent with acute myocardial infarction should be considered for the same treatment pathway. ST elevation myocardial infarction is one of the acute coronary syndromes but differs from the other presentations of ACS by being able to be diagnosed based on the clinical presentation and ECG changes alone, without needing to await the results of biochemical markers of myocardial damage (e.g., High Sensitivity Troponin T).

1.2. The ST segment elevation myocardial infarction develops in the vast majority of cases when an atheromatous plaque undergoes disruption. Even discrete plaques can rupture so it is possible that patients can present with an ST elevation MI even when they have no previous cardiac history. Disruption of the plaque causes the formation of a thrombus within the affected coronary artery. The thrombus results in a significant reduction or cessation of blood flow through the artery and the patient experiences ischemic pain and ECG changes as described above. The thrombus can completely or partially occlude the coronary artery. Coronary artery spasm may also contribute to a reduction in coronary blood flow at this time. The lack of coronary blood flow results in the death of myocardial cells. Myocardial cell death begins after about 15 minutes of the onset of symptoms / ECG changes and progresses over a period of hours. The process is almost complete after twelve hours. The size of the infarcted area can be minimised by early thrombolysis leading to reperfusion.

1.3. In England and Wales in 2019/20 more than 86,547 hospital admissions were caused by MI. According to the Myocardial Ischemia National Audit Project (MINAP), of these,65% were NSTEMIs and 35% STEMIS. Almost twice as many men had MIs than women.

1.4. If untreated, the prognosis is poor and mortality high. Appropriate triage, risk assessment and timely use of acute pharmacological and/ or invasive interventions are critical for the prevention of future adverse cardiovascular events (myocardial infarction, stroke, repeat revascularisation or death). On the Cornish mainland, the treatment of choice for patients presenting with an ST segment elevation myocardial infarction is primary angioplasty.

1.5. The Royal Cornwall Hospital treats approximately 220 STEMI patients per annum. Our aim is to treat all STEMI patients by PPCI with a door to balloon time of < 60 minutes. However, NICE Clinical Guidelines (CG 167) state that thrombolysis should be given if primary PCI cannot be delivered within 120 minutes of when thrombolysis could be given. This situation applies to all patients presenting with an ST elevation myocardial infarction on the Isles of Scilly unless helicopter transfer to the Royal Cornwall hospital is immediately available. This situation could also apply on rare occasions to patients presenting to the ED at the Royal Cornwall hospital if they cannot be taken directly to the cardiac catheter lab.

1.6. If there is already a patient in the cardiac catheterisation laboratory, then the ED Doctor should ask the operator if they are likely to meet the target for first inflation of the balloon of 150 minutes. If not, then ask the question of whether to commence thrombolysis. Similarly, if a patient is admitted directly to CCU because of a diagnostic Mobimed ECG/ typical symptoms, this same question should be asked by the CCU admitting doctor / senior nurse. Thrombolysis for patients that have presented to the Royal Cornwall Hospital with an ST elevation MI should only be given in consultation with the Cardiologist of the week or interventional cardiologist as appropriate. The following pathway should be implemented for patients needing thrombolysis.

1.7. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. Chest pain is a very common symptom leading to assessment of patients in the Emergency department and/or acute medical unit. Acute ST elevation myocardial infarction typically presents with chest pain or **discomfort.** Appropriate assessment of these patients with acute chest pain to identify acute ST elevation myocardial infarction depends on clinical evaluation and the 12 lead ECG. Measurement of Troponin indicative of myocardial injury must be carried out as a matter of routine too, but the results of this are not needed when making a decision for the need for reperfusion. Prompt reperfusion and pharmacological therapy is the main stay of treatment in this group of patients to minimise associated mortality and morbidity. Further long-term evidence-based drug therapy reduces future cardiovascular morbidity.

2.2. This guideline aims to assist the attending health care professionals in treating patients presenting with acute ST segment elevation myocardial infarction when the target of first balloon inflation for primary PCI of 150 minutes is unlikely to be achievable. The emphasis is on immediate risk assessment, pharmacotherapy, immediate transfer to the Royal Cornwall Hospital, secondary prevention, cardiac rehabilitation and post MI health and lifestyle advice.

3. Scope

This document provides guidance for any professional involved in the clinical management of patients presenting to either primary care in the Isles of Scilly or the Royal Cornwall Hospital with an ST elevation myocardial infarction. This will include:

- General Practitioners (GP).
- Specialist Nurses.
- Junior Doctors.
- Specialty Registrars.
- Consultants.

4. Definitions / Glossary

4.1. Assessment for possible acute ST elevation myocardial infarction (STEMI) Symptoms that may indicate STEMI include:

- Pain or discomfort in the chest and/or other areas (e.g., the arms, back or jaw) lasting longer than 15 minutes.
- Chest pain with nausea, vomiting, marked sweating and/or breathlessness, or hemodynamic instability.
- New-onset chest pain or abrupt deterioration of stable angina, with recurrent pain occurring frequently with little or no exertion and often lasting longer than 15 minutes.
- Consider the history of the pain, how the patient looks at the time of their presentation, the ECG, any cardiovascular risk factors, history of ischaemic heart disease and any previous treatment.

4.2. Abbreviations:

- ACS – Acute coronary syndrome.
- MI – Myocardial infarction.
- STEMI – ST elevation myocardial infarction.
- LBBB – Left bundle branch block.
- MINAP – Myocardial Ischemia National Audit Project.
- PCI – Percutaneous coronary intervention.
- CXR – Chest X-ray.
- ICH – Intracranial Haemorrhage.
- LVEF – Left ventricular ejection fraction.
- BNF – British National Formulary.
- COW – Cardiologist of the week.

5. Ownership and Responsibilities

This section provides an overview of the strategic and operational roles and responsibilities for the development, management and implementation of this policy/procedure.

5.1. **Role of the PCI Lead in Cardiology**

- Reviewing this document every 3 years (or sooner if new, relevant national guidelines are published).

5.2. **Role of the managers**

The line managers are responsible for:

- Ensuring staff are aware of, and act upon, the Trust's procedural documents.
- Implementing the procedural documents for the areas in which they apply.
- Notifying all new and existing staff on how to access both current and archived Trust procedural documents.
- Ensuring that all staff members have access to the Trust intranet site to enable access to published procedural documents.
- Ensuring that all staff members are aware of their responsibility in maintaining compliance with Trust documents.

5.3. **Role of the Cardiology speciality governance group**

The Cardiology speciality governance Group is responsible for:

- Signing off the reviewed document prior to upload to the document library0

5.4. **Role of individual Staff**

All staff members are responsible for:

- Making themselves aware of the procedural documents that relate to their role and responsibilities.
- Complying with agrees Trust procedural documents where they apply.
- Raising any queries about implementation of Trust document with their line manager.
- Alerting their line manager of any non-compliance with procedural documents.
- Where it is noted and represents an actual risk to the Trust, its staff, patients, or the public.
- Contacting the CITS Service Desk (01209 881717) if experiencing difficulties accessing the electronic Document Library.

6. Standards and Practice

6.1. **Initial assessment and treatment**

6.1.1. Oxygen to be given if O2 saturations are not know or are <94% and titrated as required with target saturations being 94-98% (88-92% for patients with hypercapnic respiratory failure).

6.1.2. 12 lead ECG: Use the paramedics ECG (Mobimed) if available. If uncertain about the criteria for STEMI seek help from CCU nurses or Consultant of the week.

6.1.3. Give Aspirin 300mg chewed.

6.1.4. Give Ticagrelor 180mg (or if contraindicated Prasugrel 60mg) in addition to the aspirin.

6.1.5. IV access.

6.1.6. Thrombolysis: Having excluded any contraindications, administer as soon as:

- Physically possible.
- Time yourself and document times in the notes.
- Aim for less than 20 minutes from the time ambulance arrives.
- Remember, "**Time=Muscle**".

6.1.7. Pain control Give morphine 2.5-5.0 mg IV as required or 5.0 – 10mg (diamorphine if morphine is not available (with 10mg IV metoclopramide or Ondansetron 4 mg IV for nausea first).

6.2. Thrombolysis for patients at the Royal Cornwall Hospital

6.2.1. Primary PCI is the treatment of choice for patients presenting to the Royal Cornwall Hospital with an acute ST Elevation Myocardial Infarction (STEMI). However, if it is not possible to transfer the patient to the cardiac catheter laboratory immediately, for whatever reason, then the need for thrombolysis to be given should be considered.

6.2.2. The admitting team must ask the primary PCI operator if they are able to achieve the arrival in hospital to first balloon inflation target of 120 minutes. If not, then thrombolysis will be given on the advice of the primary PCI operator without delay.

6.2.3. Support for this may be given by CCU staff/Chest Pain Nurses depending on the patient's location.

6.2.4. Transfer the patient with resuscitation equipment to CCU immediately AFTER thrombolysis is administered.

6.3. Thrombolysis for patients in the Isles of Scilly

6.3.1. Tenecteplase and Enoxaparin are kept at the hospital on St. Marys and are readily accessible by the paramedics there.

6.3.2. It is considered unlikely that patients presenting with an acute STEMI in the Isles of Scilly will be able to undergo primary PCI within 120 minutes from the time that thrombolysis can be given. It will also be difficult to achieve a 'call to balloon time' of 150 minutes.

6.3.3. For this reason, unless helicopter transfer direct to Treliske is available immediately, thrombolysis remains the treatment of choice for these patients who should then be transferred urgently to the Royal Cornwall Hospital for their ongoing care.

6.4. **Criteria for thrombolysis**

6.4.1. Clinical diagnosis of myocardial infarction within 12 hours of onset of symptoms.

6.4.2. And ECG changes of:

- **ST elevation of ≥ 1mm in two or more contiguous limb leads or**
- **ST elevation of ≥ 2mm in two or more consecutive precordial leads or**
- **Presumed new LBBB. No contraindications present (see check list on page 10).**

6.5. **Dose and administration**

6.5.1. Give IV bolus of 30mg of enoxaparin[5] first if indicated followed by an IV bolus of Tenecteplase[6] over 10 seconds followed by S/C doses of enoxaparin as per the tables below. The first s/c dose must be given immediately after the Tenecteplase.

6.5.2. After 48 hours, change to prophylactic s/c dalteparin 5000 iu at 2200hrs if the patient is stable, or 2.5mg s/c Fondaparinux once daily at night-time if the patient has on-going symptoms, as for acute coronary syndromes.

6.5.3. Enoxaparin routes and dosage:

Patient characteristics	**Initial IV bolus of enoxaparin**	**S/C doses enoxaparin for 48 hours**	**First 2 S/C doses enoxaparin not to exceed**
Normal adult dose < 75, eGFR >30	30mg	1mg/Kg every 12 hours	100mg each
Normal elderly dose ≥ 75 eGFR >30	OMIT	0.75mg/Kg every 12 hours	75mg each
Young renally impaired <75 eGFR <30ml/min	30mg	1mg/Kg once daily for two days	First dose not to exceed 100mg

Patient characteristics	Initial IV bolus of enoxaparin	S/C doses enoxaparin for 48 hours	First 2 S/C doses enoxaparin not to exceed
Elderly renally impaired ≥ 75 <30ml/min	OMIT	1mg/Kg once daily for two days	First dose not to exceed 100mg

NB – If the patient has been treated with Fondaparinux as per the ACS protocol and subsequently develops an ST elevation MI requiring thrombolysis, then continue with this regime. 2.5mg IV Fondaparinux may be given immediately prior to TNK depending on the timing of the most recent s/c dose in discussion with the duty cardiologist.

6.5.4. Tenecteplase dosage:

Patient Weight (Kg)	Tenecteplase (Units)	Tenecteplase (mg)	Volume of reconstituted solution
<60 Kg	6 000	30	6
≥ 60 to <70	7 000	35	7
≥70 to <80	8 000	40	8
≥80 to <90	9 000	45	9
>90	10 000	50	10

6.6. Thrombolysis Checklist[1]

A copy of this checklist is filled in and filed in the patient's medical notes.

Check List Category	No	Yes
GI bleed within 6 months.		
Stroke within 6 months.		
Documented GI ulcer within 3 months.		
History of oesophageal varices.		
Major surgery or trauma within 3 months.		
Prolonged or traumatic CPR.		
Anticoagulant therapy if INR >2.5.		
Uncontrolled hypertension (systolic >200mmHg)		
Uncontrolled hypertension (diastolic >100mmHg).[2]		
Pregnancy		
Aortic Dissection[3] (Sudden tearing pain, unequal pulses, early diastolic murmur)		

If you have ticked all the above boxes as No, thrombolyse without delay.

If you have ticked any boxes as Yes, delay thrombolysis but consider the following options with a sense of urgency.

[1]Patients who have contra-indications to thrombolysis should still be considered for **PRIMARY ANGIOPLASTY**

[2]Commence IV isosorbide dinitrate 25mg in 50mls 0.9% NaCl at 2-10mg/hr to lower BP then commence thrombolysis**.**

[3]Needs CT scan prior to deciding on thrombolysis

6.7. Anaphylaxis to antithrombotic agents

(This is very unlikely with Tenecteplase)

Please seek urgent medical review and consider:

- CHLORPHENAMINE: 10mg IV bolus diluted in 5-10mls of 0.9% saline or water- give over a minimum of one minute.
- HYDROCORTISONE: 100mg IV bolus diluted in 2ml of water for injection over 1-10 minutes.
- ATROPINE: 0.5-1.0mg IV using a minijet (if symptomatically bradycardic).

- ADRENALINE 500mcg S/C if indicated and repeat if required.

6.8. Reversing Enoxaparin and thrombolysis

6.8.1. For minor bleeds – apply sustained pressure.

6.8.2. If it is thought to be absolutely essential to reverse thrombolysis, consider the following:

- Check FBC, coagulation screen and request the lab to freeze this sample.
- Transfusion sample for group and crossmatch.

6.8.3. To reverse Enoxaparin:

Give Protamine sulphate: Give the maximum initial dose of 50mg as an IV bolus over 10 minutes. Repeat doses should be based on clinical response and not on anti-Xa or APTT levels.

- Protamine sulphate will neutralise only 20-25% of anti Xa activity, such that FFP may be required. Advice can be obtained from the on-call consultant haematologist.

6.8.4. To reverse thrombolysis

6.8.4.1. Tranhexamic acid: 10mg/ Kg, by slow IV bolus injection.

6.8.4.2. Consider Cryoprecipitate or FFP-if bleeding continues and fibrinogen <1.0 g/l.

6.8.4.3. Blood to correct blood loss.

6.9. Additional Management

6.9.1. Assess for Successful Thrombolysis.

6.9.2. An ECG should be recorded 60-90 minutes after thrombolysis as a means of determining if it has been successful or not.

6.9.3. A reduction of ST segment elevation of >50% and resolution of pain indicates success.

6.9.4. If ST segments do not show evidence of resolution and the patient has on going symptoms, then consideration should be given for the need to carry out a rescue angioplasty as a matter of urgency and should be discussed with the on-call cardiologist.

THROMBOLYSIS MUST NOT BE REPEATED

6.10. Concomitant Pharmacological Treatment – see **Acute Coronary Syndrome Pathway.**

7. Dissemination and Implantation

7.1. This document will be disseminated electronically to all relevant stakeholders once published. It will also be available on the RCHT Document library.

7.2. These guidelines are widely discussed at the induction meetings of junior doctors especially in the Emergency department, Medical assessment unit and Cardiology department.

7.3. User friendly posters with the guideline and pathways are displayed in all the relevant clinical areas.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Management of patients with STEMI
Lead	PCI Lead in Cardiology
Tool	Audit of the management of patients with STEMI
Frequency	12 monthly audit for monitoring the guideline, pathways and recommendation. Future reviews guided by the audit
Reporting arrangements	The Annual report will be reviewed through the Cardiology Speciality audit & governance frameworks
Acting on recommendations and Lead(s)	The Clinical lead in Cardiology and Cardiology department will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 1 month. A lead member of the team will be identified through speciality governance structures to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders via the Cardiology Speciality audit & governance frameworks

9. Updating and Review

9.1. This document will be updated by the PCI lead every 3 years.

9.2. Revisions will be made ahead of the review date if new, relevant national guidelines are published. Where the revisions are significant and the overall policy is changed, the Clinical lead in Cardiology will ensure the revised document is taken through the standard consultation, approval and dissemination.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval and can be re-published accordingly without having gone through the full consultation and ratification process.

9.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Administration of Thrombolysis for ST Elevation Myocardial Infarction Policy V4.0
This document replaces (exact title of previous version):	Administration of Thrombolysis for ST Elevation Myocardial Infarction Policy V3.0
Date Issued/Approved:	13 April 2023
Date Valid From:	April 2023
Date Valid To:	April 2026
Directorate / Department responsible (author/owner):	Dr S Devadathan, Consultant Cardiologist
Contact details:	01872 252678
Brief summary of contents:	This document provides guidance for any professional involved in the clinical management of patients, presenting to either secondary or primary care NHS care providers in Cornwall, with chest pain due to suspected or proven acute coronary syndrome.
Suggested Keywords:	Cardiology Chest Pain STEMI Thrombolysis
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Cardiology Governance Group
General Manager confirming approval processes:	Rachael Pearce
Name of Governance Lead confirming approval by specialty and care group management meetings:	Siobhan Hunter
Links to key external standards:	None required

Related Documents:	1. British Thoracic Society Guideline for Emergency Oxygen Use in Adult Patients: Thorax 2008 (October),63, (supplement6) 2. The routine use of aspirin in acute phase of MI significantly reduces 5-week vascular mortality (almost as much as streptokinase alone). Given early enough this will save 20-30 lives per 1000 MI`s (ISIS-2. Lancet 1988;2:349) 3. Clopidogrel and metoprolol in myocardial infarction trial (COMMIT). Addition of clopidogrel to aspirin in 45 852 patients with acute myocardial infarction: randomised placebo-controlled trial. Collaborative group. Lancet 2005:366: 1607 – 1621 4. CLARITY – TIMI 28 – Clopidogrel as Adjunctive Reperfusion Therapy. Thrombolysis In Myocardial Infarction 28. Sabatine et al for the CLARITY investigators. New England Journal of Medicine. 2005;352: 1179 – 1189. 5. Clopidogrel blocks platelet activation by inhibiting ADP binding. The CAPRIE study (Lancet 1996; 348:1329) showed that it was even more effective at secondary prevention of vascular events than aspirin. 6. Accelerated rt-PA saves 36 lives per 1000 patients treated but with every minute of delay from onset of pain lives are lost. The difference between treatment during the first hour compared to the second to third hour is 10-12 lives lost per 1000 patients treated (GUSTO,NEJM 1993;329:673). 7. TNK is as effective as rt-PA as shown by; Assessment of the safety of a new thrombolytic (ASSENT 2) Investigators, Van de Werf et.al. Single bolus Tenecteplase compared with front loaded alteplase in acute myocardial infarction: the ASSENT 2 double – blind randomised trial. Lancet 1999; **354**: 716 – 722 8. The Assessment of the Safety and Efficacy of New Thrombolytic Regimen (ASSENT)-3 Investigator. Efficacy and Safety of Tenecteplase in combination with enoxaparin, abciximab, or unfractionated heparin: the ASSENT –3 randomised trial in acute myocardial infarction. The Lancet Vol 358 August 25, 2001, pages 605-613 9. Management of acute myocardial infarction in patients presenting with persistent ST-elevation. The Task Force on the management

of St – segment elevation acute myocardial infarction of the European Society of Cardiology: Authors/task force members: Frans Van de Werf et al, European Heart Journal 2008: **29**, 2909

– 2945 (page 2921)

10. In the CARESS trial, a more conservative strategy with sending patients for angiography only in the case of failed fibrinolysis was associated with a worse clinical outcome when compared with a strategy of referring all patients for angiography and (if indicated) PCI. Di Mario et al, Immediate angioplasty versus standard therapy with rescue angioplasty after thrombolysis in the Combined Abciximab REteplase Stent Study in Acute Myocardial Infarction (CARESS-in-AMI

    : an open, prospective, randomised, multi-centre trial. Lancet 2008:**371**:559 – 568

11. Gershlick A.H et al **–** Rescue Angioplasty After failed Thrombolytic Therapy for Acute Myocardial Infarction. New England Journal of Medicine 2005: **353**: 2758 – 2768

12. Current European Society of Cardiology guidelines 2007, together with NICE guidelines published in May 2008 recommend that statin therapy should be given to all patients with CHD to achieve total cholesterol <4mmol/L OR LDL – cholesterol <2 mmol/L (eg atorvastatin 40 – 80mg).

13. GREACE study – Athyros V.G., Papageorgiou A.A. Mercouris B.R. et al; Treatment with atorvastatin to the National Education Program Goal versus `usual` care in secondary heart disease evaluation (GREACE) study. Curr. Med. Res. Opinion 2002: 18; 220-228.

14. In a randomised study of 427 patients (REACT) the event free survival at 6 months after failed fibrinolysis was significantly higher with rescue PCI than with repeated administration of fibrinolytic agent or conservative treatment: Gershlick AH et al, Rescue angioplasty after failed thrombolytic therapy for acute myocardial infarction. N Eng J Medicine 2005; 353:2758 – 2768

15. Ticagrelor versus Clopidogrel in Patients with Acute Coronary Syndromes N Engl J Med 2009; 361:1045-57

Information Category	Detailed Information
	16. MI – secondary prevention: Secondary prevention in primary and secondary care for patients following a myocardial infarction NICE guideline [CG172] Published date: November 2013
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Cardiology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
January 2011	V1.0	Initial issue	Cardiology – W Delacour and Dr R T Johnston
March 2016	V2.0	Updated the guidance	Dr Sen Devadathan Governance Lead Mr Will Delaour Chest Pain Specialist Nurse
August 2019	V3.0	Full review and transferred to new Trust template. Addition on Page 10 – Thrombolysis must **not** be repeated.	Mr Will Delaour Chest Pain Support Practitioner
January 2023	V4.0	Updated the MINAP data to cover 2019/20. Full review completed and updated. Transposed to accessible Trust template	Dr S Devadathan, SN Lauren Anstis

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Administration of Thrombolysis for ST Elevation Myocardial Infarction Policy V4.0
Directorate and service area:	Cardiology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Mr Will Delacour, Chest Pain Support Practitioner
Contact details:	0187225911

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To improve the outcome of patients presenting with chest pain due to acute coronary syndrome
2. Policy Objectives	To provide clear specialty agreed guidelines and pathways for the diagnosis and clinical management of patients with acute coronary syndrome presenting to Royal Cornwall hospitals NHS trust
3. **Policy Intended Outcomes**	Availability of a robust, measurable, Specialty agreed pathways and guidelines for the diagnosis and clinical management of patients with acute coronary syndrome
4. **How will you measure each outcome?**	Outlined in section 8 of this document.
5. **Who is intended to benefit from the policy?**	Patients presenting with acute coronary syndrome and health care professionals involved in their care

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** All Consultant Cardiologists Cardiology Specialty Group
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Mr Will Delaour Chest Pain Support Practitioner

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis