Guidelines for the administration of Thrombolysis for ST elevation MI

V5.1

14th March 2016
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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/discomfort/pressure/shortness 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 on the basis of the clinical presentation and ECG changes alone, without needing to await the results of biochemical markers of myocardial damage (eg, High Sensitivity Tropinin T).

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.

In England and Wales in 2013/14 more than 80,724 hospital admissions were caused by MI. According to the Myocardial Ischaemia National Audit Project (MINAP), of these, 41% were STEMIs and 59% were NSTEMIs. Almost twice as many men had MIs as women.
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. 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 < 30 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 angiography suite.

If there is already a patient in the angiography laboratory then the ED Doctor should ask the operator if they are likely to meet the target for first inflation of the balloon of 120 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 duty consultant cardiologist.** The following pathway should be implemented for patients needing thrombolysis.

People who have had an acute ST segment elevation myocardial infarction benefit from treatment to reduce the risk of further MI or other manifestations of vascular disease. This is known as secondary prevention.

**1.2** 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.

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 120 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

3.1 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 to the Royal Cornwall Hospital with an ST elevation myocardial infarction. This will include:

- GPs
- Specialist Nurses
- Junior Drs.
- Speciality 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 (eg, the arms, back or jaw) lasting longer than 15 minutes.

- Chest pain with nausea, vomiting, marked sweating and/or breathlessness, or haemodynamic 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
- NSTEMI: Non ST elevation myocardial infarction
- LBBB: Left bundle branch block
- MINAP: Myocardial Ischaemia 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 a detailed overview of the strategic and operational roles responsible for the development, management and implementation of this policy/procedure.

5.1 Role of the Clinical Lead in Cardiology

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

5.2 Role of the Managers

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

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 library

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 agreed Trust procedural documents where they apply.
• Raising any queries about implementation of Trust documents 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.
6. Standards and Practice

6.1 Initial assessment and treatment

- Oxygen to be given if O2 saturations are not known or are <94% and titrated as required with target saturations being 94-98% (88-92% for patients with hypercapnic respiratory failure)¹
- 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.
- Give Aspirin 300mg chewed²
- Give Ticagrelor 180mg³ (or if contraindicated Prasugrel 60mg) in addition to the aspirin
- IV access
- 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”⁴
- 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 for nausea first).

6.2 Thrombolysis for patients at the Royal Cornwall Hospital

- 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.
- 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.
• Support for this may be given by CCU staff/Chest Pain Nurses depending on the patients location.
• Transfer the patient with resuscitation equipment to CCU immediately AFTER thrombolysis is administered

6.3 Thrombolysis for patients in the Isles of Scilly

• Tenecteplase and Enoxaparin are kept at the hospital on St. Marys and are readily accessible by the paramedics there.
• 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.
• 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 on-going care.

6.4 Criteria for thrombolysis

• Clinical diagnosis of myocardial infarction within 12 hours of onset of symptoms
• And ECG changes of:
  ➢ ST elevation of > 1 mm in two or more contiguous limb leads or
  ➢ ST elevation of > 2 mm in two or more consecutive precordial leads or
  ➢ Presumed new LBBB. No contraindications present (see checklist on page 10).

6.5 Dose and administration:

• 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.
• 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 a) Enoxaparin routes and dosage

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

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 b) Tenectaplace dosage

<table>
<thead>
<tr>
<th>Patient Weight (Kg)</th>
<th>Tenectaplace (Units)</th>
<th>Tenectaplace (mg)</th>
<th>Volume of reconstituted solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;60 Kg</td>
<td>6 000</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td>≥ 60 to &lt;70</td>
<td>7 000</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>≥70 to &lt;80</td>
<td>8 000</td>
<td>40</td>
<td>8</td>
</tr>
<tr>
<td>≥80 to &lt;90</td>
<td>9 000</td>
<td>45</td>
<td>9</td>
</tr>
<tr>
<td>&gt;90</td>
<td>10 000</td>
<td>50</td>
<td>10</td>
</tr>
</tbody>
</table>
6.6 Thrombolysis Check list.¹

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

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI bleed within 6 months.</td>
<td>✓</td>
</tr>
<tr>
<td>Stroke within 6 months.</td>
<td>✓</td>
</tr>
<tr>
<td>Documented GI ulcer within 3 months.</td>
<td>✓</td>
</tr>
<tr>
<td>History of oesophageal varices</td>
<td>✓</td>
</tr>
<tr>
<td>Major surgery or trauma within 3 months.</td>
<td>✓</td>
</tr>
<tr>
<td>Prolonged or traumatic CPR.</td>
<td>✓</td>
</tr>
<tr>
<td>Anticoagulant therapy if INR &gt;2.5.</td>
<td>✓</td>
</tr>
<tr>
<td>Uncontrolled hypertension (systolic &gt;200mmHg or diastolic &gt;100mmHg).²</td>
<td>✓</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>✓</td>
</tr>
<tr>
<td>Aortic Dissection³</td>
<td>✓</td>
</tr>
</tbody>
</table>

(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.

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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**

- For minor bleeds – apply sustained pressure.
- 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 a) **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 b) **To reverse thrombolysis**

- Tranhexamic acid: 10 mg/ Kg, by slow IV bolus injection
- Consider Cryoprecipitate or FFP-if bleeding continues and fibrinogen <1.0 g/l.
- Blood to correct blood loss.
6.9 Additional Management

- Assess For Successful Thrombolysis:
- An ECG should be recorded 60 - 90 minutes after thrombolysis as a means of determining if it has been successful or not.
- A reduction of ST segment elevation of \( > 50\% \) and resolution of pain indicates success\(^7\).
- If ST segments do not show evidence of resolution and the patient has ongoing 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.\(^{10}\)

6.10. Concomitant Pharmacological treatment – see ACS protocol (Appendix 3)

7. Dissemination and Implementation

- This document will be disseminated electronically to all relevant stakeholders once published. It will also be available on the RCHT Document library.
- These guidelines are widely discussed at the induction meetings of junior doctors especially in the Emergency department, Medical assessment unit and Cardiology department
- User friendly posters with the guideline and pathways are displayed in all the relevant clinical areas
8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>All of it</th>
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<tr>
<td>Lead</td>
<td>Clinical lead in Cardiology</td>
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<tr>
<td>Tool</td>
<td>Audit of the management of patients with STEMI</td>
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<tr>
<td>Frequency</td>
<td>12 monthly audit for monitoring the guideline, pathways and recommendations. Future reviews guided by the audit outcomes.</td>
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<td>Reporting arrangements</td>
<td>The Annual report will be reviewed through the Cardiology Speciality audit &amp; governance frameworks</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>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.</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and action will commence within 1 month of report review A lead member of the Cardiology department will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders via the Cardiology Speciality audit &amp; governance frameworks</td>
</tr>
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</table>

9. Updating and Review

7.1. This document will be updated by the Clinical lead in Cardiology every 3 years.

7.2. 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 processes.

7.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval will 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.

7.4. Any revision activity will be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

7.5. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees

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

1  British Thoracic Society Guideline for Emergency Oxygen Use in Adult Patients: Thorax 2008 (October),63, (supplement6)  
   www.brit-thoracic.org.uk

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)


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


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


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).

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


16 MI – secondary prevention: Secondary prevention in primary and secondary care for patients following a myocardial infarction NICE guidelines [CG172] Published date: November 2013
12. Appendix 1. Governance Information

<table>
<thead>
<tr>
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<th>Guidelines for the administration of Thrombolysis to patients presenting with ST elevation MI in the Isles of Scilly or who are unlikely to achieve Primary Percutaneous Intervention within 120 minutes of arriving at the Royal Cornwall Hospital</th>
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<td>18/03/2016</td>
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<tr>
<td>Date Valid To:</td>
<td>18/03/2019</td>
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<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Sen Devadathan Governance Lead Mr Will Delacour Lead specialist nurse, chest pain</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252678</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>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.</td>
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<td>Cardiology Chest pain STEMI Thrombolysis</td>
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<td>Medical Director – Dr Rob Parry</td>
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This document replaces (exact title of previous version): New Document

Approval route (names of committees)/consultation: Consultant Cardiologists
Members of The Cardiology Speciality Governance group

Divisional Manager confirming approval processes Sheena Wallace

Name and Post Title of additional signatories ‘Not Required’

Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings Jon Stratton, Divisional Clinical Governance Lead

Signature of Executive Director giving approval

Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet

Document Library Folder/Sub Folder Clinical / Cardiology

Links to key external standards

Related Documents:

Training Need Identified? No

Version Control Table

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<tr>
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<td>Sen Devadathan</td>
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**[Please complete all boxes and delete help notes in blue italics including this note]**

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

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## 13. Appendix 2. Initial Equality Impact Assessment

### Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>Guidelines for the management of acute chest pain of cardiac origin in Cornwall, ST elevation MI / Non ST elevation MI / Unstable angina V1.0</th>
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<tbody>
<tr>
<td>Directorate and service area: Medicine, ED &amp; WCH, Cardiology speciality</td>
<td>Is this a new or existing Policy? New</td>
</tr>
<tr>
<td>Name of individual completing assessment: Dr Sivasankar Sangaraju</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - Who is the strategy / policy / proposal / service function aimed at?
   - To improve the outcome of patients presenting with chest pain due to acute coronary syndrome

2. **Policy Objectives**
   - To provide clear speciality 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, measureable, Speciality agreed pathways and guidelines for the diagnosis and clinical management of patients with acute coronary syndrome

4. **How will you measure the 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
6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

b) If yes, have these *groups been consulted?

C). Please list any groups who have been consulted about this procedure.

Yes, Workforce

Yes

All Consultant Cardiologists
Cardiology Speciality Group

7. The Impact

Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation,</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No ✓

9. If you are not recommending a Full Impact assessment please explain why.

It does not meet any of the criteria to require a full assessment

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names and signatures of members carrying out the Screening Assessment</td>
<td>1.</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,  
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed _______________

Date _______________
14. Appendix 3: ACS protocol (Guidelines for the management of acute chest pain of suspected cardiac origin in Cornwall)

Management of acute chest pain of suspected cardiac origin guideline - Acute Coronary Syndrome Mar 16 V6 1 FINAL