NSW HEALTH

Safety Notice 009/09

Acute Coronary Syndrome

28 April 2009

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Clinical Operations

Action required by:

- Directors of Clinical Governance

We recommend you also inform:

- Directors of Cardiology
- Directors of Emergency
- Emergency Medicine physicians and nurses
- Cardiology physicians and nurses
- GP VMOs
- All medical staff
- All nursing staff
- All other clinical staff

Expert reference group

Content reviewed by:

- Greater Metropolitan Clinical Taskforce – Cardiac Network
- NSW Rural Critical Care Taskforce
- Emergency Care Taskforce
- Clinical Excellence Commission

Quality and Safety Branch
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Website
http://www.health.nsw.gov.au/quality/sabs/index.html

Background

A significant number of patients presenting to NSW Emergency Departments with chest pain have had missed or delayed diagnosis of Acute Coronary Syndrome (ACS) resulting in poor outcomes and death. The use of chest pain pathways when used correctly can reduce the number of adverse incidents for patients presenting with chest pain. The following factors have been consistently identified through the Root Cause Analysis (RCA) process as contributing to Acute Coronary Syndrome incidents:

Contributing Factors

- Failure to undertake appropriate investigations, e.g. ECG, troponin testing.
- Failure to interpret ECGs correctly.
- No formal system for obtaining senior clinician review of the ECG.
- Delay or failure to notify the consultant on call/consultant responsible for the patient.
- Failure to review results prior to patient transfer or discharge.
- Failure to have a chest pain pathway in place for the management of patients with cardiac/possible cardiac pain.

The References and Additional Information below are provided to support clinical staff managing patients with Acute Coronary Syndrome.

References

- National Heart Foundation of Australia/The Cardiac Society of Australia and New Zealand, *Guidelines for the management of acute coronary syndromes 2006*. MJA 184;8: S1-S30.

- Triage of patients in NSW Emergency Departments (PD2008_009) http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_009.pdf

Additional Information

- Cardiac Monitoring in Adult Cardiac Patients in Public Hospitals in NSW (PD2008_055) http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_055.pdf

- CIAP Interactive ECG tutorials are freely available to all staff working in the NSW public health system. Go to the CIAP intranet site at http://internal.health.nsw.gov.au:2001 or the CIAP internet site at http://www.ciap.health.nsw.gov.au (under Clinical Tools).

Suggested Action by Area Health Services

1. Review the current management of patients with ACS.
2. Area Health Services should implement a clinical pathway for the management of ACS. (Health Service Performance and Improvement Branch at the NSW Department of Health have examples if required. Ph: 9391 9368)
3. All patients with chest pain and/or associated symptoms should undergo a process of risk stratification to define the likelihood of ACS.
4. Facilities should have a local protocol for the acquisition and review of ECGs and pathology results by a medical officer, including the interpretation and escalation of abnormal results.