Consultation Draft: Clinical Care Standard for Acute Coronary Syndrome

December 2013
Suggested citation


Acknowledgements

Many individuals and organisations have freely given their time, expertise and documentation in the development of this paper. In particular, the Commission wishes to thank the Acute Coronary Syndrome Topic Working Group and other key experts who have given their time and advice. The involvement and willingness of all concerned to share their experience and expertise is greatly appreciated.
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Consultation Draft: Clinical Care Standard for Acute Coronary Syndrome
Clinical Care Standard for Acute Coronary Syndrome

Clinical Care Standard for Acute Coronary Syndrome

1 A patient with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives a 12-lead electrocardiogram (ECG) and the results are interpreted by an ECG-qualified clinician within 10 minutes of first emergency clinical contact.

2 A patient with an acute ST segment elevation myocardial infarction (STEMI), for whom emergency reperfusion is clinically appropriate, receives primary percutaneous coronary intervention (PCI) or thrombolysis within time frames recommended by the current National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndrome.

3 A patient presenting with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives care guided by an evidence-based clinical pathway.

4 A patient admitted to hospital with a non–ST segment elevation acute coronary syndrome (NSTEACS) is managed based on a documented, evidence-based assessment of their risk of major adverse cardiac events.

5 The role of coronary angiography with a view to appropriate coronary revascularisation is considered and discussed with a patient with a non–ST segment elevation acute coronary syndrome (NSTEACS) who is assessed to be at intermediate or high risk of an adverse cardiac event.

6 Before a patient with an acute coronary syndrome leaves the hospital, they are involved in developing an individualised care plan that identifies the lifestyle modifications and medicines they should take to manage their risk factors, addresses their psychosocial needs and includes a referral to a cardiac rehabilitation program that is appropriate for them. This plan is also provided to the patient’s general practitioner.

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a The evidence base for these statements is provided in supporting documentation that can be accessed at www.safetyandquality.gov.au.
Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) is seeking feedback on two draft Clinical Care Standards.

The development of the Clinical Care Standards is a priority area in the Commission’s 2013-16 work plan as approved by Health Ministers in 2013.

The Clinical Care Standards will support:

- people who are receiving care by assisting them to know what to expect from their healthcare system
- healthcare professionals to make decisions about appropriate care
- healthcare services to examine the performance of their organisation and make improvements in the care they provide.

A Clinical Care Standard provides a small number of quality statements that describe the clinical care that a patient should be offered for a specific clinical condition.

In collaboration with consumers, clinicians, researchers and health organisations, the Commission has developed draft Clinical Care Standards for Acute Coronary Syndrome and Antimicrobial Stewardship. These comprise the first draft Clinical Care Standards, which are now available as part of a public consultation process.

The draft Clinical Care Standard for Acute Coronary Syndrome was developed by a Topic Working Group\(^b\) who used the most up-to-date clinical guidelines and standards, their professional expertise and consideration of issues that were important to consumers. In addition, existing national, state and territory work was also taken into account to ensure the draft Clinical Care Standard for Acute Coronary Syndrome complements existing efforts supporting the delivery of appropriate care, such as national initiatives led by the National Heart Foundation.

It is intended that this draft Clinical Care Standard for Acute Coronary Syndrome and the associated consultation process (refer to page 11) will provide an opportunity to elicit feedback which will allow the Commission to refine and finalise this Clinical Care Standard, and identify mechanisms that can support its practical application.

\(^b\) see Appendix 1 for the Topic Working Group membership list
Context

Acute coronary syndrome results from a sudden blockage of a blood vessel in the heart that reduces blood supply to a portion of heart muscle. Where the blockage is severe enough to lead to injury or death of the heart muscle, the event is called an acute myocardial infarction (or ‘heart attack’). The most common cause of acute coronary syndrome is atherosclerosis (or ‘coronary heart disease’) where an artery wall thickens due to a build-up of fatty materials such as cholesterol.

Despite well-developed guidelines for managing acute coronary syndrome, recent research found that not all patients receive appropriate treatments, particularly for invasive management of this condition.¹

Key to the provision of timely and effective care is for people to recognise the early signs of heart attack and call 000 for an ambulance. The National Heart Foundation is seeking to raise awareness of the symptoms and signs of heart disease.²

The Clinical Care Standard for Acute Coronary Syndrome focuses on the management of a patient with acute coronary syndrome including recognition, rapid assessment, early management and early initiation of a tailored rehabilitation plan.

The Clinical Care Standard does not override personal choice or a clinician’s judgement of a patient’s individual care or treatment needs.

Patients and carers can use information in the Clinical Care Standard to know what care to expect and make informed treatment decisions in partnership with their clinician. Clinicians and health services can use the Standard to support the delivery of high-quality care.

This document contains:
- the scope, which defines the extent of care covered by the Clinical Care Standard
- the goal, which defines what the Clinical Care Standard aims to accomplish
- Six quality statements, which describe the care a patient should receive.

Then, for each quality statement, it contains:
- the purpose, which describes the intended outcome of each quality statement
- information about what the quality statements mean for patients, clinicians and health services.

¹ www.heartattackfacts.org.au
Scope

This Clinical Care Standard relates to the care adults with suspected acute coronary syndrome should receive from the onset of symptoms to the completion of their treatment in hospital.

Goal

To improve the early, accurate diagnosis and management of an acute coronary syndrome to maximise patients chances of recovery, and reduce the risk of a future cardiac event.

Monitoring

Health services need to be aware of how well the treatment they provide matches the Clinical Care Standards. Monitoring of the performance of the clinical services provided by an organisation is a key part of the National Safety and Quality Health Service (NSQHS) Standards, particularly Standard 1: Governance for Safety and Quality.

Organisations are likely to already have mechanisms in place that monitor the care provided. However if additional measures are needed then a number of suggested indicators have been developed and can be found at Appendix 2.
Quality statement 1 – Early assessment

A patient with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives a 12-lead electrocardiogram (ECG) and the results are interpreted by an ECG-qualified clinician within 10 minutes of first emergency clinical contact.

Purpose

To improve the early and appropriate assessment of a patient with suspected acute coronary syndrome.

What this quality statement means for:

- **Patients.** If you receive emergency treatment for chest pain that might be caused by a heart attack, you can expect the clinician to perform an ECG and interpret the results within 10 minutes.

- **Clinicians.** Assess all patients with suspected acute coronary syndrome with a 12-lead ECG and interpret the results within 10 minutes of first emergency contact.

- **Health services.** Ensure systems and processes are in place to offer people with symptoms of acute coronary syndrome a 12-lead ECG and for this to be interpreted by an ECG-qualified clinician within 10 minutes of first emergency clinical contact.
Quality statement 2 – Prompt reperfusion

A patient with an acute ST segment elevation myocardial infarction (STEMI), for whom emergency reperfusion is clinically appropriate, receives primary percutaneous coronary intervention (PCI) or thrombolysis within time frames recommended by the current National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndrome.

Purpose

To ensure eligible patients receive primary percutaneous coronary intervention or thrombolysis treatment within the recommended time frames.

What the quality statement means for:

- **Patients.** If you have been diagnosed with a specific type of heart attack where the artery supplying an area of the heart muscle is completely blocked, your clinician will determine if you are able to have treatment that can quickly open the blocked arteries and restore blood flow to the heart muscle.

- **Clinicians.** Administer primary percutaneous coronary intervention or thrombolysis to eligible patients diagnosed with an acute STEMI, within the time frames recommended by current National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndrome.2

- **Health services.** Ensure systems, infrastructure and processes are in place to administer primary percutaneous coronary intervention or thrombolysis to eligible patients diagnosed with acute STEMI within the time frames recommended by current National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the Management of Acute Coronary Syndrome.2
Quality statement 3 – Immediate management

A patient presenting with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives care guided by an evidence-based clinical pathway.

Purpose

To ensure a patient presenting to the emergency department with acute chest pain or other symptoms suggestive of an acute coronary syndrome receive care guided by an evidence-based clinical pathway.

What the quality statement means for:

- **Patients.** If you go to hospital with chest pain, your doctor in the emergency department will assess your risk for a major cardiac event to guide your treatment.

- **Clinicians.** Ensure clinical management of patients with symptoms of acute coronary syndrome presenting to the emergency department is guided by an evidence-based clinical pathway.

- **Health services.** Ensure clinicians are trained and have access to a risk assessment pathway to guide treatment of patients presenting to the emergency department with symptoms suggestive of acute coronary syndrome.
Quality statement 4 – Risk stratification

A patient admitted to hospital with a non–ST segment elevation acute coronary syndrome (NSTEACS) is managed based on a documented, evidence-based assessment of their risk of major adverse cardiac events.

Purpose

To assess the risk of an adverse cardiac event and provide appropriate therapy to patients with NSTEACS.

What this quality statement means for:

- **Patients.** If you have been diagnosed with a specific type of heart attack where the artery supplying an area of the heart muscle is partly blocked, your clinician will conduct a risk assessment to determine the likelihood of a future heart event.
- **Clinicians.** Ensure clinical management of patients with NSTEACS is guided by the results of using an evidence-based risk assessment tool.
- **Health services.** Ensure clinicians are trained and have access to evidence-based risk assessment tools to guide treatment of patients with NSTEACS.
Quality statement 5 – Coronary angiography

The role of coronary angiography with a view to appropriate coronary revascularisation is considered and discussed with a patient with a non–ST segment elevation acute coronary syndrome (NSTEMI) who is assessed to be at intermediate or high risk of an adverse cardiac event.

Purpose

To ensure the risks and benefits of coronary angiography performed to determine appropriate coronary revascularisation are considered and discussed with eligible patients with NSTEMI.

What this quality statement means for:

• Patients. If you have been diagnosed with a specific type of heart attack where the artery supplying an area of the heart muscle is partly blocked, and your likelihood of a future cardiac event has been assessed as being intermediate or high, then your clinician will discuss treatment options to restore the blood flow to your heart tissue with you and/or your carer.

• Clinicians. Consider and discuss the role of coronary angiography with a view to appropriate coronary revascularisation with your patients with NSTEMI at intermediate or high risk of a future cardiac event.

• Health services. Ensure systems, infrastructure and processes are in place for a clinician to discuss the role of coronary angiography with a view to appropriate coronary revascularisation to eligible patients with NSTEMI.
Quality statement 6 – Individualised care plan

Before a patient with an acute coronary syndrome leaves the hospital, they are involved in developing an individualised care plan that identifies the lifestyle modifications and medicines they should take to manage their risk factors, addresses their psychosocial needs and includes a referral to a cardiac rehabilitation program that is appropriate for them. This plan is also provided to the patient’s general practitioner.

Purpose

To ensure all patients with acute coronary syndrome have an individualised care plan before they leave the hospital.

What this quality statement means for:

• **Patients.** Before you leave the hospital, your clinician will discuss your recovery and rehabilitation goals, and develop a plan for ongoing care with you and/or your carer. This plan will aim to reduce your risk of another cardiac event by giving you information on lifestyle changes and medicines, and referring you to a cardiac rehabilitation program. The plan will also recommend ways to address your individual needs for everyday living. This plan will be provided to your general practitioner.

• **Clinicians.** Provide an individualised care plan to a patient with an acute coronary syndrome and/or their carer before they leave the hospital. The plan will address lifestyle changes and medicines required to manage the patient’s risk factors, address their psychosocial needs and include a referral to a cardiac rehabilitation program that is appropriate for them. Take active steps to provide a copy of the plan to the patient’s general practitioner.

• **Health services.** Ensure systems and policies are in place to enable the development of an individualised care plan for a patient with acute coronary syndrome before they leave the hospital. Ensure clinicians take active steps to provide a copy of the plan to the patient’s general practitioner.
Consultation Process

The Commission is now initiating a phase of public consultation, seeking comments on the consultation draft of the Clinical Care Standard for Acute Coronary Syndrome and Clinical Care Standard for Antimicrobial Stewardship before they are finalised in 2014.

The consultation process aims to:

- determine if the quality statements within each Clinical Care Standard identify the key components of care a patient should be offered for a specific clinical condition, or defined part of a patient journey
- determine if the suggested indicators will assist local health services to monitor their progress in meeting the Clinical Care Standards
- identify activities that will support the use of the Clinical Care Standards (e.g. tools, resources, processes and strategies).

The following supplementary information is available on the Commission’s website:

- a summary of evidence sources used to support the development of each Clinical Care Standard
- consumer and health services fact sheets for the consultation drafts of each Clinical Care Standard
- draft indicator specifications for each Clinical Care Standard
- a section on frequently asked questions (FAQs), that have been developed for use by patients, carers, clinicians and health services.

The Commission welcomes any feedback on these documents as part of the public consultation process.

Questions of particular interest include:

1. How well does each quality statement cover the key aspects of care that it describes? Please provide any comments you may have, and evidence to support any modification to a quality statement.

2. What factors currently prevent the care described in the Clinical Care Standard from being achieved?

3. What factors will support the practical application of this Clinical Care Standard?

4. How relevant are the suggested indicators in supporting the monitoring of the quality statements at the local health service level? Please provide any comments you may have, and evidence to support any modifications.

5. How should the Clinical Care Standard be disseminated (e.g. web based resources, printed resources, etc)?

6. Do you have any general comments in relation to each Clinical Care Standard?

Submissions

Submissions can be sent by post, email or by completing an online survey.

All submissions received will be published on the Commission’s website, including the names and/or organisations making the submission. The Commission will consider requests to withhold part or all
of the contents of any submission made. Any submission that includes personal information identifying specific individuals may be withheld from publication or de-identified before submissions are published.

**Written submissions**

Submissions can be sent by post or email. All written submissions should be received by close of business on **Friday 14 March 2014** to be considered in the consultation process.

Submissions should include:

- name, organisation (if relevant) and contact details
- identify which of the Clinical Care Standards the comments relate to, or whether the comments relate to both of the Clinical Care Standards
- responses to the consultation questions
- any general comments
- additional information, for example, any technical or research-based evidence the Commission should be made aware of that supports the views or comments.

Written submissions marked ‘Consultation Paper on the Clinical Care Standards’ can be posted to:

Consultation on the Draft Clinical Care Standards  
Australian Commission on Safety and Quality in Health Care  
GPO Box 5480  
SYDNEY NSW 2001

Submissions can also be emailed to CCS@safetyandquality.gov.au.

**Feedback via online survey**

Feedback on the Clinical Care Standards can also be submitted via an online survey which is available at [http://www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)

The survey can be accessed by either clicking on the link, or by copying and pasting the address into your Internet browser. The survey questions will take approximately 20 minutes to complete. This survey will close on **Friday 14 March 2014**.

**Outcome of the consultation**

The results of this consultation process will be used to further refine the Clinical Care Standards. Feedback will also contribute to the identification of existing tools, and where necessary development of additional resources, which aim to assist with the implementation of the Clinical Care Standards.

**Further Information**

Any questions relating to the submission process should be directed via email to CCS@safetyandquality.gov.au or by calling the Commission on (02) 9126 3600.
Glossary

**Acute coronary syndrome**: A broad spectrum of acute clinical presentations, spanning a continuum from acute myocardial infarction to unstable angina. In most cases, it is the result of a sudden incomplete or complete blockage of a coronary blood vessel, leading to a compromise in blood supply to a portion of heart muscle.

**Acute myocardial infarction**: Commonly used to mean a heart attack, but more correctly refers only to those heart attacks that have caused some death of heart muscle.³

**Angina**: Chest pain due to obstruction or spasm of the coronary artery.

**Antiplatelet therapy**: Medicines that stop blood cells from sticking together and forming a blood clot.

**Atherosclerosis**: A process in which fatty and fibre-like deposits build up on the inner walls of arteries, often forming plaques that can then cause blockages. It is the main underlying condition in heart attack, angina, stroke and peripheral vascular disease.

**Cardiac event**: Any severe or acute cardiovascular condition including acute myocardial infarction, unstable angina or cardiac death.⁴

**Cardiac rehabilitation**: The sum of activities required to favourably influence the underlying cause of the disease, as well as the best physical, mental and social conditions, so that patients resume as normal a place as possible in the community.⁵

**Cardiac rehabilitation program**: Describes all measures used to help people with heart disease return to an active and satisfying life and to prevent recurrence of cardiac events.⁶

**Care plan**: An agreement between a consumer and health professional (and/or social services) to help manage day-to-day health. It can be a written document or something recorded in patient notes.⁷

**Carers**: People who provide unpaid care and support to family members and friends who have a disease, disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children.⁸

**Clinical pathway**: A clinical pathway explicitly states the goals and key elements of care based on clinical guidelines, best available evidence and patient expectations by facilitating communication, coordinating roles and sequencing activities of the multidisciplinary care team, patients and their carers; by documenting, monitoring and evaluating variances; and by providing the necessary resources and outcomes.⁹

**Clinician**: A healthcare provider, trained as a health professional. Clinicians include registered and nonregistered practitioners, or a team of health professionals, who spend the majority of their time providing direct clinical care.⁸

**Coronary angiography**: A procedure in which a special X-ray of the heart’s arteries (the coronary arteries) is taken to see if they are narrowed or blocked.¹⁰
**Coronary heart disease:** Caused by a slow build-up of fatty deposits on the inner wall of the blood vessels that supply the heart muscle with blood (the coronary arteries). These fatty deposits gradually clog the arteries and reduce the flow of blood to the heart.\(^{11}\)

**Coronary revascularisation:** Procedures used to restore good blood supply to the heart, for example, coronary angioplasty, which involves inserting a catheter with a balloon into a narrowed coronary artery.\(^{3}\)

**ECG-qualified clinician:** A clinician trained to understand and interpret patient ECG physiological data.\(^{12}\)

**Electrocardiogram (ECG):** A test that records the electrical activity of the heart, commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains.\(^{13}\)

**Fibrinolysis:** The breakdown of fibrin, the principal component of any blood clot.\(^{14}\)

**Health service:** A separately constituted health service is responsible for the clinical governance, administration and financial management of a service unit(s) providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients and can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients’ homes, community settings, practices and clinicians’ rooms.\(^{8}\)

**Heart attack:** Life-threatening emergency that occurs when a vessel supplying blood to the heart muscle is suddenly blocked, typically by a blood clot. The medical term commonly used for a heart attack is acute myocardial infarction.\(^{3}\)

**Hospital:** A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery.

**Medicine:** A chemical substance given with the intention of preventing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non prescription and complementary medicines, irrespective of their administration route, are included.\(^{8}\)

**Non–ST elevation myocardial infarction (NSTEMI):** A type of myocardial infarction identified by what is seen on the electrocardiogram. In a NSTEMI, the artery is only partly blocked, so only part of the heart muscle being supplied by that artery is affected.\(^{13}\)

**Non–ST segment elevation acute coronary syndrome (NSTEACS):** A condition where patients have acute chest pain but do not have persistent ST segment elevation in their electrocardiogram. NSTEACS is further divided into unstable angina and non–ST elevation myocardial infarction.\(^{13}\)

**Percutaneous coronary intervention (PCI):** A nonsurgical procedure that opens blocked or narrowed coronary arteries. A thin, flexible tube with a balloon or other device on the end is threaded through a blood vessel to the narrowed or blocked coronary artery. Once in place, the balloon is inflated to compress the plaque against the wall of the artery. This restores blood flow through the artery. During the procedure, the doctor may put a small mesh tube called a ‘stent’ in the artery.\(^{15}\)

**Reperfusion:** The restoration of blood flow to an organ or tissue.\(^{3}\)

**Risk factor:** Any variable (e.g. smoking, abnormal blood lipids, elevated blood pressure, diabetes) that is associated with a greater risk of a health disorder or other unwanted condition or event.\(^{3}\)
**ST segment elevation myocardial infarction (STEMI):** A type of myocardial infarction identified by what is seen on the electrocardiogram. In an STEMI, the artery supplying an area of the heart muscle is completely blocked.¹³

**Statins:** A group of cholesterol-lowering medicines that reduces the risk of heart attack or stroke.¹⁶

**Thrombolysis:** The breakdown of blood clots by medicine treatment. It is colloquially referred to as ‘clot busting’.³

**Unstable angina:** A form of angina that is more dangerous than normal angina but less so than a heart attack. It can feature chest pain that occurs at rest; in someone who already has angina it can be marked by new patterns of onset with exertion or by pain that comes on more easily, more often or for longer than previously.³
Appendix 1 – Membership of the Acute Coronary Syndrome Clinical Care Standard Topic Working Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Professor David Brieger (co-chair)</td>
<td>Interventional Cardiologist, NSW</td>
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<tr>
<td>Professor Andrew Tonkin (co-chair)</td>
<td>Cardiologist, Vic</td>
</tr>
<tr>
<td>Associate Professor Tim Baker</td>
<td>Emergency Physician, Vic</td>
</tr>
<tr>
<td>Professor Derek Chew</td>
<td>Interventional Cardiologist, SA</td>
</tr>
<tr>
<td>Mr Hugh Coulter</td>
<td>Consumer (heart attack survivor), Vic</td>
</tr>
<tr>
<td>Ms Natasha Eaton</td>
<td>Cardiac Clinical Nurse Consultant, Qld</td>
</tr>
<tr>
<td>Dr Paul Garrahy</td>
<td>Cardiologist, Qld</td>
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<tr>
<td>Dr Robert Grenfell (adviser)</td>
<td>National Heart Foundation</td>
</tr>
<tr>
<td>Mr Bill Hoffman</td>
<td>Consumer (heart attack survivor), Vic</td>
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<tr>
<td>Professor Joseph Hung</td>
<td>Cardiologist, WA</td>
</tr>
<tr>
<td>Professor Ian Jacobs</td>
<td>Professor Resuscitation and Prehospital Care, WA</td>
</tr>
<tr>
<td>Dr Jeffrey Lefkovits</td>
<td>Interventional Cardiologist, Vic</td>
</tr>
<tr>
<td>Professor Yussuf Nagree</td>
<td>Emergency Physician, WA</td>
</tr>
<tr>
<td>Ms Kathryn O’Toole</td>
<td>Cardiac Nurse Practitioner, SA</td>
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<tr>
<td>Professor Phillip Tideman</td>
<td>Cardiologist, SA</td>
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Commission staff

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr Michael Smith</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Ms Rosio Cordova</td>
<td>Program Director, Clinical Care Standards</td>
</tr>
<tr>
<td>Mr Neville Board</td>
<td>Program Director, Information Strategy and Safety in eHealth</td>
</tr>
<tr>
<td>Ms Lauren Deutsch/ Ms Leslie Trainor</td>
<td>Senior Project Officer, Clinical Care Standards</td>
</tr>
<tr>
<td>Ms Liz Metelovski</td>
<td>Senior Project Officer, Clinical Care Standards</td>
</tr>
<tr>
<td>Ms Sheila Matete-Owiti</td>
<td>Senior Project Officer, Indicator Development</td>
</tr>
<tr>
<td>Ms Claire Kay</td>
<td>Secretariat, Clinical Care Standards</td>
</tr>
<tr>
<td>Ms Kerryn Viana</td>
<td>Secretariat, Clinical Care Standards</td>
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Appendix 2 — Suggested Indicators

Health services need to be aware of how well the treatment they provide matches the Clinical Care Standards. Monitoring of the performance of the clinical services provided by an organisation is a key part of the National Safety and Quality Health Service (NSQHS) Standards, particularly Standard 1: Governance for Safety and Quality.

Organisations are likely to already have mechanisms in place that monitor care provided. However if additional measures are needed then the following indicators are suggested.

The detailed specifications for these indicators are provided in Indicator Specification: Consultation Draft Clinical Care Standard for Acute Coronary Syndrome. This supporting documentation can be accessed at http://www.safetyandquality.gov.au.

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<td>• CCS.ACS.1a: Proportion of ambulances that respond to acute chest pain calls, that are equipped with a 12-lead ECG in the reference ambulance service</td>
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<tr>
<td>• CCS.ACS.1b: Proportion of patients with chest pain with ECG performed within 10 minutes of first clinical contact – after arrival of ambulance</td>
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<tr>
<td>• CCS.ACS.1c: Proportion of patients, including patients presenting to Emergency Department (ED) via ambulance, with acute chest pain or other symptoms suggestive of an acute coronary syndrome with ECG performed and interpreted before or within 10 minutes of arrival to ED</td>
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<th>Quality statement 2 – Prompt reperfusion</th>
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<td>• CCS.ACS.2a: Proportion of patients with STEMI at first emergency contact presenting within 12 hours of symptom onset and receiving fibrinolysis or percutaneous coronary intervention (PCI)</td>
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<tr>
<td>• CCS.ACS.2b: Proportion of patients with STEMI, whose first emergency clinical contact is within 12 hours of symptom onset, treated with fibrinolysis before or within 30 minutes of hospital arrival</td>
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<td>• CCS.ACS.2c: Proportion of patients with STEMI, treated with PCI, who have a door-to-device time of 90 minutes or less, after arrival at a PCI-capable hospital, or 120 minutes or less if transferred from a non-PCI-capable hospital</td>
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<th>Quality statement 3 – Immediate management</th>
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<td>• CCS.ACS.3a: Proportion of patients presenting with acute chest pain or other symptoms suggestive of acute coronary syndrome, whose care is based on an evidence-based clinical pathway</td>
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<th>Quality statement 4 – Risk stratification</th>
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<td>• CCS.ACS.4a: Proportion of patients hospitalised with NSTEACS who have a documented assessment and risk stratification, using a guideline-recommended tool</td>
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<tr>
<td>• CCS.ACS.4b: Proportion of patients with NSTEACS in a hospital without angiography facilities, assessed as being at high risk for myocardial infarction (MI) and referred for angiography elsewhere</td>
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### Quality statement 5 – Coronary angiography

- CCS.ACS.5a: Proportion of NSTEACS patients, who, having been assessed as intermediate or high risk using a guideline-recommended tool, are informed of the risks and benefits of coronary angiography

### Quality statement 6 – Individualised care plan

- CCS.ACS.6a: Proportion of acute coronary syndrome patients provided with a written, individualised action plan (such as gradual physical activity, smoking cessation and therapies addressing psychosocial needs)
- CCS.ACS.6b: Proportion of patients with a final diagnosis of acute coronary syndrome who are prescribed aspirin and/or other antiplatelet therapy at hospital discharge
- CCS.ACS.6c: Proportion of patients with a final diagnosis of acute coronary syndrome who are prescribed statin therapy at hospital discharge
- CCS.ACS.6d: Proportion of patients with documented referral prior to discharge to a cardiac rehabilitation or an alternative secondary prevention program
References


