

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

Consultation Report

**Draft Acute Coronary Syndromes
Clinical Care Standard**

July 2014



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Contents

Introduction..... 4

About the consultation..... 4

Consultation process 6

Summary of consultation feedback..... 8

Next steps..... 13

Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) was created by Health Ministers in 2006 to lead and coordinate health care safety and quality improvements in Australia. *The National Health Reform Act 2011* established the Commission as an independent, statutory authority. It specifies that the Commission will formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care.

The *National Health Reform Agreement 2011* identifies that the Commission will work with clinicians to develop clinical standards for ensuring the appropriateness of care for people with specific clinical conditions, and that the Commission will recommend to Health Ministers the clinical standards suitable for implementation as national clinical standards.

The Commission has been working with consumers, clinicians, health managers and researchers to develop an Acute Coronary Syndromes Clinical Care Standard.

It complements existing efforts supporting the delivery of appropriate care, such as national initiatives led by the National Heart Foundation, and state and territory-based initiatives led by cardiac networks.

This report provides a summary of consultation findings regarding the draft Acute Coronary Syndromes Clinical Care Standard.

About the consultation

The public consultation period took place from 18 December 2013 to 14 March 2014. Sixty nine responses were received by the Commission as part of this consultation process.

Consultation documents for this Clinical Care Standard included:

- the draft Acute Coronary Syndromes Clinical Care Standard. This document articulated key components of care that a person with an acute coronary syndrome should receive from the onset of symptoms through to discharge from hospital. This included recognition of an acute coronary syndrome, rapid assessment, early management and early initiation of a tailored rehabilitation plan.
- a summary of evidence sources used to support the development of the Clinical Care Standard.
- a draft indicator specification. This document articulated a set of suggested indicators developed to assist local implementation of this Clinical Care Standard. These indicators intend to support health services in monitoring the implementation of the quality statements, and improvements as needed.
- draft consumer and clinician fact sheets.

The purposes of the consultation process were to determine if the draft Clinical Care Standard covered key components of care, the relevance of suggested indicators and fact sheets, and to identify potential enablers and barriers regarding the use of the Clinical Care Standard.

Stakeholders across Australia were contacted by post and were requested to submit feedback on the draft Clinical Care Standard. The consultation was also promoted via the Commission's website, Twitter account, *On the Radar* weekly publication and email bulletin. Members of the Acute Coronary Syndromes Topic Working Group also promoted this consultation.

Those contacted included medical colleges and societies, organisations, state health departments, Local Health Networks, Medicare Locals, consumer groups and private sector organisations. Feedback was received by either written response or online survey from a cross-section of these stakeholders. Additionally, the Commission met with key organisations to discuss the draft Clinical Care Standard in detail.

The following sections of the report provide a summary of the consultation process and responses.

Consultation process

Consultation questions

The Commission asked stakeholders to respond to the following consultation questions:

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

Submissions received

A total of 69 submissions were received. A breakdown is provided below:

Respondent type	Number of responses
Individuals	13
Colleges or associations	9
Consumer organisations	1
Jurisdictions (state or territory response)	9
Organisations:	
- General	18
- Medicare Locals	3
- Private health care	2
Local Health Networks	14
Total responses	69

Assessment of submissions

Submissions were allocated an identification number, and comments were classified according to the component they related to, such as language/structure of the document, scope of the Clinical Care Standard, quality statements, indicators, enablers/barriers, dissemination, general comments, and consumer and clinician fact sheets.

Feedback was themed for analysis and assigned into one of the following categories:

1. Consider now: Comments in this category were those relating to the scope of the Clinical Care Standard and the focus of each quality statement, terminology used, specificity, clarity of language particularly in the 'what it means' sections, relevance of the proposed indicators, supporting evidence, and barriers and enablers relating to implementation.
2. Consider in the future: Comments in this category were those suggesting extending the current scope of the Clinical Care Standard (e.g. extending the Clinical Care Standard into cardiac rehabilitation and the primary health care setting).
3. No action: Comments in this category expressed agreement and/or support for the Clinical Care Standard. Comments in this category also related to personal experience or suggestions to include large quantities of background information that are not within the domain of a Clinical Care Standard.

Following this assessment, consultation information was provided to the Acute Coronary Syndromes Topic Working Group to guide further refinement of the Clinical Care Standard.

Summary of consultation feedback

In general, there was strong support for the development and content of the draft Acute Coronary Syndromes Clinical Care Standard. Many commended the Commission for undertaking this work, and the multidisciplinary nature of topic working groups.

Feedback acknowledged that the Clinical Care Standard would provide important guidance to clinicians and health services regarding the care to be provided, and to consumers regarding the care that they should be offered.

It was also noted that the Clinical Care Standard would help address unwarranted variation in clinical practice and outcomes, and be broad enough to enable local adaptation in different local contexts.

Below is a summary, although not exhaustive, of the responses received.

Structure and language

Feedback was positive about the presentation of information. The main suggestion focused on the consistency of tense used across all documents. There was, however, general support for the development of fact sheets with suggestions on the use of plain English language for consumers.

Scope and context

There was broad agreement that the draft Acute Coronary Syndromes Clinical Care Standard covered key aspects of care within the identified scope; no important aspects of care had been missed. There were suggestions that the scope should mention that this Clinical Care Standard should also apply to existing inpatients that develop a suspected acute coronary syndrome while in hospital for a separate condition.

There was also a suggestion to reference the disparities in the management of acute coronary syndromes in the Aboriginal and Torres Strait Islander population.

Quality statements

Draft 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

Feedback identified that definitions for 'first emergency clinical contact' and 'ECG-qualified' were needed. The difference between being trained and competent in interpreting an ECG was also raised. Some suggested that this quality statement might be better placed after quality statement 3.

One comment noted that the 10 minute time frame was also applicable to primary care settings, rather than only the acute setting.

Draft 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

A number of comments highlighted the need to provide specific time frames for PCI and thrombolysis. One response identified that this quality statement should describe the need for ambulance services to have a comprehensive plan to ensure reduction in time to treatment.

Draft quality statement 3: Immediate management

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

Feedback identified that the term 'evidence-based clinical pathway' was vague and required further specificity, particularly in clarifying that this quality statement related to the use of a chest pain pathway.

It was suggested that training and competency were important components when implementing the use of the pathway, and should be supported by expert cardiac advice.

Some proposed that this statement might be better placed before quality statement 2, or merged with quality statement 1.

Responses also noted that the applicability of the quality statement was not limited to the emergency department, but could be extended to any setting where a person might present with chest pain.

Draft quality statement 4: Risk stratification

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

Comments recommended the identification of a risk stratification tool or assessment process, in order to support clinical decision-making. However it was noted that there was variability in the way that risk stratification/assessment processes were conducted, and it may therefore be difficult to gain consensus on the use of a particular risk stratification tool.

It was also noted that not all patients in rural areas were admitted to hospital, and therefore risk stratification may be led by nurses with the support of remote expert advice in rural/remote areas.

Draft 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 (NSTEMACS) who is assessed to be at intermediate or high risk of an adverse cardiac event

Feedback identified that the statement should take into consideration barriers associated with accessing coronary angiography in rural areas, and highlight the importance of timely provision of coronary angiography.

Draft quality statement 6: Individualised care plan

Before a patient with 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

A number of inclusions were suggested for this quality statement:

- that the patient receives a copy of their care plan before discharge
- that the general practitioner or relevant clinical provider receives the care plan in a timely manner
- that clinicians involved in follow-up care are also involved in the development of the care plan.

Comments also suggested further emphasis on the role of the carer, and reference to secondary prevention in addition to cardiac rehabilitation.

Feedback on indicators

There was broad support for the draft indicator specification and many noted that measurement is crucial for monitoring and improvement. It was also identified that these indicators would provide guidance for what should be measured.

Some queried the utility of presenting the indicators as voluntary indicators, suggesting that this will influence and potentially dampen their uptake. Many comments focused on the potential impact of data collection on limited health service resources.

Responses identified the scope of the indicators needed to match quality statements, and that specificity regarding certain indicators would be useful, e.g. what comprises an 'evidence-based clinical pathway', and which risk stratification tool should be used.

Some queried the omission of some medications such as aspirin, and others suggested highlighting the importance of dual therapy (aspirin and antiplatelet therapy). Additionally, cross-referencing with other relevant indicators, i.e. the national Quality Use of Medicines indicators was recommended.

The expected rate of compliance with some indicators was questioned, with respondents identifying that achieving 100 per cent compliance would not always be ideal or possible.

Some expressed concern about the use of the indicators to penalise services for failure to achieve the level of care identified in the Clinical Care Standards.

Barriers and enablers to care identified in the Clinical Care Standard

Barriers affecting the implementation of the Clinical Care Standard were identified as follows:

- Resources: funding, availability of services and equipment (e.g. access to ECG equipment particularly for ambulances, rehabilitation services) adequate staffing
- Rurality and remoteness, and the impact on the ability to meet identified time frames (e.g. achieving the 10 minute time frame for interpretation of ECGs in rural areas in terms of access to ECG equipment and appropriate expertise, or for those who present directly to hospital with less typical signs and symptoms; achieving the guideline-recommended time frames to PCI and thrombolysis in rural areas), access to services (e.g. limited access to cardiac catheterisation labs in rural areas) and specialist advice

- Fragmentation across jurisdictions and geographical areas in terms of funding streams, service delivery and communication across settings
- Systems: lack of established protocols (e.g. some services do not have a chest pain pathway)
- Measurement: Lack of linked data sets would make data collection very resource intensive. Also collection of ambulance data could be problematic, as there may be variability between volunteer and professional, and country and city ambulance services
- Knowledge: poor recognition of acute coronary syndromes symptoms by clinicians, and limited patient knowledge on the value of cardiac rehabilitation and sustaining their medication regimen post-discharge.

Enablers that can support the implementation of the Clinical Care Standard were identified as follows:

- The care identified in the draft Clinical Care Standard is currently being met around many parts of the country
- Routine measurement through registries, clear data collection processes, continued audits (i.e. the SNAPSHOT audit¹), feedback, reporting and improvement. It was noted that there are existing registries that can collect some indicators
- Presence of cardiac networks across jurisdictions that demonstrate strategic leadership (e.g. development of plans, protocols and pathways)
- The provision of education and training
- Linking in with acute coronary syndromes work being conducted for Aboriginal and Torres Strait Islander people
- Explicit linkage with the National Safety and Quality Health Service (NSQHS) Standards (e.g. Standard 9)
- Existence of secondary prevention and self-management programs (e.g. telehealth and cardiac rehabilitation programs)
- Communication across settings (e.g. ensuring that the patient's follow-up appointment is booked prior to leaving hospital)
- Tools and resources: e.g. identification of tool/s for risk stratification of NSTEMI patients, a standardised discharge statement, a structured inpatient checklist, existing protocols and pathways to support delivery of care in line with quality statements, existing patient resources (i.e. Heart Foundation consumer resources)
- Ensuring that patients/their carers understand information conveyed in the care plan
- Resourcing to facilitate best practice care, e.g. resourcing for ECG equipment and rehabilitation. It was noted that there is existing ECG capability within some ambulance services
- Translational research
- Promotion via professional colleges and peak organisations.

¹ Chew DP, French J, Briffa TG, Hammett CJ, Ellis CJ, Ranasinghe I, et al. Acute coronary syndrome care across Australia and New Zealand: the SNAPSHOT ACS study. *Medical Journal of Australia*. 2013;199(3):185-91.

Dissemination strategies

A summary of the suggested mediums for dissemination of this Clinical Care Standard and associated documents are provided below:

- **Consumers:** through social media, local media, radio, television, web-based resources in translated formats, via consumer groups and mobile/tablet devices
- **Clinicians:** through existing education sessions, tertiary curricula, in-service forums, printed resources, social media, via mobile/tablet devices, web-based resources (widgets, wiki, support tools, webinars), IT systems, resources (clinical pathways), conferences, via professional colleges and unions, and presentations to clinicians
- **Health services:** policy, via email, printed resources, intranet, key performance indicators (KPIs), agency agreements, accreditation and quality information boards
- **Other:** promotion via mail outs from cardiac networks, Medicare Locals, peak bodies, NSQHS Standards and future clinical practice guidelines (National Heart Foundation of Australia/ Cardiac Society of Australia and New Zealand).

Next steps

Feedback from the consultation process was collated and analysed, and a summary of key findings was presented to the Acute Coronary Syndromes Topic Working Group. Following this, the Clinical Care Standard was revised and finalised for submission to the Commission's various committees.

The Clinical Care Standards will undergo a process of endorsement through the relevant channels.

It is envisaged that the Commission will provide high-level implementation support for this Clinical Care Standard, with activities and resources to be identified in the coming months.

Further information about this Clinical Care Standard can be found at www.safetyandquality.gov.au/ccs.

If you would like to be kept informed about the work of the Commission, sign up to the Commission's newsletter online, or follow the Commission on Twitter @ACSQHC.