



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Operational Procedure for Rapid Access Chest Pain Clinic

Reference No:	UHB 316	Version No:	2 Year: 2014	Previous Trust / LHB Ref No:	236
----------------------	---------	--------------------	--------------------	---	-----

Documents to read alongside this Policy , Procedure etc (delete as necessary)	<i>List titles of Policy's, Procedures, Protocols, Guidelines, and Strategy's etc to be read alongside this document.</i>
--	---

Classification of document: Clinical

Area for Circulation: UHB wide

Author/Reviewee: Catherine Langdon (RACPNS)

Lead Clinician: Dr. N. Ossei-Gerning (Consultant Cardiologist).

Group Consulted Via/ Committee: All Consultant Cardiologists, Consultant Physicians and EU Consultants, Directorate Managers/Senior Nurses/Clinical Directors (Medicine/emergency medicine/cardiothoracic services). Primary Care leads: Dr. Mark Smithies (Divisional Director for Primary Community & Intermediate Care Services) and Dr. Sarah Morgan (Primary Care Cardiac Lead.

Approved by: Specialist Services
Quality and Safety Group

Date of Approval: 1st September 2015

Date of Review: 1st September 2018

Date Published: 12th July 2016

Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the UHB database for any new versions. If the review date has passed please contact the author.

OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Document Title: Operational Procedure for Rapid Access Chest Pain	3 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

Operational Procedure for the Rapid Access Chest Pain Clinic (RACPC)

	Contents	Page
1	Introduction	4
2	Aim	4
3	Scope	4
4	Roles and Responsibility	4
5	Implementation	6
6	Assessment and Non-invasive testing (N.I.T)	7
7	Emergency Contingency Plans	7
8	Development of Management Plans	8
9	Blood Tests	8
10	Documentation	8
11	Medication	8
12	Non-attendees	9
13	Inappropriate Referrals	9
14	Unexpected Patients	9
15	Equality Impact and Assessment	9
16	Audit and Data Collection	9
17	Distribution	10
18	Review	10
19	References and Further Information	10

Appendices

1	Nurse-led Rapid Access Chest Pain Clinic Protocol.	11
2	RACPC Proforma	13
3	Three Patient letter	18
4	Patient Information Leaflet	19
5	RACPC Care Plan Form & Audit Form	21
6	GP Management Plan letter	32
7	DNA Letter	34

Document Title: Operational Procedure for Rapid Access Chest Pain	4 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

1. INTRODUCTION

The National Service Framework for Coronary Heart Disease (DoH 2000) standard 8 states that

“by April 2001 there should be 50 Rapid Access Chest Pain Clinics (RACPC) to help ensure that people who develop new symptoms, that their GP thinks might be due to angina, can be assessed by a specialist within two weeks of referral. There will be 100 clinics by April 2002.”

In line with these recommendations The National Assembly for Wales’ report Tackling CHD in Wales: Implementing Through Evidence (2001) standard two states that

“Everyone at high risk of developing coronary heart disease and all those who have been diagnosed as having the disease should have access to a multifactorial risk assessment and be offered an appropriate treatment plan.”

2. AIM

The aim of the RACPC is to provide prompt assessment and evidence-based management of patients who are experiencing new onset chest pain, suggestive of angina. The purpose of the operational procedure is to provide clarity in relation to the structure of the service.

3. SCOPE

This operational procedure applies to patients referred to the Nurse-led Rapid Access Chest Pain Clinic from University Hospital of Wales General Physicians or General Practitioners within the Cardiff and the Vale area. The procedure relates to those patients seen and assessed by a chest pain clinical nurse specialist, under the clinical supervision of a Consultant Cardiologist.

4. ROLES AND RESPONSIBILITIES

4.1 The Consultant in clinic will be the primary point of contact for medical opinion; however if there is no consultant in clinic, refer to the on-call Cardiology Consultant. Should a patient require further testing or follow-up then the patient will be placed under the care of the Consultant Cardiologist on-call at the time of the clinic.

4.2 The RACPC Nurse Specialist is accountable for her/his practice under the terms of their professional body i.e. the Nursing and Midwifery Council ‘Code of Professional Standards for Conduct, Performance and

Document Title: Operational Procedure for Rapid Access Chest Pain	5 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

Ethics' (NMC May 2008). The Nurse-led RACPC is a role and may only be undertaken by a competent practitioner who has been assessed as competent to undertake the role by a Consultant Cardiologist and will work in accordance with the Rapid Access Chest Pain Clinic Protocol (see appendix one).

The RACPC Nurse Specialist will ensure that she/he complies with all University Health Board (UHB) policies and procedures which include:

- Management of Medicines
- Resuscitation Policy, Procedure and Guidelines
- Informed Consent to Treatment or Investigation
- Risk Management
- Health and Safety

Document Title: Operational Procedure for Rapid Access Chest Pain	6 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

5. IMPLEMENTATION

The RACPC is a nurse led service which will be situated in the Cardiac Outpatient Department, UHW. There will be a lead consultant and senior registrar for support if required.

The RACPC will provide a service between 9am and 5pm Monday to Friday (exclusive of public holidays).

The aim will be to provide six appointments per day, three in the morning and three in the afternoon initially with a view to increasing the appointment allocation once the service is established.

5.1 Referral criteria

- Patients with new symptoms suggestive of exertional angina.
- Patients who have previously been treated and discharged by a cardiologist and have now developed new symptoms, suggestive of exertional angina
- Patients seen in the Emergency Unit (EU) with chest pain, who have negative Troponin I (less than 0.03) results at 12hrs, with or without ECG changes (as long as the changes are not suggestive of MI or ACS).

Patients should not be referred if

- They are suspected of having an Acute Myocardial Infarction or Acute Coronary Syndrome
- They do not have a history suggestive of exertional angina
- They have symptoms which appear cardiac in origin but are not suggestive of angina for example; shortness of breath, palpitations, loss of consciousness or heart failure.

These patients should be referred to a Consultant Cardiologist or via EU as appropriate.

N.B The RACPC should not be used to obtain an earlier appointment.

5.2 Referral process

Patients can be referred to the RACPC via telephone or fax, those made by telephone must be followed up by a faxed referral form (see appendix two). Patients not felt to meet the referral criteria may be discussed with the lead Consultant Cardiologist and usually care management passed back to the General Practitioner for them to decide on the route of referral i.e. EU or Cardiology Out-patients.

On receipt of an appropriate referral patients will be contacted by the RACPC Nurse Specialist and an appointment arranged. The aim will be to see patients as soon as possible (within 48hrs of referral) and that all patients should be offered an appointment within two weeks of referral to the RACPC.

Document Title: Operational Procedure for Rapid Access Chest Pain	7 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

The date and time of the appointment will be confirmed in writing (see appendix three), and a patient information leaflet sent (see appendix four). If there is no time to send the information it will be given over the telephone.

Once an appointment has been arranged medical records staff will be informed and clinic lists will be produced on a daily basis. Patient hospital numbers will be allocated as required and hospital notes located, these will accompany all patients to clinic.

6. ASSESSMENT AND NON-INVASIVE TESTING (N.I.T)

The clinic co-ordinator at the reception desk will check the patients' demographic details these will also be cross checked with the PMS clinic list to ensure that the correct notes and patient are in clinic.

6.1 Patients will have a resting ECG and set of observations including height and weight taken on arrival at the clinic. A history and physical examination will then be taken by an appropriately competent practitioner(Consultant, SpR, Specialist Nurse or Cardiac Physiologist as deemed competent by the lead consultant); all findings will be documented in the care plan (see appendix five).

6.2 Based on all clinical findings and blood results, supplied by the referring clinicians on the referral form, the decision will then be made as to the appropriate (NIT). The Clinical Nurse Specialist, as an independent practitioner, will either be able to complete and sign the request form or will ask a medically qualified practitioner to do so as necessary. The Exercise Stress Test consent will be obtained and supervised by appropriately trained Physiologists in line with local operational policies and professional guidelines and competencies (British Cardiac Society 2003). For Myocardial Perfusion Imaging (MPI) and Dobutamine Stress Echocardiography (DSE) a letter will be written to Dr. Wheeler for an urgent appointment.

7. EMERGENCY CONTINGENCY PLANS

Patients should not be referred to the RACPC with either acute or unstable conditions. However, following initial assessment and history taking a patient may be deemed 'unstable' if any of the following apply:

- Unpredictable symptoms occurring at rest or during sleep
- Sudden increase in frequency, duration or intensity of symptoms
- Limited relief from use of sub-lingual Glycerine Trinitrate (GTN)

In the event of a patient being assessed as having unstable angina, the case will be discussed with the SpR/ Cardiology Consultant on call and arrangements made to admit the patient to hospital. Contact will be made with the Cardiothoracic Directorate bed management coordinator/ Bed Management Team and transfer to an appropriate environment arranged. The GP will be notified of the arrangements made.

Document Title: Operational Procedure for Rapid Access Chest Pain	8 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

In the event of a RACPC patient having a cardiac arrest, emergency medical help must be summoned by the instigation of the UHB Cardiac Arrest Procedure.

8. DEVELOPMENT OF MANAGEMENT PLANS

8.1 Following the NIT, the results will be presented to the Consultant Cardiologist/SpR in clinic and a management plan formulated. The management plan will include recommendations for drug management, further investigations, follow-up arrangements and supporting written information. A copy of the plan will be posted to the GP.

8.2 The patient will have all test results and the management plan explained. Risk factors will be revisited. British Heart Foundation education booklets will be given as appropriate.

8.3 Where the likelihood of a cardiac problem is thought to be low this will be explained to the patient and lifestyle modification plans documented. The GP will be informed of all findings and the management of the patient will be passed back to them (appendix six).

8.4 If a diagnosis of angina is reached, suggested medical therapy will be decided upon by the Cardiology Consultant or SpR for the GP to commence. Any follow-up appointments required for tests or consultations will be arranged before the patient leaves and documented in their management plan (see appendix five). The management plan and risk factors will be explained to the patient and any questions answered at this juncture. Should patients require angiography they will be placed on the waiting list on the day of the RACPC appointment. If the patient does not want to undergo angiography follow-up will be arranged in the cardiology outpatient clinic.

9. BLOOD TESTS

Blood tests are not routinely taken in the RACPC. Referring clinicians are asked to supply recent blood results on the referral form. Patients who do not have a recent cholesterol result available will be advised to have this checked by their GP.

10. DOCUMENTATION

The patient notes will be located and collected prior to the appointment. The visit to the RACPC will be documented in the RACPC care plan (see appendix five), which will be filed in the patient notes. The management plan will have three copies made, one copy for the GP, one for the patient notes and one for the RACPC nurse to keep for reference.

11. MEDICATION

The non-medical prescriber will be competent to commence:

Document Title: Operational Procedure for Rapid Access Chest Pain	9 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

Aspirin, Beta-blockade, Calcium Channel blockers, Nitrates, Statins and GTN spray. Should any other medication be considered necessary a medical professional (either Consultant Cardiologist or SpR) will be consulted. Patients will be supplied with appropriate medication (if required) following their consultation. The GP will be informed of this in the management plan (see Appendix 6)

12. NON-ATTENDEES

Attempts will be made to contact the patient by telephone to arrange another appointment in clinic. If the patient does not make contact with the RACPC nurse after 3 working days the GP will be informed by letter (see appendix 7).

13. INAPPROPRIATE REFERRALS

If an individual clinician is found to repeatedly refer patients who do not meet the criteria for the RACPC they will be contacted and any questions answered. Dr. Sarah Morgan (Primary Care Cardiac Lead) and Dr. Mark Smithies Divisional Director for Primary Community and Intermediate Care Services) will also be informed.

14. UNEXPECTED PATIENTS

Occasionally patients will turn up in the cardiology department because they feel unwell. These patients should be referred back to the EU for their own safety; the staff in EU is better equipped to decide the best course of action. Transfer will be arranged taking into account the condition of the patient and liaison with EU staff.

15. EQUALITY IMPACT AND ASSESSMENT

An equality impact assessment has been undertaken to assess the relevance of this procedure to equality and potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the procedure presented a low risk to the UHB. Suggested is some alternative wording below which has been approved by Keithley Wilkinson the Equality Manager for the UHB.

The UHB is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups. The UHB has undertaken an Equality Impact Assessment and received feedback on this Policy and Standards of Behaviour Framework and the way it operates. The UHB wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was **low impact** to the equality groups mentioned. Where appropriate the UHB will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

Document Title: Operational Procedure for Rapid Access Chest Pain	10 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

16. AUDIT AND DATA COLLECTION

The RACPC nurse will maintain the RACPC audit with the insertion of each patients details onto an excel spread sheet. The information will be collated and reported on an annual basis at clinical governance and divisional quality and safety meetings.

17. DISTRIBUTION

17.1 This procedure will be available via the [UHB intranet](#) and [internet sites](#). Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

18. REVIEW

This procedure will be reviewed at least every 3 years or sooner should any developments or changes in practice inform the UHB otherwise.

19. REFERENCES AND FURTHER READING

British Journal of Cardiac Nursing Feb. 2006 Vol 1 No 2 pp89-94

Keenan J (2006) Rewards and Opportunities in Rapid Access Chest-Pain Clinics

Kelly D et al (2011) Implementation of the new NICE guidelines for stable chest pain services in the UK. *The British Journal of Cardiology*. 18 (4) 185 – 188.

McManus RJ et al (2002) A Systematic Review of the Evidence for Rapid Access Chest pain Clinics. *International Journal of Clinical Practice* 56(1):4-5

NeHL (2001) Rapid Access Chest Pain Clinic Protocol

Pottle A (2005) A nurse-led rapid access chest pain clinic- experience from the first 3 years *European Journal of Cardiovascular Nursing* 4 (2005) 227-233

Document Title: Operational Procedure for Rapid Access Chest Pain	11 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

Appendix 1.

Cardiff and Vale UHB

Nurse-led Rapid Access Chest Pain Clinic Protocol.

Referral Process

- All patients referred to the RACPC will be seen within two weeks of the date that the correctly completed referral form is received.
- Referrals are received directly from GP's or general physicians by fax.
- All referral forms should be completed in their entirety including recent blood results.
- All patients will be sent an appointment letter with the date and time of allocated clinic appointment together with a patient information leaflet.

Inclusion Criteria

- 1) Patients with new symptoms suggestive of exertional angina.
- 2) Patients who have previously been treated and discharged by a Cardiologist and have now developed new symptoms, suggestive of exertional angina.
- 3) Patients seen in A&E with chest pain, who have negative Troponin I (less than 0.03) results at 12hrs, with or without ECG changes.

Exclusion Criteria

- 1) Patients suspected of having an Acute Myocardial Infarction or Acute Coronary Syndrome.
- 2) Patients who do not have a history suggestive of exertional angina.
- 3) Patients who have symptoms that appear cardiac in origin but are not suggestive of exertional angina, for example shortness of breath, palpitations, loss of consciousness or heart failure.

Clinic assessment

- * All referrals to the RACPC are to be seen by the Nurse Specialist with oversight from a Consultant Cardiologist or (SPR).
- * A base line ECG, height weight and vital signs will be recorded on arrival in the clinic.

Document Title: Operational Procedure for Rapid Access Chest Pain	12 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

* A detailed history will be taken, risk factors identified and a baseline physical examination will be performed by the Nurse Specialist.

* All patients who it is deemed appropriate to perform an ETT will be asked to do so. Despite the downgrade by NICE, all patients who are deemed suitable to perform an ETT will be asked to do so. This is because of its availability, and the fact that, **currently, more appropriate tests are less readily available.**

*Other patients will be referred for an MPI or other non-invasive investigations if available. It is hoped that in the future, when more appropriate non-invasive tests become available, that these will replace ETT in a significant proportion of patients.

- **Patients with unstable angina or severe resting 12-lead ECG changes should not undergo ETT but should be admitted for appropriate treatment.**

PROCEDURE IN THE EVENT OF A HIGH RISK TEST

* Where the ETT is classed as high risk, the Consultant Cardiologist will be notified for a decision re; coronary angiography.

* A Coronary Angiography waiting list card will be completed and taken to the appropriate Consultants secretary for actioning.

* Patients who require angiography will have a full explanation of their management plan together with written information on the procedure itself. If the patient does not want to undergo angiography an outpatient appointment will be made in the clinic of the consultant for follow-up.

* The GP letter will include recommendations of medications that should be considered to treat that patients stable angina e.g Beta-blocker, Aspirin, Statins and Nitrates, unless contra-indicated.

*The GP letter/management plan will be sent in the post. The GP letter will also include a description of the patient's clinical presentation, risk factors, ETT result, risk grading and plan of action/follow-up.

Patients diagnosed with Stable Angina.

- All patients with a possible diagnosis of Stable Angina are to be discussed with the Consultant Cardiologist and a management plan agreed.
- An outpatient appointment will be arranged, if felt to be necessary by the Consultant Cardiologist.
- Patients will be informed of their diagnosis whilst in the clinic and will be given British Heart Foundation information leaflets.
- The GP letter will include recommendations of medications that should be considered for example Beta-blockers, Aspirin, Statins, Nitrates unless contra-indicated. Patients who are unable to tolerate Beta-blockers may be considered for rate limiting calcium channel blockers as an alternative.
- The clinic letter will be sent in the post to the GP. The letter will include a description of the patient's clinical presentation, risk factors, ETT result, risk grading and management plan.

Document Title: Operational Procedure for Rapid Access Chest Pain	13 of 35	Approval Date: 01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality, Safety, Experience Committee		

Follow up

- Patients who have required follow-up as part of their management plan will have an appointment allocated based on the urgency rating expressed by the Consultant Cardiologist.
- Patients not requiring follow up will be discharged back to the care of the GP, either for further investigation of chest pain that is not thought to be cardiac, or for medical management of their chest pain using the suggested management plan.



Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

University Hospital of Wales, Cardiff Rapid Access Chest Pain Clinic Referral Form

REFERRAL CRITERIA: New or recent onset of **EXERTIONAL** chest pain suggestive of ischaemic heart disease. Fax completed forms to: **02920743916**. ***Incomplete Referrals will NOT be processed.***

Patients with UNSTABLE Cardiac Chest Pain (Acute Coronary Syndrome) should be admitted.

Patient details

Name: _____
Sex: Male / female (*circle*)
DOB: _____
ID Number: _____
NHS Number: _____
Address: _____

Tel no.: _____
Interpreter needed YES / NO (*circle*)
Language: _____

Referring Clinician Details:

Name: _____
Practice _____
Address: _____

Contact telephone number: _____

MAU/A&E referrals must state referring consultant:
Signature: _____

STEP ONE – SYMPTOMS Tick all that apply

Angina pain (NICE Criteria):

- Chest discomfort radiating to neck, jaw, or arms
- Precipitated by exertion
- Relieved by rest or GTN within 5 minutes

Non-anginal features:

- Non exertional or positional pain
- Localised, lateral chest pain
- Worse during inspiration

STEP TWO – CLINICAL DIAGNOSIS Tick ONE only

- Typical angina: score 3 of NICE criteria (above) - **refer to RACPS**
- Atypical angina: score 2 of NICE criteria - **refer to RACPS**

Document Title: Operational Procedure for Rapid Access Chest Pain	14 of 35	Approval Date:01 Sep 2015
Reference Number: UHB 316		Next Review Date: 01 Sep 2018
Version Number: 2		Date of Publication: 12 Jul 2016
Approved By: Quality ,Safety ,Experience Committee		

Non-anginal pain: score 1 of NICE criteria - **DO NOT refer to RACPS**

Patients with Non Anginal chest pain, patients with CAD risk < 10% - **DO NOT REFER** unless there is a strong clinical suspicion of CAD.

STEP THREE - RISK FACTORS *Tick all that apply*

High risk factors:

- Diabetes mellitus
- Hyperlipidaemia (cholesterol > 6.47)
- Smoking

Other risk factors:

- Hypertension
 - Family Hx of premature coronary disease
 - History of IHD/ CABG/ PCI/ PVD/ Stroke
- Specify.....

STEP FOUR - Coronary Artery Disease Risk (CAD) – see flow chart on next page

CAD risk =% High Risk / Low Risk (*circle*)

STEP FIVE - TREATMENT - consider Aspirin, GTN, Statin, Betablocker

EXCLUSION CRITERIA: (unsuitable for RACP - refer to Cardiology Pool)

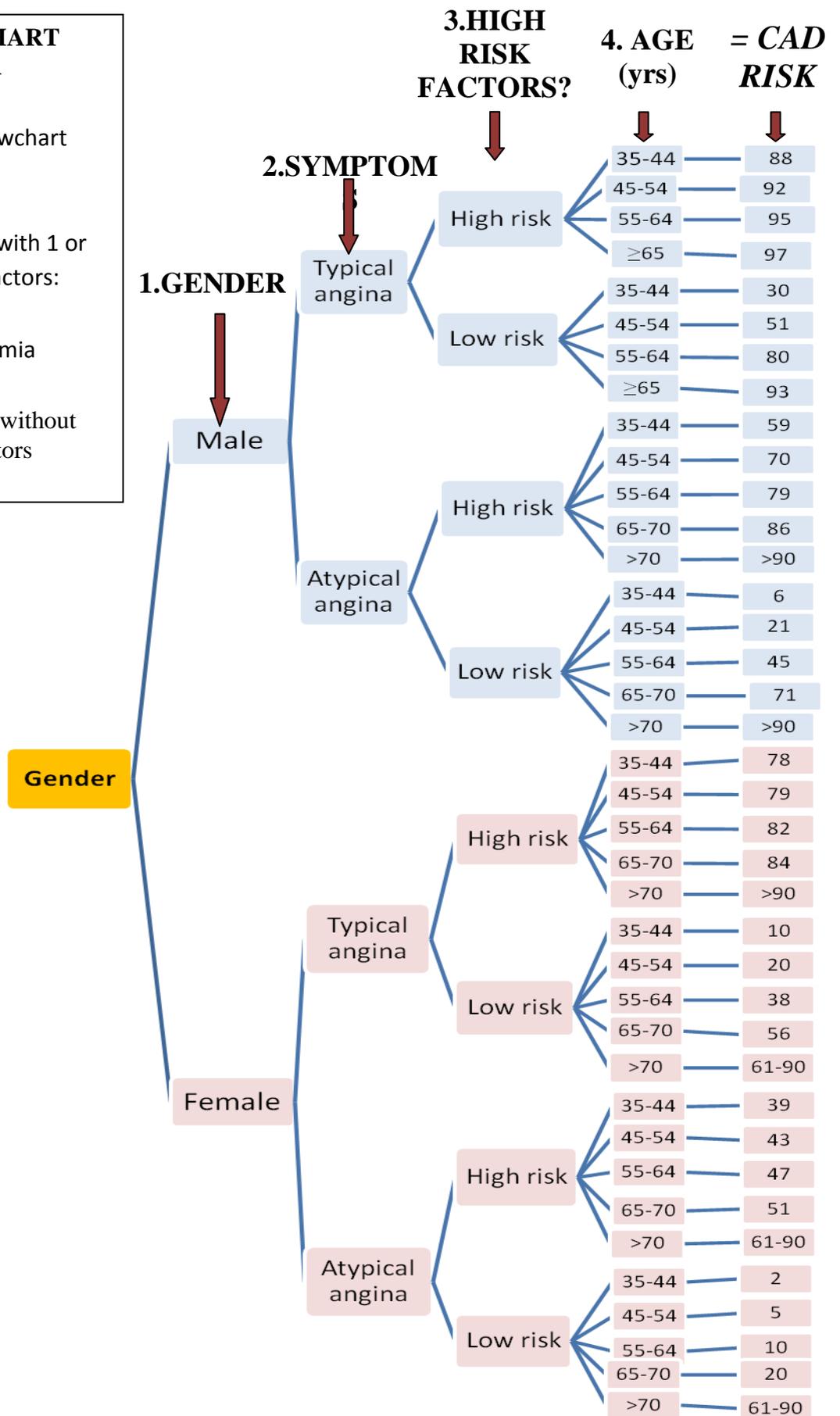
- AF/LBBB/Wolff-Parkinson White syndrome.
- BP >200/100mmHg
- Seen by cardiology in last 2 yrs
- Re-vascularised (last 5 years)

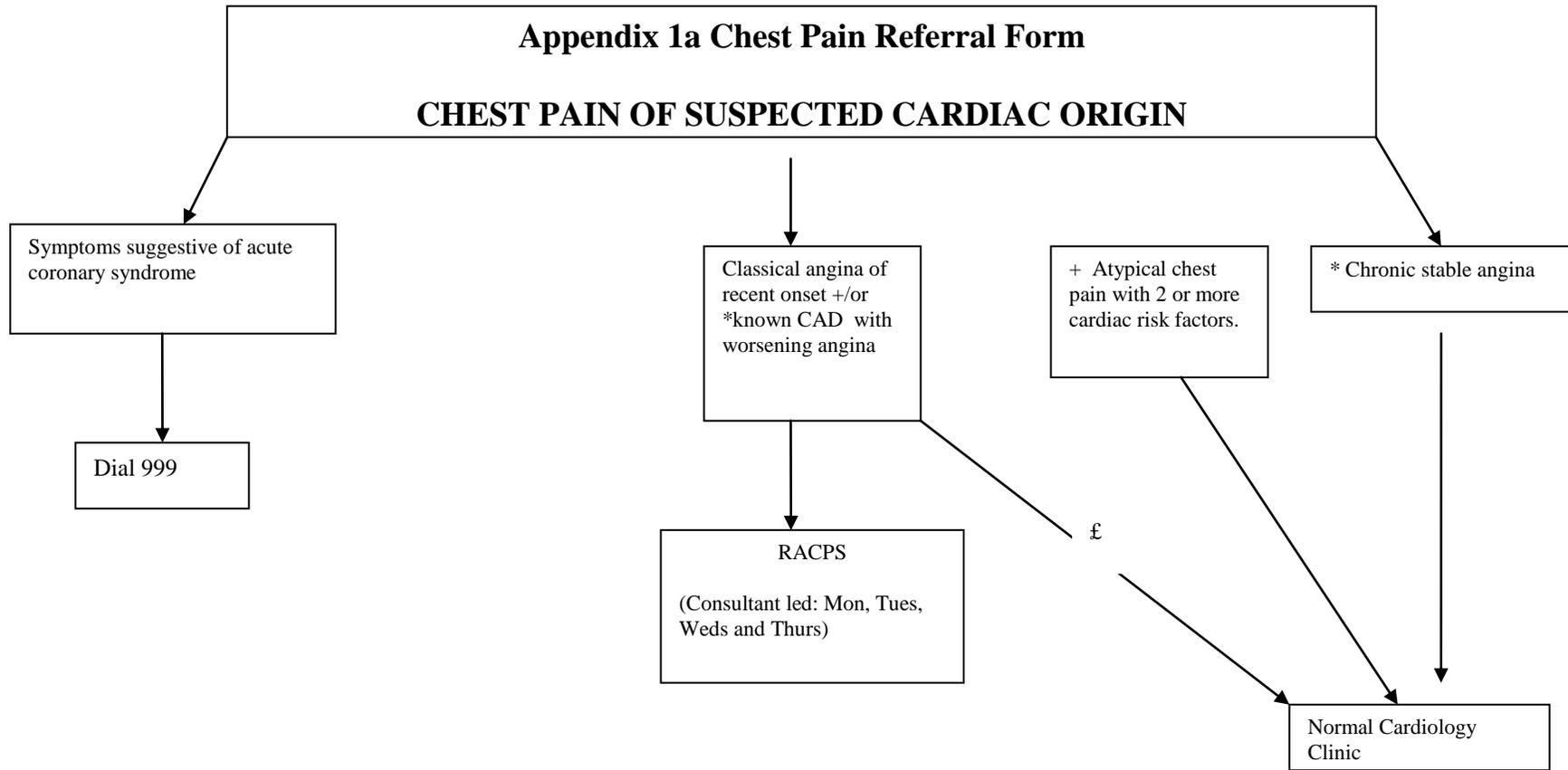
- Male < 40 female < 30
- Unexplained/untreated anaemia
- Symptomatic arrhythmia
- Cardiac murmurs/Heart failure
- Unexplained syncope

CAD RISK FLOWCHART CALCULATOR

User notes:

- Follow 4 steps of flowchart from left to right
- High risk** = patients with 1 or more of these risk factors:
 - Diabetes
 - Hyperlipidaemia
 - Smoker**Low risk** = patients without any of these risk factors

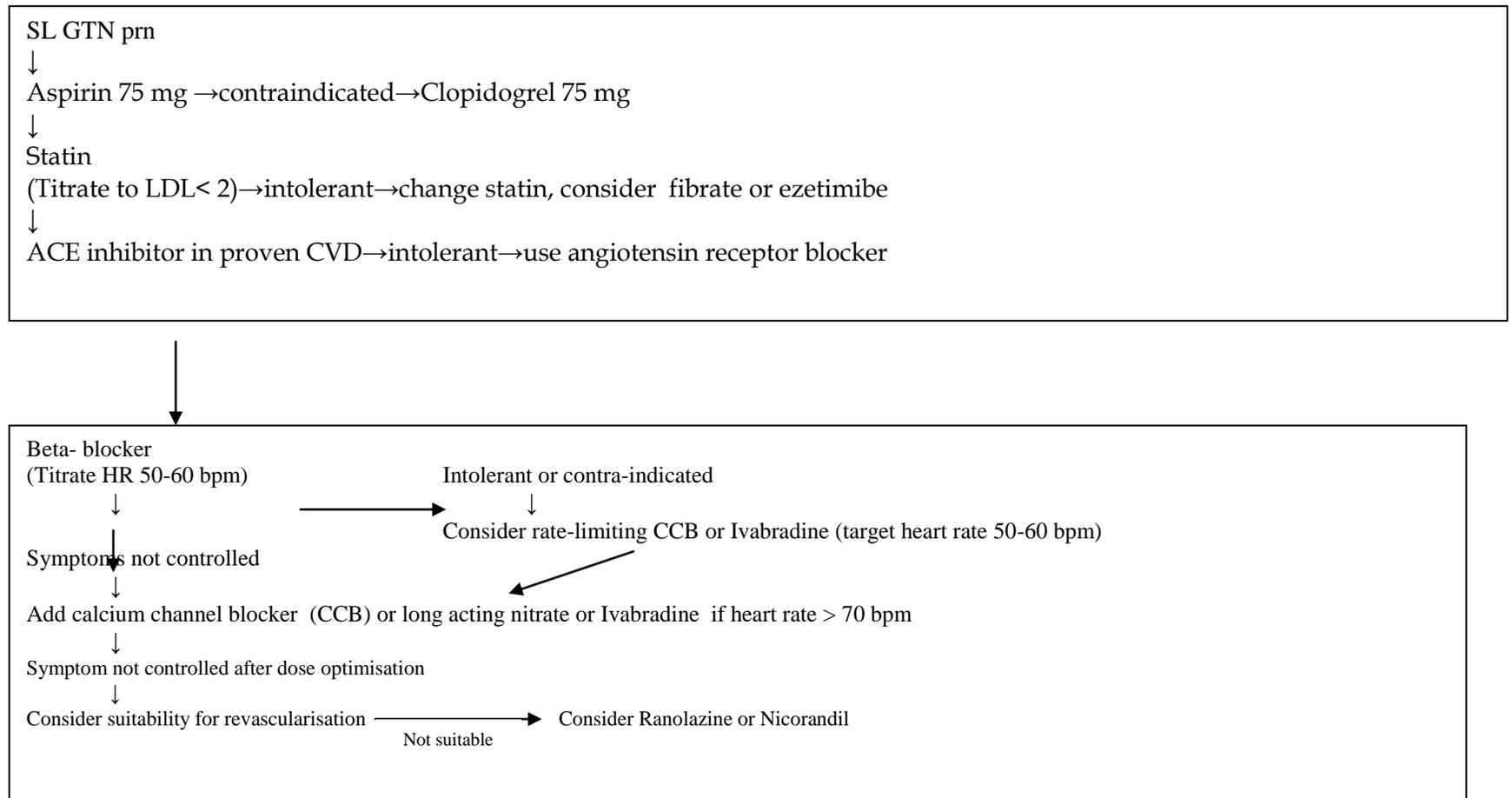




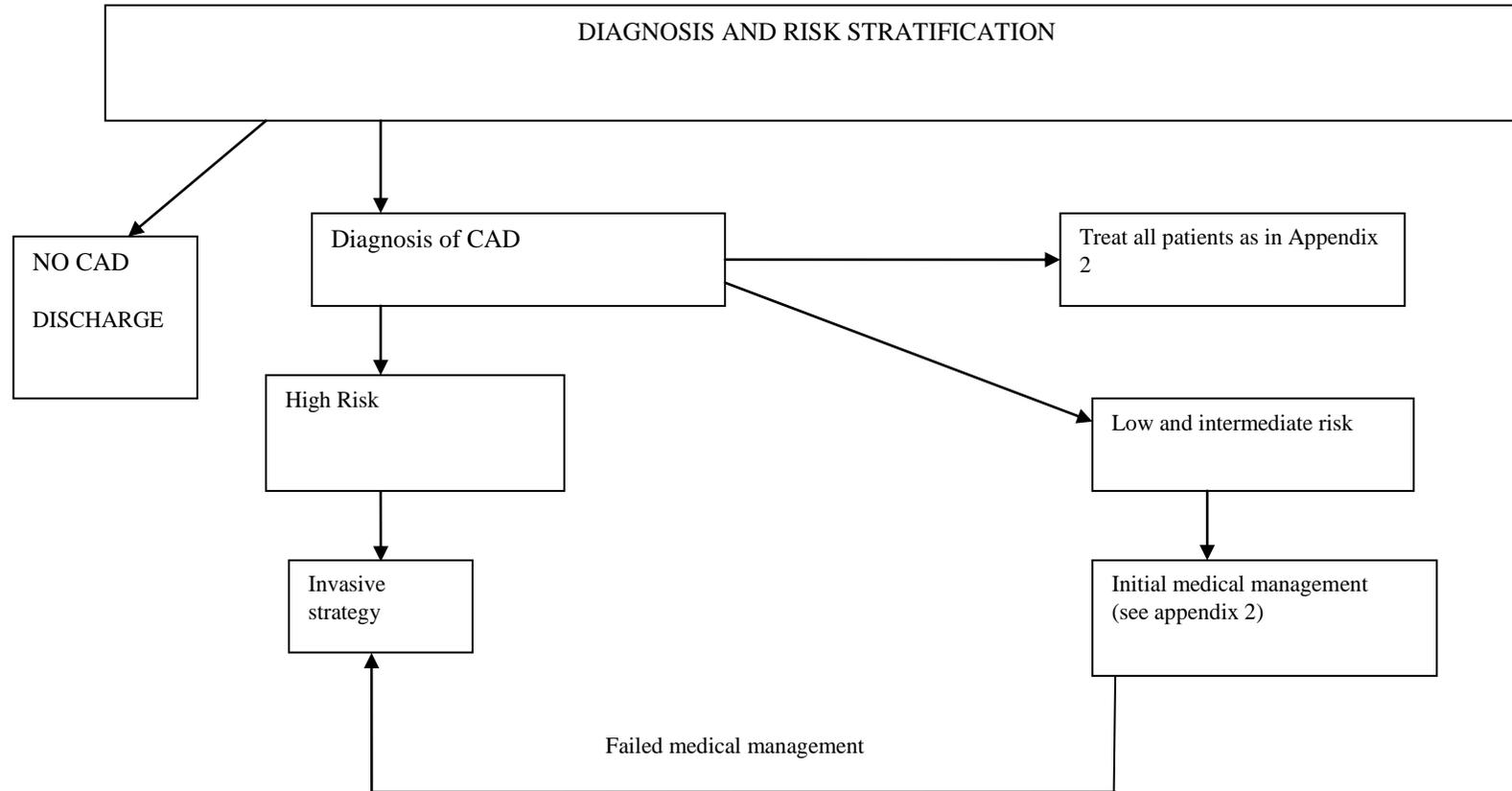
*Further evaluation in hospital may not be necessary if the patient is stable.
+Non cardiac chest pain should not be referred.

£ Significant comorbidities, eg, severe heart failure, significant lung disease, significant neurological deficit, and severe arthritis, please refer urgently to Cardiology Clinic.

Appendix 2a Chest Pain Referral Form.
ALGORITHM FOR MEDICAL MANAGEMENT OF
CHEST PAIN ADAPTED FROM STABLE ANGINA-ESC



Appendix 3a





Appendix 3.

Cardiff and Vale UHB
University Hospital of Wales
Heath Park
Cardiff
CF14 4XW

Date:

**Rapid Access Chest Pain Clinic
Cardiology Out-patient Department.**

Dear

An appointment has been booked for you to attend the above clinic on;

.....

At;.....

You will need to report to the Cardiac out-patient department near B1 Ward.

When you arrive please inform the receptionist that you have come for the Chest Pain Clinic.

Should you need to change this appointment please telephone;

Catherine Langdon on 02920745845 Bleep no. 5152

Yours sincerely,

Catherine Langdon
Rapid Access Chest Pain Nurse Specialist



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Patient Information leaflet Rapid Access Chest Pain Clinic

Appendix 4.

What is the RACPC?

Your General Practitioner will refer you to the Rapid Access Chest Pain Clinic to investigate the possible cause of your chest pain. Chest pain can be caused by several things and this clinic will look at whether your heart may be the cause.

What is involved?

At your appointment a Cardiologist (Heart doctor) or Specialist Nurse and a Cardiology physiologist will see you. We will carry out some tests to assess your chest pain and decide if you have angina.

What tests may I have done?

- **Blood tests**
- **Height**
- **Weight**
- **Blood pressure**
- **Electrocardiogram (ECG)** This is a simple recording of your heartbeat. The physiologist/ nurse will attach pads to your arms, legs and chest and a recording is then taken.
- **Exercise ECG recording:** This is a recording of your heartbeat whilst you walk on a treadmill. The treadmill begins slowly and will gradually increase. We will monitor your heart and blood pressure carefully while you perform this exercise. This test usually takes between 15-30 minutes.
- **Echocardiogram (ECHO).** This is a scan of the movement of the wall and valves of your heart. The technique uses ultrasound and therefore causes no pain or discomfort.

What should I wear?

The exercise test is not too energetic; just wear flat shoes and comfortable clothing that you will be able to move easily in, trousers would be advisable. You will not be expected to run or exercise beyond your capabilities and the test can be stopped at any time. You may have a light meal about two hours before your appointment. Avoid heavy meals prior to exercise.

What should I bring?

Any tablets, medicines or inhalers that you are currently taking.
A drink, as your appointment may last for two hours.

What will happen after the tests?

The Cardiologist or Specialist Nurse will discuss the results of your tests with you, and any further treatments or tests which are planned.

If the tests show that you do have angina, you will be given some advice and information booklets about angina by the Specialist Nurse. You will be given a copy of your results and a Risk factor Management Plan.

Your GP will be sent a copy of your Risk factor Management Plan within the next few days.

Past medical history. (Tick box if Applicable).

- Ischaemic heart disease
- Congestive cardiac failure/Left ventricular failure
- Hypertension
- Hypercholesterolaemia
- Rheumatic fever
- Transient ischaemic attacks
- Peripheral Vascular Disease
- Pulmonary embolism
- Epilepsy
- Asthma
- Diabetes
- Chronic obstructive pulmonary disease
- Liver disease
- Hyper/hypothyroidism
- Chronic renal failure
- Peptic/duodenal ulcer
- Aortic stenosis Murmurs
- Surgery (note details)
- Erectile dysfunction: Y/N
- Any other:

Presenting Complaint:

Description of symptoms:

Onset & chronology:

Location & radiation:

Quality of pain:

Severity of pain:

Alleviating factors:

Precipitating factors:

Associated symptoms:

Frequency:

Risk Factors:

Diabetic: Y/N Smoker: Y/N Alcohol Y/N (If yes, weekly units =)

Family History (1st degree relative Male < 55 years; Female < 65 years): Y/N

Cholesterol (Chol < 4 mmols, Trigs < 2.0) Y/N Hypertensive: Y/N

Current Medications (Including over the counter medications).

Allergies: Medication/tapes/creams/food/iodine/contrast medium.

Observations:

Height:

Weight:

BMI:

Blood pressure:

Pulse (note if irregular)

Respiratory rate:

SaO₂:

Temperature:

PHYSICAL EXAMINATION.

Respiratory:

Rate: Expansion: Auscultation:

 Percussion:

Cardiovascular System:

Pulse rate: bpm: Carotid Bruit: JVP: Apex beat:

Heaves/thrills: Heart sounds: Pedal oedema:

Varicose veins:

Exercise tolerance test

Any other test results

Plan.

Agreed with:

Follow up arrangements

AUDIT FORM FOR RAPID ACCESS CHEST PAIN CLINIC.

DATE OF CLINIC:

Patient's Name:

Hospital No.

Male/Female:

D.O.B:

Age:

Source of referral: A&E

Source of referral: GP If GP, note name & address:

Date referred:

Date received:

Date of appointment:

Referral Criteria:

Patients with new symptoms (less than 3 months) suggestive of exertional angina

Patients who have previously been treated and discharged by a cardiologist and have now developed new symptoms, suggestive of exertional angina

Patients seen in A & E with chest pain who have negative Trop I (less than 0.03) results @ 12 hours, with or without ECG changes (as long as the changes are not suggestive of MI or ACS).

Not met referral criteria

Reason:

They are suspected of having an acute Myocardial infarction or acute coronary syndrome

They do not have a history suggestive of exertional angina

They have symptoms which appear cardiac in origin but are not suggestive of anginal for example:

Shortness of breath

Palpitations

Loss of consciousness

Heart failure

Other

Length of consultation time:

Nurse consultation time:

Cardiff and Vale University Health Board

Investigation time:

Medical opinion time:

Cardiologist:

Diagnosis: Cardiac

Diagnosis: Non cardiac

Outcome: Angio list

Angio results:

Outcome: Echo on the day

Echo results:

Outcome: Echo referral

Outcome MPI referral

Results MPI:

Outcome DSE referral

Results DSE:

Outcome ETT on the day

Outcome ETT referral

Results of ETT:

Negative

Positive

Inconclusive

Submaximal

Patient discharged from RACPC

Patient referred to cardiologist

Patient admitted to hospital

ECG: Normal/Twave inversion/Q waves/LBBB/RBBB (delete as appropriate)

Diabetes: Y/N (Delete as appropriate)

Hypercholesterolaemia: Y/N

Smoker: Y/N

Hypertension: Y/N

Family history Y/N

History of IHD/CABG/PCI/PVD/Stoke..... (Specify)

Old Medication: Statin/Aspirin/Betablocker/GTN spray/Nitrate/other

New Medication: Statin/Aspirin/Betablocker/GTN spray/Nitrate/other

Erectile Dysfunction: Y/N

(Updated 21/03/14)

Appendix 6.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

University Hospital of Wales
Ysbyty Athrofaol Cymru

Eich cyf/Your ref:
Ein cyf/Our ref:

Welsh Health Telephone Network
Direct Line/Llinell uniongyrchol

Heath Park,
Cardiff,
CF14 4XW
Phone (029) 2074 7747
Fax (029) 2074 3838

Parc Y Mynydd Bychan,
Caerdydd,
CF14 4XW
Ffôn (029) 2074 7747
Ffacs (029) 2074 3838

CARDIAC SERVICES DIRECTORATE
DEPARTMENT OF CARDIOLOGY

MB /JP / [~PAT.CRN/U~]
[~PAT.LETTER DATE~]

PRIVATE & CONFIDENTIAL.

Dr [~PAT.GP FORENAME/U~] [~PAT.GP SURNAME/M~]
[~PAT.SURGERY/M~]
[~PAT.GP ADDR1/M~]
[~PAT.GP ADDR2/M~]
[~PAT.GP ADDR3/M~]
[~PAT.GP ADDR4/M~]
[~PAT.GP POSTCODE/U~]

Dear Dr [~PAT.GP SURNAME/M~]

[~PAT.PAT TITLE/M~] [~PAT.FORENAME/M~] [~PAT.SURNAME/M~] DOB
[~PAT.PAT DOB~] [~PAT.PAT ADDR1/M~] [~PAT.PAT ADDR2/M~]
[~PAT.PAT ADDR3/M~] [~PAT.PAT ADDR4/M~] [~PAT.PAT
POSTCODE/U~]

Date seen: [~PAT.SESSION DATE~]

This patient who presented with chest pain has been seen and assessed.

The clinical diagnosis here is:

The patient has been further assessed with ETT/DSE/MPI/Coronary CT.

The test was normal/abnormal.

Coronary angiography has/has not been organised.

Your patient has been started on :

Cardiff and Vale University Health Board

Aspirin
Beta-blocker
Statin
Other

Follow up will be in months.

This patient has been discharged.

Yours sincerely

Countersignature

CATHERINE LANGDON
CHEST PAIN SPECIALIST NURSE

DR N OSSEI-GERNING
CONSULTANT
CARDIOLOGIST
MD FRCP



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Appendix 7.

Date

Dear Doctor.....

Thank you for referring.....
.....
.....
.....

He/she failed to attend an appointment at on.....

We have been unable to contact them by telephone since. Please do not
hesitate to re-refer this patient in the future if you feel it appropriate.

Yours sincerely,

Catherine Langdon
Rapid Access Chest Pain Nurse Specialist