Washington State Department of Health

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL II Cardiac Center

Purpose: To ensure hospital preparedness when receiving ACS patients while limiting unnecessary use of hospital resources.

1. **Cardiac Activation:** For STEMI, CPA-ROSC from presumed ischemic heart disease, and patients with hypotension or pulmonary edema, i.e., patients who meet Immediate Field Criteria on the Prehospital Cardiac Triage Destination Procedure.

   All necessary components of the hospital-based emergency response to ACS should be initiated as soon as notified by EMS of an impending transport of these major ACS patients.

   These components should include the following within the hospital's scope of capability:

   a. Identify primary nurse and physician, or, where applicable, mid-level provider, who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER to receive patient.

   c. Recruit additional team members as resources allow and are required to provide for rapid evaluation and immediate care of the patient. These may include but are not limited to the following:

      - Respiratory Therapist
      - Pharmacist
      - Radiology Technician
      - EKG Technician

   d. Prepare to initiate fibrinolytic therapy for appropriate patients.

   e. Prepare for initiation of therapeutic hypothermia for appropriate CPA-ROSC patients.

   f. Identify the closest Level I Cardiac Center, determine the most rapid means of critical care transport, and activate the transport system.

   g. Initiate early consultation with a receiving emergency physician/cardiologist at the Level I Cardiac Center to which the patient will be transferred.

Hospital Emergency Response Guideline
For Acute Coronary Syndrome (ACS)
LEVEL II Cardiac Center

2. **Cardiac Alert**: For UA/NSTEMI and patients who have a prehospital high risk score of FOUR or greater on the Prehospital Cardiac Triage Destination Procedure.

   These patients should receive an immediate evaluation by the in-house elements of the cardiac team to further evaluate the possibility of a time-critical ACS being responsible for the patient's symptoms.

   The components of this response should include the following within the scope of capability of the receiving hospital:

   a. Identify primary nurse and physician or, where applicable, mid-level provider, who will meet the patient upon arrival.

   b. Identify most appropriate available bed in ER to receive patient.

   c. Recruit additional team members as resources allow and are required to provide for the rapid evaluation and immediate care of the patient. These may include but are not limited to the following:

      - Radiology Technician
      - EKG Technician
      - Lab Technician

   d. Initiate ACS 'rapid rule out' pathway.

   e. Identify the closest Level I Cardiac Center and initiate early consultation with a receiving physician.

   f. Determine the most rapid means of critical care transport and activate the transport system.

The intent of this guideline is to ensure a comprehensive response to obvious critical ACS patients while avoiding excessive recruitment of resources for patients who need further *immediate* evaluation to determine the likelihood that their symptoms are from ACS. Once that determination is made, additional personnel and interventional capabilities should be recruited appropriate to the patient's needs.