Title: Farwaniya Hospital Intradepartmental policy – Internal Medicine and Cardiology units	
Policy Owner: Internal Medicine Department	**Policy Code**: A- CCU-003
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Notes	

1.0 Purpose

1.1 The main aim of this policy is organizing the work in the medical department and specially between medical units and the cardiology unit

2.0 Definitions

2.1 High risk acute coronary syndrome (ACS) is considered when having any of the following:

- 2.1.1 ST elevation MI (STEMI).
- 2.1.2 A **Grace Score** of more than 140. (visit the link)
- 2.1.3 Ongoing cardiac chest pain.
- 2.1.4 Dynamic ECG changes
  - 2.1.4.1 ST elevation/depression.
  - 2.1.4.2 Deep symmetrical T-Wave inversion or Wellens ECG.
- 2.1.5 hsTrop equal or more than 250 in the setting of either
  - 2.1.5.1 Typical cardiac chest pain.
  - 2.1.5.2 ECG changes that are mentioned above.

2.2 High sensitivity Troponin above 100 when there is a dynamic rise and/or fall of more than 40%, should raise the concern for possible CCU admission in the context of ACS.

3.0 Patient Evaluation and Admission in the Emergency Room (ER):

3.1 The cardiologist should evaluate and admit any patient in the emergency room (ER) coming with:

- 3.1.1 High risk cardiac chest pain (based on the above definitions).
- 3.1.2 All myocardial infarctions cases (STEMI, NSTEMI) and myocarditis.
- 3.1.3 Proved Endocarditis that needs only antibiotic therapy will be admitted under medical with a daily follow-up by the cardiologist. In case the patient becomes hemodynamic unstable, needs surgical intervention, etc., will be taken over by the cardiology unit.
- 3.1.4 Cardiac chest pain and any sign of instability (instability/clinical).
- 3.1.5 Evaluate any chest pain after a recent PCI within 1 month, and admission if any suspicion of cardiac chest pain.
- 3.1.6 Evaluate any chest pain in a patient that has been discharged within 7 days from the cardiology unit with an ACS (Note that the day of discharge is considered day 0 and 7 days are counted after day 0), and admission if any suspicion of cardiac chest pain.
- 3.1.7 Decompensated heart failure in the setting of cardiogenic shock, acute pulmonary edema, active cardiac ischemia or not responding to the initial management in casualty.

3.1.8 Hemodynamically unstable arrhythmias (tachy-/ brady-arrhythmia) – if the arrhythmia is the primary insult.

3.1.9 Syncope with high-risk features (according to the ESC 2018 syncope guideline – suggesting cardiac cause) will be admitted under the cardiology team in the CCU. (Press over the link)

3.1.10 Hemodynamic unstable pulmonary embolism (non-surgical cause) requiring thrombolytic therapy (decision of thrombolysis will be taken by the cardiology unit).

3.2 **Heart failure as first presentation** - Patients that are presented with heart failure for the first time, will be admitted by the medical team and will be evaluated by the cardiologist in the ER and in the ward for follow-up and discharge plan. All the following criterions should be met:

3.2.1 Does not have the mentioned complications in point 3.1.7.

3.2.2 Does not need hemodynamic or respiratory support.

3.3 **If no bed in CCU** - For any patient who requires CCU admission and there is no bed in the CCU, he/she will be admitted under the cardiology unit in the general ward.

3.4 If a patient was recently **discharged from the cardiology unit and presented again with a non-cardiac medical complaint**, he will be assessed by the medical unit to decide about medical side admission

3.5 **Simultaneous active medical and cardiac issues** - If the patient is presented with simultaneous active medical and cardiac issues that require medical and CCU admissions (does not required ICU admission), he/she will be evaluated by the medical team (to initiate the management of his/her active medical issue) then will be admitted by the cardiology unit in the CCU and the medical problems will be followed by the medical consult team in the CCU. After stabilizing the cardiac problem (in case of myocardial infarction, five days should be passed from the myocardial infarction presentation) the patient will be either

3.5.1 Shifted back to his primary medical unit in the ward, in case his/her medical problem needs further inpatient management (medical unit senior will be informed) (review point 5.3 down), or

3.5.2 Discharged by the cardiologist, in case his/her medical problem is resolved and does not need further inpatient management.

3.6 **Disposition of the post cardiac arrest** cases from a cardiac cause is according to the following:

3.6.1 In hospital arrest gets admitted under the cardiology in the CCU.

3.6.2 Out of hospital arrest: under the medical team/ICU unless the patient is conscious. In that case the patient should be admitted under the cardiology unit in the CCU.

4.0 Consultations

4.1 All consults should be **stamped by registrar or above rank and should include his contact number**.

4.2 Response time (based on MOH transfer policy)

4.2.1 STAT/Emergency consult – 3 to 5 mins (e.g., cardiac arrest)

4.2.2 Urgent consult – 15 to 30 mins (registrar rank and above should contact the consulted service)

4.2.3 Routine consults during weekdays – within 24 hours

4.2.4 Routine consults during weekend along with contacting the consulted service by the

registrar– within 24 hours

4.3 Consults to medical team and/or subspecialities

4.3.1 Consult medical subspecialities for all active medical issues.

4.3.2 Consult medical consultation team in case of takeover is requested.

5.0 Takeover Policy

5.1 **Admitted under Cardiology** - If the patient was admitted initially under cardiology unit, after stabilizing the cardiac problem (and at least five days from the myocardial infarction presentation) but he/she requires staying in the hospital for an active medical problem, a takeover consultation can be sent to the consultation team to evaluate and decide about the takeover.

5.2 **Admitted under Medical -** If the patient was admitted to the medical team for a medical problem and developed a cardiac problem that requires shifting him to the CCU, a consult should be sent to the cardiologist and the medical registrar (or above rank) should contact them.

5.3 **Previously was Taken over by Cardiology** - If the patient was admitted initially under medical team and was taken over by the cardiology unit to stabilize the patient from a cardiac point of view, the cardiologist can contact the treating medical unit directly (without contacting the consultation team) for takeover back to medical unit (transfer note to be written by the cardiologist and takeover note by the medical senior registrar).

6.0 Urgent Echocardiography:

6.1 Urgent echo during the ONCALL should only be requested if it will change the management of the patient and should be mainly limited to the following situations:

6.1.1 Suspected cardiac tamponade

6.1.2 Suspected pulmonary embolism (PE) and CT pulmonary angiography can not be performed or the Echo will change the decision regarding thrombolysis in PE

6.1.3 Unexplained shock

6.1.4 Other cases where the senior of both teams agree upon

7.0 Disagreement

7.1 If any disagreement regarding the admission/consultation/takeover between the medical and cardiology teams, the seniors from both teams should discuss to solve the issue and escalate to a higher rank if needed.