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Homerton University Hospital NHS Foundation Trust

GERIATRIC REVIEW AFTER EMERGENCY LAPAROTOMY

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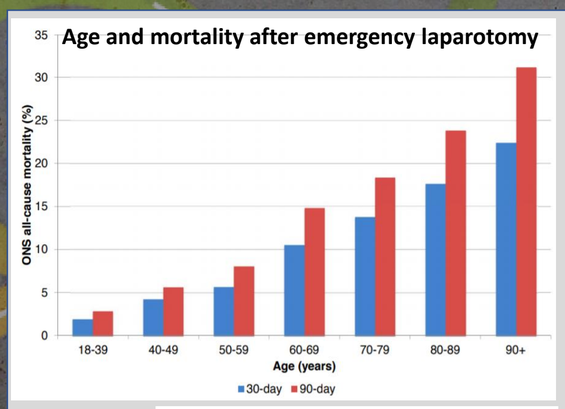
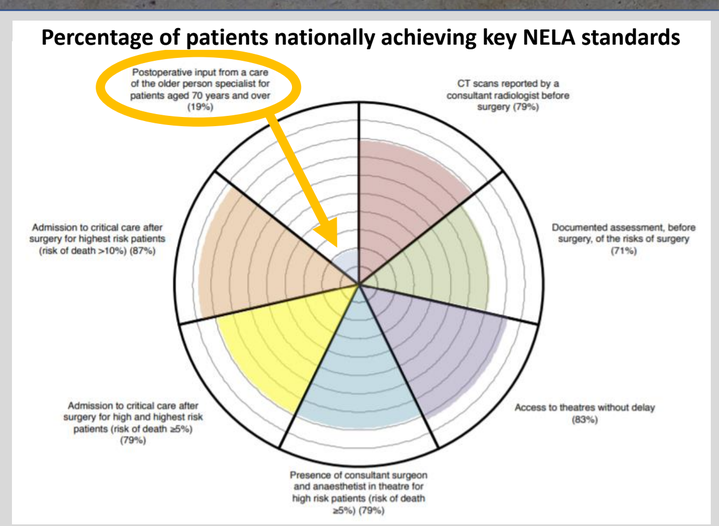
INTRODUCTION

- Mortality rates in >70s are 15-30% after emergency surgery, doubling in case of a complication.
- Frailty is associated with poorer surgical outcomes.
- NELA data show that nationally ~20% of these patients are seen by a Medicine for Care of Older People (MCOP) specialist in the postoperative period, with 3% of trusts providing regular proactive assessments [1].
- NCEPOD reports that in elderly patients who died in the 30 days following surgery, 36% received good perioperative care [2].

Homerton NELA data demonstrated that 33% of elderly emergency laparotomy patients in the year beginning May 2016 received perioperative MCOP assessment. During joint audit fora and NELA meetings with the surgical and MCOP department, we postulated that primary drivers for low review rate were MCOP capacity, patient detection, and motivation of the involved teams.





~50% of patients are aged **over 70**. Only 3% of hospitals provide **regular proactive assessments** from geriatricians for older patients after surgery.

50% over 70

77% ~Half of patients are **aged over 70**, bu **were not seen by a geriatrician**

Figures from NELA 3rd (2016-17) and 4th (2017-18) reports

METHODS

- Aim: 80% of total >70s, and 100% of those suitable (i.e. excluding those who died before ITU discharge) seen postoperatively by MCOP.
- Means: Ideas were implemented from the driver diagram (Fig 1).
- Outcomes: Data for >70s extracted from NELA database and patient notes used to confirm ITU deaths. Plotted as a run-chart with overlapping cohorts to smooth the effect of random variation and better represent overall trends.

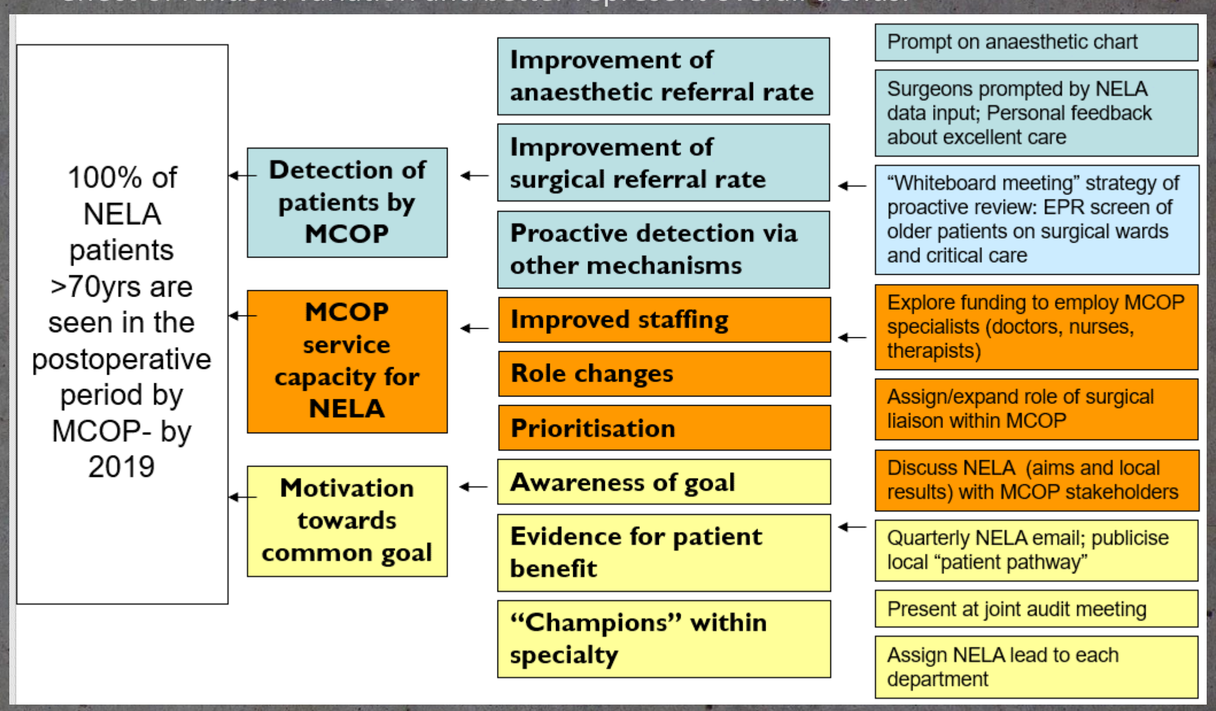
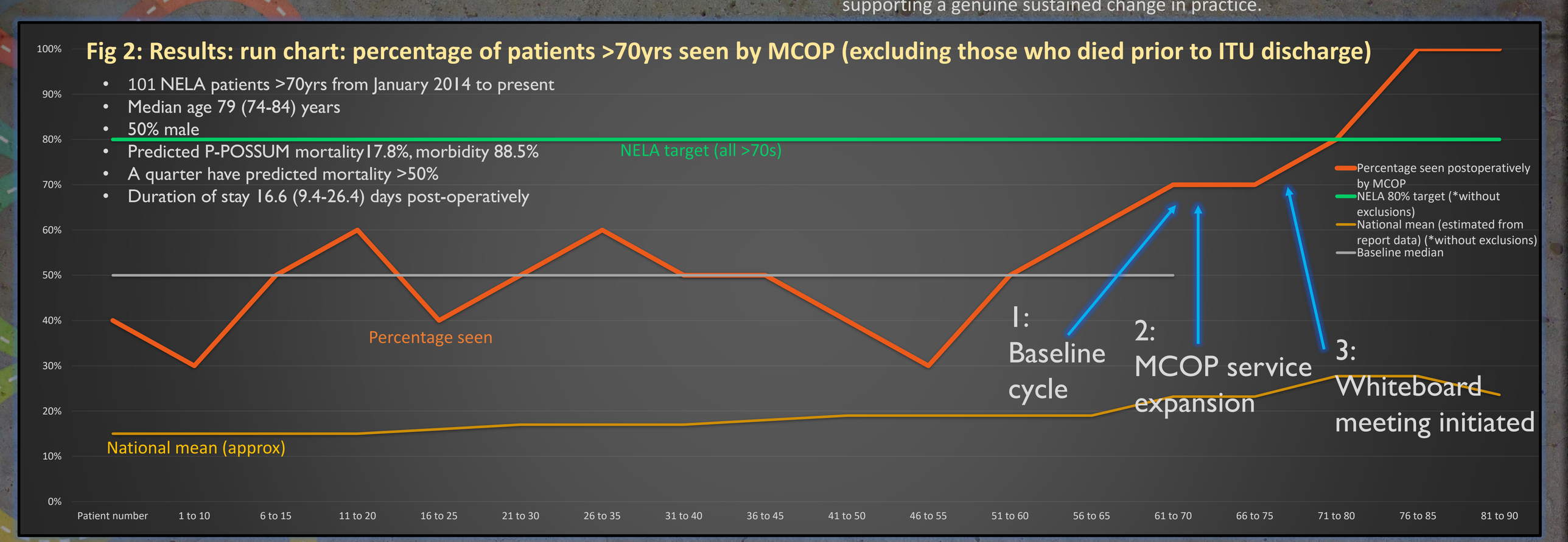


Fig 1: Drivers for change

RESULTS

- Baseline cycle May 2016-May 2017: review rate 33% total (6/18), or 43% excluding 4 patients who died before ITU discharge
- Re-audit March 2017 to July 2018: review rate 68% (19/28), or 80% excluding 4 patients who died before ITU discharge
- 4/5 eligible patients not seen were in the period March-July 2017 before MCOP department expansion.
- **From the introduction of MCOP whiteboard meeting December 2017 to present, all suitable patients were reviewed.**
- Importantly, this reflects a period beyond annual "changeover" time, supporting a genuine sustained change in practice.



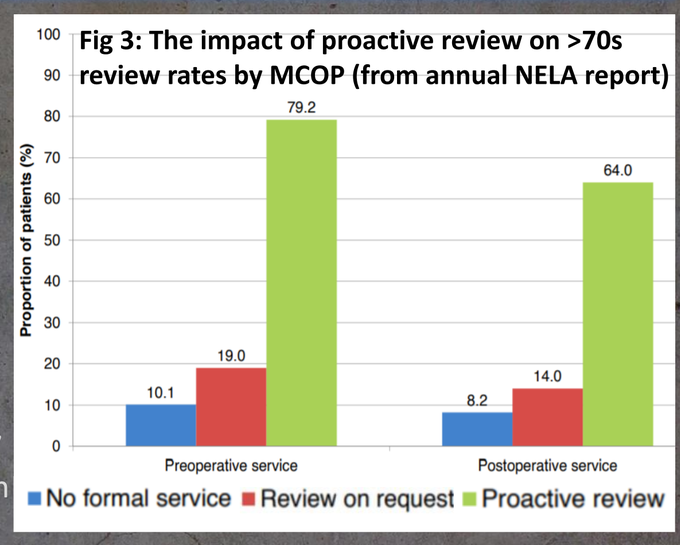
DISCUSSION

Benefits of MCOP input in other elderly surgical populations, first shown in the Proactive Care of Older People undergoing Surgery (POPS) service, have included:

- improvements in medical complication rate (pneumonia, delirium),
- quicker mobilisation,
- fewer pressure sores and inappropriate catheters,
- shorter length of stay,
- increased independence at discharge and less need for residential care [3]

In a recent multilevel analysis of NELA data, post-operative MCOP review was associated with substantially improved survival [4].

Proactive assessment has been shown to dramatically increase review rates when compared to referral-driven review, even when a specific service and pathway exists (Fig3). Based on the principles of the NHS Improvement SAFER bundle [5], in December 2017 the MCOP service introduced a daily multidisciplinary "whiteboard" meeting to the Homerton, chaired by a Consultant Geriatrician and attended by the Surgical Rehabilitation Team (SRT) doctors, therapists and nurses.



The electronic bed-boards for the surgical wards are reviewed and screened for any >70s who might require specialist expertise. These patients are then reviewed in person. The aim of the meeting is to identify outstanding patient needs, enhance MDT communication, and instigate early discharge planning, in line with BGS Good Practice standards. We expect this to provide benefit not only for our emergency laparotomy cohort, but also to allow early detection of other elderly elective surgical patients who may have complex medical and rehabilitation needs. A review of this service is ongoing.

Next steps:

- Maintain performance and data collection
- Formally assess impact on other services: NOF, younger high risk patients
- Does MCOP review impact mortality, morbidity, LOS, experience cost?
- Preoperative review: a cohesive plan from the front door

DECLARATION: Work presented orally at Barts and the London School of Anaesthesia meeting, 21/11/18. charlotte.trainer@nhs.net

REFERENCES

[1] NELA Project Team. Third Patient Report of the National Emergency Laparotomy Audit, RCoA London, 2017

[2] Wilkinson K, Martin I, Gough M, et al. An Age Old Problem A review of the care received by elderly patients undergoing surgery- A report by the National Confidential Enquiry into Patient Outcome and Death 2010

[3] Harari D, Hopper A, Dhesi J, et al. Proactive care of older people undergoing surgery ('POPS'): designing, embedding, evaluating and funding a comprehensive geriatric assessment service for older elective surgical patients. *Age Ageing* 2007;36(2):190-6

[4] Oliver C, Bassett M, Poulton T, et al. Organisational factors and mortality after an emergency laparotomy: multilevel analysis of 39 903 NELA patients

[5] https://improvement.nhs.uk/resources/safer-patient-flow-bundle-implement/