How I set up my service; reflections from Salford

14.00 - 15.00	Session F Surgery in older people **Chair: Dr David Shipway** Venue: Richard Burton theatre

Arturo Vilches-Moraga

Salford Royal NHS Foundation Trust

Northern Care Alliance NHS Group

11th April 2019

POPS

"Improving the care of older surgical patients through collaboration, education and research"

MANCHESTER 1824 The University of Manchester

University of Salford MANCHESTER

How WE set up OUR service; reflections from Salford

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Improving surgical outcomes (POP-GS)

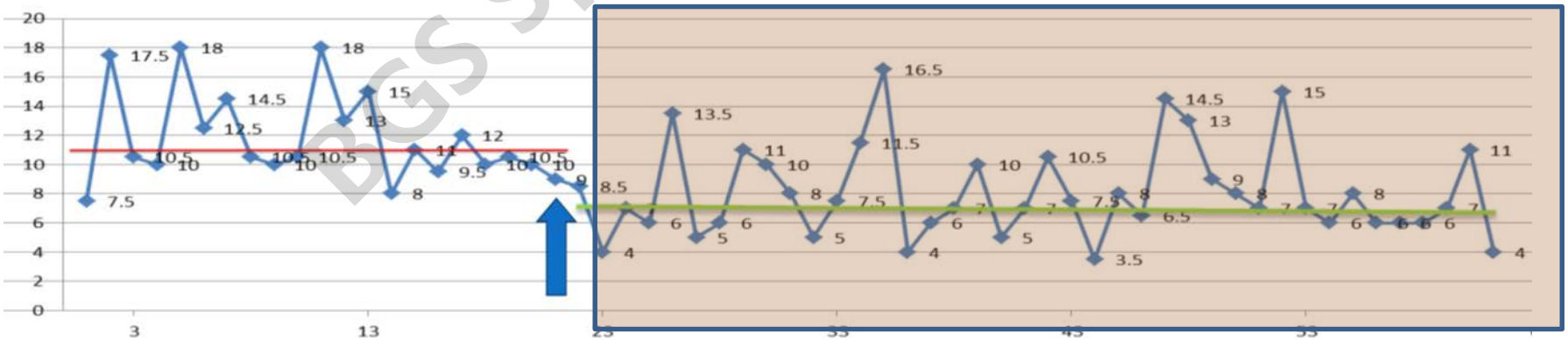
NHS
Northern Care Alliance
NHS Group

1776 patient-episodes

8th September 2014 10th May 2019

Before February 1st
11 Median

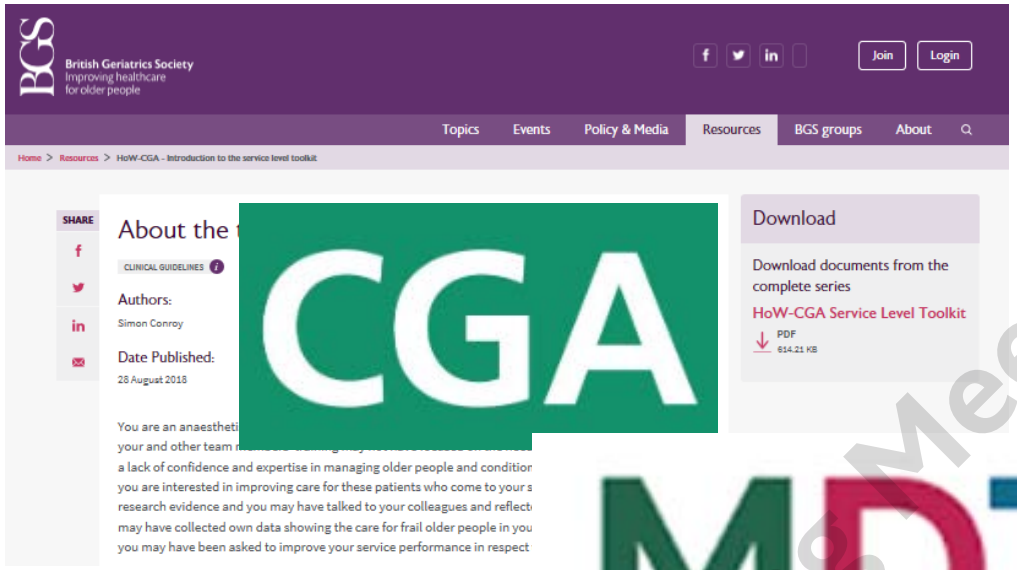
After February1st
7 Median



Overview of this presentation

- **Single best answer questions**
- **Models of care**
- **Collaborative working in progress:** Salford-POPS-GS
- **Tips :** Collaborative care in General Surgery
- **Key messages**

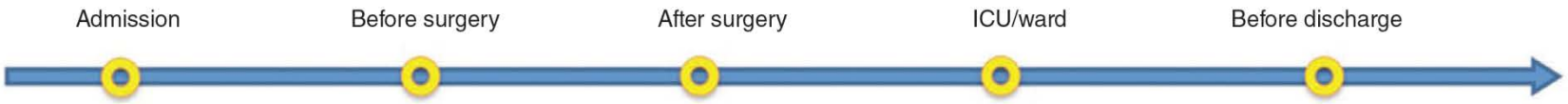
Key messages



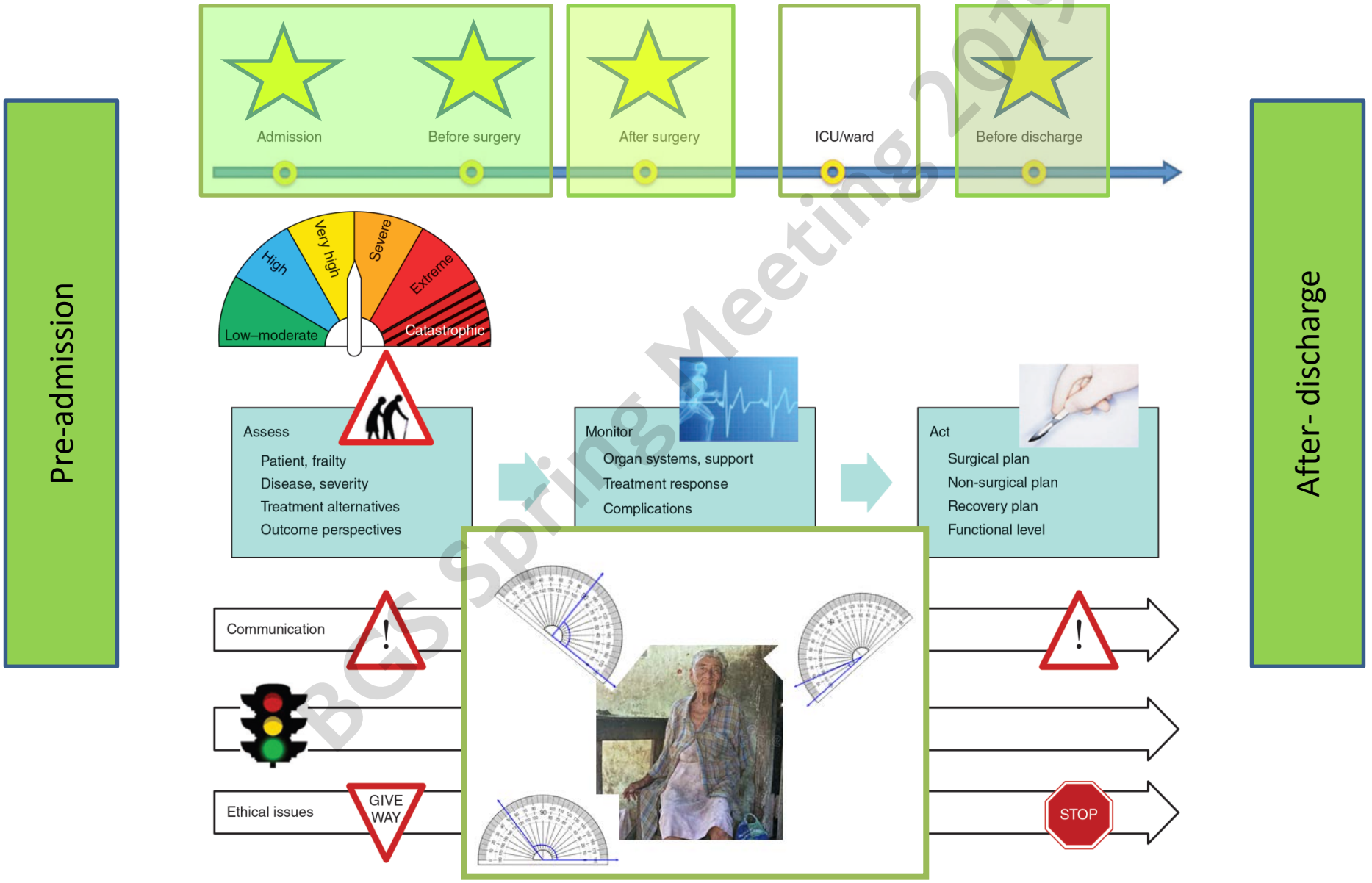
CGA

MDTea

Short Term Focus
Long Term Vision

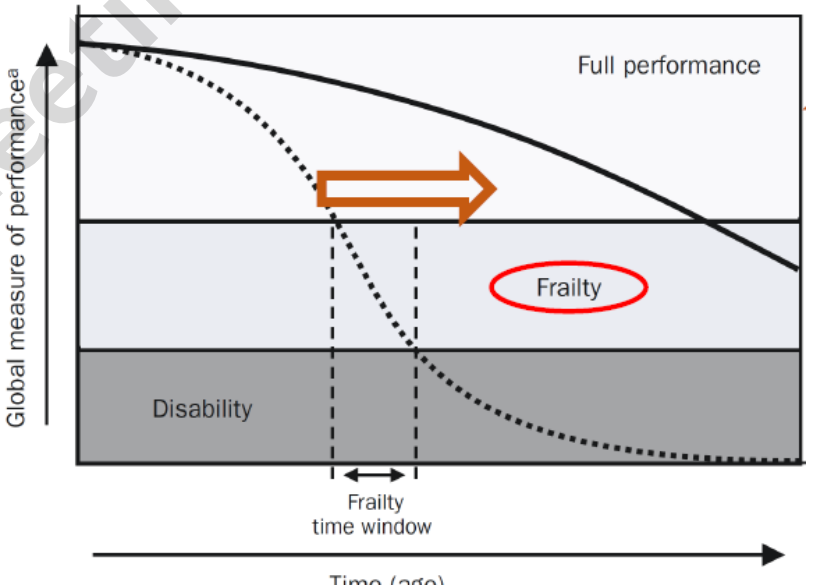


POPS@Salford



Do you support the motion that Geriatric Teams/Geriatricians' should review (perioperatively)
all **frail patients over 65** years of age
who undergo an **emergency laparotomy**?

1. Yes
2. No
3. Undecided
4. I don't'care



- Highly prevalent in Emergency Laparotomy patients
- Worse short term prognosis, more complications and readmissions
- Frailty is Easy to measure/identify

Disclosure of conflict of interests

- I am a Geriatrician…

ACM - Current Service




Delirium

Falls

Frailty

Community Services

Dom Visits | MDG | Rapid Response | RH/NH | Clinics

GOD 1

GOD 2

Front door Services

EAU

ED

Liaison Services

Orthoger

Trauma

Gen Surgery

Back door – Rehabilitation/Step down

OP Clinics

Syncope | Complex | PD

Delirium | Falls

IMC

Acute Geriatric Units

L3

L4 | L6

L5

Education

Appraisal/CPD

Quality Imp

Academic

Digital

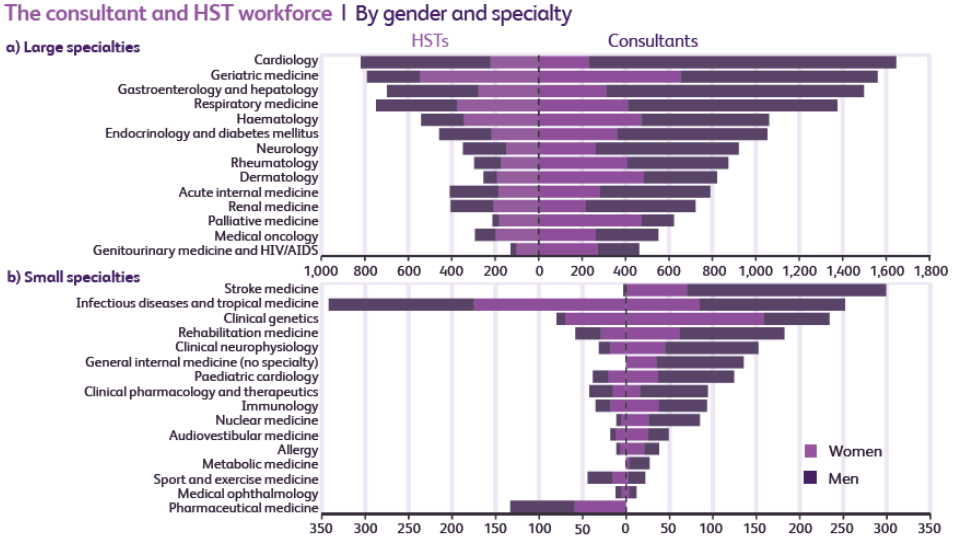
Do you support the motion that Geriatric Teams/Geriatricians' should review (perioperatively) all **frail patients over 75** years of age
who undergo an **emergency laparotomy**?

1. Yes
2. No
3. Undecided
4. I don't'care

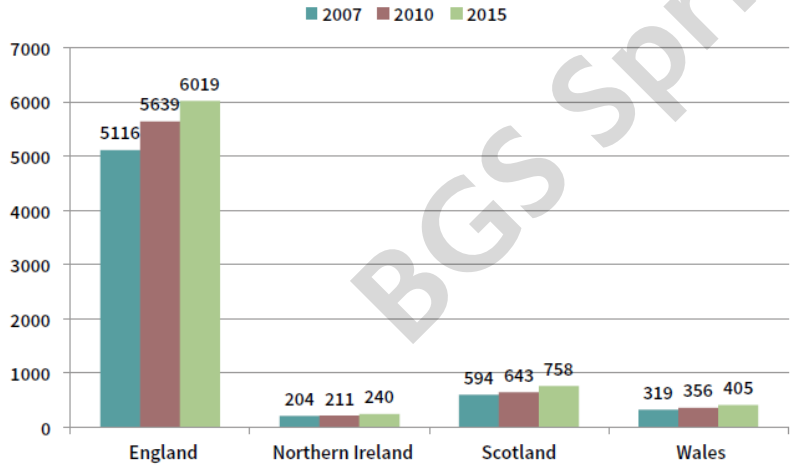
- High numbers > 70
- Higher mortality, morbidity, LOS and cost

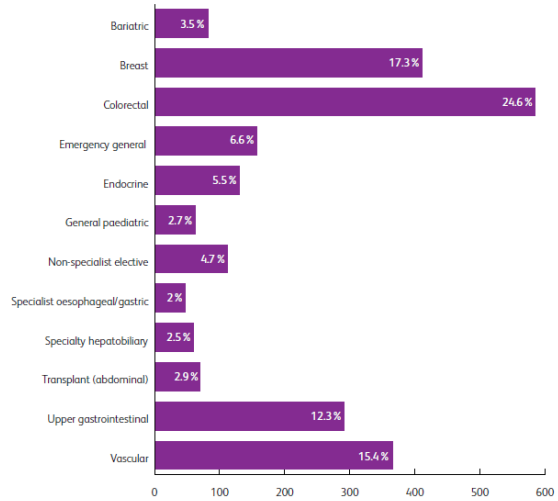
Disclosure of conflict of interests

- Ageing and Complex Medicine…



Specialty	England	Wales	Northern Ireland	TOTAL
General Surgery	2052	133	88	2273





Do you support the motion that Geriatric Teams/Geriatricians' should review (perioperatively) all **patients over 80** years of age who undergo an **emergency laparotomy**?

1. Yes
2. No
3. Undecided
4. I don't'care

Do you support the motion that Geriatric Teams/Geriatricians' should review
all **frail patients over 65** years of age
admitted to General Surgery as an emergency?

1. Yes
2. No
3. Undecided
4. I don't'care

Autonomy
Beneficence
Non-maleficence

Justice

Do you support the motion that Geriatric Teams/Geriatricians' should review
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admitted to General Surgery as an emergency?

1. Yes
2. No
3. Undecided
4. I don't'care

Do you support the motion that Geriatric Teams/Geriatricians' should review
all **patients over 80** years of age
admitted to General Surgery as an emergency?

1. Yes
2. No
3. Undecided
4. I don't'care

- **Single best answer questions**
- **Models of care**
- **Collaborative working in progress:** -POPS@Salford
- **Tips :** Collaborative care in General Surgery
- **Key messages**

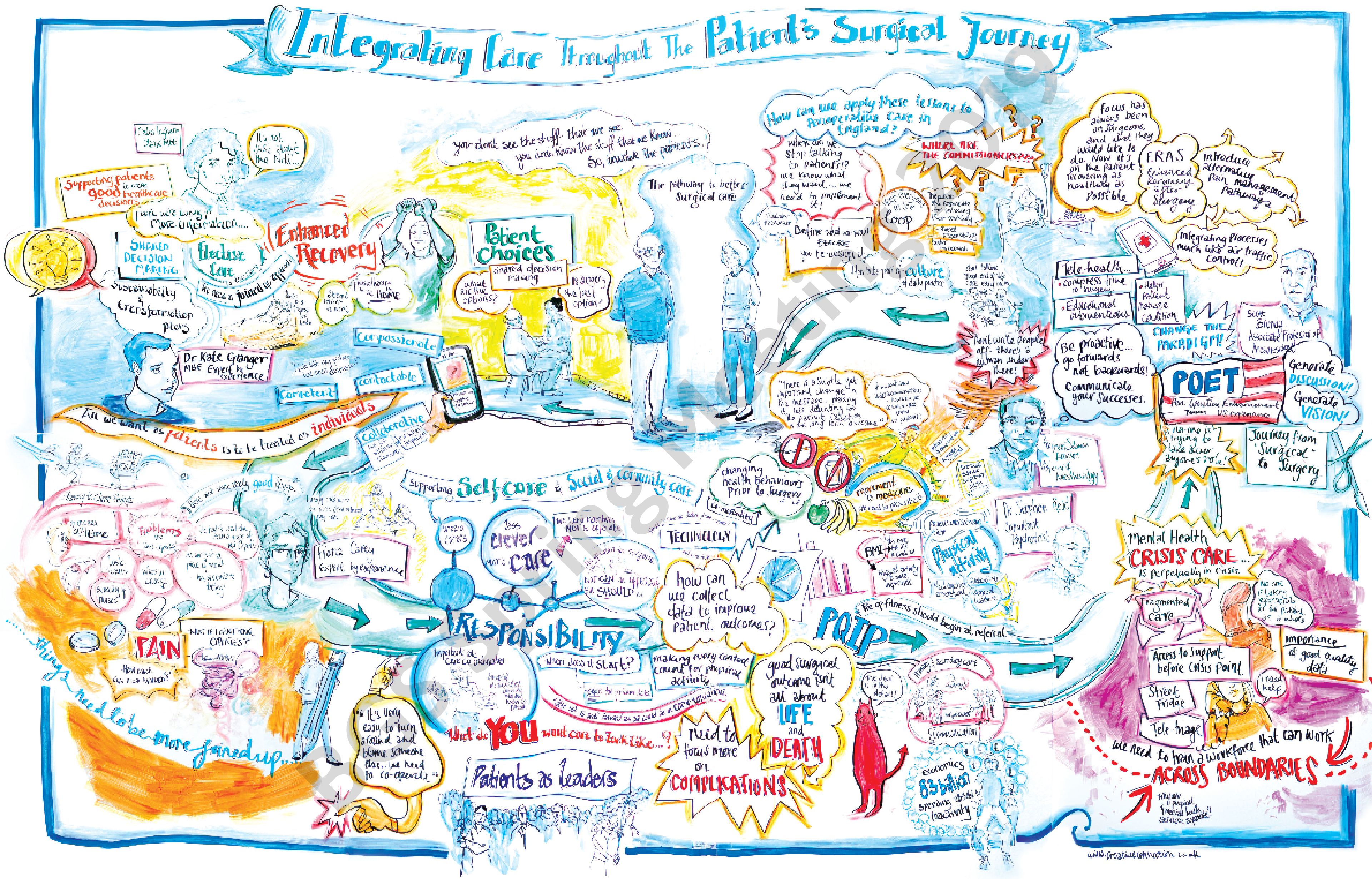
Conundrums in Emergency General Surgery

- Optimum **model of care** for older patients
- Optimum models of **preoperative optimisation/risk stratification**
- **Cost effective** service provision

Emergency surgery in the elderly: challenges and solutions

Andrew D W Torrance[1]
Susan L Powell[2]
Ewen A Griffiths[3]

Open Access Emergency Medicine 2015:7


Integrating Care Throughout The Patient's Surgical Journey
Supporting patients to make good healthcare decisions
Shared Decision Making
Enhanced Recovery
Patient Choices
shared decision making
Dr Kate Granger MBE Expert by experience
Compassionate
Contactable
Competent
Collaborative
All we want as patients is to be treated as individuals
The pathway is better surgical care
How can we apply these lessons to perioperative care in England?
WHERE ARE THE COMMISSIONERS?
Define and ... re-design
culture
ERAS Enhanced Recovery After Surgery
Introduce alternative pain management pathways
Integrating processes much like air traffic control!
Tele-health
Be proactive... go forwards not backwards! Communicate your successes.
CHANGE THE PARADIGM!
POET
Generate DISCUSSION!
Generate VISION!
Journey from 'Surgical' to 'Surgery'
changing health behaviours prior to surgery
Supporting Self care & Social & community care
Home Care Expert by experience
TECHNOLOGY
how can we collect data to improve patient outcomes?
RESPONSIBILITY
when does it start?
What do YOU want care to look like...?
Patients as leaders
Need to focus more on COMPLICATIONS
good surgical outcome isn't all about LIFE and DEATH
PQIP
Physical activity
Mental Health CRISIS CARE is perpetually in crisis
Fragmented care
Access to support before crisis point
Importance of good quality data
We need to have a workforce that can work ACROSS BOUNDARIES
PAIN
things need to be more joined up...
It's very easy to turn around and blame someone else... we need to co-operate

#rcoaperiop

Nurse delivered preoperative assessment clinic

Preoperative Anesthetist Clinic

Surgical Outpatient Clinic

Emergency Department

Surgical Assessment

Referral based on:
Surgical complexity
Multimorbidity
Geriatric syndromes
(eg frailty, cognitive disorders)
Limited functional status
Difficult decision making

POPS Preoperative clinic

Multidisciplinary CGA and optimisation
Prediction of perioperative complications
Perioperative management plan
Liaison with surgeons, anaesthetics, primary care and all AHPs involved in pathway

Surgical Admission

Joint POPS – surgical ward rounds
POPS CGA and optimisation
Ward Based MDTMs
Rehabilitation goal setting
Discharge Planning
Family meetings

Screening through:
CEPOD handover
Board round
Structured ward round
Referrals

The POPS Model

Discharge home/rehabilitation unit/care home
Signposting to primary care / other services

Discharge to
Amputee rehabilitation unit
POPS ward round and MDTMs

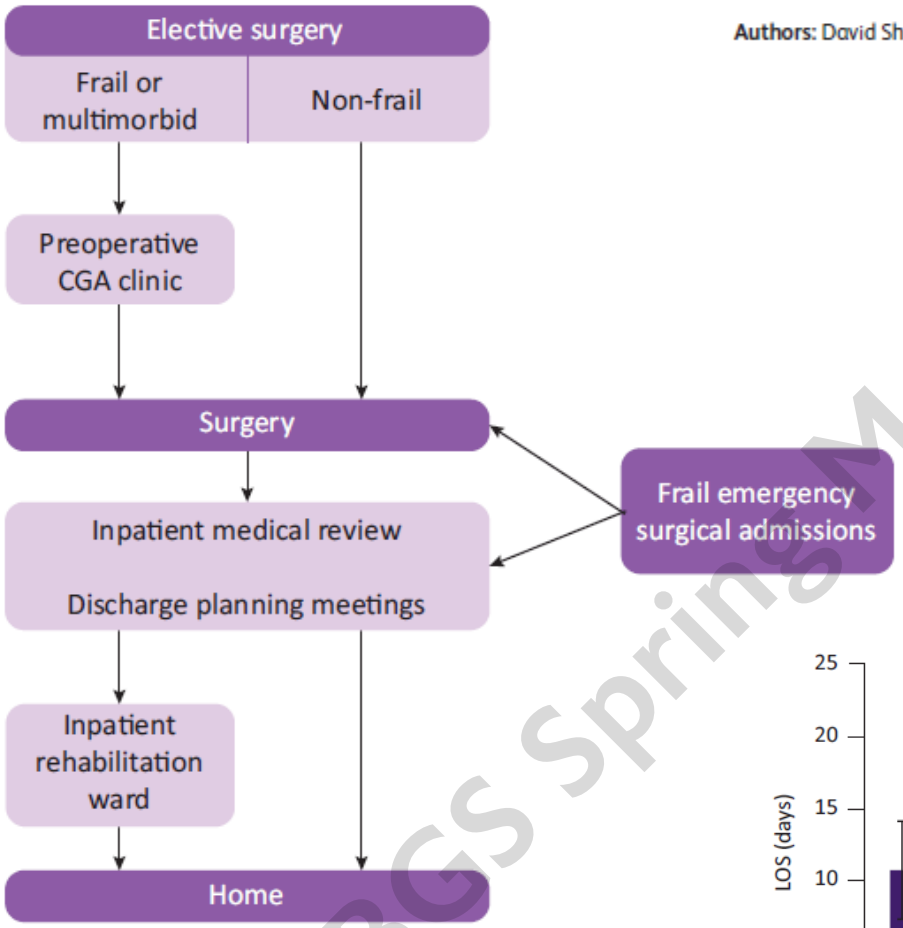
Courtesy Dr Jugdeep Dhesi - GSTT

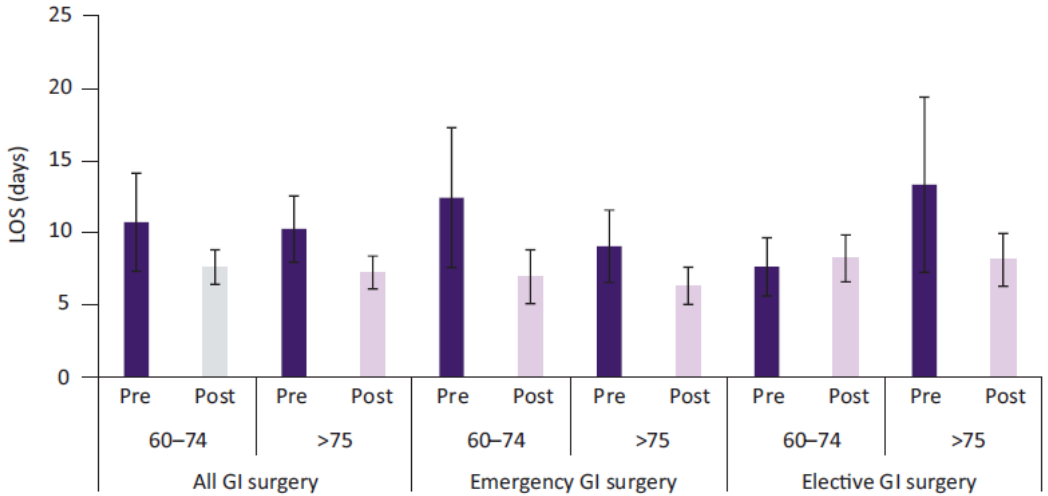
INTEGRATED CARE

Embedded geriatric surgical liaison is associated with reduced inpatient length of stay in older patients admitted for gastrointestinal surgery

Authors: David Shipway,[A] Louis Koizia,[B] Nick Winterkorn,[C] Michael Fertleman,[D] Paul Ziprin[E] and Krishna Moorthy[F]

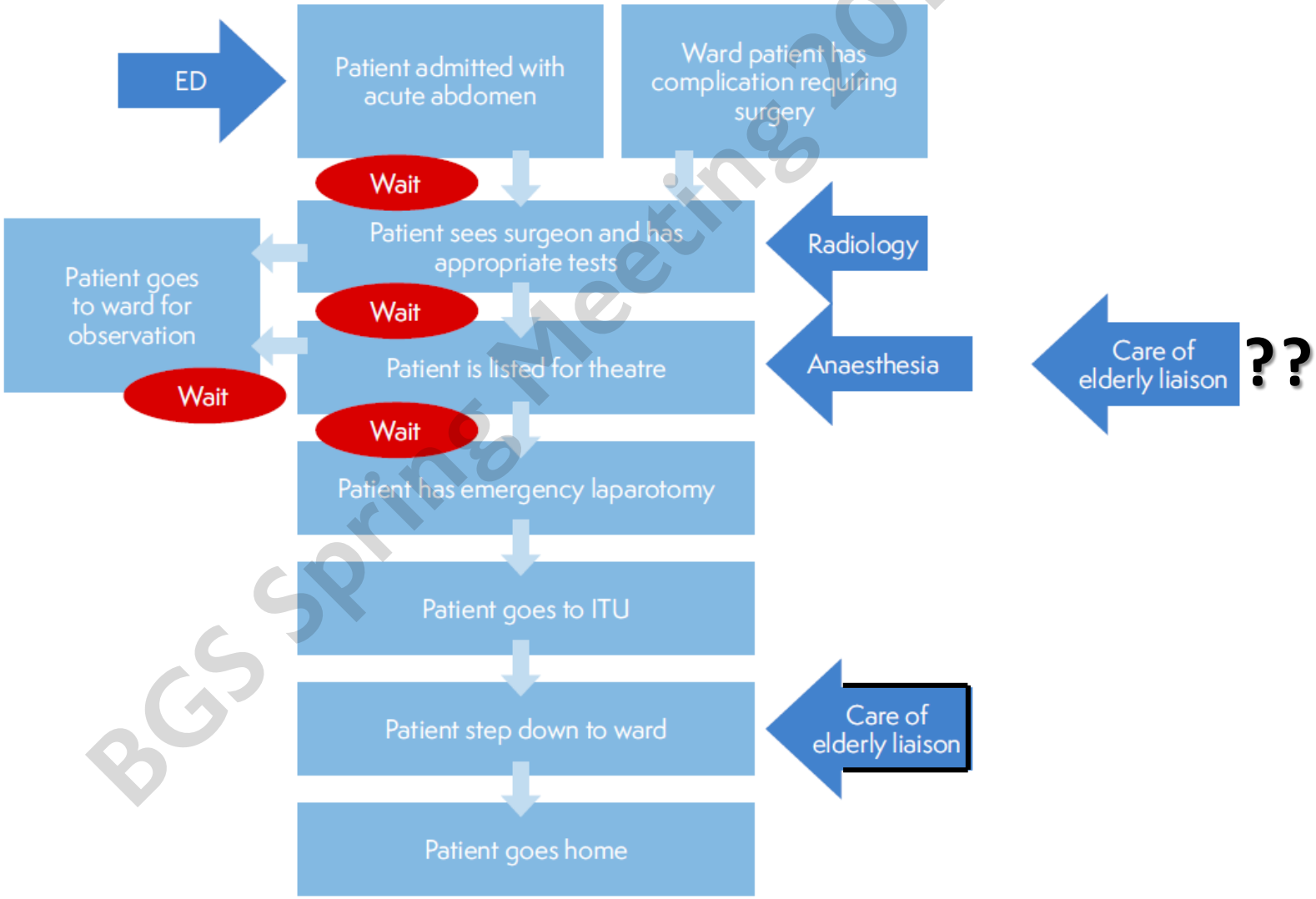
Future Healthcare Journal 2018 Vol 5, No 2: 108–16





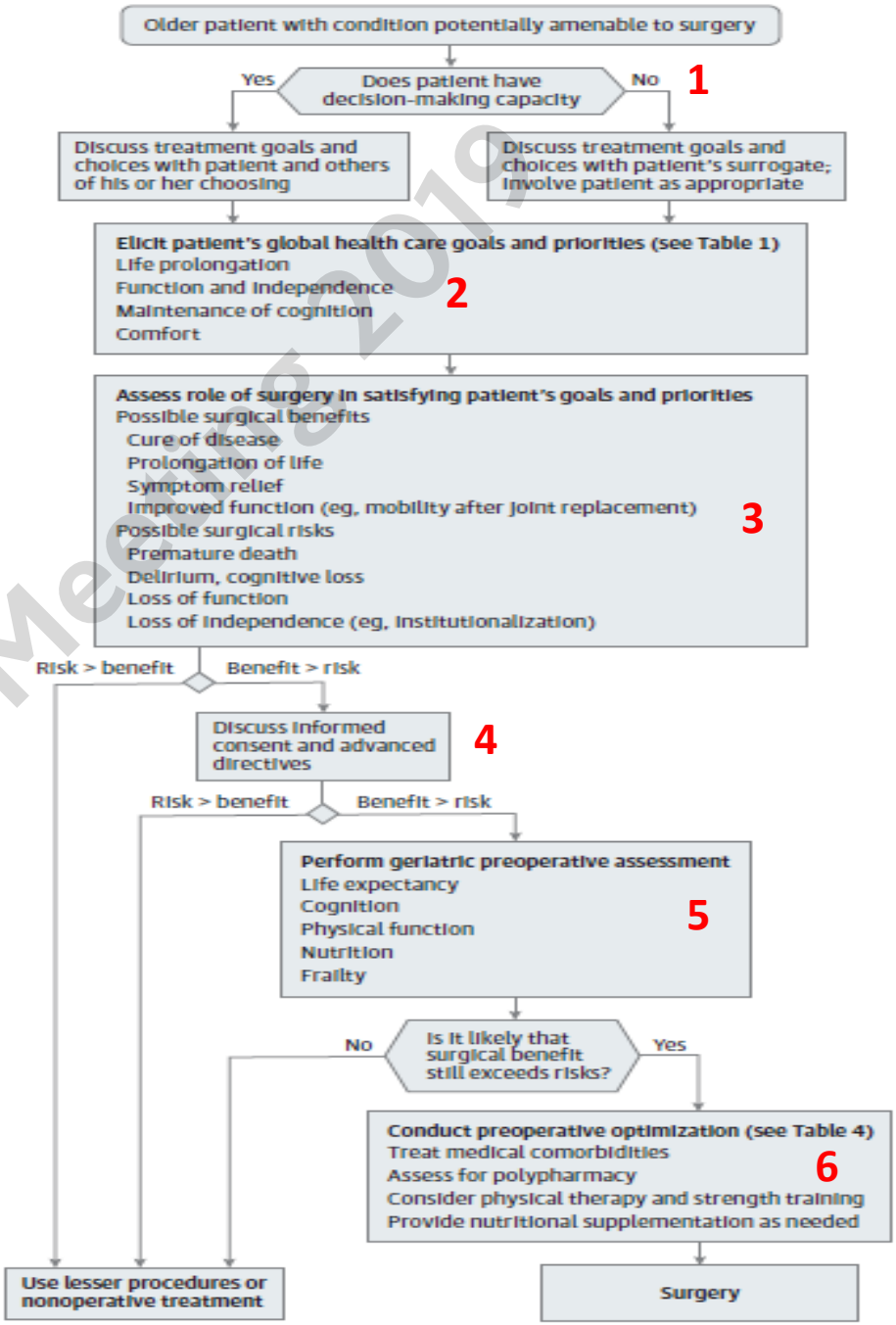
NELA
National Emergency Laparotomy Audit

Figure 13.3 An example of a high-level process map outlining the path of the emergency laparotomy patient



Older patients & surgery

1. Decision making
2. Patient's goals & priorities
3. Role/expected effect of surgery
4. Informed consent
5. CGA (geriatric team)
6. MDT Optimisation



Clinical Review & Education

Care of the Aging Patient: From Evidence to Action

Preoperative Assessment of the Older Patient
A Narrative Review

Lawrence B. Oresanya, MD; William L. Lyons, MD; Emily Finlayson, MD

JAMA. 2014;311(20):2110-2120. doi:10.1001/jama.2014.4573

Figure 2.2 Proportion of *hospitals* in Year 4 meeting key standards

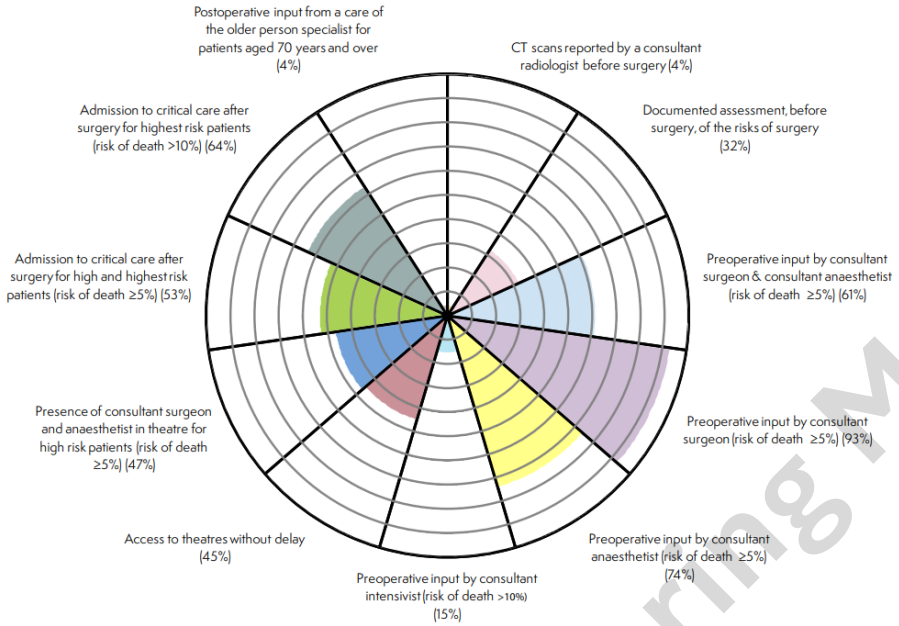
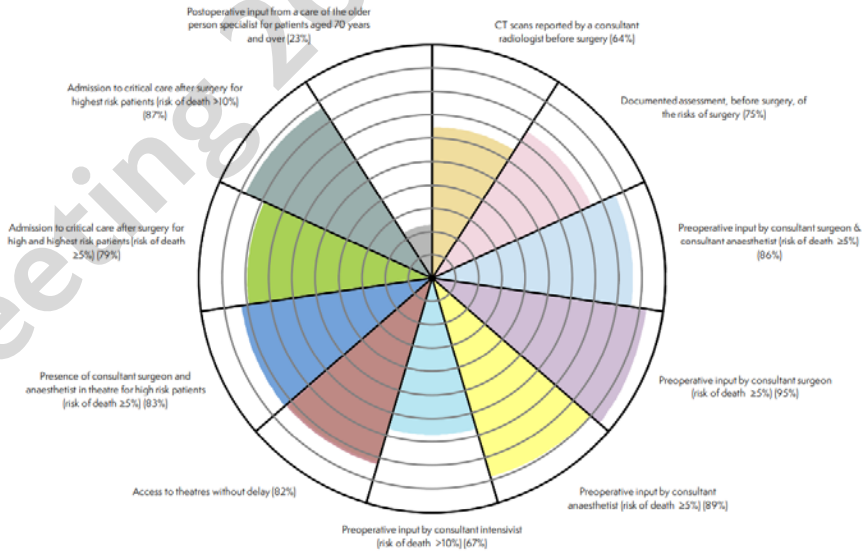
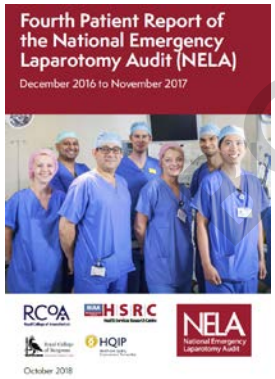
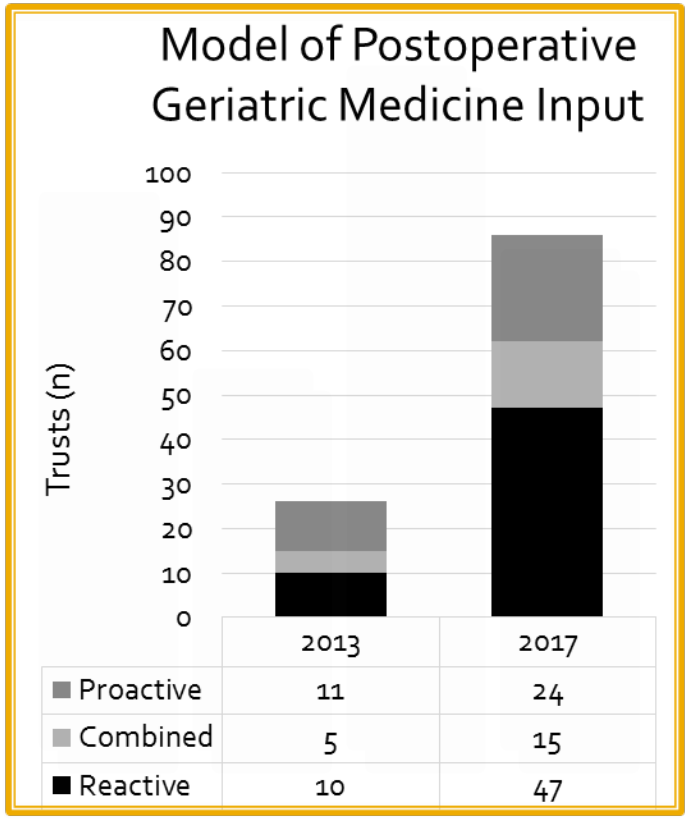


Figure 2.1 Proportion of all emergency laparotomy patients in Year 4, who had surgery between December 2016 and November 2017, meeting key standards





NELA
National Emergency Laparotomy Audit



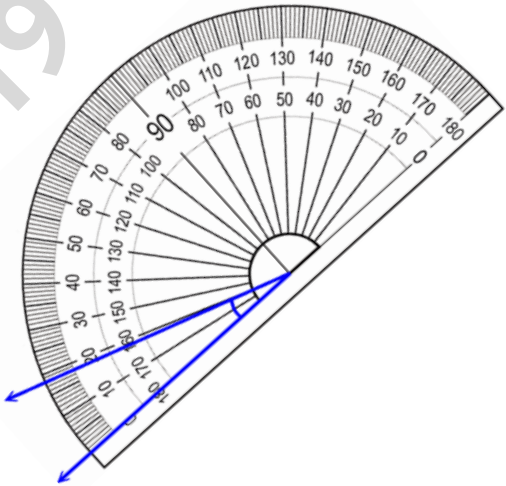
Article in press. Courtesy of Dr Jugdeep Dhesi

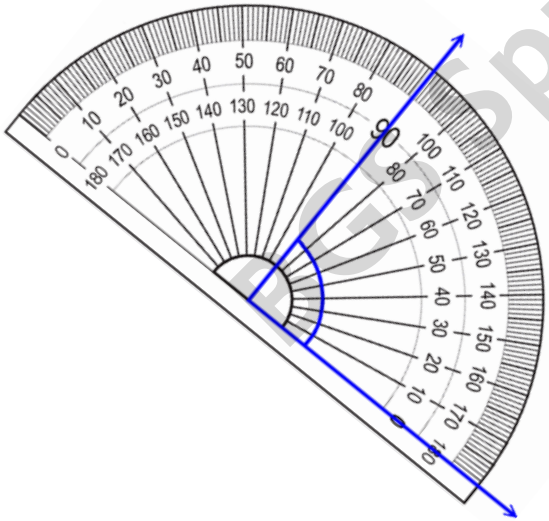
Elderly Care		
5.11	**Commissioners, Provider Executive Boards and Medical Directors:** scope requirements for Elderly Care input into patients undergoing emergency laparotomy, based on estimation of emergency surgical caseload, and work to address any shortfall	April 2019
5.12	**Clinical Directors from Elderly Care, Surgery, Anaesthesia, Intensive, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that define when input from Elderly Care should be sought	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5.13	**Local NELA leads, multidisciplinary clinical teams:** Ensure patients over the age of 70 have frailty, nutritional status, cognitive function and functional impairment assessed to inform decision-making and highlight those that may benefit from perioperative input by Elderly Care teams. Ensure these are embedded in clinical pathways	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5.14	**Multidisciplinary clinical teams:** ensure that NELA data on input by Elderly Care teams is reviewed at regular multidisciplinary governance meetings	Commence from next governance meeting (by January 2019 at the latest)
5.15	**NELA:** share information on hospitals who perform well for Elderly Care input	December 2018
5.16	**NELA:** collaborate with the British Geriatric Society to raise awareness of emergency laparotomy in older people	April 2019

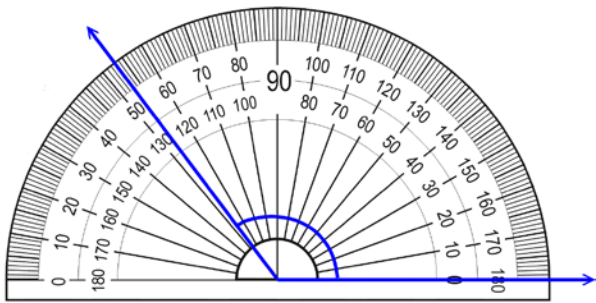
- Single best answer questions
- Models of care
- **Collaborative working in progress:** Salford-POPS-GS
- **Tips :** Collaborative care in General Surgery
- Key messages

Collaborative working

- Skills
- Goal
- Vision
- Leadership
- Communication
- Creativity
- Quality improvement
- Research







The set up: Salford-POPS-GS in-reach Service

- Proactive, daily case finding service for patients over 74-years of age (and 70 or older Emergency Laparotomy)

- Comprehensive Geriatric Assessment

(ACM Consultant InReach)

03-05-2018 | 17:03 | Senior Review

==========

85 year old independent non smoker with a diagnosis of dementia
Hypertension, hyperlipidemia, prostatism and previous TURP
Medications (6): No Allergies

Emergency admission 29/04/2018 (abdominal pain and vomiting): small bowe obstruction (adhesive)
Clinical Frailty Scale - 3
Social: Lives with wife in a house. Independent. Mobile with no aids. Recent dementia diagnosis with no behavioural symptoms
High Dependency Care: Yes
Procedure: Emergency Laparotomy & Release of Band Adhesion 29/04/2018
Complications: delirium, ileus, AKI, acute urinary incontinence

Current Function

Mobility: Independently mobile
Cognition: CAM Positive. 4AT 12
Urinary catheter

Today's Assessment:

DOLS to be completed
Most Recent NEWS Score: 2 SaO2 97% on 2L
Bowels NOT opened since admission (according to EPR)

HAT assessment completed. On LMWH
Devices: Urinary catheter
Ceiling of Care: Full

Diagnoses:
---
1. Acute small bowel obstruction (adhesions)
2. Acute kidney injury - prerenal (hypovolemia, iatrogenia)
3. Emergency Laparotomy & Release of Band Adhesion 29/04/2018 - abnormal looking jejunum
4. Extubated 30/04
5. Post-operative ileus 30/04
6. Post-operative acute urinary retention - difficulty catheterising
7. Post-operative mixed type delirium superimposed on dementia 01/05 - received olanzapine
8. Polypharmacy

Changes to medication

STOPPED Aspirin and Atorvastatin (no active indication in the absence of established vascular disease), Omeprazole (low dose and no longer indicated as not on antiplatelet agents), Bendroflumethiazide and Perindopril (AKI and low BP)
STARTED Trazodone 50mg at 6pm, Paracetamol 1gr up to QDS and Movicol OM
CHANGED -

RECEIVED Olanzapine (acute confusional state)

Discharge Plan:

Surgical agenda: bowels not yet opened. Reduced bowel sounds.

I do appreciate Mr Teesdale suffered an episode of acute urinary retention perioperatively at the time of ileus.
He is restless and we should aim to TWOC as soon as practicable (providing he is moving his bowels regularly and mobile)

Continue to omit Bendroflumethiazide, perindopril and atorvastatin
Stop aspirin all together as there isn't a clear indication. Omeprazole can also be discontinued

Pain appears under control (mild abdominal discomfort)
I suggest that we give Paracetamol 1g QDS & PRN Nefopam 30mg

Stop Olanzapine and add in Trazodone 50mg at 6pm (it will help his restlessness).
We will aim to stop pre-discharge
Please could ward staff continue to ensure usual delirium measures are taken, including regular re-orientation and reassurance, good hydration, regular bowel movements and monitoring of pain.

Information given to patient/carers:

Expected Discharge Date is 08/05/2018
Not Suitable for transfer to Pendleton Suite
Advice given to General Practitioner:
ACM Follow up: Not required

The set up: Salford-POPS-GS in-reach Service

- Proactive, daily case finding service for patients over 74-years of age
- Core team: Senior nurse, physiotherapist, Occupational therapist, geriatrician (4 DCC PA shared between 2 consultants)(4 DCC PA ACP)

- Comprehensive Geriatric Assessment
- Targeted Multidisciplinary interventions
- Timely Discharge Planning

MDT meeting Ward B2.
==========

09-05-2018	12:45	Discharge Planning

This patient is currently receiving multidisciplinary team care on Ward B2

Diagnoses:
---
1. Acute small bowel obstruction (adhesions)
2. Acute kidney injury - prerenal (hypovolemia, iatrogenia)
3. Emergency Laparotomy & Release of Band Adhesion 29/04/2018 - abnormal looking jejunum
4. Extubated 30/04
5. Post-operative ileus 30/04
6. Post-operative acute urinary retention - difficulty catheterisation - successful TWOC
7. Post-operative mixed type delirium superimposed on dementia 01/05 - received olanzapine/Trazodone - resolved
8. Polypharmacy

Current Function

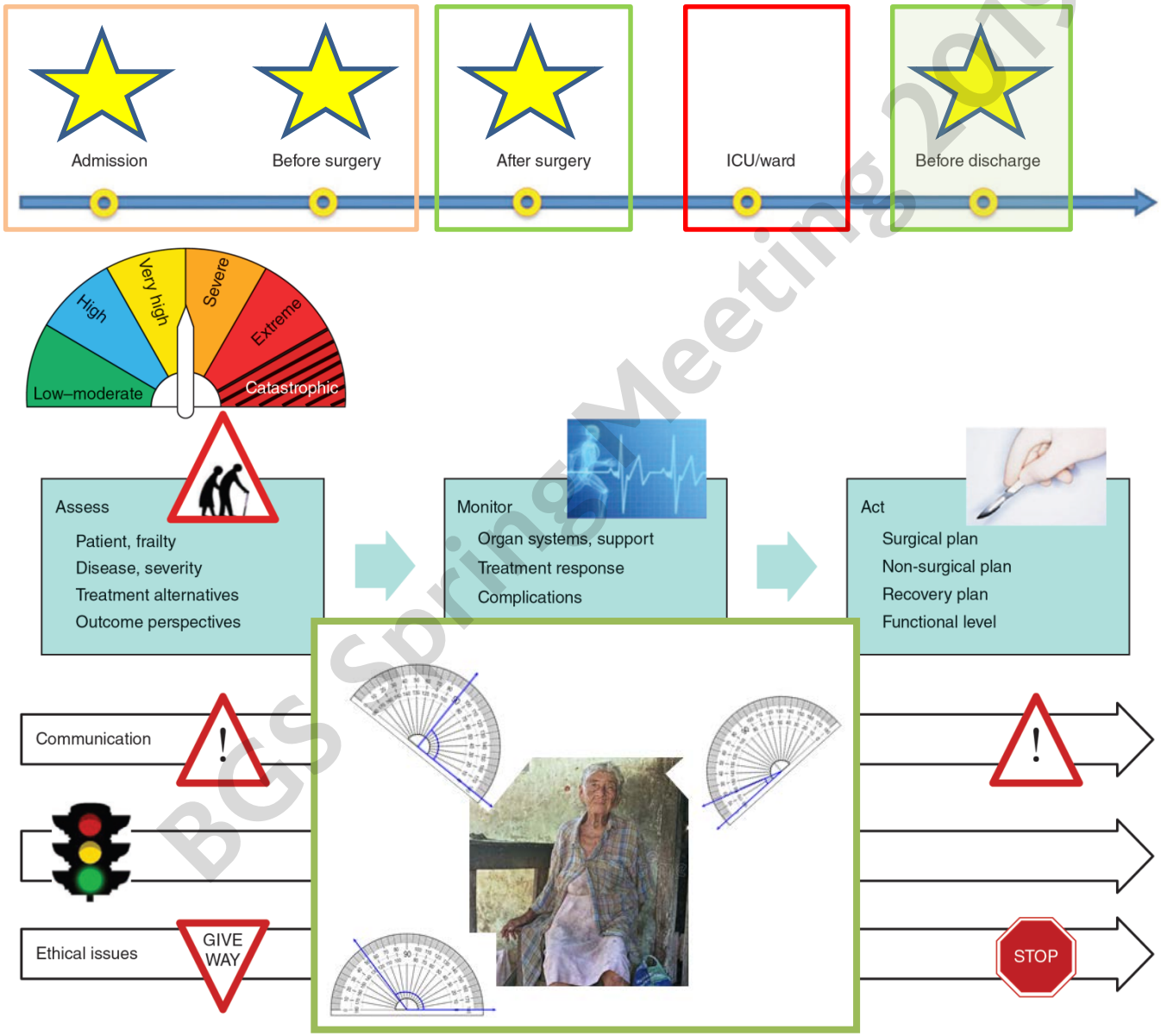
Mobility: Independently mobile
Cognition: CAM Negative.

Discharge Plan:

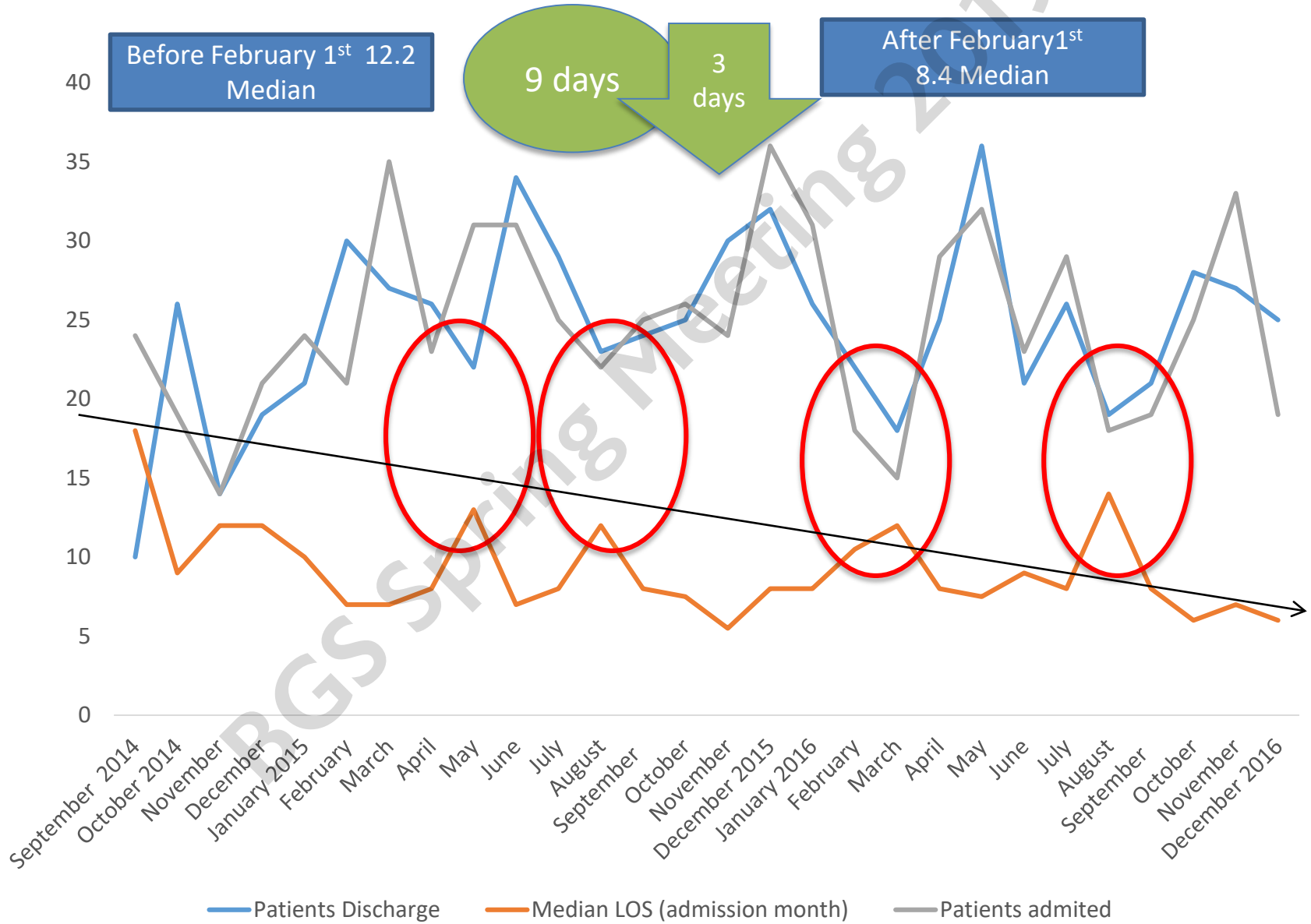
Medically fit for discharge and back at baseline
Stairs assessment and discussion with spouse Re: home today or tomorrow

EDD 09/05/2018

POPS@Salford



Continuity of care

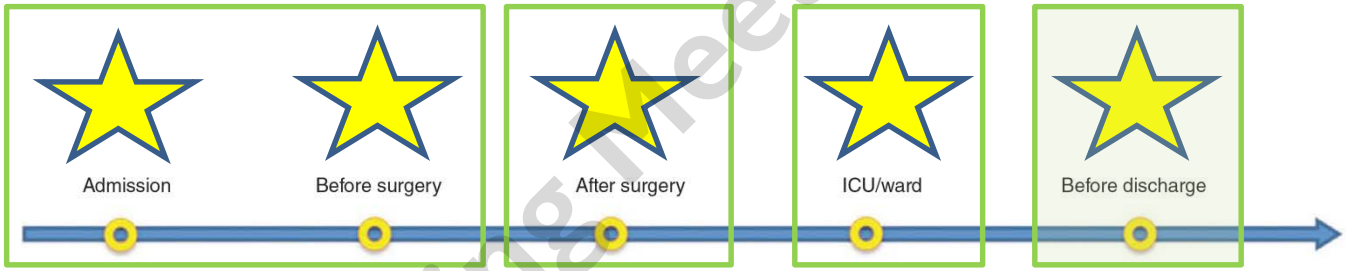


Advanced Clinical Practitioner

0.5WTE Band 8a ACP = £22,896 per annum
↓ median LoS by 1 day = £160,000
Cost saving £137,104 per year
Payback period 9 weeks

Figures calculated by Angeline Price (ACP)

- Increase compliance with NELA standard 'Assessment by MCOP Team
- Decrease median LOS patients≥75 years by 1 day within 6 months
- **Engagement with 2WWL cancer**



Community

Out patients

Hospital

Home

Residential Home

Nursing Home

Intermediate Care

Rapid Response Team

General Practitioner
District Nurses
Voluntary Sector

Care Home Staff

Patient

Relative/s
Carer/s

Surgeons
Anaesthetists
Geriatricians
Specialist Nurses
Radiology Team
IV Team
Single Organ Specialists
Dieticians
Pharmacists
Occupational Therapist
Physiotherapists
Advance Nurse Practitioner
Social **Worker**
Palliative Care **Team**

Acute Physicians

Porters
Auxiliary Nurses
Nursing Staff

Bed Managers

Pathway Manager

Emergency Department

Surgical Triage Unit

Emergency Admissions Unit

ICU/ SHDU

Acute General Surgical Ward

2WWL cancer

Our journey towards

Global Digital Exemplar

Digitised Pathways

Medicines Management

Optimising EPR

Digitised Theatres

Northern Care Alliance NHS Group

Salford Royal NHS Foundation Trust

University Teaching Trust

safe • clean • personal

Acute Surgical Abdominal Pain care pathway

GDE

- Single best answer questions
- Models of care
- Collaborative working in progress: Salford-POPS-GS
- **Tips : Collaborative care in General Surgery**
- Key messages

Tips

- Look, listen, think (SWOT)

STRENGTHS	WEAKNESS
1. Growing evidence base 2. Innovative Trust 3. Existing service upon which to develop 4. Respected by surgical colleagues 5. Financial benefits already being realised 6. Increasing numbers of older surgical patients 7. Alignment of project with Trust objectives 8. Brand new ANP roles in ACM	1. Financial pressures 2. Priorities for Medicine: emergency care 3. Change fatigue 4. Complacency 5. Staff burnout – not receptive to new ideas 6. Increasing numbers of older surgical patients 7. Organisational culture - autocratic 'top down' 8. Lack of understanding of ANP role
OPPORTUNITIES	**THREATS**
1. Increasing demand for service 2. Patient satisfaction 3 Further financial benefits 4. Demand on Geriatricians in surgery increasing 5. Literature/publication 6. Career progression 7. High motivation levels in self 8. NELA National lead an employee of Trust	1. Staff retention/ deployment 2. Surgical directorate priorities 3. Financial pressures 4. Territorialism/Defensiveness 5. Loss of key team members 6. Sickness/Absence 7. Lack of vision in management 8. Other projects requiring ANPs in other areas

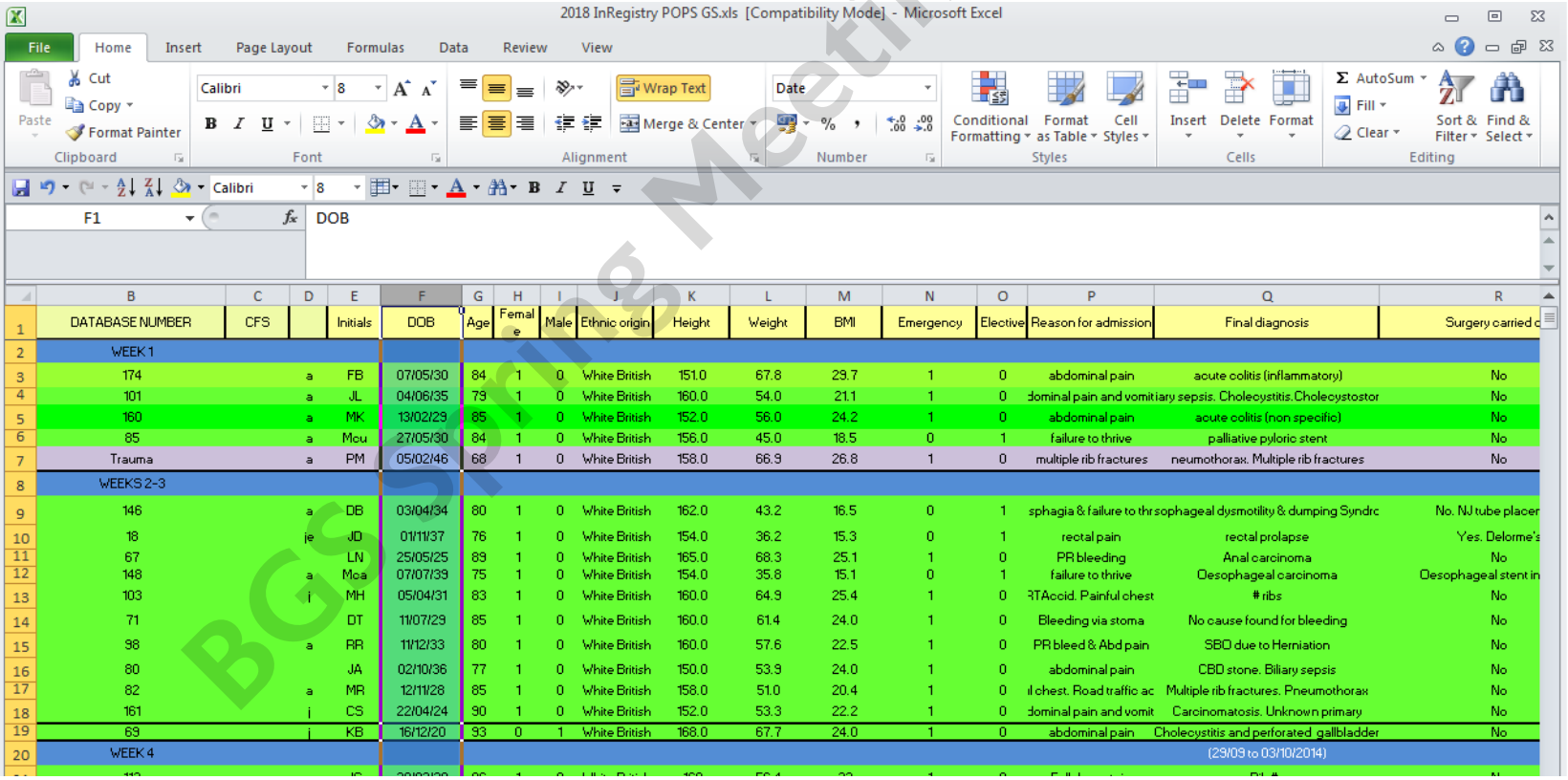
Figure created by Angeline Price (ACP)

Tips

- Look, listen, think
- Sell your idea (business plan/ Clinical Governance-MM meetings)

Tips

- Look, listen, think
- Sell your idea (business plan/ Clinical Governance-MM meetings)
- **Collect data prospectively** (IM &T, excel, database,…)



	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	DATABASE NUMBER	CFS		Initials	DOB	Age	Femal e	Male	Ethnic origin	Height	Weight	BMI	Emergency	Elective	Reason for admission	Final diagnosis	Surgery carried c
2	WEEK 1																
3	174		a	FB	07/05/30	84	1	0	White British	151.0	67.8	29.7	1	0	abdominal pain	acute colitis (inflammatory)	No
4	101		a	JL	04/06/35	79	1	0	White British	160.0	54.0	21.1	1	0	dominal pain and vomit	iary sepsis. Cholecystitis.Cholecystostor	No
5	160		a	MK	13/02/23	85	1	0	White British	152.0	56.0	24.2	1	0	abdominal pain	acute colitis (non specific)	No
6	85		a	Mcu	27/05/30	84	1	0	White British	156.0	45.0	18.5	0	1	failure to thrive	palliative pyloric stent	No
7	Trauma		a	PM	05/02/46	68	1	0	White British	158.0	66.9	26.8	1	0	multiple rib fractures	neumothorax. Multiple rib fractures	No
8	WEEKS 2-3																
9	146		a	DB	03/04/34	80	1	0	White British	162.0	43.2	16.5	0	1	sphagia & failure to thr	sophageal dysmotility & dumping Syndrc	No. NJ tube placer
10	18		je	JD	01/11/37	76	1	0	White British	154.0	36.2	15.3	0	1	rectal pain	rectal prolapse	Yes. Delorme's
11	67			LN	25/05/25	89	1	0	White British	165.0	68.3	25.1	1	0	PR bleeding	Anal carcinoma	No
12	148		a	Moa	07/07/39	75	1	0	White British	154.0	35.8	15.1	0	1	failure to thrive	Oesophageal carcinoma	Oesophageal stent in
13	103		j	MH	05/04/31	83	1	0	White British	160.0	64.9	25.4	1	0	RTAccid. Painful chest	# ribs	No
14	71			DT	11/07/29	85	1	0	White British	160.0	61.4	24.0	1	0	Bleeding via stoma	No cause found for bleeding	No
15	98		a	RR	11/12/33	80	1	0	White British	160.0	57.6	22.5	1	0	PR bleed & Abd pain	SBO due to Herniation	No
16	80			JA	02/10/36	77	1	0	White British	150.0	53.9	24.0	1	0	abdominal pain	CBD stone. Biliary sepsis	No
17	82		a	MR	12/11/28	85	1	0	White British	158.0	51.0	20.4	1	0	il chest. Road traffic ac	Multiple rib fractures. Pneumothorax	No
18	161		j	CS	22/04/24	90	1	0	White British	152.0	53.3	22.2	1	0	dominal pain and vomit	Carcinomatosis. Unknown primary	No
19	69		j	KB	16/12/20	93	0	1	White British	168.0	67.7	24.0	1	0	abdominal pain	Cholecystitis and perforated gallbladder	No
20	WEEK 4															(29/09 to 03/10/2014)	

Tips

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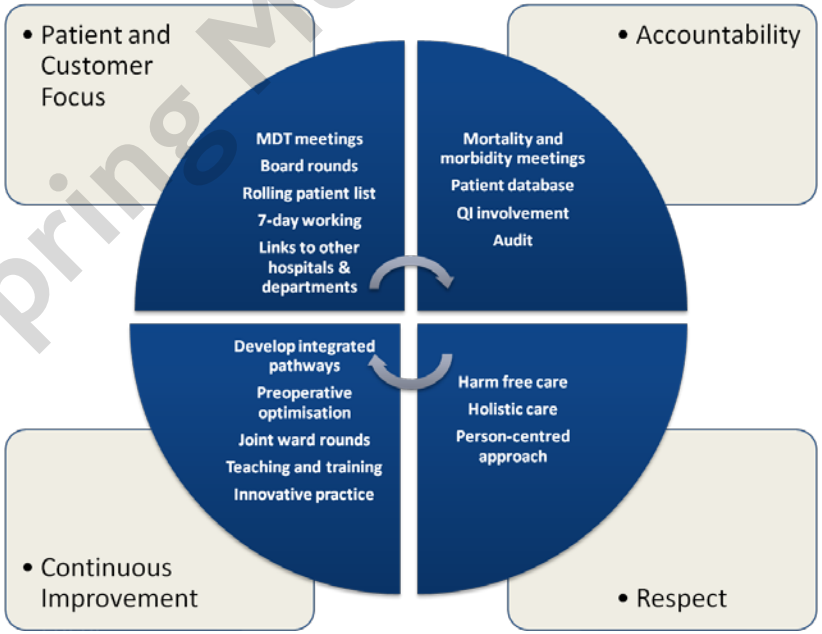

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BGS British Geriatrics Society
Improving healthcare for older people

RCoA Royal College of Anaesthetists

AGE ANAESTHESIA ASSOCIATION

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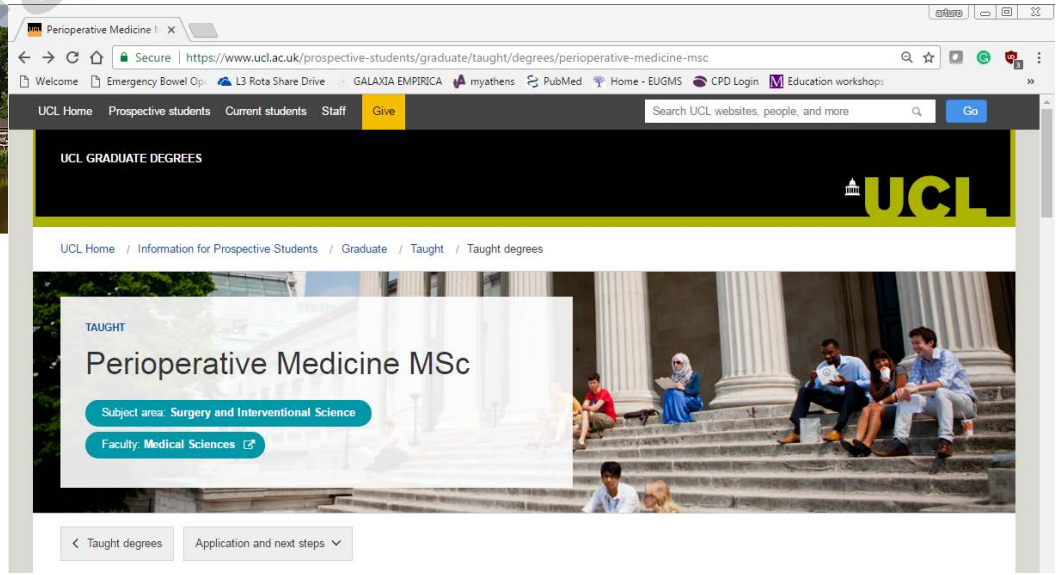
ASGBI
Association of Surgeons of Great Britain and Ireland

AAA SCIENTIFIC MEETING - BELTON WOODS, GRANTHAM on 16th & 17th May 2019



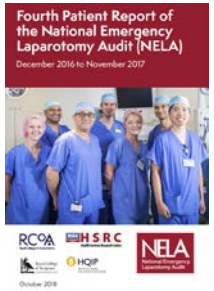
Useful reads…

Emergency general surgery in the geriatric patient

K. F. Desserud[1], T. Veen[1] and K. Søreide[1,2]

Emergency surgery in the elderly: challenges and solutions

Andrew D W Torrance[1]
Susan L Powell[2]
Ewen A Griffiths[3]
Open Access Emergency Medicine 2015:7



Frailty for Surgeons: Review of a National Institute on Aging Conference on Frailty for Specialists

Thomas N Robinson, MD, MS, FACS, Jeremy D Walston, MD, Nathan E Brummel, MD, MSCI, Stacie Deiner, MD, MS, Charles H Brown IV, MD, MHS, Maura Kennedy, MD, MPH, and Arti Hurria, MD
J Am Coll Surg. 2015 December ; 221(6): 1083–1092. doi:10.1016/j.jamcollsurg.2015.08.428.

SPECIAL ARTICLE http://dx.doi.org/10.1016/j.jamcollsurg.2014.10.019

Postoperative Delirium in Older Adults: Best Practice Statement from the American Geriatrics Society

The American Geriatrics Society Expert Panel on Postoperative Delirium in Older Adults

European Heart Journal (2014) 35, 2383–2431 doi:10.1093/eurheartj/ehu282
ESC/ESA GUIDELINES

2014 ESC/ESA Guidelines on non-cardiac surgery: cardiovascular assessment and management

The Joint Task Force on non-cardiac surgery: cardiovascular assessment and management of the European Society of Cardiology (ESC) and the European Society of Anaesthesiology (ESA)

Peri-operative care of the elderly 2014

Association of Anaesthetists of Great Britain and Ireland

Membership of the working party: R. Griffiths, F. Beech,[1] A. Brown, J. Dhesi,[2] I. Foo,[3] J. Goodall,[4] W. Harrop-Griffiths, J. Jameson,[5] N. Love, K. Pappenheim and S. White

1 College of Emergency Medicine
2 British Geriatrics Society
3 Age Anaesthesia Association
4 Intensive Care Society
5 Royal College of Surgeons

Optimal Perioperative Management of the Geriatric Patient: A Best Practices Guideline from the American College of Surgeons NSQIP and the American Geriatrics Society

http://dx.doi.org/10.1016/j.jamcollsurg.2015.12.026

Care of the Aging Patient: From Evidence to Action

Preoperative Assessment of the Older Patient
A Narrative Review

Lawrence B. Oresanya, MD; William L. Lyons, MD; Emily Finlayson, MD

JAMA. 2014;311(20):2110-2120. doi:10.1001/jama.2014.4573

AGING AND SURGERY JUNE 2017–VOL. 65, NO. 6 JAGS

Surgical Guidelines for Perioperative Management of Older Adults: What Geriatricians Need to Know

Jessica L. Colburn, MD, Sanjay Mohanty, MD, MS,† and John R. Burton, MD**

Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS®) Society recommendations☆

U.O. Gustafsson [a,b,*,q], M.J. Scott [c,d,q], W. Schwenk [e,q], N. Demartines [f,q], D. Roulin [f,q], N. Francis [g,q], C.E. McNaught [h,q], J. MacFie [h,q], A.S. Liberman [i,q], M. Soop [j,q], A. Hill [k,q], R.H. Kennedy [l,q], D.N. Lobo [m,q], K. Fearon [n,q], O. Ljungqvist [o,p,q]

ESPEN guideline: Clinical nutrition in surgery

CrossMark

Arved Weimann [a,*], Marco Braga [b], Franco Carli [c], Takashi Higashiguchi [d], Martin Hübner [e], Stanislaw Klek [f], Alessandro Laviano [g], Olle Ljungqvist [h], Dileep N. Lobo [i], Robert Martindale [j], Dan L. Waitzberg [k], Stephan C. Bischoff [l], Pierre Singer [m]

Tips

- Look, listen, think (before crossing the road)
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- Collect data prospectively (IM &T, excel, database,…)
- Pick and pamper your team (MDT)
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- Revise, attend POPS course ….
- Make sure it works for You

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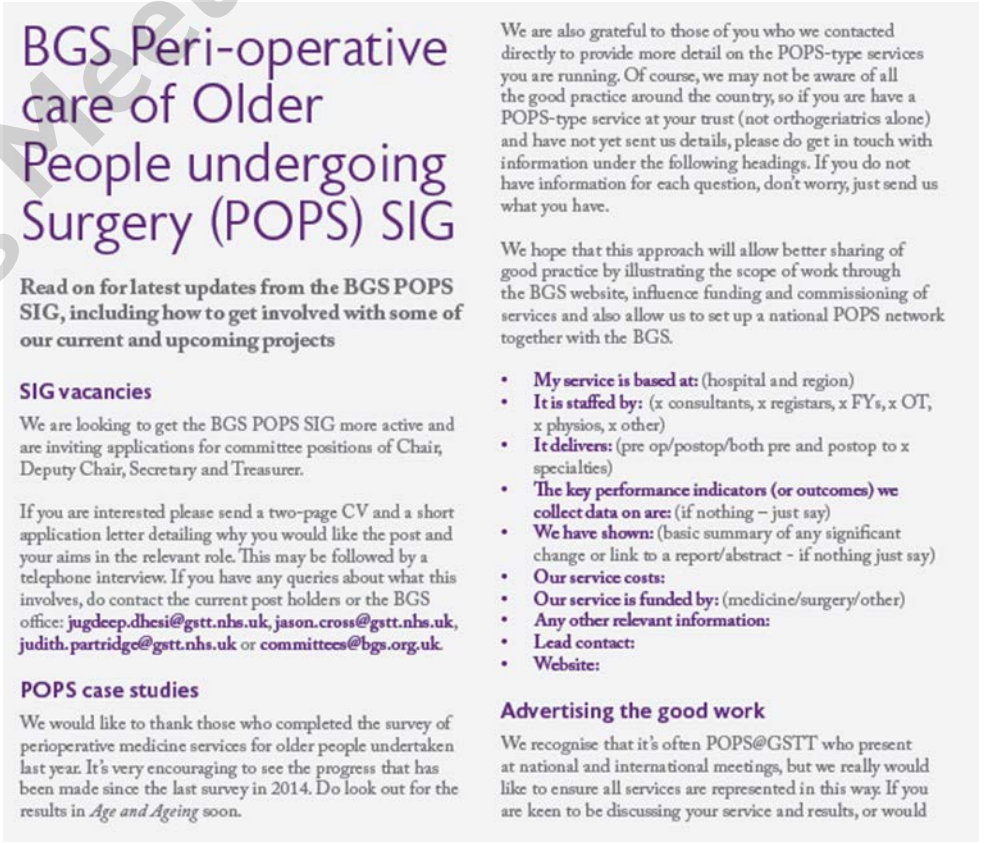
- Network



BGS Peri-operative care of Older People undergoing Surgery (POPS) SIG

Read on for latest updates from the BGS POPS SIG, including how to get involved with some of our current and upcoming projects

SIG vacancies

We are looking to get the BGS POPS SIG more active and are inviting applications for committee positions of Chair, Deputy Chair, Secretary and Treasurer.

If you are interested please send a two-page CV and a short application letter detailing why you would like the post and your aims in the relevant role. This may be followed by a telephone interview. If you have any queries about what this involves, do contact the current post holders or the BGS office: **jugdeep.dhesi@gstt.nhs.uk**, **jason.cross@gstt.nhs.uk**, **judith.partridge@gstt.nhs.uk** or **committees@bgs.org.uk**.

POPS case studies

We would like to thank those who completed the survey of perioperative medicine services for older people undertaken last year. It's very encouraging to see the progress that has been made since the last survey in 2014. Do look out for the results in *Age and Ageing* soon.

We are also grateful to those of you who we contacted directly to provide more detail on the POPS-type services you are running. Of course, we may not be aware of all the good practice around the country, so if you are have a POPS-type service at your trust (not orthogeriatrics alone) and have not yet sent us details, please do get in touch with information under the following headings. If you do not have information for each question, don't worry, just send us what you have.

We hope that this approach will allow better sharing of good practice by illustrating the scope of work through the BGS website, influence funding and commissioning of services and also allow us to set up a national POPS network together with the BGS.

- **My service is based at:** (hospital and region)
- **It is staffed by:** (x consultants, x registars, x FYs, x OT, x physios, x other)
- **It delivers:** (pre op/postop/both pre and postop to x specialties)
- **The key performance indicators (or outcomes) we collect data on are:** (if nothing – just say)
- **We have shown:** (basic summary of any significant change or link to a report/abstract - if nothing just say)
- **Our service costs:**
- **Our service is funded by:** (medicine/surgery/other)
- **Any other relevant information:**
- **Lead contact:**
- **Website:**

Advertising the good work

We recognise that it's often POPS@GSTT who present at national and international meetings, but we really would like to ensure all services are represented in this way. If you are keen to be discussing your service and results, or would

Are **YOU** looking after an older person?

Salford Royal NHS
NHS Foundation Trust
University Teaching Trust
safe • clean • personal

Ageing can cause:

- reduced bone mass
- reduced muscle strength
- problems with blood pressure control
- hearing and visual impairment

Older patients are vulnerable

When an older person comes to hospital...

we often put them in a hospital bed which restricts their mobility which can result in...

increased confusion

functional incontinence

deconditioning and muscle weakness resulting in further immobility

an increase in falls

reduced appetite and increased risk of aspiration

this is made worse by multiple medications, sensory impairment, constipation, dementia and their current illness

Stand up for **INDEPENDENCE**

and ask yourself the following...

Does my patient need the IV fluids?

Does my patient need to be in bed with the cot sides up?

Does my patient need the catheter?

Is my patient constipated?

Could my patient sit out in a chair?

Does my patient need help with eating and drinking?

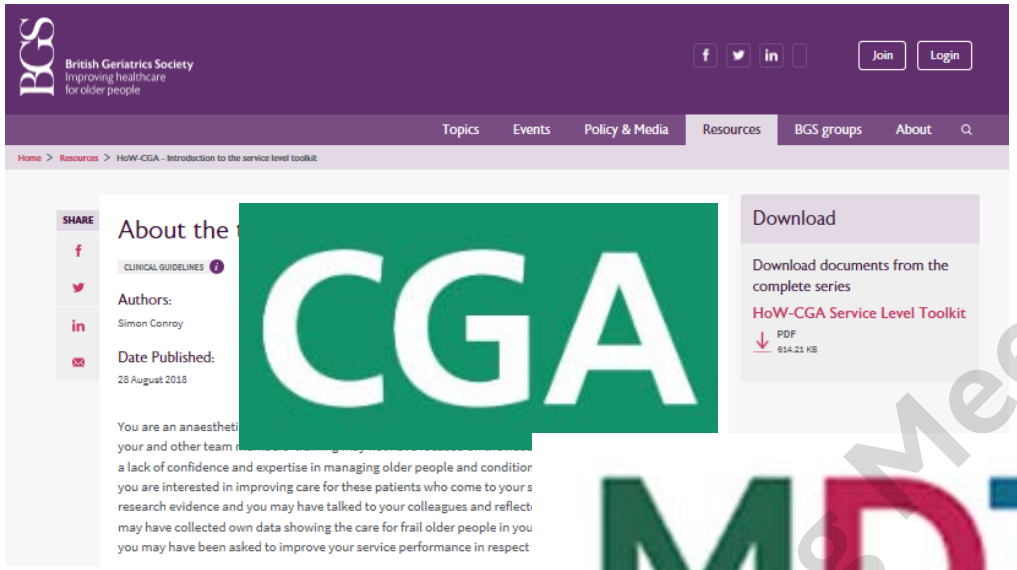
Does my patient need their glasses or hearing aid to help them communicate?

Have my patient's medications been reviewed?

By asking yourself these questions you can:

- Increase the chance of your patient going back to their own home
- Help them recover more quickly and reduce the need for ongoing support
- Reduce the risk of harm from falls, infection, delirium (acute confusion) and blood clots.

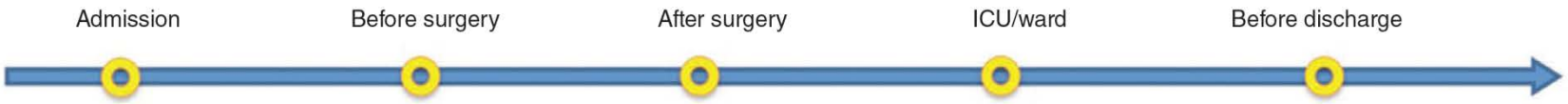
Key messages



CGA

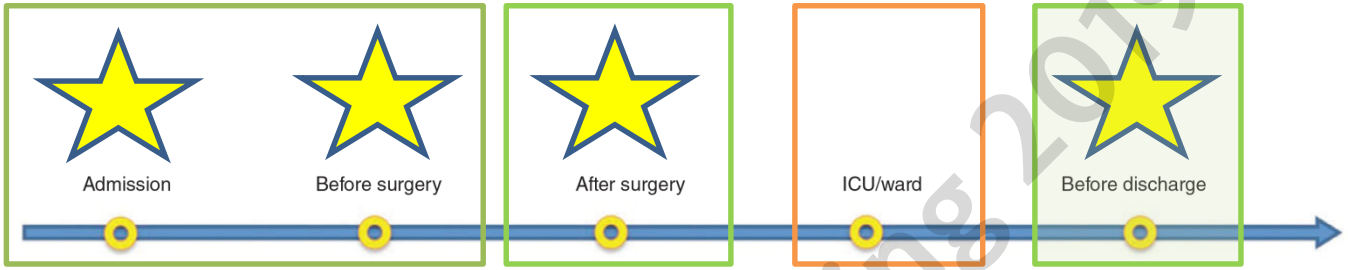
MDTea

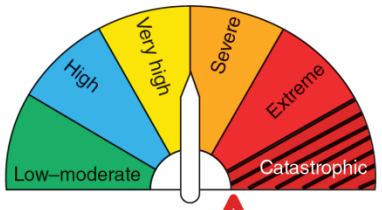
Short Term Focus
Long Term Vision



POPS@Salford

Pre-admission





Assess
- Patient, frailty
- Disease, severity
- Treatment alternatives
- Outcome perspectives

Monitor
- Organ systems, support
- Treatment response
- Complications

Act
- Surgical plan
- Non-surgical plan
- Recovery plan
- Functional level

After- discharge

Salford Royal NHS Foundation Trust

Northern Care Alliance NHS Group

arturo.vilches-moraga@srft.nhs.uk

@avilmor

MANCHESTER 1824
The University of Manchester

University of Salford MANCHESTER

POPS

"Improving the care of older surgical patients through collaboration, education and research"

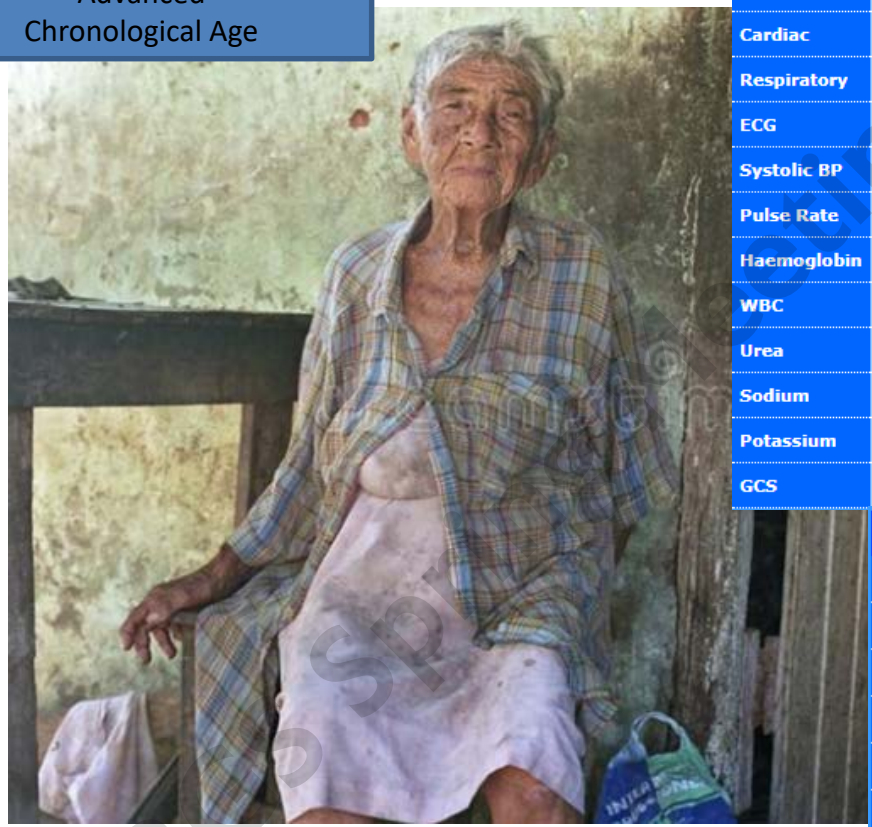
Factors predictive of mortality at 12 months

Advanced
Chronological Age

Frailty

Factors predictive of mortality at 12 months

Advanced Chronological Age



Physiological Parameters	
Age	> 70 yrs old
Cardiac	raised JVP, cardiomegaly
Respiratory	dyspnoea at rest, pulmonary fibrosis/consolidation on x-ray
ECG	ECG = any other abnormal rhythm,>4/min ectopics, Q waves, ST/T changes
Systolic BP	< 90 mmHg
Pulse Rate	<40 or > 120 bpm
Haemoglobin	<10 or >18 g/dl
WBC	>20 or <3
Urea	>15
Sodium	<126 mmol/l
Potassium	<2.9 or >5.9 mmol/l
GCS	<9

Operative Parameters	
Operation Type	Complex Major Operation
Number of procedures	more than two
Operative Blood Loss	>1000 mls
Peritoneal Contamination	free bowel content, pus or blood
Malignancy Status	malignancy + distant mets
CEPOD	emergency (within 2 hrs)

Frailty

P-POSSUM

ASA Class III-V

Complications

Time of day

Factors predictive of mortality at 12 months

Advanced Chronological Age

Cognitive impairment

Mobility impairment

Functional impairment

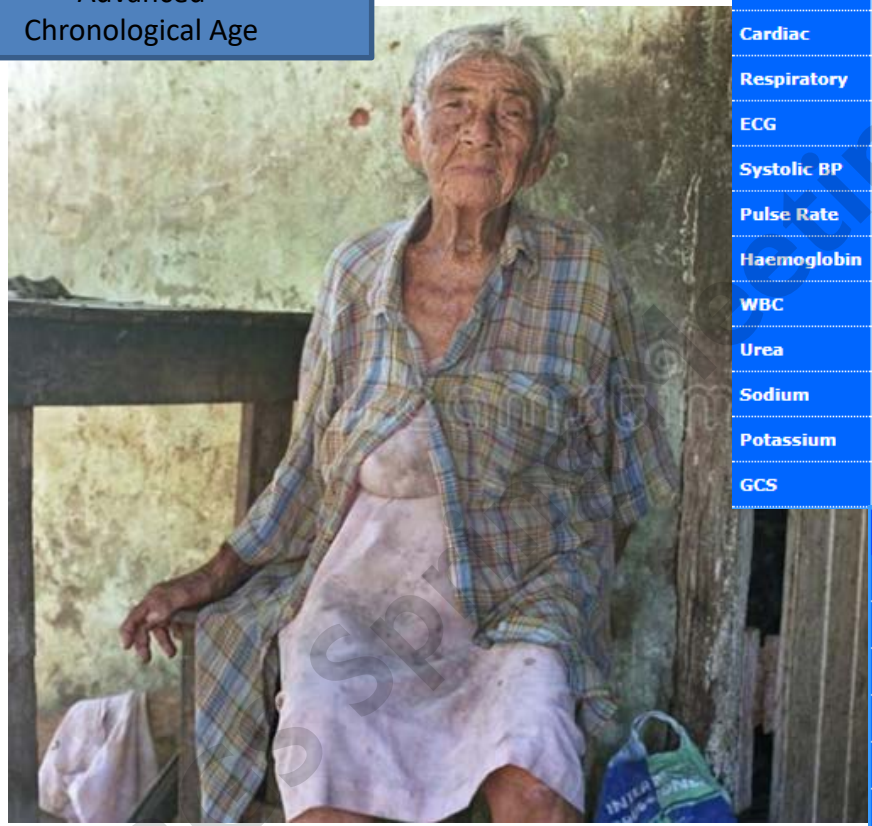
Lack of social support

Sphincter disturbance

Malnutrition

Delirium

Polypharmacy



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P-POSSUM

ASA Class III-V

Complications

Time of day

- Prospective observational study
- Aged > 74 years of age
- Emergency Laparotomy 8th September 2014 - 30th March 2017

Emergency Laparotomy (n = 113)


67.3%

32.7%

Emergency General Surgery (n = 598)

51.4%

48.6%

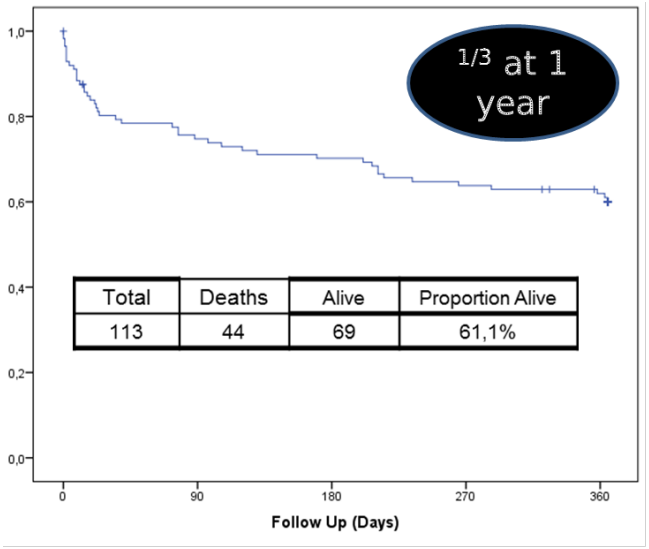
Emergency Laparotomy (n = 113)

	Wald	p	Odds Ratio	95% CI	
Not reviewed by POP-GS	11,234	,001	**6,620**	2,192	19,993
Clinical Frailty Scale 5-9	8,337	,004	**5,403**	1,719	16,982
ASA Class III-V	4,098	,043	**2,704**	1,032	7,081

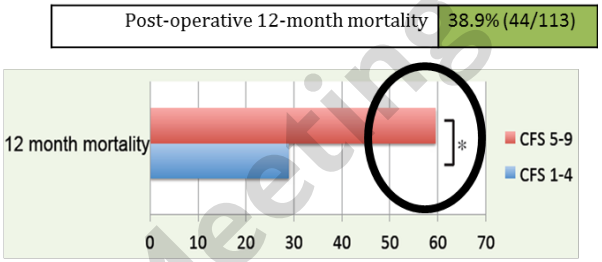
Emergency General Surgery (n = 598)

	Wald	p	Odds Ratio	95% Confidence Interval	
ASA Class III-V	21,012	,000	**2,627**	1,738	3,971
Dependent personal ADLs	15,108	,000	**2,470**	1,566	3,898
Clinical Frailty Scale 5-9	11,384	,001	**1,944**	1,321	2,860
24 hour Care	5,310	,021	**1,790**	1,091	2,937
Impaired cognition	3,965	,046	**1,459**	1,006	2,117

Emergency Laparotomy (n = 113)



Total	Deaths	Alive	Proportion Alive
113	44	69	61,1%



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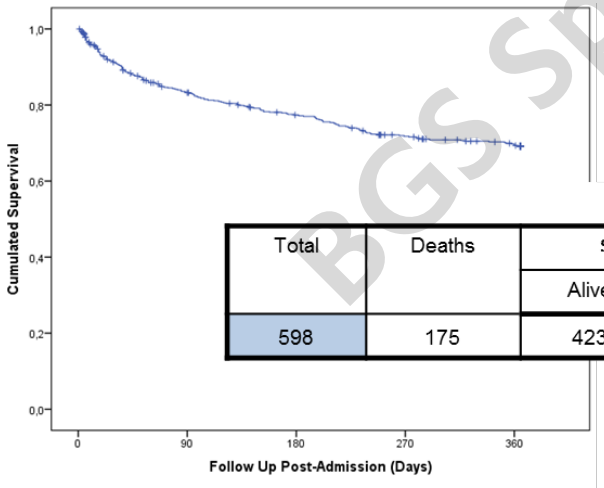
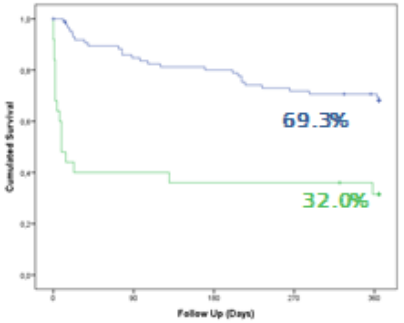


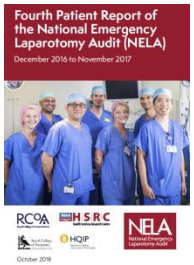
Total	Deaths	Surgery	
		Alive	Proportion Alive
598	175	423	70,7%

We must improve our Risk stratification !!!

Patients still in hospital at 20 days post-surgery	31.0% (35/113)
Patients still in hospital at 60 days post-surgery	4.42% (5/113)
30-day readmission (after discharge)	5.68% (5/88)
In hospital mortality	22.1% (25/113)
Post-operative 30-day mortality (after surgery)	19.5% (22/113)
Post-operative 90-day mortality (after surgery)	24.8% (28/113)

Review POP-GS

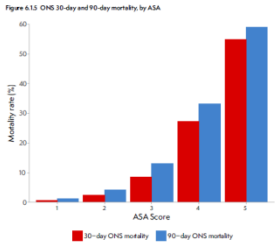


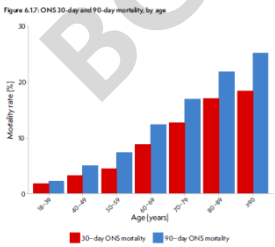


British Journal of Anaesthesia, 121 (6): 1346–1356 (2018)

Organisational factors and mortality after an emergency laparotomy: multilevel analysis of 39 903 National Emergency Laparotomy Audit patients

C.M. Oliver [1, 2, 3, 4] M.G. Bassett [3, 4, 5, 6] T.E. Poulton [3, 4, 5] I.D. Anderson [3, 7, 8, 9] D.M. Murray [3, 10] M.P. Grocott [3, 11, 12, 13] S.R. Moonesinghe [2, 3, 4, 5] the National Emergency Laparotomy Audit collaborators

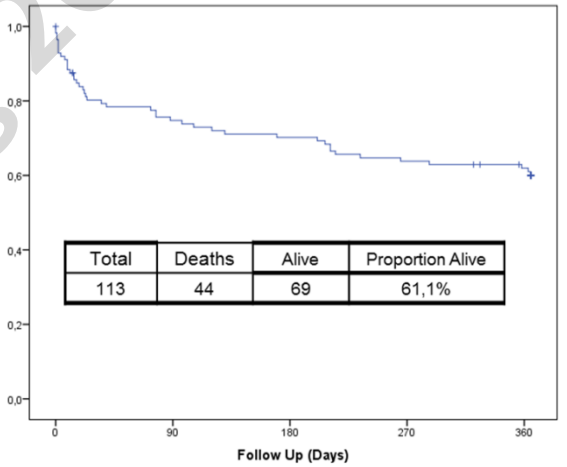


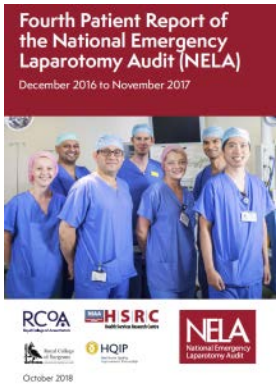


24.8% dead at 90 days

Remember patients'' wishes and expectations Quality of life and functional status!!!

Post-operative 12-month mortality	38.9% (44/113)
Readmissions within 12 months	56.8% (50/88)
Average time to first readmission, min-max	262.7 days 11-1147
Median time to first readmission	176 days





39% dead at 12 months