An age-old problem: care of older people undergoing surgery

The National Confidential Enquiry into Patient Outcome and Death last specifically reported on the provision of care for older patients having surgery 11 years ago (National Confidential Enquiry into Patient Outcome and Death, 1999). This was followed by the first *National Service Framework for Older People* (Department of Health, 2001).

The National Confidential Enquiry into Patient Outcome and Death (2010) report *An Age Old Problem* demonstrates that the quality of care is still not as good as it should be. This report took the form of a detailed review of 820 patients aged 80 years and over who died within 30 days of surgery. Most of this surgery was urgent, and half of the deaths occurred within 7 days of an operation. Clinicians reviewed case notes and questionnaires completed by the surgeons and anaesthetists directly involved with care, and concluded that only 37.5% of cases received a good standard of care, compared with what they would consider acceptable in their own practice and institution. In the remainder it was felt that care might have been improved by clinical or organizational factors, or both. In 6.4% of cases care was judged less than satisfactory.

The need for senior input

While it is expected that such a population would carry with it a lot of comorbidity, disability and general 'frailty', it was surprising that only a minority of operations were judged by operating surgeons as 'palliative'. This is testament to how difficult it may be to make accurate assessments of perioperative risk in the elderly, and highlights the need for senior input in decision making. Many patients were admitted by relatively junior doctors.

Given that the growth in finished consultant episodes in patients >75 years in the last 10 years is nearly double that of finished consultant episodes as a whole (Health Episode Statistics, 2010), trainees should all be well versed with the particular subtleties of assessment and management required in the elderly. While it was appropriate that in the vast majority of cases consultants or senior specialist trainees decided on the need for surgery, it is also important to note that preventable delays in the process were said to have occurred in 20% of cases reviewed. As in previous studies the reasons for delay were diverse, and included protracted decision making about the need to operate, prolonged preoperative stabilization and lack of ready access to an operating theatre. Numerous studies have pointed to the time-critical nature of surgery in the elderly, and this factor more than any other influenced the overall assessments of less than satisfactory care by advisors.

The report noted that senior involvement in the operating theatre from both surgeons and anaesthetists was good, and judged by advisors to be appropriate to illness severity in most cases. The frequency of perioperative complications was high. For example episodes of hypotension occurred in nearly half the cases reviewed. In addition some aspects of routine monitoring were poor, with temperature measurement being recorded in only half of the cases pre- and intraoperatively. Advisors concluded that the expectation of complications should be improved, and that careful monitoring and early proactive preventative and management strategies should be in place.

Advisors remarked on the poor level of speciality involvement by geriatricians. It would be unreasonable to expect early personal involvement of a consultant in medicine for the elderly in all such patients, particularly preoperatively when there may be some urgency to operate. Nevertheless what was found most significant was the lack of evidence of the influence of geriatricians in the day-to-day care of the majority of elderly surgical admissions, with very few surgeons stating that their patients benefited from guidelines and policies which had been developed with medicine for the elderly colleagues. Again this may be unsurprising given that some hospitals had no medicine for the elderly service on site, and the vast majority of surgical specialities, other than orthopaedics, had no specific additional funding for additional input.

High dependency care

In the 1999 National Confidential Enquiry into Patient Outcome and Death report only 6% of patients had level 2 or 3 care in the postoperative period. A marked difference appears to have developed in the interim, albeit that the population in 1999 was 10 years younger, with about 30% ultimately having care in a high dependency care unit or intensive care unit facility in the 2010 report. However, advisors did find it surprising in some cases that a higher dependency of postoperative care had not been anticipated. In approximately 10% of cases in the study critical care admission was 'unplanned'.

There is no doubt that as the older population continues to increase, there will be a need for increased level 2 and 3 care to support both medical and surgical patients. There has been an expansion in provision, particularly of level 2 beds (Department of Health, 2005). Currently the mean age for all (adult) intensive care unit admissions in the UK is around 60 years (Intensive Care National Audit and Research Centre, 2010) and many patients admitted are in their seventh decade or beyond. In advance of any further expansion in provision, the concept of 'extended recovery' was one that advisors felt should be considered for routine less major surgery in the elderly.

While the National Confidential Enquiry into Patient Outcome and Death (2010) study noted that there were aspects of care that were less than satisfac-

tory, it was felt that there were areas amenable to relatively simple measures which could improve the situation, for example better attention to good pain management. Most patients were admitted with an acute (and therefore generally painful) surgical problem. However, evidence of pre- and/or postoperative pain assessment occurred in only four out of five patients. Pain management was judged by advisors to be inadequate in similar numbers. The National Confidential Enquiry into Patient Outcome and Death (2010) report recommends that pain is assessed as often as pulse, blood pressure and other simple physiological variables (Royal College of Physicians et al, 2007), and that any assessment and management is tailored to the needs of the elderly patient (Aubrun, 2005; Hadjistavropoulos and Herr, 2007).

Conclusions

There is no reason to believe that the care delivered to patients reviewed in this study represents anything atypical. Inevitably some patients not studied would have survived despite a poor level of care and others would not survive whatever measures were taken. It reminds us that there is much that can be improved in the quality of care in all groups. BJHM

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KEY POINTS

- Only 37.5% of a population of >800 surgical patients over 80 years of age were judged by peers to have received good care.
- Preventable delays were the single most common reason for substandard care, and occurred in 20% of cases.
- Intraoperative complications were frequent despite high levels of senior input in theatres.
- Evidence that involvement by medicine for the care of elderly physicians was part of the routine pathway of care was often absent.
- While 30% of patients ultimately received critical care, 10% of admissions were unplanned.