Guidelines addressing preoperative assessment of geriatric patients aim to enhance outcomes

The number of elderly people in the US is on the rise, and so is the number of older patients having surgery. However, while advances in technology and techniques may make surgery more feasible for those age 65 and older, ensuring successful outcomes for this cohort is challenging.

Specific guidelines for the preoperative assessment of elderly surgical patients are intended to help. The guidelines—developed jointly by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and the American Geriatrics Society (AGS)—identify the following components of care that experts believe will ensure better outcomes:

- assess cognitive ability
- determine decision-making capacity
- screen for depression
- identify risk factors for postoperative delirium
- screen for alcohol and substance abuse
- evaluate cardiac risk
- evaluate risk of developing postoperative pulmonary complications
- assess ability to perform daily activities (functional status), mobility, and falls
- assess frailty
- evaluate nutritional status
- review and document medication lists
- ensure that there is an advance directive and a designated health care proxy or surrogate decision makers
- be selective about preoperative testing.

The ACS and AGS analyzed data culled from an extensive literature search to develop the guidelines, which they hope will be used to standardize the preoperative care of geriatric surgical patients.

ACS NSQIP has developed several performance measures with the Centers for Medicare and Medicaid Services (CMS), according to Clifford Y Ko, MD, FACS, director of the Division of Research and Optimal Patient Care at the ACS. One of those, the elderly surgery measure, is a risk-adjusted outcomes measure that looks at multiple outcomes in surgical patients age 65 and older.

“In our program of over 500 hospitals, we have found a large variation in terms of care and outcomes of the elderly. Taking care of the elderly differs greatly from taking care of nonelderly patients,” he says.

Establish a baseline

“Knowing things about patients preoperatively may change how you treat them postoperatively,” notes Barbara M. Resnick, PhD, CRNP, FAAN, FAANP, with the Department of Organizational Systems and Adult Health at University of Maryland School of Nursing, Baltimore. Resnick, currently chair of the AGS board, is a strong advocate for thorough preoperative screening for all elderly surgical patients.

“Screening tests would take just a few minutes and would help the next provider
who cares for them,” she says. It’s critically important to establish a baseline for the patient, because that will determine how care is approached.

Sometimes nurses or physician extenders do the screening, and sometimes it’s a surgeon, Dr Ko says. “We’ve tried to make these guidelines so that they can fit a number of different levels of training or educational backgrounds. A lot of these items are screening tests. The key thing is getting the right information to the right person—for example, if there are 3 medications that might interact with a postoperative medication, we need to talk to the primary care physician and maybe get the pharmacist involved. If a patient needs to be put on a narcotic postoperatively, how do we minimize the chance of postop delirium?”

Resnick emphasizes that if a nurse doesn’t know the person’s basic level of function prior to surgery, he or she won’t know if something happened during surgery to alter that. For example, can the patient get up and walk across the room?

Similarly, a baseline cognitive evaluation is essential. “After surgery, it’s very common for patients to become delirious. But you don’t know that unless you know where the person started. You might assume it’s dementia, whereas it’s delirium—and these are two very different things,” Resnick says.

Dr Ko can speak to this from personal experience. “I was talking to a woman in her 80s after her operation,” he says. “She didn’t have her hearing aid in or her glasses on, so she wasn’t responding appropriately. Suddenly, we thought something was going on. Was she having a stroke? Was she bleeding? Did we need to rush her down to get a head CT? All we needed to do was have her put on her glasses and turn on her hearing aid. There are things we overlook because we don’t take care of elderly patients all the time.”

In addition, some preoperative assessments can make or break recovery. “If a patient preoperatively is malnourished, they’re never going to recover. Following a high-protein diet could make a difference,” Resnick notes.

**Apply the information**

Assessing patients’ cardiac and pulmonary function prior to surgery is routine because complications in those areas present the highest risk for death. But in Resnick’s opinion, all items in the guidelines should be evaluated for all patients.

“We sometimes keep assessing instead of using the information,” she notes. But caregivers need to not only evaluate the patient but also use the information obtained to guide patient care. “If someone has cognitive impairment and is having hip fracture surgery, for example, you don’t put them alone in a room at night in a high bed with the bed rails up and expect them not to have a fall.”

Successful adoption of these screening guidelines means changing the philosophy of how we approach care, Resnick says. She believes proper use of the guidelines hinges on 3 key factors:

- **Environment.** Make sure your staff have the resources to perform the screenings, and make copies of the screening tools readily accessible.
- **Education.** Teach staff how to conduct the screening and why it’s important.
- **Incentive.** Designate a manager or expert staff member as a champion of this process, and reward providers who use screening tools. If performing these assessments were required for reimbursement, they would be performed, she believes.

Expanding the standard preoperative sheet to allow room for patients’ assessment scores would be a great way to transfer information, Resnick says. “I use a physical assessment form that exists as a Word file. I usually don’t use the forms they send me.”

Hospitals could develop preoperative forms in much the same way that surgical
checklists have been developed, with a format and criteria specific to each individual institution, Dr Ko suggests.

**Next steps**

The ACS and CMS have launched a pilot program through which NSQIP-participating hospitals will voluntarily report on select surgical measures posted to the CMS Hospital Compare website. The first report on the elderly surgery measure was released in October 2012, and more reporting will be carried out this year.

NSQIP has developed a “risk calculator” whereby NSQIP data can be plugged in to determine risk factors for complications, mortality, and so forth. “Knowing where the patients are preoperatively and knowing what their expectations are and having them participate in shared decision making with real information specific to them is something that has been piloted with this risk calculator, and it’s been eye-opening to both the patient and the surgeon,” Dr Ko says.

The risk calculator is expected to be available later this year as a website or mobile app.

Plans are underway to develop another set of guidelines that will address treatment of the elderly in the intraoperative and postoperative periods, Dr Ko says. Meanwhile, the preoperative assessment criteria would appear to have great potential for improving patient outcomes. Could they have an impact on reimbursement?

“We’re being increasingly incentivized to give better care and have better outcomes,” Dr Ko points out. “If we do something on the front end and minimize an occurrence of delirium, a fall, an infection, or an extra stay in the hospital or readmission—I think that’s where the incentives are.”

—Elizabeth Wood

**Reference**


Resnick will present “Preoperative Guidelines for the Geriatric Surgical Patient” during the 26th Annual OR Manager Conference, September 23-25, 2013, in National Harbor, Maryland. www.ormanager.com