GERIATRIC TRAUMA GUIDELINE

Background and Introduction:

The American College of Surgeons recognizes that the geriatric population is increasingly involved in traumatic injuries and has higher mortality and complication rates compared to younger trauma populations. Because of the unique changes in physiology, physiologic reserve and comorbidities, geriatric specific guidelines for trauma programs are encouraged. These guidelines aim to assist providers in improved "risk-assessment, surveillance and prevention" for our geriatric patients to minimize morbidity and mortality.

This Geriatric Trauma Guideline consolidates recommendations from the TQIP Geriatric Trauma Management Guidelines with practical application and consideration to the unique resources available for injured geriatric patients who receive care at the M Health East Bank campus.

Initial Stabilization Care Considerations:

- Activate Trauma Team Activation (TTA FULL or PARTIAL) as applicable. Elderly patients can experience significant injury even with low impact mechanisms.
- Primary and Secondary survey
- Delirium screen by ER RN within the Nursing Navigator. ER staff to notify trauma team of positive screens.
- Backboard clearance Guideline with special attention to risk of hypothermia and skin break down
- Consider medications that effect initial evaluation and care (Coumadin, anticoagulants, ASA, Beta blockers, ACE inhibitors, chronic narcotic use, benzos, antipsychotics, or hypoglycemic agents)
- For imaging consideration recommendations see Evaluation for Falls guideline:
  - Chest/pelvis x-ray, head/C-spine CT, or FAST exam
- Lab assessment: trauma lab panel includes CBC with diff, CMP, ABO/Rh type and screen. Consider ordering the following in addition to trauma order lab panel
  - Lactic acid or blood gas for baseline base deficit
  - PT/PTT/INR
  - Blood alcohol level
  - UA and urine toxicology
  - Blood glucose

General and Emergent Care Considerations:

- Assess for secondary etiology of trauma
  - ACS
  - Dehydration
  - UTI: screening order mandatory for all trauma patients
  - Pneumonia
  - Acute renal failure
  - CVA
  - Syncope
  - Hypovolemia/dehydration
- Evaluation of coagulopathy and reversal protocols
  - All trauma patients with INR >2.5 or on a novel anticoagulant to have head CT
  - TBI on Warfarin or Novel Anticoagulant with Neurosurgery Guideline
  - Reversal protocols
- Evaluation for falls Guideline (#1 mechanism for trauma >65 yo)
- Rib fracture management Guideline
- Anesthesia Services available for block management in the ER. 24 hour job code pager #: East Bank *** 777-0545; West Bank ***777-0599. This pager only accepts text messages through AMCOM
- Pharmacy considerations and resources
  - Medication reconciliation by fourth year pharmacy students or pharmacy residents. Focus is on patients who are waiting to be admitted while in the Emergency Room.
  - Starting *doses for opioid naïve patients*
    - ***IV*** *intermittent dosing*
      - *Hydromorphone 0.3-0.5 mg q2h PRN*
      - *Morphine 2-4 mg q2h PRN*
      - *Fentanyl 25 mcg q2h PRN*
    - ***IV*** *PCA dosing*
      - *Hydromorphone 0.1-0.2 mg load then 0.1-0.2 mg Q15min*
      - *Morphine 1-2mg load then 0.5-1 mg Q15min*
      - *Fentanyl 25mcg load then 10-20 mcg Q15min*
    - ***Oral*** *Starting doses for opioid naïve patients*
      - *Oxycodone 2.5-5 mg q3h prn*
      - *Hydromorphone 1-2 mg q3h prn*
      - *Tramadol 25-50 mg q6h prn*
  - Focus should be on using Multimodal pain therapy and opioid minimization. See Multimodal Pain Management order set.
  - Doses for opioid tolerant patients may need to be titrated up. Seek Pharmacy, Pain Services, or Palliative Services for expert recommendation.
  - If starting or advancing opioid treatment management, consider also starting a bowel regimen to address risk of constipation.

Admission Assessment:

- Repeated Primary, Secondary, and Tertiary surveys
- Careful review of PMHx, PSHx, medications and allergies.
- Alcohol intake assessment (mandatory)
- Code status confirmation and documentation, identify surrogate decision maker
- Palliative consult order
  - Available to all
  - For all patients ≥ 75 yo – if consult is not obtained, documentation of rationale is to be included within H&P, tertiary survey, or dc summary notes.
  - Recommended for patients with ICU stays ≥5 days
  - If patient is DNR/DNI without a signed POLST
  - Important to be clear within consult order and documentation on services requested of Palliative Services
- Consider provider to provider contact with primary care provider/referring care center if there is a concerning presentation or questions regarding baseline status.

Inpatient Considerations & Available Resources:

- Delirium Assessment & Screening: Regularly evaluate and address delirium risk factors. Monitor and provide delirium interventions.
- Ongoing Aspiration Evaluation and Screening Guideline
- Nutrition Assessment: Part of nursing admission standards
- Pressure Ulcer Risk: Part of nursing admission assessment
- Falls Risk Assessment: Part of nursing admission assessment
- Inpatient pharmacy consult available for the following considerations:
  - *Medication history IP pharmacy consult*
  - *Pharmacy IP consult – generic consult, free text request*
  - *Pharmacy/Nutrition to start & manage TPN consult*
  - *Warfarin pharmacy consult panel*
- Palliative Care Consult considerations as indicated within admission assessment.
- Psychiatry consultation: Including but not limited to concerns regarding medications, diagnosis of depression, capacity to make decisions, and/or delirium.
- Physical and Occupational therapies: Available to evaluate and assess for safe disposition planning. They can assist with referral process for home risk assessments.
- Speech therapy: automatically consulted with positive aspiration evaluation screening
- Primary Nurse & Trauma Resource Nurse: Provide falls prevention and specific injury teaching to patient and patient's family.
- Social Work and Care Coordination: To begin developing a plan for transition to post hospital care at the time of admission. Assist with coordinating medical equipment of home health services as needed/requested

Discharge considerations:

- All discharges to care facility will have DC summary complete prior to discharge
- AVS to provide clear information regarding follow up
- Trauma specific discharge teaching to be completed and documented.
- Consider home safety evaluation order

Resources:

- http://www.uptodate.com/contents/geriatric-trauma-initial-evaluation-and-management?source=search_result&search=geriatric+trauma&selectedTitle=1%7E150#H3512230
- https://www.facs.org/~/media/files/quality%20programs/trauma/tqip/geriatric%20guide%20tqip.ashx