PRACTICE GUIDELINE

Effective Date: March 1, 2019 Manual Reference: **Deaconess Trauma Services**

TITLE: GERIATRIC TRAUMA

PURPOSE: To provide a guideline for geriatric patients treated at the Deaconess Regional Trauma Center. Traumatic injury in the geriatric population is associated with higher mortality and morbidity rates compared with younger patients. Recognizing that the geriatric population has a unique set of needs, this guideline addresses the additional considerations of the geriatric population.

DEFINITIONS:

The geriatric population is defined as $\geq$ 65 years of age.

GUIDELINES:

1. T2 (see T2 ED Triage for full guideline)
    a. If the patient has trauma to the head, neck, chest, back, abdomen and/or pelvis and is on an anticoagulation or anti platelet medication (i.e. Coumadin, Plavix, Pradaxa, Eliquis, Xarelto, Brilinta), the patient will be noted as a "T2" for ED purposes and will be triaged accordingly.
    b. These patients are at higher risk for Cat II inclusion and should have a Trauma II Panel ordered.
    c. Consider additional labs including
        i. ABG for baseline base deficit
        ii. UA

2. Non-Accidental Trauma (a/k/a Elder Abuse)
    a. Refer to Hospital P&P 40-03S "Abuse/Neglect/Domestic Violence"
    b. Elder abuse is an intentional act, or failure to act, by a caregiver or another person in relationship involving an expectation of trust that causes risk or harm to an older adult.
    c. Forms of elder abuse include: physical, sexual, emotional or psychological, neglect or abandonment, and financial or exploitation.
    d. Signs and symptoms of abuse include but are not limited to
        i. difficulty sleeping
        ii. depression or confusion
        iii. unexplained weight loss
        iv. acting agitated or violent
        v. becoming withdrawn
        vi. ceasing taking part in activities
        vii. unexplained bruises, burns, or scars
    e. If suspicion of elder abuse is present, provider should contact Social Work, who will contact Adult Protective Services (APS) and law enforcement as necessary and document accordingly in the progress note.

3. Hospitalist Consult
    a. Consideration should be given to Hospitalist consult to manage the patient's loss of reserve function and/or comorbid condition(s).
    b. The trauma surgeon will remain the primary provider until Trauma Services signs off on the management of the patient.

4. Secondary Etiology
    a. Screen for
        i. Acute Coronary Syndrome (ACS)
        ii. Dehydration
        iii. Urinary Tract Infection (UTI)
        iv. Pneumonia
        v. Acute kidney injury (AKI)
        vi. Cerebrovascular Accident (CVA)
        vii. Syncope
    b. Evaluation of coagulopathy
        i. INR > 2.5 or on a novel anticoagulant should have head CT
        ii. TBI on warfarin or novel anticoagulant
        iii. Reversal protocol
    c. Evaluation for falls
    d. Rib fracture management
    e. Pharmacy considerations
        i. Medication reconciliation
        ii. Focus should be on using multimodal pain therapy and opioid minimization
        iii. Starting doses for opioid naïve patients
            1. IV intermittent dosing
                a. Hydromorphone 0.3-0.5 mg q2h PRN
                b. Morphine 2-4 mg q2h PRN
                c. Fentanyl 25 mcg q2h PRN
            2. IV PCA dosing
                a. Hydromorphone 0.1-0.2 mg load then 0.1-0.2 mg Q15min
                b. Morphine 1-2 mg load then 0.5-1 mg Q15min
                c. Fentanyl 25 mcg load then 10-20 mcg Q15min
            3. Oral dosing
                a. Oxycodone 2.5-5 mg q3h PRN
                b. Hydromorphone 1-2 mg q3h PRN
                c. Tramadol 25-50 mg q6h PRN
        iv. Doses for opioid tolerant patients may need to be titrated up
        v. If starting or advancing opioid treatment management, consider also starting a bowel regimen to address risk of constipation
    f. Delirium assessment and screening
    g. Nutrition assessment
    h. Pressure ulcer risk

5. Advanced Directives
    a. if no advanced directive is on file, consult Religious Life

6. Palliative Care
    a. Palliative Care consult recommended:
        i. Patients ≥ 85 years admitted to acute-care surgery for ≥ 2 days
        ii. Patients > 70 years with ground-level fall
        iii. Those with active malignancy

7. Fall Prevention
    a. Refer to Hospital P&P 40-58 Fall Policy
    b. Reinforce the need for home safety modifications such as grab bars, removal of rugs, appropriate lighting, etc.
    c. Consider outpatient referral to podiatrist, optometrist, nutritionist, and audiologist

REFERENCES:

- ACS TQIP Geriatric Trauma Management Guidelines
- Centers for Disease Control and Prevention
- University of Minnesota Medical Center Geriatric Trauma Guideline
- Hospital P&P 40-03S "Abuse/Neglect/Domestic Violence"
- Hospital P&P 40-58 "Fall Policy"
- Lilley EJ, Khan KT, Johnson FM, et al. Palliative care interventions for surgical patients: a systematic review. JAMA Surg. 2016 Feb;151(2):172-183.
- Lilley EJ, Cooper Z, Schwarze ML, Mosenthal AC: Palliative care in surgery: Defining the research priorities. Ann Surg. 2018 Jan;267(1):66-72.
- Mosenthal AC, Weissman DE, Curtis JR et al. Integrating palliative care in the surgical and trauma intensive care unit: A report from the improving palliative care in the intensive care unit (IPAL-ICU) project advisory board and the center to advance palliative care. Crit Care Med. 2012 Apr;40(4):1199–1206.

REVIEWED DATE	REVISED DATE
AUG 2020	JUL 2019
JUNE 2021	JUL 2020