

OBJECTIVE: Geriatric patients continue to become an increasing proportion of trauma patients as the population ages. This and other accompanying guidelines highlight specific considerations and challenges in this population.

Trauma Activation Criteria: The following criteria pertain specifically to the geriatric population. [Full activation criteria \(Chapter 1\)](#).

ADULT LEVEL 1 TRAUMA ACTIVATION CRITERIA

- High Speed Collision (> 30 MPH) **with** gross injury **AND** age $\geq$ 65 years

ADULT LEVEL II TRAUMA ACTIVATION CRITERIA

- High Speed Collision (> 30 MPH) **without** gross injury **AND** age $\geq$ 65 years
- Falls $\geq$ 10 feet **OR** *any fall with a (+) LOC $\geq$ 65 years of age*

ADULT LEVEL III TRAUMA ACTIVATION CRITERIA

- Any EMS call involving a traumatic mechanism that may result in injury, but does not meet Level 1 or 2 criteria, with a low threshold to call a Level 3 if the patient is:
 - $\geq$ 65 years old
 - AND/OR is taking anticoagulation (including ASA and Plavix)
- Fall from height not meeting Level 1 or 2 criteria, particularly those $\geq$ 65 years old
- MVC not meeting Level 1 or 2 criteria, particularly those $\geq$ 65 years old
- Pedestrian struck at low speed, particularly those $\geq$ 65 years old

Frailty Assessment:

All patients $\geq$ 65 years of age should have their Trauma Specific Frailty Index (TSFI) documented in the admission H&P if mental status, collateral history providers, and patient status allow. This is available in Cerner with the dot phrase “BZFraily.”

The Rib Fracture Frailty Index (RFF) may alternatively be used in patients $\geq$ 65 years old with the primary diagnosis of rib fractures. The RFF score can provide a predicted risk of inpatient mortality, pneumonia, mechanical ventilation, discharge to home, and prolonged hospitalization.

Considerations for Geriatric Medical Care

- Anticoagulation Management
- [WMCHealth Anticoagulation Reversal Guideline](#)
- [Venous Thromboembolism Prophylaxis](#): for patients with traumatic injuries
- Consult Physical Therapy/Occupational Therapy
- Consult Social Worker and Case Management
- Delirium Prevention and Management:
 - Assess and address underlying triggers.
 - Medication reconciliation, address polypharmacy, Beers criteria
 - Replete electrolytes
 - Treat underlying infection (UTI, pneumonia, cellulitis, bed sores)
 - Urinary retention and constipation
 - Optimize pain control

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- Discontinue any offending medications.
- Orient daily (date, day, and time)
- Promote good sleep/wake cycles.
- Avoid unnecessary nighttime disruptions unless medically needed.
- Avoid benzodiazepines or other sedatives unless necessary.
- Liberalize family/friends visits
- Avoid tethering: restraints, catheters, cardiac monitor, IV lines, nasal cannula
- Use of Antipsychotics:
 - First line: Seroquel, risperidone, olanzapine
 - Second line: Haldol, lorazepam
 - Monitor for black box warnings for above antipsychotics
- Medication Management:
 - Review home medication list and restart as appropriate
 - Review Beers Criteria list of medications
 - Ensure home medications are restarted to prevent withdrawal while discontinuing medications that may increase the risk of falling or delirium.
 - Address polypharmacy prior to discharge
- Optimize pain control
- Pressure Ulcer Prophylaxis:
 - Frequent patient repositioning, special mattresses, off-loading; refer to Pressure Injury Incision Wound tab on Cerner.
- Nutrition:
 - Consult nutrition to optimize intake (meals + supplements), consider speech/swallow evaluation to evaluate diet and need for dentures.
- Constipation:
 - Order bowel regimen for patients with or at risk for constipation.
- Miscellaneous:
 - Use vision aids and hearing aids if used at baseline – consider audiology consult if hard of hearing; consult PT/OT; liberalize visitors, especially family members; avoid urinary retention; discontinue Foley; and encourage self-voiding.

Geriatric Co-Management Consultation

Purpose: The Geriatric Trauma Co-Management Initiative was developed to optimize inpatient care of acute and chronic medical problems and to help identify, and if possible, correct underlying medical conditions that may have contributed to the trauma.

Indications:

- ≥ 55 years old with 2 or more medical comorbidities
- ≥ 55 years old with concern for a medical cause of their traumatic injury (e.g. syncope)
- All patients ≥ 65 years old

Roles and Responsibilities:

1. Patients will be admitted to the surgical services with the hospitalist as a consultant. The hospitalist attending will be the “consultant.” Co-management indicates that the consulting team will address

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all known issues within their scope of practice as determined by training, experience, privileges, and medicolegal concerns, and have order-writing privileges regarding those issues as described below.

2. Patients will be seen daily by the consulting team and a note will be documented in chart unless prior arrangements have been made between the primary and consulting teams.
3. If the consulting team recommends subspecialty consultation, this should be communicated verbally and in writing to the primary team. The consulting hospitalist will initiate discussions with subspecialty consult teams if requested by the primary team.
4. The consulting team will contact the primary team to ensure all questions and concerns have been adequately addressed prior to 'signing off.' A final note should be placed in the chart addressing any necessary follow-up with the consulting service.

Procedure:

1. Requests for co-management will be made by entering an order for medicine consult in EMR and contacting the on-call clinician. There will be a discussion between the two clinicians about the patient's course and care, specifying the urgency of the consultation.
 - a. Indications for consultation are listed above.
 - b. At night, consult the medicine service and they will write a consultation and sign out to the co-management attending in the morning.
2. The primary surgical team will remain the main point of contact for nursing, pharmacy, wound care, rehabilitation services, and other services. The primary team will refer inquiries to the consulting team when that team is addressing those issues.
 - *Examples of primary surgical team duties:* ordering imaging, activity orders, routine perioperative antibiotics, wound care, routine perioperative VTE prophylaxis, advancing diet, discussing details of prognosis and biopsy results and resultant plan of care, placing orders recommended by consult service, H&P, and DC summary.
 - *Examples of hospitalist team duties:* perioperative risk stratification and risk reduction, diabetes care recommendations, assistance with medicine reconciliation, management of pre-existing comorbidities, evaluation, and management recommendations of new/emergent medical problems, timing of foley catheter removals, and central lines (in conjunction with the primary team), participation in goals of care conversations, and IDT rounds.
3. The primary team and consulting team will discuss the patient's care daily. There will be availability for attending level conversations whenever needed. At minimum, there needs to be an attending level conversation pre-op, post op, PRN complications, and pre-discharge. Consultant will attend morning report with entire Trauma team daily at 8am, round with the Surgical Attending in the morning, and with APP/house staff each afternoon and PRN.
4. New recommendations made by the consulting team will be communicated verbally to the primary team and documented in their daily note. Primary teams will notify consult teams of any major clinical status changes (e.g., canceled surgery/procedure, results of a surgery/procedure, change in level of care, etc.).
5. The consulting team will document in the medical record the anticipated discharge date (when known) and (as appropriate) recommendations for discharge medications, wound care, activity,

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and appropriate follow-up care. The primary team will be responsible for discharge planning and the discharge process. Medication reconciliation for discharge not performed by the pharmacy department will be performed by the primary team. The consulting team will review prior to discharge. The consulting team will bill daily as a consultant.

6. Post-discharge clinic follow-up appointments will be coordinated by primary team for surgical follow up. Medicine-related follow-up appointments will be coordinated by the hospitalist.
7. If a Trauma or Ortho patient needs ICU services, patient will go to the Trauma ICU.
8. Clinical and operational conflicts will be addressed expeditiously by attending physicians and escalated to leadership of each group if unresolved.
9. The leadership of Internal Medicine, Trauma Surgery, and Orthopedic Surgery will determine mutually agreed upon quality and satisfaction metrics and meet quarterly to discuss progress on metrics and operational concerns. Quality metrics attached separately.
10. Until such time as the Hospitalist service has appropriate staffing for a 7/7 service, it will operate as a M-F service, with hospitalist cross coverage on the weekend. Hospitalists will sign out internally and round on the weekend at specified times.
11. Program leadership will review this document periodically and adjust as needed collaboratively

Palliative Care and Advanced Directives

Purpose: Palliative Care Service Consultation is to assist patients and families with coping, symptom management, complex medical decision-making, and goals of care/end-of-life issues. Early involvement of the Palliative Care Service has been associated with decreased interventions and ICU and hospital length of stay.

All geriatric trauma patients admitted to the ICU will have delineation of advance directives and a health care surrogate within 24 hours of admission using the appropriate WMC proxy or surrogate form.

In cases where physician determination of prognosis is not congruent with goals of care, a palliative medicine consultation will be requested within 24 hours of such determination.

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