GERIATRIC TRAUMA RECOMMENDATIONS

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Key Facts to Consider

- Traumatic injury in the geriatric population is:
  - increasing in prevalence
  - associated with higher mortality and complication rates compared with younger patients
- Significant injury can result from low mechanism
  - Low suspicion can lead to delayed identification and activation or resources
- Unintentional injuries were listed as the ninth cause of death for those aged 65 years and older
- Proactive Geriatric Consultation has been associated with
  - fewer episodes of delirium
  - fewer in-hospital falls
  - lesser likelihood of discharge to a long term care facility and
  - shorter length of stay”

How to Get Started

- Practice Guideline
- Activation Criteria
- Admission Order Set
- Engagement with care partners (PT, Hospitalists, Care Management, RT, etc)

- “The elderly patient continues to be at risk for under triage or lack of recognition to how serious the injury may be. Under triage may lead to critical outcomes including death”

- “Elderly Trauma” by Renee Semonin Holleran FNP-BC, PhD, CEN, CCRN, CFRN, CTRN, FAEN Critical Care Nursing Quarterly Vol 38 No3

Silver Criteria

- Age 65 or > on anti-coagulant or anti-platelet with a suspected neurological injury
  - GCS change from baseline
- Age 65 or > on anticoagulant or anti-platelet with a suspected ortho injury
- If patient would meet limited tier activation criteria, and they are age 65 or >, they would increase to full team activation

Practice Recommendations

- Objective: Patients that are 65 years of age or older will be activated at a higher tier, unless they already meet Tier 1 criteria
- Primary Survey – no change
- Secondary Survey – emphasis on medications, co-morbidities
- Tertiary Survey – focus on comorbid conditions and functional status to facilitate hospital care and discharge planning

Practice Recommendations Continued

- Additional labs in patients requiring resuscitation:
  - Lactic Acid/Blood Gas, PT/PTT/INR, Renal Function, BA, Urine toxicology, electrolytes
- Liberal use of CT
  - Risk of injury outweighs radiation exposure concerns
- Aggressive anticoagulation reversal

Geriatric Trauma Patients:

- 5 times in hospital mortality rate
- Longer intensive care unit and hospital stays
- Longer median duration of mechanical ventilation
- Higher inotropic support

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Inpatient Considerations

- Hold a family meeting within 48 hours of admission
  - Particularly if stay is anticipated to be >96 hours
  - Discuss goals of care
- Screen for pre-injury status to determine if a Hospitalist Consultation is warranted
- Utilize pharmacy support to safely and effectively provide pain management
- Closely monitor changes in intravascular volume - limited capability to tolerate significant changes:
  - I&O
  - Daily weights
  - CVP
  - Non-invasive cardiac output in the ICU

Prevention of Complications

- Evaluate daily and address delirium risk factors
- Evaluate daily for reversible causes of delirium
- Obtain a PT/OT consult within 48 hours even if injury does not impact mobility
- Institute aspiration precautions
- Initiate a bowel regimen for patients requiring opiates
- Suspected chest injuries warrant an RT consult
- Ongoing evaluation for pressure ulcers

Discharge Planning

- Post-hospital disposition should be considered and addressed immediately upon admission

- Goals to optimize patients
  - Placement in a SNF is associated with 1.6-3.9 increase risk of death compared to discharge home

Performance Improvement

- P.A.L.Li.A.T.E consortium- prognostic assessment of life and limitations after trauma in the elderly
  - GTOS tool- Geriatric Trauma Outcome Score
  - GTOS II- Estimating probability of unfavorable discharge

  - http://palliateconsortium.com/develop/index.php

“The Geriatric Era is not coming- its here”

Managram A. Evolution of G60. Geriatric Trauma Conference, 21-22 May 2015 Phoenix Arizona