

Guidelines for Management and Prevention of Delirium In Geriatric Trauma Patients

Objectives:

- Provide a guideline for recognizing and managing delirium in geriatric trauma patients.
- Provide a template for proactive co-management of geriatric trauma patients with or at risk for developing delirium.
- Provide a framework to ensure safe disposition of geriatric trauma patients.

Background:

The Trauma and Geriatric services recognize the need for specific inpatient guidelines to manage and prevent delirium in the geriatric trauma patient, in order to improve outcomes. Based on data from the Trauma Quality Improvement Program (TQIP) and corresponding geriatric care guidelines all geriatric patients with trauma diagnosis benefit from evidence based practice guidelines as well as proactive geriatric consultation. The goal of the following guidelines is to improve prevention, recognition, management and disposition of geriatric trauma patients with delirium.

Definitions:

1. A **Geriatric Trauma Patient** is any trauma patient >65 years old.
2. A **Medically Complex Geriatric Trauma Patient** is any geriatric trauma patient with a previous history of dementia or delirium or uncontrolled major medical condition (i.e. HTN with SBP > 160 after adequate pain control, DM with a hyperosmolar state). Any patient >85 will also be considered complex regardless of history.

Guideline:

1. Acute Care for the Elderly (ACE) Consultation:

- a. An ACE consultation should be obtained for all **Medically Complex Geriatric Trauma Patients**. An ACE consultation should be obtained on **Geriatric Trauma Patients** with a positive **FRAIL** score.

- Fatigue
- Resistance (inability to walk up a flight of steps)
- Ambulation (inability to walk length of football field)
- Illness (5 or more)
- Loss of weight (5% or more body weight)

An answer of YES to any of the above indicates a positive FRAIL score

b. Consult to the Hospitalist will be made on admission for:

- Consultation of the complex medical geriatric patient for care of acute or ongoing medical conditions.
- Risk stratification of the complex medical geriatric patients requiring surgical intervention.

2. Management * Use Smart Set; IP DELIRIUM

a. Nursing

- Activity –Ambulate patient ASAP according to orders.
- I/O Intake and Output – Every 8 hours including food intake
- Family Involvement – Documentation of hours family available, involved names and how they will help. Hold family meeting within 72 hours.
- Environment and Sleep Interventions
 - i. Private room if available
 - ii. No vitals between 10pm and 6 am if possible
 - iii. No non-emergent labs draws or radiologic tests between 10pm and 6am
 - iv. Noise reduction – For nighttime sleep; no daytime quiet time!
 - v. Sleep hygiene/nightly rituals.
- Orientation
 - i. Reorient and direct patient as needed
 - ii. Validate patient experience as needed
 - iii. Promote day orientation – Blinds and curtains open, lights on.
 - iv. Promote night orientation – Blinds and curtains closed, lights off.
 - v. Consistent staff whenever possible
 - vi. Avoid changing rooms and procedures after 9pm if possible
- Bladder Scan if no urinary output – Call provider if volume > 300ml
- Toilet Patient – Every 2 hours during waking hours if Out of Bed order
- Complete Intensive Care Delirium Screening Checklist (ICDSC) – ICU
- Complete Confusion Assessment Method (CAM) – Medical Surgical Floors
- Complete SBIRT
- ICOUGH
- Fall Risk Assessment-John Hopkins – **With fall prevention**
- Skin Assessment - Braden scale assessment
- Depression Screening- PHQ-2 **If positive consult ACE team**
- Baseline functional status assessment

b. Diet/Nutrition – **According to diet order**

- Offer snacks between meals
- Offer fluids between meals
- Assist With tray setup and meals
- Comfort foods
- Out of bed for meals

c. Labs- Critically evaluate the need for all laboratory tests

Additional to standard

- Vitamin D 25 hydroxy

d. Cardiac studies

- As per condition

e. Pain – geriatric dosing**Avoid nonsteroidal anti-inflammatory drugs****I. Mild Pain**Acetaminophen – 650 mg Oral, Four Times Daily – for 30 days**II. Moderate Pain**Acetaminophen – 975 mg Oral, Three Times Daily –for 30 daysOxycodone (Roxicodone) immediate release tablet - 2.5 mg, oral, Every 4 hours PRN, for 3 days**III. Severe Pain**Acetaminophen – 975 mg Oral, Three Times Daily –for 30 daysOxycodone (Roxicodone) immediate release tablet - 5mg, Oral, Every 6 hours PRN, for 3 daysf. Bowel management**Avoid stool softeners without addition of a bowel stimulant****Do not use Milk of Magnesia**- Senna 8.6 mg tablet – 2 tablet, Oral, Nightly, for 30 days for constipation- Polyethylene glycol (MIRALAX) 17g packet – 17 g, Oral, Daily PRN, constipation, for 30 days- **Bisacodyl (DULCOLAX) Select one:**- Bisacodyl (DULCOLAX) ED Tablet – 5mg, Oral, PRN Constipation x 30 days- Bisacodyl (DULCOLAX) ED Tablet – 10mg, Oral, PRN Constipation x 30 days- Bisacodyl (DULCOLAX) suppository - 10mg, Rectal, PRN Constipation x 30 days or Q72 hours if no BM

g. Evaluation (For)

- Cognitive impairment and dementia – Mini-Cog will be completed by ACE team
- Depression
- Alcohol use
- Polypharmacy and psychotropic medications
- Poor nutrition
- Hearing and Vision Impairment
- Wake Sleep cycle disturbance
- Immobilization
- Infection
- Uncontrolled pain
- Renal Insufficiency, dehydration electrolyte abnormalities
- Urinary retention – avoid urinary catheters
- Fecal impaction or constipation
- Avoid Restraints if possible
- Swallowing deficits

h. Medication management

- Follow Beers criteria
- Discontinue nonessential medications
- Continue medications with withdrawal potential
- Continue B-blocker or start if indicated
- Continue Statins when appropriate
- Adjust dosing for renal function
- Use elderly- appropriate medication and dosing
- Avoid benzodiazepines
- Monitor use of narcotics; consider early implementation of PCA
- Consider early use of nonnarcotics including NSAID's, adjuncts and tramadol
- Epidural analgesia may be preferable to other means for patients with rib fractures to avoid respiratory failure
- **Antipsychotics – Choose from following with Geriatric dosing if Delirium Present**
 - Quetiapine (SEROQUEL) tablet – 12.5 mg, Oral, Two Times Daily Standard, For 3 days
 - Risperidone (RISPERDAL) tablet – 0.25 mg, Oral, Every 6 hours PRN, for agitation, for 3 days

- Risperidone (RISPERDAL M-TABS) disintegrating tablet – 0.5 mg, Oral, Every 12 hours PRN, for agitation, for 3 days
- Ziprasidone (GEODONE) Injection – 5 mg, Intramuscular, Every 6 hours PRN, Agitation, for 3 days.
- Haloperidol (HALDOL) injection – 0.5 mg, Intramuscular, Every 6 hours PRN, Agitation, for 3 days * Only use for extreme agitation and patient unable to take PO. *Do not administer IV

- **Sleep**

- Melatonin 3mg PO QHS PRN
- Trazodone (DESYREL) tablet – 25 mg, Oral, Nightly PRN, Sleep, for insomnia for 30 days
- Trazodone (DESYREL) tablet – 25 mg, Oral, Once, for 1 dose, for insomnia AND no effect within 1-2 hours of initial dose of Trazodone.

- i. Consults

- Consult to ACE
- Consult to Psychiatry – If appropriate
- Consult to Nutrition Education
- Consult to Pharmacy
- Consult Palliative Care – If appropriate
- Care Coordination

- j. Advance Directives

- Discuss patients priorities and preferences regarding treatment (Including operative and non-operative management)
- Discuss patients post injury risk of complications
- Discuss advance directives in great deal with palliative care involvement.

3. Discharge * Begin planning on admission

- a. Assessment

- Home Environment, social supports and possible need for medical equipment and/or home health services.
- Patient/family acceptance/denial of nursing home or skilled nursing facility placement.
- Need for physical or occupational therapy

- b. Provide

- Clear discharge diagnosis with clear discharge summary
- Medication and clear dosing instructions as well as possible reactions.

- Documentation of reconciliation between outpatient and inpatient medications.
- Directions for wound care if applicable
- Provide prescriptions for any new medications if going home or assisted living facility
- Education given caregivers, achieving clear understanding of patients conditions
- Clear Nutrition plan
- Establish an appointment(s)
- Clear documentation of incident findings that require follow-up and pending tests if applicable.

c. Consultations

- Consider repeat pharmacology consult
- Consult/Update/Confirm follow up with PCP

d. Homebound – To meet CMS definition of Homebound a patient must either:

Criteria One

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or
 - Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient must also meet two additional requirements defined in Criteria-Two below.

Criteria-Two:

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Impact of Temporary Absence on Homebound Status

CMS Change Request 8444 also provides examples of temporary absences from the home that are acceptable for a homebound patient. A patient could still be considered homebound if absences from the home are:

- Infrequent
- For periods of relatively short duration, or
- Attributable to the need to receive health care treatment,

References

- Resources for optimal care of the injured patient. (2014). Chicago, Ill.: American College of Surgeons, Committee on Trauma.
- Fallon, W., Rader, E., Zyzanski, S., Mancuso, C., Martin, B., Breedlove, L., . . . Campbell, J. (n.d.). Geriatric Outcomes Are Improved by a Geriatric Trauma Consultation Service. *The Journal of Trauma: Injury, Infection, and Critical Care*, 1040-1046.
- Mohanty, S., Rosenthal, R. A., Russell, M. M., Neuman, M. D., Ko, C. Y., & Esnaola, N. F. (2016). Optimal Perioperative Management of the Geriatric Patient: A Best Practices Guideline from the American College of Surgeons NSQIP and the American Geriatrics Society. *Journal of the American College of Surgeons*, 222(5), 930-947. doi:10.1016/j.jamcollsurg.2015.12.026
- (2017). Retrieved June 01, 2017, from http://www.vnaa.org/article_content.asp?article=406#.WTAg-TcpBhE