

Guidelines for Management of the Geriatric & Medically Complex Trauma Patients

Objectives:

- Provide a framework for consultation of the medical service in medically complex Trauma patients
- Provide a template for co- management of these patients
- Provide a guideline for transfer of patients between the trauma and medical services.

Background:

The Trauma Service and Medical Service recognize the need for specific inpatient guidelines to manage the geriatric and complex medical patient to improve outcomes. Based on data from the Trauma Quality Improvement Program (TQIP), Geriatric care guideline and Healthgrades, all geriatric patients with trauma diagnosis benefit from consultation and or management with medical specialists. In addition trauma patients with active complex medical problems may also benefit from a medical consult or primary management. It is also agreed that the initial management of these patients may require both services, while ongoing care may be handled primarily by either service depending on individual patient circumstances.

Definitions:

1. A *Geriatric Trauma patient* is any 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. Admission:

- a. All patients who meet the above diagnosis will be admitted by the Trauma Service if trauma issues are primary or at least followed as a consult if they are not. This also includes outside hospital transfers.
- b. Consult to the Hospitalist will be made on admission for either:
 - i. Geriatric patient care coordination
 - ii. Medical care of acute or ongoing complex medical issues
 - iii. If the patient goes to the SICU, then medical consult shall be called on discharge from SICU team service.

2. Orthopedic low level falls

- a. Elderly patients with low level falls and ISS less than or equal 7 (ie hip, wrist fractures) and significant medical co-morbidities will be admitted by medicine as per current standard as they are not best served on orthopedics due to their numerous issues. Trauma surgery should be consulted if there exist concern for any further significant injuries.

3. Co-Management:

- a. Trauma will follow all of these patients at least 24hrs, unless otherwise discussed by the trauma and medical staff.
- b. Medicine may write orders for any acute medical care (and let trauma know) as well as provide guidance on treatment of those conditions
- c. Close communication will be maintained between the services.

4. Discharge/Transfer of Services:

- a. Once trauma determines that there are no acute ongoing trauma issues and the patient is medically stable per the medical service and can be discharged home, Trauma will handle the discharge.
- b. If the Trauma issues are stable and the patient has active medical issues that require management (such as uncontrolled hypertension, uncontrolled diabetes mellitus, or infection resulting in sepsis), the patient will be transferred to the medical service with any subspecialty surgeons following. This does not apply to patients that trauma surgery itself has recently operated on for major abdominal or chest trauma they will remain on trauma for at least two weeks post op.
- c. If the patient has chronic stable medicine issues and the patient is awaiting clearance by physical therapy/occupational therapy and/or requires placement (to

a skilled nursing facility, sub-acute rehab, or acute rehab) the patient will stay on the trauma service with medicine consult following daily.

- d. Trauma will remain on consult on *any* patient when medicine requests or to follow a minor issue.
- e. If medicine has admitted a “non-complex” trauma patient (single system i.e. wrist fracture from a standing fall) and finds that the patient has a complex injury (instead T12 fracture) they should consult Trauma immediately.
 - i. Trauma will take over care of any medical patient (as above) if the non-subspecialty or multiple subspecialty trauma issues outweigh the medical. Medicine will remain on consult as needed.
 - ii. Trauma will remain on consult at least 24hrs or till any trauma issues are resolved.
- f. Trauma patients with low mechanism of injury that have no major injury or subspecialty surgery injury (that the subspecialty surgeon is declining admission for) may be handled in one of two ways:
 - i. Admit to trauma overnight, especially if there exists concern with mechanism. The patient will be transferred to medicine the next morning if the trauma attending sees that no overnight issues have arisen and a tertiary exam is complete.
 - ii. Admit to medicine with trauma consult and f/u per work up and needed. An example is the “dizzy”/syncopal older patient with multiple medical problems not safe to go home, but with no major injuries.
- g. All transfers between trauma and medicine will need direct attending level sign over.

- h. A medical attending admitting a trauma patient or taking over as the primary service provider may call trauma to re-consult and follow patient at any time as medical condition warrants.

- i. On presentation to the ED, single system, both operative and non-operative, low mechanism injury with no medical issues should go to the appropriate sub-specialty service. This should be communicated by the ED or Trauma surgery attending once either or both feel an adequate trauma workup is done.
 - i. If the trauma services chooses to admit this patient for overnight observation, then this phone call will be made the next morning as long as the patient is “cleared” from a trauma perspective.

References

- Trauma Quality Improvement Program. (n.d.). Retrieved April 27, 2015, from <https://www.facs.org/quality-programs/trauma/tqip>
- 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.
- Resources for optimal care of the injured patient. (2014). Chicago, Ill.: American College of Surgeons, Committee on Trauma.

Geriatric trauma Admission Algorithm (See written protocol for detailed explanation)

