Patient > 65 years old

Admission Orders:
- PMH/PSH (w/in 24h)
- Medication reconciliation by PharmD (w/in 48h)
- FRAILTY Score documented

Labs:
- B12/VitD/ TSH/FT4
- Hgb A1C
- Venous lactate (if elevated obtain arterial)
- CK (prolonged downtime or crush injury)

Other:
- EKG
- Orthostatics obtained and documented

Is patient anticoagulated AND has life threatening bleeding or emergent surgical intervention?

**If questionable Factor Xa Inhibitor use, can obtain LMW heparin level to detect presence (not amount) of drug.

YES

NO

Drug Class	Anticoagulant	Reversal Plan
Vitamin K antagonist	Warfarin (Coumadin)	• Vitamin K 10mg x 1 (use caution in patients with active VTEs and/or prosthetic heart valves) • 4F PCC (Balfaxar) 1500 units IV x1 (repeat INR 30 min after administration)
Factor Xa Inhibitor	Apixaban (Eliquis) Rivaroxaban (Xarelto) Edoxaban (Savaysa) Betrixaban (Bevyxxa)	• 4F PCC (Balfaxar) 2000 units IV x1
Direct Thrombin Inhibitor	Dabigatran (Pradaxa)	• Praxbind – dosing per eStar advisor

Does patient have any of the following:
- ≥ 4 rib fxs w/increased O2 req >6L NC
- Multiple long bone rib fxs
- Severe pelvis fxs
- Hypotension: SBP <110

NO

Admission to SD

Geriatric Consult if:
- FRAILTY score 4 or 5
- Polypharmacy (>5 home meds)
- Recurrent falls
- Persistent delirium
- Concern for dementia or decision making capacity
- Mult high-risk comorbidities:
  - COPD (COPD PMG)
  - Heart Failure
  - HTN (req mult agents)
  - Uncontrolled DM
- Hip fractures/fragility fractures (consider pre-geriatric assessment prior to OR
- Okay to schedule specific geriatric work up studies outpatient (i.e. carotid duplex)

YES

Consider ICU admission

When pt transferred to SD, follow SD algorithm

GOALS OF CARE: discussion and documentation in medical record within 24h of admission

VUH Adult – Anticoagulation Resources

- Code status (mandatory)
- Identify if pt has Advanced Directive
- Identify if pt has documented POA or surrogate decision maker

Consider palliative care consult for:
- Surrogacy/advanced directive
- Family conflict concerns
- Unclear GOC
- FRAILTY score of 5

Special consideration for Geriatric Trauma Patient:

- Bedside swallow – if concerned, consult Speech therapy
- Delirium minimization (See Trauma Delirium PMG) Trauma Delirium Management
    - Avoid benzodiazepines
        - If chronically prescribed, reduce by 50% to prevent withdrawal
    - Reduce antipsychotic dosing by 50%
    - Avoid Haldol >5mg or quetiapine >100mg
    - Priority for transfer out of ICU
    - Avoid anticholinergics
    - Consider narcotic-sparing analgesia regimen
- Consider beginning a medication taper for inappropriate home medications while inpatient and continued upon discharge.
    - **https://medstopper.com/** - assists w/ developing taper schedule; ensure patient agrees
- Avoid Haldol & olanzapine in Parkinson's disease – quetiapine preferred in needed
- Avoid tramadol for pain d/t increased adverse side effects – low dose oxycodone preferred
- Sleep aids: melatonin 6mg at 18:00 preferred. May add Trazadone 25mg at 20:00 and titrate up. Avoid Ambien.
- Early mobilization and standing orders for OOBTC for all patients who are not on bed rest status.
- Consider PM&R consult to evaluate and provide recommendations for optimizing rehab potential if IPR is recommended (when SD status)

Geriatric Polypharmacy: Medications to Avoid

- Tricyclic antidepressants (i.e. amitriptyline, imipramine)
- Promethazine
- Hydroxyzine
- Benztropine
- Scopolamine
- Nitrofurantoin (do no use if Cr Cl <60ml/min)
- Alpha-1-blockers: terazosin, doxazosin. Tamsulosin is preferred if able.
- Central alpha-agonists: clonidine, guanfacine, methyldopa
    - IF clonidine is home med, restart at appropriate dose for current vitals and wean as tolerated – do NOT stop abruptly if patient has used long term.
- Barbiturates (unless indicated for alcohol withdrawal)
- First generation antihistamines (i.e. chlorpheniramine, diphenhydramine)
- Megestrol: poorly tolerated, increased VTE risk
- Anti-spasmodics (bladder): tolterodine, oxybutynin, dicyclomine, trospium
- Opiates: If long acting needed oxycontin is preferred over MS Contin (long-acting morphine)
    - If absolutely necessary for care & safety, refer to Trauma Delirium PMG
- Benzodiazepines: Do not use for insomnia, anxiety, agitation, or delirium. May be appropriate for seizure disorders, palliative care, benzo withdrawal, or peri-procedural
- Cyclobenzaprine
- Tramadol
- Oral estrogen: If on home oral estrogen, please hold while inpatient d/t increased VTE risk. Consider changing to patch on discharge.

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