OBJECTIVES

• Understand about trauma treatment and trauma-informed care
• Understand the regulatory requirements related to trauma-informed care
• Understand the best practices and approaches to trauma-informed care
• Understand how person-centered care is important for trauma-informed care
• Understand assessment and care planning
**What is Trauma**

- Results from an *event*, series of events, or set of circumstances that is **experienced** by an individual as physical or emotionally harmful or life threatening and that has lasting adverse **effects** on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being (*SAMHSA, 2014*).

**Why Trauma-Informed Care?**

**Regulation**

F699: §483.25(m) Trauma-informed care
- The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
- Will be implemented beginning November 28, 2019

**Relevant F-tags**

- F659 qualified persons
- **F699 trauma informed care (effective 11/28/2019)**
- F741 sufficient competent staff, behavioral health needs
- F740 behavioral health services
- F742 treatment/services for mental-psychosocial concerns
- F743 no pattern of behavioral difficulties unless unavoidable
§483.40 Behavioral Health Services
- For residents with documented history of trauma and/or post-traumatic stress disorder:
  • The facility must provide treatment and services to address problems/improve well-being
- For residents with no documented history of trauma and/or post-traumatic stress disorder:
  • The facility must prevent residents from becoming less socially interactive or more withdrawn, angry or depressed (unless these behaviors cannot be avoided due to a clinical condition)
  • Staff must be equipped to care for residents with history of trauma and/or post traumatic stress disorder

§483.21 Comprehensive person-centered care planning
Services must be both culturally-competent and trauma-informed

§ 483.25 Quality of Care
Care must be delivered in a way that is culturally-competent and trauma-informed

Why Trauma-Informed Care?

The ACE Pyramid

- Early Death
- Disease, Disability, & Social Problems
- Adoption of Health Risk Behavior
- Social, Emotional, & Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences
- Social Conditions / Local Context
- Generational Embodiment / Historical Trauma

Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Adverse Childhood Experiences (ACEs)

- Domestic and sexual violence
- Natural disasters
- Car, train and airplane crashes
- Military combat
- Becoming a refugee
- Homelessness
- Medical trauma
- Violent crime
- Bias and discrimination
- Hate crimes and hate speech
- Childhood physical, emotional and sexual abuse
- Childhood neglect and abandonment

Traumas Relating to the Aging Process

- Loss of loved ones;
- Loss of own capacities;
- Loss of roles and identity and of home;
- Increased dependence;
- Experiencing or observing physical, sexual, and emotional abuse;
- Childhood neglect;
- Having a family member with a mental health or substance use disorder;
- Experiencing or witnessing violence in the community or while serving in the military;
- Poverty and systemic discrimination
WHAT IS TRAUMA-INFORMED CARE

• Trauma informed care is an approach that aims to engage people with histories of trauma, recognize the presence of trauma symptoms, and acknowledge the role that trauma has played in their lives (SAMHSA, National Center for Trauma Informed Care, 2014)

• Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing

TRAUMA TREATMENT AND TRAUMA-INFORMED CARE

TRAUMA TREATMENT

• Trauma Treatment or Trauma Specific Services (TSS) are programs, interventions, and therapeutic services aimed at treating the symptoms or conditions resulting from a traumatizing event(s). (Oregon health department)

TRAUMA-INFORMED CARE

• Trauma Informed Care (TIC) is an approach, based on knowledge of the impact of trauma, aimed at ensuring environments and services are welcoming and engaging for service recipients and staff. (Oregon health department)
TYPES OF TRAUMA

- **Stress**: any experience that disrupts our sense of well-being.
- **Trauma**: an intense event that threatens safety or security of an individual.
- **Toxic Stress**: recurring negative experiences that threaten safety or security.
- **Acute Trauma**: a single, time-limited traumatic event.
- **Chronic Trauma**: multiple traumatic exposures/events over an extended period of time.
- **Traumatic Stress**: long term reaction to trauma; refers to the combination of the event, the individual’s experience/perception and the effects.
- **Complex Trauma**: experience of multiple traumatic events & impact of that experience.
- **Trauma and Stressor-Related Disorders**

TRAUMA-TOXIC STRESS

- **Positive Stress**: The body’s normal and healthy stress response to a tense situation/event.
- **Tolerable Stress**: Activation of the body’s stress response to a long-lasting or severe situation/event.
- **Toxic Stress**: Prolonged activation of the body’s stress response to frequent, intense situations/events.

- First day of school or work.
- Loss of family member, but with supportive buffers in place.
- Witnessing domestic violence in the home, chronic neglect.
SYMPTOMS OF TRAUMA

Physical signs and symptoms of trauma including shaking or trembling, inability to pay attention, sleep disturbances such as insomnia, and a racing heartbeat, pains, tense their muscles

Biological symptoms include brain function, headaches, stomach aches, sleep changes

Social symptoms include apathy, isolation, difficulty trusting, detachment

Spiritual symptoms include struggle to find meaning, anger with God

Emotional or psychological symptoms

– Anger, irritability, mood swings, including emotional or violent outbursts.
– Anxiety and fear.
– Panic attacks.
– Guilt, shame, self-blame.
– Withdrawing from others.
– Feeling disconnected or numb.
– Obsessive and compulsive behaviors.

TRAUMA IS... NOT MENTAL ILLNESS

Similar symptoms that usually misdiagnoses or label...

• Dementia
• Psychosis
• Personality disorders
• Mood disorders – bipolar, depression
• Oppositional – willful misconduct
• Hoarding is actually correlated to childhood physical or sexual abuse
SYMPTOMS FROM IMMEDIATE AND DELAYED REACTIONS TO TRAUMA

• Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect (Samsha, Tip 57)

• Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely (Samsha, Tip 57)
Immediate and Delayed Reactions to Trauma

**Immediate Emotional Reactions**
- Numbness and detachment
- Fear, helplessness, anxiety
- Disbelief or feeling unreal
- Anger, rage
- Intense happiness or elation (survivor guilt)
- Guilt
- Shock
- Disorientation
- Locus of control
- Hyperalertness
- Confusion
- Fear

**Delayed Emotional Reactions**
- Shame
- Feelings of fragility and/or vulnerability
- Emotional detachment from anything that requires emotional reactions (e.g., significant other and family relationships, conversations)
- Depression
- Irritability
- Generalized anxiety
- Feelings of being alone
- Fear of recurrence
- Irritability

**Immediate Physical Reactions**
- Nausea
- Headaches
- Tunnel vision
- Chills
- Muscular tension
- Uncontrollable shaking
- Dry mouth
- Dizziness
- Hyperventilation
- Palpitations
- Stomach upset
- Uncontrollable tearfulness

**Delayed Physical Reactions**
- Sleep disturbances, nightmares
- Insomnia (increased focus on and worry about body and pain)
- Appetite and digestive changes
- Increased need for sleep
- Increased need for rest and sleep
- Sensitivity to light and noise
- Fatigue
- Muscle aches and pains

**Immediate Cognitive Reactions**
- Difficulty concentrating
- Binge eating
- Avoidance
- Denial
- Feeling "numb"
- Feeling of being unable to recall important aspects of the trauma
- Feeling of being disconnected from others

**Delayed Cognitive Reactions**
- Invasive memories or flashbacks
- Exaggerated startle response
- Prevents memory of previous traumatic events
- Feelings of isolation
- Feelings of being "stuck"
- Difficulty making decisions
- Feelings of emptiness
- Feelings of helplessness
- Feelings of hopelessness
- Feelings of worthlessness
- Feelings of guilt
- Feelings of worthlessness

**Immediate Behavioral Reactions**
- Startled reactions
- Trembling
- Muscle tension
- Increased heart rate
- Tachycardia
- Palpitations
- Increased blood pressure
- Decreased appetite
- Increased sensitivity to light and sound
- Difficulty concentrating
- Increased irritability
- Increased aggression
- Increased anxiety

**Delayed Behavioral Reactions**
- Increased irritability
- Increased aggression
- Increased anxiety
- Increased sensitivity to light and sound
- Increased difficulty concentrating
- Increased intensity of some symptoms
- Increased intensity of others
- Increased likelihood of developing other conditions
- Increased likelihood of developing other conditions
- Increased likelihood of developing other conditions

**Immediate Emotional Reactions to Others**
- Feelings of guilt
- Feelings of inadequacy
- Feelings of isolation
- Feelings of loneliness
- Feelings of helplessness
- Feelings of hopelessness
- Feelings of worthlessness
- Feelings of guilt
- Feelings of worthlessness

**Delayed Emotional Reactions to Others**
- Feelings of guilt
- Feelings of inadequacy
- Feelings of isolation
- Feelings of loneliness
- Feelings of helplessness
- Feelings of hopelessness
- Feelings of worthlessness
- Feelings of guilt
- Feelings of worthlessness

**Sources:**
**TRAUMA SCREENING**

- Trauma-related symptoms.
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences.
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders).
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences).
- Substance abuse.
- Social support and coping styles.
- Availability of resources.
- Risks for self-harm, suicide, and violence.
- Health screenings.

**TRAUMA SCREENING AND ASSESSMENT**

- **Brief Trauma Questionnaire (BTQ)** is a ten-item self-report trauma exposure screen that can be quickly administered and is suitable for special populations such as persons with severe mental illness as well as for general population groups.
- **Upsetting Events Survey** is a modification of the Traumatic Life Events Questionnaire (TLEQ). It assesses effectively for trauma history.
- **PTSD Checklist (PCL)** is a self-report rating scale. The PCL contains seventeen questions that map onto the three DSM-IV PTSD symptom clusters: re-experiencing, avoidance, and arousal.
- **Beck Depression Inventory-II** is a well-validated self-report scale for depression that has been used with a wide range of different populations and disorders.
TR AUMA S CR E E N IN G A ND A SSE S S M E N T

• The FRAIL Questionnaire assesses five components: Fatigue, Resistance, Ambulation, Illnesses, and Loss of weight and creates an acronym to facilitate utilization (FRAIL).

• The Life Event Checklist (LEC) is a brief, 17-item, self-report measure designed to screen for potentially traumatic events in a respondent’s lifetime. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes one item assessing any other extraordinarily stressful event not captured in the first 16 items.

• The Abbreviated PCL-C: Civilian Version (PCL-C) is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD.

ADDITIONAL S C R EE N IN G A ND A SSE S S M E N T T OOLS

• DSM - 5 Online Assessment Measures

• The Healthy Living Questionnaire

• The Kessler 6 & Kessler 10 are mental health screening tools used with a general adult population.

• Resident Stress Questionnaire is a tool used in primary care settings to screen for behavioral health symptoms. It was adapted from the PHQ-9, GAD-7, PC-PTSD, and AUDIT.

• M3 Checklist provides an individualized resident assessment geared toward early detection, co-morbid illness, and identifying people in distress irrespective of their particular diagnosis. It consists of 27 questions.
**DEPRESSION:**
- **Resident Health Questionnaire (PHQ-9)** is the most common screening tool to identify depression.

**DRUG AND ALCOHOL USE:**
- **SBIRT** is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders.
- **AUDIT** (Alcohol Use Disorders Identification Test) is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption.
- **NIDAMED** is a comprehensive Physicians’ Outreach Initiative that gives medical professionals tools and resources to screen their residents for tobacco, alcohol, illicit drug, and nonmedical prescription drug use.
- **CAGE AID** is a commonly used, 5-question tool used to screen for drug and alcohol use.
- **AUDIT-C** is a simple 3-question screen for hazardous or harmful drinking.
- **DAST-10** (Drug Abuse Screen Test) is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete.

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**BIPOLAR DISORDER:**
- **STABLE Resource Toolkit** provides quality improvement resources to help clinicians identify and manage bipolar disorder.
- **The Mood Disorder Questionnaire** (MDQ) includes 13 questions associated with bipolar disorder symptoms.

**SUICIDE RISK:**
- **Columbia-Suicide Severity Rating Scale (C-SSRS)** is a questionnaire used for suicide assessment.
- **SAFE-T** (Suicide Assessment Five-Step Evaluation and Triage)

**ANXIETY DISORDERS:**
- **GAD-7** (Generalized Anxiety Disorder) is a 7-question screening tool that identifies whether a complete assessment for anxiety is indicated.
- **PC-PTSD** is a four-item screen designed for use in primary care and other medical settings to screen for post-traumatic stress disorder.
TRAUMA-ASSESSMENT

- Track changes in the presence, frequency, and intensity of symptoms.
- Learn the relationships among the resident’s trauma, presenting psychological symptoms, and substance abuse.
- Adjust diagnoses and treatment plans as needed.
- Select prevention strategies to avoid more pervasive traumatic stress symptoms.

BARRIERS AND CHALLENGES TO TRAUMA-INFORMED SCREENING AND ASSESSMENT

Treatment providers may avoid screening for traumatic events and trauma-related symptoms due to:
- A reluctance to inquire about traumatic events and symptoms.
- Underestimation of the impact of trauma on residents’ physical and mental health.
- A belief that treatment of substance abuse issues needs to occur first and exclusively, before treating other behavioral health disorders.
- A belief that treatment should focus solely on presenting symptoms rather than exploring the potential origins or aggravators of symptoms.
### Barriers and Challenges to Trauma-Informed Screening and Assessment

- A lack of training and/or feelings of incompetence in effectively treating trauma-related problems.
- Not knowing how to respond therapeutically to a resident’s report of trauma.
- Fear that a probing trauma inquiry will be too disturbing to residents.
- Not using common language with residents that will elicit a report of trauma (e.g., asking residents if they were abused as a child without describing what is meant by abuse).
- Concern that if disorders are identified, residents will require treatment that is not able to provide (Medicaid, financial, lack of special clinicians).

### Trauma Informed Approach

SAMHSA issued guidelines for trauma informed care in 2014 that outlined four assumptions, six key principles and ten implementation domains for trauma informed care.

**The Four Key Assumptions (the 4 R’s) Include:**

1. **Realization** about trauma and its impact on individuals, families and communities
2. **Recognition** of the symptoms of trauma and traumatic stress
3. **Responses** that are trauma informed at all levels of the organization
4. **Resistance to re-traumatization** at all levels including at the staff level
**Key Ingredients for Creating a Trauma-Informed Approach to Care**

**Organizational**
- Leading and communicating about the transformation process
- Engaging residents in organizational planning
- Training clinical as well as non-clinical staff members
- Creating a safe environment
- Preventing secondary traumatic stress in staff
- Hiring a trauma-informed workforce

**Clinical**
- Involving residents in the treatment process
- Screening for trauma
- Training staff in trauma-specific treatment approaches
- Engaging referral sources and partnering organizations

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**Trauma-Informed Care Approaches**

**Six Key Principles of Trauma-Informed Approaches (SAMHSA, 2014)**

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender Issues
6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA's six principles that guide a trauma-informed approach, including:

1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL, & GENDER ISSUES

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. Ongoing internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to embed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

TRAUMA PROGRAM PROCESS

1. Acknowledgement
2. Recognizing that trauma is pervasive
3. Safety
4. Trust
5. Choice and control
6. Compassion
7. Collaboration
8. Strengths-based
TR AUMA CARE PRO CESS

The Ten Implementation Domains from “SAMHSA’s Trauma and Justice Strategic Initiative July 2014” Include:

1. Governance and Leadership
2. Policy
3. Physical Environment
4. Engagement and Involvement
5. Cross Sector Collaboration
6. Screening, Assessment and Treatment Services
7. Training and Workforce Development
8. Progress Monitoring and Quality Assurance
9. Financing
10. Evaluation

WHAT CAN WE DO... FIRST!

• Training for staff
  – Know the individuals we care for, including information about their mental health, trauma history, coping, and resilience
  – Create/develop a good program for trauma-informed care
• Provide opportunities for residents, family members, and all staff to learn
• Identify and build on strengths of residents, families, staff, and facility
• Build community partnerships and become familiar with mental health professionals and community resources
  • Promote positive engagement among residents, families, and staff
And Back to Six (6) Ingredients...

Organizational Practices

- Changing organizational practices to fit trauma-informed principles will transform the culture of a health care setting
- Key Ingredients of Trauma-Informed Organizational Practices (April 2016 | By Christopher Menschner and Alexandra Maul, Center for Health Care Strategies: ADVANCING TRAUMA-INFORMED CARE)
  - Leading and communicating about the transformation process
  - Engaging residents in organizational planning
  - Training clinical as well as non-clinical staff members
  - Creating a safe environment
  - Preventing secondary traumatic stress in staff
Creating a Safe and Social-Emotional Environment

• The physical environment promote a sense of safety, calming, and de-escalation for clients and staff and
• Keeping noise levels
• Using welcoming language on all signage
• Monitoring who is coming in and out of the building
• Ensuring staff maintain healthy interpersonal boundaries
• Maintaining communication that is consistent, open, respectful, and compassionate
• Being empathetic and accommodated with needs
• Staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this, aware of how an individual’s culture affects how they perceive trauma, safety, and privacy

Developing a Program - Policies

1. Trauma-informed screening and assessment
2. Focus on trauma and issues of safety and confidentiality
3. Trauma-specific treatment or refer to appropriate trauma-specific services
4. Recognize the pervasiveness of trauma in the lives of people using services.
5. Staff training on the ways identity, culture, community, and oppression can affect a person’s experience of trauma, access to supports and resources, and opportunities for safety
6. Staff supports in work sensitively and effectively with trauma survivors
7. Staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training
Trainings: Clinical as well as Non-Clinical Staff

- Training staff in trauma-specific treatment approaches
- Involving residents in the treatment process
- Staff know and understand to perform Screening for trauma
CARE PLAN

PERSON CENTERED CARE PLAN IS A KEY

- Address training needs of staff to improve knowledge and sensitivity
- Identifies an individual's hopes, capacities, interests, preferences, needs, and abilities
- The individual is the expert on his/her life
- Practice is a collaborative process
- Individual choice is evident
- Resident's Client's voice is used in treatment plans – goals are in his/her own words
- Strength based, recovery-oriented principles
- Assess for traumatic histories and symptoms
- Recognition of culture and practices that are re-traumatizing
**Care Plan Framework**

- **Problems**: Usually the subjective data that address the physical or psychosocial symptoms: anxiety, crying, isolations, nightmares, sleepless, acting fears, voice of upsetting, withdrawal, refuse of treatments, activities, etc.

- **Support “problem” data**: Usually the objective data from trauma scales, screening test, diagnoses, past traumatic histories, events, affects, the escalated actions (crying, screaming)

- **Goal**: Learning coping techniques; sharing the traumatic issues; accept treatments; Less symptoms (timeframe)

- **Approaches**: Techniques to deescalated triggers (environment); support systems from family, peers, staff or additional professional therapies; How to increase safety? How to reduce stressors, triggers; How to engage resident into the program; How to aware the monitoring system to staff

- **Evaluation**: Get inputs from family and resident. Does the care plan work?

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**Care Plan - Psychosocial Well/IlI-Being: History of Trauma**

**Problem: (circle the related factors)**

- **ACTIVITY DEFICIT**: related to fatigue, tiredness from sleep apnea
- **ACTIVITY DEFICIT**: prefers changes in daily routine; awake most morning;
- **DECREASING PSYCHOSOCIAL WELL-BEING**: withdrawal; nightmares
- **LACK OF SOCIAL INTERACTIONS**: related too language barriers, sensory deficits
- **EXPRESSION OF**: fears, crying, sadness, negative beliefs
- **MOOD DISTURBANCE**: agitation, anger, panic attacks, self-blame, Emotional numbness
- **DISPLAY**: sleep disturbance; avoid talking about what bother, being alert, scanning (hypervigilance); Started; flashback; Self-destructive behaviors; poor impulse control; hyper-arousal; guilty;

**Contributing factors:**

- New to facility
- Limited English Proficiency
- History of PTSD
- Loss of love one
- Limited mobility

**Goal: (will be reviewed and evaluated in 90 days or until the next assessment)**

- Will participate in activity programs
- Will continue verbally expressing needs and share concerns, goals
- Will participate in having positive social interaction with peers
- Will express the triggered stresses, traumatic events and how to cope with it
- Will accept to learn a relaxation techniques
**Care Plan - Psychosocial Well/ill-Being: History of Trauma**

**Approaches:**
- Encourage resident to talk about the past, to make a goal and decision for care
- Maintain a calm, non-threatening manner while working with the resident
- Establish and maintain a trusting relationship by listening to the client
- Displaying warmth, answering questions directly, offering unconditional acceptance; being available and respecting the client’s use of personal space
- Remain with the resident at all times when levels of anxiety are high (severe or panic); reassure client of his or her safety and security

**Care Plan - Psychosocial Well/ill-Being: History of Trauma**

- Move the client to a quiet area with minimal stimuli and Maintain calmness in your approach to the resident
- Provide reassurance and comfort measures if applicable
- Observe for increasing anxiety. Assume a calm manner, decrease environmental stimulation, and provide temporary isolation as indicated
- Encourage the client’s participation in relaxation exercises such as deep breathing, progressive [**muscle**](#) relaxation, guided imagery, meditation and so forth
- Teach relaxation techniques, deep-breathing exercises. Desensitize resident to his/her memories of traumatic event
- Assess client for suicidal or homicidal ideations
**Care Plan - Psychosocial Well/Ill-Being: History of Trauma**

- Assess /screen the post traumatic events, history of trauma. Using the appropriate screening tools
- Provide visit to the resident to inform activity schedule, to encourage resident to be social interactions
- Provide instruction to encourage resident independent in ADL self-care.
- Provide assistance and supervision if needed during ADL care like set up things when resident requests
- Inform staff of resident status and his activity preference. Provide visit to encourage resident to ventilate feelings about concerns, wishes.
- Provide activities and invite resident to participate. Praise for her engagement or participation in social interactions

**Resources and References**

- Quality Improvement organization-QIM: Resources to Support Trauma Informed Care for Persons in Post-Acute and Long Term Care Settings
- CMS CE pathway: Behavioral and Emotional Status Critical Element Pathway
- A complete copy of the guidelines is available at: http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf
- SHAMSHA-TIP 57-63
- SOM 2017
- https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm