Trauma Informed Care Making It Work

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Objectives

- Understand the current regulatory guidance for trauma informed care
- Review the six principles of trauma informed care
- Employ tips and tools for program development
- Identify approaches and best practices for care delivery

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CMS QSO-20-03-NH
November 22, 2019

Memorandum Summary

The Centers for Medicare & Medicaid Services (CMS) is announcing updates and initiatives aligning with the CMS strategic initiative to Ensure Safety and Quality in Nursing Homes. These updates and initiatives include:

- **Phase 3 Interpretive Guidance:** CMS will be releasing updated Interpretive Guidance and training for the Requirements for Participation for Long-Term Care (LTC) Facilities. However, this guidance will not be released by the November 28, 2019 implementation date of the regulations. We will be releasing the guidance in the second quarter of calendar year 2020, along with information on training and implementing related changes to The Long Term Care Survey Process (LTCSP). While the regulations will be effective, our ability to survey for compliance with these requirements will be limited until the Interpretive Guidance is released.
- **Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements:** On July 18, 2019, the Department of Health and Human Services (HHS) published a final rule establishing requirements related to the use of binding arbitration agreements. This final rule amends the requirements that Long-Term Care (LTC) facilities must meet to participate with Medicare and Medicaid. The final rule can be found at: https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14945.pdf
- **Actions to Improve Infection Prevention and Control in LTC Facilities:** CMS has created a nursing home antibiotic stewardship program training; updated the Nursing Home Infection Control Worksheet as a self-assessment tool for facilities; and is reminding facilities of available infection control resources.
- **Release of Toolkit 3, "Guide to Improving Nursing Home Employee Satisfaction":** CMS has created a toolkit that helps facilities improve employee satisfaction.

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Regulatory: Phase 3

- Phase III guidance effective November 28, 2019 included:
  - Quality Assurance and Performance Improvement with implementation of QAPI
  - Infection Control with Infection Preventionist
  - Compliance and Ethics
  - Physical Environment with call lights at the bedside
  - Training

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Regulatory: F Tags

F699 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.

F659 Comprehensive Care Plans

- The services provided or arranged by the facility, as outlined by the comprehensive care plan, must be ***culturally-competent and trauma–informed.***

F741 Sufficient Staff

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and as linked to history of ***trauma and/or post-traumatic stress disorder***

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Regulatory: F Tags

F940 Training Requirements – General

§483.95 Training Requirements
A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to—
[§483.95 will be implemented beginning November 28, 2019 (Phase 3)]

F949

- *§483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). [§483.95(i) will be implemented beginning November 28, 2019 (Phase 3)*

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Trauma Definitions

- **TRAUMA**: results from an **event**, series of events or set of circumstances that is **experienced** by an individual as physical, 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 (SAMSHA, 2014)

- **Complex Trauma**: results from extended exposure to traumatizing situations, often occurring in childhood
- **Developmental Trauma**: multiple or chronic exposure to one, more forms of interpersonal trauma, (abandonment, betrayal, physical assault, sexual assault, threats to bodily integrity coercive practices, emotional abuse, witnessing violence or death)

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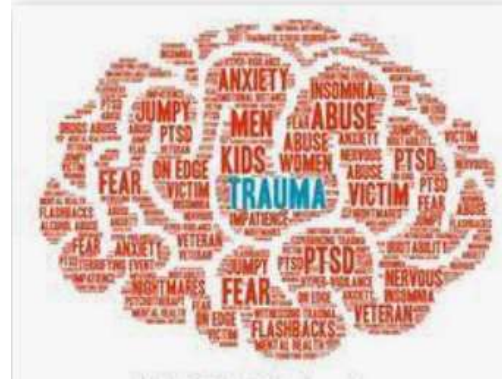
Trauma Definitions

- **Acute Trauma**: results from exposure to a single overwhelming event
- **Post-Traumatic Stress Disorder** (PTSD): a recognized mental health condition that's triggered by a terrifying event
- **Vicarious/Secondary Trauma, Compassion Fatigue**: different but related secondary stress injuries



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COVID FATIGUE IN YOUR STAFF

- Are you recognizing Covid compassion fatigue?
- Consider these measures to address:
  - Adopt buddy up mentality to check in on each other, self care(sleep, health nutrition, physical activity, relaxing, social interaction)
  - Schedule sensitivity
  - Space and nourishment at work,
  - Promote education, counseling, resources (EPA programs), call in experts
  - Promote a culture of wellness incorporating wellness activities into daily work/life and meetings

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TRAUMA-RELATED DEFINITIONS

Toxic Stress: Strong, frequent and/or prolonged adversity that stimulates the body's natural protections against stress and can have along term negative impact on neurobiology, psychology and physical health

Allostatic Load: Wear and tear on the body from toxic stress that can lead to poor health and health risk behaviors

Protective factors: Social conditions or personal attributes that help lessen the risks of trauma for an individual, family or community

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Examples of Traumatic Events

Physical, sexual or emotional abuse	Childhood neglect	Having a family member with a mental health or substance abuse disorder
Violence in the community	Natural or man-made disasters	Poverty and discrimination

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Guiding Principles of Trauma Informed Care

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Organizational Ingredients for Creating a Trauma Informed Approach

Leading and communicating	Leading and communicating about the transformation process with a goal of staff empowerment and buy-in
Engaging	Engaging residents in organizational planning with the development of a stakeholder committee
Training	Training clinical and non-clinical staff to create a trusting, non-threatening environment, identifying early champions or natural leaders
Creating	Creating a physically and emotionally safe environment
Preventing	Preventing secondary traumatic stress in staff which may lead to burnout and staff turnover
Hiring	Hiring a trauma informed workforce utilizing behavioral interviewing screening for empathy, non-judgement and collaboration

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Clinical Ingredients for Creating a Trauma Informed Approach

- Involving residents in the treatment process with active engagement in care decisions allowing feedback to drive the plan of care
- Screening for trauma with upfront/universal screening or screening later after building trust between the resident and provider
- Training staff in trauma specific treatment approaches
- Engaging referral sources and partnering organizations within a given community or network system

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Staff Training Ideas

Incorporate trauma training during staff meetings:

- Basic trauma information
- Organizational philosophy and approach to trauma informed care
- How does past trauma impact the elderly?
- How does past trauma manifest itself in trauma survivors?
- How do you approach individuals with past trauma?
- Recognizing and responding to Covid fatigue in staff

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Tips and Tools For Program Development

FACILITY ASSESSMENT
ORGANIZATIONAL ASSESSMENT
LIFE EVENT CHECKLIST
BRIEF TRAUMA QUESTIONNAIRE
BEHAVIORAL AND EMOTIONAL STATUS CEP

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Facility Assessment

Diseases/conditions, physical and cognitive disabilities

1.3. Indicate if you may accept residents with, or your residents may develop, the following **common** diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management.

Category	Common diagnoses
Psychiatric/Mood Disorders	Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions

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Part 2: Services and Care We Offer Based on our Residents Needs

- *Resident support/care needs*
- 2.1 List the types of care that your resident population requires and that you provide for your resident population:

Mental health and behavior	Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities
Provide person-centered/directed care: Psycho/social/spiritual support:	Support emotional and mental well-being; support helpful coping mechanisms Support resident having familiar belongings Provide culturally competent care: learn about resident preferences and practices with regard to culture and religion; stay open to requests and preferences and work to support those as appropriate

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Part 3: Facility Resources to Provide Competent Support and Care to our Residents

Staff Training and Competencies

- 3.4 Describe the staff *training/education* and competencies that are necessary to provide the level and types of support and care needed for your resident population. Consider the following training topics:
  - Cultural competency (ability of organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of residents)

- Consider the following *competencies*:
  - Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post traumatic stress disorder, and implementing nonpharmacologic interventions

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Attachment 1 Additional References to the Facility Assessment

Nursing Services § 483.35 - The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

Behavioral Health Services § 483.40(a) - The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e).
-These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: 483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e).

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Where are We?


Organizational Assessment

Perform an organizational assessment

- Organization Committee and Endorsement
- Environment and Safety
- Workforce Development
  - Training
  - Hiring and Onboarding Practices
  - Supervision and Support
- Services and Service Delivery
- Systems Change and Progress Monitoring

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Getting Started

Read and discuss:	Relevant sections of CMS Requirements of Participation SAMHSA Guiding Principles of Trauma-Informed Care or other identified resources Any updated guidance from CMS
Senior team and other interested members discuss and commit to a Statement of Intent	
Form a Trauma-Informed Care Implementation team	
Establish a Trauma-Informed Care team's scope of work and budget	

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Getting Started

Conduct	Identify	Review	Develop and implement	Educate
• Conduct a preliminary organizational assessment developing a plan to address the results of the assessment	• Identify local behavioral health resources and Employee Assistance resources	• Review relevant local, state and federal mandated abuse reporting requirements	• Develop and implement polices and procedures to support trauma-informed care	• Educate all staff, residents, families regarding the basics of trauma-informed care

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Missouri Model

"Purpose: To ensure that agencies do no harm; to assess the implementation of basic principles of trauma-informed approaches into various organization settings; develop a common language and framework for discussion; to help increase the effectiveness of services; wherever and whatever that are, by increasing awareness of trauma."

- Four approaches which include definitions, processes, indicators and resources
  - Trauma Aware
  - Trauma Sensitive
  - Trauma Responsive
  - Trauma Informed
- Use:
  - Informational purposes
  - Identify if the organization is meeting basic criteria for the integration of trauma principles
  - Allows for choosing placement on the continuum based on needs and setting

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Policies and Procedures

Human Resources:

- Background screening
- New staff orientation
- Training all staff and supervisors, including coaching support for performance improvement
- Performance review documentation and process
- Employment development plans including progressive discipline
- Grievance resolution practices and other conflict
- Employee Assistance Program
- Temporary or agency staff
- Contracted health professionals

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Policies and Procedures

Financial and Budget Policies

Environmental Services:

- Safety
- Privacy
- Security

Abuse and Reporting

Quality Assurance and Performance improvement

Care Planning:

- Assessments
- Person-centered care planning
- Mood and behavior policies
- Specialist referrals
- Discharge planning

Communication with:

- Employees
- Residents
- Families
- Volunteers, stakeholders, vendors and contractors

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Questions to Explore When Developing Your Screening Process

- How do you build trust prior to screening? Does your process include intake/universal or delayed screening?
- Do you alert the resident prior to the screening about the type of questions to be asked, allowing them to opt in/out?
- Is the screening conducted in a physically and emotionally safe environment?
- How will the screening information be used?
- How do staff respond if the screening triggers emotional or behavior responses?
- What is the organization's response if/when the screening is positive for trauma? Are there resources in place to assist the resident?

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Identifying the "What" in Screening

What is the *prevalence* of trauma in the population you serve? Veterans, mental illness, abuse survivors?

What are/were the *events* the resident was exposed to that may be potentially traumatizing? Is it necessary you know? Do you need to know when they occurred? Persistent exposure? Age of exposure?

What are the *effects/symptoms* the resident is experiencing? How is trauma related to these effects/symptoms? Are there additional precipitating factors to the symptoms besides or in addition to trauma?

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Trauma Screening and Assessment

Facilities should use multiple sources when identifying a resident's history of trauma:

- Admission assessment
- History and physical
- Social history and assessment
- Review of medical records
- Discussion with family and friends, if agreeable
- Observation of behaviors that may indicate past trauma
- Resident Assessment Instrument/MDS:
  - Section D Mood: D0200Resident Mood Interview PHQ9 or D0500 Staff Assessment of Resident Mood (PHQ9-OV)
  - Section F Preferences for Customary Routines and Activities F0400 Interview for Daily Preferences, F0500 Interview for Activity Preferences or F0700 Staff Assessment of Daily and Activity Preferences

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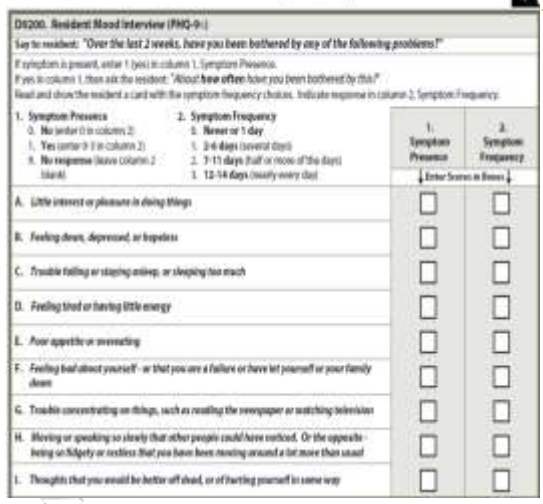
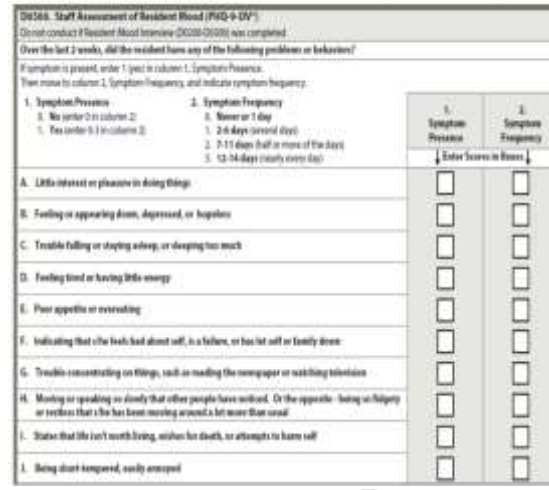
MDS 3.0 Section D Mood

D0200: Resident Mood Interview (PHQ-9©)



D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)



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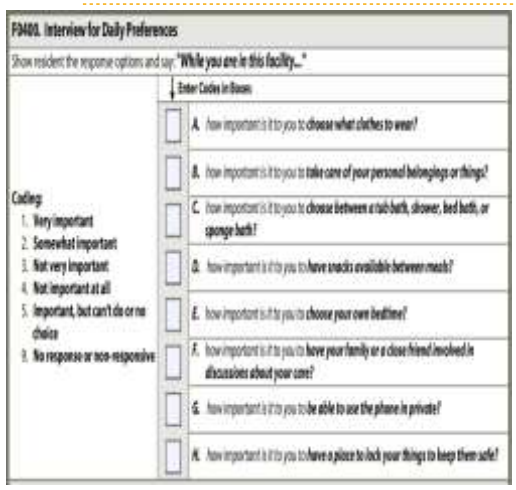
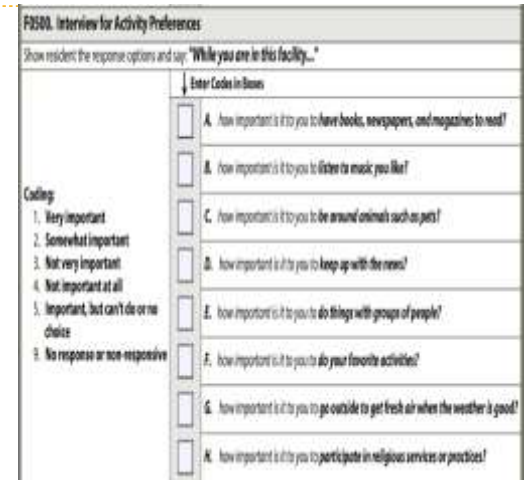
Section F Preferences for Customary Routine and Activities Resident Interview



F0400. Interview for Daily Preferences

Show resident the response options and say: "While you are in this facility..."

Coding: 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive	↓ Enter Codes in Boxes
	A. how important is it to you to choose what clothes to wear?
	B. how important is it to you to take care of your personal belongings or things?
	C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?
	D. how important is it to you to have snacks available between meals?
	E. how important is it to you to choose your own bedtime?
	F. how important is it to you to have your family or a close friend involved in discussions about your care?
	G. how important is it to you to be able to use the phone in private?
	H. how important is it to you to have a place to lock your things to keep them safe?



F0500. Interview for Activity Preferences

Show resident the response options and say: "While you are in this facility..."

Coding: 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive	↓ Enter Codes in Boxes
	A. how important is it to you to have books, newspapers, and magazines to read?
	B. how important is it to you to listen to music you like?
	C. how important is it to you to be around animals such as pets?
	D. how important is it to you to keep up with the news?
	E. how important is it to you to do things with groups of people?
	F. how important is it to you to do your favorite activities?
	G. how important is it to you to go outside to get fresh air when the weather is good?
	H. how important is it to you to participate in religious services or practices?

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Section F. Preferences for Customary Routines and Activities Staff Interview

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply

- A. Choosing clothes to wear
- B. Caring for personal belongings
- C. Receiving tub bath
- D. Receiving shower
- E. Receiving bed bath
- F. Receiving sponge bath
- G. Snacks between meals
- H. Staying up past 8:00 p.m.
- I. Family or significant other involvement in care discussions
- J. Use of phone in private
- K. Place to lock personal belongings
- L. Reading books, newspapers, or magazines
- M. Listening to music
- N. Being around animals such as pets
- O. Keeping up with the news
- P. Doing things with groups of people
- Q. Participating in favorite activities
- R. Spending time away from the nursing home
- S. Spending time outdoors
- T. Participating in religious activities or practices
- Z. None of the above

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Introductory Screening Questions

Potential screening questions to consider:

- Have you ever had an experience so upsetting that you think it changed you spiritually, emotionally, physically or behaviorally?

  For example, leading to problems: sleeping, eating, completing daily tasks, being around others or going places (behavioral), with excessive body pain/discomfort (physical), periods of prolonged sadness/tearfulness, increased fear/irritability/anger (emotional)

- Do you think any of these problems bother you now? If so, do you want to discuss the problems now?

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Trauma Screening and Assessment

- Identify the facility screening philosophy, intake/universal or delayed
- The screening tool may be a self-administered or staff-administered assessment
- Choose a screening tool to assess all admissions:
  - *Life Event Checklist* (LEC) is a 17 item, self-report assessment of an individual's lifetime direct or indirect exposure to potentially traumatic events
  - *Brief Trauma Questionnaire* (BTQ) is a 10 question self-report assessment designed to quickly screen for many different and prevalent types of traumatic experiences
  - *PTSD Checklist* (PCL) is a widely used screen for adults utilizing a 17 item, self-report rating scale
  - *UCLA Reaction Index* most commonly used measure for PTSD symptoms in children or adolescents

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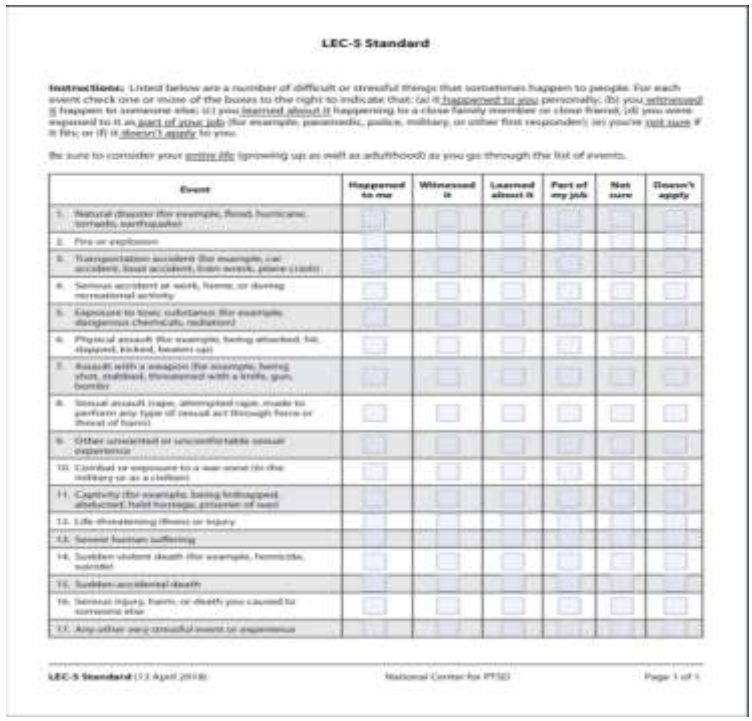


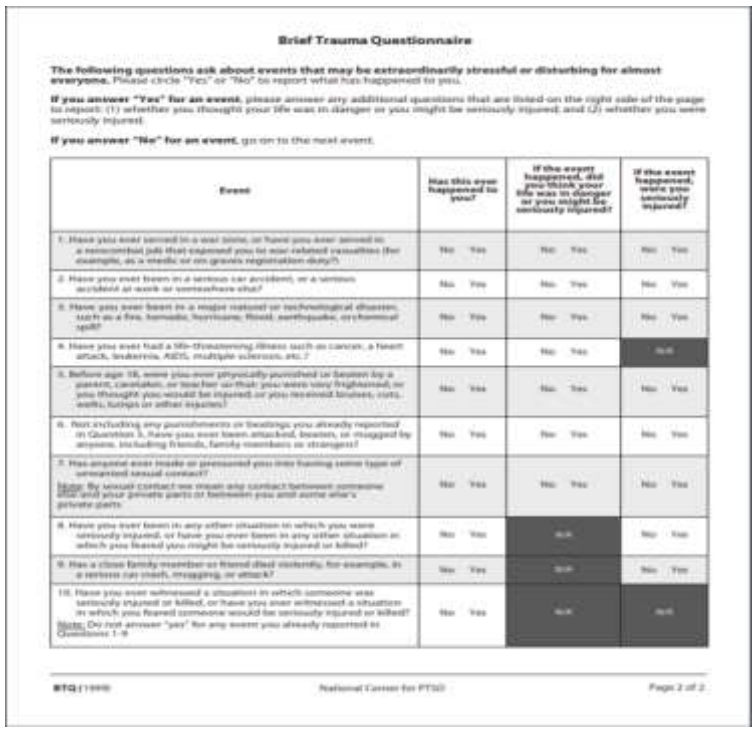
LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

LEC-5 Standard (13 April 2018) National Center for PTSD Page 1 of 1



Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty)?	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that you were very frightened, or you thought you would be injured, or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts.	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9.	No Yes	N/A	N/A

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Additional Screening/Assessment Tools

Bipolar Depression: Mood disorder questionnaire (MDQ) 13 questions that screen for a lifetime history manic or hypo-manic symptoms http://www.dbsalliance.org/pdfs/MDQ.pdf

Anxiety: Zung Anxiety Scale http://en.Wikipedia.org/Zungselfratinganxietyscale

Depression: Geriatric Depression Scale Short
http://www.Stanford.edu/yesavage/GDS.english.short.score.html

Suicide: Risk of Suicide Questionnaire Revised (RSQ-R)
http://www.integration.samsha.gov/images/res/SBQ.pdf

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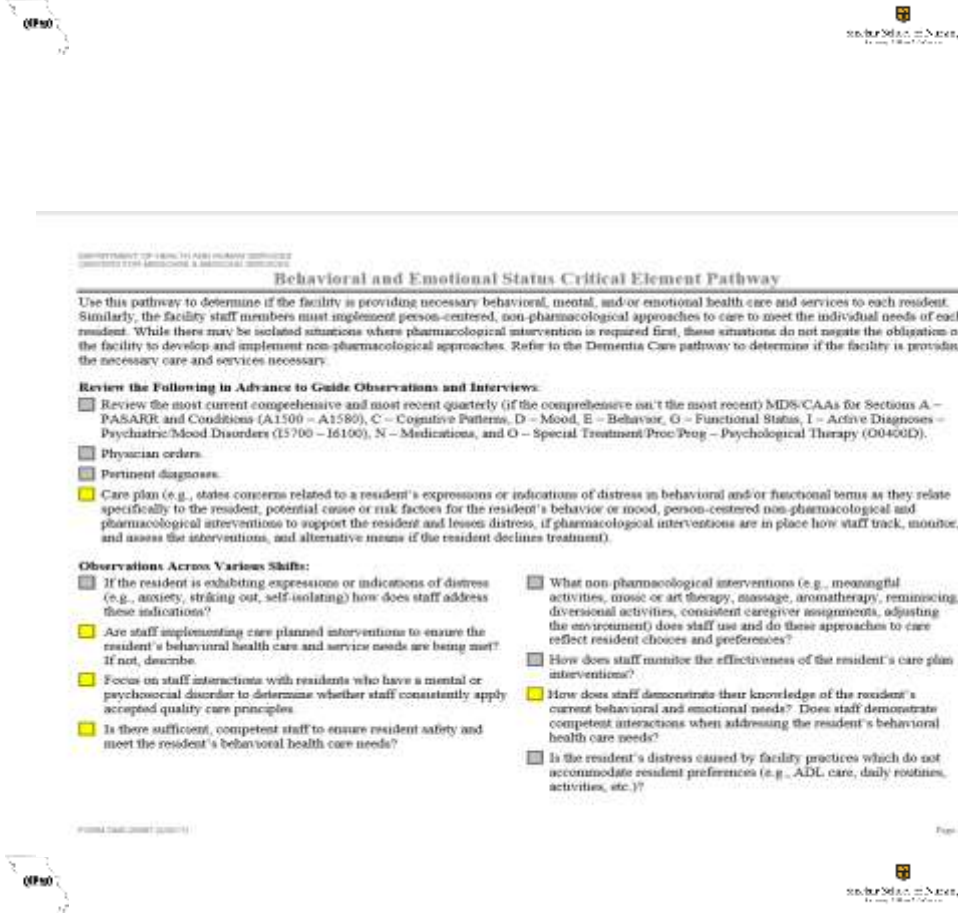

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- Physician orders.
- Pertinent diagnoses.
- Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).

Observations Across Various Shifts:

- If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- How does staff monitor the effectiveness of the resident's care plan interventions?
- How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

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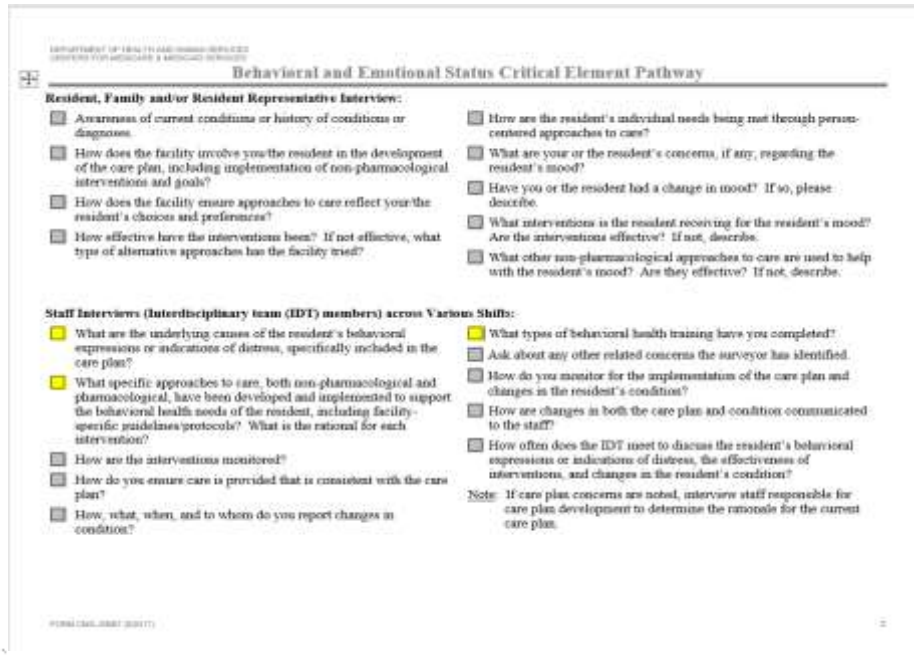

Behavioral and Emotional Status Critical Element Pathway

Resident, Family and/or Resident Representative Interview:

- Awareness of current conditions or history of conditions or diagnoses.
- How does the facility involve you/the resident in the development of the care plan, including implementation of non-pharmacological interventions and goals?
- How does the facility ensure approaches to care reflect your/the resident's choices and preferences?
- How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?
- How are the resident's individual needs being met through person-centered approaches to care?
- What are your or the resident's concerns, if any, regarding the resident's mood?
- Have you or the resident had a change in mood? If so, please describe.
- What interventions is the resident receiving for the resident's mood? Are the interventions effective? If not, describe.
- What other non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.

Staff Interviews (Interdisciplinary team (IDT) members) across Various Shifts:

- What are the underlying causes of the resident's behavioral expressions or indications of distress, specifically included in the care plan?
- What specific approaches to care, both non-pharmacological and pharmacological, have been developed and implemented to support the behavioral health needs of the resident, including facility-specific guidelines/protocols? What is the rational for each intervention?
- How are the interventions monitored?
- How do you ensure care is provided that is consistent with the care plan?
- How, what, when, and to whom do you report changes in condition?
- What types of behavioral health training have you completed?
- Ask about any other related concerns the surveyor has identified.
- How do you monitor for the implementation of the care plan and changes in the resident's condition?
- How are changes in both the care plan and condition communicated to the staff?
- How often does the IDT meet to discuss the resident's behavioral expressions or indications of distress, the effectiveness of interventions, and changes in the resident's condition?

Note: If care plan concerns are noted, interview staff responsible for care plan development to determine the rationale for the current care plan.

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BEST PRACTICES

FOUR "R"S

CARE PLANNING

IMPLICATIONS FOR SHORT & LONG STAY RESIDENTS

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The Four "R"s

- Realization: Understand what the trauma is and how it can impact the resident and their behavior
- Recognize: Assess past trauma and remain alert for the efforts of past trauma to reemerge
- Respond: Develop a care plan that addresses the trauma, including the effects of the trauma the resident experiences, i.e. how the effects of the event manifest themselves in the resident's behavior
- Resist retraumatization: ensure care plan includes the triggers for retraumatizing and the interventions to avoid such an experience, i.e. the treatment and staff approaches used to support the resident

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Care Planning

Focus	Focus on delivering person-centered care
Identify	Identify the individual's definition of safety
Pay	Pay attention to cultural, historical and gender issues, avoid stereotyping and gender or other biases
Identify	Identify individual triggers and de-escalation techniques
Engage	Engage families as appropriate, respect the resident's right to choose
Look	Look for resident-resident peer support opportunities

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CARE PLAN FRAMEWORK

- **Problems**: Subjective data that address the physical or psychosocial symptoms: anxiety, crying, isolation, nightmares, sleeplessness, acting on fears, upsetting voices, withdrawal, refusal of treatments, activities, etc.
- **Support "problem" data**: Objective data from trauma scales, screening test, diagnoses, past traumatic histories, events, affects the escalated actions (crying, screaming)
- **Goal**: Learn coping techniques; share 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 identify the monitoring system to staff
- **Evaluation**: get input from family and resident. Does the care plan work?

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CARE PLAN PSYCHOSOCIAL WELL- BEING HISTORY OF TRAUMA

Problem: (check all 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 INTERRACTIONS related to language barriers, sensory deficits
- ❒ EXPRESSION OF: fears, crying, sadness, negative beliefs
- ❒ MOOD DISTURBANCE: agitation, anger, panic attacks, self-blame, Emotional numbness
- ❒ DISPLAYS: sleep disturbance; avoids talking about what bother, being alert, scanning (hypervigilance); Startled; flashback; Self-destructive behaviors; poor impulse control; hyper-arousal; guilty;

Contributing factors: ☐ New to facility ☐ Limited English Proficiency ☐ History of PTSD ☐ Loss of loved one ☐ Limited mobility ☐ **Traumatic events:** _____

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

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CARE PLAN PSYCHOSOCIAL WELL-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 resident
- ❒ Displaying warmth, answering questions directly, offering unconditional acceptance; being available and respecting the resident'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

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CARE PLAN PSYCHOSOCIAL WELL-BEING HISTORY OF TRAUMA

- ❒ Move the resident 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 resident'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 resident for suicidal or homicidal ideations

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CARE PLAN PSYCHOSOCIAL WELL-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**

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RESIDENT IMPLICATIONS

Short and Long stay

- Employ universal trauma precautions in all interactions
- Explain each medical/care intervention in advance
- Inform individuals and families about the organization's commitment to trauma informed care
- Ask individuals and families, if appropriate, about preferences, including what would make them feel safe and comfortable during their stay
- Complete a basic psychosocial intake utilizing open-ended questions about prior adverse experiences; refer to trauma-specific treatment when appropriate

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Resident implications

Short Stay:

- Consider if the experience leading to the short stay may have been traumatic, e.g. fall, accident or frightening medical event
- Ensure discharge planning facilitates a safe setting

Long Stay:

- Learn as much as possible about the individual's need and preferences
- Communicate with clarity, respect and transparency
- Ask and observe situations and interactions that create well-being, engagement and a sense of safety
- Recognize many long stay residents have some level of cognitive impairment that may require additional sensitivities

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QAPI Considerations

Is there a system in place that monitors the organization's progress in being trauma informed?	What strategies and processes does the organization use to evaluate whether staff feel safe and valued within the organization?	How does the physical environment promote a sense of safety, calm and de-escalation for residents and staff?
Has the organization developed mechanisms to address gender-related physical and emotional safety concerns, e.g. gender-specific spaces and activities?	Does the organization solicit feedback from both staff and residents receiving services?	In what ways do staff recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to address?

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QAPI Outcome Tracking

- Number of residents screened
- Number of residents with positive screen
- Number of residents with trauma informed care plan
- Interventional outcomes &creative solutions that support residents
- Pre/post training survey results
- Survey of residents' perception of safety and satisfaction with care
- Collect and monitor progress related to work plan

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Road Map to Success

- Staff Education: understand the basic principles of trauma and trauma informed care
- Trauma Screening: create a screening process specifically designed to identify residents with a trauma history
- Care Planning; person-centered care planning with interventions specific to the trauma and trauma survivor
- Behavioral Health Services: establish a diagnosis and assist in developing a person-centered care plan

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Resources

- https://traumainformedoregon.org/resources/trauma-informed-care-principles/
- https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
- www.cms.gov State Operations Manual Appendix PP, QSO 20-03-NH, CEP 20067, RAI User Manual Version 3.0
- https://qioprogram.org/facility-assessment-tool
- https://dmh.mo.gov/trauma Missouri Model: A Developmental Framework for Trauma Informed Approaches, MO Dept. of Mental Health and Partners (2014), Policy Guidance on Screening for Trauma 2015
- Trauma Informed Care Melody Schrock, BSN, RN, RAC-CT and Katy Nguyen MSN, RN

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Resources

- www.chcs.org
- https://www.ptsd.va.gov/ Life Events Checklist
- https://www.bhevolution.org/public/trauma_screening.page Brief Trauma Questionnaire
- https://healthcentricadvisors.org Organizational Assessment
- www.leadingage.org RFA guidebook

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