Trauma Informed Care

Libby Youse, BGS, LNHA, IP
Long-Term Care Leadership Coach
Debbie Pool, BSN, RN, LNHA, QCP, IP
Clinical Educator/Consultant
MU Sinclair School of Nursing

1

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

2

IMPORTANT – CEU INFORMATION

TODAY'S WEBINAR HAS BEEN APPROVED FOR CEU HOUR(S)

IN ORDER FOR MO LNHAS TO GET CREDIT:

- It is REQUIRED that you complete a brief survey/evaluation via:
  - ✓ A pop-up at the end of the webinar, or
  - ✓ An automated email from GoToWebinar that will be sent to attendees
  - ✓ *You only need to complete it once (either via the pop-up or the email)*
- It is REQUIRED that you answer the question asking for your LNHA number.

Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is NOT YOUR CEU CERTIFICATE. Your official certificate will be sent out by QIPMO staff in approximately 2 weeks.

**The amount of your credit will be adjusted based on time spent on the webinar.*

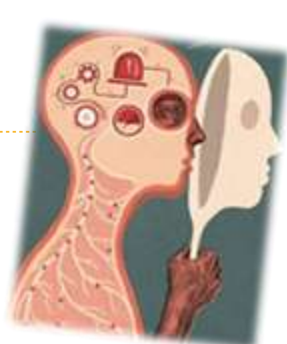
3

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

4

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).

5

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)
  - Or an intense event that threatens safety or security of an individual.
- **Chronic Trauma**: results from extended exposure to traumatizing situations, often occurring in childhood
  - Or experience of multiple traumatic events & impact of that experience.
- **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)

6

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

7

Types of Trauma

- **Stress:** any experience that disrupts our sense of well-being.
- **Traumatic Stress:** long term reaction to trauma; refers to the combination of the event, the individual's experience/perception and the effects.
- **Complex Trauma: Trauma and Stressor-Related Disorders**

8

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.

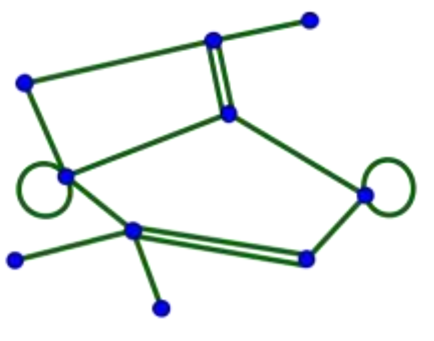
Loss of family member, but with supportive buffers in place.

Witnessing domestic violence in the home, chronic neglect.[2]

QIPMO

9

Trauma Survivors Include



This Photo by Unknown Author is licensed under CC BY-SA-NC

- Military veterans
- Survivors of disasters (natural and human- caused)
- Survivors of Abuse (physical, sexual, and/or mental)
- History of homelessness
- History of imprisonment
- Traumatic loss of a loved one

10

Why Trauma-Informed Care?

- Regulation

F699: §483.25(m) Trauma-informed care

- *§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.***

11

Intent of Requirements

- To ensure facilities deliver care and services which:
  - Meet professional standards.
  - Use approaches which are culturally-competent;
  - Account for residents' experiences and preferences;
  - Address the needs of trauma survivors; and

This Photo by Unknown Author is licensed under CC BY-SA

12

Relevant F-Tags

- F659 *§483.21(b)(3) Comprehensive Care Plans*
- *The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—*
- *(ii) Be provided by qualified persons in accordance with each resident's written plan of care.*
- *(iii) Be culturally-competent and trauma–informed.*
- F741 *§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), and [as linked to history of trauma and/or post-traumatic stress disorder.*
- F740 *§483.40 Behavioral health services.*
- *Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.*
- F742 *receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;*
- F743 no pattern of behavioral difficulties unless unavoidable

13

F-Tag 743

- *GUIDANCE §483.40(b)(2)*
- *Nursing home admission can be a stressful experience for a resident, his/her family, and/or representative. Behavioral health is an integral part of a resident's assessment process and care plan development. The assessment and care plan should include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.*
- *Facility staff must:*
  1) *Monitor the resident closely for expressions or indications of distress;*
  2) *Assess and plan care for concerns identified in the resident's assessment;*
  3) *Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;*
  4) *Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;*
  5) *Ensure appropriate follow-up assessment, if needed; and*
  6) *Discuss potential modifications to the care plan.*

14

Why TIC?

- **§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)
  - Develop and implement a process to train and assess staff competencies/skill sets as related to caring for residents with a history of trauma and/or post-traumatic stress disorder.
- **§483.12 Freedom from Abuse, Neglect, and Exploitation**
  - Develop and implement written policies and procedures to integrate abuse, neglect and exploitation into the QAPI program.
- **§483.21 Comprehensive Person-Centered Care Planning**
  - Ensure that services provided or arranged for by the facility as outlined in the comprehensive care plan, are culturally-competent and trauma-informed.
- **§483.25 Quality of Care**
  - Ensure that residents who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice.
  - Account for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization

15

Care vs Action

Trauma Treatment

A framework that considers how trauma impacts people and organizations and uses trauma knowledge to make policy, procedure and practice decisions.

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 Action

- Evidence-Based Practices, Interventions, Curriculum used with individuals and groups to create safety and improve outcomes.
- 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)

16

17

Event – Experience - Effects

Event – Actual or threat of physical or psychological harm, withholding resources essential to development. Can be single or repeated event.

Experience – How the person assigns meaning to the event depend on individual perception.

Effects – Result of the person's experience of the event may include neurological, physical, emotional or cognitive effects.

QIPMO

18

Examples of Trauma

- Domestic Violence (Witness, Perpetrator, Victim)
- Violent Crime
- School Violence
- Medical Trauma
- Accidents
- Military Combat
- Becoming a refugee
- Natural Disasters
- Experiencing or observing physical, sexual and/or emotional abuse
- Childhood neglect and abandonment
- Abandonment
- Having a family member with a mental health or substance use disorder.
- Terrorism
- Homelessness
- Death/Loss
- Severe Economic Hardship

19

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

20

Examples of Workplace Trauma

- Death, grief, suicide, accident or injury
- Bullying, threats, harassment
- Betrayal, maliciousness
- Isolation, chronic pressure, unresolved conflict
- Uncertainty, downsizing or fear of unemployment
- Noise, Chaos, Harsh or Flashing Lights
- Extreme Temperatures
- Construction Projects
- No control over physical space
- Evacuation, Lockdown, Fire, Robbery

21

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

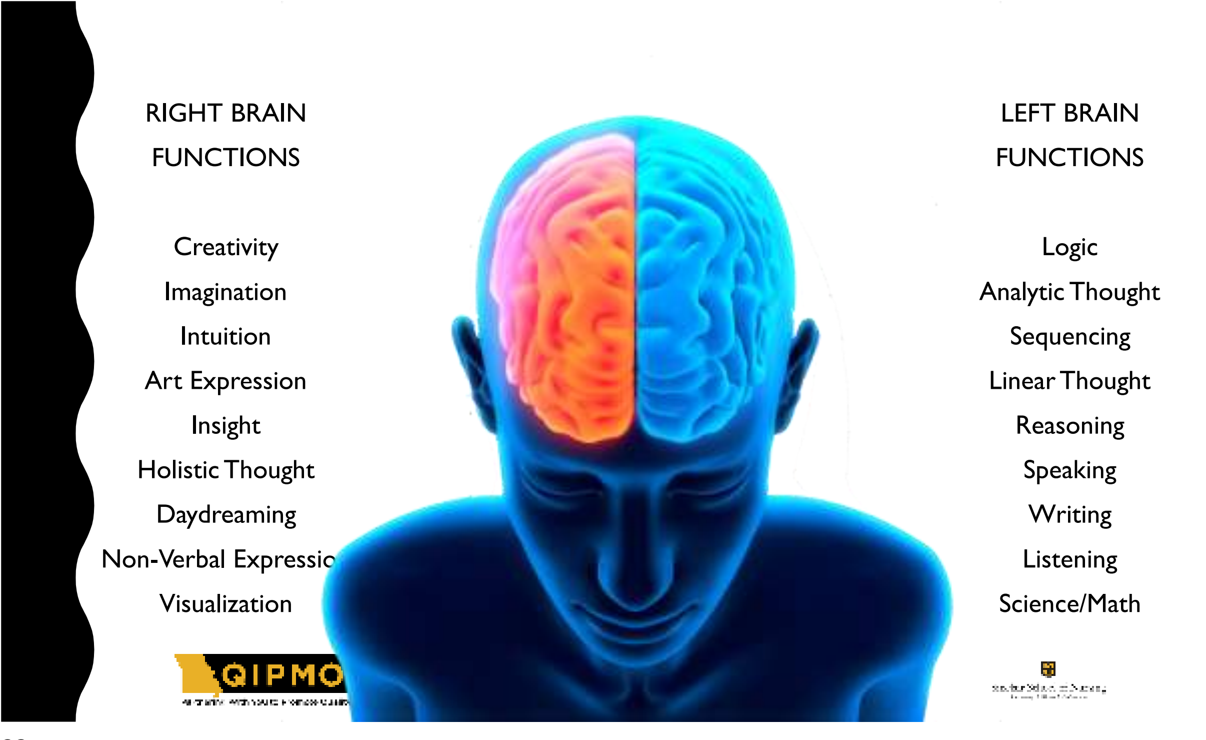
***Social* symptoms** include apathy, isolation, difficulty trusting, detachment

***Spiritual* symptoms** include struggle to find meaning, anger with God

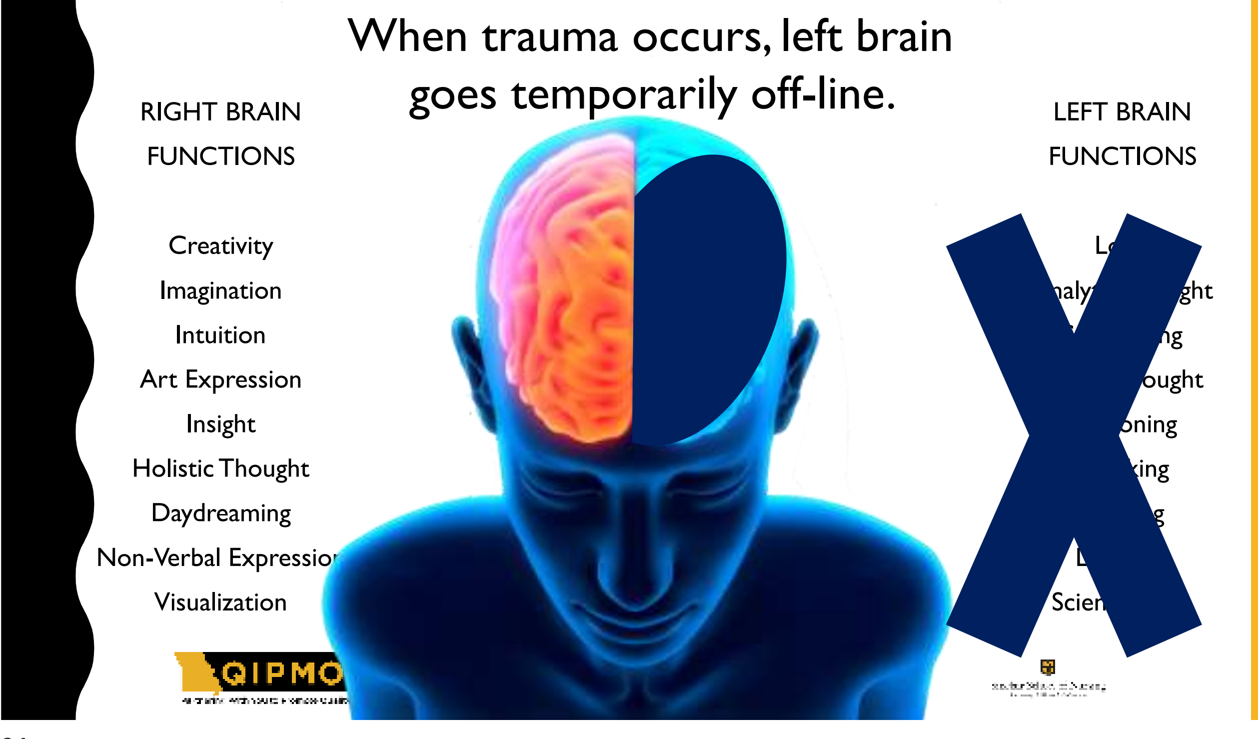
***Emotional* or psychological symptoms**

- 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.

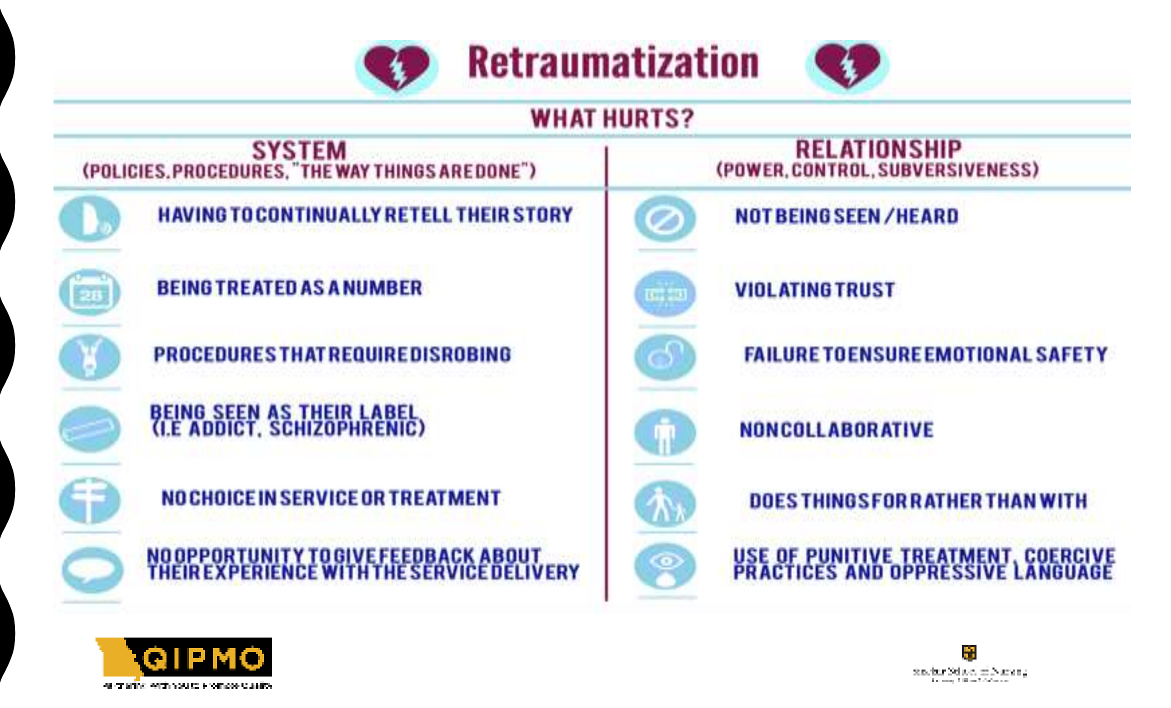
22



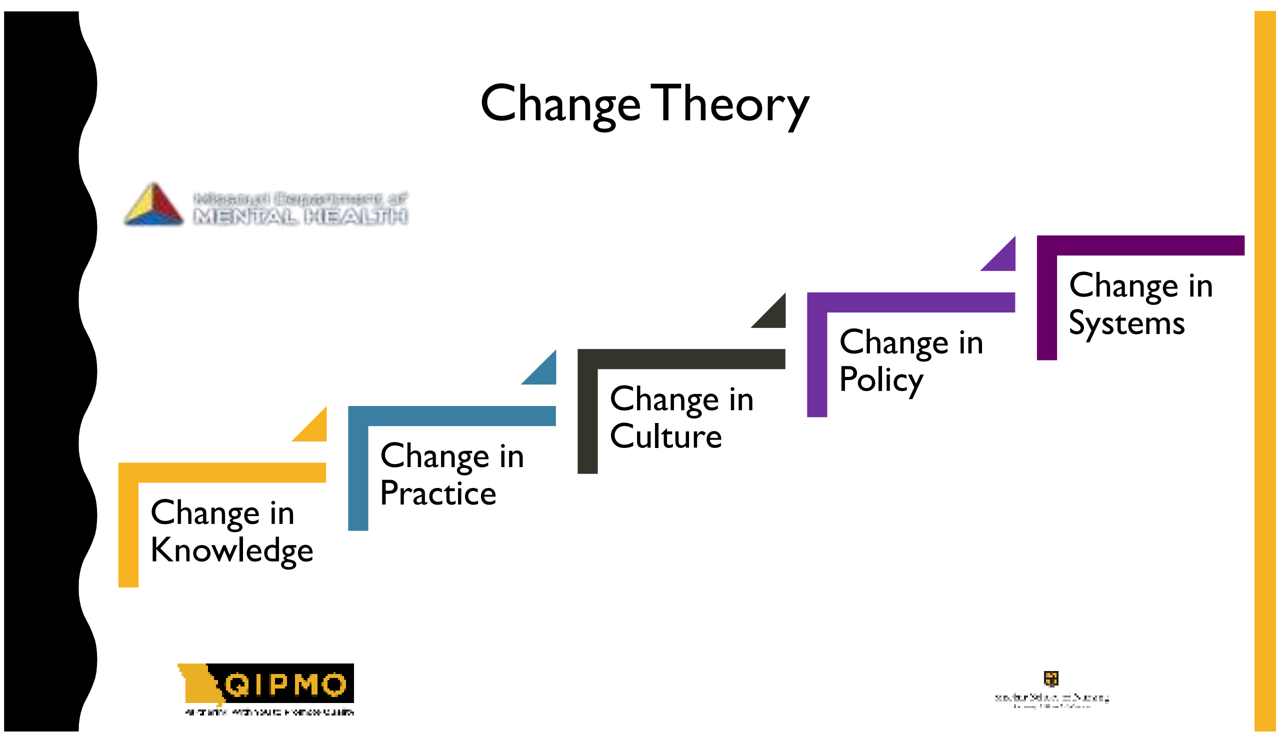
23



24



25



26

27

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:

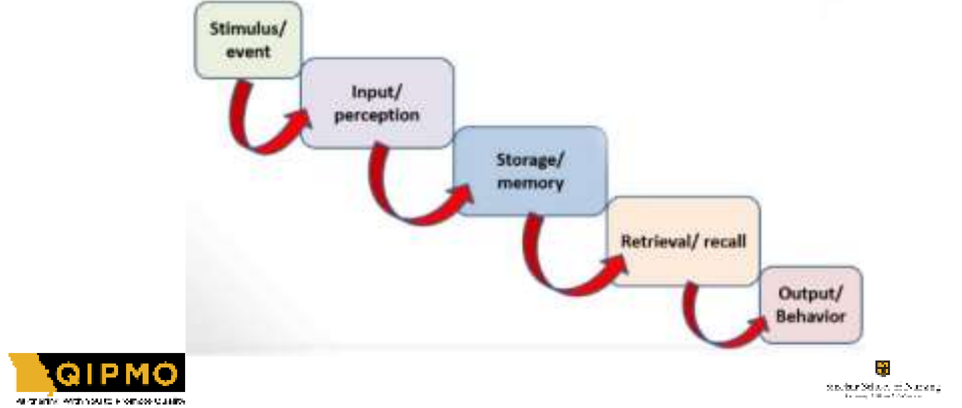
1. **Realization** about trauma and its impact on individuals, families and communities
2. **Recognition** of the symptoms of trauma and traumatic stress
3. **Responses** that are trauma informed at all levels of the organization
4. **Resistance to re-traumatization** at all levels including at the staff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

28

Triggers and Re-Traumatization

- Facilities must identify triggers which may re- traumatize residents with a history of trauma.

  "A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening."



29

Organizational Ingredients for Creating a Trauma Informed Approach

Ingredient	Description
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

QIPMO

30

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

31

Principles of Trauma Informed

SAFETY

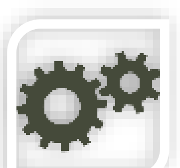
Ensuring physical, emotional and cultural safety.

TRUST

Fostering genuine relationships that promote trust. Addressing bias and historical mistrust.

CHOICE

Maximize choice. Address how privilege and power impacts perception of choice and ability to act upon it.



COLLABORATION

Minimize impact of power differential. Maximize collaboration. Share responsibility for decision-making.

EMPOWERMENT

Identify strengths and skills that lead to recovery. Recognize and respond to historical trauma and oppression.

QIPMO

...d Fallot, R (2001). Using Trauma Theory to Design Service Systems. New Directors for Mental Health Services. San Fransisco: Jossey-Bass., Missouri Trauma Roundtable

32

Screening For Trauma

- Screen every resident
- There is a lot of disagreement on when to screen.
  - Early as soon as possible
  - Or wait and build trust in the providers before being asked about trauma history.
- Regardless:
  - Treatment setting should guide screening practices. Upfront, universal screening may be more effective in primary care settings and later screening may be more appropriate in behavioral health settings.
  - Screening should benefit the patient. Providers who screen for trauma must ensure that, once any health risks are reported, they can offer appropriate care options and referral resources.
  - Re-screening should be avoided. Frequently re-screening patients may increase the potential for re-traumatization because it requires patients to revisit their traumatic experiences.
  - Ample training should precede screening. All health care professionals should be proficient in trauma screening and conducting appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).

33

Include the Resident

- **Screening for Trauma**
- **Patient empowerment**: Involve residents in the treatment process
- **Choice:** Informing patients regarding treatment options so they can choose the options they prefer
- **Collaboration**: Maximizing collaboration among health care staff, residents, and families in treatment planning
- **Safety**: Developing health care settings and activities that ensure resident's physical and emotional safety
- **Trustworthiness**: Creating clear expectations with residents about proposed treatments, who will provide services, and how care will be provided.

34

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.

35

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

QIPMO

36

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

37

INTENT OF F-TAG 741

- ***§483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and***
- ***INTENT §483.40(a), (a)(1) & (a)(2)***
- *The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.70(e). This includes residents with mental disorders, psychosocial disorders, or substance use disorders. Facility staff members must implement person-centered, care approaches designed to meet the individual needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.*

38

Key Elements of Noncompliance

Facility failed to do one of the following:

- Identify cultural preferences of residents who are trauma survivors.
- Identify a resident's past history of trauma
- Identify triggers which cause re-traumatization
- Use approaches that are culturally competent and/or are trauma-informed

39

TRAINING

40

Staff Training Ideas

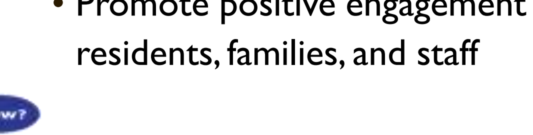
Incorporate trauma training during staff meetings:

- 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

41

What Can We Do… First!

- Continuous Training for staff
  - Know the individuals we care for, including information about their mental health, trauma history, coping, and resilience
  - Clinical – training on how to create a trusting, non-threating environment.
  - Non-Clinical - training on how to interact with residents and other staff
  - Hiring consultants
- Maybe even physical modifications to the home
- 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

42

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

QIPMO

43

Social-Emotional Environment

- Welcoming residents and staff so that they feel respected and supported;
- Ensuring staff maintain healthy interpersonal boundaries and can manage conflict appropriately;
- Keeping consistent schedules and procedures;
- Offering sufficient notice and preparation when changes are necessary;
- Maintaining communication that is consistent, open, respectful, and compassionate;
- Being aware of how an individual's culture affects how they perceive trauma, safety, and privacy.

44

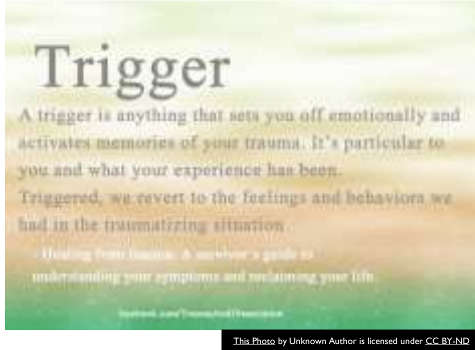
Creating a Safe and Social-Emotional Environment

- 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

45

Developing a Program - Policies

- Trauma-informed screening and assessment
- Focus on trauma and issues of safety and confidentiality
- Trauma-specific treatment or refer to appropriate trauma-specific services
- 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. (QAPI)
- Staff supports in working with sensitivity using effectiveness with trauma survivors.
- Staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training.



This Photo by Unknown Author is licensed under CC BY-ND

46

Regulatory: F Tags

- *F940*
- *§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)]*

47

Recovery

- People can recover from trauma. It is an individual journey for every person and often includes a combination of trauma education, increasing protective factors, building resilience and providing whole-person treatment.

48

Risk of Secondary Trauma

STRESS RECOGNITION IN STAFF

- chronic fatigue,
- disturbing thoughts,
- poor concentration
- emotional detachment and exhaustion
- avoidance, absenteeism, and physical illness

PHYSICAL SPACE

- Accessibility
- Lighting, Entrance & Exit
- Parking Lot and grounds surrounding the facility
- Posted information inside facility
- Adequate breakroom and restroom spaces

49

50

Facility Assessments

- https://www.law.cornell.edu/cfr/text/42/483.70
- **(e)** ***Facility assessment.*** The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:
  - **(1)** The facility's resident population, including, but not limited to,
    - **(i)** Both the number of residents and the facility's resident capacity;
    - **(ii)** The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
    - **(iii)** The staff competencies that are necessary to provide the level and types of care needed for the resident population;
    - **(iv)** The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
    - **(v)** Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

51

Facility Assessments

- **(2)** The facility's resources, including but not limited to,
  - **(i)** All buildings and/or other physical structures and vehicles;
  - **(ii)** Equipment (medical and non-medical);
  - **(iii)** Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
  - **(iv)** All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
  - **(v)** Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
  - **(vi)** Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
- **(3)** A facility-based and community-based risk assessment, utilizing an all-hazards approach.

52

Program Development: Resources and Recommendations

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

53

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

54

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

55

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).

56

Where are We?

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

57

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

58

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

59

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

60

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

61

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?

62

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?

63

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

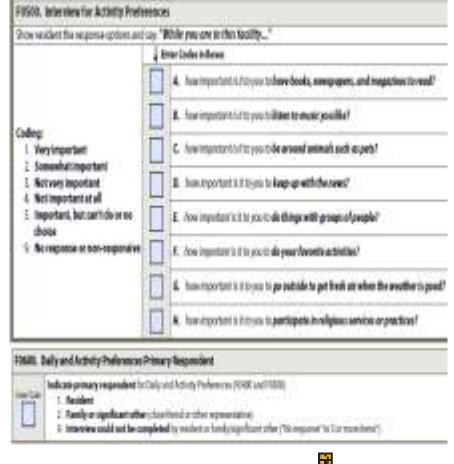
64

MDS 3.0 Section D Mood

MDS 3.0 Nursing Home Comprehensive (NC) Version 1.18.11 Effective 10/01/2023

65

Section F Preferences for Customary Routine and Activities Resident Interview



F0500. Interview for Activity Preferences

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

Enter Codes in Boxes

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

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?

F0600. Daily and Activity Preferences Primary Respondent

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. Resident
2. Family or significant other (close friend or other representative)
9. Interview could not be completed by resident or family/significant other ("No response" to 3 or more items)

66

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

67

Trauma Screening and Assessment

- The screening tool may be self-administered or staff-administered
- Identify the facility screening philosophy: intake/universal or delayed
- If choosing to perform the intake/universal assessment on all residents, the following questions could be used as introductory and seem less obtrusive:
  - Have you ever had an experience so upsetting that you think it changed you spiritually, emotionally, physically or behaviorally? For example:
  - Behavioral: Problems sleeping, eating, completing daily tasks, being around others or going places
  - Physical: Excessive body pain/discomfort
  - Emotional: Periods of prolonged sadness/tearfulness, increased fear/irritability/anger
- Do you think any of these problems bother you know? If so, do you want to discuss the problems now?

68

LEC-5 Standard

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply

LEC-5 Standard · National Center for PTSD · Page 1 of 1

69

Brief Trauma Questionnaire

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?

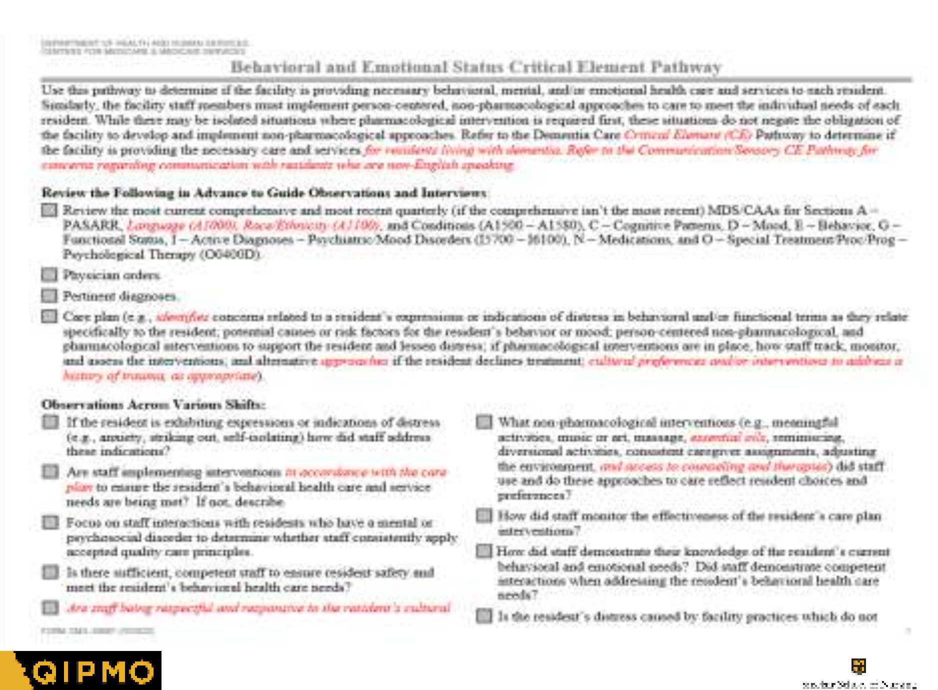
BTQ · National Center for PTSD · Page 2 of 2

70

Additional Screening and Assessment Tools

- PTSD Checklist (PCL-5) is a widely used screen for adults utilizing a 20-item, self-report rating scale, (military, civilian and specific versions) https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
- UCLA Reaction Index most commonly used measure for PTSD symptoms in children or adolescents https://www.ptsd.va.gov/professional/assessment/child/ucla_child_reaction_dsm-5.asp
- *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

71



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 *Critical Element (CE)* Pathway to determine if the facility is providing the necessary care and services *for residents living with dementia. Refer to the Communication/Sensory CE Pathway for concerns regarding communication with residents who are non-English speaking.*

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, *Language (A1000), Race/Ethnicity (A1100)*, 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., *identifies* 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 causes 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 *approaches* if the resident declines treatment; *cultural preferences and/or interventions to address a history of trauma, as appropriate*).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how did staff address these indications?
- ☐ Are staff implementing interventions *in accordance with the care plan* 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?
- ☐ *Are staff being respectful and responsive to the resident's cultural*
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art, massage, *essential oils*, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment, *and access to counseling and therapies*) did staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How did staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How did staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Did 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

QIPMO

72

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Behavioral and Emotional Status Critical Element Pathway

- ☐ How do you ensure care is consistent with the care plan?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ *How do you know a resident is a trauma survivor and what do you need to do differently for that resident?*
- ☐ *How do you know what triggers to avoid for a resident with a history of trauma?*

care plan development to determine the rationale for the current care plan.

Record Review:

- ☐ Review therapy notes, *social service notes,* and other progress notes that may have information regarding the assessment of expressions or indications of distress, mental or psychosocial needs, and resident responsiveness to care approaches.
- ☐ *Review the admission assessment, History & Physical, and social history/assessment to determine whether the facility identified the resident's history of trauma and the effects of past trauma on the resident.*
- ☐ Determine whether the assessment information accurately and comprehensively reflects the condition of the resident *and cultural preferences, as appropriate.*
- ☐ What is the time, duration, and severity of the resident's expressions or indications of distress?
- ☐ What are the underlying causes, risks, and potential triggers for the resident's expressions or indications of distress *which may re-traumatize the resident,* such as decline in cognitive functioning, the result of an illness or injury, or prolonged environmental factors (e.g., noise, bright lights, etc.)?
- ☐ What non-pharmacological approaches to care are used to support the resident and lessen their distress?
- ☐ What PASARR Level II services or psychosocial services are provided, as applicable?
- ☐ Did the facility ensure residents with *mental or* substance use disorders have access to counseling programs *or therapies* (e.g., 12 step groups)?
- ☐ Is the care plan comprehensive? Is it consistent with the resident's specific conditions, risks, needs, expressions, *cultural preferences,* or indications of distress and includes measurable goals and timetables? How did the resident respond to care-planned interventions? If interventions were ineffective, was the care plan revised and were these actions documented in the resident's medical record?
- ☐ *Did the facility collaborate with the resident, and/or resident representative, and any other health care professionals to develop an individualized care plan that addresses resident specific triggers.*
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Was behavioral health training provided to staff *in accordance with the facility assessment?*

FORM CMS-20067 (4/2022)

QIPMO

73

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Behavioral and Emotional Status Critical Element Pathway

Critical Element Decisions:

1) *Did the facility ensure trauma survivors received culturally-competent and/or trauma-informed care which accounted for the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization?*
   If No, cite F699
   NA, the comprehensive assessment did not reveal the resident had a history of trauma, PTSD, and/or cultural preferences.

2) Did the facility provide the necessary behavioral health care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
   If No, cite F740

3) Did the facility have sufficient *staff who provide* direct services and implement non-pharmacological interventions to meet the behavioral health care needs of the resident, as determined by resident assessments, care plans, and facility assessment?
   If No, cite F741

4) Did the facility provide appropriate treatment and services to correct the assessed problem for a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty?
   If No, cite F742
   NA, *the comprehensive assessment did not reveal* the resident display*ed* or *was* diagnosed with a mental or psychosocial adjustment difficulty.

5) Did the facility ensure that the resident whose *comprehensive* assessment did not reveal or who did not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD did not display a pattern of decreased social interaction and/or increased withdrawal, anger, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable?
   If No, cite F743
   NA, the resident's *comprehensive* assessment revealed or the resident has a diagnosis of a mental disorder or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD.

6) *Did the facility provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for this resident?*
   If No, cite F745

QIPMO

74

75

F656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN

- *(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)*
- §483.21(b) Comprehensive Care Plans
- **§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.**
- ***§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—***
- ***(iii) Be culturally-competent and trauma–informed.***

76

Definitions

Culturally Competent Care

- *Cultural competency, (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. it means being respectful and responsive to the health beliefs, practices and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious or social groups (https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence). The interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity.*

Trauma-Informed Care

- *Given the widespread nature and highly individualized experience of trauma, the utilization of trauma-informed approaches is an essential part of person-centered care. Facilities must recognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions. Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others.*

77

Applying the 4 Rs to Care Planning

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

78

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

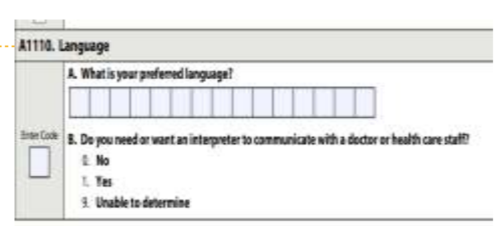
79

MDS 3.0 Version 1.18.11

Section A Identification Information

A1005. Ethnicity

A1010. Race


A1110. Language

A. What is your preferred language?

Enter Code B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

- MDS Section A A1110 identifies whether the resident wants or needs and interpreter and the resident's preferred language. Inability to make needs known and to engage in social interaction because of a language barrier can result in isolation, depression and unmet needs. Language barriers can interfere with an accurate assessment.

80

Person-Centered Care Planning

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

81

Care Plan Framework

- **Problems**: Usually the subjective data that address the physical or psychosocial symptoms: anxiety, crying, isolation, nightmares, sleeplessness, fearful, withdrawal, refusal 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 make staff aware of the monitoring system?
- **Evaluation**: Get input from family and resident. Does the care plan work?

82

Define the Problem

Potential behaviors and related symptoms:

- H/A
- Insomnia
- Weight loss (not planned)
- Stomach problems
- Feeling tense all the time
- Feeling isolated all the time
- Flashbacks (sudden, vivid, distracting memories)
- Restless
- Anxiety attacks (rapid speech, pacing, difficult focusing)
- Loneliness (feeling lonely, sad affect)
- Nightmares
- Spacing out (going away in their mind)
- Sadness (sad affect, statements of sadness)
- Trouble controlling temper
- Uncontrollable crying
- Fear of men
- Fear of women
- Feelings of guilt
- Trouble getting along with others
- Trouble breathing
- Waking up in the middle of the night
- Passing out
- Unnecessary or over-frequent washing
- Feeling that things are "unreal"

83

Goals

- Goals to reduce the number of episodes of the described behavior
- Goals are to be described by stating the episode increase, decrease or no change related to the identified behavior.
- Goals are simple to describe - they merely reflect the identified problem.
- Goal: Will be reviewed and evaluated at least every 90 days (until the next review) and modified as needed.
- Examples of Goals include:
  - Resident will decrease episodes of loneliness to less than daily until the next review
  - Resident will get ___ hours of sleep a night
  - Resident be will feel tense only _______ times per day
  - Resident will have ______ episodes of passing out
  - Resident will have no episodes of fear of men/women
  - Resident will have less than _____ episodes per daily/week

84

Care Plan
Psychosocial Well-Being: History of Trauma

Problem: (circle the related factors)

- ❒ ACTIVITY DEFICIT related to fatigue, tiredness from sleep apnea
- ❒ ACITIVITY 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
- ❒ DISPLAY: sleep disturbance; avoid talking about what is bothering, 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 ☐ **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 relaxation techniques

85

Care Plan
Psychosocial Well-Being: History of Trauma

- ❒ Assess /screen for post traumatic events, history of trauma, using appropriate screening tools
- ❒ Provide visit to the resident to inform activity schedule, encourage resident social interactions
- ❒ Provide instruction to encourage resident to be independent in ADL self-care.
- ❒ Inform staff of resident status and activity preference. Provide 1:1 visits to encourage resident to ventilate feelings about concerns and wishes.
- ❒ Provide activities and invite resident to participate. Praise for his/her engagement or participation in social interactions
- ❒ Encourage the resident's participation in relaxation exercises such as deep breathing, progressive muscle relaxation, guided imagery, meditation, etc.
- ❒ Teach relaxation techniques, deep-breathing exercises. Desensitize resident to his/her memories of traumatic event
- ❒ Assess client for suicidal or homicidal ideations

86

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 resident of his or her safety and security
- ❒ 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

87

Sample Trauma-Informed Care Plan

Problem	Goal	Intervention
Rose has a history of anxiety related to trauma history that has produced a fear of being in enclosed spaces.	Rose will experience less than daily episodes of anxiety in the next 92 days.	Rose will not be in enclosed spaces that create anxiety. Rose to face the door while in the shower room. Sit Rose near a window when in activities and in the dining room when possible. Encourage Rose to inform staff when feeling of anxiety begins. Monitor for triggers of anxiety. Report to Nurse with any identified.

88

Sample Trauma Informed Care Plan

Problem	Goal	Intervention
Rose has insomnia related to a trauma related to desert storm war.	Rose will have no more than 16 episodes of insomnia per month over the next 3 months.	Rose will be taught relaxation techniques, such as deep breathing, the use of relaxing music and smells such as coffee and eucalyptus. Encourage Rose to avoid naps during the day. Rose will engage in physical activities of her choice that will encourage sleep at bedtime. Provide non-caffeinated drinks before bedtime, such as decaf coffee, decaf chamomile tea, water, or warm milk. Rose likes her fluffy blanket at night regardless of temperature.

89

Sample Trauma-Informed Care Plan

Problem	Goal	Intervention
Jim has a diagnosis of PTSD. He was a firefighter in New York City during 9/11. Loud popping or construction noises and crowded hallways makes him panic and become very anxious.	Jim will experience fewer episodes of anxiety related to PTSD in the next 92 days.	• Staff are educated to Jim's condition and triggers and will keep Jim from construction areas. • Jim will be informed ahead of time if loud maintenance projects need to be done near his room and given the opportunity to temporarily relocate. • Staff will take Jim to the dining room first and remove him from last at his request to avoid crowded hallways. • Jim prefers to sit near the doorway during activities. • Jim has prn anti-anxiety medication if nonpharmacological measures are not sufficient to calm him.

90

Surveyor Probes

- Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?
- Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?
- Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?
- Does the care plan describe specialized services and interventions to address PASARR recommendations, as appropriate?
- *Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?*
- *For residents with a history of trauma, does the care plan describe corresponding interventions for care that are 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? (See §483.25(m))*
- Is there evidence that care plan interventions were implemented consistently across all shifts?
- Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?
- Evaluate whether the care plan reflects the facility's efforts to find alternative means to address care of the resident if he or she has refused treatment.

91

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?

92

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

93

Road Map to Success

Staff Education: understand the basic principles of trauma and trauma informed care

2

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

94

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
- 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

95

Resources

- https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
- 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
- https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Findex.html
- SHAMSHA-TIP 57-63
- SOM 2017
- https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm
- https://www.hhs.gov/ash/oah/news/e-updates/march-2019-the-need-for-trauma-informed-care/index.html

96

Sample Email from GoToWebinar

We hope you enjoyed our webinar.

Please send your questions, comments and feedback to: musonqipmo@missouri.edu.

Please take the following survey:

QIPMO Webinar Survey

Your certificate is available here: **<--- this is NOT your CEU certificate;**
<-- it's just a participation certificate that GTW emails automatically.

My Certificate

97

IMPORTANT – CEU INFORMATION

Today's Webinar has Been Approved for CEU Hour(s)

In Order for MO LNHAs to Get Credit:

- It is REQUIRED that you complete a brief survey/evaluation via:
  - ✓ A pop-up at the end of the webinar, or
  - ✓ An automated email from GoToWebinar that will be sent to attendees
  - ✓ *You only need to complete it once (either via the pop-up or the email)*
- It is REQUIRED that you answer the question asking for your LNHA number.

Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is NOT YOUR CEU CERTIFICATE. Your official certificate will be sent out by QIPMO staff in approximately 2 weeks.

**The amount of your credit will be adjusted based on time spent on the webinar.*

98

99

100

Leadership Coaches and Admin Team

www.nursinghomehelp.org/leadership-coaching
musonqipmo@missouri.edu

Mark Francis
francismd@missouri.edu
Regions 1, 3

Penny Kampeter
kampeterp@missouri.edu
Region 7

Nicky Martin
martincaro@missouri.edu
Region 2

Libby Youse
youseme@missouri.edu
Regions 4, 5, 6

Marilyn Rantz
Project Director

Jessica Mueller
Sr. Project Coordinator
muellerjes@missouri.edu

Ronda Cramer
Business Support Specialist
cramerr@missouri.edu

101

QUESTIONS

This Photo by Unknown Author is licensed under CC BY-NC

102