HealthCap
RISK MANAGEMENT SERVICES



Trauma Informed Care

Tools and Samples

- Trauma Informed Care
- Trauma Informed Care Policy and Procedure
- Department of Health Human Services Centers for Medicare & Medicaid Services: Behavioral and Emotional Status Critical Element Pathway
- Other Resources

Trauma Informed Care

Trauma-Informed Care (TIC) is an approach that assumes an individual is more likely than not to have a history of trauma. TIC recognizes the presence of trauma symptoms and acknowledges the role trauma may plan in an individual's life. TIC emphasizes respecting and appropriately responding to the effects of trauma and requires a paradigm shift from "what is wrong with this person" to "what has happened to this person".

Trauma can happen as a result of abuse, violence, or neglect. It can also be due to a loss, war, or natural disaster.

Trauma can happen to anyone, anytime, and the mental, physical, social and emotional effects of it can last a lifetime.

Certain healthcare situations can feel invasive and trigger certain feelings and emotions. That is why an approach to healthcare, known as trauma informed care, is so important. It considers the experiences of each individual, how trauma may impact their lives, what symptoms they are experiencing and then identifying ways to prevent re-traumatization.

The goal of TIC is not to treat symptoms related to a history of trauma but to provide support in a way that is appropriate for the individual who has experienced trauma. Shifting the lens of how we care for people, instead of saying, what's wrong with you, we change that into what happened to you?

Symptoms of Trauma

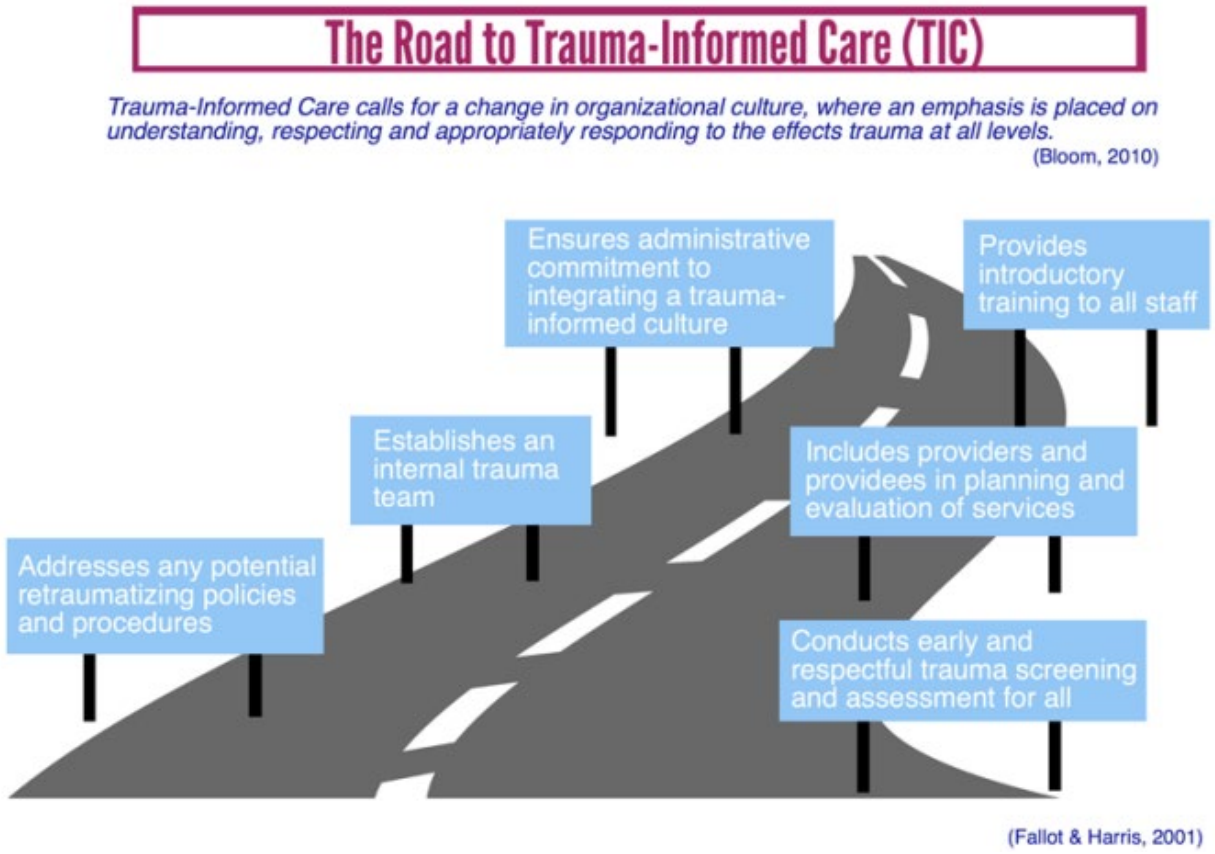
May include but not limited to:

- Being hyper-vigilant or easily startled
- Having difficulty paying attention or concentrating
- Portraying negative thoughts about themselves or the world
- Feeling guilt or blame
- Losing interest in enjoyable activities

Trauma- informed care seeks to:

- Realize the widespread impact of trauma and understand paths for recovery
- Recognize the signs and symptoms of trauma in residents, families, and staff
- Integrate knowledge about trauma into policies, procedures, and practices
- Actively avoid- re-traumatization

A comprehensive approach to trauma- informed care must be adopted at both the clinical and organizational levels. If only implemented at the clinical level without the proper support necessary for broad organizational cultural change it can negatively impact the benefits of an effective program. It also fails to recognize how essential non-clinical staff are in playing an important part of the daily lives of our residents. They often have significant interactions with residents and can be critical to ensuring that they feel safe.



Re-Traumatization

Re-traumatization is any situation or environment that resembles an individual's trauma literally or symbolically, which then triggers difficult feelings and reactions associated with the original trauma. Re-traumatization is often unintentional, however, there are some obvious practices that could be re-traumatizing such as the use of restraints or isolation. Less obvious practices or situations that involve specific smells, sounds or types of interactions may cause individuals to feel re-traumatized and are also often unintentional.

Re-traumatization is a significant concern because residents who are traumatized multiple times frequently have exacerbated trauma-related symptoms compared to those who have experienced a single trauma. Individuals with multiple trauma experiences often exhibit a decreased willingness to engage in treatment.

Trauma-Informed Guiding Values/Principles

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

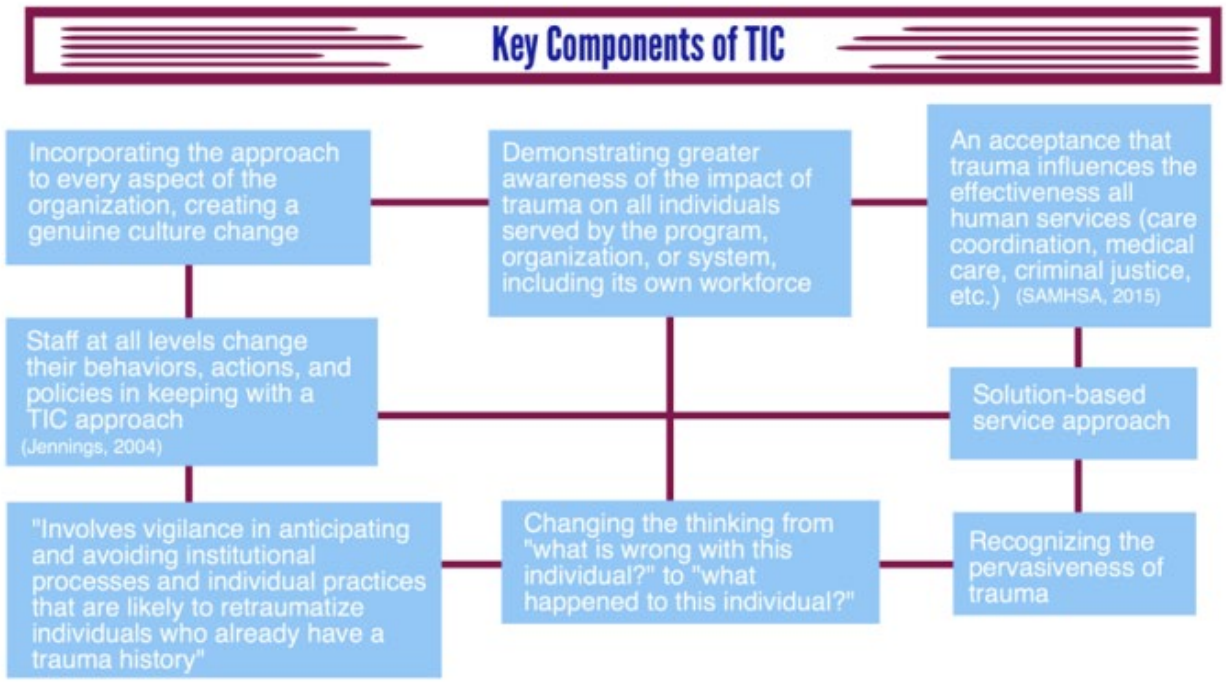
- Safety – Ensuring physical and emotional safety

- Trustworthiness + Transparency – Task clarity, consistency, and interpersonal boundaries. Decisions are made with transparency and with the goal of building and maintain trust
- Peer Support- Individual with shared experiences are integrated into the organization and viewed as integral to service delivery
- Collaboration & Mutuality – Making decisions with the individual and sharing power
- Empowerment Voice & Choice – Prioritizing empowerment and skill building, includes a belief in resilience and the ability to heal from trauma
- Cultural, Historical & Gender Issues-Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed

Ensuring the physical and emotional safety of an individual is addressed is the first important step to providing TIC. The individual needs to know that the provider is trustworthy. Trustworthiness can be evident in the establishment and consistency of boundaries and the clarity of what is expected regarding tasks. The more choice an individual has goes hand in hand with having more control over their situation. Focusing on an individual's strengths and empowering them to build on those strengths while developing stronger coping skills provides a healthy foundation for individuals to fall back on.

Key Components to Trauma-Informed Care

Creating a physically and emotionally safe environment, establishing trust and boundaries, supporting autonomy and choice, creating collaborative relationships and participation opportunities and using a strengths and empowerment-focused perspective to promote resilience are ways in which the principles of Trauma-Informed Care work to reduce re-traumatization and promote healing. This can also help reduce burnout among health care providers, potentially reducing staff turnover, and promoting a happier environment for everyone.



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Trauma Informed Care

Policy and Procedure

Policy:
The facility will provide residents who are trauma survivors, culturally competent, trauma-informed care based on professional standards, and resident preferences and experiences. Residents who display or are diagnosed with a mental health disorder, psychosocial adjustment difficulty, and/or PTSD will be provided with treatment and services to attain the highest practicable level of mental and psychosocial wellbeing.

PROCEDURE:

1. Residents will be screened and assessed upon admission to identify any history of trauma and/or post-traumatic stress disorder (PTSD).
2. Discharge records, if available, will be reviewed, and the resident/resident representative will be interviewed to determine any history of trauma and/or PTSD. (i.e., CAPS-5, Trauma Informed Questionnaire and Life Events Checklist for DSM-5 (LEC-5).
3. Findings from the assessment and interview will be documented in the resident's medical record.
4. For residents unable to complete the screening tool due to cognitive deficit, the legal representative will be interviewed, and the Trauma Informed Questionnaire and Life Events Checklist will be completed by the legal representative.
5. For residents with cognitive impairment and no legal representative, the IDT will review past medical records, if available, and any available psychosocial history in order to identify any suspected past life traumas.
6. The findings of the Trauma Informed Questionnaire and Life Events Checklist will be documented in the initial Psychosocial History by a licensed Social Worker.
7. In the event a resident has experienced a traumatic event, Social Services will interview the resident/resident legal representative regarding:

a. Potential/actual triggers that may cause re-traumatization of the resident if known.
b. Experiences, preferences, and/or other interventions that eliminate or mitigate triggers that may cause re-traumatization of the resident.

8. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus is not traumatic or frightening. While most triggers are highly individualized, some common triggers may include:

a. Experiencing a lack of privacy or confinement in a crowd or small space.
b. Exposure to loud noises, or bright/ flashing lights.
c. Certain sights, such as objects that are associated with those that were used to abuse, and or
d. Sounds, smells, and even physical touch.

9. The facility will work to facilitate the principles of trauma informed care which include:

a. Safety- Ensuring residents have a sense of emotional and physical safety.
b. Trustworthiness and transparency- Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.

SAMPLE

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.

c. Peer support and mutual self-help- If practicable, it may be appropriate to assist the resident in locating and arranging to attend support groups which are organized by qualified professionals. It may be possible for the group to meet in the facility.
d. Collaboration- There is an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision- making.
e. Empowerment, voice, and choice- Ensuring that resident's choice and preference are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.
10. The IDT team will ensure that an individualized resident centered care plan is developed for residents who have experienced a traumatic event.
11. The individualized, resident-centered care plan will include but is not limited to:
a. Identification of the stressor/past life trauma
b. Identification of interventions that mitigate against re-traumatization
c. Identification of triggers that could cause re-traumatization
d. Clinical manifestations experienced by the resident
e. Resident specific goals for preventing re-traumatization
f. Interventions including referral for Psychological and Psychiatry services as indicated
g. Appropriate recreational activities and or therapeutic relaxing interventions
h. The need to obtain assistance from outside agencies and support groups in the community
i. The specific cultural, spiritual and professional interventions that would be beneficial
12. Caregivers will be provided with education on Trauma Informed Care/Behavioral Health during new employee orientation, annually and as needed based on resident care needs.
13. Monitoring of resident's response and adjustment to placement will be done during the initial admission period through communication with the IDT and input from the resident or legal representative.
14. Trauma Informed Care Plan will be updated and revised quarterly and based on resident care needs.
15. Residents will be assessed for any history of trauma during annual assessments and with any significant change in condition.
16. Residents who experience a change in mood state with no known pattern of behavioral difficulties or mental illness will be evaluated by the IDT to determine the root cause leading to the change and a care plan will be developed. Indications of a change may include but are not limited to:
a. Decreased social interaction
b. Increased withdrawn behaviors
c. Increased anger and/or angry outbursts
d. Signs and symptoms of depression
17. Residents experiencing a change in mood state will receive assistance to include but not limited to:
a. Identifying a past life stressor/trauma that was not identified previously
b. Identifying triggers resulting in behavior/mood changes

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c. Identifying specific cultural, spiritual and professional interventions
d. Referring for psychological and/or psychiatry services as appropriate

I have read, and understand and agree to adhere to the requirements in this policy and procedure.

Administrator Signature: _____ Date: _____

Medical Director Signature: _____ Date: _____

Review Dates: _____ _____ _____ _____ _____

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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 *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

Behavioral and Emotional Status Critical Element Pathway

preferences, health beliefs and practices?

- ☐ *Do staff provide culturally competent care (e.g., clothing or food preferences, cultural etiquette, or materials in their preferred language)?*

Resident, Family and/or Resident Representative Interview:

- ☐ *Is the facility aware* of *your/the resident's* current conditions or history of conditions or diagnoses?
- ☐ How did the facility involve you/the resident in *developing* the care plan, including implement*ing* non-pharmacological interventions and goals and *identifying triggers that may cause fear or re-traumatize the resident*?
- ☐ *What non-pharmacological approaches to care are used to help with the resident's mood? Are they effective? If not, describe.*
- ☐ How did the facility ensure approaches to care reflect your/the resident's choices and *cultural* preferences?

accommodate resident *choices, including cultural* preferences (e.g., ADL care, daily routines, activities, etc.)?

- ☐ 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 *or history of trauma*?
- ☐ 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.
- ☐ *How effective have the interventions been? If not effective, what type of alternative approaches has the facility tried?*

Staff Interviews (Interdisciplinary team (IDT) members *including social services*) across Various Shifts:

- ☐ What are the underlying causes *(e.g., history of trauma, mental disorder)* 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 rationale for each intervention?
- ☐ *How do you meet the resident's needs and provide emotional support to a resident who is having difficulty coping with change, loss or coping with stressful events?*
- ☐ *How do you provide or arrange for needed mental and psychological counseling services?*
- ☐ How are the interventions monitored?
- ☐ *How did the facility determine cultural preferences which should be honored while the resident is in the facility?*
- ☐ What types of behavioral health training have you completed?
- ☐ *How do you identify and support individual resident's needs?*
- ☐ 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 did 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?
- ☐ *Ask about any other related concerns the surveyor has identified.*

Note: If care plan concerns are noted, interview staff responsible for

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?*

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*?

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

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

Behavioral and Emotional Status Critical Element Pathway

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Resident Rights F550, Abuse (CA), Admission Orders F635, Professional Standards F658, Qualified Staff F659, PASARR (CA), Sufficient and Competent Staff (Task), Unnecessary/Psychotropic Medications (CA), Resident Records F842, *Qualifications of Social Worker >120 Beds F850*.

Other Resources

What is Trauma-Informed Care? - University at Buffalo School of Social Work - University at Buffalo

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) - Past Week Version - Fillable Form (va.gov)

Clinician-Administered PTSDScale for DSM-5 (CAPS-5) - Past Month Version - Fillable Form (va.gov)

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) - Past Month/Worst Month Version - Fillable Form (va.gov)

Psychometric Properties of Nine Scoring Rules for the Clinician-Administered PTSD Scale (va.gov)

Clinician Administered PTSD Scale for DSM-IV (va.gov)

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) Clinician Training Curriculum - PTSD: National Center for PTSD (va.gov)

Why Trauma- Informed Care Matters- Cleveland Clinic (www.health.clevelandclinic.org)

Trauma- Informed Care Implementation Resource Center (www.traumainformedcare.chcs.org)

CDC Infographic: 6 Guiding Principles To A Trauma- Informed Approach (cdc.gov)

*Life Events Checklist for DSM-5 (LEC-5) - Standard Version - Fillable Form (va.gov)

Clinician Administered PTSD Scale for DSM-IV (va.gov)

CMS.gov F699- Trauma Informed Care