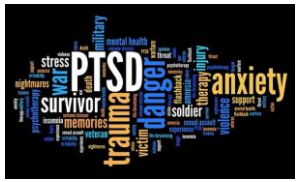
Welcome to our trauma informed care training. This is about creating a culture of wellness for all of us. I want to acknowledge that a safe environment is important for each of us. If anything we are talking about today makes you feel uncomfortable, please feel take a break.

Learning Objectives

- Learn about trauma-informed care and why we are on this journey
- Describe the signs of trauma reactions
- Learn how our own experiences affect how we respond to people
- Understand ways to respond to residents' needs
- Identify how and when to report signs of trauma



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We are going to talk about (provider an overview of the objectives in your own language)

When you hear the word TRAUMA, what comes to mind?

Often we think about or visualize situations like the pandemic, a hurricane or resident abuse. (*Feel free to modify with types of events that occur in your community. Your annual hazard vulnerability assessment is a great resource for this.)* What other types of events or situations come to your mind? (*it's okay to have a few moments of silence. You can also add additional examples after a few moments of silence to trigger discussion)*

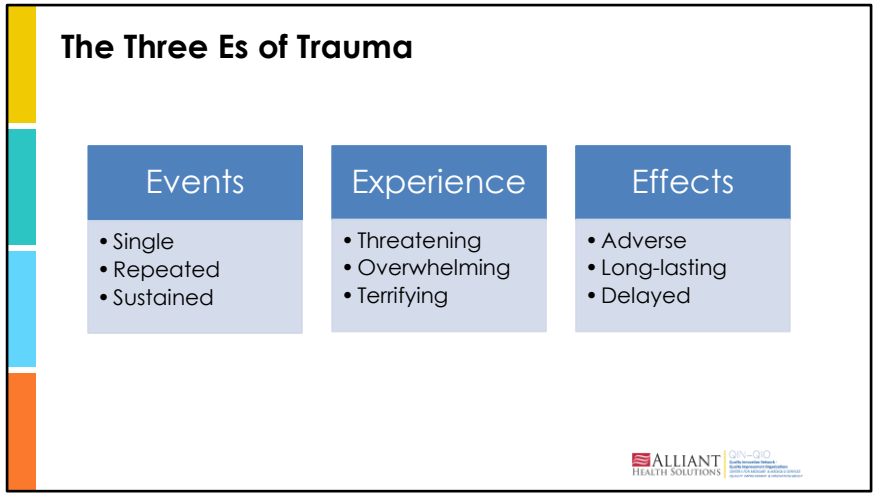
If childhood trauma is not identified as example, briefly mention how there is increasing awareness of how past trauma can resurface throughout our lives.

You can't always tell just from looking at someone if they have a trauma history. When people who have experienced trauma interact with us, this is what you may see. The person might show physical signs like headaches and fatigue. Sometimes something that you or another person say or does may trigger an emotional response like irritability, depression, or anxiety.

It could be something in the environment that changes that causes a person to have a response, something they smell, hear, or see. Triggers can be anything that might remind someone of dangerous or frightening things that have happened in their past.

Experiencing trauma causes changes in the brain and body that may occur without us even knowing it. Many people have lived through traumatic experiences, not only the people we care for but those we work with or even ourselves.

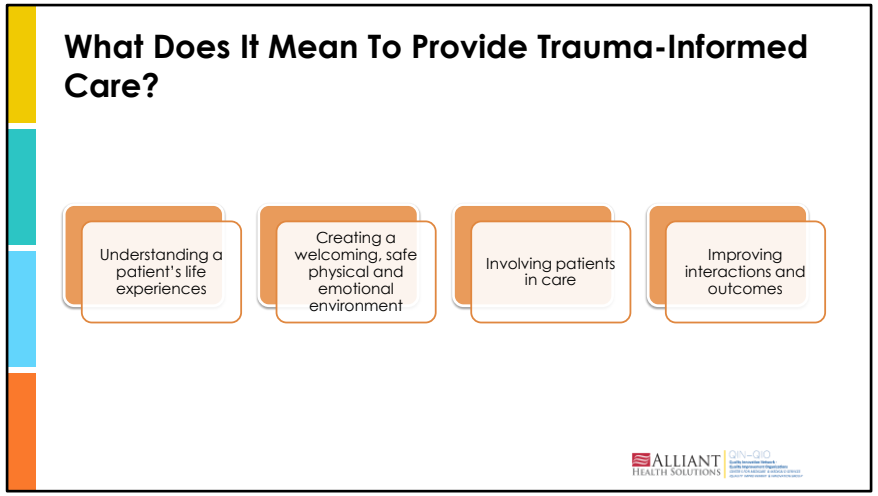
Have you worked with an older adult who has experienced trauma that you were aware of What was your experience with that individual ?



Trauma is Defined by Substance Abuse and Mental Health Services Administration also known as SAMHSA – "Individual trauma results from an **e**vent, series of events, or set of circumstances that is **e**xperienced by an individual as physically or emotionally harmful or life-threatening and that has a lasting adverse **e**ffect on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".

SAMHSA has attempted to simplify the definition by using the term "the 3 E's of Trauma- Events, Experience, and Effects"

- Events- could be a single one-time event, could be repeated events or an event that is sustained over a period of time.
- Experience- generally is how the event makes the person feel– threatened, overwhelmed, terrified for example
- Effects – can be long-lasting, delayed, adverse

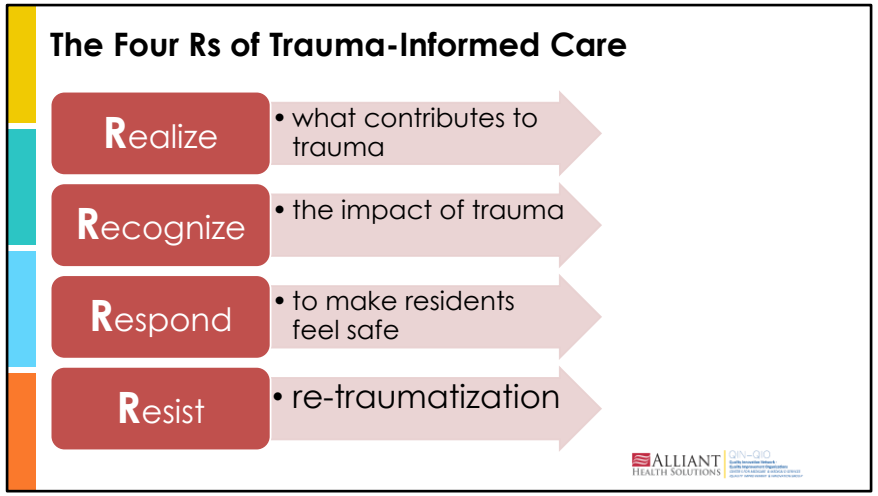


What does it mean and why is it important to be aware of and for us to provide trauma-informed care?

It starts with learning and understanding as much as we can about a patient's lived experiences. It is important to learn the person's history and talk to the patient, family, or care partner to learn as much as we can about experiences and what matter most. *(Talk a little bit about how we can talk within our culture…how does your facility create that welcome, safe environment. What ideas do you have that could make our facility even more welcoming or safe? Allow time for staff to think and share ideas – they have them!)*

What does it mean in our facility to involve patients in care? Do we talk about our patients and residents in the 3rd person in their presence? Do we encourage choices and their active engagement in care planning and goal setting and our policies? *(Allow time for discussion – plant seeds and encourage ideas)*

What is one thing we could do today?



SAMHSA (Substance abuse and mental health services) has established a Trauma-Informed Approach that we are working towards.

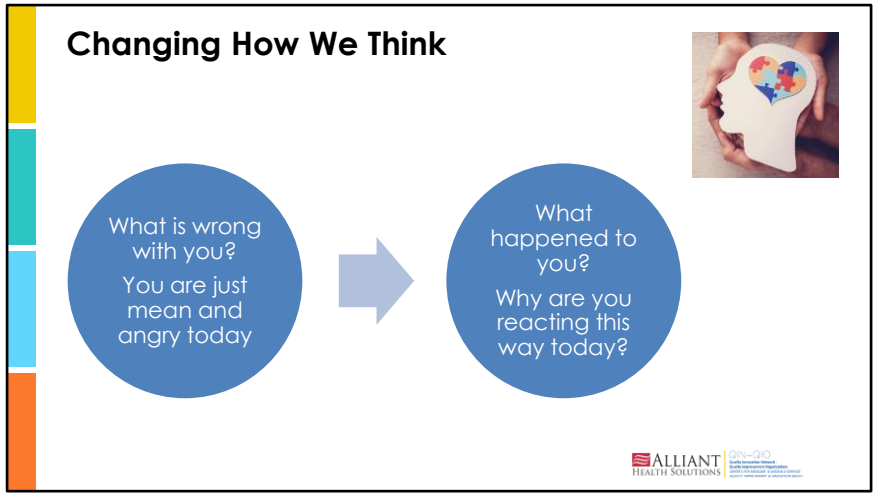
The 4 R's of trauma informed care give us a framework for an approach that works for us:

Realize: An organization, system, or program is thought to be trauma-informed when the impact of trauma is realized; For us this means doing all that we to understand as much as we can about what can contribute to a person's trauma. Things like grief and loss, poverty, childhood mistreatment, terrorist attacks, sexual assaults or abuse, natural disasters, racism, homelessness, severe injury or illness, not having enough food at home, disease. It can be overwhelming.

Recognize: the signs and symptoms of trauma in our patients, residents, families, staff, and others involved with the system; Also, Recognize – people who experience trauma may adapt by doing things that negatively impact their health- substance abuse, smoking, overeating or undereating, they may be mistrusting, guarded, startle easily, or become aggressive. Recognizing the signs of trauma is important because it can help you to make sense of puzzling behavior, can help you to ensure the patient feels safe, can help you avoid re-traumatizing the person and it may help prevent us from prescribing unnecessary medications.

Sometimes, patients or their loved ones interact with us in a way that leads us to label them as difficult. Taking a step back and recognizing they may be experiencing trauma associated with past events or even admitting their loved one to a nursing home can help us respond with compassion.

Our goal is for our responses to promote safety and well-being. One of the ways we will do this is by integrating knowledge about trauma into our policies, procedures, and practices. The more we learn about each person's lived experiences and potential triggers, the better we can avoid or resist **re-traumatization.** This also makes it easier for us to provide care in a way that is nurturing for the resident and safer for us all.



It is worth noting that while we are going to go through reactions associated with trauma history, it is not our objective to diagnose a person, nor should we assume we know what is going on with any individual. Instead, we are looking to identify individual resident needs so we can respond more compassionately and effectively.

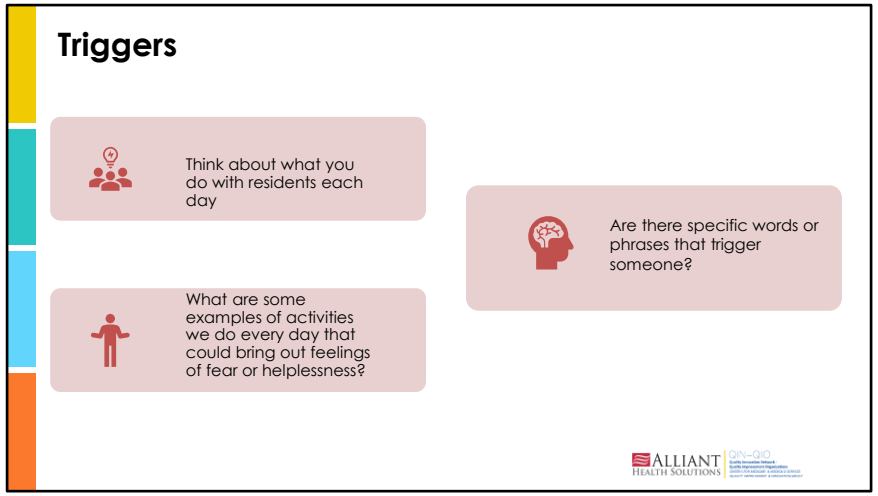
Changing our thought process. What is our automatic response (knee-jerk, gut, use what your audience will relate to) and what would an empathetic approach be?

Sometimes, asking if some is okay just gets us that automatic "yes" As learn more about each person we are caring for, we learn how to really reach them with our questions. We might also say "you seem sad today, what can I do to help you?" How you ask is really going to vary depending on your relationship with that patient.

We may say or hear someone say "what is wrong with you?" Or in report we use words like "I don't what's wrong with Mrs. R today". We make a judgment.
Thinking about how we respond to each person, other words like "did something happen"? "What happened"? might be more meaningful. How you

interact or ask one patient might be perfect for that situation and not the best approach for another resident.

What is new in this person's environment or health?



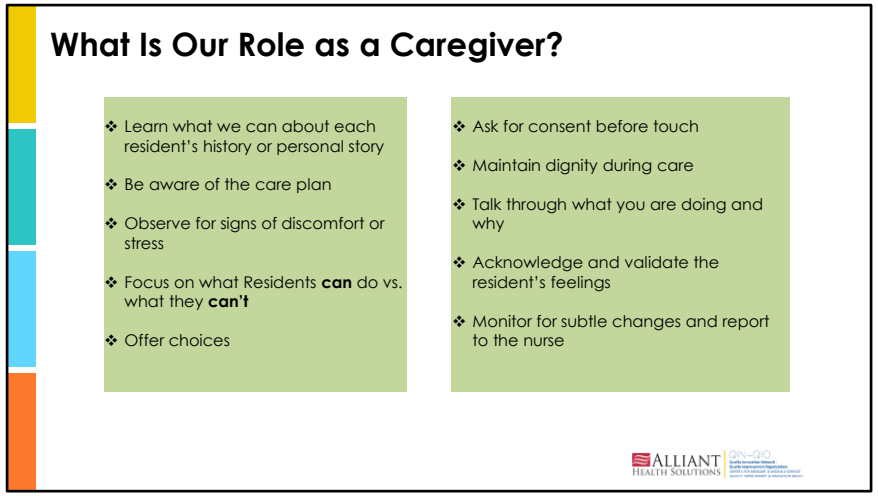
When we consider the tasks and things we do with residents every day,– to us we are completing our work, and tasks. There is a tremendous amount of loss of dignity with having to receive care from strangers. (*can also be difficult when care is provided by caregivers that you know – in a small community the caregivers could be neighbors, or friends of your grandchildren)* Have we considered how the residents/patients feel about having someone doing these tasks for them? Seeing them without clothes? You are someone unfamiliar, likely younger. Many residents are from a different generation or a different culture.

Our patients and residents who do not see, hear, or smell as well as they historically did, so even having a spoon placed in front of their faces can be startling.

What are some examples of activities that we do every day that could bring out feelings of fear or helplessness? Maybe the resident doesn't want to seem vulnerable so instead demonstrates that through anger and agitation. (*allow time for discussion as staff will likely come up with ideas less obvious than bathing, toileting, dressing or eating. Use these as examples as needed to trigger thoughtful discussion)*.

What are some examples of words we use that might be triggers? *(examples to generate discussion could be "you need to", "time for your shower", "you*

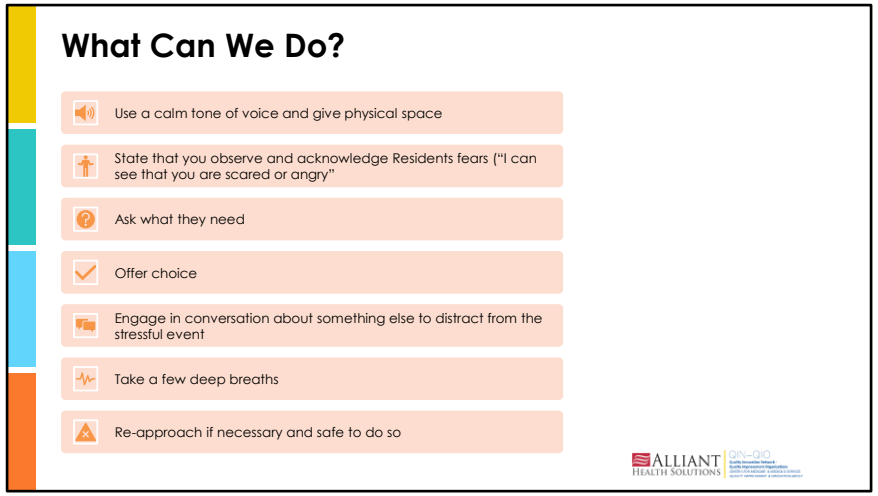
have to go to bed now", "your daughter said you need to eat"
How could we word those examples differently to allow for choice or sense of control?



It is so important to remember to report <u>any</u> change, regardless of how subtle to nursing or SW. It is better for 5 people to report the same change than for no one to report assuming everyone else is.

Let's consider some ways that we can tweak our regular routines to reduce or prevent the risk of triggering a negative reaction related to trauma history. These suggestions could be implemented whether we know about a history of trauma or not. When we review these suggestions, each item is quite reasonable and would be something we would expect from someone taking care of one of us, or someone we care about.

Guide a discussion in the context of your nursing home. For example, ask staff to share what has worked well for them when trying to maintain dignity during care? (i.e. offering choices in outfits, time to get dressed, shower, woken, etc.)

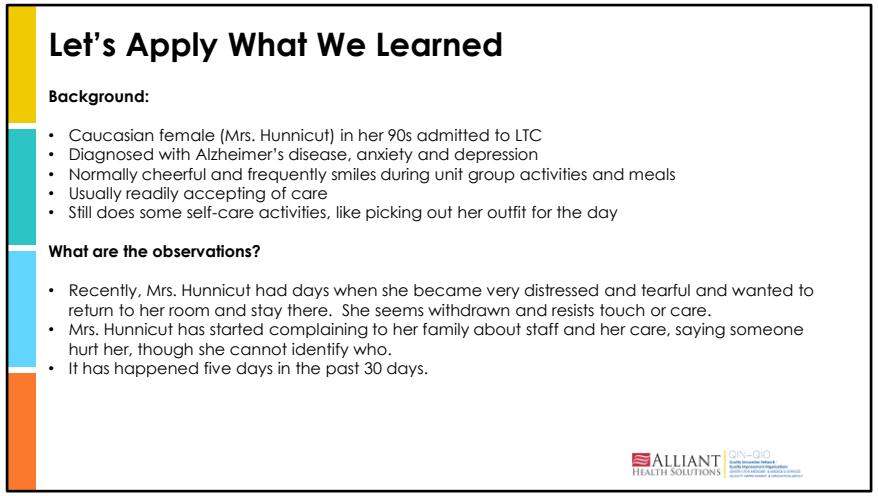


Even with our best intentions, learning and care planning, our patients and residents are people and can be unpredictable. A crisis can occur when you have an upset or agitated resident, and you feel your own stress or annoyance level rise to match. This is not an unusual response. Let's think about ways that we can ensure the situation remains safe for you and your resident.

(Review the actions we can take and ask your staff to share what has worked well for them)

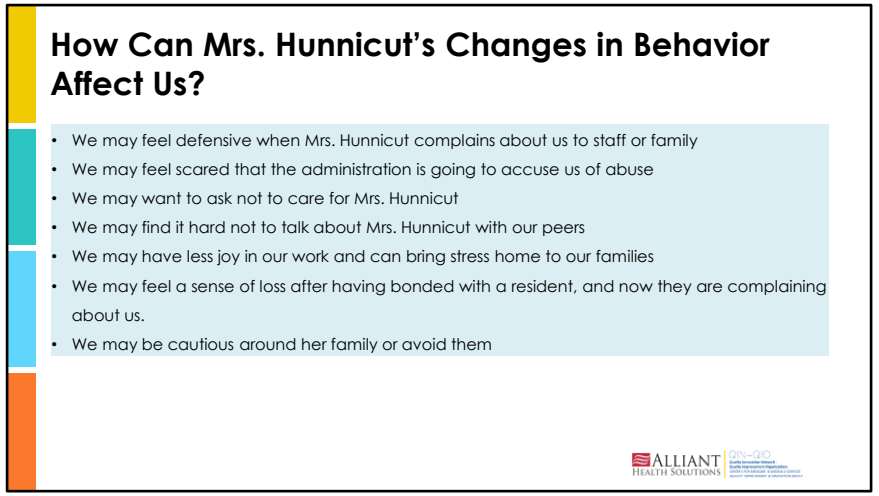
It is tempting to just skip to the last step and come up with a response that will encourage the resident to do what we need them to do because we work in an environment that always has demands for our time.

The resident's care plan should provide some guidance for knowing whether a resident generally responds well to redirection or distraction. It is really helpful to share your perspective on each resident with your care team. Each piece of the puzzle together creates the best picture of what will often work best for an individual. There are times in the moment when you have to decide to take a different approach or try to step back and get help. Re-approach if necessary or allow resident to have some quiet time. And make sure to report the interaction and your observations to nursing and/or SW. *(modify depending on your reporting structures/policies)*

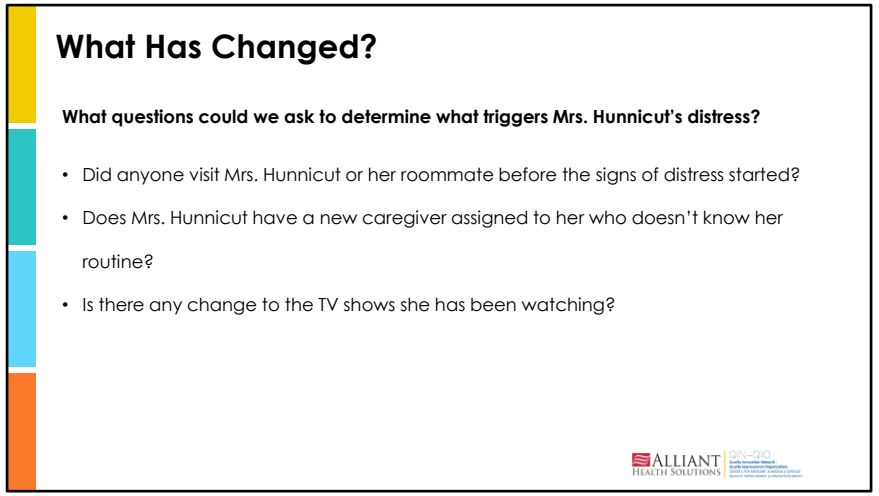


Let's take a few minutes to look at a scenario and think about what we have talked about –

In this situation, the background is……..(read the background and observations)

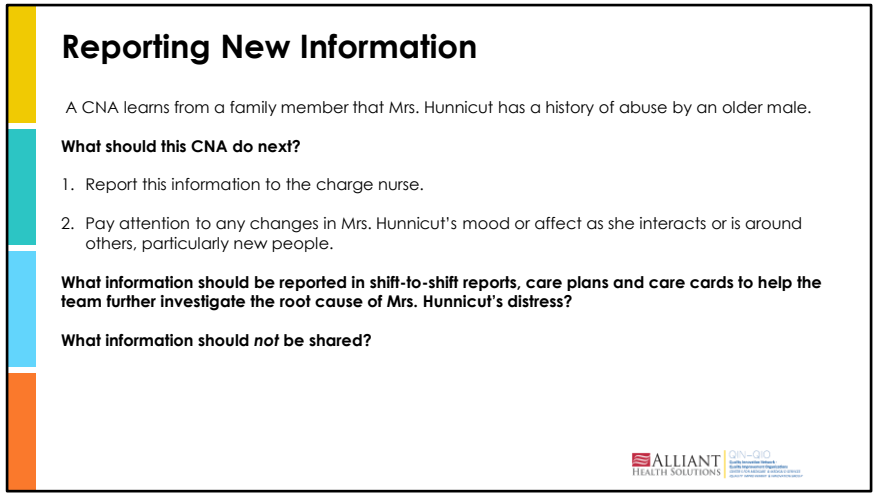


How could Mrs. Hunnicut's changes in behavior affect us as her care givers?



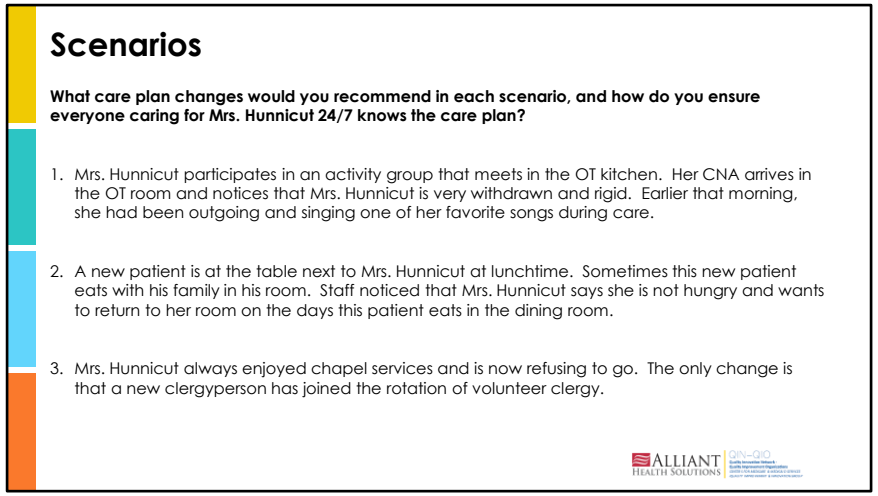
What questions could we ask to try and see what has upset Mrs. Hunnicut?

(Allow sufficient time for staff to identify additional questions)



Share the new information the CNA learned.

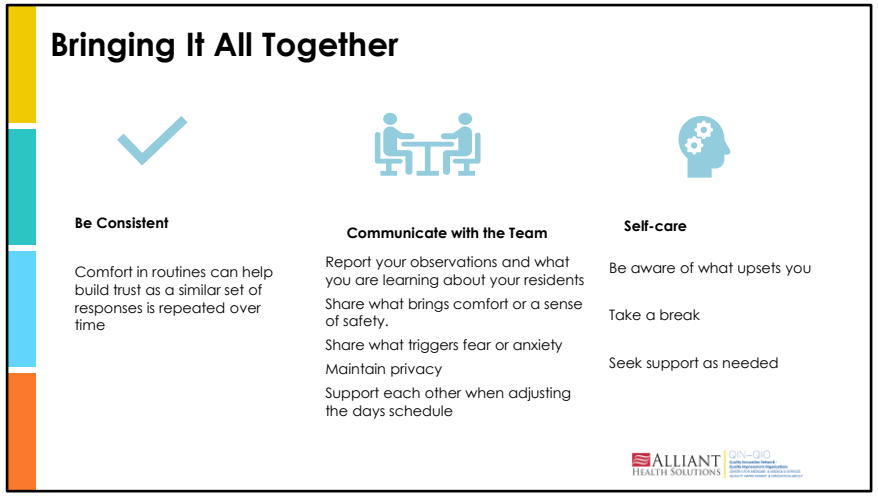
Talk about the what the CNA should do next and what types of information should be shared and not shared. In general, share what is relevant while maintaining resident privacy. For example, we would share that new older males may remind Mrs. Hunnicut of a past traumatic event and cause distress. We would not share specifics such as that Mrs. Hunnicut was sexually abused by her older uncle when she was 7.



1. Report this to the Charge Nurse who interviews the therapy staff and is able to identify this change in behavior when one particular STR male resident is in the gym. The team is able to rearrange his therapy time and gradually Mrs. Hunnicut again begins to enjoy this kitchen activity.

1. Table seating arrangements are modified to ensure this person is out of sight. Staff coached on wording that is reassuring if their paths cross . Care plan intervention could be to position Mrs. Hunnicut out of eyesight of the resident who is causing her distress.

1. Clergy begins to wear a very large name sign that says he is Pastor Steve. He frequently uses his name. Care plan includes staff to use clergy's name when escorting resident to chapel.



In summary-

We want to strive to be consistent to allow for the comfort of routines.

Communicate, communicate, communicate. We can't overcommunicate

Self care is important. *Share who your staff should reach out to for self-care support – example, your EAP, or Employee Assistance Program, HR, your open-door policy, your Medical Director in their role in your employee health program.*

Let staff know that as part of your building this culture of wellness and trauma-informed care, they may be asked at times by a member of the leadership team, or a charge nurse what they understand about trauma, what the 4 Rs of trauma are, or how to care for a resident that has experienced trauma. Reinforce that this is not a "test" but that no – one remembers everything from one training, and we learn where staff may need extra support around by asking questions.

Thank everyone for their time and consider ending with recognition of recent successes or positive feedback.

Questions?


Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS
OPIOID UTILIZATION AND MISUSE
Promote opioid best practices
Reduce opioid adverse drug events in all settings
PATIENT SAFETY
Reduce hospitalizations due to c. diff
Reduce adverse drug events
Reduce facility acquired infections
CHRONIC DISEASE SELF-MANAGEMENT
Increase instances of adequately diagnosed and controlled hypertension
Increase use of cardiac rehabilitation programs
Reduce instances of uncontrolled diabetes
Identify patients at high-risk for kidney disease and improve outcomes
CARE COORDINATION
Convene community coalitions
Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits
Identify and promote optimal care for super utilizers
COVID-19
Support nursing homes by establishing a safe visitor policy and cohort plan
Provide virtual events to support infection control and prevention
Support nursing homes and community coalitions with emergency preparedness plans
IMMUNIZATION
Increase influenza, pneumococcal, and COVID-19 vaccination rates
TRAINING
Encourage completion of infection control and prevention trainings by front line clinical and management staff
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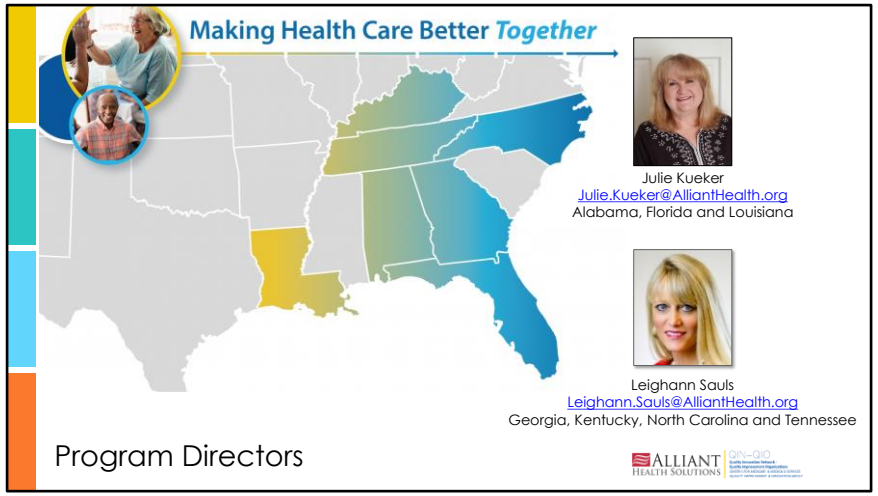

MODERATOR: If we did not get to answer your question today, please don't hesitate to reach out. Alliant Health Solutions is here to assist you.

Chat:

If you are in:
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MODERATOR: Please also join us through your favorite social channel, stay safe and have a wonderful day!

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