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IMPLEMENTING TRAUMA-INFORMED CARE:

A GUIDEBOOK

Implementing Trauma-Informed Care: A Guidebook

About LeadingAge Maryland

LeadingAge Maryland is a community of more than 120 not-for-profit organizations and a wide range of collaborators united to shape the future of aging in Maryland. Our mission is to expand the world of possibilities for aging through advocacy, education, innovation and collaboration. LeadingAge Maryland is a state affiliate of the national organization LeadingAge. Resilience for All Ages is an initiative of LeadingAge Maryland dedicated to equipping individuals and organizations to become more trauma-informed and to advance trauma-informed work with older adults. Learn more at www.leadingagemaryland.org.

Karen Heller Key – Contributor

Karen Key is President and CEO of Heller Key Management Consulting and serves as a Principal with Resilience for All Ages. Her career includes management roles in national nonprofit human services organizations, including six years at the national level with AARP, where she led the piloting of a model for engaging volunteers in improving the experiences of family caregivers and of older people receiving care at home. A lifelong student of applied neuroscience, Karen has studied the cognitive dimensions of how trauma and traumatic stress impact the brain's executive function. She has worked to apply this kind of cognitive science in human services settings, and is the co-author of an April 2015 article in the American Public Human Services Association journal Policy and Practice exploring the application of trauma-informed approaches to self-care and resilience within the human services workforce.

Jill Schumann – Contributor

Jill Schumann is the President and CEO of LeadingAge Maryland. Prior to her work with LeadingAge Maryland she served as the chief executive of Lutheran Services in America, one of the largest health and human services networks in the country. She has created ground-breaking programs in post-acute healthcare and behavioral health, and has consulted with organizations on strategy, governance, innovation, and collaboration and is a frequent presenter at conferences.

Christy Kramer – Contributor

Christy Kramer is the Director of LeadingAge DC. A licensed nursing home administrator in Maryland for 15 years, Christy began her career as administrator of a 285 bed nursing home in Gaithersburg, Maryland. Over the course of ten years, Christy participated in large scale projects including: leading the selection and implementation of the electronic medical records system; the development of a culture change strategic plan; CARF-CCAC accreditation; Maryland Performance Excellence Award application; and Annual Licensure and Certification surveys. Christy then moved to the George Washington University Master of Health Administration program where she worked with the long term faculty on curriculum development and NAB Accreditation. In addition, she counseled students on fellowship, residency, administrator-in-training and internship programs. During this time, Christy was appointed to the Board of Long Term Care Administrators for the District of Columbia. Christy recieved her Bachelor's degree from Cornell University and her Master of Health Services Administration from the George Washington University.

Lisa Schiller – Contributor

Lisa Schiller, LCSW, is Executive Director of MHY Family Services, a trauma-informed organization. She has served in management roles in local and national organizations. She is a long-time student of the practice of trauma-informed care and believes that trauma-informed organizations benefit both clients and staff through the development of safe, respectful and healthy cultures.

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INTRODUCTION

Implementing Trauma-Informed Care: A Guidebook is the second in a series of tools and resources from Resilience for All Ages designed to assist nursing homes seeking to become trauma-informed organizations.

The first, *Foundations of Trauma-Informed Care,* is a toolkit that includes:

- *Foundation of Trauma-Informed Care: A Primer*
- Six one-page lessons for staff
- Two slide presentations with notes to be used for presentations and training
- A User Guide

It will be helpful to become familiar with the Foundations before moving to implementation planning.

This Guidebook focuses on trauma-informed care implementation. It contains:

- A quick review of the basics of trauma and trauma-informed care
- An explanation of the levels of implementation and the Guidebook focus on Level One
- Steps to create an implementation plan and form an implementation team
- Special considerations for nursing homes
- A variety of resources for implementation

Training and webinar resources are available from *Resilience for All Ages* and additional tools will be available in the months to come.

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PRINCIPLES AND PRACTICES OF TRAUMA-INFORMED CARE
A Quick Review

While this section will summarize basic information regarding trauma-informed care, it is important that those using this guidebook will first have read the Resilience For All Ages publication, Foundations of Trauma-Informed Care: An Introductory Primer.[1]

In 2016 the Center for Medicare and Medicaid Services issued a set of changes to the requirements for nursing home communities that participate in Medicare and Medicaid programs.[2] Among the many changes finalized in this rule are policies designed to strengthen the provision of person-centered care to residents.[3] Person-centered care takes a holistic approach to meeting the needs of each individual resident, and considers psychosocial and spiritual aspects of well-being in addition to physical health. While the term "person-centered" mirrors CMS language, many nursing home leaders aspire to what might better be described as person-directed services and supports, characterized by a recognition of residents' rights to care that is shaped to meet their preferences and goals to the greatest extent possible.

In order to provide this kind of care to all residents, nursing home communities must be equipped to understand and work with the circumstances, needs, and wishes of people who bring with them a wide variety of backgrounds and lived experiences. Accordingly, the new Requirements of Participation include an emphasis on providing services that are culturally competent — reflecting cultural awareness and humility — and that are sensitive and responsive to the special needs of residents who have experienced trauma.

The inclusion of a focus on trauma-informed care reflects increasing recognition that the experience of trauma is widespread across the population and has significant long term consequences for health and well-being. This recognition has led to the development of approaches addressing the impact of trauma, some of them involving trauma-specific treatment, and others involving creating conditions that are sensitive to the impact of trauma and to avoiding re-traumatization.

While children's services, behavioral health, violence reduction initiatives, and programs for people who are veterans and Holocaust survivors have been practicing trauma-informed work for more than a decade, the field of aging services has come to the work of treating trauma only recently. The goal is to create safe environments for older people (and staff members) so that all services, supports and care offered — including all medical care, enrichment and socialization services — factor in the reality that some residents (and staff members) will respond differently because of trauma histories, and will benefit from having those offerings provided in trauma-informed ways.

Prevalence and Impact of Trauma

While Americans once considered trauma to be a relatively infrequent occurrence, most research finds that a majority of us — somewhere between 55% and 90% by some measures — have experienced at least one traumatic event.[4,5] Potentially traumatic experiences include: experiencing or witnessing childhood adverse events (e.g. experiencing or witnessing emotional, physical or sexual abuse or neglect, living with a parent with mental illness or substance misuse disorder, death or absence of a parent because of imprisonment); domestic and sexual violence; natural disasters; car, train and airplane crashes; combat; becoming a refugee; homelessness; medical trauma; violent crime; bias and discrimination; and hate crimes and hate speech. ▶▶▶

▶▶▶ *Prevalence and Impact of Trauma Continued.* A potentially traumatic event is any powerful event that affects a person's daily life. While not all people will experience these events as traumatic, the reality that these kinds of events can be traumatizing is essential to bear in mind, given the impact that traumatic stress has on human health and well-being.

Stress vs. Traumatic Stress

All human beings react to some external stimuli with a stress response, ranging from the physical to the emotional and to the cognitive and behavioral. Traumatic stress refers to "the emotional, cognitive, behavioral and psychological experiences of individuals who are exposed to, or who witness, events that overwhelm their coping and problem solving abilities."[6] In other words, a trauma, which produces traumatic stress, occurs when our coping mechanisms are overwhelmed by outside events.

Over the course of their lives, many older people have experienced one or more of the potentially traumatic events and experiences described above — and the impact of that earlier trauma does not disappear with age. Of course older people are subject to these events in the present as well as the past, and so may have more recent or current traumas of these kinds with which to contend.

Older people may also experience traumas related to the aging process itself, including the loss of loved ones, of their own capacities (physical and mental), loss of roles and identity and of their home, and increased dependence on caregivers. Experiences of neglect and of elder abuse are also important to consider. These losses may look like "normal" grieving, or may result in a traumatic stress response.

"A majority of us — somewhere between 55% and 90% by some measures — have experienced trauma.

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Defining Key Terms

While it is anticipated that CMS will be providing more detailed guidance, currently CMS is pointing nursing home leaders to the principles set forth in a 2014 SAMHSA resource entitled *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.[7] Accordingly, while there are many definitions of key terms offered throughout the literature on trauma, traumatic stress and trauma-informed care, those offered here are based on the SAMHSA resource. Please note that in order to make the SAMHSA guidance relevant to older people and to long term care settings, we have made minor modifications to terms used in the original publication.

TRAUMA

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically 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.

The Three E's of Trauma

The Three E's of Trauma are **event(s)**, **experience** of event(s), and **effect**.

EVENTS — can include actual or extreme threat of harm, or severe, life-threatening neglect for a child. Events can occur once or repeatedly over time. Traumatic events can occur throughout a lifetime.

EXPERIENCE — how the individual experiences an event helps determine if it is a traumatic event.

Factors include:
- ► How an individual assigns meaning to the event
- ► How the individual is disrupted physically and psychologically by the event
- ► The individual's experience of powerlessness over the traumatic event, which can trigger feelings of humiliation, shame, guilt, betrayal and/or silencing, isolation, shattering of trust, and fear of reaching out for help
- ► Cultural beliefs (e.g. about the role of women), availability of social supports, and age and developmental stage of the individual at the time of the event

EFFECT — adverse effects can occur immediately or after a delay, and can have a range of duration. Individuals may not recognize the connection between traumatic events and their effects.

Adverse effects include:
- ► Inability to cope with normal stresses of daily living
- ► Inability to trust and benefit from relationships
- ► Cognitive difficulties — memory, attention, thinking, self-regulation, controlling the expression of emotions

TRAUMA-INFORMED

A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices to actively resist re-traumatization.

The Four R's of a Trauma-Informed Approach

A trauma-informed approach can be understood through the terms **realization**, **recognition**, **responding,** and **resisting**.

REALIZATION — all those involved in your organization at all levels realize that:

- ▶ Trauma can affect individuals, families, organizations and communities
- ▶ People's behavior can be understood as coping strategies designed to survive adversity and overwhelming circumstances (past or present)

RECOGNITION — all those involved in your organization are able to recognize the signs of trauma and have access to trauma screening and assessment tools.

RESPONDING — your organization responds by applying a trauma-informed approach to all aspects of your work. Specifically, everyone on staff in every role has changed their behaviors, language and policies to take into consideration the experiences of trauma among residents, their families and staff.

Other ways this response is manifest include:

- ▶ Ensuring that the materials used in your organization — from your mission statement to manuals to policies and procedures — reflect your commitment to creating a culture of resilience, recovery and healing from trauma
- ▶ Formalizing ways for people who have experienced trauma to advise and guide the organization
- ▶ Providing staff training and guidance for supervisors on secondary traumatic stress
- ▶ Articulating your commitment to a physically and psychologically safe environment - including employees and supervisors - fairness and transparency (others would include a culture of social and moral safety)
- ▶ Adopting a universal precautions approach that assumes the presence of trauma in the lives of residents and employees and takes steps to not replicate trauma

RESISTING — re-traumatization of residents and staff members by ensuring that practices do not create a toxic environment — for example, understanding the impact of using restraints or seclusion on a resident with a trauma history.

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The Six Key Principles of a Trauma-Informed Approach

SAFETY — all people associated with the organization feel safe. This includes the safety of the physical setting and the nature of interpersonal interactions.

TRUSTWORTHINESS AND TRANSPARENCY — your organization is run with the goal of building trust with all those involved.

PEER SUPPORT — support from other trauma survivors is a key to establishing safety and hope. Peer support may be from others in the community.

COLLABORATION AND MUTUALITY — recognition that everyone at every level can play a therapeutic role through healing and safe relationships. Your organization emphasizes the leveling of power differences and taking a partnership approach with staff.

EMPOWERMENT, VOICE, AND CHOICE — your organization recognizes and builds on the strengths of people — staff members and residents. You recognize the ways in which nursing home residents and staff members may have been diminished in voice and choice and have at times been subject to coercive treatment. You support and cultivate skills in self-advocacy, and seek to empower residents and staff members to function or work as well as possible with adequate organizational support.

CULTURAL, HISTORICAL, AND GENDER ISSUES — your organization actively moves past cultural biases and stereotypes (gender, region, sexual orientation, race, age, religion), leverages the healing value of cultural traditions, incorporates processes and policies that are culturally aware, and recognizes and addresses historical trauma.

KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

Safety
Trustworthiness & Transparency
Peer Support
Collaboration & Mutuality
Empowerment, Voice, & Choice
Cultural, Historical, & Gender Issues

The Ten Domains for Implementing a Trauma-Informed Approach

SAMHSA has outlined ten domains of organizational functioning that should be addressed when implementing trauma-informed care. As is evident, they involve the entire organization. Those domains are:

- ▶ Governance and Leadership
- ▶ Policy
- ▶ Physical Environment
- ▶ Engagement and Involvement — of people in recovery, trauma survivors, residents and family members, and staff at all levels
- ▶ Cross-Sector Collaboration — all levels, departments, and teams
- ▶ Screening, Assessment, Treatment Services
- ▶ Training and Workforce Development
- ▶ Process Monitoring and Quality Assurance
- ▶ Financing
- ▶ Evaluation

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Core Principles

There are three core principles that guide trauma-informed care:

1. **The impact of adversity is not a choice.**
2. **Understanding adversity helps us make sense out of behavior.**
3. **Prior adversity is not destiny.**

PRINCIPLE 1: THE IMPACT OF ADVERSITY IS NOT A CHOICE.

Adverse or difficult life experiences affect all of us in ways that are more about neurophysiology and less about character than most of us have supposed.

Despite the commonly shared belief that 'what doesn't kill us makes us stronger,' the evidence from neurobiology and public health increasingly demonstrates that adversity causes changes in the brain and body that occur outside our awareness and are not subject to being overridden by 'grit' or toughness.

PRINCIPLE 2: UNDERSTANDING ADVERSITY HELPS US MAKE SENSE OUT OF BEHAVIOR.

We cannot fully understand behavior or respond to it effectively without understanding prior adverse experiences.

In working with older adults, clinical and non-clinical staff members are continuously — consciously and deliberately or unconsciously — observing behavior and interpreting what that behavior means. Some of this is an ongoing process with all human interactions. Some of this observation and meaning-making comes from the training that staff members receive in their professional disciplines.

When considering what observed behavior might mean, we use a number of different rubrics, among them considerations about possible medical reasons, psychosocial causes, and environmental factors.

However, the capacity to assess the meaning of behavior is incomplete without the addition of a consideration of prior adversity. A trauma-informed approach to assessing behavior does not take precedence over other rubrics — it adds an essential missing piece to the puzzle that can help make sense out of puzzling behavior and informs our understanding about why our interventions sometimes are ineffective or even backfire.

PRINCIPLE 3: PRIOR ADVERSITY IS NOT DESTINY.

In an environment of safety and support, change, healing and better lives are possible.

There are two key dimensions to emphasize regarding the potential for older people who have experienced adversity to thrive: the role of individual human potential and the role of a supportive environment.

Human potential for healing across the lifespan: Beyond the evidence and practice wisdom from multiple fields that focus on the physical, mental and spiritual health of individuals, there exists data on the impact of psychological interventions with older adults. This includes the kinds of trauma-specific interventions that may be offered through behavioral health services, along with insights from neurobiology that help explain how greater resilience and healing is possible even after the brain is impacted by traumatic stress.

The role of a safe and supportive environment: Because adverse or traumatic experiences, by definition, are the result of a lack of safety and make individuals susceptible to feeling unsafe, subsequent environments have the potential to either exacerbate the feeling of threat and danger or mitigate it. A safe environment creates a setting in which manifestations of traumatic stress are minimized and individuals experience greater comfort and opportunity for well-being and healing.

LEVELS OF IMPLEMENTATION

When an organization makes a commitment to implement trauma-informed care, it is beginning a multi-year, multi-dimensional process of change. For nursing homes participating in the Medicare and/or Medicaid programs, CMS has mandated trauma-informed care in the Phase 3 (November 2019) Requirements of Participation.

The research and practice of trauma-informed care in settings that provide supports and services to older adults is still in its infancy. Very few organizations in this field are familiar with the concepts, let alone how they can be translated into the daily life of the organization. Therefore, it is likely that even the most committed organizations will move through levels of implementation, deepening their understanding and application over a period of years. Hopefully, a community of research and practice will develop to build shared learning about effective approaches and evidence-based resources.

1 *Each organization will need to tailor implementation to its particular circumstances and resources. The first level of implementation will likely involve:*

▶ Engaging in basic education regarding trauma-informed care

▶ Establishing a multi-disciplinary team to guide implementation

▶ Conducting a preliminary organizational assessment and setting priorities

▶ Making basic changes to policies and procedures to reflect a trauma-informed approach

▶ Identifying mental/behavioral health experts in trauma to whom older adults, family members and staff members may be referred as needed

▶ Identifying ways to create a sense of safety for clients and staff

▶ Beginning to grasp what a truly trauma-informed organization might look like

2 *As organizations progress to a greater integration of a trauma-informed approach, the second level of implementation will likely involve:*

▶ Recognizing the need for significant culture change that reflects a greater degree of transparency, respect and empowerment for clients, families and staff members

▶ Translating the principles of trauma-informed care to the work of each department and staff member

▶ Identifying and addressing overt and covert barriers to a more robust trauma-informed approach

▶ Communicating the implications of trauma-informed care: to firms who provide related services such as therapy and pharmacy; to clients and family members; and to the wider public

▶ Becoming more deeply aware of the effects of primary and secondary trauma for staff members and increasingly engaging with people with lived experience of trauma

3 *And, moving forward, organizations truly committed to trauma-informed care may:*

▶ Become part of learning communities that engage in applied research and share best practices

▶ Identify measures of progress and continually stretch themselves

▶ Increase staff training and learning about trauma-informed care

▶ Strengthen behavioral health and peer support networks

▶ Connect to trauma issues in the wider community

GETTING STARTED

As your organization begins to implement trauma-informed care, the senior team must make it clear that they are invested in, and committed to, trauma-informed care.

The Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that implementing trauma-informed care requires change at many levels of an organization and, therefore, has identified ten domains that should be addressed:

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

SAMHSA has outlined a series of questions organizations can use to stimulate their thinking in each of the domains as they implement trauma-informed care.[8] This document is available at: https://store.samhsa.gov/system/files/sma14-4884.pdf

Getting Started Checklist:

Senior leaders can take the following steps to get started with trauma-informed care implementation:

☐ Read and discuss:
  ▶ *Foundations of Trauma-Informed Care: A Primer*
  ▶ Relevant sections of the *CMS Requirements of Participation*
  ▶ *SAMHSA Guiding Principles of Trauma-Informed Care*
  ▶ Any updated guidance from CMS

☐ Senior Team (and relevant others such as the Board of Directors) discuss and commit to a Statement of Intent *(page 28)*

☐ Form a Trauma-Informed Care Implementation Team *(page 13 and page 32)*

☐ Establish the Trauma-Informed Care Team's Scope of Work and Budget *(page 14)*

☐ Conduct a Preliminary Organizational Assessment *(page 29)*

☐ Create a plan to address the results of the Preliminary Organizational Assessment (in conjunction with the Trauma-Informed Care Implementation Team)

☐ Identify local behavioral health resources and Employee Assistance Program resources. Share your organization's commitment to trauma-informed care and the ways in which they may support it *(page 21)*

☐ Review relevant local and state mandated abuse reporting requirements

☐ Develop and implement policies and procedures to support trauma-informed care (in conjunction with the Trauma-Informed Care Implementation Team) *(page 27)*

☐ Educate all staff members regarding the basics of trauma-informed care *(page 38)*

FORMING A TRAUMA-INFORMED CARE IMPLEMENTATION TEAM

As with any significant change, implementing trauma-informed care will require a group of well-informed and enthusiastic champions. A Trauma-Informed Care Team will work together to plan for implementation and then guide the roll-out and ongoing development and periodic evaluation.

> " As you think about specific people to involve, identify individuals who are natural leaders and who are respected by their peers.

While the Team might be led from someone from social work, nursing, or special projects, it will be important to have the nursing home administrator on the team to ensure that all departments are engaged and involved. The Executive Director, CEO, or other end-point decision maker for the community will likely not participate directly in the implementation team, but it is critical that this person be knowledgeable about trauma-informed care and send the clear and consistent message that they are committed to creating a trauma-informed organization.

The Trauma-Informed Care Team needs to be small enough to be able to learn together, meet regularly and act nimbly. It must be large enough to involve the perspectives of individuals from various disciplines and levels of the organization. A range of seven to ten people on the team generally works well. In a nursing home setting, you will want to have people on the Team from:

▶ Nursing/Clinical
▶ Social Work
▶ Human Resources
▶ Direct Care
▶ Spiritual life/Chaplaincy
▶ Environmental Services

It is wise to invite a Certified Nursing Assistant or other direct service worker and to consider individuals from other departments as well – and to include employees from different levels of the organization. Experiential work has shown that it is best to form a separate team rather than assigning the implementation of trauma-informed care to an existing group such as quality improvement or safety committees.[9]

As you think about specific people to involve, identify individuals who are natural leaders and who are respected by their peers. People who have already proven themselves supportive of person-centered care and who are open to change make good candidates for the Team. As you speak with potential Trauma-Informed Care Team members, be aware that staff members may bring their own trauma histories. You do not need to delve into people's personal lives, but do make sure to be clear that it is fine to decline the invitation with no repercussions.

Initial commitments of Team members should be for a minimum of six months to assure continuity and effective team work. Later, other individuals may be identified as natural champions for trauma-informed care, or some Team members may need or choose to leave the Team. As staff members are educated about trauma-informed care the Team will want to develop a clear and transparent process for identifying new Team members.

The Trauma-Informed Care Team Charter

The Team will design and guide the implementation of trauma-informed care.

Specific responsibilities may include:

- ☐ Perform a preliminary organizational assessment
- ☐ Create an implementation plan to include tasks, timelines, responsibilities and milestones
- ☐ Consider what resources will be required
- ☐ Identify and address barriers to implementation
- ☐ Ensure that all staff members have a basic knowledge of trauma-informed care
- ☐ Develop and implement policies and procedures to support trauma-informed care
- ☐ Create communication vehicles to spread the word
- ☐ See that communication regarding the organization's commitment to trauma-informed care is transmitted to patients/ residents/ clients, family members, other key stakeholders (keep in mind that actions will speak louder than words)
- ☐ Consult with and engage others in support of trauma-informed care, including: medical director, other physicians, nurse practitioners or physician assistants who work with your patients/ residents/ clients; your Employee Assistance Program; mental health professionals in the area experienced in treating people with trauma; and people with lived experience of the issue
- ☐ Identify and implement practices that create a culture of safety, respect, openness, empowerment, and collaboration
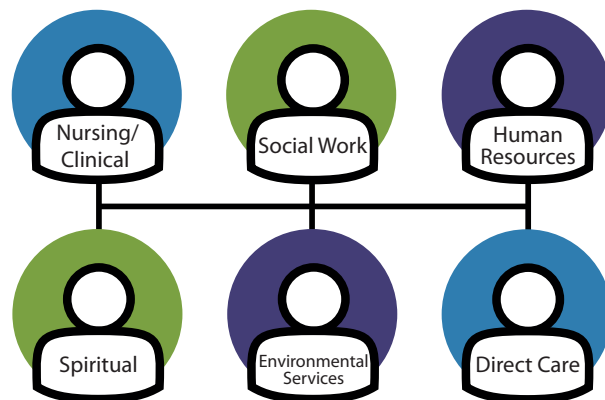
- ☐ Consider how re-traumatization and secondary trauma for staff members and patients/ residents/ clients can be avoided
- ☐ Establish and monitor measures of success in implementation
- ☐ Commit to ongoing training, and sustaining and deepening the trauma-informed culture

Some Things to Consider

- ▶ It may be important to address power/ rank/ culture differentials on the Team to assure that all Team members can participate actively.
- ▶ While there are a variety of approaches to implementing trauma-informed care, few have a significant research evidence base and most have not addressed the specifics of nursing home settings.
- ▶ The Team will benefit from someone who can play a coordinating role - scheduling meetings, creating meeting agendas, taking and distributing notes, and assuring good communication.
- ▶ In its early work and planning, the Team may benefit from the help of an external consultant or facilitator.
- ▶ Implementing trauma-informed care is not a rapid process, so patience and perseverance will be required.

CREATING A TRAUMA-INFORMED CARE IMPLEMENTATION PLAN

As with all multi-disciplinary, multi-departmental projects, implementing trauma-informed care will proceed more smoothly if a plan is created before implementation is begun. The resources in this Guidebook will be helpful in developing the plan. Be sure to become familiar with them before beginning. Remember that trauma-informed organizations benefit residents, staff and families by practicing these six core principles and so they must be kept front of mind in planning:

▶ **SAFETY** — physically, socially, and psychologically safe communities

▶ **TRUSTWORTHINESS AND TRANSPARENCY** — above board, straightforward communication

▶ **PEER SUPPORT** — being able to count on others in an open and caring way; that means asking for and offering help

▶ **COLLABORATION AND MUTUALITY** — an emphasis on leveling power differences and valuing all

▶ **EMPOWERMENT, VOICE, AND CHOICE** — recognizes, encourages and builds on the strengths of everyone

▶ **CULTURAL, HISTORICAL, AND GENDER ISSUES** — moves beyond stereotypes and is culturally aware

Sketch out the overall scope of work, then assign responsibilities and timelines. The *Implementation Plan Checklist* can serve as a basic tool and the *Getting Started* section will be useful. Key elements of an implementation plan are:

Commitment — Creating a trauma-informed organization requires commitment at all levels of the organization. Board and staff leadership must send a clear message and must commit staff and financial resources to implementation. *(Statement of Intent, Getting the Board 'on Board')*

KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

Safety
Trustworthiness & Transparency
Peer Support
Collaboration & Mutuality
Empowerment, Voice, & Choice
Cultural, Historical, & Gender Issues

Education — Because trauma-informed care is a new concept for most nursing homes education will be critical. All staff should be trained in the basics. Discussions about the implications of trauma-informed care and about possible real-time applications of this approach should be part of staff and team meetings. *(Foundations Toolkit, Pre-and Post-Test)*

Implementation Team Formation — The Implementation Team will be drawn from all levels of the organization and will serve as champions and planners to move trauma-informed care forward. They must be empowered to work across disciplines to create a trauma-informed culture. *(Forming an Implementation Team, Forming a Team Worksheet, Team Charter, Leading Change)*

Preliminary Assessment — This preliminary assessment will provide an initial view of things in place to build on and gaps that need to be filled. It can provide insights into priorities and sequencing of implementation. *(Preliminary Organizational Assessment)* ▶▶▶

▶▶▶ *Creating a Trauma-Informed Care Implementation Plan Continued.*

Communication — All stakeholders need to know of the organization's commitment to trauma-informed care. Open, transparent, straightforward communication is a hallmark of a trauma-informed organization, so communicate early and often, and offer opportunities to listen closely to all stakeholders. *(Staff and Trauma-Informed Care, Families and Trauma, Quick Review)*

Action Plan — The Implementation Team in concert with others will create an action plan and will assign responsibilities and timelines. *(Special Considerations for Nursing Homes, Resources)*

Departmental Responsibilities — While the goal is to create a trauma-informed culture across the organization, each department will need to pay attention to the implications for their specific work and create a plan for implementation. *(SAMHSA Domains/questions, Staff and Trauma-Informed Care, Physicians and Contracted Health Professionals, Relationship to Person-Centered/ Person-Directed Care, Major Neurocognitive Disorders/ Dementia, Implications for Short and Long-Stay Residents, Families and Trauma)*

Policies and Procedures — Many policies and procedures will need to be revised to reflect trauma-informed care. Using a transparent and collaborative approach to the development of these will be an important part of the trauma-informed journey. *(Quick Review, Policies and Procedures)*

Measurements of Success — As with other aspects of the organization's functioning, it will be important to identify measures of success and areas of challenge as the implementation of trauma-informed care proceeds. Results of the preliminary organizational assessment will help point toward possible measures. Using the Quality Assurance Performance Improvement approach integrates trauma-informed care measures into those of the overall organization.

Resources — As trauma-informed care becomes more widely adopted in nursing homes and other settings that provide supports and services to older adults, the research literature and evidence-based practice will grow. Onsite training and consultation can be valuable; attendance at webinars, workshops and conferences will deepen understanding; and regular review of articles and web resources will keep the organization abreast of new knowledge. *(Resilience for All Ages website)*

Going Deeper — This Guidebook, in concert with the Foundations of Trauma-Informed Care Toolkit, provides the basics for early implementation of trauma-informed care. To create a truly trauma-informed culture will require going beyond that. So, be sure the plan includes a commitment to going deeper over time.

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Taking a trauma-informed approach when caring for patients ensures we don't inadvertently re-traumatize them, and results in tailored interventions likely to improve the overall patient experience.

- Dr. Mark Lachman

"

SPECIAL CONSIDERATIONS FOR NURSING HOMES

Trauma-informed principles and practices apply in many, many settings. Since the CMS Requirements of Participation Phase 3 specifically require nursing homes to implement trauma-informed care, this section of the *Guidebook* will highlight some of the special issues nursing homes will need to address.

They include:

- ▶ Major Neurocognitive Disorders/ Dementia
- ▶ Physicians and Contracted Health Professionals
- ▶ Relationship to Person-Centered/ Person-Directed Care
- ▶ Behavioral Health Resources
- ▶ Implications for Short and Long-Stay Residents
- ▶ Staff and Trauma- Informed Care
- ▶ Families and Trauma
- ▶ Policies and Procedures

Major Neurocognitive Disorders/ Dementia

Implementing trauma-informed care in nursing home settings can be complicated by the presence of many individuals with various types and stages of neurocognitive disorders.

According to Dr. Mark Lachman, a geriatric psychiatrist, "For those with dementia who have also endured traumatic experiences, the disease often impacts their ability to protect themselves against traumatic memories and this may result in certain behavioural presentations. Taking a trauma-informed approach when caring for patients ensures we don't inadvertently re-traumatize them, and results in tailored interventions likely to improve the overall patient experience.[10]"

In an article in *Social Work Today,* T. Scott Janssen has outlined the complexities of trauma-informed dementia care.[11] There are studies indicating that people who have experienced post-traumatic stress may have a higher incidence of developing dementia, perhaps related to the effects of toxic stress on the brain. There are also studies that suggest that dementia may be a risk factor in developing delayed onset PTSD.

These intersections between trauma and dementia are further complicated by:

▶ The challenges and losses people face when entering the new and unfamiliar environment of a care setting

▶ The difficulty of getting accurate personal histories

▶ Similarities between behaviors associated with dementia and with post-traumatic stress

▶ The likelihood that frightening memories of trauma may be exacerbated by cognitive impairment

Clearly, creating a safe, supportive and respectful environment is important in addressing both post-traumatic stress and dementia. In helping people with cognitive impairment to feel calm and safe

> "Care providers who use a trauma-informed lens and practices trauma-informed principles may find themselves feeling greater safety and competence in managing and minimizing challenging behavior.

and to address behaviors that may or may not be associated with previous trauma, the general approach is to assume previous trauma. While it may not be possible to learn the specifics of the trauma, asking general questions of the person and the family may provide helpful information about previous trauma that will help to solve a behavioral puzzle. Noting and documenting specific triggers of aggressive or frightened behaviors may also provide clues. Conversely, noting and documenting the specifics of times when the individual seems calm may also provide insight and ideas for providing support and safety when emotional dysregulation or behavioral issues arise. These practices are consistent with person-centered and person-directed care that respects people as unique individuals.

In sum, while the intersections of trauma and major neurocognitive disorders are complex and the study of these intersections is in the early stages, staff with a knowledge of trauma-informed care and an organization committed to its practice will be of great benefit to both staff members and individuals in their care. For staff members working closely with persons with major neurocognitive disorders, worries about safety and effectiveness can lead to frustration, burn-out, secondary or vicarious trauma, and even job changes. Care providers who use a trauma-informed lens and practices trauma-informed principles may find themselves feeling greater safety and competence in managing and minimizing challenging behavior.
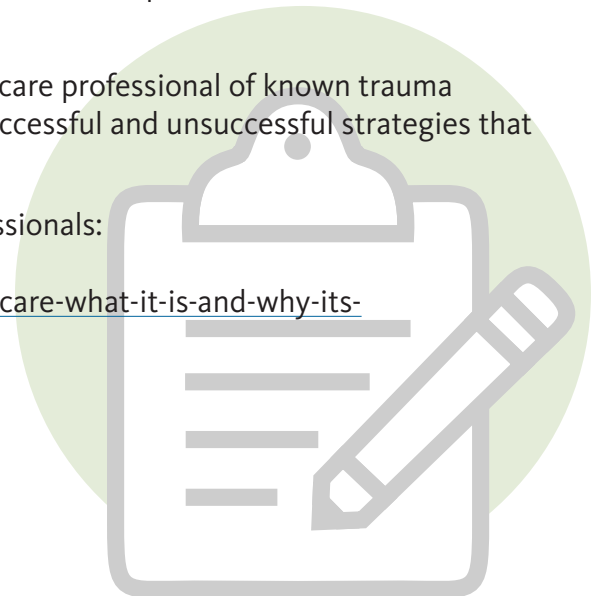
Physicians and Contracted Health Professionals

People who receive healthcare and services in nursing homes interact regularly with a variety of health professionals. These include physicians, nurses, pharmacists, therapists (occupational, physical, respiratory, speech), and diagnostic technicians. In many organizations, at least some of these roles may be contractual rather than employed-staff relationships. In the same way that staff members at every level of the organization must contribute to building a trauma-informed organization, so too, must contracted health professionals.

These professionals often must ask sensitive questions, conduct medical examinations, or administer hands-on treatments that may be painful or frightening. Such actions can trigger strong reactions in individuals with prior histories of abuse or other adverse experiences. Therefore, it is important that health care professionals are aware that many of the individuals they see have histories of trauma, given the prevalence of trauma in the general population. The organization must educate health professionals about trauma-informed care and hold them accountable for practicing in ways that promote a culture of safety, empowerment and healing.

Suggested steps include:

☐ Make explicit expectations regarding trauma-informed care part of written agreements.

☐ Include some elements of trauma-informed practice in any ongoing evaluation of the contracting health professional.

☐ Provide and document basic education about trauma-informed care for all health professionals working within your organization.

☐ Identify information and resources regarding trauma-informed care targeted to specific professions. Many professional associations such as the American Physical Therapy Association and American Academy of Family Physicians have published such information.

☐ Ensure that all health professionals are familiar with universal trauma precautions and make use of them in their practices.[12]

☐ Establish documentation processes that inform the health care professional of known trauma histories taken by other professionals and the history of successful and unsuccessful strategies that had been used to avoid re-traumatization.

☐ Share these and other articles/resources with health professionals:
  ▶ http://brsstacs.center4si.com/TICinMedicine.pdf
  ▶ https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562
  ▶ https://www.aafp.org/afp/2017/0515/p655.html

Relationship to Person-Centered/ Directed Care

The movement toward person-centered care began slowly more than two decades ago, but is advancing more rapidly with reinforcement from the CMS Requirements of Participation for nursing homes. Person-centered care (increasingly referred to as person-directed supports and services) is based upon the needs and preferences of each unique individual. It stands in contrast to some more traditional medical approaches that emphasized efficiency, schedules and standardized processes that worked well for the organization.

> " Trauma-informed care is an important puzzle piece in providing person-centered care.

Person-centered care values the individual and seeks to know and partner with each person to provide what is needed in ways that are shaped by the individual. Rather than seeing the person as a series of diagnoses or challenges to be solved by the experts, this approach seeks to know and understand the person, and care provision is guided by the choices and priorities of the person. This can be manifest in everything from food and schedule preferences to respecting end of life wishes. Person-centered care requires meaningful interpersonal relationships. Even in situations where late-stage dementia is involved, close attention is paid to what works best for the individual.

Trauma-informed care is an important puzzle piece in providing person-centered care. Trauma-informed care emphasizes these six principles.

▶ **SAFETY**

▶ **TRUSTWORTHINESS AND TRANSPARENCY**

▶ **PEER SUPPORT**

▶ **COLLABORATION AND MUTUALITY**

▶ **EMPOWERMENT, VOICE, AND CHOICE,**

▶ **CULTURAL, HISTORICAL, AND GENDER ISSUES**

These principles align well with the best of person-centered and person-directed care. Integrating trauma-informed principles into the care model of the organization will strengthen all aspects of person-centered and person-directed care.

When staff members operate within such a culture, they are able to recognize the ways in which any person may have been affected by adverse events and are alert to partnering with each person to avoid re-traumatization. Person-centered care and trauma-informed care grow out of the same fundamental view that honors the self-hood of each person.

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Behavioral Health Resources

Most nursing homes will be creating trauma-informed organizations rather than providing trauma-specific treatment. Unless the organization has a depth of expertise in behavioral health, it will need to identify resources in the community to which it can refer for trauma-specific treatment.

To comply with behavioral health-related CMS Requirements of Participation, organizations will be assessing a resident's behavioral health status and identifying needs for specialized supports and services. In most cases, the organization will already have identified practitioners who can assess and provide treatment for a range of behavioral health issues as needed. It will be important to check to see which of these practitioners has experience and expertise in treating trauma, so that the appropriate referrals can be made.

That said, in many communities there is a paucity of behavioral health resources and even fewer with gerontology or trauma specialties. It may be helpful to look for practitioners who work with veterans, abuse survivors, Holocaust survivors or others who have experienced trauma. Veterans' organizations, domestic violence organizations, Jewish organizations and organizations working with youth in psychiatric or residential treatment settings may be good resources to identify practitioners with trauma-related experience.

As trauma-informed care is implemented, it is also important to assure that there are resources available to staff members who may also have experienced adverse events. Be sure to check with your employee assistance program provider to learn what resources they have available for trauma-related concerns.

Create a list of organizations and practitioners who can provide trauma-specific treatment. This must be a high priority when implementing trauma-

informed care. Keep in mind that other service sectors may not be informed about the CMS change. Creating a dialogue that shares the needs of your organization and learns about the trauma-informed experiences of potential resources will help to find those experts that will best serve your residents and employees. Consider a protocol for a shared linkage agreement to assist in communication and shared expectations between organizations.

Possible Organizations & Practioners

Implications for Short and Long Stay Residents

Most nursing homes care for individuals who are with them for short rehabilitation-to-home stays, and also for individuals who have come to make this new setting their long-term home. As the organization plans to implement trauma-informed care there will be both similarities and differences in how they work with these two populations. In all circumstances, a trauma-informed organization will treat individuals in ways that promote safety, empowerment, transparency and respect.

Short Stay

Most people who are admitted for post-acute rehabilitation stay from three to 30 days. Since these are brief periods, the most important elements of trauma-informed care include:

▶ Employing universal trauma precautions in all interactions

▶ Explaining each medical/ care interaction in advance

▶ Informing individuals and their families about the organization's commitment to trauma-informed care

▶ Asking individuals, and when appropriate their families, about their preferences, including what will make them feel more safe and comfortable during their stay

▶ Doing a basic psychosocial intake with normalizing, open-ended questions on prior adverse experiences; referral to trauma-specific treatment when appropriate

▶ Considering whether the experience that led to the short stay may itself have been traumatic — for example, an accident or fall, or a frightening medical crisis

▶ Ensuring that discharge planning facilitates return to a safe home setting

Long-Term Care

For many individuals the nursing home will be their longer-term home. Many of the elements of trauma-informed care for short-stays apply:

▶ Employing universal trauma precautions in all interactions

▶ Explaining each medical/ care interaction in advance

▶ Informing individuals and their families about the organization's commitment to trauma-informed care

▶ Asking individuals, and when appropriate their families, about their preferences, including what will make them feel more safe and comfortable during their stay

▶ Doing a basic psychosocial intake with normalizing, open-ended questions on prior adverse experiences; referral to trauma-specific treatment when appropriate

And, while these elements apply to short stay residents as well, for people who will be moving into a nursing home for the long term the following will also be especially important:

▶ Learning as much as possible about the individual's preferences and needs

▶ Communicating with clarity, respect and transparency

▶ Asking and observing the situations and interactions that create well-being, engagement and a sense of safety on the part of the individual

▶ Recognizing that many individuals who are long-stay residents have some level of cognitive impairment that may require additional sensitivities

Staff and Trauma-Informed Care

Staff Affected by Adverse Experiences

The inclusion of a focus on trauma-informed care in the CMS Requirements of Participation for nursing homes reflects increasing recognition that the experience of trauma is widespread across the population. This includes staff members.

The ACEs study[13] demonstrates the likelihood that there are staff members at all levels of the organization who have experienced challenging life experiences. It is also likely that each of these staff members will be in a variety of situations or places with respect to the trauma they have experienced. For some, challenging life events resulted in a traumatic stress response or more significant response. It is impossible to look at someone and know whether they have experienced trauma. Further it is unwise to assume or diagnose.

Some trauma-impacted employees may have recognized the trauma and received trauma-specific treatment. These individuals may know what works best for them in coping with and healing from the long-term effects of trauma. These individuals, if willing to self-identify, may be good resources for the organization in its trauma-informed journey.

Other staff members may acknowledge that they have had difficult childhoods, lived through natural disasters or fled from war-torn countries. Yet others may be currently living in situations of domestic violence or other ongoing trauma. Some staff members will not be aware of how trauma has, or is, affecting them, nor of what might trigger their own re-traumatization.

Additionally, it is important to respect and understand that two individuals who have experienced the same event will not necessarily both identify the event as traumatic. Therefore, it is vital for employees and residents to avoid creating a predetermined list of what is considered traumatic.

It must also be acknowledged that working in the nursing home setting can, at times, result in stressful or challenging experiences. Unfortunately, there are also times of trauma in the nursing facility that may include violence, assault, disaster, and so forth. These may initiate a stress response or spark a traumatic stress response from a prior life experience.

It is for these reasons that training in trauma-informed care should be approached with care and sensitivity. When introducing trauma-informed care and throughout implementation, it is important to let staff members know that it is understood that this may be difficult subject matter and individuals need to do what is helpful for them to feel grounded and safe. As noted elsewhere in this Guidebook, it will be helpful to discuss your organization's implementation of trauma-informed care with your Employee Assistance Program (EAP) and to have them identify trauma-specific treatment expertise when needed.

Fortunately, a trauma-informed organization is a work environment that supports employees. A trauma-informed organizational culture provides an understanding, safe, transparent and empowered community of employees who recognize the signs and symptoms of potential traumas for themselves, colleagues, and residents. ▶ ▶ ▶

▶ ▶ ▶ *Staff and Trauma-Informed Care Continued.*

Staff Working with Residents Affected by Trauma

Organizations that have provided supports and services to aging veterans and Holocaust Survivors have come to assume that past trauma is a very present issue for many people they serve. They have learned what some of the specific triggers might be and have taken steps to minimize those. They have worked closely with families and learned from their wisdom and experience. They have also honored the resilience of individuals who have been through trauma when young and who have persisted nonetheless. Staff members who have worked regularly with individuals affected by trauma have learned a great deal about trauma-informed care, even if simply through experience.

At times, as noted above, staff members in these environments recognize that they themselves have been affected by the traumatic experiences of the individuals for whom they are caring. This phenomenon is called secondary or vicarious trauma. In all settings, it is important to be alert to the potential for secondary trauma among staff members for whom the traumatic stories and experiences of others may cause emotional duress. Good self-care and peer support will be valuable for them.

Staff Benefit from Trauma-Informed Workplace Cultures

By creating trauma-informed cultures, residents and employees will benefit from a safe, supportive, trustworthy and responsive environment. Trauma-informed workplaces that truly embrace the principles are great places to work. They emphasize these basic principles:

▶ Safety – physically, socially and psychologically safe communities

▶ Trustworthiness and transparency – above board, straightforward communication

▶ Peer Support – being able to count on others in an open and caring way; that means asking and offering help

▶ Collaboration and Mutuality – an emphasis on leveling power differences and valuing all

▶ Empowerment, Voice, and Choice – recognizes, encourages and builds on the strengths of everyone

▶ Cultural, Historical, and Gender Issues – moves beyond stereotypes and is culturally aware

Staff wellness and self-care are high priorities, as is accountability to one another. In a trauma-informed environment staff learn that trust must be earned and not assumed. Positive working relationships are respectful and provide support, safety, and calming in times of stress. Cultural humility is practiced. Organizations committed to trauma-informed care believe that this culture contributes to greater workplace engagement and satisfaction, and increases retention. Therefore, as trauma-informed care is implemented employee reviews and evaluations should incorporate the ways in which employees demonstrate its principles and practices.

Families and Trauma

Each family*, as is true with individuals, experiences trauma differently depending on the nature and duration of the trauma and the specific characteristics and circumstances of the family. In the nursing home setting, some family members have very close relationships with the patient/ resident/ client (hereafter resident in this section) and others may be distant or have only occasional contact. It is important to extend the trauma-informed care approach to all family members and this begins with communication that is open, transparent, and respectful.

Communication with families emphasizing that the organization practices trauma-informed care is beneficial in many ways. It provides the opportunity for family members to share their own or the resident's trauma history. It reassures family members that there will be an emphasis on safety, dignity, collaboration and respect. And, it opens the door for spreading the word about the lasting effects of trauma, and the opportunity to reduce shame and stigma. ▶▶▶

Families may be affected by trauma in many ways. And, the trauma(s) may have been experienced directly by the resident, their child or children, their spouse, their ancestors, and/or the entire nuclear or extended family. Consider just a few examples:

- ▶ The resident has recently experienced physical and/or emotional abuse by a family member.
- ▶ The resident was a refugee from war or genocide in another country as a young adult.
- ▶ The resident abused his daughter and was, himself, abused as a child.
- ▶ The family has lived in a violent, distressed and disinvested urban neighborhood and has witnessed and experienced violent death, poverty and racism for several generations.

- ▶ The family lives with the legacy of the resident having survived the Holocaust when many family members did not.
- ▶ The resident is a combat veteran and the effects of his post-traumatic stress has been a challenge for the family.
- ▶ The resident grew up with a parent with mental illness and substance misuse, but her children do not know that.
- ▶ The family experienced a devastating fire that consumed their home and resulted in a loss of life.
- ▶ One family member has had a serious chronic illness and has experienced difficult medical procedures, some of which were painful and frightening.

And, of course, the list could go on and on. As could descriptions of the ways in which these adverse experiences affected these families. Family responses could include:

- ▶ Breaking the cycle of trauma through counseling and intentional resilience building
- ▶ Keeping secrets and just moving on
- ▶ Using a variety of coping and defense mechanisms that worked, but in some ways have had adverse and unintended consequences
- ▶ Extreme dysfunction
- ▶ Fractured relationships
- ▶ Not recognizing or understanding the long-term effects of the trauma
- ▶ Recognizing and acknowledging the trauma and dealing with it as issues arise
- ▶ Using the family as a resource in ways that strengthen bonds and help with coping

Again, the list could be nearly endless. Recognizing these ripple effects, the importance of including families in a trauma-informed approach becomes clear. ▶▶▶

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* Please note that family here is meant to include biological relatives and/or others who are in close and caring relationship with the resident. In other words, a person's family includes those s/he chooses to include.

▶▶▶ *Families and Trauma Continued.* Even though the nursing home may not be providing trauma-specific treatment to residents and their families, implementing a trauma-informed approach will mean the entire staff is alert to the ways in which residents and their families may have been affected by trauma. And, consequently, they will engage with family members in new ways. For example:

▶ They will recognize that trauma may be the genesis of discord among family members regarding the course of treatment.

▶ When trauma is identified and treatment Is recommended, they will encourage the family to become involved, and will encourage families to view adverse experiences as challenges for the family to face together. However, trauma sometimes fractures family relationships and some family members, to keep healthy boundaries, may choose not to associate with others.

▶ They will treat family members with the same open, respectful, collaborative principles as they do residents and staff members.

▶ They will create safety and respect for the resident as a first priority.

▶ They will address the intersections of trauma with culture, history, race, gender, language, and will value the unique needs of diverse communities.

Trauma-informed care affects every aspect of the functioning of the organization – including relationships with families.

> " It is important to extend the trauma-informed care approach to all family members and this begins with communication that is open, transparent, and respectful.

As noted in the staff section of this book, consider:

SAFETY – physically, socially, and psychologically safe communities

- For families this may take the shape of welcoming facilities, approachable employees, operating without blame and judgement directed at the family or resident when difficult issues arise, and openness to receive feedback, concerns or questions from family members.

TRUSTWORTHINESS AND TRANSPARENCY – above board, straightforward communication

- For families this may mean extraordinary customer service when responding to questions, asking questions, and treating information that is shared with great care.

PEER SUPPORT – being able to count on others in an open and caring way; that means asking and offering help

- For families, this could mean creating support opportunities with other families, or permission to maximize a trusted relationship with staff regardless of the position in the organization.

COLLABORATION AND MUTUALITY – an emphasis on leveling power differences and valuing all

- All employees carry out their work acknowledging the expertise and importance of the family and their experiences in the care and service for the resident.

EMPOWERMENT, VOICE, AND CHOICE – recognizes, encourages and builds on the strengths of everyone

- As noted above, families feel invited and safe to join fully in the care or treatment team.

CULTURAL, HISTORICAL, AND GENDER ISSUES – moves beyond stereotypes and is culturally aware

- Relationships with the family must respect culture, history, gender, ethnic or other issues that may be similar to, or perhaps somewhat different from, the resident. All relationships respect the individual's uniqueness and value.

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Policies and Procedures

An important part of building a trauma-informed organizational culture is including trauma-informed care in the organization's policies and procedures. This includes both how policies and procedures are developed, and how they are operationalized. In the journey of becoming trauma-informed, tending how trauma-informed principles and practices are threaded through policies and procedures will advance success. Leaders need to ensure that all relevant policies and procedures reflect the organization's trauma-informed principles and practices. Pay particular attention to the following:

▶ *Human Resources*
- Background screening
- New staff orientation
- Training – staff and supervisors
- Support for supervisors to coach employee performance using a trauma-informed lens
- Performance review documentation and process
- Employee development plans including progressive discipline
- Grievance and other conflict resolutions models and practices
- Employee Assistance Program
- Temporary or agency staff
- Contracted health professionals

▶ *Environmental Services*
- Safety
- Privacy
- Security

▶ *Care Planning*
- Assessments
- Person-Centered care planning
- Mood and behavior policies
- Specialist referrals
- Discharge planning

▶ *Abuse and Reporting*

▶ *Quality Assurance and Performance Improvement*

▶ *Financial and Budget Policies*

▶ *Communications*
- With employees
- With residents
- With families
- With others – volunteers, stakeholders, vendors, and contractors

Governance-Related Policies

Once again, it is critical that in drafting and revising policies and procedures these basic principles are addressed:

▶ **SAFETY** — physically, socially and psychologically safe communities

▶ **TRUSTWORTHINESS AND TRANSPARENCY** — above board, straightforward communication

▶ **PEER SUPPORT** — being able to count on others in an open and caring way; that means asking and offering help

▶ **COLLABORATION AND MUTUALITY** — an emphasis on leveling power differences and valuing all

▶ **EMPOWERMENT, VOICE, AND CHOICE** — recognizes, encourages and builds on the strengths of everyone

▶ **CULTURAL, HISTORICAL, AND GENDER ISSUES** — moves beyond stereotypes and is culturally aware

RESOURCES
Statement Of Intent

As you undertake the journey of adopting trauma-informed approaches to care in your organization, we encourage you to review and adopt the following Statement of Intent, or something similar, as a formal indication of your understanding of what is involved and your commitment to enhancing your ability to provide person-centered care to residents who have experienced trauma.

As an organization, we are committed to learning about trauma and its effects and to engage with and implement trauma-informed approaches to the care we provide and the organizational culture we create.

We understand that:

▶ Trauma-informed care is an important component of enacting our commitment to person-centered care through which we offer individualized support and services that are responsive to our residents' wishes and goals;

▶ Our work will be informed by the guidance offered to us by the Substance Abuse and Mental Health Services Administration in its 2014 publication, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach;*

▶ Trauma impacts a significant portion of the population across the lifespan and produces physical, mental, and social health outcomes that complicate aging and can, if unrecognized, be misunderstood as manifestations of other conditions and disorders and thus subject to inappropriate treatment;

▶ Residents who have a trauma history deserve access to care that is trauma-sensitive and behavioral health treatment, as appropriate, that is trauma-specific;

▶ Our organization can and should have an organizational culture that is trauma-responsive and so avoids re-traumatizing residents and creates an environment of safety;

▶ Our staff members will need skills and guidance on identifying symptoms of trauma, talking with residents about trauma, and acting in a trauma-responsive manner;

▶ Our staff members deserve an environment and supports that acknowledge their own experiences of trauma and that working with residents with trauma histories can result in secondary or vicarious trauma for staff;

▶ We intend to involve our residents and their families as well as staff members and community partners in this journey through education and opportunities to provide input;

▶ As leaders, we must demonstrate our commitment to this approach and to sponsoring the systems change process involved in creating a trauma-informed culture;

▶ The work of implanting trauma-informed care and creating a trauma-informed culture takes time, the investment of resources, and accountability mechanisms;

▶ We are committed to full implementation of the trauma-informed care requirements as codified in the CMS Final Rule — these requirements pertain to comprehensive person-centered care planning (42 CFR 483.21(b)3(iii), quality of care (42 CFR 483.25) and behavioral health services (42 CFR 483.40).

Preliminary Organizational Assessment

The following questions are designed to help you assess the current state of your organization as you begin to implement trauma-informed care, and to identify areas that may require greater focus prior to launching a formal initiative.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't Know
Intake and Admissions					
Our admissions staff are trained to use a strengths-based, person-centered approach to interviews with prospective and new residents and family members.					
Our admissions staff ask questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Our admissions staff use a sensitive and respectful approach to interviews and respond to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
The form completed by the potential resident's physician asks one or more questions concerning adverse life experiences that may impact him or her.					

Please rate the extent to which you agree that staff in each department is currently implementing the practice described.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't Know
Medicine					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
Nursing					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					

▶▶▶

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't Know
Physical, Occupational and Speech Therapy					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
Social Services / Social Work					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
Activities / Enrichment					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
Discharge Planning					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to ensuring a smooth transition post-discharge and the continuing provision of quality care.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					

▶ ▶ ▶

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Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't Know
Environmental Services					
Using a strengths-based, person-centered approach in interacting with and providing care for residents and in interacting with family members.					
When appropriate, asking questions concerning prior life experiences that might impact the individual and be important to providing quality care.					
Using a sensitive and respectful approach to interactions, and responding to any emotional disclosures or reactions in a gentle, non-confrontational manner.					
Additional Dimensions *Below are statements about the capacity of your current staff to implement specific aspects of a trauma-informed approach. Please indicate the extent to which you are confident that staff in each specified area is ready and able to do so at this time. Please factor in both skills and attitudes in your rating.*					

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure/ Don't Know
The lead staff person in Environmental Services can design and implement a systematic review of our physical environment in a trauma-sensitive manner, looking for ways in which our facility may feel unsafe or may contribute to agitation.					
The lead staff person responsible for Training and Workforce Development can design and implement introductory education and training on trauma, traumatic stress and trauma-informed care for all staff.					
The Trauma-Informed Care team is prepared to design a way to track and assess progress toward trauma-informed care and achievement of related goals.					
The lead staff person for Human Resources can coach supervisors on managing staff to ensure trauma-informed care is provided.					
The lead staff person for human resources can coach supervisors on ways to support staff experiencing vicarious trauma or the impact of their own prior adverse experiences.					
The organization is prepared to help staff and residents access behavioral health resources.					
Additional Comments:					

Trauma-Informed Care Implementation Team Formation Worksheet

As you identify individuals who might add to the work of this team, keep in mind that it is important to select staff members from different levels – from senior leaders to direct care workers. It is also important that those selected be individuals whom others trust, and who are willing and able to be champions of trauma-informed care.

Departments	Potential Candidates	Individual(s) Selected & Agreeing to Serve	Notes
Nursing/Clinical			
Direct Care			
Social Work			
Spiritual Life/ Chaplaincy			
Human Resources			
Environmental Services			
Other			

Person who will manage coordination and communication:

Meeting schedule:

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Implementation Plan Checklist

Task	Who	What	When	Notes
Read Foundations of Trauma-Informed Care: A Primer				
Adopt a Statement of Intent				
Read relevant sections of CMS Requirements of Participation and CMS Guidance				
Read Implementing Trauma-Informed Care: A Guidebook				
Identify abuse reporting requirements				
Form a Trauma-Informed Care Implementation Team				
Orient team to team roles and to trauma-informed basics				
Hold a launch event to announce the trauma-informed care journey				
Educate all staff on trauma-informed care basics				
Establish a budget for trauma-informed care implementation				
Create a communication plan				
Perform a preliminary organizational assessment				
Develop a plan to address assessment results				

▶ ▶ ▶

▶ ▶ ▶ *Implementation Plan Checklist Continued.*

Task	Who	What	When	Notes
Address human resource practice intersections				
Address trauma-informed care with physicians and other contracted health professionals				
Identify and implement practices across the organization that create a culture of safety, respect, openness, empowerment, and collaboration				
Use external training and consultation as needed				
Identify potential barriers to implementation				
Review, revise and add to policies and procedures				
Identify behavioral health resources for residents and staff				
Establish and monitor measures of success in implementation				
Make plans to move to Level Two implementation				

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Leading Change

Creating a trauma-informed organization means creating a culture that is respectful, open, and emotionally safe for everyone. The process of becoming a trauma-informed organization will require new ways of thinking and acting. Recognizing that most organizations are also in the midst of enacting many other types of changes and transformations, this chapter will suggest a few perspectives on leading change, and will identify additional helpful resources.

John Kotter, in his classic book *Leading Change,*[14] identified an **eight step model** for change that may be helpful in implementing trauma-informed care.

One could translate Kotter's steps into a trauma-informed frame:

STEP 1. CREATE SAFETY — establish the importance of safety

STEP 2. IDENTIFY TEAM — collaborate with all stakeholders and identify an implementation team that is empowered

STEP 3. DEVELOP VISION — together, including leadership and the implementation team, develop a vision for change
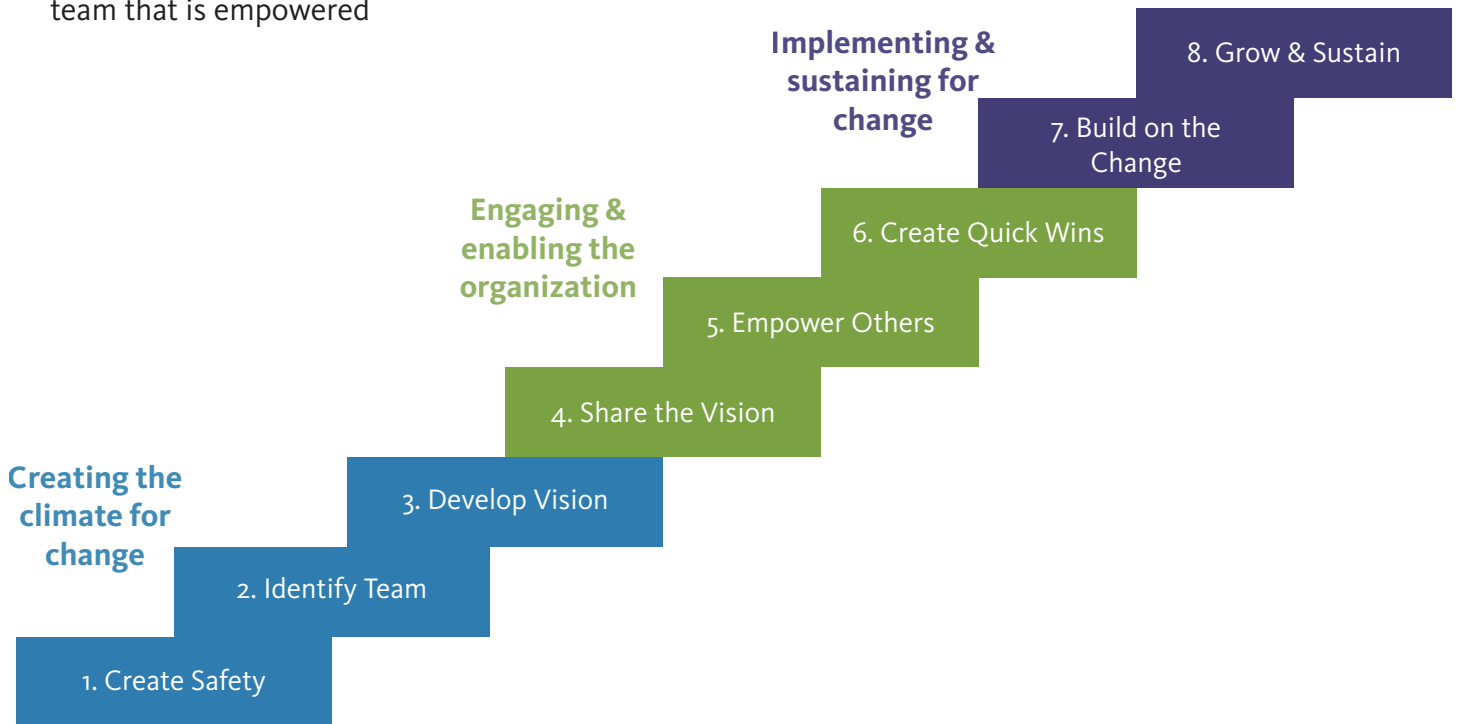
STEP 4. SHARE THE VISION — share that vision to build safety, transparency, and collaboration broadly

STEP 5. EMPOWER OTHERS — empowering others increases transparency and collaboration, and builds safety

STEP 6. CREATE QUICK WINS — plan for and create short term wins to build trust, and celebrate these

STEP 7. BUILD ON THE CHANGE — continue to emphasize collaboration, empowerment, and communication to sustain momentum

STEP 8. GROW AND SUSTAIN — incorporate ongoing change to develop, grow and sustain a trauma-informed culture ▶▶▶

Implementing & sustaining for change

8. Grow & Sustain

7. Build on the Change

Engaging & enabling the organization

6. Create Quick Wins

5. Empower Others

4. Share the Vision

Creating the climate for change

3. Develop Vision

2. Identify Team

1. Create Safety

▶▶▶ *Leading Change Continued.* Another long-time voice regarding change, William Bridges, talks about the people side of change in *Managing Transitions: Making the Most of Change.*[15] He suggests that change is situational and is often an external event (such as the implementation of trauma-informed care), while transition is the inner psychological process that individuals go through as they deal with the change. People change when they identify and grieve the losses that change involves and are able to let go of the old way. They then enter a neutral zone where the new is not yet fully embraced nor comfortable. If the transition is managed well, people move into the new reality with fresh energy and a clear understanding of how they can contribute to the vision. Bridges says that a change can work only if the people affected by it can successfully get through the transition it causes. So, it is important to recognize that different people will react differently to change and will move through transitions at different rates.

Since implementing trauma-informed care means some fundamental changes to organizational culture, here are some questions that it may be helpful to think through:

What is changing?	
What will actually be different because of the change?	
Who is going to lose what?	
What is the reason for the change?	
What are the anticipated benefits?	
And then what?	

Be aware of some of the reasons that individuals resist change. These may include:

- ▶ Weariness with constant change
- ▶ Not understanding the "why" or "what" of the change
- ▶ Uneasiness with the unknown
- ▶ Wondering if this is "the latest fad"
- ▶ Not feeling part of the change
- ▶ Lack of trust in those leading the change
- ▶ Seeing no positive benefit to the change

Again, from a trauma-informed perspective, resistance to change can result from a feeling of a lack of safety, or could result from insufficient information, or a lack of transparency or trust. Collaboration is critical in gaining buy-in for change.

For change to be successful, good leadership is needed. The team responsible for implementing trauma-informed care must communicate that this is a high priority, not only to comply with requirements, but also to create an organizational environment that will benefit staff members as well as patients/ clients/ residents. Leaders would be served well to tend direct and indirect communication. This may include how projects are prioritized and/or what resources are committed to the change effort. Facilitative leadership that models the change, listens and engages staff at all levels of the organization in coming up with ideas, and continually reinforces the change can help people embrace a trauma-informed culture.

Getting the Board 'on Board'

When an organization commits to trauma-informed care it must do so at every level. Staff leadership should work with the Board of Directors/ investors/ owners or others in governance roles to educate them about trauma-informed care and gain their commitment. It is important to emphasize that while implementing trauma-informed care is a Requirement of Participation for nursing homes in the Medicare and Medicaid programs, the organization is embracing this approach for the good of residents and staff alike.

Having those with the ultimate spending and prioritizing authority committed will ensure that the appropriate resources will be devoted to implementing and improving trauma-informed care.

There are many approaches to getting the Board 'on board', and this list of possibilities should spark additional ideas:

1. Share *Foundations of Trauma-Informed Care: A Primer* and invite them to read and discuss it.
2. Share the Statement of Intent found in this guidebook and invite adoption.
3. Ask members of the Trauma-Informed Care Implementation Team to do a presentation on the basics of trauma-informed care and the ways the organization plans to implement it.
4. Facilitate a discussion about how trauma-informed care fits into existing organizational priorities, like providing person-centered and person-directed care.
5. Invite your lead human resources staff person to talk about organizational culture, employee engagement and the role of a trauma-informed approach in creating a positive workplace environment and improving retention.
6. Invite those in governance roles to attend webinars or conference presentations.
7. If the Board engages in strategic or generative discussions at its meetings, make trauma-informed care a topic. Explore how trauma-informed care will strengthen the organization.
8. Invite the leadership of a trauma-informed organization from another field, such as children's services or behavioral health, to share how their organization has changed as a result of implementing trauma-informed care principles and practices.
9. Invite people with lived experience of the issue to share their stories.
10. Invite behavioral health experts (perhaps from your Employee Assistance Program) to discuss the importance and impact of trauma-informed work.

> **"**The organization is embracing this approach for the good of residents and staff alike.

However your organization chooses to engage those in governance roles, this will be a critical step in becoming a trauma-informed organization. By engaging the thoughts and feelings of all stakeholders about this change and by tending implementation with sensitivity, the organization will have a good beginning for creating a trauma-informed organization.

Staff Knowledge: Pre- and Post-Test

When training staff members about trauma-informed care, organizations may find it useful to administer this pre- and post-test to document each staff member's understanding of trauma-informed care. This is the answer key and the next sheet can be duplicated for use with staff members.

1. Experiencing trauma causes changes in the brain and body that occur without us even knowing it.

   a. True

   b. False

2. If an older person has experienced trauma, which of the following is NOT true:

   a. Providing support and a safe environment can help an older person heal.

   b. Our brains can really only heal and change when we are young.

   c. Older persons may feel uncomfortable talking about a past trauma because of the fear of stigma.

   d. Older persons may have experienced childhood trauma, adverse events throughout life, and specific losses associated with aging itself.

3. One key sign that an organization is "trauma-informed" is when the organization's environment <u>feels</u> and <u>is</u> safe and supportive for all people who have experienced trauma.

   a. True

   b. False

4. Only a small portion of the population has actually lived through a traumatic experience.

   a. True

   b. False

5. Trauma can be caused by:

   a. Natural disasters like fires, tornados, or floods

   b. Car, train, or airplane crashes

   c. Being the victim of or witnessing violence

   d. Emotional abuse or neglect

   e. All of the above

6. Trauma affects a survivors' health and well-being only in the days and months immediately following the traumatic experience.

   a. True

   b. False

7. If someone has lived through a traumatic experience, which of the following is true?

   a. The person might show physical signs like headaches and fatigue.

   b. The person might show emotional responses like irritability, depression, or anxiety.

   c. Every person who experiences trauma will experience the same symptoms.

   d. Both A and B

8. Learning about the signs and symptoms of trauma is important because:

   a. We can help ensure that the older persons in our care feel safe.

   b. It can help prevent misdiagnosis and unnecessary use of antipsychotic medications.

   c. It can prevent us from unknowingly re-traumatizing someone.

   d. It can help us make sense of puzzling behavior.

   e. All of the above

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9. Triggers are things that might remind someone of dangerous or frightening things that have happened in their past.

   a. True

   b. False

10. Which of these statements are true?

   a. Stress and trauma aren't exactly the same thing.

   b. Traumatic stress occurs when a person's ability to cope with an adverse experience is overwhelmed.

   c. A person's reaction to an adverse event is not a choice.

   d. A and B

   e. All of the above

11. Staff members throughout the organization may have experienced trauma.

   a. True

   b. False

12. Which of these statements is true?

   a. We need to know the specifics of a person's trauma in order to create a safe environment.

   b. Only social workers need to know about trauma.

   c. Creating a trauma-informed organization improves things for both staff members and older adults.

   d. People with dementia will forget their traumatic experiences.

A printable version of the Pre- and Post-Test can be found on the following pages.

TRAUMA-INFORMED CARE PRE- AND POST-TEST

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ENDNOTES

1   Karen Heller Key, Foundations of Trauma-Informed Care: An Introductory Primer (Baltimore, MD: LeadingAge Maryland/ Resilience for All Ages, 2018).

2   "CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-term Care Facility Residents", Center for Medicare and Medicaid Services, September 28, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-28.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir+descending.

3   Please note that for purposes of this paper and for ease of communication we are using the term "resident" to refer to individuals receiving care in a nursing home community. We do so cognizant of the fact that many communities provide rehabilitative care of shorter duration, and in those cases individuals are typically referred to as patients or using other terms.

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6   Mark D. Lerner and Raymond D. Shelton, Acute Traumatic Stress Management ™, PDF © by The American Academy of Experts in Traumatic Stress, Inc. 2001.

7   Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-14884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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10 Dr. Mark Lachman, http://www.sinaihealthsystem.ca/news/post-traumatic-stress-disorder-dementia/, accessed February 2019.

11 J. Scott Janssen, MSW, LCSW, Trauma-Informed Dementia Care, Social Work Today, https://www.socialworktoday.com/archive/exc_0218.shtml, accessed February 2019.

12 Sheela Raja, PhD; Memoona Hasnain, MD, MHPE, PhD; Michelle Hoersch, MS; Stephanie Grove-Yin, MD; Chelsea Rajagopalan, BS, Trauma Informed Care in Medicine- Current Knowledge and Future Research Directions, Family Community Health, Vol.38, No.3, pp.216-226. Copyright 2015 Wolters Kluwer Health, Inc.

13 Felitti et al., "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study."

14 John P. Kotter, Leading Change. (Boston, MA: Harvard Business School Press, 1996).

15 William Bridges with Susan Bridges, Managing Transitions: Making the Most of Change 25th Anniversary Edition (Boston, MA. Da Capo Press, 2016).

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