When the federal nursing home regulations first called for facilities to provide trauma-informed approaches as part of person-centered care as of November 2019, this complex issue received tremendous attention. Then the pandemic hit, and trauma-informed care (TIC) got pushed to the back burner as all efforts focused on managing the pandemic. Yet as the ravages of the pandemic built, the importance of TIC for staff, residents, and families reemerged. Residents and staff alike struggled with a multitude of losses, including the deaths of family and friends and curtailed connections, routines, predictability, and even sense of purpose.

What Is Trauma?
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as resulting 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" ("Trauma and Violence, updated Aug. 2, 2019, https://www.samhsa.gov/trauma-violence). However, there are other definitions. For instance, the American Psychological Association (APA) defines it as "any disturbing experience that psychological well-being"

As the ravages of the pandemic built, the importance of trauma-informed care for staff, residents, and families took center stage.

The Impact of Pandemic-Related Stress and Trauma in Post-Acute and Long-Term Care Settings
By Lisa Lind, PhD, ABPP

For those of us working in post-acute and long-term care settings during the COVID-19 pandemic, we vividly recall where we were when we heard that a novel coronavirus was detected in a nursing home in Kirkland, WA. We recall the video footage of the ambulances taking residents to the hospital. We remember when the directive of mandatory visitation restrictions was put in place and watched the impact it had on residents.

We’ve been tested for COVID-19 more times than we can count and have tried to engage in meaningful conversations through masks and face shields. We remember the feeling of walking up to our patient’s room only to find an empty bed — and sometimes an entire wing of empty beds. Some of us have tested positive and hoped we would survive unchanged. We have lost patients, colleagues, family, and friends. We remember the feelings of helplessness, sadness, grief, and anxiety of the past two years.

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TIC Story

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results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of function” as well as “any serious physical injury” (https://dictionary.apa.org/trauma).

Whatever definition of trauma that a facility uses, it is important that the team shares a common understanding. “Educate everyone including outside people coming in to do behavioral health,” suggested Barbara Ganzel, PhD, LMSW, of the Clinical Associates of the Southern Tier in New York. This helps ensure that everyone is on the same page from the start.

There also are multiple definitions of TIC. Although the Centers for Medicare & Medicaid Services has yet to provide a formal definition for use in PALTC, Dr. Ganzel noted that the agency “is pointing us toward the SAMHSA definition,” which says that “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and systems involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization” (SAMHSA’s Trauma and Justice Strategic Initiative, SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach, HHS Publication No. (SMA) 14-4884, July 2014, http://bit.ly/3AqbMKY).

TIC isn’t about pushing or forcing people to confront or address their traumas. Instead, it offers them an opportunity to consider the impact of a trauma, how they’ve coped in the past, and how we can avoid retraumatization and trigger re-traumatization.

Trauma is very personal, and it is very common. All individuals have experienced negative things in their lives, but they don’t all react the same way. “The data suggest that about 80% of the general population has a trauma in their past, but everyone has developed different ways of coping with things happening around them—whether personal or being taken out of their home and being put into a new environment,” said Dr. Ganzel. She added, “Trauma accumulates over time. Just because someone has been exposed to a trauma doesn’t mean that they have post-traumatic stress disorder. But as people become older and sicker, their coping mechanisms diminish; and they may react more to triggers.”

“The lens has to shift from diagnosis to a focus on symptoms,” said Dr. Ganzel. TIC also means moving from asking “What’s wrong with you?” to “What’s happened to you?” TIC also demands working with residents as key staff, said Dr. Ganzel suggested, “there are people who will insist that treatment is not part of trauma-informed care, but CMS is requiring that treatment be available to reduce symptoms related to trauma, whether or not there is a formal trauma-related diagnosis.”

Sarah Sjostrom, associate chief nursing officer at Hebrew Rehabilitation Center, Suffern, MA, said, “We need to think beyond regulatory requirements. It’s not enough to ask the questions, check the boxes, and be done with it. There should be more consideration and some assurance that the care being delivered addresses what TIC really means.”

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To enable them to recognize their own trauma system. The more they do this, the more they are able to help their residents.”

If you teach staff competent coping mechanisms, Dr. Ganzel observed, these help them, and they can impart these to residents. She stressed, “It’s important to teach them the difference between empathy and compassion. Empathy can lead them to re-experience traumas along with the residents. A compassionate response enables them to be more effective without depleting themselves. They need to be a compassionate, healing presence without costing them personally. This has to come out of trauma symptom management training.”

Helping staff understand what to watch and listen for is at the core of TIC. For instance, Dr. Ganzel said, “One nursing home resident started staying up at night. She didn’t want to go back to bed.” She was becoming incontinent, and she was agitated and irritable. Her care team didn’t understand what was happening with her until she was talking to a staff member one night. She told the story of having a puppy when she was a child. It was having accidents in the house, and her mother told her father to take it out and shoot it. The staff realized that her incontinence was triggering memories of this childhood trauma and causing her behavior. “Just understanding that there is something behind the behavior can make a huge difference,” Dr. Ganzel said.

Each organization will have different approaches to TIC implementation, said Ms. Sjostrom; but if a resident opens up and expresses a sensitive history, they likely have established a sense of safety with that individual. “We see that day in and day out with [certified nursing assistants] who have established a sense of trust and emotional safety with residents who seek to have these conversations. I wouldn’t encourage them to attempt any intervention alone, but they can listen and allow residents to express whatever they feel comfortable discussing,” she said. Then they can share this conversation with a nurse or other clinician and collaborate on interventions with the interdisciplinary care team.

The Power of Stress First Aid

“We have been deeply challenged by this pandemic, and this is where something like Stress First Aid [SFA] can help,” said Dr. Ganzel. SFA is a model designed to improve recovery from stress reactions. It supports and validates friendship, mentorship, and leadership actions through efforts to identify and address early signs of stress or regulatory concern, and to identify stress reactions in oneself and others and reduce the likelihood that outcomes evolve into more serious or long-term problems.

SFA is a peer support model, said Ms. Sjostrom. Its pieces are simple enough that it doesn’t require an advanced degree to use. “It’s about understanding the basic ways in which people may respond to stress and trauma and building awareness to recognize those in yourself and your colleagues.” SFA gives practitioners and staff on the front line a chance to step back and recognize their challenges. It gives them the support and tools to address issues proactively and not wait till they cause problems. “It doesn’t happen overnight, but over time you can build a more resilient team and organization,” suggested Ms. Sjostrom. “If you can truly get behind a program that supports staff and helps them support each other, it tells people that you’re there for them and trying to help healing,” said Dr. Ganzel.

Ms. Sjostrom added, “It may sound like a cliché, but it’s true. If you don’t take care of yourselves, you can’t care for others. The more we can support our teams, the better care we can provide.” She emphasized, “As we’re giving people tools and providing education, we need to be careful not to help people think that if you do this, you’re done. This is ongoing. You don’t do it once and assume everything is okay. The same is true of TIC.” (See Ms. Sjostrom’s article on Stress First Aid in this issue, p.15.)

Rolling Out TIC

Whether it’s for residents, which has some regulatory component, or staff, which isn’t regulated, TIC is only as good as the organization’s commitment to providing it. “If you don’t have good support to roll out a robust program that provides tools, training, and resources and you don’t have the commitment, it will be tough to get something meaningful off the ground. You have to commit to do more than just check the box. You have to be able to think beyond the regulations,” Ms. Sjostrom said. This calls for engagement and input of key staff, who have been given the training to identify potential concerns and possible symptoms of trauma and understand why this is important to the provision of quality care.

“In many ways, this is part of what they do every day — caring about residents and supporting them holistically,” said Ms. Sjostrom. “We can build this into workflows, but that requires staff to be well versed in what this means. You need to give people the why.”

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