Understanding Trauma-Informed Care in the PALTC Setting

"There are wounds that never show on the body that are deeper and more hurtful than anything that bleeds.” -Laurell K. Hamilton

T

raumatic events are increasingly common, and most individuals have experienced at least one traumatic event during their lifetime, including exposure to abuse or acts of violence, military combat, natural disasters, accidents, severe illness, disability or injury, discrimination, and harassment.

Everyone experiences and copes with adverse life events differently, and not all traumatic events will result in expressions or experiences of trauma. For instance, some individuals may experience posttraumatic growth and increased resilience. Limited social support, exposure to previous traumatic events, mental illness, genetic factors, and life stresses, such as sudden loss and financial instability, can all affect how an individual experiences a traumatic event.

The assessment, impact, and treatment of trauma have been well studied and implemented among children, adolescents, and veterans, but in the past several years there has been a growing recognition of the negative impact of past trauma on the health and quality of life of older adults. Unplanned transitions to post-acute and long-term care settings that are accompanied by loss of control, illness, disability, and lack of the usual support systems may result in the triggering or re-emergence of past trauma.

In November 2019, the Centers for Medicare & Medicaid Services began implementation of the third and final phase of the trauma-informed care provision for PALTC facilities (F699). The provision states that facilities “must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause retraumatization” (CMS, State Operations Manual, Appendix PP, 2017). Dr. Levenson’s article in this issue (p.6) provides a comprehensive overview of the associated regulations that focus on the provision of behavioral and mental health care and person-centered care planning for residents who have experienced trauma.

CMS has directed PALTC providers to the Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for definitions of concepts, principles associated with a trauma-informed approach, and guidance for implementation. However, surveyor guidance for trauma-informed care has yet to be made available as priorities have shifted to COVID-19 and infection control.

Despite the limited regulatory guidance on the implementation of trauma-informed care, those of us providing care in PALTC settings have seen the impact of traumatic experiences for residents, staff, and families, particularly during the past two years of the COVID-19 pandemic. We realize there is no time to waste. With so many competing demands and priorities, how can we integrate trauma-informed care into our workflow?

The Three Es of Trauma: Event, Experience, and Effect

First, it’s important to understand the SAMHSA definition of trauma and apply it to the PALTC context. SAMHSA defines trauma as an event or pattern of occurrences that is experienced as harmful or threatening and has ongoing negative effects on the person (SAMHSA’s Trauma and Justice Strategic Initiative, Concept of Trauma and Guidance for Trauma Informed Care Approach, HHS Publication No. (SMA) 14-4884, July 2014, https://bit.ly/3AqbMKY).

It is helpful to think through this definition with a specific example from the PALTC setting. While conducting a psychosocial assessment upon admission with Mrs. D and her daughter, I discovered that she was a survivor of intimate partner violence. Two decades earlier, Mrs. D experienced verbal and physical abuse from a man that she had been dating (event). Immediately after the end of this relationship, she experienced increased anxiety, a startle response, and avoided behavior whenever she heard people raising their voices or arguing (experience).

These symptoms gradually remitted over time. A male resident with Alzheimer’s disease was admitted a few weeks after Mrs. D. He occasionally became agitated in the evening and yelled loudly at the staff. Although his outbursts were never directed toward other residents, the staff would try to separate them as much as possible. It did not seem to be helping: Mrs. D appeared more anxious and fearful. She spent more time alone in her room and became somatically preoccupied with her limited mobility due to her diagnosis of Parkinson’s disease (effects).

Getting to Know Residents Through Ongoing Assessment

A trauma-informed care approach asks us to do something that long-term care does well: get to know the residents and consider their past experiences in order to offer the best care. To keep things simple at admission, consider designating a member of the interdisciplinary team to include a question about recent and past exposure to traumatic events. If the resident identifies a history of trauma, it may also be helpful to inquire about past coping strategies. This screen can be integrated into a psychosocial assessment and accompany depression screening.

A trauma-informed care approach asks us to do something that long-term care does well: get to know the residents and consider their past experiences in order to offer the best care.

Of course, learning the life stories of our residents does not only occur at admission; it continues over time as we all learn about residents’ likes and dislikes, life experiences, family relationships, interests, personality, and methods of coping. Although there are several instruments that assess the past histories and preferences of residents in order to promote person-centered care, one of my favorites is called “My Story,” which was developed by the Assisted Living Program of Anne Arundel County Department of Aging and Disabilities in Maryland to help learn about the unique needs and preferences of older adults. It is short, simple, pragmatic, and can be completed by the resident, family member, or staff. “My Story” is freely available (https://www.aacounty.org/services-and-programs/my-story) and includes an easy-to-use instructional guide.

Promote Choice and Control When Possible

Using a trauma-informed approach to care requires changes in clinical practice and more importantly at the organizational or systems level. Partnering with behavioral and mental health specialists and our social work colleagues is helpful, but all staff need to be informed and involved in order for trauma-informed care to be effective. Transitions through the health care system, illness or injury, and communal living that runs best on a schedule can all lessen an individual’s sense of control, which may trigger retraumatization. When possible, promote individual choice and help return a sense of autonomy by listening, validating, and involving residents in their own care.

For instance, while establishing a relationship with Mrs. D, one of the nursing assistants discovered that it was not only the presence of a raised male voice that she found distressing but also her inability to leave the situation of her own accord, which increased her fear and sense of helplessness. With this information, the clinical team was able to optimize the treatment of her Parkinson’s disease to allow for improved movement and make a referral to physical therapy to improve her ability to stand and ambulate safely with a walking cane. The staff reinforced this strength-based approach and helped to build Mrs. D’s resilience by engaging her in sit-to-stand
exercises and walking with her so she could eventually have an improved sense of autonomy about her own mobility.

Care for the Caregivers
Particularly over the past two years, the staff of PALTC have been exposed to previously unthinkable amounts of loss and stress. Caring for ourselves and one another has become even more important in these challenging times. In this issue, Yvette Erasmus PsyD, LP, shares with us some strategies for dealing with interpersonal conflict (p.13), and Lisa Lind, PhD, ABPP, addresses how to deal with loss and burnout (p.1). I would like to thank Paige Hector, LMSW, associate editor of Caring for the Ages, who enlisted the contributions of several experts in the field of trauma-informed care for this special issue.

While exercise, engaging in pleasurable hobbies, getting enough sleep, and eating better have all helped me over the past year, a colleague shared with me some action-oriented approaches to self-care. I consider these questions:

1. If nobody would be disappointed, would I prefer to say yes or no?
2. Looking at all positives and negatives, is fulfilling the request still worth it?
3. Would I feel comfortable making the same request of someone else?
4. By agreeing to the request, is this a precedent that I want to set for the future?

Saying “yes” is easy, but this short exercise has helped me slow down and consider whether this is truly something that I can take on at the present time. Please share with us your strategies for dealing with stress and promoting self-care.

Dr. Galik is editor in chief of Caring for the Ages. The views the editor expresses are her own and not necessarily those of the Society or any other entity. Dr. Galik is a nurse practitioner in LTC and community-based settings through a clinical practice with Sheppard Pratt Health System. She is a professor at the University of Maryland School of Nursing, where she teaches in the Adult-Gerontology Primary Care Nurse Practitioner Program and conducts research to improve care practices for older adults with dementia and their caregivers in long-term care. She may be reached at galik@umaryland.edu.

IN THIS ISSUE: KEY POINTS ABOUT TRAUMA-INFORMED CARE

• Everyone is exposed to traumatic events in their lifetime but they may not be traumatized by the events.
• When a person is triggered with a trauma reminder, also called retraumatization, their nervous system is activated. This nervous system response can be interpreted by the individual as “I’m not safe”, “I can’t protect myself”, or “I’m going to die”.
• Trauma-informed care (TIC) is founded on six principles including safety (physical and emotional); trustworthiness and transparency; collaboration; empowerment; choice; and diversity, equity, and inclusion.
• Staff should assume everyone has trauma exposure and approach all interactions with universal precautions, metaphorically “gloving and gowning” to reduce the possibility of retraumatization (see: Koury and Green, p.10 this issue).
• Approach people with the mindset of “What happened in your life (to you)?” instead of “What’s wrong with you?”
• Staff in the post-acute and long-term care setting screen for trauma while experts with trauma training assess the impact of the trauma.
• Becoming a TIC organization is a journey, not a destination, and it must include everyone who lives, works, and visits the facility.
• Multiple regulations address TIC (see Levenson, p.8 this issue).
• Being trauma-informed also supports staff in understanding their own trauma, particularly in the ongoing pandemic (see: Lind, p.1 this issue, and Sjostrom, p.14 this issue).
• Communication skills support a culture of TIC and can help bridge connections when frustrations are high (see Erasmus, p.13 this issue).
• Similar to best practices for medicine, there are best practices for empathy that include offering empathic responses, metaphorically “gloving and gowning” to reduce the possibility of retraumatization (see: Koury and Green, p.10 this issue).
• Approach people with the mindset of “What happened in your life (to you)?” instead of “What’s wrong with you?”
• Staff in the post-acute and long-term care setting screen for trauma while experts with trauma training assess the impact of the trauma.
• Becoming a TIC organization is a journey, not a destination, and it must include everyone who lives, works, and visits the facility.
• Multiple regulations address TIC (see Levenson, p.8 this issue).

Key points compiled by Paige Hector, LMSW, medical social worker, speaker, and associate editor of Caring for the Ages.