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RESILIENCE FOR ALL AGES

TRAUMA-INFORMED CARE UPDATE:

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INTRODUCTION

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. Among the many changes finalized in this rule were policies designed to strengthen the provision of person-centered care to residents. 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. 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 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.

While the third phase of the Requirements of Participation went into effect in November 2019, the CMS guidance regarding this phase was released in late June 2022. This update reflects that guidance and serves as a supplement to the other LeadingAge Trauma-Informed Care resources – the foundations toolkit and the implementation guidebook. Reviewing those resources as well as the CMS guidance will be good preparation for future surveys and for growing as a trauma-informed organization. As noted often, the CMS work on trauma-informed care and on culture is guided by the work of the Substance Abuse and Mental Health Services Administration.

F699 (483.25) on Trauma-Informed Care reads: "The facility 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 re-traumatization of the resident. The intent of this requirement is to ensure that facilities deliver care and services which, in addition to meeting professional standards, are delivered using approaches which as culturally-competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization." ▶▶▶

▶▶▶ *Introduction Continued.*

CMS has adapted the principles of trauma-informed care from SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach:

- **SAFETY** – *Ensuring residents have a sense of emotional and physical safety.*
- **TRUSTWORTHINESS & TRANSPARENCY** – *Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.*
- **PEER SUPPORT & MUTUAL SELF-HELP** – *If practicable, it may be appropriate to assist the resident in locating and arranging to attend support groups which are organized by qualified professionals. It may be possible for the group to meet in the facility.*
- **COLLABORATION** – *There is an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care and in developing the plan of care. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.*
- **EMPOWERMENT, VOICE, & CHOICE** – *Ensuring that the resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.*

Please note that the CMS guidance focuses narrowly on identifying residents who have experienced trauma, identifying situations and stimuli that may trigger trauma recall, and avoiding re-traumatization. It also calls for providing care in ways that are sensitive to cultural perspectives. Trauma-informed care in its truest and broadest sense involves a much wider approach that encompasses the entire organizational culture and benefits all residents, staff members, families, and volunteers. LeadingAge members are encouraged to go beyond compliance with the guidance to explore the wider context of trauma-informed care. ■

SCREENING

Since the experience of trauma is widespread it is always wise to assume the presence of trauma. General, normalized questions about experience of adverse events should be embedded into each psychosocial intake process.

Examples of general questions to begin inquiry might include:

> *"Because many people have had difficult experiences that have had long lasting effects for them, we have begun to ask some questions routinely. In your lifetime, have you had any stressful, frightening or upsetting experiences that have caused you ongoing distress?"*

If the answer is yes, follow up questions might include:

> *"In the past month, have these experiences caused you to..."*

- Have nightmares about it or think about it when you did not want to?
- Try hard not to think about it or go out of your way to avoid situations that reminded you of it?
- Be constantly on guard, watchful, or easily startled?
- Feel numb or detached from others, activities, or your surroundings?
- What is likely to trigger related feelings of fear, anxiety or anger?
- How will we know if a past experience is troubling you?
- What can we do to help you at those times?

It is important that each person be in control of what they wish to share and with whom. Experiences of trauma are quite powerful and many people are reluctant to share them with strangers. There are also several simple validated tools that can be self-administered (if the resident is able to complete one) and then shared with and discussed with the social worker. Links to publicly available, validated screening tools can be found in the resources section of this document. Helpful information from SAMHSA on screening for trauma is available here. The main goal of screening is to determine whether the person has a history of trauma and whether or not the person has trauma-related symptoms. It is important that the social worker doing the screening have awareness of any potential legal reporting requirements that might be at play.

The history and physical conducted by the attending physician may also uncover clues to a resident's history of trauma. Families may also be able to provide information that will be helpful in understanding a resident's trauma history, particularly with residents who have significant cognitive impairment. Observant staff members may also see signs of distress that may be the result of earlier trauma. For example, a cognitively impaired resident woke from a sound sleep and became agitated each night between 10:30 and 11:00pm. Searching for more understanding, staff noted that his room looked out onto the staff parking lot and at shift change there were car lights shining off and on. They replaced his blinds with those that blocked out the light and he slept through the night. They later learned that he was a veteran who had experienced combat. ▶▶▶

▶▶▶ *Screening Continued.*

In addition to the Resident Assessment Instrument, the psychosocial assessment should include an exploration of the resident's cultural needs and preferences. The CMS guidance places an emphasis on the intersection of trauma-informed care and culturally-competent care. Language, religious, practices, values, dietary restrictions, healthcare norms and protocols, and world view are quite different across groups, sub-groups, and individuals, so exploring those with the resident and family will help to assure that the individual receives care that is tailored to their unique needs and preferences. The guidance connects this important responsibility to many other aspects of care including quality of life, notifications, and more. The Facility Assessment (F838) should also address the cultural needs of resident populations. ■

> "It is important that each person be in control of what they wish to share and with whom."

CARE PLANNING

It is important that the nursing home organization has identified trained professional behavioral health resources with expertise in trauma treatment, so that the appropriate referral can be made in the event that a resident needs trauma-specific treatment and support. Support groups may be part of the treatment and support plan. This can then be incorporated into the care plan.

The entire staff of the organization should always assume the presence of trauma, know the basics of trauma-informed care, and use universal trauma precautions with all residents:

ASSUME that everyone has experienced trauma

APPROACH people from the front so that they are not startled

INTRODUCE YOURSELF and ask what the person prefers to be called

EXPLAIN what you will be doing and ask permission

ASK if there is anything that would make the person more comfortable

TALK with the resident, not over the resident

TREAT each person with dignity and respect, offering empowerment and choice to the degree possible

Note that many of these things also relate to resident rights and quality of life. All of these pieces fit together to make the full picture of person-centered care.

When developing a care plan for a person with a known history of trauma it is good to remember that trauma often involves being a victim of something beyond the person's control, so having control over the pace and content of trauma discussions is very important. ▶▶▶

▶▶▶ *Care Planning Continued.*

If the person is able and willing to share such information the care plan should:

▶ Identify the individual's goals related to trauma.

▶ Include interventions for any trauma-related symptoms such as substance misuse, depression, social withdrawal, anxiety, etc.

▶ Identify likely specific triggers of trauma and explain how that person's likely triggers will be mitigated (same sex caregivers, avoidance of loud situations, not attending upsetting movies, etc.).

▶ Identify ways staff can assist the person to move from the "there and then" to the "here and now" should the person become triggered (for example the 5,4,3,2,1 de-escalation of anxiety technique).

▶ Note helpful information provided by the family or resident's representative.

▶ Address trauma in the context of the resident's culture.

▶ Assure that staff members with a need to know are aware of triggers and ways to provide grounding when needed.

Of course, all guidance regarding F656 and care planning should be reflected in the Care Plan. ■

SURVEYS

To prepare for the trauma-informed care portion of a survey, it is wise to read the new guidance provided to the surveyors in the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities particularly F656 (pp229 and following), F699 (pp 419 and following), F726 (pp 462 and following), F742 (pp. 498 and following). The QSEP training slides are also useful - https://qsep.cms.gov/data/352/TraumaInformedCare.pdf.

Here is a quick summary of what is new.

New probes for 656 (Care planning) include:

▶ Does the care plan describe interventions that reflect the resident's cultural preferences, values, and practices?

▶ For residents with a history of trauma, does the care plan describe corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident? (See §483.25(m))

Key elements of noncompliance for 699 (Trauma-informed and culturally-competent care include:

"To cite deficient practice at F699, the surveyor's investigation will generally show that the facility failed to do any one of the following:

▶ Identify cultural preferences of residents who are trauma survivors;

▶ Identify a resident's past history of trauma, and/or triggers which may cause re-traumatization;

▶ Consistently use approaches that are culturally competent and/or are trauma-informed."

Surveyors will use the General Critical Element Pathway for 699 and there are multiple pages of new guidance at F699. ▶▶▶

▶▶▶ *Surveys Continued.*

No new survey guidance regarding trauma-informed and culturally competent care at 726 (Sufficient staff with appropriate competencies), but there are several relevant items:

▶ "Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas."

▶ "Cultural competencies help staff communicate effectively with residents and their families and help provide care that is appropriate to the culture and the individual. The term cultural competence (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. With regard to health care, cultural competence is a set of behaviors and attitudes held by clinicians that allows them to communicate effectively with individuals of various cultural backgrounds and to plan for and provide care that is appropriate to the culture and to the individual."

No specific new guidance for 742 (Treatment and services for persons with a history of trauma or post-traumatic stress disorder) but emphasis on trauma and PTSD is likely to be highlighted this year: KEY ELEMENTS OF NONCOMPLIANCE §483.40(b) & §483.40(b)(1)

To cite deficient practice at F742, the surveyor's investigation will generally show that the facility failed to:

▶ Assess the resident's expressions or indications of distress to determine if services were needed;

▶ Provide services and individualized care approaches that address the assessed needs of the resident and are within the scope of the resources in the facility assessment;

▶ Develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident;

▶ Assure that staff consistently implement the care approaches delineated in the care plan;

▶ Monitor and provide ongoing assessment as to whether the care approaches are meeting the emotional and psychosocial needs of the resident;

or

▶ Review and revise care plans that have not been effective and/or when the resident has a change in condition and accurately document all of these actions in the resident's medical record.

Please note that because of the likelihood of psychosocial and actual harm, F 699, F 726, and F 742 are generally rated at deficiency severity level 2 or higher. ■

RESOURCES

- LeadingAge -Foundations Toolkit and Implementation Guide
- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities particularly F656 (pp229 and following), F699 (pp 419 and following), F726 (pp 462 and following), F742 (pp. 498 and following)
- Resources to Support Trauma Informed Care for Persons in Post-Acute and Long Term Care Settings –
- Quality Improvement Organizations:
- QSEP training slides
- SAMHSA Concept of Trauma and Guidance for a Trauma-Informed Approach
- Trauma-Informed Care in Behavioral Health Services

Validated brief trauma screening instruments:

- Life Stressor Checklist
- Trauma History Questionnaire
- Stressful Life Events Questionnaire