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Implementation of Trauma Informed Care in Nursing Home Settings

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Trauma-informed care (TIC) emphasizes the need for engagement at every level, including management, direct care staff, and clients,^{1,2} assuming that all stakeholders involved might have a past traumatic experience affecting current behavior. Through TIC, staff **realizes** the pervasive nature of trauma, **recognizes** it in clients, themselves, and peers, and the agency **responds** with policies and practices **resisting** re-traumatization.³ TIC mitigates the long-term effects of traumatic experiences, including earlier morbidity and mortality, and post-traumatic stress disorder (PTSD)^{4,5} by ensuring safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; contextualized by historical and cultural factors.³ Medicare/Medicaid certified nursing homes must use TIC as part of person-centered care, such that a resident's plan of care must be culturally competent and trauma

informed, take a resident's preferences into consideration, and reduce or eliminate re-traumatization triggers*. However, there is little research examining TIC in aging services.^{6,7}

Nursing homes face two main challenges in implementing TIC: (1) TIC consists of principles not practices. This flexibility allows settings to adapt TIC to their contexts, but makes it difficult to determine the best actions. (2) Abundant regulations and scarce resources constrain nursing homes.

Building on the TIC Organizational Change Manual⁸ and resources from Trauma Informed Oregon, our study team helped two nursing homes in the Western region of the U.S. implement TIC. We interviewed each nursing home's administrator and someone they identified as knowledgeable about the nursing home's TIC efforts. Our interviews reveal that nursing home leaders have a wide range of understandings of TIC; however, respondents consistently report that TIC implementation requires the setting be person-centered, concerned with how the resident's personal history might be influencing their current reaction to care. Moreover, the interviews highlight two essential strategies to consider in the uptake of TIC: Internal education and ongoing technical assistance. Having someone who understands the community context is valuable as they can provide regular training and guide staff through immediate situations.

Despite the regulatory and practice need for TIC in nursing homes, there is little research on implementation and many systemic barriers. Some structural barriers to TIC in nursing homes are factors associated with poor quality of care such as lack of resources, staff turnover, and lack of time. Some nursing homes use trauma-informed practices but are not using a TIC lens. Their

* 42 CFR 483.21 (b) (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must – (iii) Be culturally-competent and trauma-informed.

42 CFR 483.25 Quality of Care (m) Trauma-informed care. 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.

practices provide care that ensures safety, promotes trustworthiness and transparency, and other principles promoted by the trauma-informed care lens, but do not consider the role of trauma in behaviors. They need education and time to make systematic changes and create policies and procedures to sustain those changes.

Two key factors seem to be the availability of internal technical assistance for on-the-ground training, and ongoing mentoring and support, perhaps from an external entity. The Institute for Trauma and Trauma Informed Care recommends champion teams,⁹ a potentially useful model in nursing homes, where staff turnover and siloed roles make sustainability challenging. Champion teams ensure ongoing internal technical assistance when staff changes. When champion teams represent different areas of the nursing home, they ensure TIC information and culture is disseminated across disciplines.

External mentoring can train-the-trainer, supporting internal champions with real time feedback⁹. However, we are learning through our current experience with nursing homes, external mentoring requires time and resources, which can be lacking in nursing homes. It is difficult to protect time for TIC in the face of more urgent matters. Additionally, more work is needed to understand what qualifications external coaches should have.

Nursing homes should implement TIC, because it is required and residents and staff have risk factors for trauma and the long term negative effects of trauma can be significant. More research is needed because nursing homes need concrete strategies to implement TIC well, in the face of limited resources and competing demands. Nursing homes are required to address residents' behavioral health needs and TIC ensures all residents and staff have the opportunity to have their distress addressed. Regulations may be the impetus for nursing homes to implement TIC but resources and support are needed for it to be done well.

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