**Policy**: The facility will ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice, as well as residents’ preferences and experiences to eliminate or mitigate triggers that may cause re-traumatization. Residents will be screened and assessed upon admission to identify any history of trauma and/or post-traumatic stress disorder (PTSD). Residents who display or are diagnosed with a mental disorder, psychosocial adjustment difficulty, and/or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial wellbeing.

**Definitions:**

**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

**Trauma-informed care** is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumata. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies,

procedures and practices to avoid re-traumatization. Referred to variably as “trauma ­informed care” or “trauma-informed approach

**Culture** is the conceptual system that structures the way people view the world—it is the set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world**.**

**Cultural competency** is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring, and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in the community.

**Culture**

The increasingly changing demographics of nursing homes has led to the need to provide culturally competent care. In addition to racial and ethnic diversity, this also includes religious preference, sexual orientation, and gender identity.

**Principals of Trauma Informed Care will be utilized when developing a care plan for a resident impacted by trauma that include:**

* **Safety** – Ensuring residents have a sense of emotional and physical safety.
* **Trustworthiness and transparency** – Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.
* **Peer support and 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.
* **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 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, and choice** – Ensuring that 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

The IDT Team will identify triggers that mayre-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. While most triggers are highly individualized, some common triggers may include

* Experiencing a lack of privacy or confinement in a crowded or small space.
* Exposure to loud noises, or bright/flashing lights.
* Certain sights, such as objects that are associated with those that used to abuse, and/or
* Sounds, smells, and even physical touch.

**Procedure**:

1. Upon admission, the admitting RN will review hospital discharge records to determine any history of trauma and/or PTSD.
2. The RNS will document any findings in the Nursing Admission Assessment.
3. The Social Worker will utilize a standardized Trauma screening tool to evaluate for any history of a traumatic experience they may have experienced on admission, and upon significant change in condition as well as interview the resident/resident representative regarding potential past life trauma.
4. The Social Worker will document the findings of the Trauma screening in the initial Psychosocial History and initiate a Trauma CCP for any resident that has experienced a traumatic event.
5. When the resident is unable to complete the screening tool due to cognitive deficit, the representative will be interviewed, and the Trauma screening will be completed with the Representative.
6. When the resident has cognitive impairment and has no representative, the IDT will review past medical records and any available psychosocial history in-order to identify any suspected past life traumas.
7. The IDT Team will ensure that an individualized resident centered care plan is further developed and individualized. The care plan will include but is not limited to the following:
* Identification of the stressor/past life trauma
* Identification of interventions that mitigate against re-traumatization
* Identify potential and/or triggers that could cause re-traumatization
* Clinical manifestations experience by the resident
* Resident-specific goals for preventing re-traumatization
* Experiences, preferences, and /or other interventions that eliminate or mitigate triggers that may cause re-traumatization of the resident.
* Interventions including referral for Psychological and Psychiatry services as indicated
* Appropriate recreational activities and or therapeutic relaxing interventions
* The need to obtain assistance from outside agencies and support groups in the community
* The specific cultural, spiritual, and professional interventions that would be beneficial for the resident.
1. Caregivers will be provided with education on Trauma Informed Care/Behavioral Health on initial orientation, yearly and as needed to meet resident care needs.
2. Monitoring of resident’s response and adjustment to placement will be done during the initial admission period through interdisciplinary collaboration and communication, with input from resident and representative
3. Trauma Care Plan will be reviewed and revised quarterly and as needed.
4. The IDT will identify any resident who experiences a change in mood state with no known pattern of behavioral difficulties or mental illness to include but not limited to:
* Decrease in social interaction
* Increase in withdrawn behaviors
* Displays of increased anger and/or angry outbursts
* Depressive symptoms
1. Residents that fit the categories listed in # 11 will be evaluated by the IDT to determine the root cause leading to the change in mood state and a care plan will be developed for same.
2. Residents that experience a change in mood state will be reviewed by the IDT team and an individualized care plan will be developed/reviewed as needed.