Organizational and Staff Resources About Trauma-Informed End-of-Life Care

NHPCO
Leading Person-Centered Care

DEVELOPED BY NHPCO'S WORK GROUP

Resources available: www.nhpco.org/education/tools-and-resources/trauma-informed-end-of-life-care

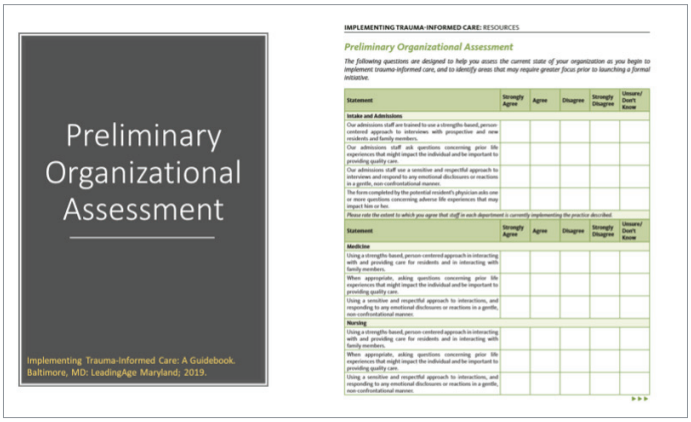
NHPCO is committed to ensuring hospice and palliative professionals and volunteers are knowledgeable about trauma-informed end-of-life care and that they practice in manner that actively resists traumatization or re-traumatization of those receiving and providing care. To this end, NHPCO has formed a Work Group to define the term, educate hospice and palliative care professionals and volunteers, and support the provision of trauma-informed end-of-life care.

Please note: *Work Group members have found these resources useful in their work establishing an organizational trauma-informed approach. Resources can be adapted to meet organizational needs. Staff should not utilize if they do not feel prepared, are uncomfortable, or if there is a possibility that a resource could cause trauma to surface. The resources need to be integrated into existing organizational and staff resources.*

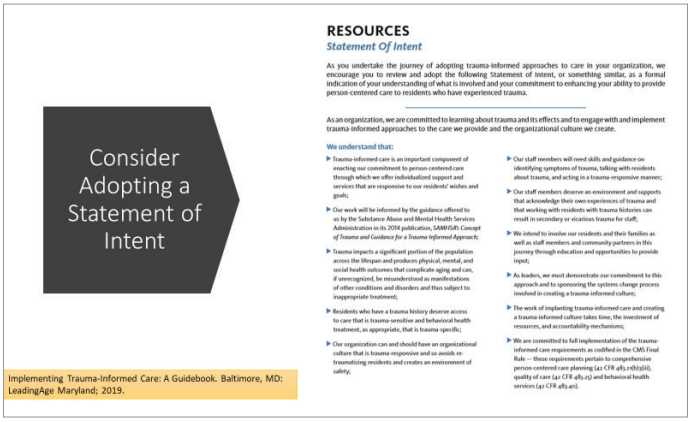
Implementing Trauma-Informed Care: A Guidebook

Published 2019 by LeadingAge Maryland

Preliminary Organizational Assessment pages 29–31



Statement of Intent page 28



The Trauma-Informed Climate Scale-10 (TICS-10): A Reduced Measure of Staff Perceptions of the Service Environment

Trauma-informed climates prioritize staff and client experiences of safety, trust, choice, collaboration, and empowerment. **The Trauma-Informed Climate Scale (TICS) was developed to measure staff perceptions of these values within the service environment.** The aims of the study were to create a modified version of the original TICS and assess its psychometric properties to increase its efficiency and appropriateness in human service settings.

Trauma-Informed Climate Scale 10 (TICS-10) | Item (Scale)

*Note. * Indicates reverse scored items.*

- When I come to work here, I feel emotionally safe. (Safety)
- If I am upset at work, I know that other staff and supervisors will understand. (Safety)
- I'm not sure who I can trust among my co-workers, supervisors, and administrators.* (Trust)
- I can trust my supervisor to be fair in dealing with all staff. (Trust)
- I feel like I have a great deal of control over my job satisfaction. (Choice)
- I don't have many choices when it comes to doing my job.* (Choice)
- The leadership listens only to their favorite employees.* (Collaboration)
- The administration here does not share decision-making with the rest of the staff.* (Collaboration)
- This organization doesn't seem to care whether staff gets what they need to do their jobs well.* (Empowerment)
- Staff is not supported when they try to find new and better ways to do things.* (Empowerment)

The Primary Care PTSD Screen for DSM-5

U.S. Department of Veterans Affairs | The National Center for PTSD | www.ptsd.va.gov

The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview.

Assessment Page 5

Example

In the past month, have you ...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?	YES	NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
3. been constantly on guard, watchful, or easily startled?	YES	NO
4. felt numb or detached from people, activities, or your surroundings?	YES	NO
5. felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

DSM-5 Supplemental Materials Curtesy of Barbara Ganzel

Direct Screening

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...

1. Have had nightmares about it or thought about it when you did not want to? **YES/NO**
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? **YES/NO**
3. Were constantly on guard, watchful, or easily startled? **YES/NO**
4. Felt numb or detached from others, activities, or your surroundings? **YES/NO**
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? **YES/NO**

If yes, ask if they would like to share what has been bothering them. If no, accept that and note it.

Worksheet to supplement the PC-PTSD-5

Figure in chapter: Ganzel, B., Kusnat, N., Cheatham, C., Hector, P. & Clarke, D. (accepted). Trauma-informed long-term care. In R. Portley (ed.), Managing the long-term care facility: Practical approaches to providing quality care (2nd Edition, Chapter 3). John Wiley and Sons.

Box 3.9 **DELAYED REACTION TO TRAUMA**
Signs & Symptoms of Posttraumatic Stress

Possible Delayed Emotional Reactions YES/ NO source_____
Irritability; Aggression; Negative affect; Distress at trauma reminderes; Fear of trauma happening again; Negative thoughts about self; Detachment; Feelings of vulnerability; Mood swings; Grief reactions.

Possible Delayed Physical Reactions YES/ NO source_____
Nightmares; sleep disturbance; Hypervigilance/Heightened startle; Persistent fatigue; Changes in appetite or digestion or cortisol levels; Lowered immune function/more colds and infections; Focus on aches and pains

Possible Delayed Cognitive Reactions YES/ NO source_____
Intrusive memories; Flashbacks; Exaggerated self-blame or blame of others about the event(s); Difficulty concentrating; Belief that avoidance or other behaviors will protect them from trauma; Avoidance of trauma-related feelings or memories or preoccupation with the event; Panic & phobia-like behavior in response to trauma triggers; Inability to remember key features of the trauma

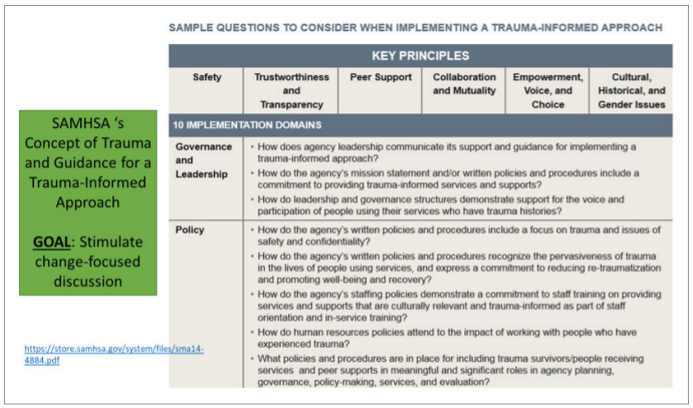
Possible Delayed Behavioral Reactions YES/ NO source_____
Avoidance of event reminders ; Decreased interest in activities; Risky or destructive behavior; Isolation/withdrawal; Disrupted social relationships; History of abuse of alcohol or drugs

Possible Delayed Existential Reactions YES/ NO source_____
Questioning ("why me"), disillusionment, cynicism; Loss of purpose or faith; Hopelessness; Also potential adaptive responses such as re-establishing priorities, redefiniting meaning and importance of life, reviewing life assumptions to accommodate trauma.
Adapted from HHS (2014). *TIP-57*, pp. 61-62.

Concept of Trauma and Guidance for a Trauma-Informed Approach

U.S. Department of Health & Human Services | Substance Abuse and Mental Health Services Administration

Sample Questions to Consider When Implementing a Trauma-Informed Approach | Pages 14–16



The Infusion of Trauma-Informed Care in Organizations: Experience of Agency Staff

The implementation of trauma-informed care is a transformational organizational change, incorporating all levels of staff and fundamentally changing the hierarchical structure of the organization (Bloom, 2006). This study explored the impacts of trauma-informed care implementation on staff and how staff experience the principles of trauma informed care: safety, trustworthiness, choice, collaboration, and empowerment. **Findings suggest that different levels of staff experience trauma-informed care implementation differently.**

Exploring the Dimensionality of Trauma-Informed Care: Implications for Theory and Practice

The study expands research on trauma-informed care. In previous research the dimensions of trauma-informed care were found to have large correlations (Kusmaul, Wilson & Nochajski, 2015), suggesting the dimensions may share an underlying dimension. **The results indicate that Harris and Fallot's dimensions are unique but strongly related, sharing an underlying dimension.**

The Experience of Medical Trauma Scale (EMTS)

The EMTS **assesses factors that contribute to a patient's distress while in the hospital setting and that can exacerbate a traumatic stress response to medical care.** Such factors are distributed in the following categories: Communications with Clinicians, Physical Discomforts, Environmental Discomforts, and Emotional Discomforts.