


Trauma-Informed Care and Nutrition

NUTRITION CONNECTION



An overview of what trauma-informed care is and what to consider

Trauma-informed care is a relatively new focus area for health care, and on November 28, 2019 nursing homes were required to implement new trauma-informed care regulations. This was part of the Phase 3 rollout of the revised Medicare/Medicaid requirements for participation. While these regulatory requirements involve long-term care (LTC), trauma-informed care applies to all healthcare settings. This article presents an overview of what trauma-informed care is, and what to consider for person-centered care for food, nutrition, and dining services.

Trauma-Informed Care regulations in LTC are incorporated primarily under survey F-tags F699 (Trauma-Informed Care) and F658 (Services Provided Meet Professional Standards), as well as potentially under F741 (Sufficient/Competent Staff-

Behavioral Health Needs) and/or F949 (Behavioral Health Training).

The two key regulations involved include:

- **F699 (Quality of Care):** The regulatory language states that *“Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choices, including but not limited to the following:*
(m)Trauma-informed care. The facility must ensure that residents who are trauma survivors receive culturally competent,



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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.

- **F658 (Comprehensive Person-Centered Care Planning)**

(b) Comprehensive care plans.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(iii) Be culturally competent and trauma-informed.

Source: Electronic Code of Federal Regulations, Title 42, Part 483, Subpart B.

TRAUMA-INFORMED CARE DEFINED

The Centers for Medicare & Medicaid Services (CMS) does not define Trauma-Informed Care and will address specific guidance when they release a revised Appendix PP, "Guidance to Surveyors for Long-term Care Facilities," in the *State Operations Manual*. CMS has steered providers toward guidance developed by the Substance Abuse and Mental Health Services Administration (SAMHSA): *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.

SAMHSA, which like CMS is part of the U.S. Department of Health and Human Services, has developed a concept of trauma based on the three "E's" which include:

- Events – what happened to the person.
- Experience – how the person perceives and reacts to the event.
- Effects – the psychological, physiological, spiritual manifestations.

Per SAMHSA, "Individual 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 involves an organizational culture that represents a paradigm shift from "What is wrong with you?" to "What happened to you?" Providers say they do person-centered care, but that may not always be the case when you really look closely. Trauma-informed care means providers must get better at driving a person-centered model, because trauma-informed care is individualized to the trauma survivor.

An organization with a trauma-informed care culture relies on having "best-practice" screening and assessments, and a strong person-centered care plan. Certified dietary managers (CDMs), registered dietitian nutritionists (RDNs), and registered diet technicians (RDTRs) must work with the director of nursing services (DNS) and the interdisciplinary team (IDT) to implement a trauma-informed approach related to food and nutrition in the screening, assessment, care planning, and staff training processes.

TRAUMA ASSESSMENTS AND FOOD, NUTRITION AND DINING APPLICATIONS

Strong resident screening and assessments become the foundation for good care plans. Some recommendations the IDT can take to implement effective trauma screening and assessments include:

Determine the trauma-informed care screening options

To date, there is no trauma screening or risk-assessment tool for long-term care providers that is either widely accepted or promoted by CMS. The SAMSHA principles and the revised Appendix PP from CMS should help providers

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better understand which residents they need to screen for trauma or when those screenings must occur.

The trauma-informed screen requires developing a rapport with a resident so they feel safe, secure, and comfortable. Providers will have to take the time with that person for them to open up and share.

Use the Minimum Data Set (MDS) tools

Components of the MDS can be used to screen for trauma. Standardized assessments that look for potential warning signs of trauma are built into the MDS. Examples include the Resident Mood Interview, Assessment of Resident Mood; the Brief Interview for Mental Status (BIMS), Staff Assessment for Mental Status, Interview for Daily Preferences, Interview for Activity Preferences, Staff Assessment of Daily and Activity Preferences; and the behavioral symptom items in section E (Behaviors). The information in these assessments can help in identifying some areas related to food and dining environments that may be traumatic to them.

Realize the broad scope of trauma

Often, post-traumatic stress disorder (PTSD) receives the most attention; however trauma is different for everyone. What is traumatic for one may not be traumatic for another, and often people may not even be aware of some of their traumas. For example, people can be traumatized by going through a natural disaster, such as a flood or hurricane; a man-made disaster, such as a fire; childhood or adult sexual assault or domestic violence; or drug or alcohol addiction. One factor to consider that may have been a trauma for residents is food insecurity. Food insecurity for the aging in the United States is increasing. The most recent report—released in 2019—reported that 5.5 million seniors, or 7.7 percent of the senior population, were food insecure in 2017.

Respect residents' rights to not share details of their trauma

Providers often do not have to know the exact nature of the trauma when screening residents and can look for cues to help identify triggers that produce trauma. The resident that always wants to eat alone or frequently hides food may need to be assessed to eliminate or mitigate triggers that may result in re-traumatization for them.


SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

SAMHSA has identified six key principles of a trauma-informed approach in the organizational culture:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

According to SAMHSA, those six principles should then align throughout the organization across the following 10 implementation domains:

1. Governance and leadership
2. Policy
3. Physical environment
4. Engagement and involvement
5. Cross-sector collaboration
6. Screening, assessment, treatment services
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation



FAMILIES SHOULD BE ENGAGED in trauma-informed care as appropriate, however trauma can influence whole families, and there may be interpersonal issues of which to be aware.

TRAUMA-INFORMED CARE WITH FOOD, NUTRITION, AND DINING

Trauma-informed care is not a foodservice or nutrition program offering a simple fix that can be plugged into the clinical or care planning process software. However, here are some recommendations to assist with trauma-informed care in overall nutritional care and services:

Focus on delivering person-centered care

Trauma-informed care is person-centered care, and the more we know about an individual helps in identifying any particular foods or dining situations that may need to be individualized.

For example, one resident may want to eat their meals with other residents while another resident may not want to eat with others. Each person who has experienced trauma needs to feel safe—whether it be physical, emotional, psychological, social, mental, spiritual, or physical safety. What matters is the individual's definition of safety vs. the provider's definition. All of the foodservice staff needs to understand how to let the resident guide the discussion of trauma, as well as interventions to offer that can be put in place to help them.

Pay special attention to cultural, historical, and gender issues

Providers need to be culturally competent to understand that the way any one person has learned to see the world and to behave in the world is not the only way. Other people have learned other ways, so respect and curiosity are helpful. It is important to understand the person's history and how that history fits into their larger historical or cultural perspective.

Providers that have residents who speak other languages or come from other cultures should identify people on staff or in the community who can help with literal translations and cultural translations. They can explain what a behavior means in the correct cultural context. Without that insight, a provider can unknowingly complicate a resident's trauma.

Be careful involving family

Families should be engaged in trauma-informed care as appropriate, however trauma can influence whole families, and there may be interpersonal issues if the resident has a trauma history. For example, the resident may have abused their family members, or the whole family may have experienced a trauma, such as a house fire in which a family member died. Consequently, providers need to respect the resident's right to have certain family members involved or not as they choose.

CONCLUDING COMMENTS

Food, nutrition, and dining are important components to incorporate into trauma-informed care. Many times, residents are admitted into facilities having been challenged with food insecurity or living situations where food and meals were involved in traumatic events in their lives. Residents that lived through The Great Depression in the United States or through various wars may have certain foods or environments that trigger trauma. For example, a resident that lived through the Depression and is observed frequently hoarding food may be concerned there is not going to be enough food available. At times, a resident may have an eating disorder in an attempt to cope with their trauma, suppress painful emotions, or to regain a sense of control. As leaders in nutrition and food services, we need to incorporate the principles of trauma-informed care in providing person-centered care in all aspects of food and nutrition services for successful outcomes. ■

REFERENCES

- *State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 11-22-17)*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. U.S. Dept. of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA) (Rockville, MD), <https://nicic.gov/samhas-concept-trauma-and-guidance-trauma-informed-approach>
- *The State of Senior Hunger in America 2017: An Annual Report*. Prepared for Feeding America, May 14, 2019. Professor James P. Ziliak University of Kentucky and Professor Craig Gundersen University of Illinois, <https://www.feedingamerica.org/research/senior-hunger-research/senior>



This Level I article assumes that the reader has entry level knowledge of the topic. The desired outcome is to ensure a foundation of basic concepts of the subject matter.

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- Per SAMHSA, individual trauma results from an event, series of events, or set of _____.
 A. Screening resources
 B. Circumstances
 C. Predetermined criteria
- Trauma-informed care involves an _____ culture.
 A. Informal
 B. Exterior
 C. Organizational
- Trauma-informed care means providers must get better at driving a _____, because trauma-informed care is individualized to the trauma survivor.
 A. Person-centered model
 B. Clinical software program
 C. Strong institutional model
- SAMHSA has identified six key principles of a trauma-informed approach in the organizational culture including the following: safety; trustworthiness and transparency; peer support; collaboration and mutuality; cultural, historical, and gender issues; and _____.
 A. Payor source
 B. Empowerment, voice, and choice
 C. Medicare enrollment and verification
- One factor to consider that may have been traumatic for residents is _____.
 A. Food security
 B. Comfort food
 C. Food insecurity
- Food insecurity for the aging in the United States is increasing with the most recent report that _____ seniors, or 7.7 percent of the senior population, were food insecure in 2017.
 A. 5 million
 B. 5.5 million
 C. 6 million
- An organization with a trauma-informed care culture relies on having “best-practice” screening and assessments and a strong _____ care plan.
 A. Preplanned
 B. Institutional
 C. Person-centered

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