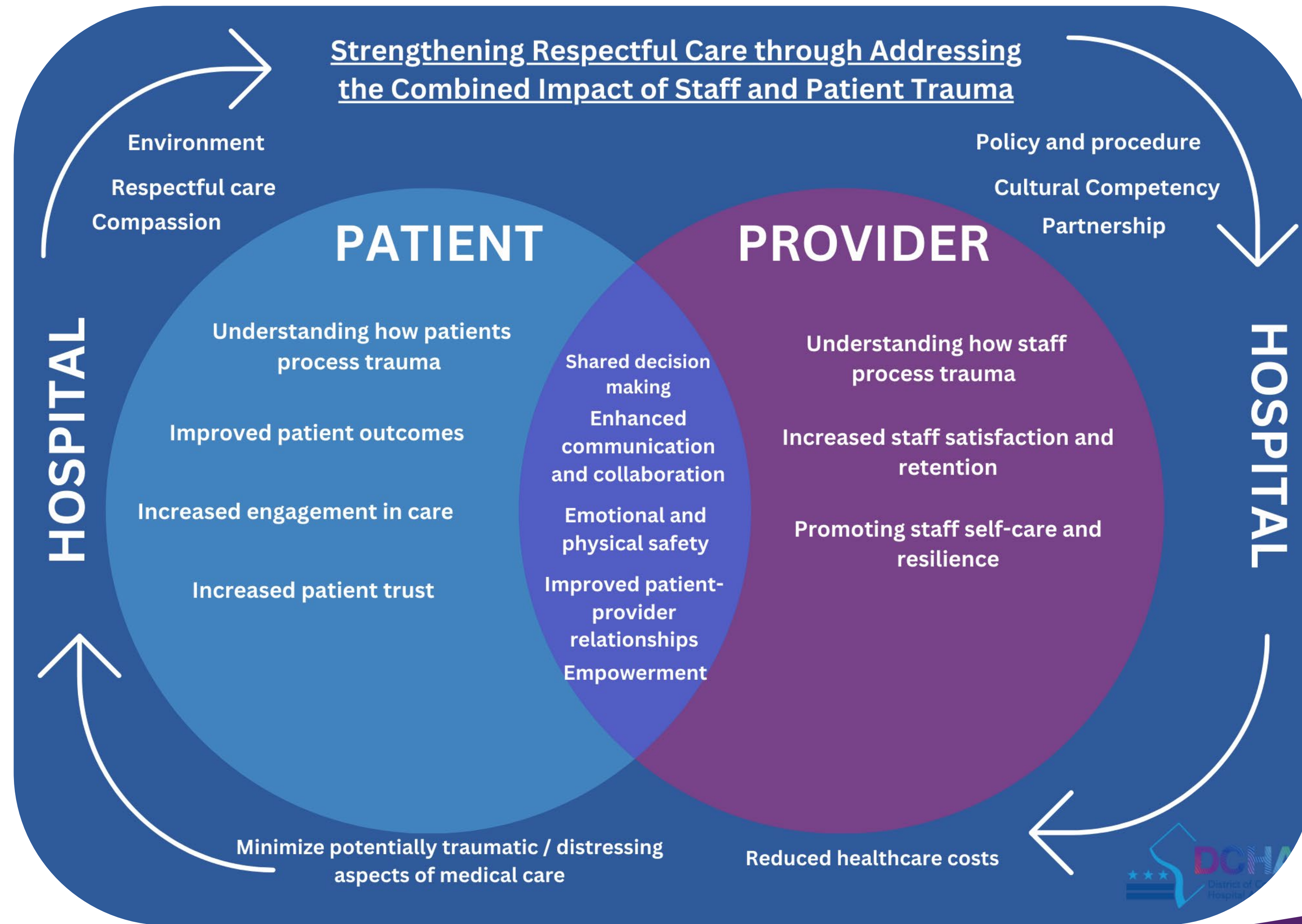
District of Columbia
Perinatal
Quality Collaborative

Addressing the Combined Impact of Staff and Patient Trauma to Strengthen Respectful Care

Trauma-informed Support for Providers and Patients through Simulation



STRENGTHENING RESPECTFUL CARE THROUGH ADDRESSING THE COMBINED IMPACT OF STAFF AND PATIENT TRAUMA.

1. PRE-SURVEY 5 MINS
Participants will be given the pre-survey in-person via paper format to complete right before the pre-learning.

2. PRE-LEARNING 30 MINS
Participants will engage in a pre-learning session led by Krysta Dancy on the impact of trauma on providers and patients.

3. PRESENTATION 10 MINS
Dr. Sheetal will lead a brief presentation on trauma and respectful care and provide an overview of the simulation scenario and roles.

4. FACILITATED SIMULATION 20 MINS
Ashley Foster and Drs. Cigna and Farhi will lead the 20-minute simulation.

5. DEBRIEFING 20 MINS
Krysta Dancy will lead the discussion and debriefing after the simulation. **Patient observers will share their feedback**

6. POST-SURVEY 5 MINS
Participants will complete post-survey via paper after the simulation to evaluate their experience.

PQC District of Columbia Perinatal Quality Collaborative

DCHA District of Columbia Hospital Association

Results

Value:
91% found the trauma simulation exercises valuable for **enhancing practical skills and decision-making.**

Confidence:
93% reported feeling more **confident in providing effective care for trauma-related cases.**

Collaboration:
91% noted **improved teamwork in managing trauma cases.**

Capability:
76% reported **improvement in the capability to handle traumatic cases**

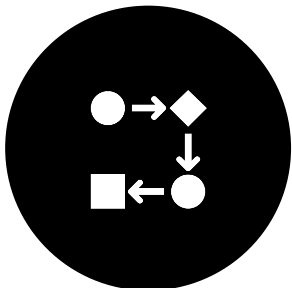
Feedback and Support:
88% rated **Patient feedback as a valuable component**

63% of **participants felt well supported.**

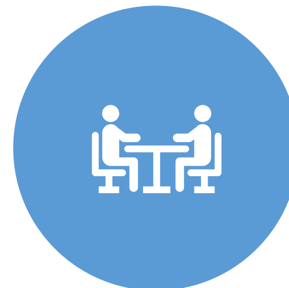
Process of Improvement Recommendations

Pre-learning Preparation: Focus on pre-learning for all participants to establish a uniform knowledge base.

Toolkit Development: Develop comprehensive toolkits with resources for communication strategies, stress management, and trauma-preventative care.



Continuous Feedback: Implement an ongoing feedback system to continually refine training sessions.



Enhanced Debriefing: Introduce structured debriefing sessions to reflect on experiences and discuss improvements.

Trauma-Informed Perinatal Care

Understanding the intersection of PTSD and Birth

Krysta Dancy, MA, MFT

ACOG

2021 Committee Opinion 825

“[OBGYNs] should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels of their practice…”

Agenda

1. Understanding trauma and birth
2. Risk factors, co-morbidities and vulnerabilities
3. Trauma among professionals
4. Addressing trauma in a clinical setting

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1. Understanding Patient Trauma

From a CNS perspective

Over **30%** of families have clinically significant trauma symptoms as a result of their birth.

Between **6-8%** of families have PTSD.

-Alcorn, Odonovan, Patrick, Creedy, & Devilly, 2010

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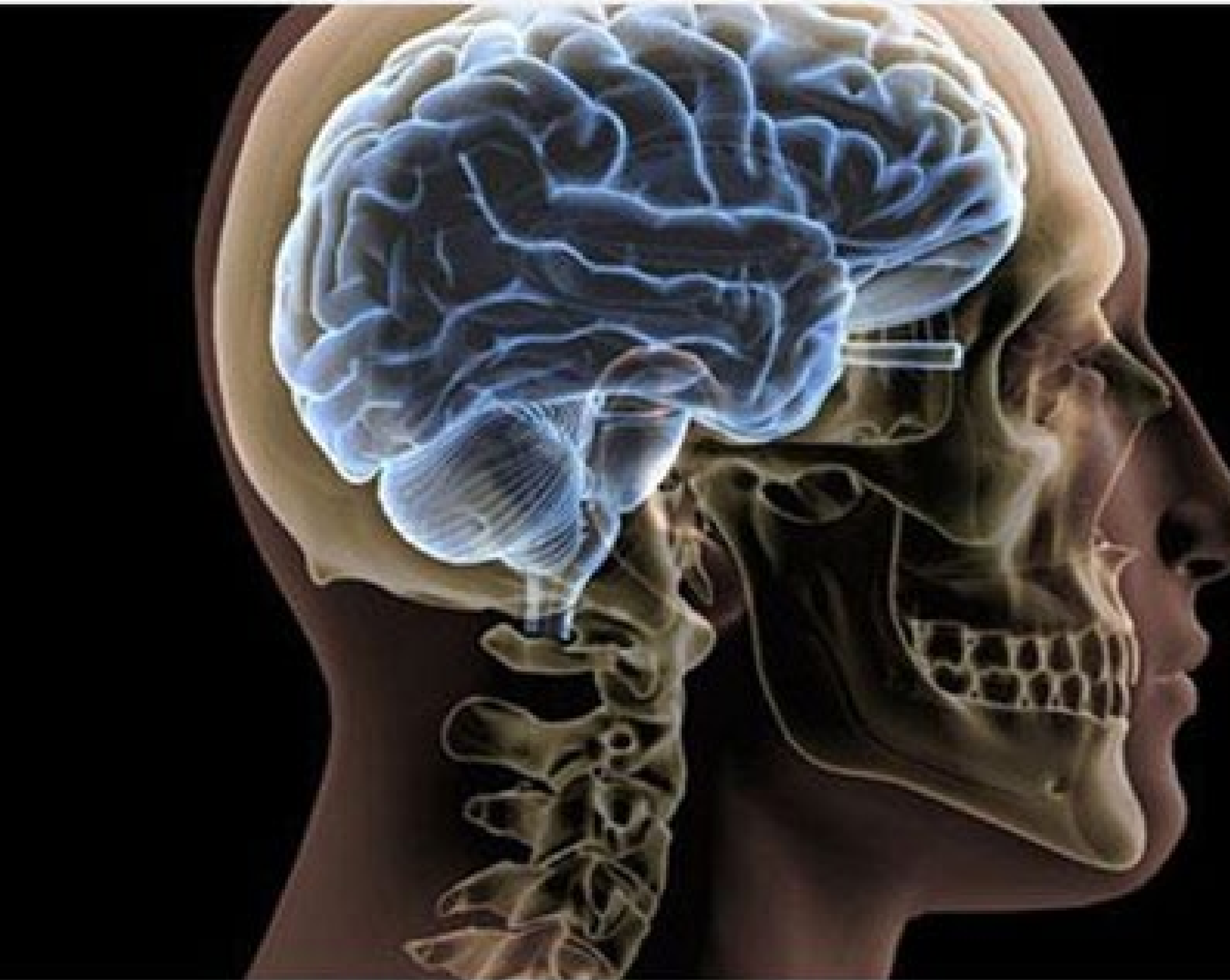

Normal Memory

1. Fresh Details-
   felt viscerally
2. Details fade
3. Memory becomes factual-
   loses detail and felt sense

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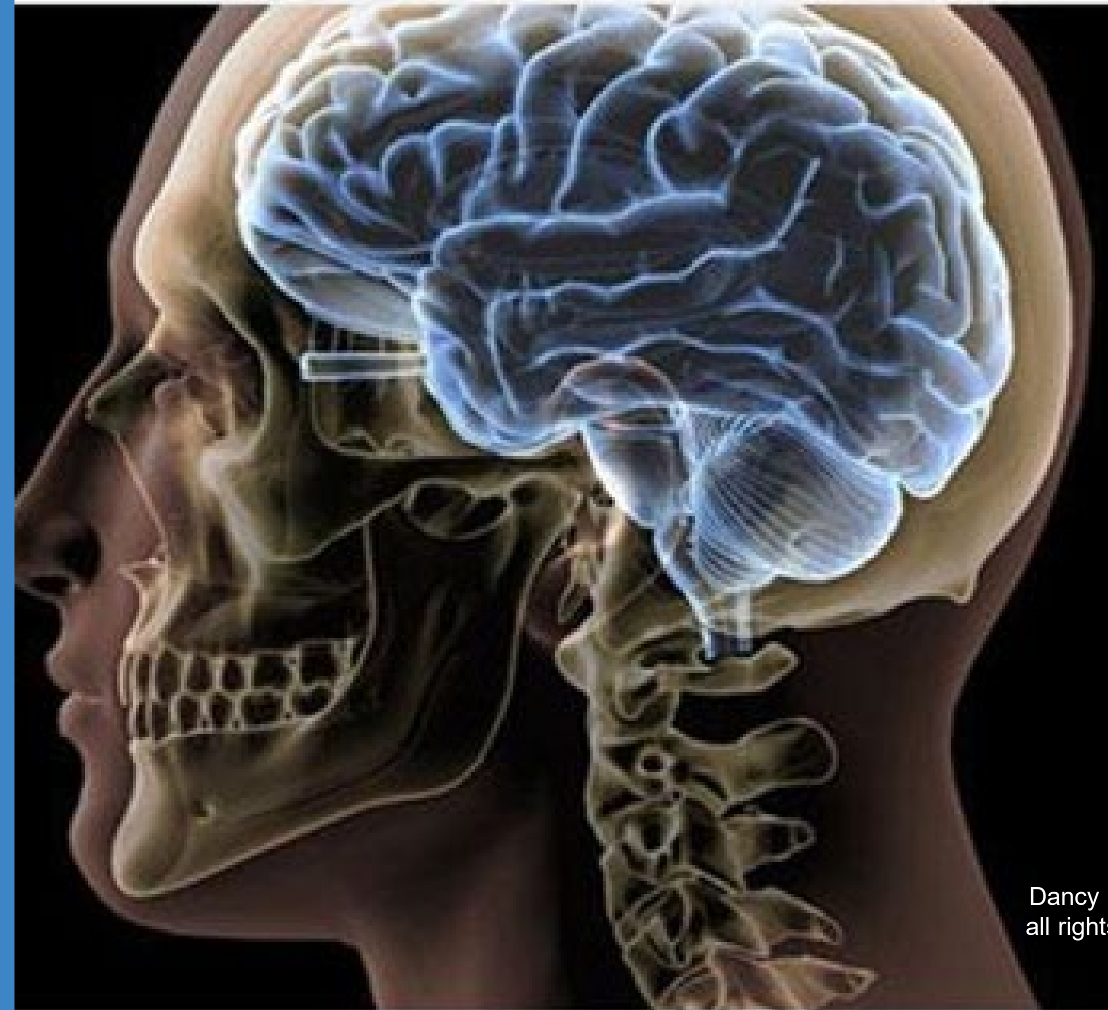
Traumatic Memory

1. Fresh Details-*felt viscerally or numbed*
2. Details do not fade
3. Memory stays vivid- *in felt senses*



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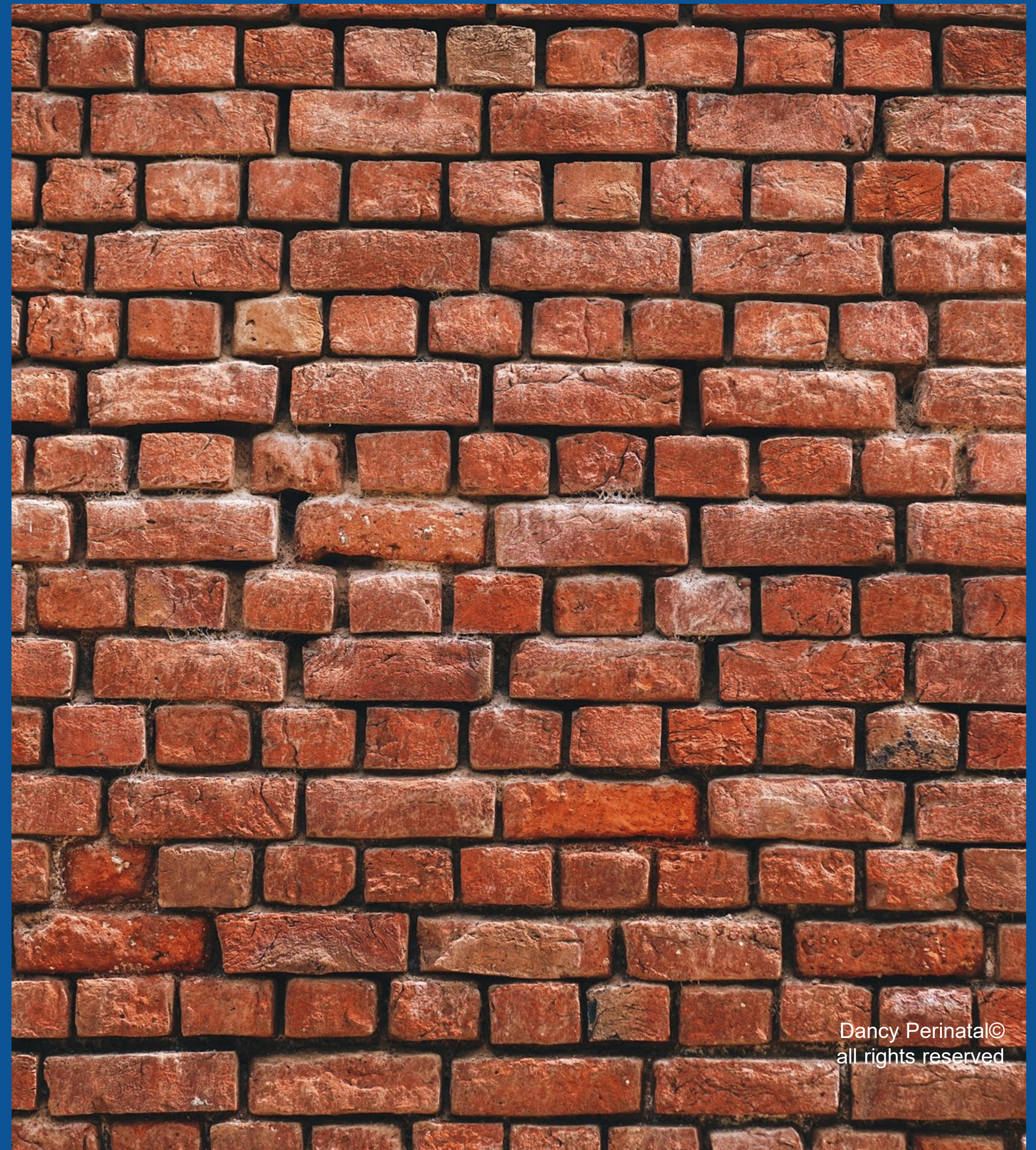
A Wall Is Created

- → **New Experiences**
- → **New Memories**
- → **New Learning**
- → **Positive Aspects**



Flashback

- → **Full memory**
- → **Bodily reaction**
- → **Dreams**
- → **Compulsive replay**

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“Trauma is not the story of something that happened back then. It’s the **current imprint** of that pain, horror, and fear living inside people.”

- Bessel Van Der Kolk, MD

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2. Risk Factors & Co-morbidites

Which of your clients are most at risk for trauma after birth?

Birth Trauma Vulnerabilities

Soderquist et al., 2009

Depression during pregnancy=

16x risk

Fear of Childbirth=

6x risk

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Trauma as cause?

Prenatal PTSD is correlated with low birth weight and reduced gestational age.

Sanjuan et al 2021, Shaw et al 2014

Risk of Suicidality

Mare et al 2021

Postpartum PTSD +
Perinatal Depression

Depression + Alcohol use +
Substance Abuse

(Depression + PTSD + Food insecurity
+ Intimate partner violence + ACES)

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Trauma Survivors Giving Birth

19.6% of women have experienced contact sexual violence

32.5% of women have experienced severe physical violence

ACE: SUD, Low birth weight, decreased GA

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(Centers for Disease Control and Prevention, 2022)

3. Trauma & Professionals

Truly a trauma-informed setting

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35%

Of OB nurses have Secondary or Vicarious Trauma

(Beck, Driscoll, & Watson, 2013)

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37.8%

Of OB/GYN reporting “High PTS” symptoms during Covid

(Kiefer et al 2020)

Professional Impact

- 2x more likely to consider quitting
- Increase in burnout scores
- Decrease in compassion satisfaction
- Higher rates of absenteeism

(Sheepstra 2020, Tigaro 2018)

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Do I Have Professional Trauma?

- Secondary Traumatic Stress Scale
- Compassion Fatigue Scale-Revised
- Impact of Event Scale- Revised*

Flashbacks impact provider health and relationships…
and treatment decisions.

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Models for Care

Provider and nurse PTSD

1. “POPPY Programme”- Slade 2018
2. Critical Incident Support Program (CISP)- Dancy Perinatal 2022

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“Providers are the tools of their own trade. They deserve the same care they are expected to give. When providers are cared for we see a trickle-down impact to the staff and the patients in their care. Creating a culture of healing is not a happy accident; it is an intention set from the top.”

- Krysta Dancy MFT

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4. Trauma Informed Care

Addressing Patient Trauma in a clinical setting

Prevention, Assessment and Referral

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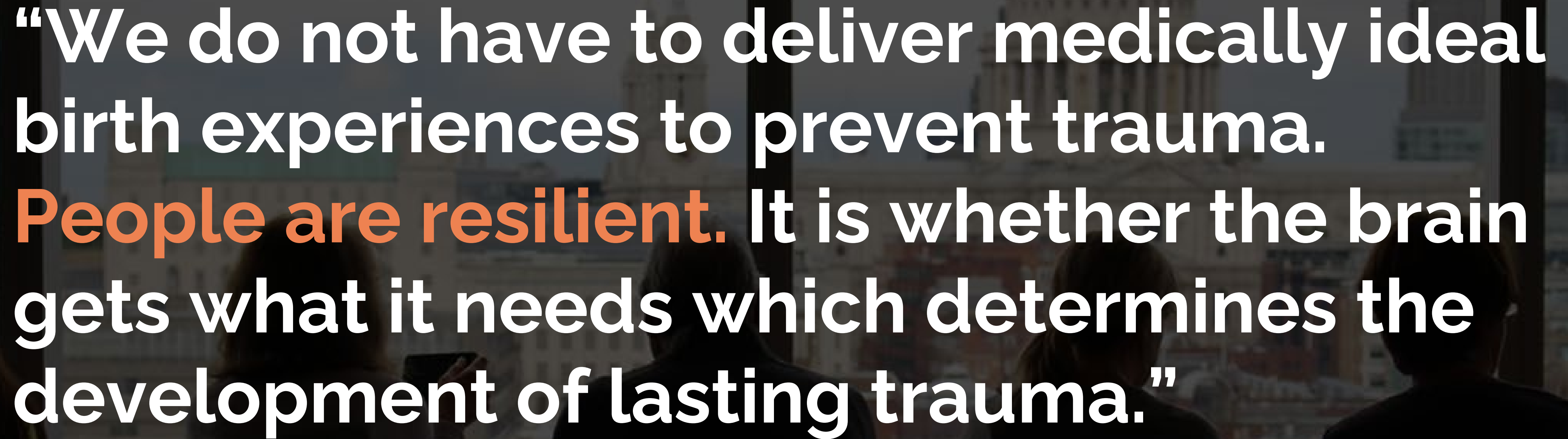

- Krysta Dancy, MFT

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Trauma Informed Care Model

For Healthcare Settings

1. Addresses professional support need
2. Appropriate care for survivors
3. Care that is preventative of trauma
4. A plan for trauma when it occurs

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Trauma-Informed Care Principles

1. It’s not personal
2. Ambiguity invites projection
3. Increase patient control
4. Affirm goodwill whenever possible

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Trauma Immediately Postpartum

- Psychological Shock* (#1 predictor)
- Amnesia, Memory Fog or confusion
- Intense Crying
- Disengaged or Helpless
- Dissociative or Flat
- Intense Pain
- Distress

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Effective Therapeutic Referrals

- EMDR
- Brainspotting
- CISP©
- Somatic Experiencing
- Body/Neurological trauma techniques
- Narrative
- Group*

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DCPQCGWUTIC

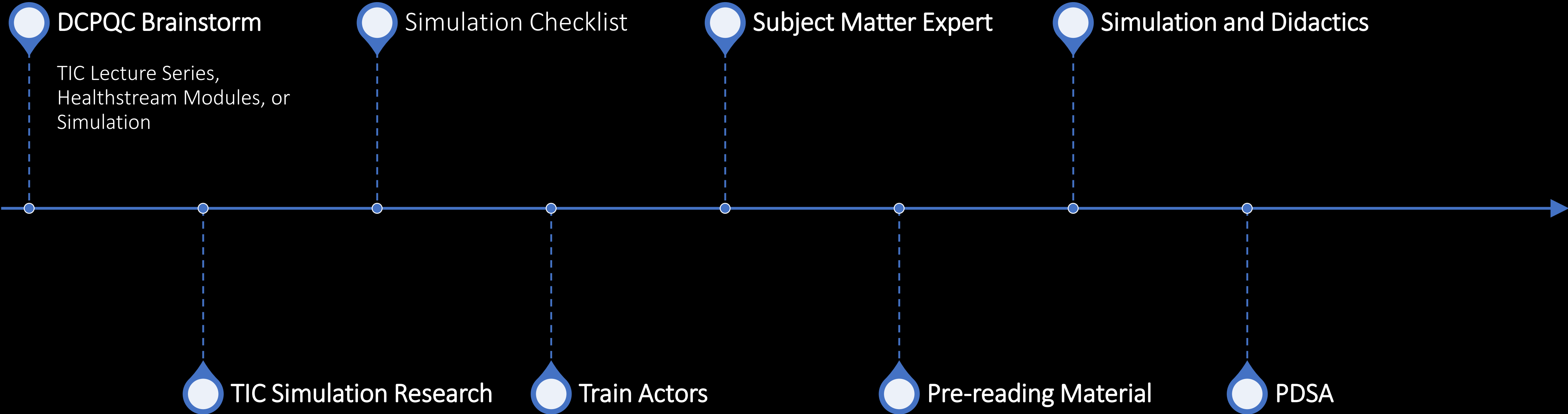
Trauma Informed Care

Sheetal Sheth MD FACOG CPHG

Osereme Abulu MD

The George Washington University Hospital

Timeline



TIC Simulation

OB History:
Elective second trimester termination, age 14

Elective first trimester termination, age 15

Two miscarriages, age 17 , Preterm delivery, age 20

30-week NSVD of XX neonate, weight 3 pounds

Medical History:
HPV+

BMI 37

Surgical History:
Cholecystectomy, age 18

D&C X 2, incomplete spontaneous abortions

Social History:
Marital status: Single

Lives with maternal grandmother, boyfriend (FOB), and daughter

Simulation Checklist

History Taking and Physical	❑ Knock to enter (Safety) ❑ Before history: remove support persons for history ❑ Take history- express empathy and validation ❑ Ask about plan for pain control (does she want an epidural?) ❑ Identify safe word for exam ❑ Explain code strong and security ❑ Consent for cervical exam before mock exam ❑ Explain findings avoiding medical jargon ❑ Invite family back
PPH	❑ Explain the situation to Pt. ❑ Re-state the SAFE words ❑ Before fundal exam: "We discussed in case of an emergency, I may need to do an exam. If you feel uncomfortable or want me to stop at any point, say "PAUSE or STOP" ❑ Perform fundal assessment and massage (mock) ❑ Talk through steps that you would do during a PPH ❑ Mobilize the team (e.g., charge RN, primary provider, anesthesia) Assigns roles, for example: RN to measure QBL, RN to record care on whiteboard, Staff to take blood draws to laboratory, Staff to move newborn to RNry for care, request primary provider come to the bedside to evaluate Pt. ❑ The learner escalates tx options and offers various options to help stop bleeding, medications, IR and JADA. Clearly explains to Pt. about JADA ❑ Learners: Should clearly explain the situation and restate stop words before placing JADA
Patient Debrief	Learner to say: I recognize that must have been traumatic- I want to go over in detail what happened so that we have time to answer all your questions. Before we do that, it's important that you bond with your baby, we are going to clean up and make sure you are comfortable. We will come back to talk with you and your family to answer any question.

Standardize Patient Training

- Your name is Antonette Jones; you go by “Toni.” You are 22 years old, single female with an eleven-month-old daughter, Samantha “Sami.” You found out you were pregnant again 2 months after Sami was born. You are now 36 weeks (about 8 and a half months) pregnant with your second liveborn baby. You are having another girl. Her name will Joan after your mom who died eight years ago; you will call her “Joni.” You are now on Labor and Delivery because you started having contractions every 8 minutes since last night and your water broke at 6am this morning. The contractions are painful and come every 5 minutes. Every few contractions, you must stop and breathe through them. The nurse has already hooked you up to the fetal monitors. The baby has a normal heart rate despite being premature. You are swaying back and forth near the bed. Sami was born without an epidural last time. Your boyfriend and his mother insisted that you have an unmedicated birth even though you felt like you needed an epidural last time. As soon as you were admitted this time, you asked to speak to the anesthesiologist immediately. By the time they came to see you, your boyfriend, his mother, and his sister had already arrived and once again told her she could not have an epidural.
- Opening Statement: “I’m here because I am leaking fluid and having contractions.”
- You are frustrated this morning for a few reasons. The first is that you could not get an epidural. The second is that despite living with your grandmother, boyfriend and Sami, you had to call an ambulance because no one would take you to the hospital. Everything about this pregnancy has been more challenging because of limited support, juggling work, school and Sami. Sami was born early at 32 weeks; you went into early labor and your boyfriend blamed you for this. When your water broke this morning, the last thing that your boyfriend said to you was, “Great, another early baby! Your body is so useless and weak; it can’t even make it to 9 months.” He went back to sleep. Your boyfriend has been out of work for over two years. He refuses to wear condoms and feels that birth control pills are bad and causes women to be moody. He didn’t let you fill your birth control prescription, and you got pregnant immediately after Sami was born. Your grandmother and your boyfriend do not get along. However, she allows him to stay in her home because he was kicked out of his parent’s house. Your grandmother requested that you and your boyfriend contribute to household expenses. You got a job at H&M to support Sami, buy groceries etc. You also just got your degree from the local City College; you are hoping to become a social worker. Now that you are having another baby, that dream of becoming a social worker seems to be getting further and further away. You really wanted your grandmother to be your support person; your boyfriend insisted that she stay home with Sami.

The Script

If they do not ask the support team to step out, you should provide limited details.

"This is my second pregnancy; Sami was a normal vaginal delivery at 32 weeks. She weighed three pounds and stayed in the NICU for 6 weeks. I have no medical/surgical complications. I don't smoke, drink or do any drugs of any kind. I feel safe and live with my partner and grandmother."

If they ask the support team to step out, you should provide more details about your history:

OBHX: This is your sixth pregnancy. You started getting your periods at age 14 but they were very irregular. Your first pregnancy was at age 14 after your mother had just died. You didn't realize you were pregnant because you only had two periods ever. You were raped by a family member. Your grandmother figured out you were pregnant, and you had a termination at 18 weeks (about 4 months). You found out you were pregnant again at age 15 and had a termination at 8 weeks (about 2 months). You had two miscarriages at age 17 one at 15 weeks (about 3 and a half months) and the other at 16 weeks (about 3 and a half months). You needed a D&C for both miscarriages. Your current boyfriend and his family think you have only been pregnant twice.

As far as your gynecologic history, you were diagnosed with chlamydia and treated at age 15 and 16. You had a pap smear at age 21 that was abnormal. You were diagnosed with HPV. You did not follow up with the OBGYN regarding this diagnosis. You also did not tell your current boyfriend because you were afraid of his reaction. When you found out you had chlamydia in high school, your partner at the time was so angry; he attacked you and punched you in the head. You were admitted to the hospital for 24 hours as you had a major concussion.

Regarding your medical and surgical history. You have a history of asthma and use an inhaler on occasion. Your BMI is elevated-37. You are conscience about your weight because your current boyfriend teases you and makes inappropriate comments about your appearance especially when pregnant. You feel bad about yourself because you never lost weight after Sami's birth and gained 20lbs this time around. Between Sami, work, and school you have not had time to exercise. You had two D&Cs and your gall bladder removed.

Your mom died at an early age. She had uncontrolled diabetes and high blood pressure. She was the victim of gun violence. She was shot outside of your home. You still startle with loud noises. After she died, you started smoking and consuming alcohol. You smoked a ½ PPD for nearly 7 years. You quit at age 20 when you found out you were pregnant with Sami. As for alcohol when you are not pregnant, you drink >5 shots a few times per month. You have blacked out in the past. You have driven a car intoxicated before. When you turned 21, your grandmother shared her concerns about your drinking with you. She felt that this was a coping mechanism for the sexual assault and loss of your mother. You started therapy to work through this history. Again, you have not shared this information with your current boyfriend. He thinks that mental health, trauma, therapy etc are silly. You share that while your boyfriend has never physically harmed you, he has a lot of strong opinions. He does shout and curse alot; the louder he gets, the more anxious and triggered you become. You often feel like you are frozen when he is screaming at you. The last time this happened one week ago. You found a women's sweatshirt in the car. You thought it might be his mom's or sister's. When you started to ask about the sweatshirt, he thought you were accusing him of cheating again; he started shouting. He grabbed the sweatshirt and slammed the front door shut; the whole house rattled.

The Script: The Healthcare Provider Should…

- Recognize your trauma and be empathetic
- Identify areas that may need follow up-they may offer an STI panel
- Explain the safety procedures at GW (Code Strong vs Security), allias, removal from the hospital
- Identify a safe word for you to say if you are feeling triggered by the experience or by your partner. "If you ask for pineapple juice, we call security and escort your boyfriend out of the hospital."
- Fill out the white communication board
- They will need to complete a cervical exam with a chaparone (they won't really)
    - They will ask "What is the hardest part of the exam?"
        - For you the hardest part of the exam is the pressure felt when someone touches the cervix
        - What makes it easier, is if you deep breath and hold someone's hand
    - How do you want me to communicate to you for a routine exam? Emergency?
        - You want a calming voice – No shouting
        - You want everything explained to you
- They will ask you for a STOP word (PAUSE for I NEED A SECOND and STOP for STOP)
- They will do an exam and you will be 5 centimeters dilated
    - They will offer options regarding the next step (epidural, pitocin, wait etc)
    - They will write this on the communication board
- They will ask your permission to re-invite the family back to the room. For which you agree.

Simulation Day

- Pre-Reading QR Code
- Didactics
- Ground Rules
- Simulation
- Debrief

What is Trauma?

- "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 "TIC"

What do we mean by trauma?

What do we mean by a trauma-informed approach?

What are the key principles of a trauma informed approach?

What is the suggested guidance for implementing a trauma-informed approach?

How do we understand trauma in the context of community?

SAMHSA-Substance Abuse Mental Health Service Administration

What is TIC?

- A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization.

6 Principles of TIC

1. Safety – physically and psychologically safe
   - "knocking being invited in, keeping areas well lit"
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
   - "leveling, healthcare partners"
5. Empowerment, Voice and Choice
   - Informed consent-risk, benefits and alternatives
   - Shared decision making
   - Values clarification
   - Self-advocacy skills
   - Ways to provide feedback
6. Cultural, Historical, and Gender Issues

Trauma-80%

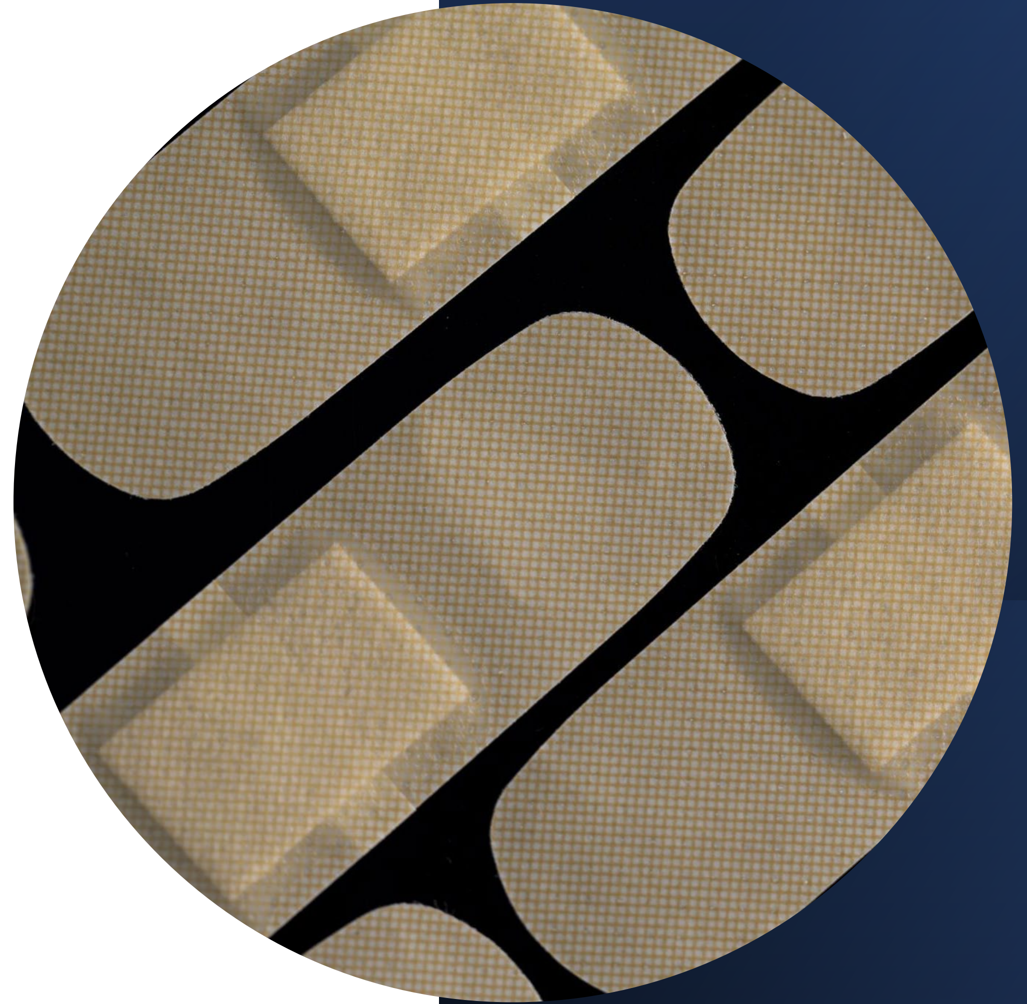
- Up to 80% of pregnant women have been exposed to trauma, violence, or childhood maltreatment (Seng et al. 2009)
- Up to 1 in 5 of trauma-exposed pregnant women have posttraumatic stress disorder (PTSD) worldwide (Yildiz, Ayers, & Phillips, 2017)
    - (Includes women with fetal anomalies, severe pregnancy complications)
- Trauma exposure increases risk of both PTSD and major depression (Seng et al. 2009)

Why TIC

- Low birth weight
- Increase preterm delivery
- Increase metal health disorders, exacerbations, PPD
- Increase re-traumatization
- Missed diagnosis – STI

Build Trust

Assess for Physical Violence



Assess for Sexual Violence

Empathy

1. Build Trust

Many women have had experience with violence. I am going to ask you some questions about violence, since these experiences can affect your health.

It is important that we conduct part of your visit with just you in order to ensure your privacy. Would you mind if your[friend, partner, family member] stepped out for a moment?

Answering questions about violence may be uncomfortable, but knowing what you've been through helps me take better care of you.

2. Assess Physical Violence

Have you ever been in a relationship where your partner has hit, pushed, or slapped you?

Have you ever been in a relationship where your partner threatened you with violence?

Have you ever been in a relationship where your partner has thrown, broken, or punched things?

3. Assess Sexual Violence

Has anyone ever made you have intercourse, oral or anal sex against your will?

Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat?

Has anyone ever taken advantage of you sexually when you were too drunk or out of it to stop it?

Have there been any other situations in which another person tried to force you to have unwanted sexual contact?

If the patient endorses ANY item from Step 2 or 3, proceed to Steps 4 and 5.

4. Empathize

That must have been difficult to talk about. Thank you for trusting me with this information.

IT IS NOT YOUR FAULT that someone hurt you. No one deserves to be treated that way.

You deserve to be treated with respect in all relationships. You especially deserve to feel safe and comfortable. I am concerned and would like to help.

Common Phrases to Avoid

WHAT NOT TO SAY:

1. “You haven’t had any issues with trauma, right?” (Leading question)
2. “Any trauma or abuse?” (Not a full question; semi-leading; vague terminology)
3. “Have you ever been raped?” (Vague terminology; open to various interpretations)
4. “Has anyone ever molested you?” (Vague terminology; open to various interpretations)
5. “Has anyone ever touched you inappropriately?” (Vague terminology; open to various interpretations)
6. “Have you experienced domestic violence?” (Vague terminology; open to various interpretations)
7. “Any issues with abuse you want to talk about?” (See #2; patient may not want to talk about it and still appreciate the opportunity to disclose)
8. “I know how you feel.” (Generally, self-disclosure is best avoided as providers don’t necessarily “know” how a patient is feeling.)
9. “Why didn’t you report it/tell someone?” (Victim-blaming)
10. “Were you drunk/intoxicated? What were you doing/wearing at the time?” (Victim-blaming; It is not provider’s responsibility to determine veracity of the patient’s disclosure).

TIC in OBGYN

PRACTICE PHRASES TO USE DURING OBSTETRIC EXAMS/PROCEDURES

- "I won't go ahead with any part of the procedure until you tell me you are ready."
- "Sometimes it can be hard to tell someone that you are uncomfortable. What is the best way for you to tell me when you need me to stop the exam? People sometimes say, 'Wait' or 'I need a second' or 'Stop please.' Why don't you try saying it now."
- "The most important thing is for me to know that you are doing okay."
- "I notice that you are tense/upset. I am stopping what I am doing."
- "These procedures can be more uncomfortable when you are tense or upset. What is the best way for you to be comfortable?"
- "If there is risk to you or your baby, I may need to perform a procedure that causes discomfort. We will do everything we can to make you as comfortable as possible. It is important that you let us know how you are doing."

Debrief

- PDSA
  - Groups were too large
    - Split into two groups
  - Second victim provider doing the H&P
    - Immediately after the simulation added a break
  - Second victim provider doing the H&P
    - Given the opportunity to opt out of feedback session
  - Second victim provider doing the H&P
    - Opts into feedback but needs a way out of the session

Adapt, Abandon, or Adopt

- "END SCENE":
  - Provider completing the simulation is escorted out of the simulation
  - Five-minute break and nourishment
  - Option to opt in or out of participating in the group debrief
  - Opt out: written feedback provided
  - Opt in:
    - They start the debrief "They are in control"
    - Secret signal
      - If they remove the pen cap, signals a debrief wrap up
      - Written feedback provided

Questions

Thank you!