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REVIEW ARTICLE

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Trauma-informed care within residential aged care settings: A systematic scoping review

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Abstract

Objectives: The importance of trauma-informed care (TIC) within residential aged care (RAC) settings has been increasingly recognised. TIC would ensure that older people who have experienced trauma over their lifetime have their needs better understood and accommodated. This scoping review examined the extent to which TIC has been applied within RAC settings.

Methods: A scoping review was conducted according to Cochrane recommendations and the PRISMA-ScR checklist. A systematic search of six databases (Embase, Emcare, CENTRAL, CINAHL, PsychInfo and Medline) was performed in July 2022 and March 2023 and peer-reviewed primary research, in English and involved RAC staff or residents (aged 65 years and over) providing or receiving TIC were eligible for inclusion. Studies focused on trauma intervention, assessment, screening, or treatment were excluded. Thematic synthesis was performed to extract themes relating to trauma-informed practice, barriers and enablers to TIC, and outcomes from the application of TIC approaches.

Results: Five articles were included. There was little evidence of the implementation of TIC interventions in RAC settings. Only one study examined the application of a TIC framework in a RAC setting. However, there was some evidence that approaches that consider resident's experience of trauma have emerged from practice experience and been used in RAC as an extension of person-centred care.

Conclusions: Whilst trauma-informed approaches to resident care are emerging through practice experience, and despite policy recommendations to do so, there is little evidence that formal TIC interventions or frameworks have been applied to RAC internationally. This study highlights a gap in research and practice and makes several recommendations for further research and implementation of TIC in RAC.

KEYWORDS
residential aged care, trauma, trauma-informed care

Key points

- Trauma is a common human experience that impacts older people living in Residential Aged Care (RAC) settings.
- There is evidence that trauma-informed approaches to resident care are being used by RAC staff.
- There is no evidence of a formal trauma-informed care (TIC) intervention that addresses the trauma needs of residents and staff in a RAC setting.
- It is recommended that a TIC intervention be co-designed, implemented and evaluated to demonstrate the benefits of TIC for RAC staff and residents.

1 | INTRODUCTION

Trauma is a common experience, with up to 90% of the population exposed to a potentially traumatic experience in their lifetime.[1–3] Trauma is the lasting psychological impact of an experience or chronic set of conditions that overwhelm a person's ability to cope with stress.[4–6] It can result from experiences including child abuse, sexual assault, family violence, physical injury, accidents, natural disasters, wartime experiences, witnessing a violent crime, or witnessing another person's exposure to a traumatic experience.[1,2,7]

In the general population 6%–12% of people will develop post-traumatic stress disorder (PTSD),[1,2,8,9] which is a clinical diagnosis characterised by persistent re-experiencing, avoidance of trauma-related stimuli, and altered mood following exposure to a traumatic event.[5] However, many people will not meet the diagnostic criteria for PTSD but are impacted by psychological trauma symptoms.[8,9] It is estimated that up to 70% of older people aged 65 years and over have experienced at least one potentially traumatic event in their lifetime.[10] PTSD prevalence estimates for older people range between 2% and 4%[2,8,11–13] with re-emergence of PTSD common, and more chronic, in later life.[8,13–16]

Trauma-informed care (TIC) is a system-wide approach to service delivery that recognises that anyone (staff, clients, family members) may have experienced trauma.[6,17,18] It requires a basic understanding of trauma and its impacts to provide a service system environment that avoids re-traumatisation through the routine use of trauma-sensitive approaches.[18,19] Initially developed for use in psychiatric settings, TIC has an established evidence base in other settings, including health care, child and family services, and education.[17,18,20] An increasing number of models and frameworks guide the application of TIC.[6,17,21,22] Whilst TIC is not a therapeutic approach or trauma treatment modality, nor can it replace these,[18] it can minimise the risk of further harm by focusing on wellbeing and safety,[19,23] restoring power through autonomy, choice, and control, and building self-worth.[17] Further benefits of TIC include reduction of service costs, decreased trauma symptoms, improved health outcomes and quality of life,[13,24–27] increased staff satisfaction and reduced burnout through the promotion of staff collaboration,[28] and improved patient care.[29]

With an ageing population, increased longevity, and life expectancy, there is increasing demand for residential aged care (RAC) services.[30] TIC approaches are recommended within RAC settings to ensure that older people who have experienced trauma over their lifetime have their needs better understood and attended to Refs 13, 30–33. The extent to which TIC has been applied within aged care settings, particularly RAC, is currently unknown.

This scoping review examined the application of TIC within RAC settings. The aims of this scoping review are to:

1) Describe the TIC approaches (models, frameworks, and interventions) that have been applied in, or developed for, RAC,
2) Assess the outcomes of TIC approaches for RAC residents, and
3) Explore the barriers and enablers to implementing TIC approaches within RAC.

2 | METHODS

A scoping review with a systematic search was conducted according to Cochrane recommendations and the guidelines described in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).[34,35] A scoping review was selected due to the broad and exploratory nature of the review aims, to identify and map the available evidence of TIC in RAC.[36]

A systematic search strategy was developed in consultation with a specialist librarian. Customised search terms (MeSH subject headings) and keywords were compiled based on the research aims using the OVID Medline platform and translated to other databases as appropriate. These search terms and keywords were developed around three broad categories of 'residential aged care', 'older people', and 'trauma-informed care'. Six electronic databases (Medline, Embase, Emcare, PsychInfo, Cochrane Central Register of Controlled Trials (CENTRAL), and Cumulative Index to Nursing and Allied Health Literature (CINAHL)) were searched up to March 2023. These databases were selected as they provide indexing for articles and journals across a broad range of medical and allied health disciplines including aged care, geriatrics and TIC. Supporting Information S1 provides the search strategies for all databases searched. Reference lists of articles were searched for additional studies.

2.1 | Study selection

The initial literature search was conducted from inception up to 10th July 2022. Given the time between the initial search and preparation for publication exceeding 6 months,[35] a second search was conducted to include any recently published papers. The search was updated up to 20th March 2023 using the same strategy developed for the initial search.

Articles were included if they:

a) were peer-reviewed primary research (qualitative, quantitative, or mixed methods),
b) were available in full text and English, and
c) involved RAC staff or residents (aged 65 years and over) providing or receiving TIC or a trauma-informed approach.

Studies were excluded if they were not exclusive to older people living in a RAC setting (i.e., retirement living, community-based housing, long term care that does not provide aged care) and did not separate this out in the analysis; non-primary research papers (editorials, systematic reviews, conference abstracts, and grey literature); did not describe or examine trauma-informed approaches; and focused on trauma intervention, assessment, screening, or treatment of symptoms.

TIC was not defined using a particular framework but rather the inclusion of studies for this review was broadly scoped as any description of RAC approaches in which trauma is explicitly considered in its application.

2.2 | Screening

Search 1: Search results from each database search were imported into EndNote 20 reference management software.[37] Duplicates were identified and removed. Covidence[38] systematic review management software was used for screening. Two independent reviewers (AM and DB) screened the titles and abstract of each article according to the eligibility criteria described above. Full-text articles were retrieved to assess further the eligible studies or clarify eligibility. Two independent reviewers (AM and KH) screened the full-text articles. Any conflicts were resolved by consensus at each stage, and a third reviewer (DA) was available to resolve any disagreements. Exclusions were tabulated with the reasons for their exclusion (see Figure 1).

Search 2: Search results from each database search were imported into EndNote 20 reference management software.[37] Duplicates were identified and removed. AM and DA screened the titles and abstract of each article according to the eligibility criteria described above. Full-text articles were retrieved to assess further the eligible studies or clarify eligibility. AM and DA screened the full-text articles. Exclusions were tabulated with the reasons for their exclusion (see Figure 1).

Quality appraisals were conducted by one reviewer (AM) using the JBI checklist for qualitative research.[39]

2.3 | Data extraction

A customised template was created for data extraction. Extracted data included study characteristics (country, study design, data collection method, study inclusion criteria, number of RAC homes, number of participants, participant demographics, resident diagnoses) and findings (TIC approaches, TIC type (practice or framework), measures, outcomes, and implementation barriers and enablers).

2.4 | Study synthesis

Thematic synthesis was conducted for qualitative studies[40] by one reviewer (AM). The steps undertaken were to:

1. Read through each paper several times to become familiar with the studies with particular focus on the results and discussion sections.
2. Code the results and discussion sections line by line using open coding (e.g. knowing the resident, flexibility, reliving trauma, understanding, relationship etc.).
3. Organise the codes from Step 2 into related areas (e.g. emotional connection, empathy, safety, and trust were grouped together with relationships).
4. Use these groups of codes to construct descriptive themes.
5. Give labels to the themes to describe the concept in a single sentence (e.g. The themes knowing the resident, ask the family or staff, don't ask the resident and know your history was given the label “TIC requires knowledge about the resident's life”).
6. Analyse the themes in the context of TIC to address the research aims.

Content analysis was conducted to assess the frequency of each code.

3 | RESULTS

The first electronic search (database inception to July 2022) identified 452 articles, and of these, 149 duplicates were removed, resulting in 303 articles that were screened using titles and abstracts by two independent reviewers. Based on selection criteria, 273 articles were excluded. The remaining 30 articles were reviewed in full text by two reviewers, and 26 articles were excluded based on the inclusion and exclusion criteria.

The second electronic search (July 2022–March 2023) identified an additional 50 articles, including 17 duplicates. Title and abstract screening excluded 28 articles based on selection criteria. The remaining five articles were reviewed in full, and one was retained for inclusion in the review. A total of five studies were thus included in this review (Figure 1).

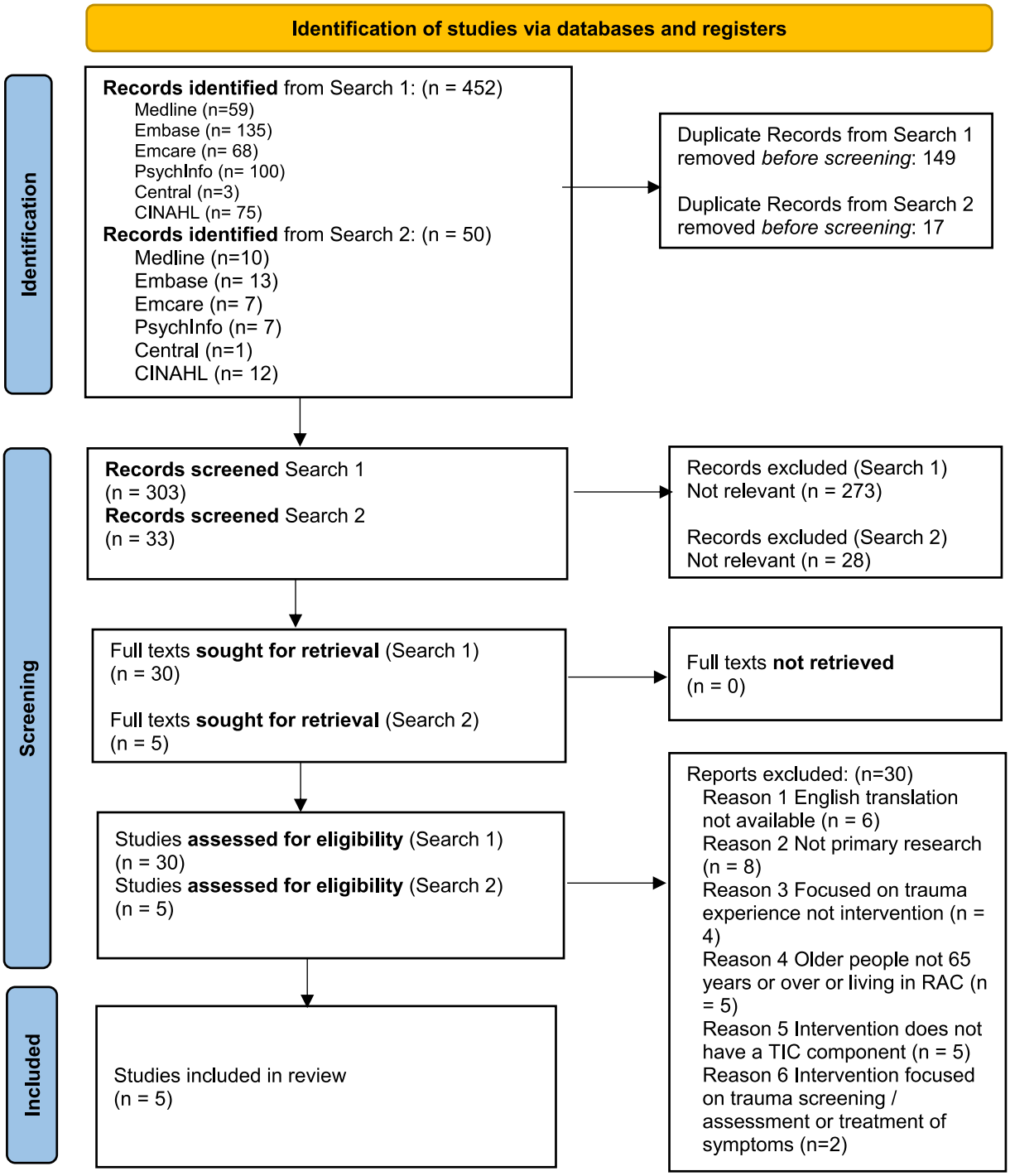

FIGURE 1 PRISMA flow diagram selection process.

3.1 | Study characteristics

Of the included studies, two were conducted in Australia,[41,42] one in the United States (US),[43] one in Canada,[44] and one in Sweden.[45] The studies were published between 2017 and 2022. All five studies were qualitative, using interviews, focus groups, observation, and document review for primary data collection.

Participant groups comprised RAC staff in four studies, with two studies[42,44] including both staff and residents. All studies reported number of RAC homes; 12 were represented, ranging from 1 to 4 homes per study.[41–45] Where locations were reported,[41–43] two thirds of the RAC homes were in a metropolitan area.

Study sample sizes ranged from 4 to 5 residents[42,44] and 9–70 staff or caregivers.[41,42,45] Most staff participants were female (66.7%–94%). In the two studies where age was reported,[43,45] staff age ranged from 20 to 66 years, and resident age ranged from 90 to 96 years. Study characteristics for all included studies can be found in Table 1.

TABLE 1 Study characteristics.

Author(s), year	Amateau et al., 2022	Craftman et al., 2020	Ritchie et al., 2022	Teshuva et al., 2017	de la Perelle et al., 2022
Country	USA	Sweden	Canada	Australia	Australia
Study design and data collection	Qualitative (focus groups)	Qualitative (interviews)	Qualitative (interviews and participant observation)	Qualitative (focus groups)	Qualitative (interviews and observation)
TIC framework	SAMHSA, Harris & Fallot	Not reported	Not reported	Not reported	Harris & Fallot
Sample of interview questions	Not reported	What do you consider to be important to keep in mind when caring for people with dementia who have experienced this kind of trauma? How do you think one can avoid triggering the memories of people who survived the Holocaust or experienced similar trauma?	Not reported	Participants were asked about their positive and negative experiences of working with Holocaust survivors and their families.	In your opinion and experience, what are some of the ways that psychologically traumatic events affect the residents here? How might you change your approach to care for a person with a history of psychological trauma? Can you tell me about your understanding and experience with trauma-informed care? What is trauma-informed care to you? How are staff here supported to understand and deliver TIC?
No. of RAC homes	4	1	2	4	1
Number of staff	18 (CNAs)	9 (nurses' aides)	4 caregivers, 11 healthcare providers	70 aged care workers	9 staff
% Female staff	94%	66.6%	2% (caregivers), 82% (staff)	87%	Not reported
Staff demographics	44% (n = 8) Black or African American, 44% (n = 8) white or Caucasian, 11% (n = 2) Asian, age range 20–66 years, average 41 years, average 15 years job experience	Aged 28–57 years, mean 53 years, working experience of 3–14 years, mean 10 years, 3-year upper secondary education from a health care programme that included theoretical studies and practical training, 8 days-shift and 1 night-shift staff.	Caregivers were 3 sons and 1 daughter. Healthcare workers were 9 female, 2 male	Jewish facilities, 50 females and 5 males; general facilities, 11 females, 4 males	Variety of roles and locations

(Continues)

TABLE 1 (Continued)

Number of residents	0	0	4	0	5 (1 interview without audio recording, 4 informal comments without interview)
Resident demographics	NA	NA	Veterans aged 90–96 years, lived in care for 1–3 years, all Caucasian and male.	NA	Not reported

The studies varied in approach to data collection and only two studies[42,45] provided the interview questions. Two studies[42,43] utilised TIC frameworks[6,17] to analyse results. Each study described components of practice that participants highlighted as important in caring for residents who have experienced trauma.[41–45] These components have been summarised in the thematic synthesis.

3.2 | Quality appraisals

All included studies were scored high (ranging from 8 to 10 out of 10) according to the JBI critical appraisal checklist for qualitative research.[39]

3.3 | Description of TIC themes in RAC

Thematic synthesis of the results from the studies resulted in eight themes that describe TIC for older people living in RAC. The codes and themes from the thematic synthesis are summarised in Table 2. Four of the five studies specifically focused on older people in RAC who were war veterans or survivors of the Holocaust, genocide, or mass trauma.[41,42,44,45]

3.3.1 | TIC requires knowledge about the resident's life

Knowing the resident as a foundational component of TIC is described as knowing the life story and background, including trauma history and its impacts on the resident.[41–45] Understanding the resident's history through collecting life story information, including any military or wartime experiences, was reported to be a critical approach to understanding the potential for a trauma history.[41–45] Knowing the resident enables care adjustments and helps staff anticipate potential trauma symptoms and related behaviours.[44,45] Teshuva, Borowski & Wells[41] reported that sensitivity was required when asking residents about their trauma history. However, rather than obtaining sensitive trauma-related information directly from residents, Craftman et al.[45] advise collecting information from someone other than the resident (such as next of kin) to avoid triggering a trauma response from the resident. However, Ritchie et al.[44] and Craftman et al.[45] reported that often the resident has shared little or nothing of their experiences of trauma with family or friends. Understanding significant historical events that occurred during a resident's lifetime further allows for the potential impact of trauma to be considered for that resident.[41]

3.3.2 | TIC requires an understanding of trauma and its impacts

The studies describe that a basic understanding of what trauma is and how it may impact residents' perspectives, emotions, and behaviours is a necessary component of caring for residents who may have experienced trauma.[41,42,44,45] Understanding the context of RAC from a trauma-focused lens was also described as understanding the resident's perspective of their environment or care situation.[41,43–45] As indicated in Table 2, two studies highlighted an interplay between PTSD and dementia and the additional complexities in managing trauma in these residents.[44,45] Training was described as a critical component of the provision of TIC to address this need for trauma understanding. It was reported that staff need to be trained in TIC on an ongoing basis[42,43] as staff are trained in the practical aspects of care and not the relational aspects, leaving them underprepared for this work.[43] Staff training should include three main areas: understanding trauma and its impacts, provision of TIC and vicarious trauma.[42,43]

3.3.3 | Safe relationships are the foundation for TIC

TIC approaches described in the studies were based on establishing safe and trusting relationships between staff and residents.[41–45] In addition, empathy was highlighted as critical to establishing an emotional connection and conveying care to residents who have experienced trauma.[41,44] Strategies for building trust included spending time to build positive relationships[45] and being friendly, honest, kind, respectful, and reliable.[41]

TABLE 2 Thematic synthesis of qualitative findings.

Descriptive theme	Codes	Frequency of codes	Example text
TIC requires knowledge about the resident's life	Know the resident	5 papers, 13 occurrences	*"Knowing the life story enables adjustments in the care"*[45]
			"Knowing about the Veteran's life story, including military trauma history, was described as an important part of informing care approaches"[44]
	Ask the family or staff	3 papers, 6 occurrences	*"Help from the next of kin was often needed to gain information about the PWD's life story"*[45]
	Don't ask the resident	2 papers, 3 occurrences	*"asking the person about their past was strictly avoided out of respect for their integrity and to avoid triggers"*[45]
	Know your history	1 paper, 2 occurrences	*"Holocaust awareness provided important context for understanding some everyday interactions with survivors"*[41]
TIC requires an understanding of trauma and its impacts	Understanding trauma	4 papers, 8 occurrences	*"important to be aware and take into account that the person could suddenly be reminded about their traumatic past"*[45]
	Understand the context	5 papers, 24 occurrences	*"features of the service demonstrated to residents that care was both trauma-informed and specifically veteran informed"*[42]
			"I want to understand the resident a little bit better and know where they are coming from."[43]
			"symptoms associated with PTSD symptoms and dementia are always present amid care interactions."[44]
			"a basic understanding of the impacts of trauma on survivors' lives are critical. This knowledge is the foundation for understanding who these clients are and how they respond to their surroundings"[41]
	Training	2 papers, 11 occurrences	*"none of the CNAs indicated they had received any training in supporting residents, themselves, or each other through trauma, grief, or loss"*[43]
			"CNAs in nursing homes attend to residents' bodies, minds, and spirits, yet their professional education prepares them for the physical tasks of caregiving and not the relational aspects of care"[43]
			"Orientation training for staff focussed on understanding the impact of past trauma on residents, finding ways to avoid triggers, and offering residents a sense of choice and control in all care behaviours"[42]
Safe relationships are the foundation for TIC	Relationships	5 papers, 8 occurrences	*"Caring for these people was dependent on a trusting relationship"*[45]
			"Providing care for Veterans with co-occurring PTSD symptoms and dementia requires a trusting relationship"[44]
	Emotional connection	1 paper, 2 occurrences	*"importance of establishing an emotional connection before approaching any care interaction"*[44]
	Empathy	2 papers, 2 occurrences	*"Empathy was described as an important part of building a trusting relationship, conveying a message of, "I care about you"*[44]
	Safety	3 papers, 8 occurrences	*"Residents clearly felt relaxed in the setting and able to get the attention they needed"*[42]
			"Ensuring that survivor clients feel safe"[41]
	Trust	4 papers, 10 occurrences	*"trusting relationships that felt authentic"*[42]
			"gaining the confidence of a survivor with dementia"[45]
TIC supports residents to manage trauma symptoms	Avoidance of triggers	4 papers, 18 occurrences	*"an environment where the person was protected from triggers in daily life"*[45]
			"being cognizant of the potential for heightened sensitivity to everyday aspects of care"[41]

(Continues)

TABLE 2 (Continued)

Descriptive theme	Codes	Frequency of codes	Example text
	Strategies	4 papers, 16 occurrences	*"Being patient, talking and acting calmly, and including the person in the process, were important practices when assisting a PWD in the shower. Keeping calm and working 'step by step'"*[45]
			"expected observed behaviours included (but were not limited to) activities such as knocking on doors and awaiting permission to enter, use of residents' names, rescheduling care tasks to suit, reducing noise or requests, using non-verbal communication, paying attention to concerns and resolving complaints"[42]
			"strategies for building trust, such as being friendly, honest, kind, respectful, and reliable; and strategies for giving clients as much control over their care as possible, including "never forcing anyone to do something they don't want to do," "working together with the clients," "listening to their wishes," "reading the situation," and "being flexible."[41]
	Diversion	2 papers, 4 occurrences	*"The PWD's short-term memory was used to divert a harsh thought in order to calm the person"*[45]
			"using redirection in this population can also result in an opposite effect of exacerbating PTSD symptoms"[44]
	Reduction of fear	2 paper, 7 occurrences	*"the person experienced the situation as less threatening and uncomfortable"*[45]
	Listening	3 papers, 3 occurrences	*"Some considered it important to let the person tell their story. In general, these carers believed that the storytellers were bearing witness; they either needed someone to know what had happened to them or, in some cases, they were releasing unbearable feelings of guilt"*[41]
	Validating perspective	3 papers, 5 occurrences	*"the NAs experienced that the person's difficult feelings needed to be confirmed"*[45]
TIC takes time	Slowing down	2 papers, 3 occurrences	*"And slowing things down is very important"*[44]
			"Staff approached their work in a quiet and unhurried manner"[42]
	Take more time	4 papers, 15 occurrences	*"I feel like he needs a lot of one-and-one. A lot of attention. So for me, I, we take the time. We take the time. So, we kind of leave him for the last, so we have enough time for him"*[44]
			"To reduce fear, the health care providers have found that more time is needed to complete care"[44]
TIC reflects PCC practices	Person-centred care	1 paper, 4 occurrences	*"Each person's unique life story provides an essential basis for care and PCC was therefore even more essential"*[45]
	Being guided by the resident	2 papers, 4 reference	*"Following the PWDs' expressions of their situation"*[45]
			"anticipated needs without imposing care"[42]
	Flexibility	2 papers, 9 occurrences	*"To manage the need for more time, participants have developed workaround strategies"*[44]
			"There is a need to have flexibility in staffing arrangements and switch with another health care provider"[44]
	Stay calm	2 paper, 4 occurrences	*"talking and acting calmly"*[45]
			"Non-verbal behaviours facilitated a quiet and calm atmosphere and avoided noise for people with sensory impairments"[42]
	Routine and consistency	2 papers, 7 occurrences	*"A constant routine in daily schedules and ensuring the consistency of care providers give a sense of familiarity and safety"*[44]
	Choice and control	4 papers, 11 occurrences	*"by offering choices about timing of tasks or meals, residents experienced a sense of control"*[42]

TABLE 2 (Continued)

Descriptive theme	Codes	Frequency of codes	Example text
			"giving clients as much control over their care as possible, including "never forcing anyone to do something they don't want to do," "working together with the clients," "listening to their wishes," "reading the situation," and "being flexible."[41]
TIC requires teamwork	Teamwork	3 papers, 6 occurrences	*"the importance of working in teams with common goals for the care of each individual"*[45]
			"Effective teamwork allowed staff to find solutions to issues and offered a strengths-based focus to their work"[42]
	Information sharing	2 papers, 5 occurrences	*"so that knowledge about how the person is best cared for was communicated to all staff"*[45]
	Shared goals	1 paper, 2 occurrences	*"Working in teams with common goals for the care of each individual"*[45]
	Peer support	4 papers, 9 occurrences	*"Staff regularly thanked each other and relied on each other to assist as needed"*[42]
			"Carers who worked in team situations found that informal debriefing with peers was helpful for checking with others about how to interpret challenging situations."[41]
	Reflection	2 papers, 2 reference	*"Problems and challenges that were raised concerning the care of a person were resolved and reflected on in the team"*[45]
TIC is for everyone	Organisational commitment	2 papers, 6 reference	*"urgent need for organisational support and nursing home culture change"*[43]
			"the policy and framework of the organisation, 'Janus Keys', set the standard for how residents could expect to experience care and were implemented via procedures and role modelling of senior staff"[42]
			"To fully adopt trauma-informed care in any organisation requires a commitment to continuous change at the individual and organisational levels"[43]
	Vicarious trauma	4 papers, 18 occurrences	*"Hearing stories about survivors' traumatic experiences and losses can be distressing and can result in secondary traumatic stress reactions."*[41]
			"CNAs working in nursing homes are negatively impacted by residents' trauma, loss, and deaths"[43]
	Self-care	2 papers, 10 occurrences	*"carers employed self-care strategies such as not taking aggressive behaviour personally and maintaining a sense of humour"*[41]
			"managers who were able to provide emotional support and help them to set emotional and professional boundaries around care relationships with particular survivors"[41]

3.3.4 | TIC supports residents to manage trauma symptoms

Four studies reported identifying and avoiding triggers[41,42,44,45] as an approach to managing agitating memories and trauma responses. Understanding the person's life story and being able to understand the resident's perspective allows staff to identify and avoid potential triggers.[41,42,44,45] Ritchie et al.[44] and Craftman et al.[45] highlighted a focus on reducing residents' fear responses. Awareness of the physical environment and its potential for activating traumatic memory was reported as important, particularly in the context of Holocaust survivors.[41,45] Examples included open spaces with groups of people being a reminder of Concentration camps, and confined spaces (such as showers) being a reminder of gas chambers and the experience of being unable to escape.[45] de la Perelle et al.[42] also described environmental considerations to avoid triggers such as noise reduction, lighting, quiet spaces, music and access to the outdoors but reported deliberate interior decoration to reflect resident's

war experiences as acknowledging their history rather than reminding them of traumatic events.

Intimate care activities such as showering were reported as an opportunity to consider trauma-informed approaches[41,44,45] because of the increased vulnerability and therefore potential for retraumatisation of residents during these activities. Strategies for managing trauma-induced emotions and behaviours included: use of diversional activities such as giving them something they like, singing, use of touch, or use of humour; including the resident in the care process, explaining what was going to happen, working step by step with sufficient time; being patient, assisting the resident in calming down, acting calmly; use of non-verbal communication; and listening to the resident and validating their perspective.[41,42,44,45]

3.3.5 | TIC takes time

All five studies highlighted the importance of taking additional time to complete care tasks with residents who have experienced trauma.[41–45] In addition, it was reported that slowing down during care tasks, spending time connecting with the resident, and giving them extra time and effort reduces the responsive symptoms of trauma, such as physical aggression.[41,43,44]

3.3.6 | TIC reflects person-centred care practices

Two studies[42,45] identified overlaps between trauma-informed approaches and person-centred care (PCC). de la Perelle et al.[42] posit that TIC is an extension of PCC. Examples of PCC approaches that were reported to be important for residents who have experienced trauma included: placing the resident and their individual needs at the centre of care; being guided by the resident; being flexible and adjusting care practices to the resident's needs; having consistency in routine; and promotion of resident empowerment, autonomy, and choice and control.[41,44,45] Some aspects of PCC reportedly can exacerbate trauma symptoms for residents. Ritchie et al.[44] reported that sometimes having consistent care providers can trigger responsive behaviours and that some flexibility within the team may be warranted. The biographical approach promoted in PCC was also reported to be inappropriate for some residents as it can trigger distressing memories.[41] Therefore, sensitivity during the collection of biographical information is recommended.

3.3.7 | TIC requires teamwork

Multidisciplinary teamwork and peer support were reported as crucial to delivering TIC.[41–45] Elements of teamwork reported to support TIC included: working toward shared goals; communication (information sharing, brainstorming); providing support to each other; and reflective practice and sharing of strategies.[41–45]

3.3.8 | TIC is for everyone

Two studies[42,43] identified that TIC is intended for whole communities (staff, residents, and their families). TIC was framed as an organisational change model in which a culture of TIC practice must be present at all levels of the organisation[42,43] and embedded into organisational policy and frameworks.[42] This includes management commitment to TIC approaches, resourcing, training and supervision to staff to provide TIC, role modelling and emotional support provision to staff, and awareness of and ways to address vicarious trauma.[41–43] Specific features of a trauma-informed organisation were reported to include transparency and communication, safety, adequate resources, emotional support, and staff wellbeing.[43,44] It was also reported that TIC training should be delivered to all levels of staff from induction onwards to promote a trauma-informed organisational culture.[42,43]

3.4 | Outcomes of TIC

As none of the included studies were intervention studies, outcomes were not reported. However, three papers that reported existing practices that align with TIC reported benefits to residents and staff of trauma-informed approaches.[42,44,45] Reported benefits to resident behaviours included reduced responsive behaviours (agitation and aggression)[44,45] and increased acceptance of caring activities.[45] Residents also reported increased sense of safety, empowerment, agency, reassurance, and that they are respected, listened to and have their privacy ensured.[42]

3.5 | Barriers and enablers for TIC

Four of the studies[41,43–45] did not directly address barriers or enablers to the implementation of TIC as no specific model of TIC was implemented. However, de la Perelle et al.[42] described contextual factors that contributed to creating a TIC setting in one RAC home. Enablers described by de la Perelle et al.[42] included organisational policy and frameworks which align with external regulatory frameworks and the principles of TIC, training of staff, high staff morale and commitment, effective teamwork, an environmental focus on dignity and comfort, and a specific liaison role and volunteers that supported veteran focused care.

Some barriers to TIC practice were identified throughout the findings on trauma-informed approaches to RAC.[41–45] To know the resident, access to information on the resident's relevant trauma history is dependent on family members knowing about this history, and it was reported that this is often not the case.[44,45] Lack of organisational support and system constraints, including time, resources, staff shortages, staffing ratios, differential treatment, organisational disrespect, and low wages, were also reported as barriers to the provision of TIC.[43,44] It was also identified that the task-focused nature of the work allows for little flexibility, which was reported to be essential for TIC.[44]

4 | DISCUSSION

This review described the trauma-informed approaches that have been applied in, or developed for, (RAC) and explored the barriers, facilitators, and outcomes of TIC in RAC. Despite substantial evidence of the impact of trauma across the lifespan,[19,46–48] there is a paucity of literature on the application of TIC in RAC settings. The studies included in this review illustrate that some staff use TIC approaches in some RAC settings. However, these studies indicate that many approaches have evolved from practice experience rather than the implementation of a formal TIC intervention.[41–45]

TIC has been applied in various settings, including education, mental health, primary health and child and family services.[20,49] In addition, there is evidence of TIC approaches being applied for older people in primary care, palliative care and housing.[13,18,49] This finding highlights a gap in research relating to TIC interventions explicitly designed for and implemented within RAC settings. All of the studies in this review are relatively recent, highlighting that research in this area is emerging and more work is needed.

4.1 | Similarities and differences between TIC and TIC in RAC

The findings of this review reflect many of the TIC principles applied in other settings, however, there are some contextual differences within the RAC setting. These are described in the sections below.

4.1.1 | TIC requires knowledge about the resident's life

Whilst TIC frameworks[6,50] refer to screening and assessment of clients for trauma, the application within RAC described within this review is more focused on understanding the biographical history of the resident rather than clinical assessment or screening. Knowing about the resident's life is a key PCC principle that assists in the individualisation of care.[51–53] In the context of TIC, this allows for individualisation of care, which accommodates a history of trauma for the resident. TIC also takes the position that anyone who has contact with the service (clients, staff, communities) has the potential to have experienced trauma.[6,17,18] The studies in this review operationalise this as an understanding of the historical context of residents which may have exposed them to traumatic events. However, there is a gap in the application of this TIC principle for staff and the broader RAC community.

4.1.2 | TIC requires an understanding of trauma and its impacts

The need for an understanding of trauma and its impacts highlighted in this review is consistent with TIC principles such as those described by SAMHSA[6] and Harris and Fallot.[17] In addition, studies in this review highlighted a key focus on the impacts of trauma on staff (vicarious traumatisation) as a product of the relational care they provide to residents in addition to the understanding of the impacts of trauma on residents.

Practice approaches have evolved through experience and reflection on the possible causes of resident distress.[41,44,45] Additionally, where a TIC framework was applied in a RAC setting, a focus on war-related trauma was evident[41,42,44,45] however, there was little acknowledgement of childhood trauma and other traumas throughout adulthood that may re-emerge and impact older people. There is an identified need for these perspectives to be broadened to other staff who may not have the awareness or knowledge required to consider trauma in their practice approach.[43]

4.1.3 | Safe relationships are the foundation for TIC

The core principle of establishing safe and trusting relationships as a foundation for TIC is consistent with TIC principles.[6,18] The studies illustrated specific strategies for establishing safe relationships between staff and residents in the RAC context including focus on relationship building as a priority, and soft skills to create the relational context for care.

4.1.4 | TIC supports residents to manage symptoms

TIC is not a trauma treatment or intervention and therefore the management of trauma symptoms is not a focus of TIC.[6] However, this review has demonstrated a potential for TIC to support residents to manage symptoms of trauma which would contribute to the reduction of clinical and behavioural interventions such as restraint and behaviour management plans. A key principle of TIC is avoiding retraumatisation through a focus on the avoidance of known triggers.[54] However within the context of RAC, knowing the resident allows for a more individualised understanding of triggers to reduce these in the environment and approaches to care in addition to the more general avoidance of known triggers. In particular, there was a focus on the potential trigger of intimate care activities which is not as applicable in many other settings where TIC is used (i.e. clinical settings, education, out-of-home-care). The studies illustrated recommendations for strategies to approach intimate care tasks from an understanding of resident vulnerability during such times.

4.1.5 | TIC takes time

Taking additional time is not specifically a TIC principle. In some clinical settings, being patient, being guided by the pace of the client, and taking time are part of clinical practice, these are not specific to TIC.[55] In this review, there was a described need to slow down, take

extra time with care tasks, and spending additional time with residents in order to reduce the activation of trauma responses. Contextually, this is a key point of difference as RACs are a very task focused and time pressured environment. The findings highlight the benefits of prioritising relational care over task completion in a work environment where completion of tasks is often a key focus for staff.

4.1.6 | TIC reflects PCC practices

Unlike other settings where TIC has been applied, this review highlights an intersection between PCC and TIC approaches being applied in RAC, such as the need to know the resident, tailoring support to the resident, and enabling choice and control. PCC is widely regarded as a best-practice approach to caring for older people living in RAC[54,56–58] and is focused on interpreting and regulating unmet needs, relational aspects of care and the impact of environments on behaviours,[59] which aligns with the principles of TIC.[6,17,31] Additionally, the documented outcomes of PCC align with those of TIC, including improved resident wellbeing and quality of life, reduced psychological distress, improvements in staff job satisfaction and wellbeing and reduced burnout and work-related stress.[58,60–62]

Whilst TIC is not specifically PCC as it is more broadly focused on the impacts of trauma on clients, staff and the organisation, there are highlighted overlaps from this review. This review highlighted examples where PCC approaches, which may be effective with some older people, are re-traumatising and problematic when that older person also has a trauma history[44] and is inconsistent with TIC. These findings suggest that an integration of PCC with TIC could enhance the benefits of PCC in a trauma-informed way. This would result in a TIC approach specific to the RAC context that may also be applicable in primary care and other settings for older people where PCC is used.

4.1.7 | TIC requires teamwork

TIC is a multidisciplinary approach that has been demonstrated through its application in a variety of settings.[13,17,18,20,49] Aged care is a multidisciplinary environment, with a variety of roles engaged in care delivery. However, this review highlights the importance of an integrated approach to resident care using TIC. The studies described sharing of strategies, communication, peer support and reflective practice as critical to taking a teamwork approach to resident care and all fall within the realms of TIC.

4.1.8 | TIC is for everyone

TIC is intended for whole communities.[6,17,18] However, many of the findings in the study highlighted individual approaches to TIC and only two studies indicated an organisation-wide approach, only one of which has been implemented and the other a proposed model. The studies focused on TIC approaches to resident care and highlighted a gap in organisational approaches, particularly TIC for the benefit of staff and the wider RAC community (i.e. resident families). This highlights a gap in TIC practice in RAC.

4.2 | Barriers and enablers for TIC implementation

The few results regarding barriers and enablers for TIC implementation in RAC in the limited number of studies presented were consistent with other literature. The enablers described by de la Perelle et al.[42] included organisational policy and frameworks, training of staff, high staff morale and commitment, effective teamwork, an environmental focus on dignity and comfort, and specialist roles. These enablers are consistent with the SAMHSA implementation domains including physical environment, engagement and involvement, and training and workforce development.[6] They also reflect the enablers for TIC implementation in healthcare settings[63] which are comparable contexts to RAC.

Barriers to the provision of TIC included limited access to information about the resident, lack of organisational support and system constraints, and the task focused nature of RAC.[43–45] The review by Huo, Couzner[63] reflected these barriers to TIC implementation and described additional barriers to the implementation of TIC in healthcare settings which may have potential relevance when considering TIC implementation in RAC. Some of these comparable barriers include resistance to change, lack of consumer engagement, insufficient staff skill, time constraints, competing priorities, lack of leadership or organisational commitment, staff turnover, and lack of resources. In addition, a lack of adherence to other implementation domains such as progress monitoring, evaluation, and cross sector collaboration may be potential barriers to implementation success.[6]

4.3 | Recommendations for future research

Given the lack of a specific TIC intervention or model for RAC, and increasing requirements for TIC to be implemented in RAC,[13,64] there is an opportunity to draw on existing practice models used in other settings[18,20,62] and RAC staff experience to explore the development of a model of TIC for RAC settings. The findings from this review build on the existing evidence for TIC to inform several recommendations for further research: (1) the design of a TIC intervention for RAC, (2) the development and implementation of training for RAC staff and organisational leaders, (3) taking an organisation-wide approach to TIC for RAC settings, and (4) implementing system-wide approaches that support TIC in RAC.

4.3.1 | Designing a TIC intervention for RAC

The context of RAC is a unique environment for the application of TIC. Other settings in which TIC has been applied include occasional, acute

or therapeutic contexts such as early childhood services, out-of-home care, hospitals and clinical services.[17,18,20] RAC combines residential care, medical care and lifestyle support which provides an opportunity for a systemic and multidisciplinary application of TIC across multiple touchpoints in the life of the resident whilst also reducing the burden of care on staff from various disciplines. Trauma-informed RAC environments would ensure safe, empowering and supportive residential care. TIC approaches to lifestyle care could support safe and supportive social interactions and activities for residents. An organisational adoption of TIC may ensure that staff and the families of residents are supported to reduce the risk of vicarious traumatisation. TIC in RAC would combine the benefits of application in other settings, to extend PCC practices and contribute to organisational culture change for the benefit of staff, residents and their families.

It is recommended that future research to inform the development of a RAC specific application of TIC utilises a co-design approach. Co-design is a participatory approach to the design of programs and interventions that ensures that the developed product meets the needs of its recipients.[65] A TIC model for RAC developed with staff, residents, and their families would combine research evidence of other TIC models with existing practice wisdom and the resident voice to inform a model of TIC that is applicable and feasible in a RAC setting.[31]

4.3.2 | Developing and implementing TIC training

This review highlighted that many RAC staff may be unequipped for the relational nature of the work, which can be taxing and impact their emotional wellbeing.[43] This can lead to a lack of appropriate care for residents and vicarious traumatisation of staff.

RAC staff require knowledge and skills to manage a range of trauma responses to be trauma-informed. Given the lack of literature in this area, there is no known formal TIC training for RAC organisations that has been systematically applied or evaluated, highlighting a further research gap. Amateau, Gendron & Rhodes[43] propose a model of TIC including staff training as a core component; however, this has yet to be implemented or evaluated. de la Perrelle, Klinge[42] reported training was incorporated into staff orientation. Still, the extent to which other organisational staff are involved in this training or the opportunity for ongoing training was not explored. Furthermore, outcomes for staff and residents were not reported, limiting the demonstration of the efficacy of TIC being translated into practice.

The findings in this review highlight the need for staff training on trauma, its impacts, approaches to managing trauma in older people living in RAC and management of secondary stress. TIC strongly focuses on workforce development through training, knowledge acquisition, and continuous practice improvement strategies.[6,66]

It is therefore recommended that any developed model of TIC for RAC should include a training and workforce development component to ensure staff proficiency and knowledge on how to use TIC approaches and manage secondary stress.[66] It is also acknowledged that information provision, whilst necessary, is insufficient to ensure translation to practice change.[51,67–69] It is recommended that training be continuous and practical, using local champions or mentors, supervision and ongoing feedback.[58,67]

4.3.3 | Organisational TIC in RAC

TIC is an organisational approach and not focused solely on training for frontline staff. Amateau[43] presents a case for an organisational change model that demands management commitment to TIC at all levels of the organisation, including culture change, resourcing, training and emotional support provision to staff.[43] The findings of this study[43] are consistent with the implementation domains provided by SAMHSA,[6] which target the organisation's leadership, governance, policy and practice levels. This study is supported by de la Perrelle, Klinge,[42] who reported an organisational approach to TIC by aligning TIC principles with organisational and regulatory frameworks.

These findings support the recommendation for an organisational approach to TIC in RAC through which the impacts of trauma on staff and residents are addressed through system-wide TIC practices.

4.3.4 | Implementing systemic changes

It was identified in this review that the existing systemic context in which RAC homes operate may pose challenges to the provision of TIC.[43] It was highlighted that the relational aspect of care requires time and attention, an additional time impost in a task-heavy and fast-paced environment.[41,43–45] Applying TIC in RAC would require additional resourcing or reallocation of resources to enable adequate time for staff to provide TIC to residents. However, there are potential benefits to TIC that may balance this additional resourcing, such as reducing distress, agitation, and responsive behaviours, which would free up time for focus in relational care.[13,23,28] This is an additional area in which an organisational culture supportive of TIC is required for TIC to be applied effectively.

Several calls for systemic change to enable TIC in RAC settings have highlighted areas for change.[31,32] These include the development of policy to support TIC practices in RAC, cross-system collaboration, including TIC training in mainstream curricula, collaboration with staff and people with lived experience, changes in risk management, and appropriate resourcing.[31,70] Further research is needed with a focus on the development of TIC approaches for RAC settings, and advocacy for system change.

5 | LIMITATIONS

Few studies are included in this review, indicating a lack of evidence of TIC approaches applied in RAC settings. However, this review did not include grey literature, which may have revealed informal studies

of TIC approaches in organisations that do not have access to academic evaluation. In addition, six of the excluded studies were not in English and may have been intervention studies that could have been relevant.

The included studies are restricted to specific trauma categories, highlighting a narrow focus of TIC research on war-related trauma. Unfortunately, this has resulted in findings that may not apply to older people who have experienced other forms of trauma.

The voices of residents with trauma are minimal in this review, with only two studies including resident participants[42,44] however, this is a literature-wide issue. Older people are generally underrepresented in research for many reasons, including concerns regarding cognitive impairment impacting their capacity to consent or communicate, and relying on third-party or proxy informants.[8,71] In addition, whilst TIC is promoted to benefit everyone in the RAC community, the voices of families were also absent in these studies.

Due to the lack of studies identified in this review, outcomes, barriers, and enablers of TIC in RAC were limited. Therefore, this review aim was unable to be sufficiently addressed.

6 | CONCLUSION

This study has highlighted a need for further research into TIC in RAC settings. Whilst there is some awareness of the impacts of trauma on older people living in RAC, and some staff have applied TIC approaches to resident care, there is an opportunity identified for the development and evaluation of a TIC intervention that will meet the training and systemic needs of organisations to support TIC approaches for older people who have experienced trauma.

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CONFLICT OF INTEREST STATEMENT

The authors declared no potential conflicts of interest with respect to the research, authorship or publication of this manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the sourced publications. The extracted data is available as a Supporting Information S2.

ETHICS STATEMENT

Ethics approval was not required for this study as there was no primary data collection.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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