THE IMPACT OF TRAUMA-INFORMED CARE ON PATIENTS IN THE EMERGENCY DEPARTMENT

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ABSTRACT

Trauma is highly prevalent within the Emergency Department (ED). The Centre for Addiction and Mental Health ([CAMH], n.d.) defines trauma as the emotional response and physical reaction to a distressing event. Since 2019, ED's have experienced increased incidence and severity of clinical presentations (Finkelstein et al., 2021; Powers et al., 2024). An increase in clinical presentations to the ED, increases incidence of trauma-exposure and prevalence of trauma. Despite a high incidence of trauma exposure and increasing prevalence of trauma in the ED, healthcare providers lack appropriate knowledge surrounding psychosocial care (Afzal et al., 2022). Patients who have experienced traumatization in health settings, are at risk of decreased future engagement with health services and an increase in high-risk behaviours (Reid et al., 2022; Whetten et al., 2012; Vallieres et al., 2025). Trauma-Informed Care (TIC) is a new emerging framework adopted by health practitioners to recognize and reduce impacts of trauma on patients (Brown et al., 2022). This quality improvement project aimed to pilot an education session to increase emergency nurses (EN) awareness surrounding TIC and its implementation in practice via an educational session. The project's findings suggest ENs affirm the need for TIC education in clinical practice, within the ED.

Key Words: Trauma-Informed Care (TIC), Emergency Department (ED), Emergency Nurses (EN), Urgent Care, Trauma.

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SECTION 1: INTRODUCTION

Problem Statement

Trauma is highly prevalent in the field of emergency medicine, as presentations to the emergency department (ED) originate from, and may lead to, varying degrees of trauma (Brown et al., 2022). Trauma is already prevalent within the ED; however, since the Covid-19 pandemic, ED's have seen increased triage acuity, meaning increased severity in clinical presentations of illness (Finkelstein et al., 2021; Powers et al., 2024). An increase in acuity of presentations equates to elevated incidence of trauma, increasing trauma exposure levels for patients. Despite a high incidence of trauma exposure and prevalence of trauma in the ED's, healthcare providers lack appropriate knowledge surrounding psychosocial care (Afzal et al., 2022).

Unless a patient's presentation is explicitly related to a traumatic experience, psychosocial care, or a trauma-informed approach can be missed within their care plan. The risks associated by ED patients developing trauma or risking re-traumatization have shown a future decreased engagement with health services (Reid et al., 2022).

Trauma-Informed Care (TIC) is a new emerging framework adopted by health practitioners to recognize and reduce impacts of trauma on patients (Brown et al., 2022). The Centre for Addiction and Mental Health ([CAMH], n.d.) defines trauma as the emotional response and physical reaction to a distressing event. Using a holistic lens, the clinician will reframe delivery of care based on a patient's trauma-profile with the primary goal being to create and develop safety, trust, support, empowerment of patients with a focus on marginalized communities (Trauma-Informed Care Implementation Resource Center [TICIRC], 2025; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Project Purpose

The problem identified for my quality improvement project involves the current lack of Trauma-Informed Care (TIC) provided by nurses to adult patients in the Emergency Department (ED). The proposed solution to ensuring patients do not experience significant trauma or risk re-traumatization is an education session provided to ED nurses on TIC. With the aim of the project being to increase awareness of TIC for ED nurses, in order to implement TIC into their own clinical practice. The project itself, is a pilot project, consisting of a 30–45-minute presentation, using Microsoft PowerPoint on TIC. The presentation provided an overview of what is trauma-informed care, its application in practice, and how it can be implemented using case-based scenarios. The project's intent was quality improvement; thus, data collection consisted of a post-evaluation survey completed by the participants and a one-week post-presentation check in. The data collected was used for assessment of participants learning and feedback for future presentation considerations. The pilot project was presented to four Emergency Nurses (EN) working within the University of Alberta Hospital (UAH) ED.

SECTION 2: LITERATURE REVIEW

Search Terms

For the literature review I analysed and examined 44 sources consisting of peer reviewed research and journal articles; primary statistics and research data; and gray literature surrounding TIC. Sources selected were published within the timeframe of January 1, 2018 to January 1, 2025. Excluded from this timeframe were five articles published prior to 2018 that offered significant relevance to TIC, this included but was not limited to SAMHSA's TIC framework, and Merrills Principles of Instruction. Other exclusions were applied to literature centring around paediatrics (under 18 years old), and non-peer-reviewed sources.

Initial searches were conducted through search engines such as google scholar for generalized academic terminology, and research related to the project's topic. Searches were then conducted using nursing-specific databases: CINAHL, MEDLINE, APA PsycINFO. Further literature was sourced from medical academic databases: PubMed, EMBASE, OVID/Medline.

The search terms used for the literature review surrounding TIC in the ED included: "Trauma-Informed Care," further abbreviated "TIC," "trauma informed principles," "emergency," "urgent care," "adult." Boolean operators "AND," "OR," Parentheses, quotation marks were used to obtain literature specific to adult in the emergency department. Search Terms used for literature specific to defining trauma, and types of traumas were reviewed using keywords "psychological," "emotional," "environmental," "developmental," "physical," "acute," "chronic," "complex," and "secondary," These search terms were used primarily to define trauma, in order to understand the relevance and implications of a trauma-informed approach to care.

What is Trauma?

Trauma is the umbrella term associated with emotional or psychological duress related to a life-altering event that results in long-lasting effects (CAMH, n.d.; TICIRC, 2025). Trauma can occur to any individual indiscriminate of age, sex, gender, mental or physical capacity. Due to the varying forms and degrees of trauma, generally types of traumas can be described as: acute, chronic, complex, physical and emotional/psychological. Trauma can be experienced on a primary level, meaning the trauma is experienced by the individual, or secondary level, meaning the trauma occurred to someone else, but impacted associated individuals. Lastly, trauma can be further broken down to an individual, interpersonal, communal, or systemic/societal level (PTSDUK, 2025; TICIRC, 2025; SAMHSA, 2014).

Acute trauma refers to an isolated traumatic experience, this event only occurred once but had significant long-lasting impacts on the affected individual. (The Trauma Practice [TTP], 2025). Examples of acute traumas are often displayed as sexual or violent assaults; however, acute trauma extends to experiences involving terrorism, medical malpractice, natural disasters, or death of someone close to you. Chronic trauma, compared to acute, occurs over an extended period of time. This form of trauma can involve exposure to multiple traumatic events over a long period of time, or describe compounded traumas: multiple traumatic events building up over-time (Ross et al., 2021). Chronic trauma is described to have an emotional element keeping the individual in a continued cycle of traumatic experiences due to guilt or shame (TTP, 2025). Examples of chronic trauma can be familial abuse, domestic violence, school bullying, long-term misdiagnoses and medical gaslighting (TTP, 2025). Medical gaslighting occurs when a health provider makes a patient question and becomes unsure of their own symptoms, experience, or health history. Medical gaslighting in regard to complex trauma is often described similarly to

chronic trauma, in that it involves multiple traumatic experiences over a prolonged period of time (Lewis et al., 2021; Ross et al., 2021). Although complex trauma is differentiated by the severity of the trauma, as seen in the individual's response to, and disturbances in personality after the traumatic experiences (Ross et al., 2021).

Physical, psychological and emotional trauma are differentiated in two ways: by the response exhibited after experiencing a traumatic event and the nature of the trauma experienced. Psychological or emotional trauma received its title to describe traumatic experiences that have a profound impact on psyche, and a trauma response that results in intense emotions, and mental anguish (Spytska, 2023). While physical trauma involves a traumatic event that results in bodily harm. Some examples of physical trauma include: car or sporting accident, or human error while using dangerous tech/machinery. Trauma(s) will not always fall neatly within the physical, psychological or emotional categories, this is why presentations can involve a combination of the traumas described above. An individual can experience extreme psychological duress regarding memories that involve physical sensations.

Primary and secondary trauma relates to how a person experiences said trauma. Primary trauma occurs directly to an individual, while secondary trauma impacts someone who is indirectly involved in the traumatic event: witnessing harm occurring to another, or a close relationship with the individual harmed (PTSDUK, 2025). A primary traumatic experience is an event where an individual is the primary or sole victim of harmful or distressing events. Due to the negative physical and psychological toll of the individual directly experiencing the event they will often seek out care and support. Due to this, individuals directly involved in a traumatic event can present to the ED for help.

Secondary trauma has been described as the trauma acquired by repeated engagement with a traumatized individual (Ellis & Knight, 2021). Through exposure to another's trauma, a person's own feelings of discomfort and unease can surface, creating their own trauma they have to heal from (Ellis & Knight, 2021). Secondary trauma is often seen in nurses, as their line of work requires them to interact with traumatized individuals seeking help, and treatment. Examples of traumas nurses may interact with can be a physical injury, witnessing death, or hearing a retelling of a traumatic event. These traumatic events can result in unpleasant thoughts and feelings, leading to the nurse requiring help of their own.

Individual traumas involve and occur to one individual. This can include being the victim of sexual assault, or medical malpractice (CAMH, n.d.; Ramos, 2021). While interpersonal trauma relates to trauma associated with interactions between two or more individuals, which can include child abuse, or domestic violence (Mikolajewski & Scheeringa, 2021; TICIRC, 2025).

Communal, systemic/societal or social forms of trauma relate to traumas experienced by a group of individuals from the same geographical location, culture, religion, ethnicity or nationality: these can include racism, war, natural disasters or terrorism (CAMH, n.d.; TICIRC, 2025). Two examples of a relational experience of trauma experienced by a collective historically is the Holocaust, and African American slavery (TTP, 2025). Despite the resilience within these communities, these collective traumatic events were not without physical impact. Holmes et al. (2023) also describes an additional type of trauma, labelled as: neurobiological. Neurobiological trauma relates to the psychological impacts of trauma in childhood carried into adulthood that effectively rewires their brain. Campbell (2022) describes how psychological trauma exhibits a similar response in the brain to when individuals experience physical pain.

These experiences of trauma irreversibly change the way brains function and develop, leading to the predisposition of other psychiatric conditions such as depression, and personality disorders (Campbell, 2022). In other words, trauma changes the way an individual's brain functions. In cases involving neurobiological trauma, nurses may not be able to prevent initial traumatization, as it often occurs in childhood. Instead in these cases, nurses can change their own approach to practice, (e.g. implementation of TIC) to prevent further harm. Trauma-Informed Care is a framework that guides nurses' clinical practice and decision making to promote patient safety, and prevent re-traumatization.

Everyone has experienced some type or level of trauma within their lifetime, what varies is how an individual handles their trauma. Some are able to cope and move on, others are impacted by their trauma for longer periods of time, and risk having the negative feelings associated with that trauma re-emerge (re-traumatization). This is why a Trauma-Informed approach was created to assist nurses in helping patients navigate trauma and its impacts.

Trauma-Informed Care

Trauma-Informed Care (TIC) is an approach to care, and framework that outlines how understanding and recognizing trauma, its causes and outcomes, at an individual to societal level, allows practitioners to implement measures to reduce its impacts on patients (SAMHSA, 2014; TICIRC, 2025; Holmes et al., 2023). The primary goal of TIC is to prepare health clinicians in understanding, recognizing, and preventing traumatization, and re-traumatization (SAMHSA, 2014).

TIC is noted to be used under alternate terms such as: Trauma and Violence Informed Care, a Trauma-Informed Approach, and Trauma-Informed Practice. For consistency purposes,

TIC will be the primary term used throughout this paper. Trauma-Informed Care is a framework that follows a process of assessment, planning, and implementation of changes in a nurse's clinical practice in order to improve care outcomes for patients. This framework is known as the Four Rs of TIC.

Four Rs of Trauma-Informed Care

SAMHSA (2014) heavily delved into the theoretical application and framework of TIC, creating the Four Rs to guide a trauma-informed approach. The Four Rs are a linear thought process for clinicians to apply TIC, described as: realize, recognize, respond, and resist (SAMHSA, 2014).

The first R, "Realize" consists of understanding how trauma operates and in turn, impacts patients (Goddard, 2021; SAMHSA, 2014). The second R, "Recognize," calls for clinicians to identify symptoms and presentations of trauma during interactions and assessments (Goddard, 2021; SAMHSA, 2014). Thirdly, "Respond," depicts the implementation of a trauma-informed approach into practice (Goddard, 2021; SAMHSA, 2014). Lastly, the fourth R, "Resist," arguably the most important, the application of measures to prevent re-traumatization (Goddard, 2021; SAMHSA, 2014).

The "Realize" of the SAMHSA (2014) TIC framework engages the collective, whether that be at the individual or organisational level, to holistically understand the impacts of trauma. This involves understanding signs and symptoms of trauma, and how or why individuals may be pre-disposed to trauma. This stage also encourages one to be an active participant in learning about trauma and how it impacts the individual, or community. With the overall intent or goal behind this step is to have prior knowledge on how trauma may influence a person, situation, or

system in order to reduce its impact. By understanding how trauma operates, and how someone may be impacted by trauma, one can feel prepared to address trauma through implementing interventions to reduce its impact. From a nursing perspective, when providing care to a patient, implementing the "Realize" stage of the TIC framework would involve entering a care environment with prior knowledge and understanding of trauma. That knowledge and understanding is then used to realize how an individual or environment may be affected by trauma, and how trauma may manifest itself: patient behaviour, or discriminatory policies.

The second step in the framework is "Recognize." This requires individuals, groups or organizations to identify and understand signs and symptoms of trauma. Using the prior knowledge identified in the first step, the second stage requires critical thinking, into how might trauma present itself. Recognizing trauma comes with the understanding that trauma can exist amongst patients, families and communities. As a nurse, one identifies intersections of trauma based on the patient's identity, background, and environment. A nurse would use their patient assessment and chart review to recognize and identify potential or actual traumas. While "Realize," and "Recognize" appear similar, the key difference between the two is realize focuses on awareness surrounding trauma, while recognize focusses on identifying potential for or actual traumas.

"Respond," the third step in the TIC framework involves taking action toward the implementation of TIC. At an individual level, the third step involves applying interventions based on the prior steps knowledge, awareness, and assessment. This stage favours action over words. Impacts of the "Respond" stage are more prominent at an organizational level. The application of TIC at an organizational or structural level involves policy development and integration into practice. Nurses and patients alike appreciate their health needs being recognized

and prioritized. Policy that identifies TIC, calls for it's implementation in practice, and outlines its impact for patients, creates a clear and direct standard for care.

The final step in the framework is to "Resist" re-traumatization. This is an intentional effort made by individuals, groups and organizations to continue the application of a trauma-informed approach. Without momentum for continued change, TIC can not fulfill it's intended overarching principle of increasing patient safety. This step highlights that TIC is an ongoing and evolving process.

Other variations of the "Four Rs" are present within the literature, some creating additional Rs. For example, in the case of Ramasubramanian et al. (2021) an addition of "Replace" and "Reframe" were added to the Four Rs framework, designed to acknowledge systemic and socially dominant forms of trauma. The fifth, and sixth Rs, "Replace" and "Reframe" instruct social-justice oriented individuals to replace an egalitarian mindset with an equity-based mindset and reframe ideologies that maintain systems of oppression that create and feed into societal traumas (Ramasubramanian et al., 2021). Racialized or marginalized groups experience increased rates of violence, and harm; this includes physical, psychological and social forms of harm. These experiences translate into traumas and due to how society functions, this cycle of trauma is maintained. Replace and reframe seek to purposefully address and restructure systemic and social constructs to prevent the aforementioned experiences of trauma. The Four Rs is one framework developed specifically for implementing TIC. Another theory developed from the TIC framework, that considers a different approach to TIC is Trauma-Informed Theory of Behaviour.

Trauma-Informed Theory of Behaviour

Trauma-informed theory of behaviour (TTB) is a novel theory that consists of identifying the extent of one's trauma to implement individualized long-term health-promoting behaviours (Marks, 2021). The theory components consist of identifying the type and extent of an individual's trauma, how the trauma presents and adapting a constructive response to this behaviour (Marks, 2021).

TTB is based upon the TIC framework created by SAMHSA (2014) in which they speak heavily on the importance of promoting resilience within populations impacted by trauma, but do not explicitly identify resilience as a proponent of the Four Rs, or key principles of TIC. Marks (2021) wanted to explicitly identify and hone in on the impact of, and importance of building resilience in individuals impacted by trauma.

Individuals with trauma are already vulnerable and at risk of adverse health outcomes. With individuals who have a history of traumatization there is a high incidence of participating in risk-taking behaviours such as substance misuse, high-risk sexual activity, and intentional physical violent assault (Michaels et al, 2021). Re-traumatization also plays into traumatized individuals seeking high-risk outlets to manage symptoms related to their trauma (Michaels et al., 2021). TTB encourages individuals with experienced trauma to mitigate re-traumatization by limiting further exposure, building a resilience-based mindset, and prioritizing health-conscious behaviours (Marks, 2021).

While Trauma-Informed Care (TIC) accounts for the actions clinicians may take to assist and prevent re-traumatization of individuals, TTB builds upon the patient's capacity to make decisions to lower the incidence of re-traumatization (Brown et al., 2022; Marks, 2021). Nurses

implementing TIC will provide education to promote patient understanding of individualized pathways in alleviating the risk of re-traumatization; therefore, implementing TTB.

If applied to the TIC framework, and integrated into practice, TTB would ideally be implemented by the clinician during the "Respond," and "Resist" phases. A scenario example of its implementation is as follows: patient A with increased sensitivity to screaming, loud noises and graphic imagery while attending the ED is exposed to patient B screaming in pain for a degloving injury. Patient A's nurse implements TIC, by closing the patient curtain to block unsettling imagery, and asks the patient what would help them stay calm and promote safety. Patient A requests earplugs, and a warm blanket.

A TTB approach would be the nurse ahead of patient B's arrival asking the patient to identify possible triggers, and to think of ways in which they cope with triggers outside of the ED. The patient when cued by the nurse identifies they use headphones with a noise cancelling feature, and listens to music with their eyes closed to reduce auditory and visual stimuli that may be unsettling. When patient B arrives, patient A independently puts on their noise cancelling headphones, and listens to music with their eyes closed.

TTB promotes patient autonomy, and involvement in their own care plan, in reducing impacts of trauma, and actively preventing re-traumatization, ultimately developing a resilience-based mindset (Marks, 2021). TTB and TIC's Four Rs are both frameworks that are easy to understand, and simple for nurses to implement into practice; however, SAMHSA does elaborate on how TIC can be implemented in practice via six principles of a Trauma-Informed approach.

Trauma-Informed Care in Practice

SAMHSA (2014) also identified six principles of a trauma informed approach: safety, trust, peer support, collaboration, empowerment, and social/historical considerations. Each principle relates to an aspect of implementing TIC into practice.

1. *Safety*. A nurse must be actively involved in creating an environment of physical and psychological safety for the patient, and each other, through communication, environment, and choice (SAMHSA, 2014). Communication refers to being considerate of the language, and words that individuals may be sensitive to (SAMHSA, 2014; Scott et al., 2023). Environment considers how appearance and scenery can impact an individual's sense of safety and comfort (Scott et al., 2023). Lastly choice involves promotion of autonomy.
2. *Trust and Transparency*. A nurse must implement veracity, and maintain open, clear lines of communication with the patient (SAMHSA, 2014). This principle stresses the importance of building rapport with the patient. A nurse should clearly communicate the patient's care plan to the patient and interdisciplinary team (Scott et al., 2023). This aims to reduce uncertainty, and ambiguity for the patient.
3. *Peer Support*. The role of the nurse for this principle is encouraging a support system for the patient (SAMHSA, 2014). Nurses should also reach out to colleagues for support, if unable to provide safe and appropriate TIC (SAMHSA, 2014).
4. *Collaboration and Mutuality*. This principle asks the nurse to collaborate with a multi-disciplinary team to promote a safe care environment. (SAMHSA, 2014).

When implementing TIC, the nurse should model respectful relationships with colleagues.

5. *Empowerment, Voice and Choice*. This principle promotes and recognizes that autonomy for patients is promoted, and patients are seen as individuals (Scott et al., 2023). Patients' needs, choices and perspectives are also affirmed by the nurse (SAMHSA, 2014). Patients are encouraged to be involved in their care plan, and their feedback is valued (Scott et al., 2023).
6. *Cultural, Historical and Gender Issues*. This principle involves understanding, and acting on personal or organizational bias, and stereotypes surrounding race, ethnicity, culture, and identity (SAMHSA, 2014) This principle asserts that a trauma-informed approach requires an individual to advocate for inclusive policies, increasing availability of services (Henshaw, 2022). The role of the nurse is to be active in creating an environment that is culturally inclusive and safe.

Implementation of TIC does not solely involve implications and considerations of the patient; it is a multi-faceted framework that influences a nurse's approach to patient care delivery. Critical thinking, collaboration, growth and development are principles nurses develop from TIC implementation (Agboola et al., 2021; SAMHSA, 2014). Due to TIC's broad application, the framework has impacts and influences on the individual (patient), professional (nurse), and organizational level.

Impact of Trauma-Informed Care

TIC is a broad framework that can be implemented both in personal and professional settings. TIC offers a standardized approach, that is simple and accessible. Due to this, TIC can

be readily implemented by nurses, even within a fast-paced environment such as the ED. The implementation of TIC enhances both the nurse's clinical practice and delivery care, as well the patients' safety and satisfaction interacting with healthcare services. Despite the success of TIC in practice, barriers still exist to its integration and implementation.

The Patient

The ED is often the first point of contact when individuals seek help after undergoing a traumatic event. Individuals seeking care in the ED, especially amongst those that suffer from mental health concerns or violent injuries, often have a prior history of trauma (Fischer et al., 2019; Ramasubramanian et al., 2021). Due to these factors ED clinicians interact with individuals who have experienced or will experience trauma on a daily basis. Inappropriate or lack of psychosocial care carries the risk of maintaining or exacerbating poor patient health outcomes (Reid et al., 2022).

Patients who are at risk of, or have experienced trauma in healthcare settings are less likely to engage with future care and are more likely to engage in high-risk behaviours, including unsafe sex, drug use, and attempted suicide (Reid et al., 2022; Whetten et al., 2012; Vallieres et al., 2025). Engaging in high-risk behaviour, while avoiding health delivery services, increases patients' risks of developing complicated health histories, increasing burden on health services (Taber et al., 2014). Increased awareness and implementation of TIC by nurses has been shown to result in increased patient attendance in accessing health services (Reid et al., 2022). Individuals with trauma may avoid health care environments due to fear of re-traumatization, leading to unaddressed health concerns, resulting in additional presentations to the ED. These frequent presentations, can increase ED wait times, and delay delivery of health services.

Increased attendance for initial and primary concerns prevents repeat presentations to the ED, resulting in reduced wait times and improved organizational flow.

Nursing Practice

Nurses are often the first point of contact for patients in the ED, making their interactions with patients the determining factor in whether patients will receive safe and holistic care. TIC aids in developing nursing practice by promoting critical thinking, advancing patient-centred care, and improving safety outcomes for patients and staff alike (Agboola et al., 2021). Nurses' continued exposure to trauma can put their mental and physical health at risk. Some examples of these risks include: compassion fatigue, and secondary trauma (Qin et al., 2025). TIC aims to offset the burden and risk of re-traumatization for both nurse and patient (Qin et al., 2025). TIC encourages nurses to maintain ethical standards of practice and encourages nurses to implement the nursing process for each patient encounter (Dowdell et al., 2022). To promote further implementation of TIC in practice, nurses must understand the theory behind TIC.

Goddard et al. (2021) speaks to the current need for explicit teaching of TIC in nursing education programs and the role nursing professors play in advocating for, and incorporating TIC framework into theory. As nursing research grows and the outcomes of TIC are recorded, an increased need for its addition to nursing education develops (Goddard et al., 2021). As the body of TIC research in nursing grows, so follows the expectation for TIC to maintain a significant role in practice at an organizational level.

Few studies have directed their research toward a trauma-informed approach specifically for clinicians, due to exposure of traumatic incidences to not just patients, but staff providing

care. To keep the scope of the project focused, TIC within the project will cover the impact on patients primarily.

Institutional/Organizational

TIC has proven to yield prominent results in practice from the perspective of both nurses and patients alike. Research also demonstrates TIC at organizational levels improves function and delivery of care services (Agboola et al., 2021; Goldstein et al., 2024). Despite this, organizational implementation of TIC is largely uncommon. SAMHSA, (2014) for this reason also developed the Ten Implementation Domains. These domains help address the impact of TICs use at a structural, institutional or organizational level (Goldstein et al., 2024). The Ten Implementation Domains identified by SAMSHA (2014) highlight the socio-political, and structural sectors that have the most significant influence over the successful implementation of TIC at an organizational, or institutional level. These domains as defined by SAMHSA (2014) are:

1. *Governance and Leadership*. Governance and leadership act as role-models, demonstrating how to facilitate discussions surrounding implementation of TIC into organizational structure.
2. *Policy*. Policy provides a standardized guide for nurses integrating TIC into practice. It also allows organizations to formalize a trauma-informed approach as a necessity in patient care.
3. *Physical Environment*. To promote a physical environment in which TIC is implemented for patients, an environment must first promote a similar trauma-informed approach to safety and well-being for its staff.

4. *Engagement and Involvement*. Increasing engagement and involvement of individuals of whom directly benefit from and depend on TIC implementation. This primarily includes trauma survivors and their support persons.
5. *Cross Sector Collaboration*. Cross sector collaboration involves the dissemination of a trauma-informed approach across multiple organizations and structures, with the goal of a consistent approach to TIC across different clinical environments.
6. *Screening, Assessment, and Treatment Services*. Screening, assessment, and treatment services involves nurses taking an evidence-based, holistic and culturally safe approach to implementing TIC based on a patient's individualized needs.
7. *Training and Workforce Development*. Training and workforce development creates, maintains and sets standards for education surrounding TIC.
8. *Progress Monitoring and Quality Assurance*. Progress monitoring and quality assurance maintains an ongoing effort to implement, assess, re-assess and modify TIC in clinical practice.
9. *Financing*. Financing is key in developing and maintaining education, implementation, and quality improvement of TIC.
10. *Evaluation*. Evaluation is used to determine effectiveness of TIC on patient and organizational outcomes.

Integration of TIC at a structural or organizational level requires multiple individuals, parties and processes to ensure efficacy and sustained delivery of a trauma-informed standard of care. While TIC has been proven effective at an organizational/institutional level, current literature surrounding policy integration of TIC is limited due to financial and political

constraints (Bargeman et al., 2022). TIC implementation at an organizational level was only one barrier identified within the literature.

Barriers to Current Practice

Current barriers to TIC in practice is lack of education provided to nurses on TIC; lack of organizational dissemination and policy creation surrounding TIC; and time constraints. The literature on primary care providers' opinions on TIC in practice heavily reflected how clinicians felt underprepared in implementing TIC due to a lack of knowledge on the foundations of TIC, its principles and most prominently how to implement TIC into their practice (Kokokyi et al., 2021). Clinicians identified the need for ongoing engagement and follow up by educators on implementation of TIC, and interventions during specific clinical examples (Stokes et al., 2024).

While healthcare providers were able to self-identify needs for potential barriers to TIC implementation, other literature showed more favourable attitudes surrounding TIC were demonstrated by newer generations of nurses (Vincenti et al., 2021). This identifies a possible barrier being age-determinate: potentially more senior nurses may struggle to implement modern models of care into their practice.

Literature undeniably showed that organizational involvement in the dissemination and implementation of TIC within facilities was associated with positive perceptions of TIC from employees, with increased confidence in understanding and implementation of TIC (Vincenti et al., 2021; Stokes et al., 2024; Kokokyi et al., 2021; Goldstein et al., 2024). Despite the literature available showing TIC's positive impact on the care environment with appropriate education and training, current literature still remains limited on TIC.

Literature Gap

Despite being a novel framework, TIC shows increasing interest within the literature. Current interest and research surrounding TIC is generally directed toward implementation in practice for patients that are children or adolescents. Few studies showed significant breadth and coverage of TIC's implications for practice for adult patients. While a larger body of literature exists showing the impact of TIC's impact specifically on children and adolescents, this literature cannot be applied to adults. Adult patients have a separate set of social, political, and financial needs compared to those under the age of 18, these needs include: community support systems, income and housing considerations.

The literature was also insufficient in regards to communal, socio-economic, societal and systemic considerations of trauma and respective application, and impacts of TIC. Holmes (2023) briefly speaks to how current models of TIC cannot be readily applied to Indigenous communities' needs for healing and trauma prevention, especially in regards to organizational implementation. Further research on larger organizational and structural implications for TIC is needed.

Another critique is the lack of a unanimous or consistent scale used to measure data on perceptions of TIC for both patients, and staff. Due to the heavily qualitative nature of TIC, there is not one prominent quantitative evaluative scale used throughout the literature. Of the literature that exists, some such as Baker et al., (2016) created their own psychometric evaluation titled: Attitudes Related to Trauma-Informed Care (ARTIC). The scale primarily used on clinicians providing TIC identified seven subscales described as: underlying causes of trauma presentations, impact of trauma, clinician response to trauma presentations, work ethic, self-sufficiency, opinion of their work, whether they support TIC, and overall organizational/systemic

support for TIC (Baker et al., 2016). ARTIC used a suggested seven-point Likert scale response scale for individuals to pick from (Baker et al., 2016). Prior to ARTIC another lesser-used scale was the Trauma-Informed Belief Measure, used to assess understanding and beliefs of TIC by staff (Baker et al., 2016; Brown et al., 2011). While rigid in their collection of data, these quantitative measures were imperfect in their sustained use across literature.

Lastly, while the literature is saturated with implications of, and considerations for clinical practice, and healthcare-settings, there is not an extensive focus on primarily nurses and TIC. The literature discussing healthcare provider perspectives of TIC, focused on physicians, and mental health professionals. Increased scope of literature and research surrounding TIC and nursing, as well as other interdisciplinary team members should be considered.

Recommendations

Despite extensive evidence promoting TIC as a cost-effective, accessible, and impactful framework in clinical practice for both clinicians and patients, it is not yet heavily integrated into practice. Clinicians have identified that a barrier to implementation of TIC in practice is a lack of educational opportunities (Lewis-O'Connor et al., 2023). In the presence of appropriate TIC education at an individual and organizational level, staff and patients have reported increased safety, and improved care delivery (Brown et al., 2022; Kokokyi et al., 2020; Meredith et al., 2022). As TIC is incorporated to clinical and educational settings, nursing research is expected to further develop (Goddard et al., 2021).

Following along with increased education for TIC, is an increased organizational approach to dissemination and awareness of TIC. Introducing TIC into policy ensures accountability and replicability of its principles into practice by nurses: every patient care

scenario will have the expectation of a TIC approach. Organizational implementation of TIC with associated policy development, allows for a Trauma-Informed approach to be catered toward differing health facilities (Reid et al., 2022). Varying healthcare facilities and environments have the capacity to adopt TIC into practice; however, without an organizational push to integrate facility, or discipline-based expectations of TIC in practice, healthcare environments TIC implementation will remain limited.

Nursing Practice Considerations

With nursing practice considerations, TIC can be readily implemented by nurses in practice, due to its framework following a linear, step-by-step thought process already similarly applied in nursing practice. The TIC framework has a similar linear thought-process to the nursing process. Both the nursing process and TIC framework promote nurses to gather knowledge; develop a plan based on the patient's presentation and needs; implement measures to treat and prevent concerns; and evaluate outcomes of the intervention, and make changes as required (SAMHSA, 2014; Lofgen et al., 2023). The TIC framework can be integrated and adjusted to time-constraints of the ED, as well as the needs of the patient. There is little limitation on how frequently the TIC framework can be used on one, or multiple patients. TIC is flexible and adjustable to individual patient needs, but also each nurse's individual practice. Increased implementation of TIC by nurses, will aid in the organizational need for TIC integration into policy, and an institutional/systemic shift toward recognizing the impacts of psychosocial, trauma-conscious care delivery.

SECTION 3: PROJECT DESCRIPTION

Background

University of Alberta Hospital (UAH) Emergency Department is a tertiary level one trauma and burn centre located in the heart of Edmonton. It is responsible for cases within Alberta, as well as up north into portions of British Columbia, Saskatchewan, Northwest Territories and Yukon (University Hospital Foundation [UHF], 2025). The UAH ED is the first point of contact for specialists regarding traumas, receiving approximately 1800 major trauma cases annually (UHF, 2025). Due to its status and service area UAH ED's wait time, defined as the time from triage/registration to initial physician assessment, have the highest median average of 7.9 hours across all Edmonton hospitals in 2023 (Emergency Caring, 2023). The scale used to assess triage acuity at the UAH ED is the Canadian Triage and Acuity Scale (CTAS). The CTAS scale is used to prioritize level of care for patients presenting to the ED (Alshaibi et al., 2021). The CTAS scale ranges from level one, most acute requiring resuscitation, to level five, non-urgent (Alshaibi et al., 2021). The Health Quality Council of Alberta ([HQCA], 2025) highlights for every five in ten patients the average wait time for a CTAS level three to five was 4.3-5.9 hours from January 2023, with a steady increase to 4.9-8.1 hours in December 2024 respectively.

Due to the high prevalence of trauma throughout presentations to the UAH ED, and exacerbated wait times, nurses are not always able to provide the appropriate trauma-aware, psychosocial care to patients. TIC is favoured as an intervention in this regard, due to its low-cost, and accessible implementation (Greenwald et al., 2023). Despite the urgent need for TIC implementation in practice, nurses still require further understanding of TIC, and guidance on its implementation in practice.

Project Goals

The pilot-project's two primary goals were to: increase awareness of Trauma-Informed Care to ED nurses, and to receive feedback from the pilot project toward implementation of an official TIC educational session. Increasing the Emergency Nurse's (EN) awareness of TIC aimed to enhance the nurse's understanding of how, and when TIC can be implemented in their own practice, and increase their comfort in educating peers on a Trauma-Informed approach.

Target Population

The target population for the pilot project included ENs, both Licensed Practical Nurses (LPN), and Registered Nurses (RN), working out of the University of Alberta Hospital Emergency Department. Due to the nature of the project being a pilot-project, only four ENs were selected to participate, and other multidisciplinary team members were not included at this time. There were no restrictions for ENs based on level or extent (years) of nursing experience.

Project Development

During the timeframe of February through March 2025, informal conversations with UAH ED unit management (UM), clinical nurse educator (CNE), and patient care coordinator (PCC) occurred via email. Email communication consisted of a brief outline of the project intent, goal, audience, and relevance to practice surrounding TIC for UAH ENs. My intention initially was to implement a short presentation to staff on work time. However, on March 19, 2025, it was determined due to time-constraints, and multi-designate approval required of the project from the UAH, that this was not feasible. A feasible solution that allowed for the project to be effectively implemented without organizational constraints was to pilot the education session with a small

number of nurses, incorporate feedback, and present to a larger audience, including ENs and other interdisciplinary staff at a later time.

Ethics Determination

A determination of ethics form was submitted to the University of Alberta, research ethics office to determine whether the proposed project required ethics approval from the Research Ethics Board (REB). Based on the review, it was determined that REB review was not required. The intent of the project is a quality improvement initiative, with the goal of increasing ENs awareness surrounding TIC. The official letter of determination is attached as Appendix A.

Project Overview

The project was a pilot project, consisting of a PowerPoint presentation on TIC, provided to ENs in the UAH ED. The goal of the pilot project was to increase ENs awareness of TIC, in order to implement TIC into their own practice, with an anticipated increase in patient safety within the ED. The presentation addressed: what is TIC; TIC's relevance to the emergency department; application and implementation of TIC in practice; and highlighting specific populations disproportionately impacted by trauma, requiring TIC. The project also discussed two theories related to TIC (Five R's, and TTB), and incorporated two case-studies. The case studies were incorporated to help ENs integrate newly acquired awareness of TIC into practice.

The project was then delivered to four ENs during the month of June, with data collection and review completed by the end of June 2025. All presentations and related surveys took place within a three-to-four-week period. The pilot-project educational session was presented to the four ENs individually, over a 30–45-minute timeframe, concluding with a post-presentation feedback survey, and followed by a one-week check-in post-presentation. Data obtained from the

pilot project was reviewed and synthesized in the subsection titled "Data Collection and Synthesis" below. The project deliverable and data obtained will be shared with UAH ED management and educators for future consideration and implementation of a TIC-specific educational session, or formal organizational learning.

Project Planning

Project inputs, outputs, and goals were created prior to pilot-project implementation, and can be seen in the Program Logic Model (PLM) in Appendix B. Project inputs consisted of four voluntary ENs participating in the project; physical and digital resources required for the educational session/presentation; and a one-month timeframe to complete the project activities. The project outputs consisted of a minimum of three ENs attending the presentation and reporting increased awareness surrounding TIC. Another identified output was at least half of the ENs would reportedly have implemented TIC in their own practice after a one-week time period. Projected outcomes for the pilot project were ENs reporting increased awareness of TIC as well as identification and implementation of TIC in their own practice. The primary intent and objective of the pilot project was to obtain feedback from the participating ENs, to put toward future presentations on TIC. The pilot project's success measures/indicators included: weekly deadlines for presentations and data collection were met; ENs would attend the educational session and report increased awareness; ENs would report they had observed or implemented TIC measures in practice at the one-week check-in.

Merrill's Principles of Instruction

The pilot project and project deliverable were heavily influenced by Merrill's Principles of Instruction (MPI). MPI follows four phases: activation, demonstration, application, and integration (Merrill, 2007). The first phase "activation" directs learners to a previous experience

or knowledge surrounding the content and in doing so creates a foundation for new knowledge (Merrill, 2017). The second phase "demonstration" provides an example of the content being taught and later implemented. Followed by the third phase, "application," in which learners actively engage in applying newly learned skills in a real or simulated case environment (Merrill, 2017). Lastly, "integration" applies to how learners share and reflect on newly acquired knowledge (Merrill, 2017).

MPI has been favoured as an approach to learning and instructional design due to its relational approach to learning based on real-life examples (Badali et al., 2020). The Lesson Plan developed in Appendix C can be used to refer to specific PowerPoint slides discussed in the following paragraphs. The first phase "activation" can be seen on slide five titled "TIC in practice: what does it look like?" Slide five engages the audience (ENs) in reflection based on their own previous experience with TIC. With an understanding of the foundations of TIC discussed on slide four, the nurses are able to "activate" prior knowledge and create links from theory-to-practice. Activation is also seen on slides six to nine, where the audience is provided with examples of how to implement the Four Rs TIC framework.

The "demonstration" and "application" phases of MPI integrates experiences with critical thinking, allowing learners to apply learned knowledge in real-time (Cai & Maollem, 2021). Another principle noted by Merrill, is "problem-centred," which describes the need for realistic, case-based scenarios that are relatable, and applicable to the learners (Cai & Maollem, 2021; Merrill, 2017). The case studies discussed further in the project deliverable, allow for nurses to implement new knowledge on TIC, retain learned knowledge, bridge theory to practice, and identify similar situations in practice. Authentic real-life scenarios creating relevance for the

learner are the key focuses of MPI, allowing for increased effectiveness in the delivery of learning material and new knowledge (Cai & Maollem, 2021).

Project Deliverable

The pilot project deliverable was created in the form of a PowerPoint presentation, an overview of which is seen in Appendix D, and was presented using digital formats such as zoom, and in-person on a media device (laptop), depending on EN needs, schedule and availability. In-person presentations were initially favoured by myself, for increased engagement and interpersonal discussion; however, digital means was favoured by three out of four ENs due to flexibility and accessibility. ENs were provided the option to take notes; however, to promote engagement with the content, a copy of the presentation, along with resources provided throughout the presentation, was sent to participants to review prior to, and outside of the session.

Resources identified for ENs to access outside of the presentation primarily consisted of gray literature. Gray literature was favoured due to means of accessibility for ENs who do not have access to research or journal articles that are not open-access. Content pertaining to the case-studies, was sourced primarily from sources written by, and representing the respective communities: lesbian, gay, bisexual, transgender plus (LGBT+) and First Nations Canadian.

PowerPoint presentation was selected due to its accessible, low-budget, and multi-media capabilities (Rosyiddin et al., 2023). The Presentation contained 15 slides (excluding references), each slide presented over approximately two-to-five minutes, with a total presentation time of 30-45 minutes. Two slides covered general content on TIC; six slides focused on the Four Rs framework and TTB; and the remaining two slides consisted of case-studies. The general flow of

the PowerPoint presentation, and content covered in each slide is covered with added depth in Appendix C.

Theory Integration

Slides five to 10 of the deliverable (PowerPoint) covered the main theoretical concepts to TIC: the Five Rs of TIC, as well as TTB. These two approaches to TIC were added to enhance the participating ENs ability to implement a trauma-informed approach within their own practice and promote autonomy in their patients on managing their own trauma. ENs learned during the pilot project how to approach the implementation of the Five Rs and TTB based on patient presentation, trauma-history and care needs. To apply their knowledge learned slides 11 and 12 featured case studies to help the ENs assess and implement the appropriate TIC interventions based on a case-specific example.

Case Studies

The deliverable (PowerPoint presentation) incorporated two case studies which followed a patient-based scenario. Each scenario involved a patient from a marginalized community that ENs are often exposed to. The first case study involved an individual from the LGBT+ community: explicitly a non-binary individual. This community was selected due to transgender and non-binary individuals from the LGBT+ community having multiple points of contact with healthcare teams, including the ENs, during early childhood, into adulthood: with presentations primarily relating to their gender identity (Ramos, 2021). Healthcare trauma for this population can present as misgendering, denial of identity, or blatant disregard for health needs like affirming care (Ramos, 2021). Each presentation to the ED can elevate the risk of re-traumatization, as traumatization for this population can occur from within health settings (Ramos, 2021). The other case study focussed on a First Nations Canadian, due to the complex

history and trauma surrounding historical medical abuse, in segregated hospitals, as well as residential schools (Breault et al., 2021). Indigenous peoples were often experimented on, neglected or abused, within historical health facilities, that promoted health in name only (Breault et al., 2021).

These two case studies aimed to highlight the complex nature of trauma, the risk of re-traumatization, and the importance of TIC. Case-based scenarios encourage nurses to think critically, engage in relational practice, implement knowledge learned, and promote self-reflection on potential bias, or knowledge gaps in their own practice (Shahzad et al., 2022).

Project Implementation

The pilot project was implemented over a one-month period, Starting June 1, 2025, to June 29, 2025. The one-month period was divided into weekly increments for deadline purposes. As outlined in Appendix B, a two-week period was designated to presenting the education session to the four ENs: this was to ensure a flexible time-frame that adhered to the nurses' work schedules, while leaving room for any attendance, or technical concerns. The digital presentations took place on June 7th, 9th, and 24th via Microsoft Teams meetings. While the in-person presentation occurred on June 22nd. Within the week after each presentation a post-presentation check-in occurred. The final week of June was dedicated to reviewing and synthesizing data, and feedback obtained during weeks one through three.

Data Collection and Synthesis

Data collection consisted of a post-presentation evaluation form as seen in Appendix E. The evaluation form consisted of six questions: four quantitative five-point Likert-scale questions ranging from strongly disagree to strongly agree and two qualitative questions. These

Likert-based questions were used to assess learning and awareness of TIC. While the qualitative questions were used for feedback for future project improvement. The post-presentation questionnaire purposefully incorporated quantitative questions designed similarly to the ARTIC scale. The Artic scale is a formal questionnaire used to assess healthcare providers attitudes surrounding TIC (Traumatic Stress Institute, n.d.). The use of a Likert scale-based assessment tool allowed for TIC to be standardized and assessed across multiple settings, in potential future applications. The one-week post-presentation check in was in the form of an in-person informal discussion used for further qualitative data collection on impact of TIC education in clinical practice, and further feedback for future project improvement.

The post-presentation survey (see Appendix E) was completed by all four participating ENs immediately following the presentation. The results of the Likert-scale survey questions were plotted into Microsoft Excel, while open-ended questions were grouped based on similarities and ideas of content.

Key Findings

The data collected was reviewed and grouped into three subsections: Likert-style questions, open-ended feedback, and open-dialogue. These subsections allowed for results and feedback to be summarized based on the data involved, feedback collected, and how the feedback was obtained.

Likert-Scale Question

The first question asked was “I have used trauma-informed care in my practice prior to this education session.” 75% or three in four nurses selected “agree,” while only one nurse indicated they disagreed. The second question asked “As a result of the presentation, I can

confidently explain what trauma-informed care is to a peer." A majority of 75% selected "strongly agree," and 25% selected "agree." The third question asked "As a result of the presentation, I feel confident in my understanding of trauma-informed care." 50% of nurses selected that they "strongly agree," and 50% selected they "agree." The fourth question asked "as a result of the presentation, I know and understand how to implement trauma-informed care." Three in four nurses (75%) indicated they "strongly agree," with one nurse indicating they "agree."

To summarize, 100% of nurses for questions indicated that they had improved knowledge and understanding of TIC (question three). All nurses indicated they felt confident in explaining TIC to a peer, and understood how they can implement TIC in practice (question two and four). The Likert-style questions pre-made responses allowed for feedback from the ENs to be easily interpreted. Open-ended questions were also available to allow the participating nurses to elaborate on their experience in their own words.

Open-Ended Feedback

For the open-ended feedback a thematic analysis was implemented to identify and group common response patterns in feedback in order to understand group themes, or ideas (Lochmiller, 2021). The open-ended feedback question asked: Do you have any feedback, questions or recommendations for future education sessions? Common themes identified were: (1) applicability of TIC for the ED, (2) the case studies being valuable for understanding TIC, and (3) the wide application TIC has in practice.

1. *Applicability of TIC for the ED*. Majority of nurses mentioned that TIC is heavily applicable and needed within the ED. One nurse in their feedback stated *"this is*

especially important in the emergency department, where the environment is fast-paced and exposure to traumatic events is frequent and often intense." All nurses participating agreed that TIC was relevant to their practice as an ED nurse.

2. *Case Studies*. Three of the four nurses had written about how the incorporation of the case studies aided in understanding the presentations material, as well as implementing the TIC framework. While three nurses wrote about this explicitly, all nurses had mentioned similar feedback through open-dialogue.
3. *Application of TIC*. Another aspect of feedback specifically mentioned by multiple nursing participants was the diverse nature of TIC. ENs reported that the TIC framework is not only applicable to patients within the ED but can also be applied to colleagues, and peers. One nurse stated *"we work with all these traumatic cases, but we're not the patient, so it's like, when do we get considered?"*

Despite the valuable feedback provided on the post-presentation survey, all nurses were more forthcoming with feedback obtained through open-dialogue. This open dialogue occurred throughout the pilot-project presentation, post-presentation and during the one-week follow up.

Open-Dialogue

The primary guiding question for the one-week check-in, was whether the knowledge gained on TIC transferred over to the nurse's clinical practice. Through open-dialogue that occurred post-presentation and at the one week check in, participating nurses shared feedback that they did not write within the formal survey. Two nurses mentioned wanting further elaboration on "what is trauma," and varying types and degrees of trauma. All participants had

also mentioned in similar words, that my preparedness, flow and delivery of the presentation contributed to more satisfactory outcomes in their learning.

The case studies were also heavily spoken on by participants in open-dialogue both immediately after the presentation and with the one-week check in. One nurse had explicitly mentioned the case studies "bridged the theory-practice gap." While two other nurses mentioned after going through the case studies the previous presentation slides began to "make sense."

Majority of nurses mentioned they were more aware of when or how they could apply TIC in practice as a result of the presentation. Two of four nurses reported working through the Four Rs and using the TIC framework in practice. Amongst all participating nurses, there was a unanimous recognition of the presentation improving their understanding of TIC.

Interpretation and Limitations

While analysing the feedback provided, it was evident that the presentation and the topic of Trauma-Informed Care in the ED was successful in increasing the participating nurse's knowledge surrounding TIC. A contributing factor both reported by ENs and observed by myself, that lead to a beneficial outcome, was the way information, especially the theoretical frameworks, was presented. Nurses were able to follow the content with ease, due to flow and how the materials were presented. The case studies showed the most significant impact, by helping nurses to apply the learned content, and further understand TIC through real-life scenarios. Without the case studies, I do not feel the same impact would have been achieved, as the case studies also helped engage the nurses to apply their new knowledge.

A different observation made through analysing the survey results and also participating in open-dialogue, was many nurses were more forthcoming with feedback through open-

dialogue, rather than the open-ended survey questions. The one-week check in and post-presentation open-discussions directly with participants was also a valuable addition to the pilot project. For future considerations, I would add probing questions for dialogue at the end of the presentation, for similar results in available feedback.

Of the selected ENs two nurses were senior clinical staff, with nursing experience ranging from 10-20 years. The other two ENs were newer nurses with only one-to-two years nursing experience. This range in nursing experience, while not intentional, allowed for a diverse variety of feedback. The two ENs who were not previously as familiar with TIC were both a senior and junior nurse. This highlights the value, and need for further TIC education for ENs across multiple experience-levels.

Findings Summary

Overall, the projected outcomes and expectations of the pilot project were successful, as 100% of participants reported improved knowledge surrounding TIC, and felt comfortable with applying TIC in practice or explaining TIC to peers. This solidifies that the content and initial design of the presentation were effective, but some adjustments are required to enhance nurse learning and engagement in future implementations.

SECTION 4: REFLECTION

Project Development

The design, function and delivery of the project changed considerably throughout its development. The initial concept surrounding the need for a trauma-informed approach to emergency nursing was created from personal insights and reflections in my own nursing practice within the ED. The chaotic, turbulent and ambiguous nature of the ED is as fast-paced for nurses providing care, as it is for patients receiving it. From my observations in clinical practice, if a patient did not present for a trauma-related concern, the patient's trauma could go unaddressed, resulting in no trauma-informed measures taken. Having a prior passion for understanding and integrating TIC into my own nursing practice, I felt it beneficial to spread this same awareness to my nursing peers.

Early into developing this project, I faced my first hurdle, with the obstacle being limited literature available on TIC, in particular, its application within nursing practice. I had understood this may be a potential hurdle, as TIC was a novel framework, that had not been previously discussed within my recent undergraduate education or within professional practice settings. Despite this, I have read through copious academic journals, government publications, grey literature and E-books to consolidate relevant literature. Thankfully empirical evidence of TIC and its impact within ED's is developing, allowing for the successful completion of the deliverable.

Another hurdle that impacted the delivery of the project was gaining approval for the education session to be delivered to ENs at the UAH ED. I was unaware of the lengthy process required to gain approval to present the education session. Approval for educational

presentations at the UAH ED required multiple members of management to review and approve the education session. Due to the project being early in its development, approval was unreliable, and I was unable to get a firm answer. This was unexpected, and to keep the project on-track, a decision was made with my supervisor to design a pilot-project. This decision was made after a month of communication to management, and educators at the UAH ED went unanswered, even with timely follow-up. The pilot project allowed for reliable delivery of the education session and collection of feedback.

The PLM in Appendix B, was one of the first materials developed for the project. The PLM was designed to clearly outline the required resources, projected outcomes and intent for the pilot project. The PLM proved extremely beneficial in maintaining my focus and direction for the pilot project. I referred back to the PLM throughout the entirety of the design process, and while presenting the pilot project.

The project goals and outcomes identified were to increase ENs awareness of TIC, in hopes of increasing nurses' awareness of its application in their own clinical practice. Analysis of the post-presentation feedback received, confirmed that the identified outcomes were achieved. The presentation of TIC in the ED was successful in increasing the participating ENs knowledge and awareness surrounding TIC. Even with successful outcomes, challenges were still present throughout the design and delivery of the pilot project.

Through feedback and reflection on initial concepts of the project, an educational session, via PowerPoint was determined to be the most effective means of communicating the concept of TIC, and its relevance to the ED. A consistent, and surprising challenge throughout the presentation design and implementation process was the time-frame. Despite a large amount of time dedicated to developing and revising the Lesson Plan as seen in Appendix C, the time

awarded to each slide, in the presentation was changed extensively. While presenting, even at a steady pace, I often finished well-within the pre-arranged timeframe for the presentation slides.

Throughout the entirety of the project's development process, content related to the pilot project involved receiving and implementing feedback my supervisor, PhD student, and my peer within the master's program. While feedback and revisions were expected, the extent of which feedback was received and implemented was a novel experience to me. Despite this, the feedback received from multiple individuals, especially that of a fellow student was immensely valuable. The implementation of feedback allowed me to further develop my pilot project in ways I had not previously considered.

Other outside input, feedback and involvement included apply for and receiving an ethics determination. This process mostly involved ensuring my project summary included all relevant information, and was worded specifically to fit a quality improvement (QI) objective. After the final application was submitted, the response on a determination of ethics review was quick. This process also helped clarify what was QI versus research. Some questions I was required to ask myself, while developing my pilot project, was whether I was using existing research to improve care delivery in a specific area, or was I creating new research and answering a hypothesis? My pilot project did fall under QI, and was further developed with these expectations in mind.

Personal Insights

Throughout the development of this project there were both anticipated and unexpected challenges to navigate. An unexpected challenge that occurred during the few remaining semesters working on this project was a personal family emergency. I had travelled urgently to Australia to attend to my grandfather's sudden health emergency, of which was looking terminal.

As I worked on my project from a hospital bedside as a patient's family member, not as a nurse, I saw the need for TIC within nursing care from a patient's perspective. With ambivalence and a new perspective, I continued my work on this project.

This project also happened to be the first experience I had with graduate level education. Despite my passion and prior knowledge on a Trauma-Informed approach, the undertaking of extensive sourcing and integration of literature has developed my knowledge and understanding of TIC significantly. This is also my first experience within an educator role, of which I have a foundation of expertise. This new area of nursing required a shift in mindset to understanding this role-change. Familiarizing myself with the process, time, dedication and effort to ensuring nursing educational material is of a high academic standard, has developed my confidence in advancing my professional nursing practice.

Another challenge that I did not expect to encounter, was the formatting of scholarly documents, and use of Microsoft word and excel to create my proposal. Despite growing up in the technological generation, I found this work to be tedious, but understandably necessary for the readability, and flow of the document.

Despite these challenges, there were several successful outcomes to this work. The project deliverable PowerPoint presentation, I personally felt was visually appealing, engaging and flowed appropriately. This was also affirmed with feedback, I had received from the participating nurses. The case studies were identified by the ENs, to have been chosen to accurately and respectfully represent their respective marginalized communities: the LGBT+ community, and First Nations Canadians respectfully. I also agree with this feedback provided, I felt the case studies explored their respective communities with depth, and empathy. It has always been intentional to incorporate marginalized communities and their stories within my

work, whether that be personal, academic or professional. The topic of TIC allowed me to highlight the lived experience of vulnerable members of society and share their stories. As a nurse I will continue to advocate for and share education on individuals, peoples and communities that experience oppression.

This graduate project has been one of my most challenging, yet rewarding experiences. I have found newly developed confidence in sourcing, compiling, and presenting information at a scholarly level. I've also found myself advocating for growth, development and change within my clinical nursing practice environment. These skills I have developed will continue to be used in future graduate programs, and assist in my development into nursing leadership roles. I have growing confidence in my ability to apply these skills in my future clinical or academic roles.

Implications for Nursing Practice and Future Research

TIC despite being a novel framework has already shown potential benefits for nurses and patients alike; however, nurses lack knowledge surrounding TIC, and it is due to limited education available relevant to TIC, and its application in practice. All four participating ENs reported having no formal education or training on TIC outside of the pilot presentation, despite its relevance within the ED. This highlights that there is still a need for TIC education on an individual and organizational level. With no shortage to trauma presentations to ED's, TIC remains crucial to ENs clinical practice.

Current lack of exposure to TIC for ENs stems from a lack of organization dissemination of educational content surrounding TIC, leading to nursing unfamiliarity with TIC in practice. Another barrier to TIC education and incorporation into clinical practice is a lack of literature available on TIC, explicitly TIC in nursing practice, and within the ED. Future research

surrounding TIC would benefit from including nurses' perspective, and integration of TIC in practice. Increased familiarity of TIC and its incorporation into clinical practice allows for available subjects, and case-examples for TIC research.

Future considerations for TIC education is the need for other interdisciplinary team-members to have access to educational resources and increased awareness surrounding TIC. With the feedback and data obtained from the pilot-project, and the completed PowerPoint presentation can now be shown to UAH ED leadership, with the intended outcome of being incorporated into ED educational seminars. These educational seminars organized by UAH ED educators, are accessible to all ED interdisciplinary staff, including ENs, physicians, healthcare aides, etc. Incorporating this project's PowerPoint in the ED's educational seminars will increase dialogue surrounding the presence of TIC implementation within the ED. Increased ED staff awareness surrounding TIC, creates dialogue surrounding the importance of organizational training and education on TIC. Lastly, this pilot-project on TIC in the ED and related feedback from ED nurses, provides a foundation for future potential projects surrounding TIC education.

Next Steps

The results and feedback received from the pilot-presentation has been shared with UAH ED management and educators to gain approval for the education session on TIC to be shown at a semi-annual educational bootcamp organized for the UAH ED specifically. Current feedback from UAH ED management and educators has been positive regarding the implementation of this education session on TIC. Currently no organizational learning exists that covers content related to TIC. The PowerPoint presentation created and finalized for the pilot project will be submitted to multiple levels of management within the UAH ED, and AHS. This will be done to obtain approval to present this educational session to ED staff on behalf of the UAH ED.

Conclusion

TIC is well regarded across the literature as an innovative and impactful addition to healthcare practices (Brown et al., 2022). TIC as a framework guides healthcare staff through a process of assessment, reflection, critical thinking, and development of individualized care. Both nurse and patient testimonials provide insight into the positive outcomes of TIC including but not limited to: increased patient re-engagement in health services, improved psychosocial wellbeing; facilitating a safe healthcare environment; and promoting a holistic, patient-centred approach to care (Reid et al., 2022; Brown et al., 2022). Nurses currently lack appropriate educational resources on TIC; however, with appropriate education surrounding TIC, nurses have increased confidence in its implementation in their own practice. Feedback from my pilot project indicated that TIC is accessible, and easy-to-implement in practice, when ENs are exposed to appropriate TIC education. This project aimed to continue to address barriers relating to, and encourage implementation of TIC in practice.

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APPENDIX A: ETHICS APPROVAL

RESEARCH ETHICS OFFICE

2-01 North Power Plant (NPP)
11312 - 89 Ave NW
Edmonton, Alberta, Canada T6G 2N2
www.uab.ca/reo

April 18, 2025

annabelle lewis
Faculty/Department: University of Lethbridge Master's of Nursing
Email: annabelle.lewis@uleth.ca

Dear annabelle lewis:

RE: Determination of Ethics Review Requirement

Thank you for requesting a determination for your project: "The use of Trauma-Informed Care in the Emergency Department for Prevention of Re-Traumatization and Increased Patient Safety". We have reviewed the details provided in your submission received on 2025-04-18 00:19:47.

The project that you have outlined meets one of the conditions described under Chapter 2 of TCPS2 (2022) as an activity that does not require REB review and, unless you make changes to the project, ethics approval is not needed. As such, the project has been determined to be outside of the REB's mandate. However, please note that if data is collected for the purposes of such activities but later proposed for research purposes, it would be considered secondary use of information not originally intended for research, and at that time may require REB review.

Sincerely,

Charmaine N. Kabatoff
Senior Officer, REB for
Anthony S. Joyce, PhD
Chair, Health Research Ethics Board - Health Panel

APPENDIX B: PROGRAM LOGIC MODEL

Program Logic Model for Trauma Informed Care in the Emergency Department

Situation: The Emergency department (ED) has a high prevalence of trauma with limited application of psychosocial or trauma-informed care (TIC) provided to adult patients.

Program Goal: To increase awareness and understanding surrounding trauma-informed care, it's principles and, its application in practice within the adult emergency department.

Target Population: Emergency Department Nurses

Inputs	Activities	Outputs	Short Term Outcomes (1 - 6 months)	Mid-Term Outcomes (6 months - 1 year)	Long-Term Outcomes (1 year - 3 years)
Four ED nurses (volunteered time for presentation). Timeframe: 4 x 30-45-minute presentations with each ED nurse over 2 weeks, post-presentation 1 week check-in, 1 week to synthesize and review data. Physical resources: computer, screen, paper (for notes), pens. Digital resources: Video/audio application (zoom, teams), powerpoint, word document, camera/microphone.	PowerPoint Presentation (8-10 slides) on TIC in the ED (30-45-minute digital presentation). 2 case studies included in the presentation. Post presentation feedback (quantitative/qualitative, 4 questions) 1-week post-presentation check in (qualitative, 5 minutes discussion).	75% of ED nurses in attendance report improved understanding on trauma-informed care post-presentation. 75% of ED nurses report improved awareness on how to implement trauma informed principles into their care post-presentation. 50% of ED nurses report having implemented TIC principles in practice, or observed a situation that involved TIC at the 1-week post presentation check in. Synthesize and review survey data within a 1-month period.	Increased awareness of TIC by ED nurses who attended the presentation. ED nurses are able to assess where and when TIC can be incorporated into their practice.	Increased awareness and implementation of TIC by ED nurses who did and didn't attend the presentation. Nurse Educators share knowledge on TIC to nurses who did not attend the presentation. Management encourages ED nurses to become informed on TIC and implement into their practice.	TIC is offered as organizational learning. ED nurses are aware of TIC, how to implement it and share knowledge surrounding TIC with their peers. ED nurses actively implement TIC to every patient with individualized changes to how it's implemented.

Assumptions:

ED nurses will be interested in, and open to learning about TIC and growing/adding to their clinical practice.

ED nurses will have the time and/or volunteer their time for professional growth and learning with/without pay.

ED nurses will have 30-45-minutes outside of work hours to volunteer time for project presentation.

ED nurses will maintain open communication post-presentation for 1 week check-in.

ED nurses will have access to and know how to use digital media software such as zoom/Microsoft teams.

APPENDIX C: LESSON PLAN

TIME	EXERCISE AND ACTIVITIES	GUIDING QUESTIONS/FOCUS	LEARNING GOALS	TEACHER	LEARNER	ASSESSMENT & LEARNING
1200	Slide 1: title page	n/a	n/a	Introduces self and project briefly	n/a	n/a
1200	Slide 2: Objectives		Identifies learning objectives for the presentation as described below.	States learning objectives and role of the learner.	Has a clear plan and focus for what they should be learning.	
1201	Slide 3: Background and Relevance to Practice	How does the ED play into healthcare trauma? What makes the ED different to other health environments?	Introduces prevalence of trauma in ED for patient and staff. Outlines current lack of psychosocial care for trauma not related to presentation.			Creating relevance for ED nurses' clinical practice (why they should learn about TIC).
1205	Slide 4: What is Trauma-Informed Care?	What do you know about trauma-informed care?	Describes principles of TIC: overarching goal to recognize potential for trauma, individualizing care based on trauma-assessment to minimize re-traumatization of patients.		Gives brief answer on their current knowledge-surrounding TIC.	Assess baseline knowledge of TIC, and introduce the foundation of TIC to expand on following slides.
1210	Slide 5: TIC in Practice: What does it look like?	Has there been a time you may have implemented TIC without knowing? What presentations or history may cue you to implement a TIC approach? Can/Does TIC need to be implemented with every patient?	4 R's of trauma-informed care: realize, recognize, respond, resist and resilience. Review patient history, initial patient assessment and mentally prepare need for individualized measures based on trauma-profile.	Asks guiding/probing questions on nurse's current awareness surrounding TIC.	Gives brief verbal answer to the presenter on their current awareness and implementation of TIC in their own clinical practice/experience.	Aids ED nurses in being able to recall and recognize instances of TIC or potential for TIC in the ED. Nurses learn a 5-step approach to TIC: how to assess need for and implement changes.
1212	Slide 6: Realize	How does a nurse implement the "Realize" phase?	Understand how this stage is about developing and	Elaborates more extensively on each stage of	Asks clarifying questions	Links clinical practice to the TIC framework.

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		How would you implement this phase in your nursing practice? Where does this fit into the clinical setting?	growing a knowledge-base and foundation for implementing TIC. Knowledge is required for implementation.	the 5 R's framework. Answers questions as needed.	based on slides content.	
1215	Slide 7: Recognize	How does a nurse implement the "Recognize" phase? How would you implement this phase in your nursing practice? Where does this fit into the clinical setting?	Understand difference between Realize and Recognize stages. Understand how to identify potential signs and symptoms of trauma. Be alert during a nursing assessment and read the patients body language and presentation. Holistically view the patient for potential trauma's related to identity, background or environment.	Elaborates more extensively on each stage of the 5 R's framework. Answers questions as needed.	Asks clarifying questions based on slides content.	Links clinical practice to the TIC framework.
1218	Slide 8: Respond	How does a nurse implement the "Respond" phase? How would you implement this phase in your nursing practice? Where does this fit into the clinical setting?		Elaborates more extensively on each stage of the 5 R's framework. Answers questions as needed.	Asks clarifying questions based on slides content.	Links clinical practice to the TIC framework.
1221	Slide 9: Resist	How does a nurse implement the "Resist" phase? How would you implement this phase in your nursing practice?		Elaborates more extensively on each stage of the 5 R's framework.	Asks clarifying questions based on slides content.	Links clinical practice to the TIC framework.

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		Where does this fit into the clinical setting?		Answers questions as needed.		
1224	Slide 10: Trauma-Informed Theory of behaviour (TTB)	What differentiates TTB from TIC?	Trauma-Informed Theory of Behaviour.	Provides example scenario of TTB	Reports that they understand the differences between TIC and TTB	
1227	Slide 11: Case study on LGBT+ Trauma in the ED	What aspects of care are important for this patient to prevent re-traumatization? How may the patient's identity and health trauma impact their care? What interventions can you implement to make sure this patient feels safe? What supports may the patient need?	Case study comprising of: -Young adult - non-binary -limits interactions with healthcare due to fear of being misgendered and heightened gender dysphoria -increased anxiety due to health trauma -has no support persons present	Asks probing/leading questions. Verbalizes alternate and additional factors and interventions that the learners did not identify. Builds on learner's responses and encourages further discourse surrounding the case study and TIC. Answers questions learners may have.	Participates and answers probing questions based on case study scenario.	Assess Ability to identify and implement TIC based on patient situation and through probing questions. Links theory to practice, and encourages similar critical thinking in the clinical setting.
1234	Slide 12: Case Study on Indigenous Trauma in the ED	What aspects of care are important for this patient to prevent re-traumatization? How may the patient's identity and health trauma impact their care?	Case Study comprising of: -elderly Indigenous woman -grew up in residential schools, and experienced segregated hospital care -is physically/verbally aggressive with physical	Asks probing/leading questions. Verbalizes alternate and additional factors and interventions that the learners did not identify.	Participates and answers probing questions based on case study scenario.	Assess ability to identify and implement TIC based on patient situation and through probing questions. Links theory to practice, and encourages similar critical

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		What interventions can you implement to make sure this patient feels safe? What supports may the patient and family need?	assessments, care, and being touched -Has family present at bedside	Builds on learner's responses and encourages further discourse surrounding the case study and TIC. Answers questions learners may have.		thinking in the clinical setting.
1240	Slide 13: De-brief	What in the case study stood out to you? Do you feel the case scenarios were realistic? Have you seen similar cases in your own nursing practice?	Assess nurses critical thinking, implementation and awareness of TIC principles. Allow nurses to self-reflect on assessment, implementation and future considerations of TIC in their own practice. Lists resources on TIC, LGBT+, and Indigenous communities: With a focus on intersections of healthcare, wellness, and trauma.	Guides nurses through self-reflection of implementing TIC through case studies. Directs nurses to resources for future learning and development.	Speaks through thought process for case study, how they approach their own practice, and approach to potentially implementing TIC.	Assess ability to identify and implement TIC based on patient situation and through probing questions. Encourages self-reflection via case-studies, with the goal of encouraging similar self-reflection in clinical practice.
1245	Slide 14: Summary	Has your awareness and knowledge of TIC changed since the beginning of this education session? Was there something that you thought	Reiterate key points from slides 2-7.	Provides post-project survey questions. Answers any further questions, and is open to feedback from learners.	Completes post-project survey questions. Asks clarifying questions on the content and provides feedback.	Takes acquired awareness into practice environment, reflects on growth and development in regards to TIC and implementing it in practice.

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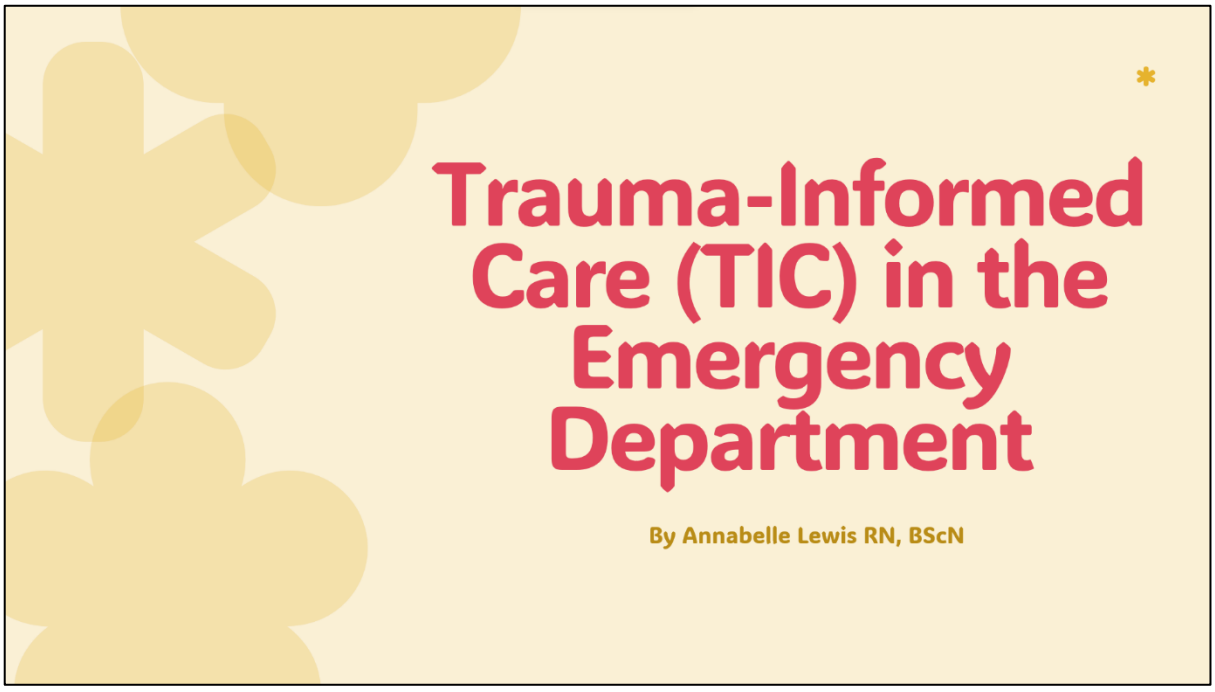
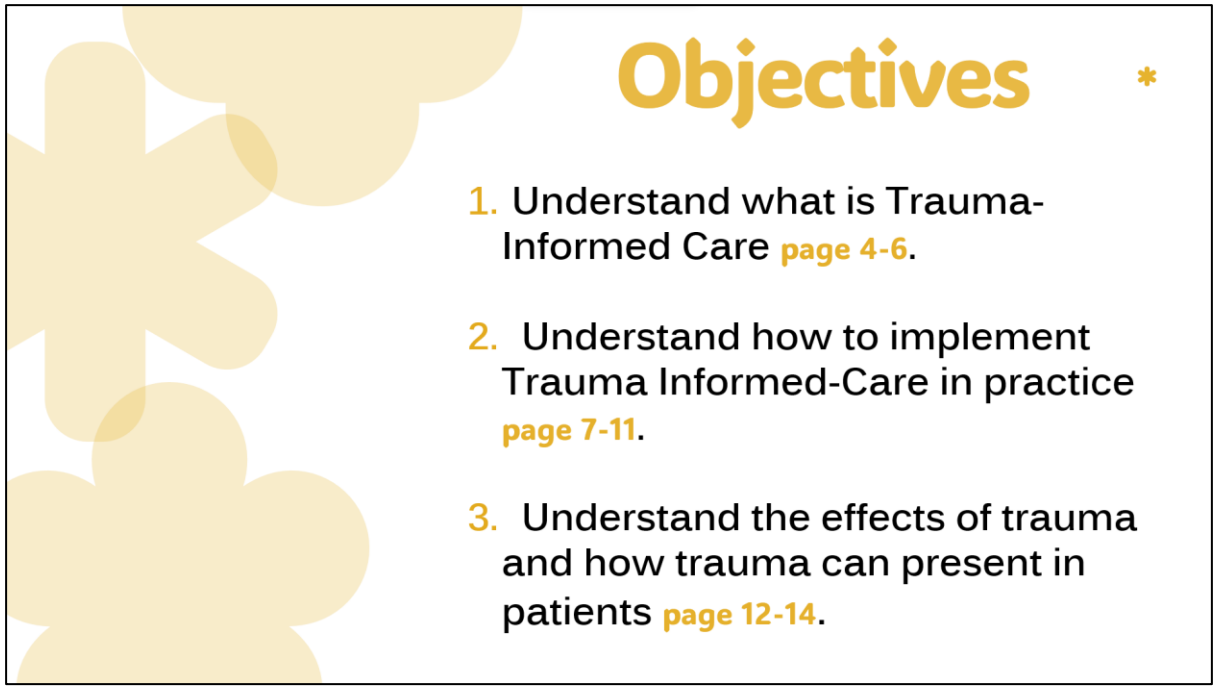
		would be covered/spoken about that you feel should be incorporated into future education sessions?				
1245	Slide 15: Resource links	Links provide to continue education, and growth beyond the presentation session.			Students may refer to these resources after the presentation for further guidance and learning.	

APPENDIX D: PRESENTATION





APPENDIX D: PRESENTATION

Background and Relevance to Practice

- University of Alberta Hospital (UAH) ED is often the first point of contact regarding trauma cases (University Hospital Foundation [UHF], 2025).
- UAH ED's wait times are the highest in the province (Emergency Caring, 2023; Health Quality Council of Alberta [HQCA]).
- Limited time and resources prevents appropriate trauma-aware, psychosocial care (Afzal et al., 2022; Greenwald et al., 2023).
- TIC is a low-cost, and accessible intervention nurses can readily implement (Greenwald et al., 2023; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

What is Trauma-Informed Care (TIC)?

- Trauma is defined as a life-altering event that causes emotional, psychological or physical harm, with long-lasting results (Centre for Addiction and Mental Health [CAMH], n.d.; Centre for Health Strategies [CHS], 2025; The Trauma Practice [TTP], 2025).
- TIC is an approach to care that helps nurses recognize, respond and reduce impacts of trauma for patients (CHS, 2025; Lofgren et al., 2023; SAMHSA, 2014).
- TIC is a holistic approach to care that helps nurses recognize the role trauma plays in a patient's life and interactions within the healthcare system (Huo et al., 2023; SAMHSA, 2014; TTP, 2025).

APPENDIX D: PRESENTATION

TIC in Practice: What does it look like?

4 R's

- **R** Realize – how trauma impacts patients.
- **R** Recognize – symptoms and presentations of trauma.
- **R** Respond – implement a trauma-informed approach.
- **R** Resist – prevent re-traumatization[14].

(Goddard et al., 2021)

Realize

Realize is implemented prior to interacting with patients, and even outside of the clinical setting.

When implementing Realize a nurse should:

- Identify gaps in their own knowledge on trauma.
- Understand types and degrees of trauma (e.g. primary, secondary; acute, chronic, physical, emotional).
- Feel confident in their understanding of signs & symptoms of trauma.
- Understand the varying levels of trauma (e.g. individual, community, societal, structural).

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Recognize

Recognize resembles a nursing assessment to identify how trauma is impacting your patient.

When Implementing Recognize a nurse should:

- Assess for signs and symptoms that go beyond the patient's presentation (e.g. extreme responses to simple interventions).
- Make mental note of potential intersections for trauma while reviewing the chart and during patient assessment.
- Identify factors influencing trauma via identity, background, and environment.
- Ask your patient to identify known trauma's.

Respond

Respond is the implementation of interventions to help a patient through a trauma response, or prevent re-traumatization. This stage favours actions over words.

When implementing Respond a nurse could:

- Identify patient's personal coping mechanisms.
- Remove, decrease and/or provide distractions for triggers.
- Provide reassurance, comfort and emotional support.
- Reach out for support from peers and leadership if there are barriers to TIC.

APPENDIX D: PRESENTATION

Resist

Resist is the work done after, and outside of patient interactions. It's an ongoing and intentional effort to continue the application of TIC.

When implementing Resist a nurse would:

- Continue and increase the implementation of TIC in their own practice.
- Encourage organizations to formalize TIC in practice.
- Use TIC in all interactions including with: colleagues, peers, and family.
- Continue to re-assess, and re-implement the Resist and Realize stages on further process and quality improvement within your healthcare setting.

Trauma-Informed Theory of Behaviour (TTB)

- TTB is a patient-based approach to prevention of re-traumatization (Marks et al., 2021).
- Patients are taught and encouraged to identify their own triggers and implement interventions to assist with triggers (Marks et al., 2021; Michaels et al., 2021; SAMHSA, 2014).
- The difference between TTB and TIC is who is implementing the interventions. In TIC the nurse implements changes to prevent re-traumatization, for TTB the patient implements changes (Marks et al., 2021; Michaels et al., 2021; SAMHSA, 2014).

APPENDIX D: PRESENTATION

Case Study: LGBT+ Trauma in the ED

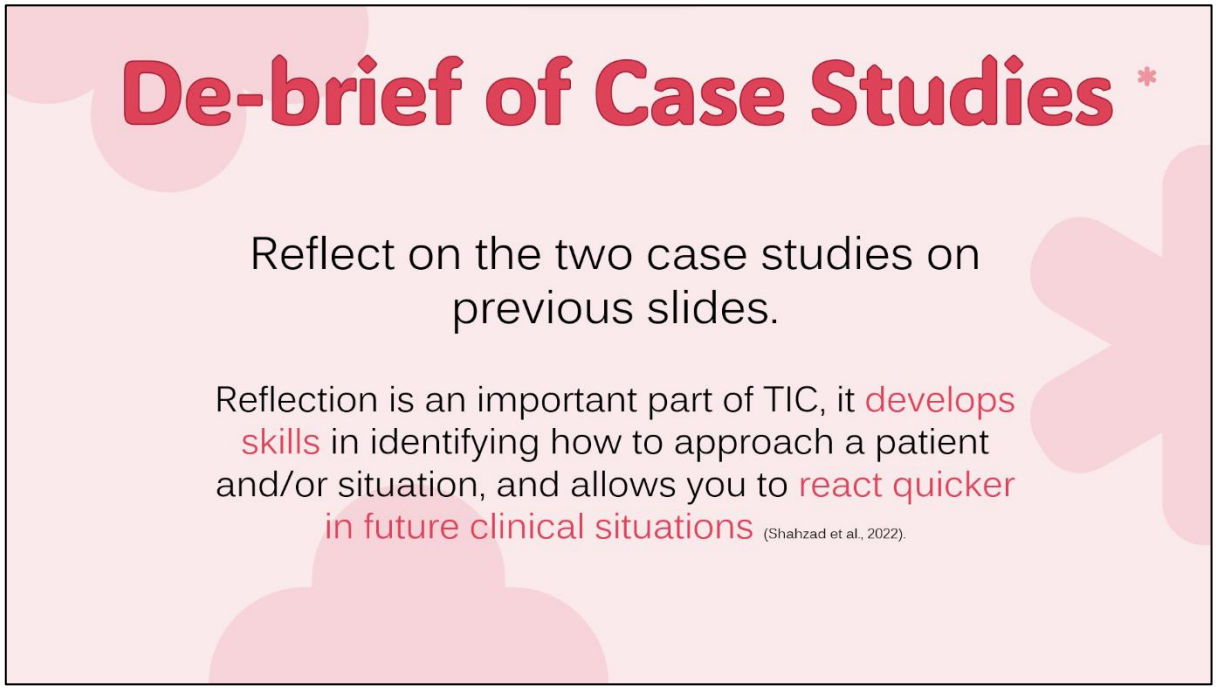
Riley, a 26-year-old non-binary individual. Uses they/them pronouns and was assigned male at birth. Riley has not seen a doctor for over 6 years, due to being misgendered by their nurse throughout their last emergency visit. This misgendering continued despite Riley informing staff of their pronouns. Riley's presentation to the ED this time is for suicidal ideation, and they have no support persons present.

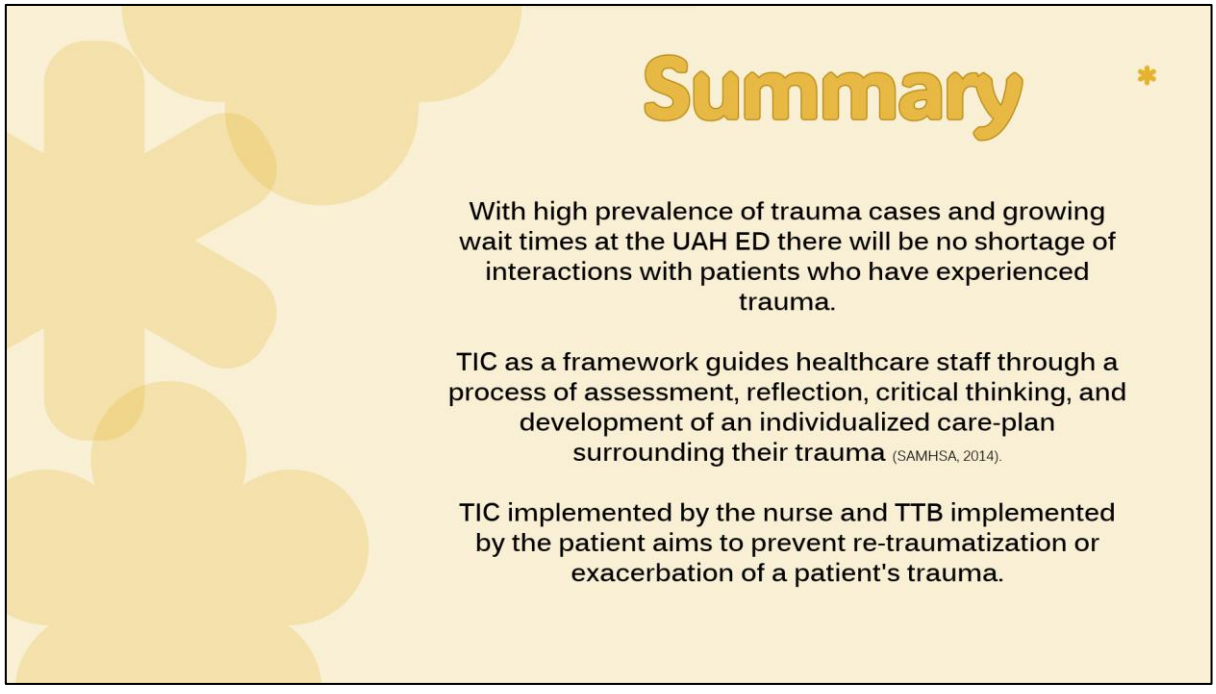
Case Study: Indigenous Trauma in the ED

Tina, 90-year-old female, presented to the emergency with new onset acute confusion. When trying to perform your assessment on Tina she becomes physically and verbally aggressive. Tina's family is at the bedside and trying to reorient Tina. Tina then states "They're going to hurt me again; they'll leave me here to die".

The family informs you that Tina was a residential school survivor, and she spent time in a segregated hospital when she was 30 years-old.

APPENDIX D: PRESENTATION





APPENDIX D: PRESENTATION

Links to resources

TIC

TIC Institute

SAMHSA Trauma-Informed Care PDF

LGBT+ Health

The Trevor Project

Pride Centre of Edmonton

Indigenous Health, Trauma & Healing

Impacts of residence schools and required healing

Structures of Indifference eBook

multi-media resources for Indigenous learning

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APPENDIX D: PRESENTATION

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APPENDIX E: POST-PRESENTATION SURVEY

Trauma-Informed Care Post-Presentation survey

Circle the response that most accurately reflects your experience.

1. I have used trauma-informed care in my practice prior to this education session:

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

2. As a result of the presentation, I can confidently explain what trauma-informed care is to a peer:

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

3. As a result of the presentation, I presentation i feel confident in my understanding of trauma-informed care:

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

4. As a result of the presentation, I know and understand how to implement trauma-informed care:

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

5. Do you have any feedback, questions or recommendations for future education sessions?