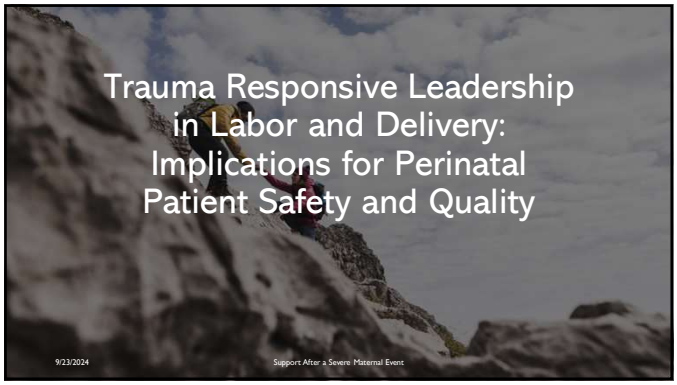

1

Sponsored by a Grant from MDMOM

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MDMOM
Maryland Maternal Health Innovation Program

2

Objectives of Todays Event

- Identify the impact of trauma on the healthcare workforce, quality, safety, and retention.
- Discuss key strategies that leaders can use to debrief with nurses and providers after a severe event to promote staff wellbeing.
- Create a trauma-responsive leader toolbox to support perinatal nurses and providers.

3

Adriane Burgess

Senior Director of Innovation in Patient Safety and Quality
Maryland Patient Safety Center

- Dr. Burgess has been a registered nurse for over 25 years working in a variety of maternal-child health clinical settings. She holds certifications in health care quality, childbirth education, and inpatient obstetrical care. Currently, she works as the Senior Director of Innovation in Patient Safety and Quality at the Maryland Patient Safety Center where she leads several statewide initiatives to promote quality and safety in maternal and neonatal care. In 2023, Dr. Burgess received AWHONN's Award for Excellence in Leadership and was inducted as a fellow in the Association of Women's Health Obstetric and Neonatal Nurses and in 2024 was elected their Board of Directors. She is passionate about moving forward and supporting initiatives aimed at improving outcomes for birthing people and their babies.

4

Tara Ryan Kosmas

Executive Director
Debriefing the Front Lines

Life as a pediatric burn survivor shaped Tara's experience and led her to the nursing profession. Tara's nursing experience spans 20 years and includes burn trauma ICU and nursing education with an emphasis on debriefing and peer support. Tara is the Executive Director of the national nurse led mental health organization, Debriefing the Front Lines. Debriefing the Front Lines provides debriefing of single incident and Cumulative Care Taking Trauma®, emotional wellness offerings, sobriety support and continuing education workshops for nurses working the bedside and beyond.

5

Maggie Runyon

Founder, Your BIRTH Partners
Co-Founder, Trauma Informed Birth Nurse

Maggie is a nurse, educator, and writer. She began her nursing career in 2009 and has since practiced in hospitals and communities nationwide, primarily in labor and birth environments. Maggie maintains a bedside practice at a community hospital in Pennsylvania, in addition to her non-profit work as Founding Executive Director of Your BIRTH Partners. Maggie is currently pursuing her PhD in Nursing and loves educating, mentoring, and learning alongside other nurses. Her research interests are trauma-informed care, secondary traumatic stress, trauma-responsive work environments, and nurse identity.

6

Kayleigh Summers

Kayleigh Summers is a licensed therapist, writer, speaker and private practice owner in Downingtown, PA. She specializes in perinatal trauma and has specific training in both perinatal mental health and EMDR. Kayleigh uses her training as a licensed therapist and her lived experience as an Amniotic Fluid Embolism survivor to collaborate with hospitals and medical staff to understand the patient experience of birth trauma along with ways to prevent and mitigate that trauma. Kayleigh has also created thriving birth trauma support communities through Instagram and Tik Tok, as well as her podcast, where she provides connection, story sharing, and resources to support those experiencing birth and other trauma. You can find her @thebirthtrauma_mama

7

MDMOM Program Evaluation, IRB No. 13694

IRB Determination Date: August 30, 2023

Survey about Attitudes towards Trauma-informed Care in Perinatal Settings

- We invite you to complete a survey on attitudes towards trauma-informed care in perinatal settings.
- The survey is voluntary. We estimate it will take approximately 10-15 minutes to complete.
- Results will be used to guide organizational change efforts and advance provision of trauma-informed care in perinatal settings.

Scan the QR code or visit:
https://jh.qualtrics.com/jfe/form/SV_42Agihyh81UdJC6

8

Trauma Responsive Leadership and Support after a Severe Maternal Event Implications for Perinatal Quality and Safety

Adriane Burgess PhD, RNC-OB, CCE, C-ONQS, CPHQ, FAWHONN
Senior Director of Innovation in Patient Safety and Quality
Maryland Patient Safety Center

9

Objectives

- Discuss the current literature on the impact of severe maternal/neonatal events on health care providers.
- Discuss how perinatal leaders can implement trauma-informed practices into their leadership to ensure nurses and providers feel respected and recognized.

10

What outsiders think we do in labor and delivery

11

Current State of Maternal and Neonatal Health

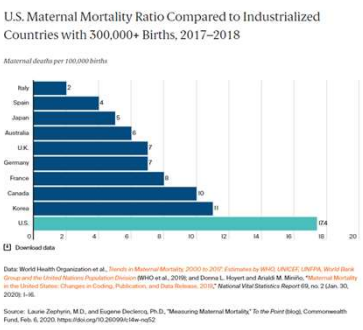
12

In 2022, 817 women died of maternal causes in the United States, compared with 1,205 in 2021, 861 in 2020, 754 in 2019, and 658 in 2018 (2). The maternal mortality rate for 2022 decreased to 22.3 deaths per 100,000 live births, compared with a rate of 32.9 in 2021

U.S. Maternal Mortality 2022

13

The U.S. has the worst MMR as compared to other industrialized countries



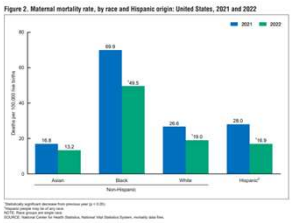
Data: World Health Organization et al., *Trends in Maternal Mortality, 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (WHO et al., 2019); and Donna L. Hoyert and Arialdi M. Miniño, "Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2017," *National Vital Statistics Report* 69, no. 2 (Jan. 30, 2020): 1–18.

Source: Laurie Zephyrin, M.D., and Eugene Declercq, Ph.D., "Measuring Maternal Mortality," *To the Point* (blog), Commonwealth Fund, Feb. 6, 2020. https://doi.org/10.26099/4t4w-np52

14

Disparities in Maternal Mortality in the U.S.

- In 2022, the maternal mortality rate for non-Hispanic Black womens 49.5 deaths per 100,000 live births and was significantly higher than rates for White (19.0), Hispanic (16.9), and Asian (13.2) women



Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024. https://dx.doi.org/10.15620/cdc/152992

15

Patient Acuity is Increasing

- In 2017-2018, approximately 13 percent of women aged 18-39 years had chronic hypertension.
- In 2011- 2016, approximately 3 percent of women aged 20-44 years were diagnosed with diabetes and for more than half of these women their diabetes was not under control.
- In 2015-2016, the prevalence of obesity was 36.5 percent among women aged 20-39 years, and 44.7 percent among those aged 40-59 years.
- In the previous month, nearly 10 percent of pregnant women reported using alcohol and approximately 5 percent reported drug use (marijuana, opioids, cocaine, and others).

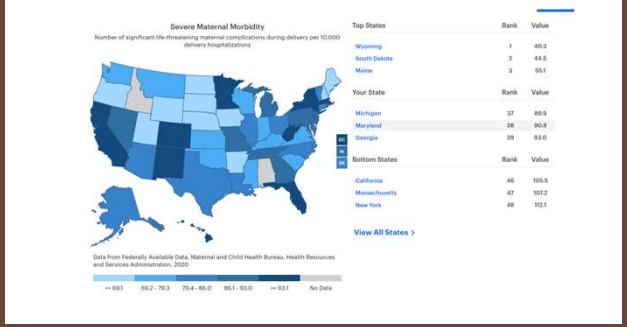
Office of the Surgeon General (OSG). The Surgeon General's Call to Action to Improve Maternal Health [Internet]. Washington (DC): US Department of Health and Human Services; 2020 Dec. Available from: https://www.ncbi.nlm.nih.gov/books/NBK568220/

16

Severe Maternal Morbidity

- As many as 60,000 women in the U.S. experience unexpected outcomes during labor or delivery that have serious short- or long-term effects on their health and well-being
- Severe Maternal Morbidity in the United States | Pregnancy | Reproductive Health |CDC

17



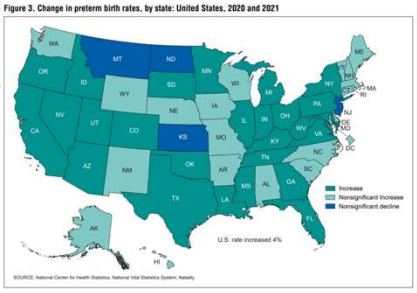
18

Stillbirth

- In 2020, about 21,000 stillbirths were reported in the United States (CDC, 2022 Stillbirth Data and Statistics | CDC).
- In the United States, the stillbirth rate is 5.9/1,000 live births. This means one out of every 160 deliveries ends in stillbirth.

19

Figure 3. Change in preterm birth rates, by state: United States, 2020 and 2021



Osterman, M., Hamilton, B., Martin, J., Driscoll, A., and Valenzuela, C. (2023). Births: Final Data for 2021. National Vital Statistics Reports 72(1) National Vital Statistics Reports Volume 72, Number 1 January 31, 2023 (cdc.gov)

20

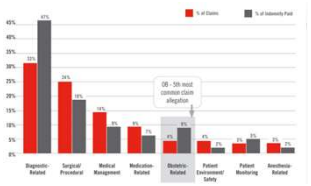
Neonatal Death

- Neonatal death happens in about 4 in 1,000 babies (less than 1 percent) each year in the United States. Non-Hispanic Black women are more likely to have a baby die than women of other races or ethnicities.
  - The most common causes of neonatal death are premature birth, low birthweight and birth defects.

21

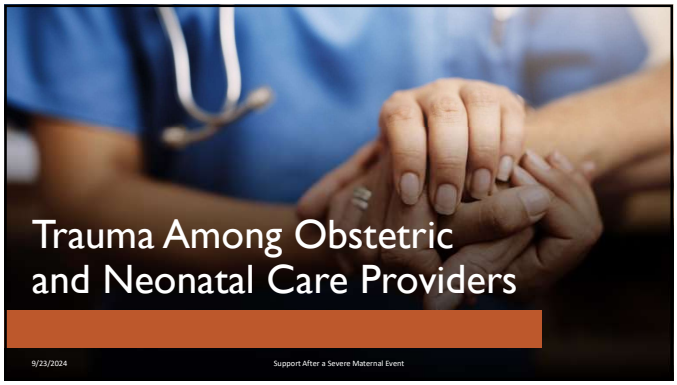
Obstetric Litigation

- 80-90% of OB-Gyns report being sued during their career
- 50% of Ob-Gyns in the U.S. report being burned out and that litigation stress has been linked to depression and even suicide among providers
- Obstetric-related claims are the fifth largest category of medical professional liability claims and the fourth highest category of indemnity payments, accounting for 4% of claims and 8% of indemnity paid



Hanscom et al. (2018). A Dose of Insight: Maternal/Fetal Risks Using Claims Analysis to Improve Outcomes. Converys

22



Trauma Among Obstetric and Neonatal Care Providers

23

Adverse Events in Obstetrics

In their study of several hundred OB/GYN nurses, Finney et al., (2021) found that significant levels of emotional trauma were present

- Approximately 64% of nurses reported being involved in an adverse outcome in OB-GYN
- Of those same nurses, 92% reporting experiencing between 1-5 adverse events in their careers
- Nearly half of nurses surveyed by researchers reported that during their career, they had experienced feelings of secondary victim trauma

Finney, R. E., Torbenson, V. E., Riggan, K. A., Weaver, A. L., Long, M. E., Allyse, M. A., & Rivera-Chiauzzi, E. Y. (2021). Second victim experiences of nurses in obstetrics and gynaecology: A Second Victim Experience and Support Tool Survey. Journal of Nursing Management, 29(4), 642–652. https://doi.org/10.1111/jonm.13198

24

Kruper et al. (N=27)

95% reported involvement with adverse medical events

75% had symptoms of traumatic stress.

- Anxiety (81%),
- Guilt (62%), and
- Disrupted sleep (58%)

Using different services based on symptoms

- Friends
- Peer to Peer support (anxiety)
- Debriefing (guilt)

Kruper, A., Domeyer-Klenske, A., Treat, R., Pilarski, A., & Kaljo, K. (2021). Secondary Traumatic Stress in Ob-Gyns: A Mixed Methods Analysis Assessing Physician Impact and Needs. Journal of surgical education, 78(3), 1024–1034. https://doi.org/10.1016/j.jsurg.2020.08.038

25

Nicholls et al. (2021) (N=144)

- Labor and delivery nurses
- 35% of respondents met symptom severity scores associated with Secondary Traumatic Stress Scale
- 84.7% of respondents reported witnessing a traumatic birth.
- After witnessing a traumatic birth, respondents used
  - co-workers,
  - family, and
  - friends as sources of support.

26

Cankaya and Dikmen (2020)(N=266)

- 37.2% of the maternity nurses/midwives met the criteria for posttraumatic stress disorder
- A positive correlation was found between PTS total score and
  - the number of years in the profession,
  - the number of traumatizing events,
  - quality of work life,
  - burnout symptoms,
  - compassion fatigue,
  - posttraumatic cognition,
  - negative cognition about the world, and
  - negative cognition about the self.

27

NICU and Neonatal Care (Ravaldi et al. 2023)

- Receive limited training on how to communicating bad news
- "communicating baby's death" and "informing on autopsy results" are often traumatic
- The majority of HCPs showed some degree of post-traumatic stress symptoms: 34% medium and 35.3% severe.
- Professionals with training in bereavement care and/or in communication had less probability to develop stress symptoms

Ravaldi C, Mosconi L, Mannetti L, Checconi M, Bonaiuti R, Ricca V, Mosca F, Dani C and Vannacci A (2023) Post-traumatic stress symptoms and burnout in healthcare professionals working in neonatal intensive care units: Results from the STRONG study. Front. Psychiatry 14:1050236. doi: 10.3389/fpsyt.2023.1050236

28

Labor and Delivery (Shorey & Wong, 2022)

- Midwives and labor and delivery nurses expressed powerlessness in advocating for women on many occasions, and
- Health care providers often had feelings of guilt and self-blame after adverse events.
- Inadequate support from their colleagues and organizations, which influenced their ability to cope with the aftermath of trauma and their decision to stay in the profession.

Shorey, S., & Wong, P. Z. E. (2022). Vicarious Trauma Experienced by Health Care Providers Involved in Traumatic Childbirths: A Meta-Synthesis. Trauma, violence & abuse, 23(5), 1585–1598. https://doi.org/10.1177/15248380211013135

29

RESEARCH Open Access

The impact of severe perinatal events

Given the shortage of maternity staff and the importance of a sustainable workforce for effective maternity care, the impact of traumatic perinatal events requires serious consideration in maintaining their wellbeing and positive engagement when conducting their profession.

Conclusion The impact of traumatic perinatal events on maternity care providers ranged from severe negative responses where care providers moved position or resigned from their employment in maternity care, to responses where they felt they became a better clinician. However, a substantial number appeared to be negatively affected by traumatic events without getting adequate support. Given the shortage of maternity staff and the importance of a sustainable workforce for effective maternity care, the impact of traumatic perinatal events requires serious consideration in maintaining their wellbeing and positive engagement when conducting their profession. Future research should explore which maternity care providers are mostly at risk for the impact of traumatic events and which interventions can contribute to prevention.

Nieuwenhuijze, M., Leahy-Warren, P., Healy, M., Akcay, S., Aydin, R., Calleja-Agius, J., Gobeyn-Tricas, J., Hadjigeorgiou, E., Hartonen, K., Henrikson, L., Horsch, A., Lange, U., Murphy, M., Pierron, A., Schäfers, R., Pajalic, Z., Verhoeven, C., Berdun, D. R., & Hassan, S. (2024). The impact of severe perinatal events on maternity care providers: a scoping review. BMC health services research, 24(1), 171. https://doi.org/10.1186/s12913-024-10395-y

30

Events listed as traumatic or contributing to trauma

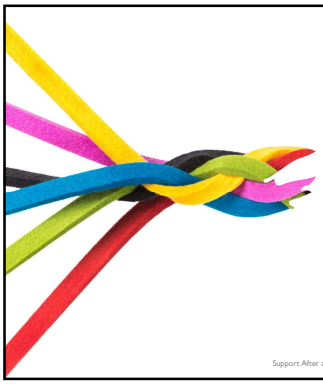
Maternal or neonatal death/stillbirth/fetal loss	Hemorrhage	Abortion care	Events involving a difficult delivery (e.g. shoulder dystocia)
Sudden and unpredictable events	Perceived preventability	Acute sensory experiences	High emotionality.

Rivera-Chiauzzi, E., Finney, R. E., Riggan, K. A., Weaver, A. L., Long, M. E., Torbenson, V. E., & Allyse, M. A. (2022). Understanding the Second Victim Experience Among Multidisciplinary Providers in Obstetrics and Gynecology. Journal of patient safety, 18(2), e463–e469. https://doi.org/10.1097/PTS.0000000000000850

Support After a Severe Maternal Event

Sheen, K., Goodfellow, L., Balling, K., Rymer, J., Weeks, A., Spiby, H., & Slade, P. (2022). Which events are experienced as traumatic by obstetricians and gynaecologists, and why? A qualitative analysis from a cross-sectional survey and in-depth interviews. BMJ open, 12(11), e061505. https://doi.org/10.1136/bmjopen-2022-061505

31



How perinatal nurses and providers feel

- Negative emotions and symptoms
  - Anxiety
  - Disturbed Sleep
- Lost their self-confidence
- Responsibility and regret
- Impact on practice and care
  - Patient safety
  - Decision making
  - Teamwork
  - Capacity for empathy

Support After a Severe Maternal Event

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How perinatal nurses and providers feel

- Challenging professional identity
  - intensions to leave their profession
- Guilt
- Insecurity
  - perceptions of insecurity regarding the organizational system, managers
- Loneliness
  - "Left alone with the emotional surge"

9/23/2024

Support After a Severe Maternal Event

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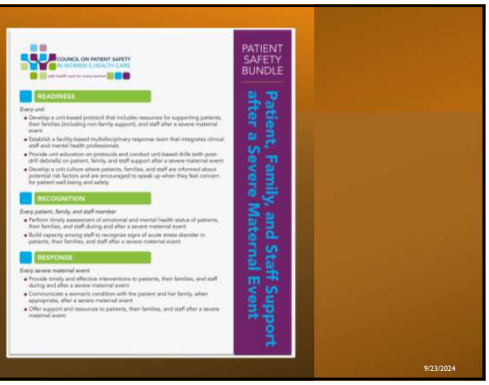
Addressing Severe Events

34



35

National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event

- Multidisciplinary teams should work together to customize a workable and feasible protocol
- Have clear guidelines on when and how to activate the support team
- Educate all team members, including nurses, on the existence of peer support resources and why these resources are important and should be utilized.
  - Education can occur through department meetings, professional conferences on morbidity and mortality, e-mails sent to involved clinicians after an event, and even screensaver templates within the institution.
- Birth facility leaders should actively monitor the mental and emotional status of all individuals who are involved in a severe maternal event and perform timely assessment
  - Breslau Post-Traumatic Stress Disorder Screening Tool

Morton, C. H., Hall, M. F., Shaefer, S. J. M., Karsnitz, D., Pratt, S. D., Klassen, M., Semenuk, K., & Chazotte, C. (2021). National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event. Journal of obstetric, gynecologic, and neonatal nursing : JOGNN, 50(1), 88–101. https://doi.org/10.1016/j.jogn.2020.09.160

36

National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event

- Build capacity among staff to recognize signs of acute stress disorder in patients, their families, and staff after a severe maternal event
- Establish a Culture of Debriefs (Huddles)
- Multidisciplinary Review of Severe Maternal Morbidity Events to Include the Perspectives of Women and Families

37

They want services…

Slade et al., 2020 reported that 91% of their sample of 839 obstetric physicians wanted an institutional system of care.

38

Interventions

- Team/Peer support are essential
  - Colleague versus institutional support
  - Conversations with peers
- Screening for trauma
- Psychological education
  - Prepare maternity nurses/midwives/providers for exposures
  - Training on how to communicate bad news
- Structured case conferences for emotional debriefing
- Safety and transparency with opportunities for group processing
- Professional sharing groups that allow doctors to share their experiences and to gain awareness about their colleagues' traumas
- End of shift meetings for midwives and team bonding sessions for residents

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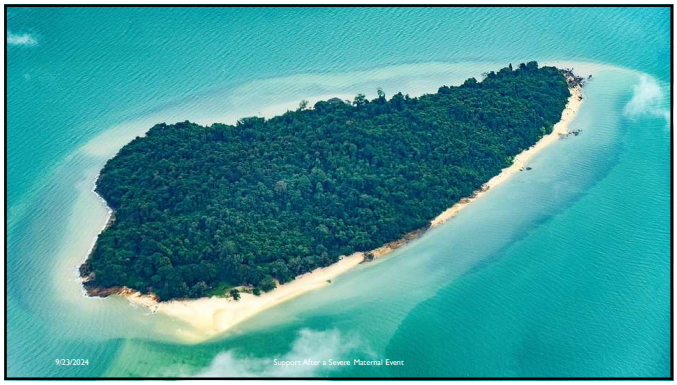

40

Barriers to Implementation of Support

- Limited connection between peer support/EAP to labor and delivery
- They often try to go it alone
  - The culture in obstetrics and gynecology was identified as a barrier to trauma support
- Low level of participation with support
- Awareness of supportive services
- Normalization of adverse events
- No structured debriefing or those debriefing are not trained

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Reflection on Best Practices

- Are you connected with your institutions peer support services? Does your team use them regularly?
- Do you have a predefined list of serious maternal/neonatal events that you follow up with your team to assess the need for support?
- Do you practice how to debrief during drills and simulations?
- Does your team share support resources during debriefs after an adverse event?
- As a leaders do you actively reach out to your team after a SMM?
- Do you provide education on the importance of peer support after a serious event in labor and delivery/NICU or the impact of trauma to staff in these units?
- What is your timeline to follow up? (i.e. what does your process look like)

42

Trauma Informed Care: Key Tenets and Safety

43

What do we know about the current state of nursing?

- 87% feel burned out.
- 84% are frustrated with administrators.
- 84% feel they are underpaid.
- 83% feel their mental health has suffered.
- 77% feel unsupported at work.
- 61% feel unappreciated.
- 60% have felt uncomfortable having to work outside of their comfort zone in the past year.
- 58% of nurses have felt frustrated with their patients.
- 58% of nurses have felt unsafe at work in the past year

Pepe, A., & Robinson, K. (2023). Leadership and Trauma-Informed Care: Working to Support Staff and Teams. Journal of emergency nursing, 49(2), 172–174. https://doi.org/10.1016/j.jen.2022.11.001

44

What causes trauma in healthcare?

Arthur et al. (2013) defined trauma as "experiences that overwhelm an individual's capacity to cope" (p. 6).

- Trauma responses are triggered in the workplace based on emotional scars
  - Stressful professional experiences,
  - Increased workload,
  - A terrifying event (affects staff directly or indirectly)
  - Trauma after the pandemic
  - Being physically harmed or near harm

Wignall A. (2020). Trauma-Informed Nursing Leadership: Definitions, Considerations and Practices in the Context of the 21st Century. Nursing leadership (Toronto, Ont.), 34(3), 24–33. https://doi.org/10.12927/cjnl.2021.26246

45

Impact of Trauma on Healthcare Workers

- Headache
- Social isolation
- Anxiety
- Depression
- Emotional volatility
- Leaving job
- Addictive behaviors
- Suicidality
- Also impacts patient safety!

AWMC (2021). Work-related stress & trauma: Supporting the mental health Of health professionals. Retrieved from https://www.awmc.org/wp-content/uploads/2021/05/AWMC-Monograph-Work-Stress-Trauma.pdf

46

What is trauma informed care?

Needs to be implemented at the clinical and organizational level!

A trauma-informed approach acknowledges that healthcare organizations and care teams need to have a complete picture of a person's life situation

Trauma Informed Care Implementation Resources Center (n.d.). What is Trauma Informed Care? Retrieved from https://www.traumainformedcare.chcs.org/wp-content/uploads/Fact-Sheet-What-is-Trauma-Informed-Care.pdf

47

What is trauma-responsive leadership?

"Trauma-responsive leadership is not about treating or diagnosing, but it does provide leaders with tools, strategies, and skills to disrupt continuums of harm and to implement policies that can mitigate the harmful effects of trauma to **foster an environment of psychological safety."**

- Both a style of leadership and a set of tools supporting leadership practice (Manderscheid 2009)

Khalid, O., Tillena, K., Sarraf, K. (2023). Supporting the Public Health Workforce with Trauma-Responsive Leadership Skills retrieved fromhttps://www.astho.org/communications/blog/supporting-the-public-health-workforce-with-trauma-responsive-leadership-skills/#:~:text=Trauma-responsive%20leadership%20is%20not%20about%20treating%20or%20diagnosing%2C,trauma%20and%20foster%20an%20environment%20of%20psychological%20safety.

48

49

Leading a Culture of Safety: A Blueprint for Success

9/23/2024

Support After a Severe Maternal Event

50

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4'R's of Trauma Informed Care

Realize the widespread impact of trauma and understand paths for recovery;

Recognize the signs and symptoms of trauma in patients, families, and staff;

Respond by integrating knowledge about trauma into policies, procedures, and practices; and

Resist re-traumatization.

52

"A trauma-informed approach to leadership recognizes that the leaders must not be focused solely on accomplishing work or managing people. ***Leaders must recognize trauma at individual, group and system levels.*** They must not only intellectually understand trauma and its impacts but also be able to ***integrate theoretical knowledge*** into an active trauma-informed practice. Leaders must finally ***set up the conditions for people in their care to be safe from re-traumatization***, which may require leaders to actively address and ***dismantle organizational patterns and structures that perpetuate trauma***."

Wignall A. (2021). Trauma-Informed Nursing Leadership: Definitions, Considerations and Practices in the Context of the 21st Century. Nursing leadership (Toronto, Ont.), 34(3), 24–33. https://doi.org/10.12927/cjnl.2021.26396

53

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

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How the 6 Principles of Trauma Informed Care are reflected in your Leadership

Safety

- *Create predictable, consistent experiences and spaces where people feel welcome and are clear on what is expected of them*

Trust and transparency

- *Built when leaders are inclusive, follow through on what they commit to and are honest with their teams*

Peer support

- *Work with power and understanding that the impact of institutional and hierarchical power*

Wignall A. (2021). Trauma-Informed Nursing Leadership: Definitions, Considerations and Practices in the Context of the 21st Century. Nursing leadership (Toronto, Ont.), 34(3), 24–33. https://doi.org/10.12927/cjnl.2021.26096

55

How the 6 Tenets of Trauma Informed Care are reflected in your Leadership

Collaboration and Mutuality

- *Create environments where learning and curiosity can be explored without violence or judgement*

Empowerment, Voice, and Choice

- *Explore how to return control, enable self-determination and choice to your team and implement shared decision-making*

Cultural, Historical, and Gender Issues

- *Create environments which support individual and cultural differences*

Wignall A. (2021). Trauma-Informed Nursing Leadership: Definitions, Considerations and Practices in the Context of the 21st Century. Nursing leadership (Toronto, Ont.), 34(3), 24–33. https://doi.org/10.12927/cjnl.2021.26096

56

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What can perinatal leaders do?

Realize the widespread impact of trauma on your staff

Recognize the signs of trauma in your staff

Respond by fully integrating trauma-informed practices into your interactions with staff, as well as in your clinical and organizational policies and practices

- How do you respond after a traumatic event on your unit
- What resources do you share?
- How do you follow up in the days and weeks after the event?

Seek to actively resist re-traumatization of your staff

Tweedy, D. (2023). Trauma Informed Leadership: An Approach for Healthcare. Retrieved from https://healthadministrationdegree.usc.edu/blog/trauma-informed-leadership

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What can leaders do?

- •Cultivate a culture of posttraumatic growth
- •Understand the trauma response
- •Hold space when team members (or you) are experiencing a trauma response
- •Promote open conversations
- •Strive to respond with compassion and empathy
- •Create safe and respectful environments
- •Diminish stigma associated with expressing emotion and need for support
- •Be present and emotionally accessible
- •Model and inspire self-care

Kolomeitz, M., & Pela, M. (2021). Trauma-informed leadership and posttraumatic growth. Nursing management, 52(12), 28-34. https://doi.org/10.1097/01.NUMA.0000803036.39811.a3

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Four relational practices[4]

Practice	Meaning	Language
Attuning	• Practice of human connection • Shutting out distractions, focusing attention, and listening • Being present • Noticing	• Thank you for coming to me… • I feel honored that you would share… • It makes sense you would feel….
Wondering	• Practice of curiosity and genuine interest • Suspending judgment and assumptions • Noticing • Listening	• How are you…really? • What worries you? • What's most important to you? • What do you need?
Following	• Practice of quiet listening • Staying with what we hear and notice • Being in the moment • Allowing expression of emotions	• Tell me more about… • Do I have this right? • What's most important to you right now?
Holding	• Practice of creating a safe space • Doing what we said we would do • Remembering what we've been told • Taking the right action • Listening without defense • Honoring boundaries	• I remember when you told me… • I'll follow through and make sure… • Thank you for being open and vulnerable with me… • I'm here.

Relational Practices

Tools to Practice Trauma Informed Leadership

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