15.7: Spotlight Activity

This Spotlight Activity is based on a real case originally presented in, “Trauma-Informed Care in Nursing Practice” by Dowdell and Speck (2022). Identifying details have been changed or omitted to protect the anonymity of the client.\(^{[1]}\)

Dana is a 34-year-old female who arrived at the Emergency Department with a neck injury she reports “happened this morning when I slipped and fell.” The nurse notes that Dana’s address given is in a different community about 50 miles away from the hospital. Initial physical examination revealed bruise patterns in various stages of healing all over Dana’s body and three linear abrasions over the trapezius muscle on the right side of the neck consistent with attempted strangulation.

While awaiting diagnostic testing results, the nurse established a therapeutic nurse-client relationship and asked Dana a few follow-up questions about the events leading up to the injury and the relationship with the partner. Dana stated, “We fight a lot” and “My partner has a lot of angry outbursts.” Upon the nurse’s use of effective therapeutic communication, Dana shared that the injury resulted from “being choked and beaten,” and the partner had done similar actions on “several previous occasions in front of the children.” Dana then told the nurse, “My partner can’t find out that I am here in this hospital.”

A contrast computed tomography (CT) scan revealed swelling of Dana’s right carotid artery and soft tissue in the neck. Laboratory tests also indicated that Dana had severely elevated blood sugars resulting in diabetic ketoacidosis (DKA). The health care team initiated a medication regimen to safely manage the DKA and also prevent a stroke from the injury.

The nurse noted that, over time, Dana became increasingly agitated in the ED with repetitive neurological assessments, fingersticks for bedside glucose levels, and the noises and high activity level of the ED. Establishing physical and psychological safety for both Dana and staff became a nursing priority during Dana’s time in the ED.
Following trauma-informed care (TIC) guidelines to create a safe environment, the nurse asked Dana, “What do you need to feel safe here right now?” Dana immediately responded, “I can’t have all these people coming at me. It’s too much – too much noise, too many people touching me, it’s just too much.” The nurse moved Dana out of the trauma bay, which was near the ambulance entryway, and into a room where the nurse was able to close the door. The nurse also posted signage on the door asking all staff and visitors to contact the nurse before entering the room. Following agency protocol, the nurse swiftly gained Dana’s consent for anonymity, meaning the client’s name and room number(s) would not be shared with anyone outside of the hospital. Following these nursing actions, Dana’s anxiety and agitation levels dropped noticeably in the ED. When an ICU bed became available, she was transferred there for medical management.

Dana was present during the handoff report from the ED nurse to the ICU nurse to validate information and it also improved Dana’s sense of safety. Following the TIC cue given by the ED nurse, the ICU nurse asked Dana, “What else do you need to feel safe here right now?” Dana requested a private room, if available, to rest, listen to music, and “stay calm.” The ICU nurses implemented a safety plan that included consistent staff and coordinated, clustered care. This plan minimized disturbances, thereby providing dedicated periods for rest between timed blood glucose monitoring and nursing monitoring of Dana’s neurologic state and neck swelling.

While in the ICU, the nurses taught Dana evidence-based methods for reducing anxiety, including deep breathing, grounding techniques, and moderating anxiety-provoking stimuli such as social media and electronics. In addition, the nurses noted the vocal and nonverbal cues that indicated Dana was feeling anxious, such as speaking in a raised voice or using rapid hand movements while speaking. Noticing these behaviors allowed nurses to ask follow-up questions such as “Do you feel safe at this moment,” then review anxiety-reducing techniques by asking Dana, “Which technique would you like to use now?” By offering person-centered choices and creating a predictable structure around clustered nursing actions, the nurses promoted a feeling of safety for Dana as well as techniques to self-regulate anxiety.

The health care team identified Dana’s priority health concerns as DKA management and decreasing the risk for a stroke following nonfatal carotid trauma. The nursing team added Dana’s increased risk for subsequent fatal strangulation as a priority concern that must be addressed before discharge. However, when asked by the nurses, “What is important to you to include in your discharge plan,” Dana identified the priorities of finding safe housing and employment with fair pay. Therefore, the nursing team recommended that upon discharge, Dana would transfer directly to community wraparound services for a variety of assistance including transitional housing, job training, day care, medical care, and cognitive behavioral therapy.

Reflective Questions

1. What actions did the nurses perform with Dana to implement Trauma Informed Care (TIC)?
2. What other actions do you plan to implement with your patients regarding TIC?
3. “Dana” could be a male or a female, and Dana’s “partner” could be a male or a female. Do gender differences or sexual orientation affect your attitudes toward Dana’s risks and follow-up care?
4. How might Dana’s children be affected by Dana’s ongoing abuse?
5. What if Dana’s partner showed up at the hospital with a gun threatening to kill Dana? How would you respond as a nurse to keep yourself, other patients, and staff safe?

30-38. https://journals.lww.com/ajnonline/Fulltext/2022/04000/CE__Trauma_Informed_Care_in_Nursing_Practice.22.aspx