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Corrigendum



Regarding the May 2022 article, Mo Y-H, et al. Development and Validation of a Nomogram for Predicting Sarcopenia in Community-Dwelling Older Adults. *J Am Med Dir Assoc* 2022;23(5):715-722.

In Table 1 the “uninterrupted sedentary time”, the “<2” should be the reference rather than “>4”.

DOI of original article: <https://doi.org/10.1016/j.jamda.2021.11.023>

Corrigendum



Regarding the March 2022 abstract supplement of the journal. *J Am Med Dir Assoc* 2022;23(3).

[https://www.jamda.com/issue/S1525-8610\(21\)X0012-6](https://www.jamda.com/issue/S1525-8610(21)X0012-6)

The following abstract was missing from the Quality Improvement section of the abstracts.

Developing a Standardized Tool to Screen for Trauma and Training Nursing Home Staff in Trauma Informed Care

Presenting Author: Sheetal Gambhir, MD, Emory University

Author(s): Sheetal Gambhir, MD; Sahebi Saiyed, MD, MPH, CMD; Alexis Bender, PhD

Background: Trauma Informed Care (TIC) is a CMS requirement and failure can result in the citation of F-tags to the facility. Trauma can increase risk for obesity, substance use disorders, depression, suicide, an increase in healthcare use, and overall increased mortality. TIC seeks to educate patients and staff about the long-term effects of trauma and work towards reducing the risk of re-traumatization and increasing physical and psychological safety. There is currently no gold standard screening tool for trauma and the few that exist are mostly used in the research setting and are too cumbersome to administer.

Objective/Aim: To develop a screening tool and training for Trauma Informed Care.

Quality Improvement Methods: We created a screening questionnaire using literature and social worker input to implement TIC. We conducted training sessions in two nursing homes - BT and AGR. These sessions were hour-long interactive session explaining TIC, how to use the screening tool, and role playing to assess practical challenges of implementing TIC. The participants completed surveys pre- and post-training to assess their understanding of, attitudes toward, and their comfort in engaging with screening and caring for patients for TIC. We conducted paired sample t-tests for each item for the entire sample and separately by facility. BT had begun a systematic screening process. We also assessed changes in screening patterns pre- and post-training.

Results: The training was given to 12 trainees, 5 at BT and 7 at AGR; 16% of trainees were white. All trainees were women and between the ages of 20 and 55. BT were trained social workers and AGR trainees included LPNs, CNAs, and nursing and social work staff. In the overall sample, there was a significant positive change in self-rated knowledge of TIC pre-test ($M = 1.75$, $SD = 1.13$) compared to post-test ($M = 3.75$, $SD = 0.75$), $P = .001$, as well as an increase in knowledge about how trauma affects patients pre-training ($M = 3.18$, $SD = 1.72$) to post-training ($M = 5.64$, $SD = 0.81$), $P = .004$. In separate facility results, self-rated knowledge was only significant for AGR and not BT, indicating the change in the overall sample was driven by AGR attendees. Although knowledge and attitudes increased with training, most trainees requested additional training on TIC, especially among patients with dementia. Based on case tracking at BT in the 27 days prior to training, we admitted 43 new patients and only 2.3% of those screened positive for trauma. After the training, 43 patients were admitted in a span of 18 days out of which 7 (17%) patients screened positive for trauma. Training likely enabled staff to be more assertive with screening and having a standardized tool likely helped. We are currently collecting data on change at AGR and will present when data are complete.

Conclusions: A standardized screening tool coupled with training for staff helps boost efforts to screen patients for trauma and aid nursing homes deliver TIC. Future training should emphasize the nuanced aspects of TIC.

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