

TRUST IN ACTION

Building Trust, Delivering Care

A Trauma-Informed Practice Session for Nursing and Provider Teams

Participant Workbook

ASK

before acting

EXPLAIN

what and why

OFFER CHOICE

wherever one exists

Name

Role / discipline

Unit / organization

Conference / date

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How to Use This Workbook

This workbook follows the session slide by slide. Each part has a color. When the slide changes color, turn to the matching section here. Write in it. Nothing you write is collected.

Session at a Glance

Part	Topic	Format
Opening	Trust Poll	Live poll, full group
Segment 1	What Trauma Looks Like	Mini-lecture plus table vignettes
Segment 2	Trust in Action	Paired role play or group discussion
Segment 3	Trauma-Informed Care in Your Setting	Table process mapping
Closing	Commitment Cards	Individual plus share-out

What You Will Find Inside

- **Readiness Tracker.** Four quick checkpoints. You rate yourself at the start and again at the close.
- **Activities.** Vignette notes, role play notes, and a process map for your unit.
- **Exercises.** Short practice tasks you can repeat with your team after the session.
- **Evidence and references.** Peer-reviewed briefs and full citations in the back.

EVIDENCE BOUNDARIES

Peer-reviewed literature supports the trauma-informed framework and selected technology findings.

Disclosures

- No relevant financial relationships with ineligible companies are reported. Confirm this wording against the conference disclosure form.
- Abridge and virtual nursing are discussed as applied examples, not product endorsements.
- Local operational guidance does not replace policy, legal guidance, clinical judgment, or organizational procedures.
- AI-assisted tools supported drafting and visual design. The presenter remains responsible for final accuracy and citations.

OPENING

Trust Poll

Live poll, full group

Learning Objectives

By the end of this session, you will be able to:

1. **Differentiate** observable behavior from potentially stigmatizing interpretation during patient encounters.
2. **Apply** the six principles of trauma-informed care to nursing and provider workflows.
3. **Demonstrate** Ask, Explain, Offer Choice in ambient documentation and virtual nursing scenarios.
4. **Identify** one workflow or environmental change your unit can make within 30 days to strengthen patient trust.

Trust Poll

How quickly does a patient decide whether to trust you? Mark your poll answer.

☐ A. Within seconds	☐ B. Within the first few minutes
☐ C. By the end of the first visit	☐ D. Over several visits

Think of a time you were the patient or family member. What did someone do in the first minute that made you relax, or brace?

Readiness Tracker

Four checkpoints run through the session. This is a reflection pulse, not a test. Nobody collects it.

Checkpoint 1: Starting Point

Rate each statement from 1 (not yet ready) to 5 (ready to use consistently). You will re-rate these at Checkpoint 4.

Statement	1	2	3	4	5
Recognize: I separate observation from interpretation.	☐	☐	☐	☐	☐
Respond: I use Ask, Explain, Offer Choice in real time.	☐	☐	☐	☐	☐
Technology: I explain purpose, alternatives, and accountability.	☐	☐	☐	☐	☐
System: I identify workflow conditions that affect trust.	☐	☐	☐	☐	☐

Checkpoint 2: Translate the Framework

Mark the statement that best describes where you are now.

☐ A. I need examples.	☐ B. I can revise phrases with support.
☐ C. I can use the framework routinely.	☐ D. I can coach others and identify barriers.

One phrase I want to practice:

Readiness Tracker (continued)

Checkpoint 3: Technology and Trust

R = Ready. P = Needs practice. L = Needs local clarification.

Statement	R	P	L	Who can answer my L?
Consent and choice: I explain purpose, alternatives, and the right to decline.	☐	☐	☐	
Role clarity: I explain what each care role owns.	☐	☐	☐	
Verification: I describe the required human review.	☐	☐	☐	
Escalation: I know when to pause and confirm local guidance.	☐	☐	☐	

Checkpoint 4: What Changes Now?

Re-rate your Checkpoint 1 statements. Compare. Then choose your next action.

Statement	1	2	3	4	5
Recognize	☐	☐	☐	☐	☐
Respond	☐	☐	☐	☐	☐
Technology	☐	☐	☐	☐	☐
System	☐	☐	☐	☐	☐

☐ PRACTICE: use one phrase next shift	☐ CLARIFY: confirm one local policy
☐ REDESIGN: change one trust-risk point	☐ SHARE: teach one colleague

SEGMENT 1

What Trauma Looks Like

Mini-lecture plus table vignettes

Why This Matters

- **About 70 percent** of adults report at least one traumatic event in their lifetime (SAMHSA).
- Patients with trauma histories show higher rates of missed appointments, delayed care, and leaving against medical advice.
- Trust forms in seconds. Tone, body position, and word choice register before clinical skill does.

THE CORE SHIFT

Not: *"What is wrong with this patient?"*

Ask instead: **"What happened to this patient, and what do they need from us right now?"**

A time a patient seemed "difficult" and I later learned more. What changed my view?

What patients on my unit see, hear, or feel in the first minute of care:

What Trauma Can Look Like

None of these prove a trauma history. They are signals to slow down and offer more control. Describe the behavior. Hold the interpretation loosely.

Presentation	What you might see	Possible meaning (hold loosely)	Trust-building response
Avoidance	Missed appointments, delayed care, declined exams, leaving before discharge.	Staying away from a setting or procedure tied to past harm or a prior bad visit.	Ask what got in the way. Make the next step easier. Set clear expectations.
Hypervigilance	Checks the door, startles easily, tracks every movement, cannot settle.	Scanning for threat in an unfamiliar, loud space.	Announce entry. Position so the patient can see the door. Narrate each step.
Mistrust of providers	Questions each step, declines recording or video, asks for a different clinician.	Protecting control. Some communities carry documented reasons for medical mistrust.	Be transparent. Follow through. Offer choice. Do not argue or over-reassure.
Shutdown or over-compliance	Quiet, flat, over-apologizing, agrees to everything without questions.	A freeze or appease response under stress.	Slow down. Check understanding. Name the right to pause or stop.

UNIVERSAL PRECAUTIONS APPLY TO TRAUMA

You cannot identify trauma survivors by appearance, diagnosis, or demographics. Practice trauma-informed care with every patient, the same way you use gloves with every patient.

Screening tools help. Behavior-based cues (flinching at touch, door-checking, over-apologizing, shutdown) reach patients who will never disclose.

The Six Principles of Trauma-Informed Care

SAMHSA and CDC name six guiding principles. Here is what each one looks like on shift.

Principle	What it looks like on shift	I already do this
1. Safety	Knock before entering. Explain before touching. Watch positioning: sit at eye level for hard conversations, never block the door.	☐
2. Trustworthiness and transparency	Say what you will do, then do it. Narrate delays. If you promise to return in 20 minutes, return or send word.	☐
3. Peer support	Connect patients with others who share lived experience when programs exist. Normalize support groups without pressure.	☐
4. Collaboration	Treat the patient as a partner in the plan, not a recipient of it. Ask what has worked for them before.	☐
5. Empowerment and choice	Offer options wherever one exists, even small ones. Left arm or right. Door open or closed. Now or after breakfast.	☐
6. Cultural, historical, and gender responsiveness	Ask, do not assume. Some communities carry documented reasons for medical mistrust. Earned trust answers that history better than reassurance does.	☐

The principle I practice least under time pressure, and why:

Activity 1: Table Vignettes

Your table will review one vignette. Read it aloud, talk it through, and capture your thinking on the next page. These are fictional composite cases. They do not represent specific patients or encounters.

VIGNETTE A: THE PRE-OP PATIENT

Ms. R., 52, is in pre-op for an elective hysterectomy. She pulls her gown tight across her chest and asks three times who will be in the operating room. She asks whether she will be "out the whole time." When the anesthesia resident reaches to place monitoring leads without speaking, she pulls back and says, "Can you tell me first?" A colleague mutters that she is "high maintenance."

VIGNETTE B: THE MISSED FOLLOW-UPS

Mr. D., 61, has type 2 diabetes. He has missed three endocrinology appointments in six months, and his chart lists him as "noncompliant." Today he arrives 25 minutes late, apologizes repeatedly, and sits in the chair closest to the exit. When asked about his glucose logs, he says he forgot and looks at the floor.

VIGNETTE C: THE QUIET ADMISSION

A 34-year-old patient is admitted overnight with pneumonia. During the admission assessment, the patient answers "fine" to every question and keeps watching the door. The patient flinches when the automatic blood pressure cuff inflates. When the nurse asks to listen to the patient's back, the patient freezes and says "okay" very quietly.

VIGNETTE D: THE IMAGING ROOM

Mr. T., 45, is scheduled for an MRI. In the imaging suite he asks if the door can stay open and whether someone can talk to him during the scan. The technologist says the door must be closed and the scan takes 40 minutes. Mr. T. begins sweating, says he needs the restroom, and does not return for 15 minutes.

Vignette Notes

Our vignette: ☐ A ☐ B ☐ C ☐ D

Behaviors that could signal a trauma history:

What we would want to know before labeling this patient:

Which of the six principles was missing, and where?

One change for the first three minutes of the encounter:

Exercise 1: Notice Without Labeling

Labels like noncompliant, drug-seeking, difficult, or frequent flyer follow patients into every future encounter. They shape how the next provider treats them before saying hello. Rewrite each observation. The first row is done for you.

Observation	Label to avoid	Neutral description	Information still needed
Declined exam, then agreed	Uncooperative	Declined exam. Agreed after explanation of each step.	What made the difference?
Repeatedly looks toward doorway			
Declines a second recording			
Does not want a video interaction			
Becomes quiet after a role change			

A labeling phrase I have heard in handoff, and how I would rewrite it objectively:

SEGMENT 2

Trust in Action

Paired role play or group discussion

The Trust-in-Action Framework

Three moves. Each takes seconds. Use them with every patient.

Move	What it means	Sounds like
ASK	Get permission before acting.	"Is now an okay time?" "May I check your incision?"
EXPLAIN	Describe what you will do and why, before you do it. Narrate delays and handoffs too.	"I will walk you through each step before I begin."
OFFER CHOICE	Return control wherever a real choice exists, even a small one.	"Left arm or right?" "Door open or closed?"

Phrases That Work

- *"Before I start, I want to walk you through what I am going to do. Stop me anytime."*
- *"You are in charge here. We can pause whenever you need."*
- *"Is there anything about being in the hospital that is hard for you? I ask everyone."*
- *"I do not need the details. I want to know how we can make this easier."*

What to Avoid

- **Labels.** Calling patients difficult, noncompliant, or dramatic in charting or handoffs. The label travels and shapes every encounter after yours.
- **Surprise touch.** Touching, uncovering, or repositioning without warning.
- **Blocking.** Blocking the door or standing over a seated patient during hard conversations.
- **Curiosity questions.** Asking personal trauma questions out of curiosity. Ask only what changes the care plan.

TIME PRESSURE IS NOT THE REAL BARRIER

Asking permission, narrating actions, and offering small choices take seconds. Mistrust costs more time downstream: refusals, escalations, security calls, AMA discharges, and readmissions.

The most common misconception: trauma-informed care means asking patients about their trauma. It means designing every interaction so disclosure is never required for safe care.

Exercise 2: Language Laboratory

Name the trust risk in each phrase, then rewrite it with Ask, Explain, or Offer Choice. Example: "Hold still, this will not hurt" dismisses the patient's experience. Try: "You may feel pressure. Tell me if you want me to pause."

Original phrase	Trust risk	Revised phrase
"I'm going to check your incision."		
"I have to record this."		
"The virtual nurse is coming on now."		
"This will only take a second."		
"You need to calm down."		

Quick Practice Prompts

Write the words you would use in each moment.

Moment	What I would say
Before touching or repositioning	
Before activating a recording	
Before connecting a virtual nurse	
When the patient changes their mind	
When there is a delay or handoff	

Activity 2: Role Play

Work in pairs or trios. Switch roles each round so everyone plays each part. If role play does not fit your table, read the scenario aloud and script the first 60 seconds together.

Role	Your job
Provider	Use Ask, Explain, Offer Choice. Try at least one phrase from the Phrases That Work list.
Patient	Read your card. Stay in role. Notice the moment something shifts for you.
Observer	Use the checklist below. Note one phrase worth stealing.

Scenario Cards

SCENARIO 1: IV START

Patient: The last time someone started an IV, it took four tries and nobody explained anything. You pull your arm back when the provider reaches for it. You do not want to explain why.

Provider goal: Start the IV while restoring as much control as possible.

SCENARIO 2: AMBIENT RECORDING CONSENT

Patient: You are unsure about being recorded. You worry about who will hear it and where it goes. You do not want to seem difficult.

Provider goal: Introduce ambient documentation transparently and honor the decision either way.

SCENARIO 3: VIRTUAL NURSE ADMISSION CHECK-IN

Patient: A screen turns on in your room. You did not know anyone could see you. You pull the blanket up and go quiet.

Provider goal: Orient, protect privacy, offer control, and close the loop.

Observer Checklist

Move	Heard it	Missed it	Exact words used
Asked permission before acting	☐	☐	
Explained before acting	☐	☐	
Offered a real choice	☐	☐	
Narrated a delay or next step	☐	☐	
Named the right to pause or stop	☐	☐	
Avoided labels and curiosity questions	☐	☐	

Role Play Notes

As the provider, the move that felt least natural to me:

As the patient, the moment something shifted for me:

One phrase I heard that I want to steal:

Applied Example: Ambient Clinical Documentation

EVIDENCE BOUNDARY

The trauma-informed teaching point is generalizable. Abridge is the local operational example. Always check product-specific directions against current local policy and training resources.

Trust-Safe Sequence

Moment	Trust-building action
Before recording	Explain purpose, what is recorded, who is responsible for the final note, and the right to decline. Get affirmative verbal consent.
During the encounter	Keep the technology visible. Keep your attention on the patient. Honor requests to pause or stop.
Before filing	Review and correct the generated draft before finalizing documentation.

SAMPLE INTRODUCTION

"I use a tool that listens to our conversation and drafts my note, so I can look at you instead of the screen. I review everything before it goes in your chart. You can say no, or ask me to stop at any time. Is it okay to use it today?"

Exercise 3: Build Your Consent Introduction

Write your own version in your words.

Purpose of the tool:

What will occur:

How the patient may benefit:

Right to decline or stop:

Who remains responsible:

Question that asks for an affirmative response:

Decision Pathway

Scenario	What I would say	What I would do	What I would document or hand off
Patient withdraws consent during the encounter			
A visitor enters the room			
Patient accepts care but declines recording			
Generated content is inaccurate			

Applied Example: Video-Enabled Virtual Nursing

BALANCED EVIDENCE MESSAGE

Virtual nursing may support satisfaction and workflow efficiency, but published findings are mixed. Role clarity, staffing, communication, and local implementation matter.

Four Trust Moves

Move	What to do
Orient	Introduce the virtual nurse, role, and purpose before connecting.
Protect privacy	Confirm who can see or hear and whether the screen position works.
Offer control	Ask permission to begin. Explain how to pause, mute, or end.
Close the loop	Clarify bedside and virtual responsibilities and summarize next steps.

Exercise 4: Virtual Room Readiness Scan

Readiness check	Yes	Needs attention	Planned adjustment
Patient understands the virtual nurse's role.	☐	☐	
Purpose of the interaction is clear.	☐	☐	
Everyone who can see or hear is identified.	☐	☐	
Screen and audio protect privacy.	☐	☐	
Patient knows how to pause or end.	☐	☐	
Bedside and virtual responsibilities are clear.	☐	☐	
Next steps will be summarized.	☐	☐	

Role-Clarity Handoff

Before the virtual connection ends, every person in the room should know who owns what.

The virtual nurse will:

The bedside nurse will:

The provider will:

The patient or care partner will:

Before disconnecting, the team will confirm:

SEGMENT 3

Trauma-Informed Care in Your Setting

Table process mapping

What Most People Do Not Think About, But You Are Probably Doing

1. The environment is a clinical intervention

- Overhead paging, alarm noise, and fluorescent lighting can activate a stress response before any provider enters the room.
- Waiting room chair placement matters. Seats with backs to the door raise vigilance for trauma survivors.
- Exam tables that face away from the door increase distress. Position patients so they can see who enters.

2. Routine procedures are high-risk moments

- Dental work, pelvic exams, EKG lead placement, and imaging require exposure, touch, and stillness. These mirror conditions of past harm for many survivors.
- Blood pressure cuffs and restraint-style positioning can trigger panic in patients with histories of physical violence or incarceration.
- Anesthesia and sedation remove control and memory. Pre-procedure conversations about what happens while the patient is under build more trust than most teams realize.

3. The patient's chart carries trauma forward

- Labels like noncompliant, drug-seeking, difficult, or frequent flyer follow patients across every future encounter.
- Requiring patients to repeat their trauma story at every visit, to every provider, is re-traumatization. Systems that document once and share appropriately protect patients.
- A documented no-show pattern often maps to trauma avoidance, transportation gaps, or a prior bad experience, not disinterest in health.

4. Staff carry trauma too

- Secondary traumatic stress and burnout degrade the patience and presence trauma-informed care requires.
- Organizations practice trauma-informed care internally through debriefs after codes, deaths, and violent events.
- A supervisor who models the six principles with staff makes it far more likely staff extend them to patients.

5. Time pressure is not the real barrier

- Asking permission, narrating actions, and offering small choices take seconds.
- Mistrust costs more time downstream: refusals, escalations, security calls, AMA discharges, readmissions.
- Trauma-informed care does not mean asking about trauma. It means designing every interaction so disclosure is never required for safe care.

6. Universal precautions apply to trauma

- You cannot identify trauma survivors by appearance, diagnosis, or demographics.
- Practice trauma-informed care with every patient the same way you use gloves with every patient.

- Screening tools help, but behavior-based cues (flinching at touch, door-checking, over-apologizing, shutdown) reach patients who will never disclose.

How Trauma-Informed Care Is Practiced Across Settings

Check what your unit does now. Your "Not yet" marks are good candidates for Activity 3.

From the previous page, the one my unit overlooks most:

Setting	Practice	We do	Partly	Not yet
Intake and registration	Private check-in areas instead of open-counter conversations about symptoms and insurance.	☐	☐	☐
	Forms that ask "Is there anything that would make your visit easier?" instead of demanding trauma history.	☐	☐	☐
	Universal screening framed as routine: "I ask everyone these questions."	☐	☐	☐
Exam room	Knock, pause, and announce name and role before entering.	☐	☐	☐
	Chaperone offered as standard, not by request.	☐	☐	☐
	Gowning minimized: uncover only the area being examined, only as long as needed.	☐	☐	☐
	Permission asked before every touch, with the option to stop honored immediately.	☐	☐	☐
Inpatient units	Consistent assignment: same nurses when possible, so patients rebuild predictability.	☐	☐	☐
	Bedside shift report that includes the patient instead of talking over them.	☐	☐	☐
	Whiteboards updated with names, plans, and expected times.	☐	☐	☐
	Doors, curtains, and lighting adjusted to patient preference and documented for every shift.	☐	☐	☐
Emergency and behavioral health	Verbal de-escalation first. Restraint and seclusion as last resort, with mandatory debrief after every use.	☐	☐	☐
	Trauma-informed physical design: calming rooms, reduced stimulation areas, clear sightlines.	☐	☐	☐
	Comfort menus offered before crisis: weighted blankets, dimmed lights, a support person.	☐	☐	☐
Pediatrics	Child life specialists prepare children with age-appropriate explanation and rehearsal.	☐	☐	☐

Setting	Practice	We do	Partly	Not yet
	Parents given a defined role (comfort positioning) instead of being removed from the room.	☐	☐	☐
	One-voice protocols so the child hears a single calm narrator.	☐	☐	☐
Procedural and surgical areas	Pre-procedure walkthroughs: what the patient will feel, hear, and smell.	☐	☐	☐
	Agreed stop signals for awake procedures, honored without negotiation.	☐	☐	☐
	Post-anesthesia reorientation scripts: name, place, what happened, who is present.	☐	☐	☐
Organizational level	Trauma-informed care embedded in onboarding and annual competencies, not one-time training.	☐	☐	☐
	Patient advisory councils that include survivors reviewing policies and forms.	☐	☐	☐
	Workforce support: EAP access, peer support programs, critical incident debriefing.	☐	☐	☐
	Hiring and evaluation criteria that measure how staff treat patients, not only clinical metrics.	☐	☐	☐
Documentation and handoff	Behavioral descriptions replace judgment labels: "declined exam, agreed after explanation" instead of "uncooperative."	☐	☐	☐
	Care preferences (door open, female providers, no surprise touch) documented in a visible banner so patients never have to re-request.	☐	☐	☐
	Warm handoffs: the current provider introduces the next one before leaving.	☐	☐	☐

Rural Health: Policy, Trust, and Innovation

Rural patients reach every health system, through transfers, partner sites, telehealth, and virtual nursing. Policy decisions made in 2025 and 2026 are changing which rural services exist and which technologies arrive to fill the gaps. Each new tool is also a new trust moment.

Rural Health at a Glance

Indicator	Figure	Why it matters for trust
Rural hospital finances	41% of rural hospitals operate at a negative margin. 417 are vulnerable to closure. (Chartis, 2026)	Patients may have lost a local hospital or service and now travel or transfer for care.
Closures and service cuts	206 rural hospitals closed or stopped inpatient care since 2010. 331 stopped obstetrics, 2011 to 2024. (Chartis, 2026)	A transfer far from home removes familiar people and places, which raises vigilance.
Mortality gap	Working-age rural adults had 43% higher natural-cause mortality than urban peers by 2019, up from 6% in 1999. (USDA ERS, 2025)	Patients may carry grief and loss from their community into the encounter.
Childhood adversity	About 40% of rural children have one or more ACEs, compared with 34% of urban children. (Merrell & Crouch, 2020)	Universal precautions matter. Assume trauma may be present.
Medicaid coverage	24% of rural residents have Medicaid, compared with 21% of urban residents. (KFF, 2025)	Coverage changes can drive missed care and avoidance that looks like "noncompliance."
AI adoption gap	Predictive AI: 56% of rural hospitals vs. 81% of urban. Critical access 50% vs. 80%. Independent 37% vs. system-affiliated 86%. (ASTP, 2025)	Rural patients and staff may meet AI tools for the first time with less local support to explain them.

WHY THIS BELONGS IN A TRAUMA-INFORMED SESSION

Closures, long transfers, coverage churn, and unfamiliar technology each remove information, predictability, or control. Those are the same losses Ask, Explain, and Offer Choice are built to restore.

The Policy Landscape

Four policies shape rural care and innovation right now. Check local guidance for how each applies to your organization.

Policy	What it does	Timeline	Impact on innovation and trust
Rural Health Transformation Program (2025 reconciliation law, Pub. L. 119-21)	\$50 billion to states, \$10 billion per year. All 50 states received first-year awards of \$147 million to \$281 million. Allowable uses include telehealth, remote monitoring, EHR upgrades, cybersecurity, AI, workforce, and behavioral health. Provider payments are capped at 15% and capital at 20% of each award.	FY2026 to FY2030. Awards announced December 29, 2025.	CMS names AI scribes, remote monitoring, and digital tools as state priorities. New tools will reach rural patients fast. Consent, transparency, and human review have to travel with them.
Medicaid changes in the same law	KFF estimates federal Medicaid spending in rural areas will fall by \$137 billion over 10 years. The \$50 billion fund offsets about 37% of that. Work requirements apply to expansion adults.	Work requirements begin January 1, 2027. Most cuts land after the rural fund ends in 2030.	Coverage churn can lead to missed visits and delayed care. Treat gaps in care as information, not defiance. Grant-funded tools may outlast the coverage that pays for follow-up.
Medicare telehealth flexibilities (Consolidated Appropriations Act, 2026)	Keeps the home as an originating site with no rural-only limit, allows audio-only behavioral health, lets FQHCs and RHCs serve as distant sites, and waives the in-person behavioral health visit requirement. Hospital at home continues.	Signed February 3, 2026. Telehealth through December 31, 2027. Hospital at home through September 30, 2030.	Audio-only keeps a choice open for patients with weak broadband or who decline video. Short extension windows make long-term investment harder for small hospitals.
Rural Emergency Hospital designation (Consolidated Appropriations Act, 2021)	Lets small rural hospitals end inpatient care and keep emergency and outpatient services with enhanced Medicare payment.	Available since January 1, 2023.	More patients stabilize locally and then transfer. Warm handoffs and shared preferences matter more across sites.

A Rural Trust Lens for Technology

A nursing scoping review of rural attitudes toward telehealth found four themes: relationships, privacy, acceptance of limited access, and self-sufficiency (Pullyblank, 2023). Each one changes how Ask, Explain, and Offer Choice should sound.

Rural value	What you may notice	Ambient documentation move	Virtual nursing move
Relationships matter	Trusts the local nurse. Wary of a stranger on a screen or a device in the room.	Introduce the tool as part of your care, not a replacement for your attention.	Bedside nurse introduces the virtual nurse by name first. Use a warm handoff.
Privacy in a small community	"My cousin works at the clinic back home. Who sees this?"	Say who can access the recording and the note. Make declining easy and without penalty.	Confirm who can see and hear on both ends. Close the door. Check the screen position.
Used to limited access	Does not ask for more. Accepts long drives and delays without complaint.	Ask directly: "Would you like me to use this today, or not?"	Offer the choice to pause or continue later. Do not treat silence as consent.
Self-sufficiency	Minimizes symptoms. Reluctant to seek help or use behavioral health services.	Normalize: "I ask everyone." Keep the focus on their goals.	Frame the virtual nurse as extra support for them, not as monitoring.

PLAN FOR THE CONNECTION TO FAIL

Broadband and rural connectivity still lag. Before any video interaction, tell the patient what happens if the call drops: who will come to the room, how long it will take, and whether audio-only is an option. Unexplained silence after a dropped call erodes trust fast.

Exercise 5: Policy to Practice

COMPOSITE RURAL SCENARIO

Mr. H., 68, farms in a rural county. His local hospital stopped inpatient care last year, so he was transferred 90 miles to your unit. On admission he is offered a virtual nurse check-in and an ambient-scribe visit with the provider. He says, "My cousin works at the clinic back home. Who is going to see all this?" His video connection drops twice. This is a fictional composite case.

1. What policy or system factors shaped this encounter before he arrived?

2. What trust risk comes with each technology here?

3. Write your first 30 seconds using Ask, Explain, Offer Choice.

4. What is the plan if the video fails again?

5. What must the handoff back to his local team include?

Map Innovation to Trust on Your Unit

List programs or tools reaching your rural patients or partner sites, such as RHTP-funded telehealth, remote monitoring, AI scribes, virtual nursing, or transfer centers.

Tool or program	Trust risk for rural patients	Trust-in-Action move	Who owns it

Integrated Case Exercise

COMPOSITE TEACHING SCENARIO

A patient repeatedly checks the doorway, declines a second recording, and says they do not want another clinician on the screen. This is a fictionalized composite case and does not represent a specific patient or encounter.

1. Notice What behaviors are directly observable?

2. Pause What should not happen until more information is obtained?

3. Clarify What questions protect choice without asking for trauma disclosure?

4. Respond Write the first 60 seconds of nursing or provider language.

5. Coordinate What must the bedside clinician, provider, and virtual nurse understand?

6. Document Write a neutral, clinically useful note that includes preferences without judgment labels.

Activity 3: Process Mapping

Pick one routine process on your unit and walk it through the patient's eyes: what they see, hear, and feel at each step.

- ☐ Admission
- ☐ Rooming
- ☐ Triage
- ☐ Bedside assessment
- ☐ Imaging
- ☐ Education
- ☐ Handoff
- ☐ Discharge

1. Process our table chose:

Rural lens: if your process involves transfers, partner sites, or telehealth, add travel distance, connectivity, local privacy, and staffing to your map.

Follow the Patient's Experience

Workflow step	What the patient sees or hears	Where control is lost	Information or privacy risk

2. Steps where the patient loses control, information, or privacy:

3. Our single worst friction point:

4. Our low-cost fix, star table within 30 days:

Redesign the Highest-Risk Moment

Trust-risk point	Proposed change	Responsible role	Required resource	Evidence of improvement

Possible evidence of improvement

- The patient can explain the technology's purpose.
- A meaningful alternative exists.
- Preferences are visible at handoff.
- Roles and next steps are clear.
- The patient does not have to repeat the same request.

CLOSING

Commitment Cards

Individual plus share-out

BEFORE YOU LEAVE

Complete Checkpoint 4 in the Readiness Tracker. Compare it with Checkpoint 1 and pick your next action: Practice, Clarify, Redesign, or Share.

My 30-Day Commitment

One behavior I will start, stop, or change on my next shift:

How a colleague could observe it:

The person I will tell so I follow through:

START	STOP	SUSTAIN
<i>One behavior I will add</i>	<i>One habit or phrase I will drop</i>	<i>One practice I will make more consistent</i>

Make It Stick

What evidence will show the change occurred?

What barrier do I anticipate?

What will I do if the barrier occurs?

What will I do if the barrier occurs?

Accountability partner and 30-day review date:

Accountability partner and 30-day review date:

Notes

EVIDENCE AND REFERENCES

Evidence at a Glance

Read after the session or share with your team

EVIDENCE-TO-PRACTICE MESSAGE

Trauma-informed education is most useful when principles are converted into observable language, workflow steps, and team behaviors.

Evidence theme	What the literature supports	Practice implication
Provider education	Education can improve knowledge, confidence, awareness, and attitudes.	Use measurable objectives and active practice.
Nursing practice	Reviews identify positive attitudes alongside knowledge and implementation gaps.	Teach specific behaviors for real clinical contexts.
Universal precautions	A safe interaction should not depend on trauma disclosure.	Apply respectful, choice-preserving practices with every patient.
Implementation	Specialty context, time pressure, team collaboration, and organizational support influence adoption.	Redesign workflows, not only individual communication.

Evidence-to-Practice Matrix

Evidence	Clinical meaning	Ambient documentation	Virtual nursing
Transparency and choice	Explain what will happen and preserve refusal.	Explain recording, purpose, responsibility, and alternatives.	Explain the remote role, who can see and hear, and how to stop.
Collaboration	Build the plan with the patient.	Ask when and whether recording is acceptable.	Invite the patient to shape timing and participation.
Human accountability	Technology does not replace professional responsibility.	Review and correct generated drafts.	Clarify bedside and virtual responsibilities and follow-up.
Workflow design	Trust depends on systems and handoffs.	Document preferences and communicate changes in consent.	Close the loop and hand off patient preferences.

Peer-Reviewed Evidence Briefs

Study	Design	Population / setting	Key finding	Use in this workbook
Chin et al. (2024)	Systematic review	Provider education and patient care	Trauma-informed frameworks were associated with improved provider knowledge, confidence, awareness, and attitudes.	Supports measurable education and simulation-based practice.
Qin et al. (2025)	Hybrid systematic narrative review	Nursing practice and education	Generally positive attitudes alongside knowledge gaps and implementation barriers.	Supports standardized, practice-specific nursing education.
Yang et al. (2026)	Scoping review	Nursing knowledge, attitudes, and practice	Training, time constraints, setting, experience, and interprofessional collaboration influenced implementation.	Supports specialty-relevant training and team-level redesign.
He et al. (2025)	Multicenter cross-sectional study	Nurses in trauma center-certified hospitals	Favorable attitudes and practice with persistent knowledge gaps.	Supports baseline assessment and targeted education.
Lubbers & Bowen-Withington (2026)	Scoping review	Adult nursing care	Supported universal trauma-informed precautions and identified a theory-to-practice gap.	Supports safe care without requiring disclosure.
Chang et al. (2026)	Training program development	Emergency department providers	A content-validated program was developed using review, qualitative needs assessment, and expert validation.	Supports blended, context-specific learning activities.

Reflection: Which finding changes something in my practice, and what?

Technology Evidence Briefs

AMBIENT CLINICAL DOCUMENTATION

Recent studies report potential reductions in documentation burden and perceived cognitive workload, with patient-centered benefits in some settings. Findings do not remove the need for clinician review, accuracy checks, and ethical and legal safeguards.

VIRTUAL NURSING

Recent reviews and studies describe potential patient satisfaction and workflow benefits, but evidence remains limited or mixed for workload, safety, and financial outcomes. Virtual nursing should complement, not replace, adequate bedside staffing and resources.

Questions for Critical Appraisal

- Was the study peer reviewed and indexed?
- Was the design observational, experimental, quality improvement, or review?
- Were outcomes objective, self-reported, or both?
- Did the setting match your clinical context?
- Were adverse effects, verification burden, trust, and implementation limitations reported?
- Is the evidence about a product, a technology category, or a specific workflow?

Rural Health Evidence and Policy Briefs

These sources differ in type. Peer-reviewed research, federal data, industry analysis, and policy analysis each answer different questions.

Source	Type	Key finding	Use in this workbook
Pullyblank (2023)	Peer-reviewed scoping review (nursing)	Rural telehealth attitudes turn on relationships, privacy, acceptance of limited access, and self-sufficiency.	Basis for the Rural Trust Lens.
Chang et al. (2025), ASTP	Federal data brief	Predictive AI use: 56% of rural vs. 81% of urban hospitals. Independent hospitals 37% vs. 86% for system-affiliated.	Shows the rural innovation gap.
Thomas et al. (2025), USDA ERS	Federal research analysis	Rural working-age natural-cause mortality rose to 43% above urban by 2019.	Context for loss and grief in rural communities.
Chartis (2026)	Industry analysis	41% of rural hospitals have negative margins. 417 are vulnerable to closure.	Context for transfers and service loss.
Saunders et al. (2025), KFF	Policy analysis	Rural federal Medicaid spending is projected to fall by \$137 billion over 10 years.	Context for coverage churn and avoidance.
CMS (2025)	Federal announcement	All 50 states received RHTP awards. State plans include AI scribes, telehealth, and remote monitoring.	Links policy to the technology in this session.

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Guidance and Practice Resources

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