OBA NURSING ACADEMY · TRAUMA-INFORMED CARE · OBA-TIC-2026

Course Syllabus

Trauma-Informed Care: Practice, Not Therapy · OBA-TIC-2026 · 8.5 CPD hours · fully self-directed online

DOCUMENT CONTROL

- Programme: Trauma-Informed Care: Practice, Not Therapy (OBA-TIC-2026)
- Audience: Student and Facilitator
- Version 1.0 | Issued 19/09/2026 | Review due 19/09/2027
- Provider: OBA Nursing Academy

SCOPE OF PRACTICE AND CURRENCY

- This programme is professional development. It is not a qualification, it is not therapy training, and it does not make any learner able to treat trauma, to diagnose a trauma-related condition, or to take a trauma history as a clinical assessment. Those are role-limited and are governed by your qualifications, your service's policy and, for treatment, the Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, PTSD and Complex PTSD. It is not clinical advice about any individual, and it is not personal support for a learner's own experiences - for that, the support lines in this programme and a treating clinician are the right places. Where your service's policy or your jurisdiction's legislation differs from anything in this course, those apply.
- Sources and their versions, retrieved 19/09/2026. Trauma-informed practice and the five principles: Blue Knot Foundation, Trauma-Informed Practice fact sheet for workers, DEC 23 Version 1, and the Blue Knot Practice Guidelines. Treatment of trauma: Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, PTSD and Complex PTSD - living guidelines, approved by the NHMRC Chief Executive Officer on 23 June 2020 with updated recommendations approved 22 December 2021, each approval valid for five years. Prevalence: Australian Child Maltreatment Study, 2023. Restrictive practice: NSQHS Comprehensive Care Standard (2nd ed), Actions 5.35 and 5.36; NDIS Quality and Safeguards Commission. Cultural safety: Ahpra and National Boards shared Code of conduct, June 2022.

NOT stated in this course, because they belong to a treating clinician, to legislation, or to your workplace: any trauma therapy modality, protocol or technique; any diagnostic criteria or screening tool score; your jurisdiction's mandatory reporting threshold, mechanism and list of mandated reporters; your jurisdiction's restrictive practice authorisation pathway; and your service's referral, supervision and debriefing arrangements.

1. Programme overview

Trauma-Informed Care: Practice, Not Therapy is a fully self-directed, entirely online professional development programme delivered through the OBA Nursing Academy learning management system. There are no scheduled classes, no live sessions and no clinical placement. Learners complete eleven modules at their own pace, followed by a case study assessment and a single summative assessment.

THE DISTINCTION THE WHOLE PROGRAMME RESTS ON

• Trauma-informed care is NOT treatment for trauma. It is how ordinary care is delivered so that it does not re-traumatise.

• Blue Knot Foundation's own wording: trauma-informed practice "rests on awareness of the impacts of trauma (AS DISTINCT FROM DIRECTLY TREATING IT), emphasises a 'do no harm' approach and aims to avoid re-traumatisation."

• And the corollary that makes the framework workable: YOU DO NOT NEED TO KNOW WHAT HAPPENED. Nothing in this programme asks a learner to take a trauma history, to screen for one, or to ask anybody what happened to them.

Who it is for

- Registered and enrolled nurses in every setting - this is now expected practice across Australian health, aged care, disability and mental health services, and it is usually taught either as a slogan or as therapy
- Assistants in nursing, personal care workers and disability support workers, who provide the most intimate care, spend the most time with the person, and are the least likely to have been taught any of this
- Midwives and maternity staff - birth trauma is one of the most consequential and least discussed forms of iatrogenic trauma in Australian health care
- Mental health and alcohol and other drug workers, for whom the framework is oldest and the gap between policy and practice is often widest
- Aged care staff, where the resident may have been a child in an institution, a refugee, or a survivor of family violence, and where nobody has ever asked and nobody should have to
- Internationally qualified nurses, for whom the Australian frameworks - cultural safety, regulated restrictive practices, mandatory reporting - are usually entirely new
- Emergency department staff, where almost every element of the environment works against the framework and small changes therefore do the most
- Educators, clinical leads and managers responsible for making a service trauma-informed rather than for saying that it is

How it is delivered

- Fully self-directed. No scheduled classes, no live sessions, no clinical placement.
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a knowledge check.
- A case study assessment of five unfolding situations, and a 60-item summative assessment.
- Five optional interactive practice tools, excluded from the claimable CPD figure.
- Three fillable workplace instruments: an environment and practice walk-through, a re-traumatisation review, and a team conversation guide.
- No graphic content anywhere in the programme, and support lines on every module.

How this programme looks after the people taking it

A LARGE PROPORTION OF THE PEOPLE TAKING THIS COURSE ARE SURVIVORS.

The Australian Child Maltreatment Study found that 62.2 per cent of Australians experienced at least one type of child maltreatment. That figure is the argument for the whole framework, and it

is also a statement about this course's own audience: whatever room you are in, a majority of it has a history, and you are not going to know which people.

So this programme is built to the same standard it teaches. It carries no graphic or detailed account of abuse, assault or violence - not in a case study, not in an assessment item, not on a slide. Where a case needs a history it is named in a clause and not described. Nothing here is included for effect.

Every module carries the support lines. You may stop at any point and come back; nothing is timed and there is no penalty. If a module is harder than you expected, that is information about the module's subject rather than about you - and the services below exist for exactly this.

SUPPORT - FOR YOU, NOT FOR A PATIENT

- Blue Knot Helpline and Redress Support Service - 1300 657 380. 9am to 5pm, seven days. Specialist support for adult survivors of complex trauma, and the national body behind most of this course's content.
- 1800RESPECT - 1800 737 732. 24 hours, seven days. The national domestic, family and sexual violence counselling, information and support service. Text 0458 737 732, and webchat and video call are also available 24/7.
- 13YARN - 13 92 76. 24 hours, seven days. Crisis support for Aboriginal and Torres Strait Islander people, in a confidential, culturally safe space, answered by Aboriginal and Torres Strait Islander Crisis Supporters.
- Nurse & Midwife Support - 1800 667 877. 24 hours, seven days, free and confidential, for nurses, midwives and students - including about the effects of the work itself.
- Lifeline - 13 11 14. 24 hours, seven days. National crisis support.
- Open Arms - Veterans & Families Counselling - 1800 011 046. 24 hours, seven days, for current and former ADF members and their families.
- You may stop this programme at any point and come back. Nothing is timed and there is no penalty.

Programme outcomes

On completion, learners will be able to:

1. State the distinction between trauma-informed practice and trauma-specific treatment, in Blue Knot Foundation's own wording
2. Explain why the framework does not require - and does not permit - a clinician to go looking for a person's trauma history
3. Name the 5 principles of trauma-informed practice, and describe what each looks like in a specific clinical interaction
4. Explain why HOW care is provided matters as much as WHAT is provided
5. Name the eight common mechanisms of re-traumatisation in health care, and explain why each is an ordinary part of competent practice rather than an error
6. Apply a single change to a routine task that removes most of the risk without adding time
7. Recognise both hyperarousal and hypoarousal as distress, and identify which is more often missed
8. Respond to an unsolicited disclosure without asking a single question about the event, and decide what to record

9. Explain why restrictive practice is the intervention most likely to re-traumatise, and state the national position on its use
10. State the definition of seclusion, and identify it where the door is not locked
11. State the National Scheme definition of cultural safety, and who determines it
12. State that mandatory reporting is jurisdictional, and identify what must be found out about the learner's own
13. Distinguish vicarious trauma from burnout, and explain why the distinction changes what helps
14. Apply the framework in the settings where it is hardest, including the learner's own

2. Module structure

Module	Title	CPD hours	Knowledge check items
00	Orientation: What This Course Is, and What It Is Not	0.50	6
01	What Trauma Is, and What It Does	0.50	6
02	The Five Principles, at a Bedside	0.50	6
03	You Do Not Need the Story	0.50	7
04	Re-traumatisation: the Ordinary Things That Do Harm	0.50	7
05	Behaviour Is Communication	0.50	6
06	Restrictive Practice, and Why It Re-traumatises	0.50	6
07	Cultural Safety and Intergenerational Trauma	0.50	6
08	Children, Young People and Mandatory Reporting	0.50	5
09	The Settings Where It Is Hardest	0.50	4
10	The Workforce: Vicarious Trauma, and the Survivors Among Us	0.50	5
	Module subtotal	5.50	64
	Programme information documents	1.55	-
	Case study assessment (5 unfolding cases)	0.53	-
	Summative assessment	0.97	60
	CLAIMABLE CPD TOTAL	8.5	

Module hours are the measured time for that module's video, learner guide, knowledge check and workbook activity. Section 2 below shows how every figure in this table was measured.

Indicative workload, and how the CPD hours were arrived at

The CPD figure for this programme is not asserted. It is measured from the content: narration at 135 words per minute, reading at 130 words per minute for dense clinical prose, knowledge checks timed to include reading every rationale, and the assessments timed as measured

reading plus a stated decision allowance. Individual learners vary, and a learner who claims a different figure should claim their actual time.

Component	Measured time	How it was measured
Module videos (11)	88 min	Narration word count at 135 wpm
Student learner guides (11)	108 min	Guide word count at 130 wpm
Module knowledge checks (11)	54 min	Stem, options and every rationale, read and answered
Reflective workbook activities (11)	88 min	Writing time for the five prompts in each module
Programme information documents	93 min	Rendered page word counts at 130 wpm
Case study assessment	32 min	19 minutes measured reading plus 30 seconds per decision across 25 steps
Summative assessment	58 min	28 minutes measured reading plus 30 seconds per item across 60 items
MEASURED TOTAL	521 min (8.68 h)	Sum of the above
CLAIMABLE CPD	8.5 hours	The measured total, to the nearest half hour

The measured total is 8.68 hours and the claimable figure is 8.5 - the measured total to the nearest half hour, rounded DOWN rather than up. This is a shorter programme than most in the OBA series, and that is a property of the subject rather than a defect in the course: it carries very few thresholds and figures, because there are very few to carry. The programme has NOT been padded to reach a rounder number, because the whole point of deriving the figure is that it is not chosen.

The five optional practice tools - which principle is missing, say it differently, practice or re-traumatisation, before the restraint, and the scope of practice self-check - add approximately a further 85 minutes. They are deliberately excluded from the claimable figure, because they are optional. A learner who completes them may claim that time as additional self-directed CPD.

Module 00 - Orientation: What This Course Is, and What It Is Not

How the programme is structured and assessed, and the single distinction everything else depends on: trauma-informed care is not treatment for trauma. It is how ordinary care is delivered so that it does not re-traumatise - and it does not require you to know what happened to anybody. The module also sets out how this course looks after the people taking it, because a large proportion of them are survivors.

Learning outcomes

- State the distinction between trauma-informed practice and trauma-specific treatment, in Blue Knot Foundation's own wording
- State that the framework does not require a trauma history to be taken, and explain why it cannot
- Distinguish this course from Trauma Nursing Fundamentals, which is about physical injury
- Describe how this programme is assessed, and what the certificate does and does not establish

- Identify what this course deliberately does not state, and where each of those things properly belongs
- Locate the support lines, and know that stopping part-way through is expected rather than a failure

Key terms: trauma-informed practice; trauma-specific treatment; re-traumatisation; Blue Knot Foundation; scope of practice; learner safety; universal framework; CPD evidence

Module 01 - What Trauma Is, and What It Does

What trauma actually is - a state of high arousal in which coping is overwhelmed - and why that definition is about the person's capacity rather than about how bad the event was. The difference between single-incident and complex trauma, and why the less familiar one is the more common. What unresolved trauma does over a lifetime and across generations. And the reframe that carries the rest of the course: not what is wrong with this person, but what has happened to them.

Learning outcomes

- State Blue Knot Foundation's definition of trauma, and explain why it describes the person's capacity rather than the severity of the event
- Explain why fight, flight and freeze are described as initially protective
- Distinguish single-incident trauma from complex trauma, and state which is more common
- Describe what intergenerational and iatrogenic trauma mean, and why the second is the one a clinician can act on
- Recognise both hyperarousal and hypoarousal as trauma responses, and explain which one gets missed
- Apply the reframe from what is wrong with a person to what has happened to a person

Key terms: complex trauma; single-incident trauma; hyperarousal; hypoarousal; dissociation; intergenerational trauma; iatrogenic trauma; window of tolerance

Module 02 - The Five Principles, at a Bedside

The five principles of trauma-informed practice, and what each one looks like in an actual clinical interaction rather than in a strategic plan. The point that decides whether this framework is real in a service: how care is provided matters as much as what is provided. And the reason the principles work at all - every one of them returns some control to somebody whose experience was of having none.

Learning outcomes

- Name the five principles of trauma-informed practice as used in Australian services
- Describe what each principle looks like in a specific clinical interaction
- Explain why HOW care is provided matters as much as WHAT is provided
- Identify genuine choices inside an ordinary clinical task, and distinguish them from the appearance of choice
- Explain why the principles work - that each returns control to somebody whose experience was of having none
- Apply the principles without knowing anything about the person's history

Key terms: safety; trustworthiness; choice; collaboration; empowerment; psychological safety; false choice; predictability

Module 03 - You Do Not Need the Story

The module that prevents the harm this training most often causes. Trauma-informed practice does not require - and does not permit - a clinician to go looking for somebody's history. Why 'what happened to you' is a way of thinking rather than a question, what is wrong with asking, what to do when somebody discloses anyway, what to record, and the two exceptions that must be known before they are needed rather than worked out in the moment.

Learning outcomes

- Explain why trauma-informed practice does not require knowing a person's history
- State why asking a patient for details of what happened is outside the framework and outside the role
- Distinguish an unsolicited disclosure from an elicited one, and respond appropriately to the first
- Apply the six-step response to a disclosure without asking a single question about the event
- Decide what to record after a disclosure, and what not to record
- Name the two exceptions to the person's control over their own information, and state why both must be known in advance

Key terms: disclosure; eliciting; scope of practice; confidentiality; documentation; referral pathway; mandatory reporting; re-traumatisation

Module 04 - Re-traumatisation: the Ordinary Things That Do Harm

The eight ways health care re-traumatises people, and the uncomfortable thing they have in common: not one of them is a rare event, a mistake, or something a bad clinician does. Every one is an ordinary part of a good day's work under time pressure. Which is exactly why the framework targets how care is delivered rather than who delivers it - and why 'be more compassionate' is not an intervention.

Learning outcomes

- Name the eight common mechanisms of re-traumatisation in health care settings
- Explain why each is an ordinary part of competent practice rather than an error
- Identify the mechanisms present in a routine clinical task you perform yourself
- Apply a single change to a task that removes most of the risk without adding time
- Explain why 'be more compassionate' does not address the problem
- Distinguish what is within your control from what belongs to the environment or the system

Key terms: re-traumatisation; unannounced touch; exposure; powerlessness; unpredictability; being talked about; false choice; environmental stressors

Module 05 - Behaviour Is Communication

What behaviour is telling you, why arguing with a survival response fails, and what actually de-escalates - which is mostly not talking. The six words that recast distress as a character flaw and follow a person through every subsequent admission. And the point that makes all of it work: a dysregulated clinician cannot regulate anybody, which makes your own state a clinical variable rather than a wellbeing matter.

Learning outcomes

- Apply the reframe from what is wrong with this person to what is this behaviour telling me
- Explain why reasoning with a highly aroused person does not work, and what does
- Recognise hypoarousal as distress and explain why it is more often missed than agitation

- Describe what de-escalates, and identify the common responses that escalate instead
- Name the six words that recast distress as character, and state what each one costs the person
- Explain why your own regulation is a clinical variable rather than a personal matter

Key terms: de-escalation; hyperarousal; hypoarousal; dysregulation; co-regulation; stigmatising language; documentation; escalation triggers

Module 06 - Restrictive Practice, and Why It Re-traumatises

The intervention that reproduces the exact experience - powerlessness, no exit, being overpowered - that a large proportion of the people it is used on have already survived. What the national position is, what seclusion actually means, the five regulated restrictive practices in disability settings, what is required afterwards, and the one question that changes practice at a ward level: not whether it was justified, but what happened in the two hours before.

Learning outcomes

- Explain why restrictive practice is the intervention most likely to re-traumatise
- State the national position on restrictive practices and where it sits in the NSQHS Standards
- State the definition of seclusion, and identify it when the door is not locked
- Name the five regulated restrictive practices under the NDIS Quality and Safeguards Commission
- State what is required after restraint has occurred, and who it applies to
- Apply the two-hours-before question to a real episode, and identify the upstream change

Key terms: restrictive practice; seclusion; restraint; chemical restraint; environmental restraint; authorisation; debriefing; minimisation

Module 07 - Cultural Safety and Intergenerational Trauma

Why cultural safety and trauma-informed care are the same framework rather than two adjacent ones: for Aboriginal and Torres Strait Islander people, trauma in Australia includes colonisation, dispossession, the forced removal of children and the ongoing experience of racism in health services - which makes a health service that is not culturally safe a source of trauma in its own right. The National Scheme definition, the two words in it that services lose, the four obligations in the Code of conduct, and where to go for material written by the people it is about.

Learning outcomes

- State the National Scheme definition of cultural safety, and who determines it
- Explain why cultural safety and trauma-informed care are the same framework rather than two
- Name the four obligations for culturally safe and respectful practice in the shared Code of conduct
- Explain why cultural safety cannot be achieved by completing training
- Describe what intergenerational trauma means in the Australian context
- Identify where to go for material written by Aboriginal and Torres Strait Islander people

Key terms: cultural safety; ongoing critical reflection; colonisation; systemic racism; intergenerational trauma; Stolen Generations; self-determination; 13YARN

Module 08 - Children, Young People and Mandatory Reporting

How trauma presents in children and why it is so often met with a punitive response. What mandatory reporting actually requires - a reasonable belief rather than certainty - and why this course states none of the detail, because it differs in every state and territory. How to tell a child what you have to do. And the connection that runs back through the whole programme: the adult in front of you was a child before.

Learning outcomes

- Describe how trauma commonly presents in children and why it is frequently misinterpreted
- Explain why consistent care rather than punishment is what is required, and that boundaries still matter
- State that mandatory reporting is jurisdictional, and identify what you must find out about your own
- Explain why the threshold is generally a reasonable belief rather than proof
- Describe how to tell a child or young person what you have to do, before you do it
- Connect the adult presentations in this course to childhood experience

Key terms: mandatory reporting; reasonable belief; dissociation in children; punitive response; consistent care; disclosure by a child; jurisdictional; child protection

Module 09 - The Settings Where It Is Hardest

Seven settings in which the framework is hardest to deliver, and what specifically makes each one hard. Emergency, where the building works against you and the small things therefore carry everything. Maternity, where birth trauma is one of the most consequential and least discussed forms of iatrogenic trauma in Australia. Aged care and disability, where the most intimate care is delivered by the least supported staff. And the pattern underneath all of them: intimate care, repeated, by people the person did not choose.

Learning outcomes

- Identify what specifically makes the framework hard to deliver in each of seven settings
- Explain why birth trauma is a form of iatrogenic trauma and name its common elements
- Describe why aged care and disability settings carry particular risk during personal care
- Explain why a person may find routine intimate care intolerable and not say so
- Identify the change available in a setting where the environment cannot be changed
- Apply the framework to your own setting, including the parts that are hardest there

Key terms: birth trauma; iatrogenic trauma; personal care; emergency department; supported decision-making; communication support; custodial settings; intimate care

Module 10 - The Workforce: Vicarious Trauma, and the Survivors Among Us

The module that makes the rest of the programme sustainable. Vicarious trauma as a foreseeable occupational exposure rather than a personal weakness, and why it is different from burnout in a way that changes what helps. The arithmetic fact that a large proportion of your colleagues are survivors. Why an organisation cannot delegate this to individuals. And the last test of whether a service is trauma-informed, which is what happens in its tea room.

Learning outcomes

- Define vicarious trauma and explain why it is an occupational exposure rather than a weakness

- Distinguish vicarious trauma from burnout, and explain why the distinction changes what helps
- Explain why a worker's own regulation is a precondition for trauma-informed service delivery
- State why a large proportion of the workforce are survivors, and what follows from that
- Identify what an organisation must provide, and what cannot be delegated to individuals
- Apply the framework's own standards to how this subject is discussed among colleagues

Key terms: vicarious trauma; burnout; supervision; debriefing; lived experience; psychological safety; organisational responsibility; tea room test

3. Assessment

Component	Type	Weighting	Attempts
Module knowledge checks (11)	Formative, immediate feedback with rationales	Not graded	Unlimited
Reflective workbook	Formative, self-directed	Completion required	n/a
Case study assessment	Formative, branching decisions with feedback	Completion required	Unlimited
Summative assessment	60 single-best-answer items	100% - pass mark 80%	2

Summative assessment blueprint

Module	Items
00	2
01	6
02	6
03	7
04	7
05	6
06	6
07	6
08	5
09	4
10	5
TOTAL	60

Pass mark is 80 per cent (48 of 60). Learners have 2 attempts. The certificate of completion is issued automatically on a pass.

The assessment is bound by the same two rules as the rest of the programme. No item's correct answer involves asking a person what happened to them - several items carry that as a DISTRACTOR, because it is the error the course exists to prevent. And no item contains a graphic or detailed account of abuse, assault or violence.

4. Standards and regulatory mapping

Framework	Elements addressed	Where
Blue Knot Foundation - Practice Guidelines and trauma-informed practice resources	The five principles - safety, trustworthiness, choice, collaboration, empowerment; the distinction between trauma-informed practice and directly treating trauma; complex trauma; the reframe from what is wrong with a person to what has happened to them	Modules 01, 02, 03 and 05

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, PTSD and Complex PTSD (NHMRC-approved living guidelines, Phoenix Australia)	What trauma-specific treatment is, who delivers it, and therefore where the boundary of this course sits. Named as the referral destination, not reproduced	Modules 00, 03 and 11
NSQHS Comprehensive Care Standard (2nd ed) - Minimising patient harm	Action 5.35 minimising restrictive practices: restraint, and Action 5.36 minimising restrictive practices: seclusion - including the definition of seclusion, training requirements and debriefing after restraint	Module 06
NSQHS Partnering with Consumers Standard (2nd ed)	Partnership in care, shared decision-making and informed consent - which is the standards language for the choice and collaboration principles	Modules 02 and 04
NDIS Quality and Safeguards Commission - behaviour support and restrictive practices	The five regulated restrictive practices, the requirement for authorisation under the jurisdiction's process, and behaviour support planning	Modules 06 and 10
Ahpra and National Boards - shared Code of conduct (June 2022)	The National Scheme definition of cultural safety, and the four obligations for culturally safe and respectful practice	Module 07
NMBA Code of conduct, Code of ethics and Standards for practice	Person-centred practice, respectful relationships, practising within scope, and the professional obligation not to cause harm	Module 00 and the scope documents
Australian Child Maltreatment Study (2023)	The prevalence figure that makes a universal framework the only coherent one - 62.2 per cent of Australians experienced at least one type of child maltreatment	Modules 01 and 08
Jurisdictional child protection legislation	Mandatory reporting - who is mandated, what is reportable, the threshold and the mechanism. Differs between states and territories and is deliberately not stated here	Module 08
Jurisdictional mental health, guardianship and disability legislation	Authorisation, reporting and review of restrictive practice. Differs between states and territories and is deliberately not stated here	Module 06
Aged Care Quality Standards	Dignity and choice, personal care, and the minimisation of	Modules 06 and 10

	restrictive practices in aged care settings	
Royal Commissions - institutional child sexual abuse; aged care; disability; Bringing Them Home	The Australian evidence base for why services themselves are a source of trauma, and the reason this framework is now expected rather than optional	Modules 07, 08 and 10

5. Scope of practice

This programme is written for a mixed audience. Every module identifies what each role may and may not do. The full activity-by-role matrix is published separately as the Scope of Practice Mapping document (facilitator) and the Student Scope of Practice Card.

THE RULE THAT GOVERNS THE PROGRAMME

- Completing this course does not authorise any learner to treat trauma, to diagnose a trauma-related condition, or to take a trauma history as a clinical assessment.
- Almost every row of the scope matrix about HOW CARE IS DELIVERED reads yes for every role. That is the finding rather than a defect: the framework is the ordinary conduct of ordinary care, and the roles with the least training have the most contact.
- What is role-limited here is not being trauma-informed. It is TREATING, DIAGNOSING, ELICITING and AUTHORISING.
- Where an organisation's policy is more restrictive than this course, the organisation's policy applies.

6. Resources and further reading

A full directory of Australian organisations, with live links, is published as the Further Reading and Organisation Directory. Four sources matter more than the rest, and three of them are free. Blue Knot Foundation's Trauma-Informed Practice fact sheet for workers is three pages and is the spine of Modules 01, 02 and 05 - it is the source of the five principles, of the definition, and of the 'as distinct from directly treating it' wording that decides what this course is. The Australian Child Maltreatment Study is the source of the 62.2 per cent figure, and therefore of the argument that the framework must be universal. The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, PTSD and Complex PTSD are named here so that a learner knows what trauma-SPECIFIC treatment is and who delivers it - which is how they know where their own role stops. And the fourth is local: your own jurisdiction's mandatory reporting requirements and your own service's restrictive practice authorisation pathway, neither of which this course states because both differ between states and territories. Support lines for learners are on every module: Blue Knot Helpline 1300 657 380, 1800RESPECT 1800 737 732, 13YARN 13 92 76, Nurse & Midwife Support 1800 667 877, Lifeline 13 11 14.

7. Completion and CPD

15. Complete all eleven module knowledge checks.
16. Complete the case study assessment.
17. Achieve 80 per cent or above in the summative assessment within 2 attempts.
18. The certificate of completion is then issued automatically, carrying the learner's name, the completion date, 8.5 CPD hours and a unique certificate identifier.
19. Registered and enrolled nurses should retain the certificate together with their reflective workbook as CPD evidence, as required by the NMBA registration standard.