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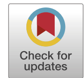
How Do We Move Forward With Trauma-Informed Care?



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A B S T R A C T

Trauma is not limited to adverse childhood events or abuse, but also a host of situations of loss, chronic stressors, and now the COVID-19 pandemic. Interprofessional teams must be able to recognize and treat trauma on the frontlines and behind the scenes. Understanding, assessing, and educating staff and patients on trauma, its physical and mental effects, and using trauma-informed approaches in practices throughout the health care system is vital for nursing and the multidisciplinary team. We provide an overview of trauma and its effects and how to help patients at all levels of recovery moving forward.

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Introduction

Psychological trauma comes in many shapes and sizes and is not limited to traumatic events such as physical, emotional, sexual abuse, or domestic violence but also includes a host of situations involving loss, such as separation; natural disasters; bullying and cyberbullying; chronic and historical stressors, such as poverty, racism, and intergenerational trauma;[1,2] and now the COVID-19 pandemic.[3,4] This unprecedented public health crisis has left many infected with the virus, but the social distancing practices to limit the spread of the disease, the amount of misinformation and changes in information, and the varied public and political responses have additionally caused significant strain on individuals and the health care system as a whole.[5]

Advanced practice registered nurses (APRNs) and interprofessional teams must be able to recognize and treat trauma and chronic stress during this pervasive health crisis and beyond.[3,4] Just as APRNs and other clinical leaders have showed their creativity, agility, and flexibility by responding to disruptions in patient care, resourcing, workload, and point-of-care testing with the COVID-19 pandemic,[6] APRNs can use a trauma-informed care (TIC) model to explore patient and peer responses to the COVID-19 pandemic for integrated and personalized individual and system-wide resilience, growth, and healing. COVID-19 has brought myriad forms of mental health and stress challenges, including concerns about disease contact, worry about socioeconomic issues, fear about intentional spread, traumatic stress syndrome, compulsive checking or reassurance-seeking behaviors,[7] and increased burnout in nurses and other health care workers.[3] It will take vigilance and understanding of the impact of the current pandemic not just on past trauma but as its own insidious trauma. APRNs as frontline caregivers are positioned to move forward using TIC across 3 domains: patients, peers and other health care workers, and the organization.

Background

Negative Health Care Effects of Trauma

The relationship between a multitude of traumas, childhood abuse, household dysfunction and the subsequent sequelae of negative medical, psychological, and substance use disorder effects into adulthood was first described with the adverse childhood experiences (ACE) study in the 1990s.[8] Since then, there has been a plethora of empirical studies[9–16] on a variety of populations looking at the negative health consequences of trauma and exposure to traumatic events across multiple disciplines involving a variety of social determinants of health. For many, psychological injury sets up an already distressed individual to perceive the complex medical system as additionally burdensome, invalidating, and distrustful, exposing them to retraumatization.[10] This can contribute to subsequent episodes of exposure and ineffective responses to negative events. This is even more evident today when the psychological ramifications of COVID-19 exceed the number of people with the disease[7] and the health care system itself is a potential source of exposure.

A large amount of information is available on the connection between exposure to trauma and negative health consequences. For example, women with higher ACEs are more likely to experience unwanted pregnancy/abortion, endometriosis, pelvic inflammatory disease, and problems with menstruation/ovulation, poorer overall health, illicit drug use and difficulty completing tasks due to physical and/or mental health conditions.[14] Up to 65% of all clients and 75% of women in substance abuse treatment report childhood abuse.[15] ACEs contribute to 7 of 10 leading causes of death in the United States; affect brain development, immune and hormone systems, and genetic expression; and higher ACE score increases risk of dying 20 years younger.[10] Exposure to childhood trauma or

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ACEs are linked to chronic physical illness such as severe obesity, diabetes mellitus, cardiovascular disease, stroke, autoimmune disease, sleep problems, chronic lung disease, cancer, and psychological illness such as depression, anxiety, posttraumatic stress disorder (PTSD), and substance abuse.[11,12,14,17,18] There are also negative impacts on medical outcomes such as engagement, no show rates, medication adherence and access to care;[14] poorer overall health and earlier death.[13]

Traumatic experiences also make individuals more vulnerable to victimization and potential perpetration later in life[19,20] and have effects on attachment, biology, affect regulation, dissociation, behavioral regulation, cognition, and self-concept[21] and can lead to pervasive and intergenerational trauma. The ongoing effects of the traumatic impact on the COVID-19 pandemic remains to be seen, but considering the pandemic is a chronic stressor, we can consider health care response and burnout a definite possibility.[3]

Chronic stress can lead to burnout in APRNs and health care workers. Burnout is a state of mental and physical exhaustion associated with work or caregiving activities and results from chronic stress that is not appropriately dealt with. Burnout often starts with a stress arousal response, which can make those affected initially seem more engaged, energetic, and dedicated; but this can move beyond that to emotional exhaustion and burnout, with a number of negative correlations causing emotional disturbances, physical symptoms, isolation, reduced performance, or cynicism in the workplace.[7] In a study of more than 2,000 health care workers, 15% of nurses reported feelings of burnout, and 56% said their facility was ineffective at addressing staff burnout.[22] Another study focused on staff response to patient safety events found that 1 in 7 participants had encountered a safety event that created feelings of depression, anxiety, and self-doubt within the past year. The majority, 68%, felt as if they did not receive institutional support.[23]

The common and cumulative nature of trauma requires screening but also for APRNs to understand the patient and peer responses to trauma, resource utilization, and creation of a healing-centered environment.[24] Understanding the physiology of trauma, TIC, and implementation across the health care system is vital for APRNs now more than ever.

Polyvagal Theory

There are several neurobiological responses that provide information into the development of symptoms as a response to trauma, one of which is the polyvagal theory. This theory offers insight into the physical response to psychological trauma and the connection between the 2 for APRNs to gain a better understanding of a more intense response to trauma and the influence of TIC.

The ability for the brain to distinguish safety from danger has evolved with improved understanding of the autonomic nervous system.[25] Our brains were thought of as having 2 complementary but opposite parts, sympathetic versus parasympathetic, fight–flight versus rest–rebuild, but the polyvagal theory expands this to a hierarchical 3-part circuit based on the evolution of the system.[25] The 3 circuits expanded are composed of the immobilization circuit (freeze), the fight–flight circuit, and the social engagement circuit.[25] The vagal pathway regulates the nerves of the face and head and includes more sophisticated responses as part of the social engagement system such as muscles of listening, hearing, talking, providing facial expressions, affect, and response, which regulates the ability to socially respond to situations in the environment.[26]

Trauma survivors can have both an overreaction and underreaction to perceived danger, to include inappropriate reactions to completely safe situations, and can lead to symptoms such as pain, depression, anxiety, and gastrointestinal issues.[27] The vagus nerve is a natural damper,[28] and vagus nerve stimulation is Food and Drug Administration (FDA) approved for drug-resistant epilepsy and depression, but there is also evidence that the effects could be used for a larger range of disorders such as sepsis, lung injury, traumatic brain injury, rheumatoid arthritis, diabetes, and possibly pain disorders such as fibromyalgia and migraines[29,30] and inflammatory bowel disease, anxiety, and PTSD.[28] Activities such as diaphragmatic breathing, self-compassion, psychosocial interventions, and empathy from others encourages the brain that the environment is harmless. Feeling safe facilitates general health, helps learning, critical thinking, and productivity; while feeling unsafe can really wreak havoc on the system.[26]

It is harder to feel vulnerable when there are strong social support interactions, so connections are key to activating the system.[26] With the COVID-19 pandemic, we must also consider the additional negative effects of social isolation according to this theory. Social distancing can decrease emotional self-regulation and overall health, but ending social distancing may also increase the sense of danger, causing poor immune response, additional stress response, physical and psychological dysregulation, and higher risk for infection.[30] TIC principles lend themselves to acknowledging and creating this environment.

Trauma-Informed Care

Historically, the TIC movement came to light within the behavioral health arena in the late 1990s, due to injuries and deaths associated with restraints in inpatient psychiatric treatment and because trauma-related issues were more commonly dealt with in behavioral health settings.[15] In more recent years, more attention has been given to the potential for traumatic childhood experiences and their impact on health, thus making the trauma-informed approach a best practice for all clinical areas where APRNs work.[31] APRNs as trusted health care providers are perfectly positioned to recognize potentially traumatic histories based on the medial sequelae and thus in an ideal position to introduce patients to resiliency practices.

TIC is composed of 6 principles: safety, trustworthiness, peer support, collaboration, empowerment, and responsiveness or cultural considerations.[15] TIC interventions are important for patients, peers/APRNs, and the organization and can be applied along all of those domains. Recognizing that TIC concepts coincide with social engagement as described in the polyvagal theory[27-30] can enhance interventions. For patients, APRNs enhance communication to model healthy relationships and improve health outcomes.[32] Care shifts from “what’s wrong with you?” to “what happened to you?” in an effort to provide a safe, inclusive, nonjudgmental environment for recovery. TIC supports wellness, even though the initial focus is acknowledging the impact of trauma, care is still based on building connections, a concept that acknowledges the brain and body’s response to trauma in an effort to decrease that response and support healing.[15,32] TIC has been shown to improve patient satisfaction and treatment retention.[33]

For APRNs, there continues to be little training regarding TIC and trauma responsive treatment.[31] TIC provides education on a multitude of physical and psychological issues that can come from the complicated, invalidating, and potentially retraumatizing health care environment, so this approach can be used by all APRNs to aid recovery and support posttraumatic growth not just with patients but also each another.[15,34] Staff satisfaction and improved organizational climate through improved perceived safety and transparency in the organization, and positive changes in policies, procedures, and practices after training and application of TIC principles.[33]

One study validated that the lack of confidence that primary care staff have in their own abilities to discuss trauma related issues contributes to practice habits of avoidance of the topic.[31] This study also revealed that patients with PTSD scored their primary care providers significantly lower for perceptions of care rather than the general patient population and affirmed improved scores for perception of care in partnership, engagement, and patient-centered domains after TIC training.

An additional cause for avoidance of trauma discussion could be the intrinsic need for self-protection from health care staff. This may be especially applicable if APRNs and other staff have received no formal TIC training; as TIC, secondary trauma, and self-care are infrequently taught in nursing school.[35,36] Staff can experience secondary or vicarious trauma responses that occur not by directly experiencing traumatic events, but by the cumulative effect of hearing trauma histories.[1,15] Understanding the potential of secondary trauma in health care workers is as important as understanding the prevalence of trauma,[15] especially since COVID-19 has been such an enduring experience.

It is essential for APRNs and other health care staff to receive education and support in TIC.[31] This process requires a cultural shift from focus on tasks and high productivity to one that embraces the importance of trust and purposeful avoidance of retraumatizing patients or staff at the individual and organizational levels.[32,37] At that level, organizational stress can present many barriers for integrating TIC on a systems level. Executive leadership support is as important as frontline staff activation.[38] Trauma can inhibit the ability to speak up, potentially undermining organizational functioning and contributing to an unhealthy organizational culture and poor morale. TIC has contributed to improved patient care practices, climate and education for patients and APRNs.[37] TIC considers the public health burden of trauma, particularly the need to acknowledge racial inequities and health disparities by promoting racial equity and understanding of current and historical racism, cultural, and gender differences.[31] Achieving greater health equity using the TIC principles, which offer actionable and practical efforts for more inclusive and person-centered treatment also aligns with Healthy People 2030[39] leading health indicator criteria.

Therefore, understanding trauma, the effects on physical and psychological health, treatments, and TIC as a fundamental skill for all APRNs, so that patients can truly be partners in their care along with an interdisciplinary team of health professionals,[40,41] but also aid APRNs in decreasing the potential consequences of COVID-19 and other stressors among themselves. Using TIC to help with burnout among APRN peers and colleagues across the system is another important factor. The emotional contagion of trauma requires that we consider TIC to be a universal precaution.[15]

Using universal precautions to break the chain of infections is no different from using TIC to break the chain of reactions that follows trauma. COVID-19 has shed much light on the amount of stress and trauma patients and health care workers alike face, and this pandemic has really refocused our use of personal protective equipment as a society. The principles of standard precautions include the use of appropriate personal protective equipment such as gloves, masks, and gowns. The principles of TIC, include identifying the pervasive impact of physical, social, and emotional health for patients and staff to prevent early adversity and opportunities to adopt treatments to support people across generations.[15,31] Collaborative facilities within the Veteran's Affairs (VA) and Department of Defense (DoD) share important trauma related background, principles, and a model program for APRNs to use not just for care of patients during this health care crisis but also for care of staff throughout the entire clinical environment.

Implementation

Creating a foundation for trauma-responsive care that supports posttraumatic growth and healing began with simple steps toward creating a workforce that recognizes not only the presence of trauma but the importance of supporting resilience and hope. In the wake of COVID-19, this became even more apparent of an initiative that could be used by all APRNs. This is not highly complicated and does not require expensive resources; it does require leadership support, staff engagement, and time.[38] APRNs and the multidisciplinary team can readily utilize TIC principles as a bridge from task oriented concepts to person-centered care.[36] The program initiated during this collaboration focused on 3 components: training and education, support, and purposeful wellness across the 3 domains of patient, peer, and organization outlined here and in the Table.

Training and Education

TIC Is the New CPR, APRNs and health care staff understand and respect the need for CPR to preserve brain function and that CPR is an emergency, lifesaving, and critical step in the chain of survival universally recognized and trained.[42] It is with that same importance that TIC should be trained and applied to interrupt this severe sequelae of trauma effects for patients, staff, and the organization.[15] *TIC Is the New CPR* was developed and adopted to signify the importance of the TIC training. Using the Substance Abuse and Mental Health Services Administration (SAMHSA)[15]-based train the trainer program composed of an overview of trauma, ACEs outcomes, disparities and insidious trauma specific issues, secondary trauma and self-care, and a focus on resiliency, hope, and support skills. One hundred thirty-seven primary care staff across 6 disciplines were trained over a 6-month period of time, 100% voiced that the education was necessary, and several participants from multiple sessions mentioned that the information validated their experiences and the focus on self-care was appreciated, and often under looked in the health care environment. After training, 98% of the participants reported feeling that this information would immediately help them to provide a higher quality of care and 97% intended to put the information to practice immediately. A condensed version of TIC training was provided to another 120 staff members, faculty, and students. Resiliency support skill building was discussed, and simple scripts were provided for staff to use with patients as they move toward discussions about recovery, hope, and posttraumatic growth.

TIC champion training provided train-the-trainer level education for 72 influencers across 4 systems of care. This group consistently voiced the importance of the positive impact this project could bring to patient care and staff support. This was further supported by significant improvements in mental health screenings and patient satisfaction. External peer review audits confirmed that completion of mental health reminders for PTSD and depression, as well as suicide assessments improved to exceed national benchmarks. Patient satisfaction scores improved in the dimensions of communications and comprehensiveness to significantly surpass national benchmarks.

The *TIC Is the New CPR* model became more formalized, allowing for SAMHSA-based train-the-trainer education to a multidisciplinary group of "TIC Champions." As more resources were allocated for the project, more training and materials for purposeful wellness, staff support and new best practices were initiated. TIC is the new CPR has been implemented in 4 total systems, with similar posttraining evaluation outcomes.

TIC Is the New CPR implementation directly affected staff empowerment and support, including exploring and supporting

Table
Implementation of *TIC Is the New CPR* in the Veteran's Affairs (VA) and Department of Defense[15,32]

Category	Patient Initiatives	Peer/APRN Initiatives	Organizational Initiatives	TIC Principles
Training and Education	Screening for trauma because of increased awareness Offering additional resources as traumas are identified Using shared understanding and language about trauma such as "what has happened to you?" not "what is wrong with you?" and TIC concepts with patients to enhance safety, trust, collaboration and empowerment Acknowledgment of connection between historical trauma and present-day experiences, and consequences	Shared understanding and language about trauma and TIC Shift in focus that healing happens in relationships Explore symptoms as adaptation/survival skills to traumatic events for staff and patients Understanding of how to help people feel safe (making decisions, using their voice, discussing their needs, etc) Understanding of the disruption trauma has cause with feelings of control, connection, and meaning Building on success, nurturing resiliency, building autonomy, facilitating communication, positive relationships Support for what they choose, believe them, thank them for trusting you enough to talk about it, and express sympathy	Shared understanding and language about trauma and TIC Lead and communicate about the changes Culture of learning and curiosity Collaborative and reflective Train staff in TIC	Safety: establish safe physical and emotional environments in which basic needs are met, safety measures are in place, and responses by staff are consistent, predictable, and respectful Trustworthiness/transparency: Allow them to make daily decisions about programs and services, and participate in the creation or review of policies and procedures Peer support: instill hope and facilitate peer-to-peer support, outreach, and holistic care; focus on strength, resiliency and future-oriented goals. Collaboration-safe relationships can heal, foster positive communication, Establishing safe, authentic, and positive relationships can be restorative
Support	Involve patients in the healthcare process Support all, but acknowledge communities and individuals disproportionately impacted by trauma Offer peer support resources	Peer support roles receive additional training and champions support resilience and trust for patients and each another Explore ways for staff to get more training (trauma-focused or otherwise) Engagement in frontline staff Peer support and coaching Provided during employee orientation	Identification of champions Leadership support Policy and procedure changes to support TIC principles Engage patients in planning Create a safe environment	Empowerment and choice: stay well informed about options, and allow opportunities to make decisions about care and choices Support choices as their choice Encourage participation in their own goals Responsiveness, cultural/historical considerations: aware and supportive of historical responses on race, gender, culture
Purposeful Wellness	Warrior Beat[43] drumming circle as a technique for connection and for decreasing the cognitive overload Breathing and mindfulness techniques	Warrior Beat[43] drumming circle Brain breaks (activities to decrease cognitive workload such as mindfulness, meditation, art, music, creative outlets) Postvention and present-vention protocol with peer support for second victim for staff	Culture of reflection over reaction Prevent secondary stress in staff Address and prevent burnout and staff turnover	Culture impacts perceptions about what is trauma and how to respond and can also be immense source of strength that needs to be considered Be aware of gender issues, LGBTQIA+ (lesbian, gay, bisexual, transgender, questioning, intersex, asexual), and BIPOC (Black, Indigenous, and People of Color) historical traumas

APRN = advanced practice registered nurse; TIC = trauma-informed care.

new best practices. A group of 13 clinicians were provided evidence-based trauma-focused psychotherapy training to enhance support for these techniques. Improvements in and additions of therapeutic modalities provide state-of-the-art, yet patient-centered, approaches to treatment. Skilled clinicians and providers expand services to meet treatment needs of patients with a wide variety of options, ranging from traditional cognitive approaches to more limbic support-oriented approaches.

Support

TIC opens a cultural transformation that can only be successful if all levels and disciplines are empowered and engaged. Acknowledging that staff members bring their own lived experiences that impact their ability or willingness to consider a trauma-informed and trauma responsive approach, attention to staff as well as patient needs and feedback during this transformation was of highest importance.[38] Organizationally, executive and line leadership were fully supportive of moving the program forward, incorporating multidisciplinary champions throughout the system to include APRNs. Frontline staff were empowered with opportunities to become trainers, peer support, join the committees to support and to provide peer support themselves by volunteering to lead activities on their own or with assistance. *TIC Is the New CPR* was also provided to all staff during new employee orientation.

The TIC champions received a 2- to 3-day training including TIC fundamentals and participated in teach-back sessions through collaboration with TIC experts from the Department of Mental Health and Addiction Services.[15] Champions were primarily responsible for educating and supporting unit-based staff. A very important role for TIC champions is to inspire transitions to person-centered care. Education sessions focus not only on the prevalence of trauma, organizational, and individual roles in TIC but also secondary trauma and self-care. Staff are taught simple methods to support resilience and trust with patients and each another. Basic scripting to support resilience includes phrases such as 'Thank you for trusting me enough to share your story," "I'm sorry that happened to you," "I support you, whatever you choose to do."

In addition, staff were taught recovery and resilience coaching skills to be able to support one another. Not every patient with trauma issues will receive psychotherapy, and not all staff members need to have the capacity to deliver it, but all health care workers should be able to support others in the process of recovery and developing resiliency practices. Preparing multidisciplinary teams at all levels to integrate trauma-responsive behaviors and attitudes into daily practice is of maximum importance. Organizational culture shift that leads to a sustainable behavioral change supported by leadership will prevent poor outcomes and superficiality.[38] Multiple unit/department-based champions to serve as trainers and influencers for staff support to improve wellness activities and explore how we talk to one another as well as patients has been implemented across the organization.

Purposeful Wellness

Another component is focused on purposeful wellness. Patients, staff, faculty, and students are provided with education and experiences to help manage anxieties and stressors. One initiative used the power of drumming through a collaborative effort with "Warrior Beat,"[43] a veteran-operated drumming for resilience and recovery program. Fifteen hospital-based facilitators were trained to conduct drum circles for inpatient and outpatient patient wellness groups. During the facilitator live training phase, an 81-year-old veteran stopped in to watch and was fully participating, receiving his certificate of completion as a drumming circle facilitator. His comment was "I am 81 years old, I am ready to do something new with my life." The program pivoted online with the emergence of COVID-19. Once the virtual drumming program was established, patients in 12 additional states requested to participate. Feedback from patients included appreciation feeling connected with others again. In addition to providing this virtual care to veterans, virtual drumming groups have been made available for staff across a 3-state network containing 10 VA systems of care. Weekly drumming groups are available to all staff. Feedback from participants is consistently positive whether or not each participant uses a drum. Staff members have commented that they look forward to this each week and it helps to clear the minds.

Staff members consistently verbalized that receiving TIC education validated their own experiences as caregivers and providers. This model also actively attends to the potential for secondary or vicarious trauma and has integrated the concepts of "second victim" into the postvention protocol for staff working with patients. Similarly, staff are provided with help to manage anxiety and stressors that come from working with patients. Postvention was first defined in suicide literature as care to address bereaved persons after someone dies by suicide,[44] but the majority of postvention efforts focused on family and friends, rather than health care teams.[45] A more formalized approach and training was integrated as a result of ongoing collaboration between the DoD and VA.

Given the social unrest and increased focus on health care inequities during COVID-19,[6,7] more focus has also been placed on historical trauma as well as increased health risks to medical staff, and collective trauma has become more prevalent. *TIC Is the New CPR* brought staff support to a more "present-vention" perspective with the integration of a second victim response peer support program. This program provides resources and training for peers to support each another with the intent of helping staff cope with stress and stress responses. Staff often feel more comfortable discussing stressful situations with others who understand their practice.[23] The second victim response team serves to allow peers to provide basic support to each another—not as a replacement for employee assistance or other formal individual or organizational interventions but in addition to them.

There have also been a number of positive contributions that have come out of this initiative. Since the COVID-19 pandemic began, both the DoD and VA organizations have implemented support for frontline staff focused on "purposeful wellness" as resilience and grit strengthening practices providing limbic resets. "Brain breaks" were initiated for staff as a weekly reconnection and grounding exercise to decrease cognitive reactions. Drumming circles, meditation, mindfulness, journaling, music, nutrition and spirituality support, and other activities have been used during the COVID-19 pandemic to help staff decrease their cognitive workload, even if only for 15 minutes, and damper the heightened response to support emotional self-regulation, adequate immune response, and health. These activities have been well received and attended in more than 80 sessions, and a similar 10-session protocol was created for students.

Discussion and Recommendations for Future Practice

COVID-19 has magnified the health equity issues in our system, which is the focus of TIC. The principles of TIC are more applicable

now than ever. TIC provides the opportunity for APRNs to rediscover the joy of working in nursing in the first place, and rather than focus on what patients are not doing, the shift to "how can I help?" and "what can I do to support you?" is crucial to the care nurses provide. There is no agreed-upon TIC measurement,[46] and TIC indicators were not formally evaluated as part of this project. As nurses, it is challenging to evaluate communication processes that are opened with our skills, in line with "Nightingale Metrics,"[47] such as use of therapeutic communication skills, helping patients open up about their past experiences, or proactive, holistic care, such as is offered with the TIC principles.

Shawn Ginwright[24] suggests we can take TIC even further to healing-centered engagement (HCE) and move beyond "what happened to you," to "what is right with you?" Trauma and well-being are pieces of the environment to include in treatment planning. Healthy People 2030[39] has challenged us to look at economic stability, education, and health care access and quality, environment, and social and community context as measurable facets of health. TIC helps bring awareness to additional risk factors that add to the improving public health outcomes and address social determinants of health, health disparities, and health equity.

The collaborative efforts using TIC principles for both staff and patient wellness and care continues to evolve with COVID-19 precautions, but using trauma theory, interventions, care, and response from a multidisciplinary team are important pieces. Training, education, support, present-vention, and purposeful wellness are powerful tools to combat trauma. Activating and empowering health care staff across the DoD, VA, and the nation to take part in supporting posttraumatic growth for patients and themselves will lead to true cultural transformation that will overcome typical organizational barriers to change.

We are in this together. It is less burdensome to collaborate with patients and each another for better care, better health, and resiliency of patients and the health care workforce. Using *TIC Is the New CPR* as a guide for all APRNs presents an opportunity to thrive in health care as we move forward.

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