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Feature Article

Psychiatric Advanced Practice Nurses Contributions to Supporting Survivors and Caregivers Affected by the Boston Marathon Bombings

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Objective:
The role of the psychiatric advanced practice nurse in promoting psychological health and resiliency for patients, their families and staff following the Boston Marathon bombings is reviewed.

Background:
On April 15, 2013, 2 bombs exploded near the finish line at the Boston Marathon. Within minutes, 39 patients suffering from multiple injuries presented at a level I trauma center. The magnitude of this event and its effect on our hospital required a comprehensive response that would promote resiliency and healing.

Rationale:
Lessons shared from responders to other tragedies were helpful in guiding our interprofessional efforts. The multiple layers of our response are reviewed to offer learnings that may inform others as they work to promote resiliency and healing following traumatic events.

Description:
In response to this event, we utilized a trauma-informed care framework emphasizing physical, psychological, and emotional safety to assist staff, survivors, and families on their journey of healing.

Conclusion:
Emotional reactions were dramatic but were eased by the psychological care and education that our patients, their families, and staff received in the first days to weeks after the bombings.

Implications:
The psychiatric advanced practice nurse can influence positive outcomes by utilizing a trauma-informed care framework.

KEY WORDS:
clinical nurse specialist, marathon bombing, psychiatric advanced practice nurse, resiliency, trauma-informed care

On April 15, 2013, 2 bombs exploded near the finish line at the Boston Marathon. Within minutes, first responders were triaging the injured and sending them by ambulance to area hospitals. Brigham and Women's Hospital (BWH), a level I trauma center, received 39 patients suffering from multiple injuries, some requiring immediate lifesaving surgeries. Everyone was in disbelief that this was happening in our beloved city on a day filled with positive energy and cheer. The hospital declared an external disaster that impacted our entire facility. Every available clinician was deployed to the emergency department to help move patients to inpatient floors in order to create space for incoming trauma victims. Soon after the bombing, the hospital was secured (locked down) requiring staff to remain on site until further notice.

As a level I trauma center, it is not uncommon for us to receive patients with traumatic injuries from shootings, stabbings, falls, or car crashes, but the magnitude of injuries that came with this bombing exceeded the norm. The sheer number of patients arriving in the emergency department simultaneously, with catastrophic blast, burn, and shrapnel injuries, was extraordinary even by our standards. Hospital leadership gathered at the command center used so many times for emergency preparedness drills, to ensure a dynamic

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organizational response.[1,2] However, on this day, it was not a drill. Our BWH marathon was just beginning.

The marathon bombings were the first of multiple challenges we would face that week. Two additional safety threats followed. A locked car that was left unattended outside an entrance to the hospital prompted evacuation of the building. Later that week, a "Shelter in Place" order was activated by the state following active shootings in the city from attempts to apprehend the alleged perpetrators responsible for the bombings. Local and federal law enforcement presence increased and included state and federal police carrying riffles and large capacity guns patrolling the hallways and front door. This combination of security, crowd control, and surveillance of visitors and staff, coupled with the large media presence and influx of dignitaries visiting the injured, added to the surreal experience. All of these served as reminders that what had occurred in our beloved city required mindful attention and intentionality[3] to facilitate healing and hope within an environment overflowing with stress and fear. The purpose of this article is to reflect on the role of the advanced practice psychiatric nurse in promoting psychological health and resiliency for patients, families, and staff following the Boston Marathon bombings.

ROLE OF THE ADVANCED PRACTICE NURSE

The magnitude of this event and its effect on our hospital required a comprehensive response that would promote resiliency and healing.[4–6] Lessons shared from responders to tragedies such as 9/11, Hurricane Katrina, Newtown, and others[7–10] were helpful in guiding our interprofessional efforts. The Psychiatric Nursing Resource Service (PNRS) at BWH consists of advanced practice nurses (APNs) with a specialization in adult mental health nursing. As clinical nurse specialists, we were able to actualize the full scope of our roles in influencing patients, nursing practice, and systems outcomes.[11–13] The APNs within the PNRS provide education and coaching to nurses throughout the hospital and expert consultation to patients with heightened psychological care needs.[14] The role of the PNRS is to positively influence the psychological care provided to patients and their families either directly or through the situated coaching of direct care nurses and interprofessional team members. In addition, the PNRS serves as resource to the organization providing expertise in current evidenced based approaches to psychological care and often represents the department of nursing in practice development initiatives to improve patient care.

The PNRS is closely engaged with the burn/trauma nursing and interprofessional staff, providing regular consultation and coaching for patients, their families, and staff around the broad continuum of psychological responses to trauma. We use a trauma-informed care (TIC) framework to emphasize strength, resiliency, and physical, psychological, and emotional care and safety for staff and survivors as they are cared for and recover from injuries.[15–18] Given the paucity of consensus-based definitions for this framework, our adaption of TIC is composed of the shared principles described in the literature.[16]

The role of the PNRS in the organization positioned us perfectly to take a leadership role in shaping the organization's psychological response to this event. As APNs, we utilized our clinical expertise, knowledge of the system and unit cultures, and the established relationships forged with clinicians and leadership to facilitate a comprehensive plan.[14] During these events, the many modalities of communication available to us in the 21st century became both helpful and burdensome. Initially, staff received calls, texts, and online messages from family and friends checking to see if they were safe and offering information about what was happening outside the hospital. This was helpful initially when the information about the bombings was scarce. Our clinical response to the bombings did not leave time for anyone to turn on a television or check the Internet to read the latest updates. It was only when staff returned home that they were able to see, hear, and read the news. As the initial shock of what happened began to dissipate, the frequent, graphic replaying of the bombings and play-by-play news updates took an emotional toll on staff, patients, and visitors with multiple layers of acute stress reactions.

RESPONDING TO PATIENTS AND THEIR FAMILIES

The morning following the bombings, the PNRS rounded on each of the units that had received survivors to touch base with nursing leadership about immediate needs of patients, their families, and staff. This allowed us to triage our responses based on the evolving needs of the organization. Many patients in the trauma intensive care unit (ICU) had several family members waiting for news and updates. The number of family members exceeded the capacity of our family waiting area, resulting in a large number of people displaced into the hallways. Anxiety and fear were high, and we realized that an immediate response to provide family members information and a forum to be heard would prevent an escalation of tension. We collaborated with interprofessional team members on this unit utilizing TIC principles to recognize the visible, varied responses to this trauma, find an opportunity to promote physical and emotional safety, prevent retraumatization, and to provide support for optimal wellness for these family members and loved ones.[16] Research[19] after 9/11 identified social environments that inhibited discussion of feelings led to higher levels of distress; therefore, our immediate goals were to create a forum to decrease anxiety, provide information and education, and promote an environment where multiple layers

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of healing could take place. We offered an impromptu multifamily support group to all available family members in the first 24 hours. We met in the only room large enough for the group, provided nourishment, and invited them to tell us who they were and whom they were there for to support. As each family told their story, we were provided a window into what they were experiencing and were able to know them and our patients as individuals. We reviewed our roles (social work, care coordination, physician, nursing, psychiatry, PNRS, chaplaincy, and patient and family relations) and provided an overview of the broad scope of physical and psychological care their loved ones would receive over the following days and weeks. We provided information about the hospital and the ICU environment, identified support available to them, and addressed immediate concerns and questions. We stressed the importance of trauma awareness to also include self-care practices and encouraged them to get sleep, take refresh breaks away from the unit, eat nourishing meals, and limit exposure to media coverage to prevent retraumatization and to promote psychological resilience. Resilience has been defined in the trauma literature as an outcome pattern following a possible traumatic event characterized by a stable trajectory of healthy psychological and physical function.[6] We reminded family members that these self-preservation strategies were vital to ensure they would be in the best position to help their loved one when they returned home. Instilling hope about recovery and providing updates about the clinical progression toward a return home were essential for (providing) care during this time of crisis.[20]

WORKING WITH LEADERSHIP AND STAFF

The BWH executive leadership gathered together representatives from multiple interprofessional role groups to assess and implement the organization's response. This group met several times to review evolving needs of staff, patients, and their families in order to ensure real-time deployment of resources to aid recovery. As psychiatric APN members of nursing leadership, we brought skills and knowledge to the planning meetings that influenced and shaped the organizational response. We offered our formulated assessments, interventions, and insights into the psychological care needs of each area affected by this tragedy, including the survivors, their families, and staff. We stressed the importance of a clear, cogent, and organized response to address and contain the psychological impact. The day following the bombings, it was evident that each patient and their family were well cared for and had the appropriate clinicians consulted to address their psychological care needs. Knowing that the plans of care for patients and their families were in place, we were able to focus our efforts on the staff to ensure they received what they needed to continue to provide care. Numerous unit-based meetings were held throughout the hospital to further assess, support, and provide care for staff that were affected in a multitude of ways. The PNRS partnered with Employee Assistance Program (EAP), chaplaincy, and psychiatry to lead these meetings in a coordinated manner. Many staff members had been at the scene of the bombings as runners, spectators, or volunteers in the medical tents. Some became first responders to the horror at the scene; some ran from the disaster confused and overwhelmed by the mass of bystanders fleeing the bombing area not knowing what had just occurred. Some had friends or family running in the marathon; others were working in the hospital the day of the bombing or on subsequent days, during the building evacuation or the "shelter in place" mandate; some were not working and felt guilty that they had the clinical skills needed to help, but were not there to help. Still others had loved ones (parents, spouses, siblings and friends) who were first responders (EMS, police, firefighters, nurses, and physicians) and were experiencing the psychological trauma at home, as well as at work.

Nurse directors identified the best options and modalities for providing their staff information and support at the unit level. In the days that followed, the PNRS led formal and informal groups on many units and reviewed the spectrum of responses the staff could experience. Reactions to traumatic events are varied and dynamic, and understanding the range of normal responses to these abnormal events would aid in their path to recovery.[21] The collaborative relationships we had with nurse directors on each unit were essential for providing in the moment support for staff. We organized nurse specific groups and interprofessional groups (chaplaincy, EAP, occupational health, nursing leadership, PNRS, psychiatry, psychologist, social service) as requested by leadership, acknowledging that the recovery process could be different for each person and stressing that the vast majority of the responses were normal. Similar to the education provided to the victims' family members, staff were encouraged to sleep, maintain a healthy diet, limit TV/Internet exposure, and engage in healthy distractions and enjoyable activities to promote physical and emotional wellness. We coached the staff on how to thank family and friends for support while directing them away from having to retell the story. "Thanks for asking, I'd rather not talk about it but would enjoy going to a movie, or taking a walk, etc." We encouraged them to practice themselves what they were encouraging patients and families to do, namely, to designate a spokesperson to limit the number of people in their lives contacting them for information.

ONGOING CARE

As patients improved physically and moved out of the ICU to step-down units, they began to have a wide range of

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emotional reactions. It was clear that providing clinical resource support and coaching to staff around acute stress reactions would continue to be a major component of our work. The PNRS provided a daily physical presence and in the moment support to the staff through continued coaching, education, care planning assistance, and evaluation of patients in collaboration with other consultants. Coaching nurses on what to say to support patients' and families' psychological health was equal in importance to acknowledging the range of emotional responses they would experience while providing care to patients. We continued to educate clinicians about the acute stress response they and their patients may encounter.

In addition to group meetings, individual supports were identified and made available for all staff through the EAP, Occupational Health Services, and psychiatry. By week 3, employees were responding well to the support offered, and things were beginning to return to normal. Many nurses at 3 weeks remarked, "It seems like it happened so long ago." During the fourth week, an employee wellness fair led by the Occupational Health Services was held on all shifts. In the planning meetings with leadership, the PNRS suggested a wellness fair as a way to provide continued care to staff at a time when acute stress reactions to a traumatic event would typically be over, but when symptoms of ongoing psychological concerns may emerge.[22] A variety of integrative therapies were offered to assist staff toward their continued healing and self-care including yoga, meditation, Reiki, massage, qigong, acupuncture, and nutrition information. Tea for the Soul sponsored by chaplaincy and the soothing sound of our harpist playing throughout the hospital are familiar to staff at BWH and were included in the wellness fair.

LESSONS LEARNED

Anyone who has run the Boston Marathon knows that there's a stretch of road referred to as "heartbreak hill" that hits when the runners are facing a wall of physical exhaustion between miles 21 and 22. Every runner must conquer heartbreak hill to get to the finish line. Knowing about heartbreak hill in advance allows runners to prepare themselves mentally in order to push through. Just like those runners, each of our patients, their families, and staff pushed through their own heartbreak hill to get to the finish line. Emotional reactions were dramatic but were eased by the psychological care and education that our patients, their families, and staff received in the first days to weeks after the bombings. Identifying that every person experiences different psychological reactions at different times throughout a traumatic event paved the road and process to healing.

Throughout this tragedy was evidence of a "can do" attitude that was critical. The focus on resiliency and psychological health organizationally was paramount in addressing the responses from patients, families, and staff. Bringing together key personnel and experts within the organization as soon as possible to respond to the varying degrees of expected and unexpected reactions to trauma ensured there was support provided at every level. Situated coaching and education of staff in the broad range of psychological responses to stress, illness, and trauma, along with information on how to respond to symptoms of acute stress, were imperative to ensure staff could take care of themselves as well as their patient, their family, and colleagues. The omnipresent focus on the staffs' most basic self-care needs was overwhelmingly appreciated and allowed them to remain focused on providing their patients "excellent care, by the best staff, in the safest environment."[23] While attending to the safety issues and extreme media focus was unavoidable, given an event of this magnitude, it was essential to have designated areas within the hospital where large crowds could gather so care could continue. Resiliency is built 1 day, 1 shift, and 1 person at a time. Celebrating the successes and anticipating the challenges that might present tomorrow helped to build a solid foundation from which to work.

It was both helpful and upsetting to not know all the events as they were initially unfolding. We found having an organizational approach helped to keep staff informed and freed them up from having to seek out the information on their own. In the role of psychiatric APNs, it was important to expand our focus and sphere of influence from patients and families to the nurses and interprofessional clinicians who were providing physical and emotional care. We assisted in developing plans of care addressing the psychological care needs of patients and interventions to help heal staff. Our patients, their families, and staff have lived through a story of trauma, healing, and hope, and our relationship has been forever changed.

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