CPI *Unrestrained* Transcription

Episode 72: Ted Sandquist

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Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, a CPI podcast series. This is your host, Terry Vittone. And today, my guest is Mr. Ted Sandquist of Blackstone Consulting. Hello and welcome, Ted.

Ted: Good morning, Terry. How are you?

Terry: I'm doing great. How are you?

Ted: I'm great.

Terry: Good. We're grateful to have you on. Blackstone Consulting is an international service provider with over 6,000 employees serving clients as diverse as the US Army, Goldman Sachs, and the healthcare giant, Kaiser Permanente. Ted's current role at Blackstone is serving as the national training and compliance manager in healthcare, security, and shared services. Ted is also a CPI Certified Instructor. Today we're going to talk with Ted about his remarkable personal history featuring his fascinating counter-intelligence work for the US Army in Japan and how it led him to a role at Blackstone, a role where CPI training and verbal de-escalation skills have figured prominently. So, connecting the dots should be very interesting. So, let's start today, Ted, by having you talk about your professional history in the military. I think it's important to know the formative experiences that bring you to the work you do now.

Ted: Sure. Thank you. Yeah. So, in 1996, I was managing a bookstore, and growing up, I had always wanted to be an army guy, and I hadn't jumped at that opportunity and I still wondered about it. So, I decided to enlist at that time, and I did. I turned 27 years old in basic training, went on to the counter-intelligence school in Fort Huachuca, Arizona, completed that, went to Airborne School at Fort Benning, Georgia, completed that, and then was assigned, surprisingly, to Japan, which at the time, I was really unaware that we really had an army presence in Japan. So, I was assigned to a field office as a counter-intelligence agent there. The primary mission for us at that time was to collect strategic-level intelligence through liaison with host nation government agencies, the Japanese Self-Defense Forces. And my area of responsibility was from Tokyo up north all the way to the Island of Hokkaido.

So, when I got there, as a young soldier, I really knew nothing of the Japanese culture. And I was assigned—I'll call him a young man, [but] he was not a young man, Yanase-san, who had been actually working with US Forces since 1948. He started out in the kitchens of the various military bases and worked his way up to become a translator for intelligence-collection activities for the US Army. He really took me under his wing and taught me all the nuances of the culture and the importance of being sensitive to the culture that we are engaging. Oftentimes, in my view—oh, let me say, I am giving my opinions here. I'm not speaking for Blackstone Consulting nor Kaiser Permanente. This is my view of the realm that we're talking about here.

Because we were collecting these intelligence requirements from the commanders, it was critical that we are sensitive to the culture and we collected this intelligence from building relationships and building rapport with the various government agencies and their self-defense forces. And he just mentored me from how you present your business card to how you use your chopsticks, or hashi. All of those things, all of those little nuances helped to build rapport with our host and proved to be very effective technique.

Terry: How so?

Ted: Well, let's see. Just as an example. Yanasa-san spent hours with me on how to properly use chopsticks or hashi, how the only thing that should move is the upper chopstick. The lower chopstick should remain stable and unmoving. And in doing that, I think, without exception, it was always noted and commented on when we would have dinners with our host. Typically, how it would go is we would go and do an office call and we'd spend about, I don't know, 45 minutes to an hour discussing current affairs, personalize on that thing, and things of that nature. And then we would get down to business and talk about the intelligence requirements, and what we were looking for, what they were currently focusing on. And after getting done with that and hopefully eliciting information, we come together again a couple of hours later for a dinner. And how you conducted yourself was very, very closely watched—not overtly. I never felt that they were watching my behaviors, but I knew that they were because they would always comment on, "Hey, well, you use chopsticks very, very well. You presented your meishi—your business card—very respectfully."

And all of those things helped to endear me to the host, which in turn helped them to converse with me more freely and openly. Does that make sense?

Terry: Yeah. So, because you learn the protocols that spoke to respect for the culture, they opened up more to you.

Ted: Absolutely. Absolutely.

Terry: I was wondering what intelligence requirements you might have had in the day.

Ted: Well, at that time, and currently, the commander issues a list that are called PIRs, or priority intelligence requirements. And these are things that analysts and the commanders have looked at and the information that they would like to know, be it, you know, how many tons of scrap metal are being shipped to North Korea, things of that nature. Does that make sense?

Terry: Sure.

Ted: Right. So, we're tasked with those, we prioritize those, and go out and collect upon those priority intelligence requirements.

Terry: So, you feel that there's maybe an analogous thing here where you learned to be very particular in your regard for a culture, and its habits and protocols, and that it made you more aware to those things in general.

Ted: Absolutely. Absolutely. If you're not sensitive to the culture that is hosting you, and if you don't abide by their culture and if you come in brash and loud and aggressive, as Americans tend to be, that can often be a real turnoff and a deal-breaker.

Terry: Yes. So, that brings some of the ideas about cultural sensitivity and how we're going to talk about that a little bit later. Today, you work as the national training and compliance manager for Blackstone. What are the fundamentals of Blackstone Consulting as a business? Could you explain that for me?

Ted: As a business?

Terry: Yeah.

Ted: Okay. So, BCI, Blackstone Consulting, our core values are really clearly defined. You know, we value diversity and we believe that, you know, differences in perspective and culture and background contribute to the overall success of the business as a whole. Right? We're goal-oriented. We view our success [as] when we help our clients achieve their goals. There's a big focus on teamwork, that in order to be successful, we have to work together, help one another, and [have] high-level respect for everyone on the team. And we pride ourselves in being flexible and able to adapt to the ever-changing environment that we find ourselves at.

Terry: Okay. So, what exactly do people pay you to do?

Ted: Me?

Terry: Well, no, I mean Blackstone Consulting. I mean, does—so work at, say, with Kaiser, I mean, what do you do for them?

Ted: Well, so we provide healthcare security and shared services for Kaiser. We're the primary holder of the security contract with Kaiser Permanente nationally. We subcontract that out to Securitas USA. Now how we manage that in my role, we manage the training programs for our officers who are entering the healthcare realm. Because I don't know if you're aware how different security operations in a healthcare environment look compared to, let's say, in a corporate setting. It's very radically different. Our security officers are supremely trained because they really are part of the care team. Their duties in healthcare go far beyond just simply observing and report. We are interactive, we are engaged. We are tasked with performing any reasonable tasks to maintain the safety of the patients, and the staff, and ourselves.

Terry: So, you may be called upon to do some things that puts you in harm's way.

Ted: Absolutely. And that happens on a daily basis.

Terry: So, talk about your current role with Blackstone and the roles that preceded it, if you would.

Ted: Okay. Well, currently, I am national manager of training and compliance for Blackstone. And in that role, we develop training. I am helping to develop the training programs and the trainers that present the material to both security and the healthcare staff. The security officers in healthcare, they go through something called the Standard Awareness Training, which addresses chemical, biological, radiological, nuclear, and explosive threats. It's an awareness thing, just a standard awareness. They further go through something called First Responder Operations, which, excuse me, which within the community that we serve, if there is a mass casualty event, or a chemical spill, or something of that nature, and the hospital is expecting to have what's called a patient surge, right, EMS had been sent out to bring these people to the hospital, people in the community are coming to the hospital themselves, we are charged with providing service to the hospital so that they are able to provide the best care to the community.

And then what that looks like is we provide access control, crowd control, traffic control, and assist with decontamination operations, and ensuring that, if it is a chemical situation, for example, that the hospital maintains its clean environment, right? So, in other words, if we're expecting 100 people to show up into the hospital and there's been a chemical spill, for example, people presenting may have some of that chemical on them. And if they gain entry into the hospital, they risk contaminating that clean environment. So, they set it up in such a manner that the only access people have is through the decontamination corridor.

Terry: So, somebody comes in with—there's a chemical spill, you've got maybe a mass of people that need treatment, so you would function as gatekeepers then?

Ted: Yeah. We would function as, you know, maintaining the sterile environment of the hospital so that we are able to provide the care to the community in need. Because if someone who is contaminated gains access before being decontaminated, they risk contaminating the whole hospital.

Terry: Sure.

Ted: And then further—and then what is unique is all of our security officers go through, we call it MAB training: management of aggressive behavior. Part of that is CPI. And that's where the crossover happens and where the security really becomes part of the care team. Whenever possible, our trainers will have security and frontline staff in the same class so that they are able to build some rapport with each other, recognize that they have a common goal, which is to take care of our patients. There are lots of—

Terry: So—

Ted: Go ahead.

Terry: Well, I would just want you to expand on your role as a CPI Certified Instructor and start when you consult as a Blackstone worker.

Ted: Well, so unfortunately, in my role, I am not afforded the opportunity to instruct CPI very often anymore. I do so to maintain my certification. My primary focus, you know, in my prior role with Securitas, I was their training manager for the South Bay. And I serviced five hospitals in the South Bay. And I would teach roughly three CPI classes per week, give them an initial or a refresher. So, now I manage how those classes go. I'm starting to develop a trainer program so that our instructors are delivering the material in an effective manner. Because really, when it comes down to it, if our instructors are not engaged, if they are not subject matter experts, they're just reading from a slide and nobody comes away with anything. And so, the manner in which that you present the material needs to be dynamic, needs to be engaging in order for learning to happen.

Terry: And during our pre-interview, you offered some really insightful observations about healthcare settings and how they differ from educational or long-term care settings, especially in terms of how crisis situations can develop. Could you share some of that with our listeners?

Ted: Sure. Well, so, I equate it to, if you think about it, nobody wants to be in the hospital, right?

Terry: Right.

Ted: If you are coming to the hospital, something's wrong. I use the example of the birth of my daughter. I wanted to be there. I was excited to be there, but I was also filled with anxiety and stress. Right? But typically, people just walking through the doors of a hospital, whether they're a patient, a visitor, or a family member, or whatever, that induces stress and anxiety. Right? Nobody wants to be there. Right? And here's the rub: we've chosen to be there. And something that I think is often forgotten is that this is a choice that we've made. We've chosen to work in a healthcare environment. Right? None of our patients really wish to be there and we need to acknowledge that, lead with acknowledgement.

The challenge that we are faced with is time is compacted, right? Whereas in a long-term care setting or an educational setting, those individuals have the time to really learn about who they're working with, what triggers them, what helps mitigate those triggers. You know, they're able to formulate strategies and it's—in a healthcare setting, we're at a much faster pace and our time with our patients is compacted, Right? And crisis develops very quickly, and we have to be quick on our toes and intervene early to prevent an escalation.

Terry: So, when people come to the hospital, they are already starting to anticipate stress with the experience?

Ted: Absolutely. I think that that starts from the minute that they park, and they get out of the car, and they walk through the doors.

Terry: And we certainly see it reflected in the statistics of violence against people who work in healthcare and hospitals. That certainly is—I mean, we see 70% of nurses are assaulted. I don't think there's any other line of work where the numbers are that high. And it's surprising that people should be giving care and assistance to people are the ones who are attacked most often on the job.

Ted: Yes. And, I mean, I distinctly remember being blown away by that data. And it made absolutely no sense to me when I first came into this environment. You know, my problem was, "Well, wait a minute, these people are trying to help. They're trying to help. Why are they hitting them? Why are they smacking them? Why are they biting and spitting on them? What is going on?" You know? And to me, in my opinion, it just points back to the fact that the people are coming there to the hospital, to the ED, some of them in the worst moments of their life, right? They're stressed out. There is a perceived loss of control. They're scared, they're anxious, and about to get some tests where they may have some bad news. I mean, that's very stress-inducing. And, under those influences, people act differently. I mean, we act differently.

Terry: You had an interesting observation when I talked to you before in our pre-interview. You said that we might associate violence in a hospital with an emergency room where there's a high degree of stress, there might be a gang member that comes in and the other—I've heard that other gang members, the rival, will actually come into the emergency room. There's all kinds of wounds there. I mean, we expect violence there. And I think in mental health units as well, where there's going to be some friction and conflict between people because of the reason that they're there. But you mentioned that violence is even more prevalent on just plain old hospital floors than it is in emergency or mental health units. Why is that? It seems contrary to our intuition about that.

Ted: It really does, doesn't it? I mean, if you were to ask that question, people's automatic response would be, yes, in your behavioral health facility. But the data shows that patient-initiated violence incidents occur more frequently on the floors. And I think that there's several—there's no one thing that contributes to that. In my opinion, I think that we have to consider the longer length of stay culture. The culture, in many ways, it's become—there had been an attitude of, well, this is just—it comes with the job. Right? But for me notably, there's been, until recently, thanks to Senate Bill 1299, there's been a notable absence of training in workplace violence prevention for nursing staff, frontline staff on the floors. They have not had, how, you know, de-escalation training. They have not had recognizing escalating behaviors trainings. And I think that we're going to start to see a change in the numbers as we push more training out to nursing staff and clinical staff on the floors.

Terry: You mentioned, in situations that might escalate towards patient or visitor violence, that it's important to slow situations down. In your experience on these floors where you have this pressure cooker environment, how can healthcare workers do that?

Ted: Well, I like to call it speed bumps, and Kaiser uses a phrase called "pause, plan, and prepare." We often become inured to our environment. Our norm might not be the norm of everybody else, but it's become our norm. This is what we're used to. We kinda go on to autopilot. And I encourage staff and I encourage security to stop and take a deep breath. Consider what it is that you're going to go into the room of this patient to do. Consider how you're going to do it and have a backup plan. Right? If we can do that, our safety profile goes way up, you know. We can keep ourselves from entering the autopilot mode and consider everything in regard towards safety. Before we go in and engage, we're raising our safety profile and keeping, you know, the patient safe as well as

ourselves. The data shows that engaging security early and often with patients that have displayed escalating behaviors raises the safety bar for everybody concerned. So, taking that minute, just even to take that deep breath, ground yourself, and then engage, helps everyone be safer.

Terry: Now, you mentioned—you said, the phrase "on autopilot" there. And when we talked earlier, you shared an observation about how people are basically unconscious when they drive to work in the morning. What does that mean? And how is it important to regard to the Integrated Experience healthcare workers might have with the people they serve?

Ted: Well, it's very true. And I think that you'll agree, if you think about it. For myself, I will often get up in the morning, get in my car, drive to work, and park in my parking spot. And it's almost like I regain consciousness. I'll have no conscious recollection of what took place from the time I left my house to the time I got to my destination.

Terry: So, you're that driver, huh? I see.

Ted: Well, yeah. You know, I have to say, you know, because I've arrived at my destination, that everything went fine, but, you know, we are not as aware as we could be, right? And the Integrated Experience is this: we have challenges in our daily lives. And if we don't acknowledge and keep those at the forefront of our mind, they affect how we interact with people. You know, we can be the escalating factor.

Terry: Truly.

Ted: We really can. The Spear Group uses something called—and Kaiser has started using this as well for quite some time—the AIDET acronym. Have you heard of that?

Terry: I have not.

Ted: AIDET, it's an acronym. It stands for Acknowledge, Identify, Duration, Explanation, and Thank You. And so, when you come into the room, you acknowledge that person's situation and any family members or visitors that are in the room. You acknowledge how tough it is and how this is probably not one of their best days. You introduce yourself and tell them with security, "This is why I'm here." The D stands for duration, and that's usually for clinical staff saying how long this is going to take. But I use it as saying, describe why you were here. You explain why you're here. And then you thank them for their time and their attention. And that's very helpful for all concerned.

Terry: So, it's a way to kind of take yourself out of the autopilot of going into a room and, okay, here's another chart, here's another patient, you know, kind of like a number in a series, and sort of snapping yourself back into a mindfulness.

Ted: Absolutely. Absolutely.

Terry: Interesting.

Ted: You'd consider your part in this, right? What is our part in this? What is our part in keeping this person as comfortable as we possibly can? And if you think about it, really, it's a self-serving

program, right? If I adhere to the principles of acknowledgement and empathy and really try and approach it through their eyes, that makes my days go smoother and more safely. One of the times that I was giving one of the classes, I was talking to a bunch of ED nurses about empathy and taking the time and I could see her getting agitated by what I was saying. And so, I paused. I said, "What's going on? What's up?" She said, "I don't have time to do any of this. I don't have time to listen to these people. I don't have time to empathize and say, oh, it's going to be okay. You know, I don't have time." You know, she said, "I have a guy pooping over here. I've got a guy throwing up over there." Right? "I've got somebody else screaming for their meds over here. So, I don't have time to listen to this guy and empathize with him."

I said, "Okay, you know, I get it. You're busy, you're busy. And I understand that, but here's the deal. You don't take that minute to empathize, you don't take that minute to acknowledge that person's situation, and he's already on an escalating path and he continues to escalate, and he feels blown off, and he feels disrespected. And he continues to escalate, and continues to escalate, and continues to escalate to a point where, here we go, we've got to go to restraints." So, investing a little bit of time on the front end and preventing an escalation pays off in dividends on the tail end if that patient stays with us.

Terry: Now, you became a CPI Certified Instructor in 2016. I'm wondering what your initial impressions of the training were.

Ted: Well, as I said, before, I was a little bit taken aback on the level of violence in our hospitals. And it was learning a new language to me on how we do this. But I was able to find parallels to what we did in the army. You know, I spoke about the liaison and the rapport-building in Japan. What I didn't mention was once the wars kicked off, that started the deployment cycle from where I was deployed in support of the global war on terrorism. So, an example that I like to use when I'm giving a class during my time in Iraq and Afghanistan, and when we would deal with detainees, and oftentimes, not always, but oftentimes, I would leave with an acknowledgement and an empathy statement with them. You know, they had a preconceived notion of what was going to happen when I came into the room. And oftentimes, I would walk in and I would hand them a bottle of water and I'd say, "Listen, you know . . ." One person in particular comes to mind. This was an individual that was bombmaker and he had been, over the past six months, building bombs, building IEDs, and blowing up my soldiers, our soldiers. You know, I was not very fond of this person, right? But we had finally got this guy and we needed to know more information from him. And this guy was scared, and rightfully so.

And I paused, and I came up with my plan, and I took some deep breaths because, you know, my emotions were running very high. I walked into the room and I handed him a bottle of water. I said, "Listen, we need to have a conversation. But before we start that conversation, I want you to know that I get it, that I understand why you're doing what you're doing." And, Terry, I tell you, the look on his face was—he did not know what was going on because he, you know, had an idea that something bad was gonna happen.

Terry: Well, I mean, they may have heard about some of the enhanced interrogation techniques.

Ted: Correct.

Terry: And probably thought water would've been used for a very different purpose at that point.

Ted: Could have been. Yeah. But I said, "Look, we have to have this conversation, but I get it. I understand why you're doing what you're doing." And he looked at me with a quizzical look of—he didn't know what to do with that. And I went in, I said, "Listen, if I was at my home, which is where I want to be, by the way, in the middle of the night, some people kicked in my door, and rushed into my house, and terrified my daughter, and scared my wife, and blindfolded me, and took me away from my family, I would be building bombs and blowing you guys up, too. So, I get it. I understand why you're doing what you're doing. But the thing is we have a common goal. You want us to go home." He starts to nod, and I said, "I want to go home." He starts to nod. "Here's the rub. Here's the deal. The more you blow us up, the more you shoot at us, the more you of us you kill, the longer we're going to stay and the more of us are going to come, and I want to go home. You want us to go home. So, I think you can see that we have a common goal, if you can look at it that way. Does that make sense to you?" And he keeps nodding.

He said, you know, through his translator, "Yes, that's exactly right." I said, "Okay. Good. I'm hungry. Are you hungry?" "Yes, I'm hungry." "Okay. I'm going to go get a sandwich. I'll be back in about 10 minutes. I'll bring you a sandwich, too. Is that okay for you? "Yes, that would be great." "Okay." So, I stepped outside that room, and shut the door, and I took a very, very deep breath because that was a huge challenge for me. I was personally invested and personally affected by the work this individual had been doing. And it took an extreme effort on my part to control my emotions and truly empathize. But I had the goal in the forefront of my mind: "This is helping us to go home." And it very often set the tone for interactions like that.

And I really believe that the same thing applies when we're dealing with these people who are in crisis. They're in crisis, you acknowledge their situation, you empathize with their situation, and you create a common goal, making them whole again so they can go home and be with their loved ones.

Terry: Nicely said. So, that's a really interesting way that you—I mean, bringing that experience into the CPI model is just fascinating to me. So, you had developed a lot of the concept of the Integrated Experience was something you had already developed in a more stressful situation than you would ever be put into where—well, not to speak for people who work in emergency rooms, certainly, but, I mean, seeing a foreign combatant who would have, you know, killed members of your branch of the military, I mean, I can't imagine what that must have been like.

Ted: I didn't have the vocabulary for it then. But that's exactly what I was doing. It was an Integrated Experience.

Terry: Wow. Well, thank you for sharing that. That's really a very, very enlightening story. So, how did the interview wrap up? Did you obtain from this person what you wanted to?

Ted: We had three days of conversation, is what we had. And through that conversation, I was able to determine the answers to the questions that we had to further exploit and interrupt that cell that was building bombs and placing IEDs.

Terry: What country was that?

Ted: That was Iraq.

Terry: It was Iraq. Wow. So, you had three days of conversation. And I guess you learned to be—and through this approach, you were able to form some trust with this man, and some connection, and he then opened up to you.

Ted: Yeah, I was able to develop some rapport, right, which really was key. You know, and let me be clear, that that didn't always work, right? Some of the people that we would deal with had a visceral hatred that no amount of empathy or acknowledgement could break through.

Terry: Well, really fascinating. You know, something you said during our pre-interview I think is very quotable, about de-escalation and restraint. And I think this would apply here. You said, "If we need to go hands-on, we've missed something." It sounds like there's really something very important going on with that thought. Could you expand on that for us?

Ted: Sure. I absolutely believe without a doubt in my mind that for 99% of the escalations, that if we have to go hands-on, we have to do restraints, we've missed something. You know, I'll often hear feedback, "Well, that guy just snapped." And I'll say, "Okay, well, I agree that it may appear that this person just snapped, and it came out of nowhere, but let's look back from the time that this patient entered our care to the point of escalation and examine that." There are indicators, there are signs that they show us. And if we are paying attention, we can pick up on those things and intervene early. Right? If we're proactive in our efforts, we come from a place, from pro-activity instead of reactivity, you know. And that points back and tend to us slowing down and paying attention. We're paying attention. If we're consciously aware of where we are at emotionally, right, we're better able to be consciously aware where they are emotionally. And if we do that, we can see those signs and intervene early, it often pays off in the end and everyone being safer.

Terry: So, it's just a way to—it's a statement to frame anticipating going into what could be a crisis situation, or you know a patient is agitated, if we need to go hands-on, we've missed something. Just to reframe where your own head is before you engage, I think it's very effective.

Ted: Yeah. We have to acknowledge that they're already in a crisis situation. They're already there. And I use the ED a lot as an example because that's where the focus of the training has been. Right? They're already in a crisis situation just by coming into the emergency department. They're there. Right? And how we interact with them can drive where that state goes, right, can drive how smoothly it goes. It's not their responsibility. That is not our patient's responsibility. It's ours.

Terry: Okay. And to close today, Ted, and—fascinating stuff. Thank you for sharing it with us. CPI's recently released a new training program called *Verbal Intervention*™. I know that you've had a chance to review some of our literature about it. I'm wondering if you thought it was well-designed to fill the training gap in the healthcare settings today.

Ted: I think that there are challenges to overcome. I think that you package it in such a way that it allows for the valuable content to be delivered to as many people as possible. Right? Because when we get down to it, it's hard to get leadership to invest time into the training, if you get my meaning.

Terry: I do.

Ted: I mean, it's always hard to, you know, to get the funding and the investment of time for staffing to do that. So, I think that's well-suited for that. Yes.

Terry: Do you think that verbal intervention skills, when you were training CPI, was something that people especially were enlightened by?

Ted: I think so. I think, you know, it's about coming up with a strategy and coming up with a plan on how you're going to communicate with these people, which haven't been a focus. You know, the focus has been clinical. Right? What's wrong with this person? What do they have going on with their tummy? What do they have going on with their shoulder? What do they have going on with whatever it is? You know, and they're seen as an object as opposed to a person, often. So, I think that that's valuable. There's a great video, and I don't know if you've seen it—the Cleveland Clinic put it out, and it's all about empathy. Are you familiar with that?

Terry: I have seen it, yes.

Ted: Yeah. And it gets me every time. It's so powerful. We don't know what these people have going on with them. We have to assume and approach them in such a way to consider what it is they're going through outside of their medical condition.

Terry: You know, I think the one you're referring to, it shows a number of—it goes close-up on people in a hospital setting, and then they're looking concerned, and it says underneath, "Just received a cancer diagnosis."

Ted: Correct.

Terry: And so, it really has the underlying situation that you could never glean from just observing them. And it makes you realize they could be in a totally different reality than you are in at that moment. And it makes you realize, you know, there's a story behind every face that you see.

Ted: Absolutely. Absolutely.

Terry: All right. Well, what inspires you these days, Ted?

Ted: My daughter, Norma, inspires me in every aspect of my life. What inspires me in my work is I consider it my duty to help keep our frontline medical staff safe, to enlighten them and give them tools that will help them go home safe from their campus, right? We all have, in our daily lives, we have highlights to our daily lives. Right? I'm sure you have them, right?

Terry: Sure.

Ted: I keep those highlights in the forefront of my mind on a daily basis because that's why I'm doing what I'm doing. You know, I go to work so I can come home and have a highlight with my daughter. Our nursing and our frontline clinical staff, they go to work so that they can come home and exchange their highlights. You know, we work so that we can live, but oftentimes, we find

ourselves killing ourselves with work. I think that the success of these workplace violence prevention programs are really—their effectiveness starts with our self-awareness. I firmly believe that. It's important work, you know. And I'm very enthusiastic that SB 1299 being put in place has enabled us to expand and touch healthcare workers who maybe have not been given the opportunity to learn these critical tools to keep themselves and their patients safe.

Terry: Is that California State Bill 1299?

Ted: That's correct.

Terry: Yeah. Okay. All right. Well, thank you so much, Ted, my guest today on *Unrestrained*. Unless you have a final thought, Ted, I think that was pretty good.

Ted: No, thank you for having me.

Terry: Yeah. Our guest has been Mr. Ted Sandquist of Blackstone Consulting. Thank you so much, Ted.

Ted: Thank you, Terry.

Terry: And thank you all for listening. —