CPI *Unrestrained* Transcription

Episode 11: Sarah Lohse

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Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone. Today I'm joined by Sarah Lohse, the Director of Behavioral Health Services at SSM St. Mary's Health Center in St. Louis. Hello and welcome, Sarah.

Sarah: Thank you so much for having me.

Terry: Thank you. Sarah earned her BSN degree from Southeast Missouri State University in 2004 and her MBA from St. Louis University in 2008. She began her work as a bedside nurse and worked in both pediatrics and on telemetry prior to work in leadership positions. After earning her MBA, Sarah worked as a charge nurse on a telemetry unit, then as a team leader and nurse manager on a medicine/oncology unit.

Three years ago, she began her current position as Director of Behavioral Health Services at SSM St. Mary's Health Center in St. Louis. Today our interview is going to focus on an entity at the hospital called BERT, or the Behavioral Emergency Response Team. BERT is based on a team approach that brings medical and behavioral health professionals together to work collaboratively when a patient is in the beginning stages of an acute crisis. The purpose is to distinguish between different kinds of escalating behavior early on and to ultimately decrease the use of physical restraint.

All right, Sarah. Can you begin by talking about the BERT acronym and the conditions at SSM and in the regional market that stimulated the creation of this team?

Sarah: Yes, of course.

Terry: Okay.

Sarah: As you mentioned, BERT stands for Behavioral Emergency Response Team, and what prompted the beginnings of BERT was the need for additional support for our medical units including the emergency department, outpatient areas, and just medical telemetry, ICU, those types of areas, emergency rooms, additional

support for those areas for whenever patients were escalating. How it began is I started in my position in January of 2012 and our VP at the time, who is still our current VP, Dan Body, identified that he had a vision that he wanted to try to provide some sort of resource team for those departments that I just identified. I had just come from medical, as you identified in my background. Most of my background is from medical, pediatrics, telemetry, medicine, oncology, and I didn't have any behavioral health experience.

I was acutely aware of what the needs were for medical professionals trying to provide de-escalation to escalated patients. I was really well positioned to try to help create a team and operationalize it to address the needs on medical because I had just been there.

The conditions were that in the St. Louis area there were a lot of predisposing factors that contributed to the need for this. We had several other facilities in our region that had recently closed that had behavioral health support so we had started seeing an influx of behavioral health patients to our SSM facilities. While the behavioral health employees were CPI certified and had the training needed to provide care in de-escalation, the ancillary areas did not. They were suddenly seeing these patients because, as we know, our behavioral health patients have an increase in medical co-morbidities and they don't always come straight to behavioral health.

We see a lot of patients that come into the emergency room for one reason; they may come in because they're suicidal, but we discover that they have a raging wound that needs to be addressed so they go to medical and then they become escalated on medical, and they didn't know how to de-escalate them. It had a lot to do with the conditions. There's an increase in behavioral health patients, an increase in medical co-morbidities, and a lack of resources in the area to provide support to the medical units.

Terry: It's almost like a perfect storm went into the creation of BERT.

Sarah: Yes. That is true.

Terry: I see. You have these patients coming in from other facilities that are closing in the regional area and an increased volume of patients and so you see this need and that stimulates you to create BERT. How do you go about choosing the team members and can you talk about maybe the departments' roles? How does this team get pulled together specifically to be part of behavioral emergency response?

Sarah: When I first started in behavioral health, the behavioral health leadership team met to talk about BERT. So our VP, Dan Body, said this is kind of what the vision

should be and then from there the leadership team . . . so I met with a couple other directors. I met with the director from our St. Joseph's Health Center campus. I met with a director from our De Paul campus. I met with our CPI champion, Matthew Rabbit, and we all came together to say, "Who do we think should respond? Who are the right people who are qualified? What additional training do they need? What resources do they need?" We came together and created our operational vision.

Terry: Was there a specific incident that said, "This has gone too far and we need to do this," or was there a collection, just a gathering opinion that this was required?

Sarah: No. There wasn't a specific incident. It was more a cultural change.

Terry: I see.

Sarah: When our VP, Dan Body, started in 2010 or 2011 (somewhere in there, it was before I came), he really set the tone for what the culture should be. And so he set the tone for we need to really be a center for healing. We need to be here supporting patients. We changed a lot of our language. We don't use verbiage such as "takedowns." We talk about physical interventions.

We really adapted the CPI model and so once . . . I think that he started in 2010 and we were on a good path within behavioral health as to where our culture was moving. This was really taking it to the next step to reach out to the medical units to really say, "This is who we are and what we're all about and we want to work with you to make sure that we're all on the same page."

Terry: I see. That's really good in understanding how this vision for the culture stimulated the creation of the team. Could you go back, Sarah, to the departments and roles and why they were picked to be part of the team?

Sarah: Yes, of course.

Terry: Thank you.

Sarah: We have, in St. Louis, St. Mary's, the hospital I work at, is a part of a bigger network. And in St. Louis, there are seven different hospitals. The pilot really started at my hospital, which is St. Mary's, because I was such an advocate for this program. It is now live at all of our campuses, and I can talk specifically about some of those other ones whenever there's variation, but for most of the conversation I'll be talking about my specific hospital, which is St. Mary's.

Terry: May I ask, Sarah, what made you so passionate about this response team?

Sarah: Because I worked in medical and I knew where the gaps were, I really came in to behavioral health knowing that . . . I really came in to behavioral health understanding what the deficiencies were, so my lens was so different. So many people that work in behavioral health have always worked in behavioral health and that's the only lens they have and that's what they see. Coming from medical and not being exposed to behavioral health, I had so much to learn and I was really seeing things very differently.

Terry: So that "outside looking in" perspective gave you a very fresh set of eyes about what sort of responses were needed to de-escalate.

Sarah: Yes.

Terry: Okay.

Sarah: Once I met with the other directors in behavioral health because, again, I didn't know a lot about behavioral health. I had just taken CPI. I was only in my position for a couple months. I knew what medical needed because I had just come from medical, but I didn't know the behavioral health side. That's why my first step was to meet with my counterparts in behavioral health to say, "Okay. I know what medical needs. Please talk to me about the behavioral health workflow, the resources, and the process. Tell me more about the culture, all of those things."

I then went back to my peers, my counterparts, and I knew that I would need to involve nursing operations, security, and our operators at a minimum. We had a meeting with our administrative director of nursing operations, our team leader for security, as well as the person who's over the operators, and said, "This is a vision for what we want to do. We want to create this team that's going to provide a resource for the emergency department and medical units whenever a patient escalates. Here's what we're thinking but we need you guys to be a part of it. It can't just be us. We need to work as a team. Are you on board? Are you supportive?"

They said, "Absolutely. Tell us what we need to do." They were just as excited as we were. The response team involves, we send one of our charge nurses from behavioral health. They typically bring one of our psych techs that have a bachelor's degree in psychology or sociology.

Terry: Sarah, may I interject? Is this after a call has come through?

Sarah: Yes.

Terry: Okay. So this is a scenario that would set the team in action.

Sarah: Right.

Terry: Great. Okay.

Sarah: The actual response team consists of the charge nurse for behavioral health as well as they typically bring a tech with them unless, for some reason, they can't, but they usually bring a psych therapist, which has a bachelor's in psychology or sociology. Our administrative or nursing supervisor responds, and security, so we have four responders.

Terry: I see. You have the charge nurse, the nursing supervisor, security, and—

Sarah: Normally one of our techs.

Terry: And a tech as well. Okay. Now what's a scenario that calls the team into action? What sort of real-life examples where someone is—How far along are they? Can any one of these members notice this happening?

Sarah: Normally it's called by someone on the floor.

Terry: Mm-hmm.

Sarah: It's normally the bedside nurse or the bedside tech for someone who's working on a non-behavioral health unit.

Terry: Okay.

Sarah: It's normally down in the emergency room or it's on a medical floor. We get a wide variety of calls. Let me back up just a little bit to tell you about the code that we already had in place.

Terry: Okay.

Sarah: Before BERT, we had what's called the Code Strong. A Code Strong was for any type of escalation. It was an overhead page so as soon as someone was escalating staff would call our emergency hotline number, which for us is 4444, tell the operator they needed a Code Strong, and then everyone who was available responded. The Code Strong is still in place. We haven't gotten rid of Code Strong. The idea of BERT is to supplement it because you are going to have patients that are going to go from zero to 100, that are going to go from zero to super escalation in two seconds flat, and you do need a lot of people to respond to that.

Terry: Mm-hmm.

Sarah: BERT is designed to supplement it in when you know someone is escalating. CPI teaches us the four stages of escalation: anxiety, defensiveness, acting out, and tension reduction. When we do education, when we rolled this out and we did education to the staff working on medical and in the emergency departments, what we told them is recognize these stages. When a patient is anxious or defensive, call a BERT. If the patient is acting out, call a Code Strong.

Terry: I see.

Sarah: That's how we tell them to differentiate it. It's not always consistent. You get staff that panic and go ahead and call a Code Strong when it really should have been a BERT, and sometimes you get them calling a BERT when it probably should have been a Code Strong. So it's not perfect but at least now we have different levels of response for the different levels of escalation.

Terry: I see. That's good. I see that BERT would precede the Strong. When the BERT team is assembled who takes . . . how do you decide? Is it usually the charge nurse that takes the lead?

Sarah: Yes, the behavioral health employees. When we provided education for the responders, what we told them is that the behavioral health responder is in charge. They take the lead. If at any point it becomes a Code Strong, then there may be a dynamic where security takes over. It really just depends. We're very fortunate, particularly at St. Mary's. We do work very well with our security team so we've always been able to have a good relationship with them.

Terry: Okay. You guys have something for BERT called the "go bag" that is brought along with you when you go to a situation that's escalating. Can you describe what that is and what's in that?

Sarah: Yes. The reason that we have a go bag is at my campus in particular, and this is also true at one of our campuses, is that we are not located right in the main part of the hospital. We have . . . the campus that I'm on, St. Mary's, we have the main building and then there is a bridge that connects us, the building I'm in, to the main hospital. We're on the fourth floor so anytime we get a BERT we essentially have to run down two flights of stairs, across a bridge, and over into the main hospital. We really need to have everything we could possibly need with us because to go back and try and get it is going to take way too much time. The purpose of the go bag is that we have a binder that has all of our paperwork in it, which is one of the most important things.

Terry: Sure.

Sarah: We fill out a form that we use for data tracking whenever there's a BERT, and it gets filled out by our behavioral health charge nurse. And it's basically just a bunch of check boxes. There's room to write a narrative, but the idea behind it is that it's very quick and easy so they should not be spending more than a minute or two filling it out. We also have in that binder involuntary paperwork. In the event that a patient would be escalating and say they're wanting to leave and they're actively suicidal and we need to make that patient involuntary, we have the paperwork we need to do it right then and there.

Terry: Right.

Sarah: Also in the bag we do have a set of our nylon violent restraints.

Terry: Mm-hmm.

Sarah: I do not believe . . . as far as actually using the nylon restraints, we have maybe used them once or twice in the two years that this program has been active. We have had to do therapeutic holds to administer medication, but that's the most common type of restraint that we would do when responding to a BERT.

Terry: Could . . .

Sarah: They . . . Go ahead.

Terry: I just wanted to maybe put that number of two, twice, into perspective. How many times has the BERT team been called into action in the last two years?

Sarah: Oh my goodness. I do not have those numbers in front of me.

Terry: Okay.

Sarah: We get on average . . .

Terry: A couple hundred or?

Sarah: We get on average probably about . . . oh it's more than that. We get on average probably about one a day at my campus so we have . . . and that's on average . . .

Terry: So potentially we're looking at 700 or 800 of these.

Sarah: Yes.

Terry: Okay. That's a lot.

Sarah: Yes. They get calls very frequently, very frequently.

Terry: So it seems like there's definitely . . . the need is definitely there. How about the challenges and successes that the team is encountering in these hundreds of interactions?

Sarah: The greatest success of this is really the qualitative feeling that the staff has over on medical. When I round, and I talk with them, they just feel so more supported. They feel safer. They feel like they have additional support.

Terry: Mm-hmm.

Sarah: It's really not something that is easily quantified or measured. As far as some of the challenges that we've seen, we have not really seen a result in injury. What we have seen . . . I'm sorry. What I should say is we haven't seen a result, a reduction in employee injury. We have seen a change in the type of employee injuries that we're getting.

Terry: That's interesting. Hopefully less severe.

Sarah: Yes. Less severe, but in general, we've seen a shift in the culture when they report. When we first started this, we would see things, because I sit on an employee safety team and we go through and read occurrence reports that get filed from employee injuries. You would see things written by a floor nurse that says, "I entered the room and the staff member had the patient in a headlock." You don't see that anymore. Those are things that we're not necessarily quantifying but just the change in the verbiage, a change in the culture, a change in the approach from our partners in medical.

Terry: Well, it would seem logical to assume that if those headlocks aren't happening, that (lack of) contact between people is going to eventually buy down physical injury or confrontation, of putting your hands on in other words. I don't know if there's such a thing as a typical encounter but . . . so you guys have to, it gets called in, there's some walking or the team takes some time to assemble and at that point . . . Now how long is a typical encounter with BERT been lasting? Do you have a feel for that?

Sarah: Yeah. It normally lasts about 30 minutes.

Terry: Okay.

Sarah: They really can't do it much faster than that. It should take between 30 and an hour. Anything longer than an hour, we have some opportunities to communicate a little better.

Terry: Mm-hmm.

Sarah: The average one is anywhere from 30 minutes to 60 minutes.

Terry: You're finding that this is generating a feeling of greater safety and confidence in staff.

Sarah: We've had a reduction in Code Strong.

Terry: Okay.

Sarah: That has been our biggest quantifiable success.

Terry: Mm-hmm.

Sarah: Is that as we saw BERT increase we saw Code Strongs reduced.

Terry: Mm-hmm.

Sarah: Our thought behind that was whenever a Code Strong was called it was all available staff but it was usually all available males that responded.

Terry: I see.

Sarah: They were not CPI trained. Our perspective is that anytime we can reduce the number of Code Strongs that is a win because we don't want people who aren't CPI trained responding and feeling the need to put hands on patients. Even though we haven't seen the quantifiable success in reducing employee injuries, we have seen a quantifiable success in the reduction of Code Strongs.

Terry: I see. You said that there was a palpable sense of greater comfort among responders since BERT.

Sarah: Yes. Not responders, the employees, the recipients, the employees who are activating the team.

Terry: Oh, okay. So not the people who actually form the team.

Sarah: Correct.

Terry: The people who are actually calling for it to be assembled because clearly they know that the skilled team is going to show up to deal with this escalation.

Sarah: Right.

Terry: That would create great comfort, I think, for anybody who would be on the front line of that.

Sarah: It's also given our staff, the behavioral health employees, a sense of confidence and a great sense of pride in what they do because they're going and they're the resource and it really reinforces for them that the work that we do on behavioral health, that their skill required, that it's valuable. It has provided a sense of pride for them as well.

Terry: In the exercise of that judgment they get a sense of ownership in the process.

Sarah: Mm-hmm.

Terry: That's excellent. Can you talk about the BERT doll a little bit? It would be interesting for people to imagine what that is, I think. There's a mascot for the BERT program there.

Sarah: Yes. I have to say that he is a big part of why we were so successful. It really is something that just happened by accident. When a staff member calls the emergency line, the 4444, and says, "The patient's throwing green beans at me. I need the BERT team," and they tell the operator, "The patient's in Room 368. Please send the BERT team," the operator has on their screen, they have to click on an icon for any type of code whether it's a code blue, code strong, code whatever, they have to click on an icon to send a text page and then it goes to beepers to the people who are going to respond.

Terry: Mm-hmm.

Sarah: The IT guy emailed me and said, "What do you want the icon to be?" We were searching all around trying to figure out the icon, and we have a brain and we had the psych symbol and then we stumbled across this little guy that says, "Have a stress-free day." We thought, "That's kind of cute. Let's make him the icon."

Terry: I should describe it or you can if you like. It's a little, what we used to call a little troll doll with the long hair and the big smile and the open arms. Go on, sorry.

Sarah: No, it's fine. He's actually a stress ball.

Terry: Oh.

Sarah: When you squeeze him he talks. Whenever we made him the icon we then ordered a bunch of them and got him labeled with BERT and our logo on the back. People love them. They're everywhere all over the hospital, at nurses' stations, on desks, in offices.

Terry: Oh.

Sarah: When you squeeze him, do you want me to squeeze him so you can hear what he says?

Terry: Sure. Yeah.

Sarah: All right. Here's what he says.

Doll: Woo-hoo, do I feel great! It's going to be a stress-free day today. Hee hee hee.

Sarah: When we started promoting BERT, we ordered a bunch of these and started distributing them and telling them, "This is BERT and here's what it is. Please call us." Everybody loved the BERT doll so it was a real quick . . . they immediately got it. They immediately got what it was all about.

Terry: What a great tie-in that just as a visual and then just as an identity for the BERT program. That's fantastic. Is there anything else, Sarah, you'd like to add in today about BERT that I haven't talked to you about?

Sarah: Just wanted to reinforce that, like I said, it originally went live at SSM St. Mary's Health Center in St. Louis. We also went live with the pilot at St. Joe's Health Center in St. Charles, which is a suburb of St. Louis. It is currently live at all of our facilities within the St. Louis region, all SSM facilities within the St. Louis region including Cardinal Glennon, our children's hospital.

We had to slightly modify it. Cardinal Glennon, because they are so specialized because they do purely pediatrics, they really took ownership. We said, "This is what we've done at the adult hospitals," and they said, "Okay. We'll take that and make it our own." They added a social worker to respond to their BERT because a lot of their escalations are not the kids; it's the parents.

So they added a social worker to really address a lot of those issues. It's probably the only other thing that I wanted to add. Oh. The last thing that I wanted to add is that we have specified that for all the adult hospitals, BERT is only for a patient.

Terry: Mm-hmm.

Sarah: At all of our facilities we, as clinicians, don't lay hands on visitors.

Terry: Right.

Sarah: Only security does that.

Terry: Mm-hmm.

Sarah: There's a separate code for if there's a visitor escalating. That has the potential to change in the future and at Glennon. Obviously, all they're really dealing with are visitors. So theirs is a little bit unique and a little bit different. So if anyone has questions about Cardinal Glennon specifically or pediatric facilities, you can let me know and I can connect them with someone at Cardinal Glennon.

Terry: Excellent, Sarah. Thank you very much. My guest today on *Unrestrained* has been Sarah Lohse. She is the Director of Behavioral Health Services at SSM St. Mary's Health Center in St. Louis. Thank you very much, Sarah.

Sarah: Thank you so much. It was a real opportunity. I appreciate it.

Terry: All right. You're welcome.