CPI *Unrestrained* Transcription
Episode 26: James Gulbranson & Paul Ruegemer – Part 1
Length: 51:47
Host: Terry Vittone

Terry: Welcome to *Unrestrained*, the podcast series from CPI. Here you can enjoy conversations where professionals on all sides of crisis and behavior management relax and open up about themselves, their workplace, and their clients. You'll get the latest tips and trends from the best in the business, so tune in often to integrate their experiences with your own.

Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone. Today we have the privilege of doing a video podcast with Mr. James Gulbranson and Paul Ruegemer of St. Cloud Hospital that is part of the CentraCare Health System in Minnesota. It is a nonprofit health system that includes six hospitals, seven elder-care facilities, 18 clinics, and numerous outpatient and inpatient services. Hello and welcome, James and Paul.

Paul: Thank you.

Terry: Let me tell you a little bit about our guests. James Gulbranson is a safety and security specialist for CentraCare Health and has worked in the security field for 14 years. He is also a licensed Minnesota police officer with five years' experience in law enforcement. He is a taser, baton, and handcuffing instructor who has trained both police and security personnel. James has been certified in CPI's *Nonviolent Crisis Intervention*® [training] since 2011 and our *Prepare Training*® program since 2014, and he has taught over 1,500 hours of the training programs to over 3,500 healthcare professionals at CentraCare. He is married and has three boys ages 5, 8, and 10. In his free time, James likes to golf and competes on a men's roller derby team.

Paul Ruegemer has been a safety and security officer for CentraCare Health for 10 years and has worked for the organization for 12 years. He is a taser, baton, handcuffing, and use-of-force instructor, who has trained both police and security personnel. Paul is certified in CPI's *Nonviolent Crisis Intervention*® and *Prepare Training*® programs and has taught over 2,300 hours of *Nonviolent Crisis Intervention*® [training] in the last four years and over 100 hours of [the] *Prepare Training*® [program] in the last year. Paul has trained over 5,000 healthcare professionals in CentraCare. Paul has a wife and two children that are 1 and 3 years old. In his free time, Paul likes to hunt and fish and spend time in his cabin in Tower, Minnesota.

James and Paul gave a presentation titled "Practice-Based Evidence" at CPI's Instructor Conference in New Orleans last July, detailing the hospital's implementation of CPI training and the positive outcomes it has helped to produce at CentraCare Health. We are fortunate that they are willing to give that presentation for us again today, so our Certified Instructors and other interested people around the world can enjoy and learn from it. If you're ready then, James and Paul, please begin.

James: Thank you. So I'll give a quick overview of some of the topics we're going to cover today that we covered at the conference. First thing we're going to talk about is a little bit more about [the] CentraCare Health entity that we have, the different hospitals, the different clinics [that] were alluded to, and some of the different staffing issues we have at those locations.

We're going to talk about the history of CPI, both [the] NCI [*Nonviolent Crisis Intervention*®] and PTP [*Prepare Training*®] program and training that we've had at CentraCare Health. Again, talking about successes we've had there and how we've used both NCI and PTP to train our staff and make them better prepared to handle these kinds of situations. We'll show some graph examples of some positive outcomes we've seen over time through using this training.

Again, we'll touch on some reductions in high-level aggressive incidents. We'll talk about staff being better prepared and feeling safer at work, which is really important. And then we'll also spend some time talking about the *Crisis Development Model*℠, how we use that model to try to develop more strategies and more tools for our staff to better prepare them to deal with aggressive, escalating behaviors as they do occur.

So to start off, we'll talk briefly about CentraCare Health. Our main campus is in St. Cloud Hospital, Minnesota. We have a predominant amount of our staff, security staff, at that location. We are staffed with security at a few other of our off-site locations as well. Again, like Terry mentioned, we have our primary campuses at St. Cloud. We also have five critical access hospitals throughout central Minnesota. We have a number of clinics. We have a number of outpatient service departments as well. Some of the other areas and some of the staff we trained are everything from social workers to home care staff, to therapists, to daycare aides in some of our locations.

So we have a wide variety of staff that we train, both inpatient and outpatient style staff that we have in our locations. We also have nursing homes, long-term care, assisted living facilities, and training staff there, obviously, that's a little bit different environment. They're not dealing with some of the same circumstances that an inpatient hospital staff would deal with or mental health staff member or any of our staff members would deal with.

We really like the NCI program and the PTP program, especially because it's so versatile and it can work in a variety of settings. It works for young. It works for old. It works for any of our inpatient, outpatient facilities. So it's a good program, and it does allow us that ability to tailor the content we need to have to the staff's most pressing needs, and that's one of the definite benefits we've seen using this program.

We started—the NCI program started—when a couple of ER staff members wanted some extra training for their staff. They brought the NCI program into our facility, and it was initially just a training for ER staff, mental health staff, and security staff. Those were the only assigned staff who would go through the program, and for about two years it continued in that manner.

Eventually, with the observation that we had an increased level of aggressive incidents, increased level of people being more difficult—challenging, nonproductive behaviors from both patients and visitors—it was determined that we would want to provide a little extra training for all staff in our facility. And in 2012, a decision was made to move forward with training NCI program to all of our patient care staff in our facility.

Want to talk about that for a minute?

Paul: Sure. So we rolled it out in 2012. We did a two-year requirement to roll that out. So all the staffers had two years to get through the program. We had roughly 3,500 identified staff members to go through the program at that point, and so we were offering classes, evenings and weekends, to get this done. As we rolled this through, we've seen a lot of very good changes at our campus, at the St. Cloud Hospital campus, and we'll show some graphs of that as we work through the presentation, showing those good changes throughout.

After we identified and we got through all the staff members at our St. Cloud Hospital location, we then rolled out NCI to all of our five critical access hospitals and all the other off-site type of locations, offering them as an option, and then they slowly have been coming on board, mandating it for all of their patient care staff as well.

Initially we added, as James said, the PTP program. We added that in 2014 for our non-clinician staff. We'd identified non-patient care staff members, business office, HR type of staff to be able to come to [the *Prepare Training*® program] as well, as they were requesting some sort of additional training as to what to do with somebody who is becoming aggressive or violent at that point as well.

James: And that was definitely a learning curve in terms of identifying the appropriate staff to have the appropriate training. And when we looked to provide some extra training, again, for, Paul talked about it, grounds-keeping staff, maintenance staff, business office staff, other staff that maybe even have some patient contact, nutrition services, housekeeping staff, what training best fit their needs, and we really liked that PTP program for a couple of reasons. Granted it was a little bit shorter, but obviously, for budgetary reasons, that can be an advantage, but it was aligned with the NCI program. The verbiage was very similar. The *Crisis Development Model*℠ was still in place. So we found that everyone was having the same verbiage taught to them. Everyone was understanding that Anxiety stage. Everyone was understanding the verbal stage, and then at that physical stage, how to best respond.

So we made sure everyone on campus, not just our patient care staff, were kind of up to that right level of training, and everyone was using the same terminology. That's definitely a big change we saw. A good example of this in security, especially before we started this training, we'd get a call from a staff member saying, "I've got a guy up here who's really angry." That can mean a lot of things. When we talk about this training for staff, we help them to identify. Is the person in your lobby, arms crossed, pacing around? That guy could be angry, yeah. Is he standing at the desk yelling and screaming at you, at the Defensive stage? Yeah, that guy is angry as well. Is he throwing a chair at you? Is that guy angry? Yeah, he's angry as well, but their behavior is going to dictate our response.

We really worked with staff to identify what behavior are we seeing and really keying that into what's our best possible staff response, and that goes for our patient care staff as well as, again, non-patient care staff that do come in contact with a lot of our clients, our visitors, and patients as well. So we really like the integration of using the PTP and NCI program for assigned staff. They gave us a lot of flexibility in our training as well.

Paul: First thing I'll talk about here is one of our graphs that we're going to pull up. It's our percentage of initial NCI staff members trained, and so as it works through you can see we started off with July of 2013, and that's when we had the big push to start. We started fiscal year July 2013, end of 2012, for fiscal year. We got everybody trained up as you guys see. When we get to about May of 2013 or so, '14 fiscal year, towards the end of that fiscal year, we had roughly 90-ish percent staff members trained. That's a key number because that's when we had almost all of our staffers trained, and you'll see that as we work through the rest of our graphs, the changes we've seen at our facility as well.

We did have a—when we look at our graph that's pulled up, you'll see a decline that occurs. What ends up happening there is we identified multiple other staff members that need to come to NCI. And so that kind of reflects that change of bringing more people into that, and we slowly got everybody trained in our NCI program for our entire campus.

James: Again, at that point where it looks like there is a drop-off, as we're seeing more and more success, as you can see we ramped up our training pretty considerably from just the handful of ER and mental health and security staff in our facility up through the identified 3,500 or so staff that needed to be trained.

As we were having more staff trained, as there was better word of mouth, as we were seeing even good results in the early stages, more areas, more departments, more staff wanted to be brought in on this and wanted to be—to be able to go to this training. So, again, we had a little bit more hiring and we had a lot more staff directed that should be going to this training.

You can see as the graph goes forward, we are trying to get close to that 100% mark of all identified staff, and generally at this point, we're floating pretty close to 100% as new staff come on board. We train them within the first three months of hire, but it usually happens even quicker than that. So we try to get everyone on board. It's part of the new staff process as well as getting them signed up for their NCI class. It has really become a cultural shift in our organization, but that is a really important part of the training they receive anywhere in our facility.

Paul: All right, our next graph that we have pulled up on your screen will be our work days lost and our work days modified due to aggressive incidents. As you can see, in fiscal year 2012 we were quite high with our days modified, which means a staff member is unable to perform their normal duties and they are assigned other tasks throughout our hospital. They are obviously not doing patient care. And then our days lost, obviously them being off.

As you've seen from our previous graph, Percentage of Staff Trained [in *Nonviolent Crisis Intervention*® training], there is a direct correlation as we get to fiscal year 2014, of that

dropping off substantially of days modified and days lost, coinciding with our *Nonviolent Crisis Intervention*® training.

There's no other variables that were factored into that. There's nothing else that really changed at CentraCare other than NCI being rolled out, and so we've seen that dramatic decrease in days modified/days lost by our staff members, which obviously really pertains to our NCI program, really gives us a good snapshot at how this has helped our hospital and our staff members at this point.

James: And I think that two years seems like a long time when you've got that large amount of staff that you identified to go through. You know, thousands of staff. I think having it at a shorter time period like that was important because you got everyone quickly up to a certain level of training and experience and readiness. And again, as you can see here, and as we'll see going forward in some of our other data examples, some really meaningful changes occurred that really can be directly related to the training staff received.

Again, talking about—I'll break down a little bit how our classes go as well. We limit our classes to—if it's one Instructor, we have 12 staff in the class. It'd be capped at 12. If we have two Instructors available to teach, we do a class of up to 24, and then if we do have three Instructors, it would be 32. But generally, we focus on two Instructors and that 20 to 24 staff member range, and that does give us that good amount of time. It gives us 8 hours to work with a small group of staff, really focusing on their needs, their concerns, and they get some one-on-one time that really helps them ask the questions they maybe need to ask and gives us time to answer those questions in a meaningful way, again, using the CPI model [*Crisis Development Model*℠] as our guide through that.

So beneficial, and again, those small group sessions really are beneficial, and again, we'll see that going forward here.

Paul: Absolutely. Our next slide we have is our total workers' compensation expenses due to aggressive incidents. So when we started tracking these, we worked through when we started, again, at fiscal year 2012 prior to us starting the NCI program rollout. As you see, as we got to fiscal year 2014, you see the significant drop-off on the graph of workers' compensation incidents. And so again, just getting back to staff members getting done through NCI and this change that we're seeing of less injuries, less problems with staffers who need to be off work, less expense for organization as well, as far as for workers' compensation.

And so again, that really gets home the fact of NCI being done has really had a big shift at our facility, and we'll talk through that as we work through. James will talk about our sitter hours here.

James: So I added this information as well. It's important, especially when you're looking at, and again, we had a great amount of support from our leadership up through the level of president and vice presidents at our facility that identified this idea of violence and healthcare in the workplace, but in healthcare in general. Very behind helping staff, very behind providing services and what we needed there in terms of basically staffing hours and

the financial end of it. So we had a lot of good backing from our leadership early on. And again, we mandated this program for staff well before it was a statewide mandate to have all staff trained.

So I think we're really ahead of the curve and really have to thank the leadership that we have in our organization for providing that extra resource and providing that encouragement to do these programs. In looking at trying to roll a program like this out for a larger entity, like a hospital—trying to find where does this save us money, where does this help us, where does this not only provide good care, but we also want to look at the financial end of it.

One thing that came out of this in looking at some of the documentation here is our sitter hours. Those are where staff are assigned to sit with a patient. Some could be for medical reasons, like fall risks or pulling out tubes, and some can be for people who are suicidal, on a hold, etc. in our facility. And that takes us—certain staff members have got to be in the room 24/7 with this person. And looking at going from 2012 and going forward, you see the amount of time that we're assigning sitters to patients has steadily decreased.

Now, again, our patients that are fall risks haven't changed a lot there, but the amount of sitter hours we use, I think, partially has gone down because of extra staff training and really thinking about what does this person need. Does someone need to be on a one-to-one sitter? Can we just provide some extra rounding with staffing? Can we provide our staff better training so that they can deal with these issues as they occur with their patients and maybe not require that sitter? Because in the past, a lot of staff would see a patient as being potentially difficult and want to have that sitter just to take the load off and not have to deal with them so frequently and have staff on there at all times, but maybe that was not always the best choice.

So by getting all staff some extra training, they felt a little more confident to maybe handle some of these situations without tying up as many resources. So, again, looking at some of the documentation here, you can see over time the amount of sitter hours we utilized did decrease as well. So that's one thing to look at in terms of cost savings as well, so certainly good.

Paul: Our next graph, we have—we're showing our violent incidents. We do have a reporting system for violent incidents, even if somebody isn't injured or hurt. We have this reporting system, and so our next graphs, we break them down into different levels, one through five, which is done by our occupational health department. So they are identified. They meet with the staff member and classify it in a number as far as what type of event had occurred.

So when we start on our graph on the top left, it basically just talks about near-miss. It's talking about lower-level type of situations because, as you see, as our NCI got trained [staff was trained in the *Nonviolent Crisis Intervention*® program], those numbers went up.

A lot of our lower-level incidents, which are the top two, and working our way down are the lower-level incidents, and those went up, and we had some questions as to why we're

getting more of these happening. One of the things we really push in our NCI programs and PTP programs and any of our educational programs is making sure we're reporting what's happening because if we don't report what's happening, we're not likely to get the resources to help solve this problem that's happened.

So we had a very sharp increase in reporting. It's not that there was any more incidents occurring; it was a fact of staff were now feeling enabled and empowered to report what they had going on there, and as we look at those graphs, we work our way down towards the level four, level five, where we're talking about staff member injuries, staff members off work. It coincides directly with our other graphs of those that went down.

We had a higher level, and now they're trending down, and so that goes to the fact of higher reporting, but yet we're reducing the higher-level incidents, and that was the big payoff going to NCI, PTP, and so that we could get the staff trained, get them reporting so we know what's going on, so we know where we need to add things or we need to add more resources. So that was an important one as well, as we're working through the program.

James: Looking at this as well, the higher level, increased level, of staff dealing with people that are more verbal, dealing with people more at that Anxiety stage or Defensive stage, that's where we want people intervening, and that's the big thing we push for is we should be intervening at that stage before it gets to that level where there's a physical intervention needed or assault occurring.

We did see those numbers increase in terms of staff reporting dealing with people who were more agitated, who were yelling or swearing or shouting, because we empower the staff to deal with those behaviors at lower stages, and oftentimes, we could stop it at that point before it did escalate any further.

So that's another reason we saw that big increase in lower-level numbers and we see a big increase in our security calls as well that we know that over time, we can talk about that in a little bit as well.

We'll now look through some of the changes we made as a result of our NCI training, as a result of our PTP training for staff, and how it correlates. And the model we really used was that *Crisis Development Model*[SM]. How do we empower staff at each of those stages when they're dealing with behaviors that are occurring? How do we best empower them to manage those behaviors, deal with them, and have the resources they need?

In looking at the first level here, that first stage of the crisis model being Anxiety, how do we best intervene when people are at that level? This stage was probably one that we maybe had the most trouble selling to staff. And I know for Paul and myself when we went through the training, this was the stage we went through quickly as well. We didn't really think it was as applicable. Am I supposed to just walk up to somebody who looks angry or upset and ask them what's going on? Ask them what we can do?

It seems counterintuitive. It doesn't seem natural, but as we train through this, as we put these methods into practice, you can see how they can be really effective and can help

somebody and can stop a situation from escalating. You've got someone in a lobby who's upset about the wait time. They don't know how long it's going to be. If staff doesn't talk to them, they could eventually escalate to the point where they're being verbal or more. Just telling staff, even approaching someone who looks upset and telling them a reasonable expectation of the time of the wait. Now this is how long a wait time is. This is when we're going to get you in. This is what's going on.

Keeping them updated can be a form of this relieving that anxiety that comes at this stage. So really getting staff just to appreciate when they identify something that's out of place, in a patient, in a visitor, something that's out of the normal behavior that they normally see, trying to intervene, trying to take that time to intervene at that point before it could potentially escalate.

Another big push we added in as a result of this training for staff was calling for extra help. A big thought in nursing that we found from a lot of staff that had been there for 10, 15, 20 years was the expectation, even on themselves, was they deal with the situation on their own until it's completely beyond the point where they can handle it anymore—usually at that physical stage.

We really worked with them and talked with staff, identifying that you can call for staff. You can call for assistance earlier, and oftentimes you should be calling for some extra help, and that extra help could simply be another coworker. It doesn't necessarily have to be a security or law enforcement or any kind of special team you have in your location.

If something doesn't feel right, if you're concerned about a behavior, trust that instinct—call some extra help in. Call a coworker to stand by while you talk to a patient. Go in with two staff members if something doesn't feel right, making sure you take that little step because oftentimes after an incident, maybe a higher-level incident, we talked to staff and they identified early on that something didn't feel right. They were feeling uncomfortable in a situation, but they didn't take any steps there. So really empowering staff to know if something doesn't feel right, call another staff member. Call security. We'll come up; we'll stand by. We'll assist you with any situation, or even at these lower-level stages that maybe seem like we should just avoid the problem there.

Paul: And then we'll talk about this anxiety, this nonverbal behavior (for all of our Instructors, obviously out there, you know what anxiety is). So again, that nonverbal type of behavior, and the big thing, when you really think about when we're instructing these programs, is trying to bring in examples from the real world and bringing in examples obviously from work as well.

When me and James started teaching this program, the primary staff teaching us were mental health nurses and ER nurses, and the problem we noticed as we were rolling this program out was all their examples were from the ER, from the mental health, and when we have an oncology medical ICU nurse, it's hard for them to relate to that when we're talking about ER/mental health.

So being able to bring in different examples. An example I like to utilize at this anxiety nonverbal stage (we're talking about nonverbal) is thinking about what you would expect if you were in the situation or if you were in their shoes. The example I give is if you're out to eat at a restaurant and the glass of whatever you're drinking is empty. What do you do first to get the message to the waiter/wait staff that you need a refill? What are you going to do at that point?

Oftentimes, you're moving your glass at the edge of the table, staring at them, slurping your straw; you're addling the ice. You're trying to send them a nonverbal message, and it's the same thing as we identify with our patients. Our patients are doing the same thing. They're coming into our lobbies tapping their feet. They're looking at their watch. It's the same thing, and so if we go up and acknowledge it, just like that drink glass example, if that waiter/wait staff comes up and acknowledges you and refills your drink, there's nothing more for us to do at that point or for them to do.

And so think about that in relation to us at work as well of what do you want to have somebody doing when you come in here, and taking that step to do that, of telling people how long it's going to be, how long the wait is, etc. Same example as that drink glass. If our needs aren't met, and now we're sitting there and they've walked by five or six times not refilling that drink that's on the side of the table, now we're going to do something different, and now we're going to bump up behavior.

So what we want to try to prevent is patients, clients, coworkers, etc., from bumping behavior because we're not getting that nonverbal message. We don't want them getting to that defensive, verbal type of stage because we didn't get it, and so it's picking up on behavior, and that's an important one as well. We talked a little bit about that defensive verbal stage, and we talked about this with our staff members. It's being able to recognize what do you need for a team because obviously that verbal stage, as we all know, can look a lot different depending on the person.

And so again, identifying what do you need for that team, what do you need to call at this point? Oftentimes, this is where for our verbal situations we're telling our staff to call our B.E.R.T. team, which is our Behavioral Escalation Response Team. Me and James, we'll talk quite a bit more in depth on our B.E.R.T. team a little bit later on, but again we're calling that B.E.R.T. call. This is for that verbal patient.

This team has 10 minutes to get to that location. It only consists of three people. It consists of a mental health staff member, a nurse generally; one of our security officers; and then a urology tech/orderly staff member. Again, they have 10 minutes to get there. They meet with the nurse from that unit, from that area. They meet with them, consult with them, come up with a plan, possibly meet with the patient. They might bring in other resources like pharmacy, psychiatry, etc.

But this team is there as a resource, as a consult to help our staffers and the rest of the units and really to model and show what this can look like, and we'll talk more about B.E.R.T. numbers later on, but again calling early, intervening early is our big push as James alluded to earlier. Oftentimes, what used to happen is staff would wait until that person is

throwing a chair or they're punching somebody, and they'd wait until that last minute to call anybody. We're really encouraging people to call early, intervene early.

Another big one from a slide we've pulled up, calling security early, having security officers intervene early. Again, with all of our staff members that are in St. Cloud campus that our patient care staff members trained in NCI, there's never anybody showing up that doesn't know how to deal with these incidents that are occurring, and so we have that advantage of having everybody trained. We know that whoever we're calling, they're going to know what's going on, and they're going to know how to best intervene at that point as well. And so that's quite a bit to our advantage as well.

James: Another change we made in our program, and over time with any program, it can be repetitive if you have staff going and refreshing every year. We found that if we had any complaints from the program, it was that the refresher program was the same every year, and staff wanted to see something different.

We went to one of the CPI conferences and did a breakout session about refreshers and found out there's a wide variety of NCI refreshers that are available to be used to meet that refresher need, and so going forward, we'll actually be rotating. We do our Key Point Refresher. This last term here, we've been doing the Setting Limits refresher for all of our staff going through, and there's a lot of other options out there. And we're going to rotate back between the key point, and this year it's going to be setting limits, and then it'll be back to the key point, and after that we'll choose another refresher option.

One, to keep staff engaged, and two, it gives us the ability over time to see what issue does staff most need extra help on or are requesting extra assistance on. We chose the Setting Limits refresher for this term of training because we felt it could maybe best meet the needs of a widest majority of our staff. A lot of staff think setting limits is just when someone has difficult or challenging behavior. How do we manage that? And that's certainly a big part of it, but part of that, too, is what kind of limits, what kind of boundaries, do we set before issues even occur? How do we manage the situation? How do we state our guidelines maybe before a situation even needs to have a limit set there?

So we have a lot of staff going to this program, and we've seen some good results coming from it. So a good tip we had there was to alternate refresher programs to keep it fresh, keep it interesting for our staff.

Going back to the B.E.R.T. my colleague Paul talked about, another reason we wanted to add that program in, this B.E.R.T. team, is that we saw a lot of people calling for our high-level team (which we'll talk about here shortly) at this stage, when someone is upset, yelling, or shouting, or swearing.

Oftentimes in the past, staff would call for our large response team, and if you've got someone that's upset or angry and you run 15 people into their room, that does not calm the situation down. It never makes the situation better. We found that oftentimes our staff response at this stage was escalating the behavior and making it worse. And that's a big push we have in our training is for staff, one of the first things we tell them is we want to

give you some tools to help you de-escalate the situation certainly, but we don't want you as a staff member to go in a situation and by what you're doing, you actually make the situation worse. And we saw that we were doing that quite a bit. We were calling this big response team in a situation that would maybe just need one or two trained staff members to come in and try to assess and manage.

So this is probably one of the bigger changes we definitely made as a result of some of our training of staff in this program.

Paul: Absolutely. Our next one [slide] we have is talking about that acting-out person, and so again, when we do get to the extent of that larger physical type of an incident, talking to our staff members and talking about what's the expected response here.

A big thing we pushed was for staff not to intervene alone. We started looking at a lot of our injuries occurring to our staff members. A lot of them were occurring when staff members were trying to intervene alone or not calling for help, and so we're really pushing on intervening as a team, utilizing a team, getting out of that room, and getting that team involved, which all of us know for NCI and for PTP is getting that team involved and then going in and readdressing.

Utilizing those other team members, we have our larger, as James was alluding to as well, our behavioral response team, our Security Alert Behavioral Response Team as we call it, which is paged overhead on our campus at St. Cloud, and that does have multiple people that are responsible for responding, but it does initiate, as James said, roughly 15 people coming to that location, and that group is bringing restraints and a lot of people because we are assuming that we have a physically acting-out person.

And so by us identifying and working through the CPI model, it's being able to call appropriately like James was saying, not having that security alert being called for somebody that's just yelling and screaming. Calling the appropriate team to get that appropriate response is important in making sure that we're utilizing our teams correctly.

James: Again, at this stage, and Paul talked about this team. Our security alert team, it's 15 people. It's all available security staff and that could be four to six staff members. It's going to be a couple of urology orderly staff. It's going to be staff from mental health, ER, available staff from that area, administrative nursing supervisor. A wide variety of staff are responding from all over our building.

Certainly we want to limit the right staff responses as well, but another issue with those kinds of calls is it's very disruptive to the hospital environment. You've got staff coming from the ER, mental health, security. It could be spread all over campus. Same with some of the other staff, running through our facility to a location.

What we really want to stress to staff is if you need that team, be comfortable calling it and knowing that there's a bunch of people running to come help you, and we should be there very quickly. But on the other side of that, we don't want to initiate this team that is very disruptive if we don’t need it. We don't want to cause that extra disruption, and that's where the advantage of that B.E.R.T. comes into play. Staff that are responding are walking.

We're getting to the room as quickly as we can, but we're not causing as big of a disruption there.

The other part about this that we worked on, in looking at what training we need because as we're getting staff trained in NCI, and now we found that we had all of our staff on campus trained to a certain level, which was very good, and we had staff from ER, mental health deal with those situations a little more often. We maybe wanted to provide a little extra training for them.

Paul and I, we identified an extra need that we had there. We found that we worked with the mental health staff quite a bit, and security. We worked together quite a bit. We were on a lot of calls together, but we determined we don't train together. We don't have any trainings together. We don't do any simulations or anything together.

So we set up a simulation training lab for our security staff and mental health staff, where we would do a scenario. Paul or I would be the actor, and the other person would facilitate it. And we'd do a group of two security staff and two mental health staff responding to a call, and we recorded it so we were able to have staff work on a specific kind of behavior, specific kind of issue, and watch it from beginning to end with them, and sit down and actually do an immediate debrief. That helped not only us learn from that, but that really helped our staffs get a little more comfortable with each other, of working with each other, of calling each other, and doing some training together. So if we're on a real call, we know what to expect from each other.

So we added that and we did add a restraint element to that. Again, we added some extra training in for our mental health staff on actually putting restraints on, because again we—obviously, our goal is to avoid as many restraints as we can, but some situations—if someone does need to be restrained, we still want to do that as safely as we can using those best practices.

So we did some extra trainings where we have Paul act as our person that's acting out and the staff member going to scenario, and they practice putting the restraints on in a more dynamic environment. Certainly not full speed but certainly a little bit more than just walking through it as well, and Paul took the lead in doing that training and some other training with their ER staff as it relates to restraint.

Do you want to talk about that briefly?

Paul: We added—at our facility, again, we try to avoid restraints as much as we can. Initially, when we started doing our NCI program, rolled out to all of our patient care staff, we also did a short part on restraints, talking about the restraints obviously utilized as a last resort, but also getting all of them up to speed too, because a lot of them maybe hadn't had time to actually get a restraint in their hand, look at them.

And the big thing with restraints, and then when we talk about restraints, is if we don't apply them correctly, we obviously have a higher risk of an adverse effect with that patient, and so we wanted to make sure staff were getting them on right. One of the things we added recently in our facilities is we've added restraint chairs. We have restraint chairs in

our mental health and in our ER now. So we're doing training on that to make sure all of our staff are trained. Again, as a last resort, but if we do end up getting to that, if we have this equipment, we need to make sure that we are training our participants, our people, the best we can.

And so we run simulation labs with them as well, making sure they know how to put them on. Again, we put them through a short scenario, get them talking, mainly to me at this point, talking to me about what's going on, trying to de-escalate me, go through the *Crisis Development Model*℠, and then ultimately, it doesn't matter what they're going to say. I'm going to get to the point of restraints, and then we want to make sure they're doing it as a last resort, that they're not coming in too soon and doing it, and if they do, we talk about it. We work through it.

And so we tape it. We make sure that we can go back and we can look at what can we do differently here. How's their positioning in the room? What was your body language sending to me? And did we maybe do it too soon? Should we maybe have done it sooner? And so thinking about that as well. And so we really work through our different restraint trainings and our different acting-out behavior as well, because there's a wide range of responses because again, looking at what that person is really doing.

James: And we have the advantage. We have a simulation lab at our St. Cloud Hospital location. A number of rooms are set up just like patient rooms but they have cameras in them that we can practice any of our scenarios we'd like to in there, and we even used some of those videos for our NCI training to watch afterward, like Paul mentioned.

Look at a scenario. Again, it's not meant to pick apart what was done wrong, but it is how did staff respond to this person? How did they approach? Did they all surround the person right away? What was the staff's body language? And we use that to touch on all the areas of that, of the NCI program, of how did they respond. How did the patient respond? What did the staff do well? What can we learn from that? What is their positioning in the room?

Even those nonverbal things are nice to be able to look at right after the fact, either for the staff involved in the stimulation or for all of our staff afterward to really get some good takeaways and really think about how do I respond to a patient in a crisis. How do I enter a room even? What was my body language sending? And again, we want to touch on and reiterate those points because it is important, that message we are sending nonverbally as well.

And then the last part of the *Crisis Development Model*℠ that we talk about is the Tension Reduction stage, and that's after the incident is over. Again, talking about what do we learn from that? That's another thing we like to stress in our programs after an incident occurs, beyond the debriefing process, is also for our staff is what are we taking away? What do we learn? What can we do better next time, and how can we use this information to help us and everyone else in our facility?

One thing that we started is a security rounding trial and then a security rounding group that we did, and with that group we found that some staff felt that maybe they didn't see

security a lot in the area. They'd feel more comfortable if security was checking on them when they had a difficult patient or a challenging patient. And we had a subgroup meet to talk about how can we best deal with this situation. So in security we did a trial on our neuro unit. We asked a volunteer there, and what we did there is we had a staff member and security every 5 hours would round to their unit specifically and meet with the nursing staff that had any kind of difficult patients. And that could be anyone with any kind of difficult, challenging behavior.

So we had security rounding this unit. Again, one person would touch in at least once every 5 hours with staff, meet with the charge nurse, get any updates about patient changes, plans for patients to move to other units, discharges, etc. And we got that little extra stop on this unit, and during that trial, we had some interesting things occur after that trial, some interesting information we got after the fact because we had staff fill out evaluations every day beforehand and then afterward, what their perception was. And the number that's really shocking is we found 92% of staff felt more safe on their unit with this little change in us in security stopping once every 5 hours just to touch base and talk with them.

The other thing that was probably most surprising for me after this trial ended (we did it for three months), when it was over they talked to staff about three months later, and they still thought we were doing a trial. They still felt we were checking in more. I think part of that was staff felt more comfortable. When they'd see security walk by, they'd feel more empowered to flag us down, tell us if there is concern. It made us more aware of security and made that connection with the staff a little bit more. I think that was probably the biggest gain we had from that change was [we] identified the unit that was having struggles, which was the neuro unit, and how do we provide them better support?

Again, this was one thing we could do after an incident to say, "How can we best support the staff? How can we best provide them service within the capabilities we have?" And by stopping and checking with them, passing along in our office, we would pass along any challenging patient behaviors we saw on their unit for the next staff to go and follow up on. So the nursing staff felt like us and security were more well prepared and more versed in the challenges they were having specifically. They were quicker to call us for issues, and we did see decrease in incidents occur during that trial certainly.

Another thing Paul and I became part of is the Aggressive Incident Prevention Committee after we started teaching. That was a committee that was put in place to really address these kinds of behaviors that we're seeing, not just in ER and mental health but in our whole facility, in all of our medical units. So as part of that committee, we review incidents that occur. We talk about—we have some of the subgroups to deal with specific unit issues or general issues throughout our organization.

A couple of good things that we started to do through this Aggressive Prevention Committee is start to branch these ideas out to our other critical access hospitals who maybe have less resources than we have. They don't have security, most of them. They don't have mental health staff or units there.

So how do we best help them? And a part of this committee as well is we put on a training for other sites a couple of times a year. They can come together. We can share some of our successes. We can share some of our tools we've utilized to help not only in our main campus, but get everyone else from other hospitals on board with some of the best practices and some more tools that they can utilize.

You want to talk about new treatment there?

Paul: The other thing we implemented, and this was going on even prior to us teaching there, working towards this. We started on our mental health unit. We started with a unique treatment plan. Because one thing we are finding is after these incidents occur, we dealt with it. We've moved on.

Sometimes when we deal with people, not even on a frequent basis, but over and over again as they come into our facility, is it's like we're starting over every time. We don't have a plan in place. We don't know what the plan is when they come back in, and so after an aggressive violent incident, we generally will trigger some sort of unique treatment plan. Either our case managers, our mental health case managers will trigger this on any of our floors we're on, our mental health, our ER, or even our social workers will trigger this, and they sit down with the patient and talk about what are we going to do to prevent this from happening again. What can we do as an organization to help you so that this doesn't happen again?

And then also on top of that, we talk about our expectations as well. Going forward, what do we expect of you as the patient as this goes forward, an acceptable behavior that maybe happens. If it happens, this is what we're going to do; this is our response. So, again, really having that buy-in with the patient of being a part of that and having our frontline staff that are dealing with the patient, having a plan in place so that they know “what do I do next time?” What works best with this person? What's the best practices? What are we allowed to do with this person? What does work with this person is important as well. And so really thinking about that.

The other thing we have on here is that follow-up from the mental health RN or case manager after a B.E.R.T. call. So after any of our B.E.R.T.s occur (our Behavioral Escalation Response Team), roughly 2 hours, hour, depending on the patient, later, one of our staff members from our mental health unit case manager and staff will call up to the floor where it occurred, talk to the RN involved, see if there's been any changes, see if they need anything. Offering that support afterwards is important as well. We’ve gotten a lot of positive feedback in that as well. They're calling back. We care. We're definitely taking an initiative of trying to prevent those behaviors from going forward. And sometimes being able to identify if we may need to do some things different or we need to do some things better.

And so having that follow-up is important as well after that B.E.R.T. call occurs. So it isn’t everybody shows up, then everybody leaves, and now they're by themselves either. So they have that support.

James: That was a good change made there, is that we are providing that support after incident as well. We're not just responding to the call to help, which is certainly vital and important, but staff are feeling that they're being supported even after the incident, even with a phone call a couple of hours later, because if there are concerns brought up, then we can try to reinitiate the team. We can try to come up with some more options for that person. And then again as well for security when we have a B.E.R.T. called, we put that up on our pass along board so other staff know that this patient—what occurred with the patient, what the plan is going forward so that if they respond up there, then they're not starting from scratch either.

Going back to the security rounding idea, again adding those things in after the fact, how can we support staff, after our trial for that security rounding, as you can imagine a lot of the other units wanted to get on board and wanted to have that trial or wanted us to come to their unit and do that. And looking at the time restraints that will come from that, we found that maybe would be something we wouldn't be able to do in our security department, but what that did is it led us to getting a printout every day because we don't have access to the computer records there.

We get a printout every day of any aggressive patients that have either had aggressive incidents occur or score high on our Broset tool or are identified by staff as maybe being difficult or challenging.

We get that printout every day of patients in the hospital that meet those criteria so that our staff can look at that, and then we can do extra rounding on those areas and those units that are most in need. So it helped us get that communication tool from staff on the floors who, again, oftentimes assumed we had the same access to information they did, and we really didn't. We didn't know something unless they told us, and again, that goes right back into what we've been talking about all along for staff is notifying us, telling us when there's an issue, getting help right away, whether that being calling us in security with a heads up or whether that be calling a coworker, calling a B.E.R.T. or emergency response team, utilizing the different tools we have in place and using those to make a safer work environment for them.

Paul: Absolutely.

Terry: Great job, guys. So I just have a couple of questions if I could. And one question I had is about the way you've been able to supplement your *Nonviolent Crisis Intervention*® training with our *Prepare Training*® [program]. Our *Nonviolent Crisis Intervention*® [training] is typically used in a hospital or educational or juvenile correction setting, and [the] *Prepare Training*® [program] is used more typically in a business or even a retail environment, but you guys have been able to effectively integrate those two.

Paul: Absolutely.

Terry: Could you explain that a little more?

Paul: So when we were talking about when we worked through NCI, and again, we were working through the other patient care staff. We were having a lot of our—because again,

in a hospital setting we have a lot of all those other types of people as you were just identifying. We have our HR, our building grounds, our business center staff right on-site with us, and oftentimes they're seeing patients or they're seeing some of these incidents occur. So a lot of them were identifying what do we do, what's expected of us. And it wasn't really appropriate to have them come in through our longer eight-hour program of NCI just because there's a lot of things in there that really didn't pertain to them.

And so we started looking for ideas. We were tasked by our Aggressive Committee to start looking at different options. Myself and James, and we stumbled upon PTP on [CPI's] website, looked into it, and found that that would be the best option for our staff, and again, because it gets right up to that point of that person acting out, and then getting for that team, and the nice thing we really liked about it is it pairs nicely with NCI, where all the terminology is the same, as James was hitting on earlier. The terminology is the same, so when they're calling us, we know what they're trained on. We know what they're talking about, and so that really helped us as well.

It was also pivotal for us in rolling this out to all of our hospitals, all of our critical access hospitals because now we have a shortened version because, again, our smaller hospitals maybe didn't have the budget to roll out this eight-hour NCI right away, and so we started rolling out this PTP with it and we started getting a lot of their staff, their leadership staff, their business office staff, through it—and we realized we were getting a lot of good outcomes from it as well.

Terry: Outstanding.

James: Yeah, with that, the *Prepare Training*® [program] as well, it's vital. It's congruent like Paul mentioned, and it gets staff up to—the big concern we had with the NCI program, a lot of staff, a lot of leaders weren't signing their staff [up] because they were getting hung up on the physical intervention part of it.

Our staff aren't going to be—if something happens, they're not going to be—our lab staff is not going to be in there restraining a patient. If something happens there, our HR person walking down the hallway and nutrition's not going to be in there restraining the patient, and that's certainly true and accurate, but all the other—that's a very small part of the program, and that's what we tried to get across to them, and providing this PTP program cut out the physical aspect. It still taught staff what to do in a violent or aggressive incident, taught them to get out of there, stay safe, all those good tools, but it didn't go into them having to go hands-on, which they wouldn't do as part of their job.

So it really works well for the different staff we had, and managers felt a little more empowered to decide. Do my staff more need this NCI training or do they more need PTP? A big advantage we're seeing now at the location I work at with an attached nursing home is staff is identifying certain people they want to go to the full NCI and certain staff to go to the PTP, and we talked about how that will work well because they pair perfectly together. So it gives managers a little more leeway to determine how they want to use their budgets and what staff are best appropriate to do it.

Terry: It gives them flexibility. That's excellent.

James: Definitely flexibility.

Terry: Another question I had was if you had maybe a hands-on success story de-escalating a person or a situation using CPI techniques.

James: Sure, I can tell about something that happened. I think in Paul and my role as not only security staff, who are that frontline staff walking through the building, interacting with staff on a daily basis—when we're not doing that, we're generally teaching the programs, and we're seeing staff, the same staff members, come to our programs. So when something does occur and we show up, sometimes it does feel like there's an extra level of expectation. "Oh, the security guys are here that also teach the NCI program. Now, they can obviously fix anything."

Obviously, that is not always the case, but I remember responding to a call on our locked mental health unit. There's a behavioral IC within the mental health unit for more challenging patients. I got called on there to deal with the patient who was in that area. They had their scrub shirt off, and they were—had a couple of them, and they were swinging them as a weapon, hitting the glass on the door, telling any staff that came in they're going to get hit. So, thankfully, staff had gone to this program. They stayed in the locked nursing area, didn't go in there to try to deal with this guy until we had a big team there.

So we got a big team there, and I remember when we had a brand-new staff member show up, just had gone through our training, was there, and I'm like, "Oh, this is probably good for them to observe. It could—might not go very well. This person's not backing down."

In my mind, before this person got there, I figured, "Okay, we've got to get enough people here, and we're going to run in there and take them down." There's not much else we can do. They're off their meds. They're not thinking clearly. They're swinging a shirt, trying to whip us with it, and new staff member got there, and I felt the need to—we need to show this person how it's done right. We need to spend time talking with this guy.

So from the area where we were safe and the patient was safe, again, risky behavior he was doing, but he wasn't hurting himself and he wasn't hurting us at that point.

So we had time to intervene verbally first. We had some time to talk to him, set some good limits with this guy, told him our expectations, spent about 2 or 3 extra minutes talking to this guy than maybe in my mind I thought we would have, primarily because we had this newer staff member there and really wanted to model that good behavior for them.

And surprising enough, we got the guy to—I only told the guy he needed to go back in his room and sit on his bed. He needed to stay in there for the next half hour. I gave him the limits that the staff had required, opened the door and talked to the guy, and he said he would do it. We set the limit. He walked in his room on his own, sat down on his bed. We didn't have to administer meds. We didn't have to go hands-on restraint.

Giving that little bit of extra time, setting the limits, giving him time to best respond even in that very high-level critical state—it was a big success, and it's important to note that even in a situation that seems like there's no other option except physical, sometimes there are other choices there, too.

Terry: I think that's a good illustrative example. Thank you.

Thank you for joining us today on *Unrestrained*. Tune in again soon for another interview with an expert in behavior management. Until then, this is your host, Terry Vittone, hoping your intention is prevention.

CPI *Unrestrained* Transcription
Episode 26: James Gulbranson & Paul Ruegemer – Part 2
Length: 24:59
Host: Terry Vittone

Terry: Welcome to *Unrestrained*, the podcast series from CPI. Here you can enjoy conversations where professionals on all sides of crisis and behavior management relax and open up about themselves, their workplace, and their clients. You'll get the latest tips and trends from the best in the business, so tune in often to integrate their experiences with your own.

For the second portion of our interview today, James and Paul are going to talk about a team intervention approach known as B.E.R.T. (Behavioral Escalation Response Team). What this basically is is a way for a hospital to call staff together when a patient seems to be escalating and they want to de-escalate through a team approach before it turns into a security event. All right, take it away.

James: Thank you very much. We started a B.E.R.T. subgroup, and it's part of our Aggressive Incident Prevention Committee. We started this subgroup to look at how do we bring in a team that can respond to that Defensive stage? We talked about that before already, but how do we best respond at that Defensive stage when someone is escalating? Could be non-compliant, yelling, screaming, threatening occurring. How do we get that best response there that isn't that big team of 15 coming in running?

This first was identified to this group. It's been identified to Paul and myself over time, and it was something we even realized, because we had a lot of calls where someone threw their meal tray on the ground and then we got called for a security team and 15 people showed up, and we made the situation worse. How do we best respond there? How do we provide staff the tools? And as we were training staff, we found that they didn't feel like they had the best tools. They could call security for a lot of things, or they could call our security alert behavioral situation and there was nothing in between, nothing in between the early stages and someone physically acting out.

So we wanted to bridge that gap and figure out what kind of team or what kind of service could we provide at that stage. So we had a subcommittee, a breakout of our larger aggressive group to tackle this issue of how do we put together a team. What do we do to manage this kind of situation? There are some other organizations [that] use a situation called a B.E.R.T. as well, so we certainly referenced what they had done but also tried to make the situation our own as well.

I think a big part of that was just in how we named the team as well. We still call it the B.E.R.T. A lot of places call it the "Behavioral Emergency Response Team." We felt it may be better, or more beneficial, to go "Behavioral *Escalation* Response Team" because this is behavior that's escalating. It's maybe not an emergency and maybe getting staff's mindset off of thinking that this is an emergency. This is escalating behavior, and that helps them

maybe better think about how their response looks as well. The behavior is escalating, but we're not at that emergency yet. So we really want to look at how we set that up.

We heard from a lot of staff, and again, it was the staff that were part of that bigger security response team. They were responding, running through the building, getting pulled away from their tasks, and ended up going to a room or going to deal with a patient that there was nothing they needed to do for that. And that can be frustrating for staff when they feel like they are being called away frequently when it's not needed. So by providing this B.E.R.T. team, we wanted to give them some more staff on the floor, some more tools.

Part of that was selecting and training the members of the response team. Who were we going to have on this team? This started as a trial. This B.E.R.T. team started as a trial in October 2014, and we were going to do a three-month trial for our whole facility, except for our ER and the mental health unit. So this B.E.R.T. team is still designed today to be for any of our medical units outside of the ER and mental health. The thought there is, one, we already have security staffed in our ER 24/7 as well as behavioral nurses, as well as a lot of ER staff that are comfortable dealing with these situations. Same goes with the mental health unit. So we didn't need this response team to go to those areas. This was predominantly for any of our inpatient medical units.

So we needed to select what members would be part of this team. Especially as this trial started off, we didn't have funds to add more staff that weren't already on-site. We needed to utilize the staff and resources we currently had. So security was identified as one group that would be beneficial, as well as our mental health charge nurse that's working on their unit. We also utilized orderlies or urology tech staff who were also there 24/7 and are part of our bigger response team, and they're used to responding to and dealing with behavioral situations. That was a good third person we felt to add to that group that also didn't add any additional resource dollars in doing that.

So once we had the initial staff that would be involved selected, we needed to work on what training they received.

You want to talk about the training of the B.E.R.T. team staff before the season rolled out?

Paul: So we looked at the training for our B.E.R.T. team staff members. For our mental health staff members that were going to be responding. Again, generally we were having our charge nurses, our more senior nurses, going from our mental health unit. So we started looking at what they are going to need. And the big hurdle we had, and I got this training going with them, was not how to obviously deal with the patient or anything like that, because they're very good at that already. It's knowing where to go when they do get called.

Our mental health staff members, they work on their unit and a lot of them know where the cafeteria is and know where the mental health unit is, and that's about it. And so the biggest thing we had to do was—we have a very large campus, a 489-bed hospital. So it was being able to get them to the location of these B.E.R.T.s in an efficient manner, walking there, so that they were comfortable. They knew where they were going. So one of the

biggest things we did was we spent about an hour, an hour and a half just walking them around the hospital. I was giving them ideas of how to get, the best way to get, to rooms, and then just telling them a room number and having them get me to that room number.

And [teaching] them to understand our elevator system. We have multiple elevators that go to all the different floors, and so which one is going to be the best one to get you there? What's the best way to get you there was an important one.

The other thing we did was we also did some training on different types of behaviors we maybe see in a medical hospital setting, maybe a little more than what we see in a mental health setting. An example, we talked about deliriums. We did a little delirium piece where we had one of the nurses from the floors come in and talk about delirium that can occur in a hospital. So working through different ideas and what we may be seeing, and then also getting them comfortable with just going around our facility.

It seems simple for myself and James; we move around our facility all day. But when you get somebody who's never moved around, it's very difficult to get them efficiently to a place and be able to feel comfortable getting there, where they are called or summoned.

James: The second part of that was staff education for the rest of the staff in the hospital, making them aware of this trial we're starting. Posters up, meeting with staff, talking about how to use this team once it was in place, when you should be calling it, how to call it, understanding who is going to be responding, understanding what that function is going to be, and really working with them, telling them we are going to have this three-month trial, and making them feel confident that they can use this and call us and get a good staff response.

So we'll talk about some of the things that go into calling a B.E.R.T.

Paul: So we talked about when to call a B.E.R.T. We'll have this pulled up here on the screen for you guys. We got a couple different ideas here when the staff is worried about patient behaviors. Again, as James hit on, it's that escalating behavior, change in behavior, like when we talked about that anxiety and that nonverbal behavior. That change in behavior that we're maybe seeing, threats or perceived threats against staff members themselves, sexual threats issued, stuff like that as well, concerns about a 72-hour hold, disruptive behavior that can obviously upset the unit.

With our B.E.R.T. calls, our B.E.R.T. calls are only called for our patients as well. Staffers don't call them on any of our visitors or anything like that, as this team is coming in as a consult to help. If they have an issue with a visitor or anybody else, they generally call in security. We're taking care of them. So getting the staffers on board of what do you call or why would you be calling this and knowing that it is this escalating behavior that's occurring and getting the staff members up there and looking at it.

When we talk about our 72-hour holds, that was a place where oftentimes a person would be placed on a 72-hour hold on a medical unit, and staff members would not really have any people around. And [like] we always talk about in our NCI classes, if you were being placed on a 72-hour hold, is anybody ever happy to be placed on a 72-hour hold? Well, no.

So thinking about what do I maybe need for a team around the hold? We don't need 15 people up here, but maybe we can get this B.E.R.T. team up here. We can get them to help us get this person, their paperwork, get them on the hold and understand it, because we deal with this quite often versus maybe waiting and delivering it and hoping it goes well, and then all of a sudden, it doesn't, and now we're calling this big team.

So again, really think about when to call a B.E.R.T.—again, that escalating behavior. Under that verbal behavior as well, that can be occurring, so really think about that as well. We talk about how we call them. Again, we have 25 inpatient units at our St. Cloud Hospital location. 24 hours a day, this team is available, like James said already. We have our emergency code where we call any code. It is 3333 for us to call a code. Our B.E.R.T. is not paged overhead. One push our hospital has had in the last year to two years has been to reduce the number of overhead paging in our hospital. We no longer will page anybody overhead for a doctor or for anybody else. Only things that are really paged overhead are emergencies. So we talk about our security alert behavioral emergency that we talked about with the 15 staff members. That is paged overhead, but this B.E.R.T. team is not paged overhead.

Security is notified by the radios and then we also have a pager system. So if a B.E.R.T. is initiated, our customer contact center will then initiate the proper paging, and we'll page those people and call security and let them know. Again, our response time is generally around 10 minutes or sooner. Staffers are not expected to run up there, but we're looking for a 10-minute or less response time. And again, we have that RN from mental health, security, and urology techs responding. And so again getting our staff to call appropriate codes is important, and calling early or intervening early is a big push behind this B.E.R.T., and we will talk about some numbers as we work through as well.

So we have an algorithm set up here for our Behavioral Escalation Response Team. When we were rolling this out, we were having confusion as to which one’s which and what do I call, so we put this out for staff members to really think about what's the behavior and what's appropriate to call. So we have this posted so staff members can get at it. Are they threatening us? Are they an immediate danger? Well then, maybe we’re calling that security alert versus what's the other behavior we have occurring. Are they angry, upset, yelling? That type of behavior. So it really flows to where you guys can see that on your screen with your slide, but again it’s looking at what's going to be the most appropriate response at this point for that. And again, it’s pretty self-explanatory there.

James: Definitely. I’ll talk a little bit about the team members that are on the B.E.R.T. You had already talked about how it's a mental health staff member or case manager, a security officer, and urology staff member. So the other part of that team is the primary staff nurse, the person that's calling the B.E.R.T. They are still in charge of the patient. They're still overseeing the patient in their care, doing all the documentation, everything.

But they're our first person to go to for this type of incident when it occurs. So they're a big part of the team as well, because they're going to be the staff member that's still there when that team leaves. So it's not very beneficial for them to step away, have the B.E.R.T.

team coming in and deal with the patient and leave, and now, the nurse coming back, not knowing what the plan is. So we work very closely with the primary nurse of the patient where the B.E.R.T. is called.

The mental health nurse or case manager, as one of our responders, again, they can act as the lead. We don't get too hung up on who's in charge of the B.E.R.T. call, who's leading the situation. It depends on what's going on. And another part that helps us decide who the lead is, it's who the patient feels most comfortable with. Who are they talking to? Oftentimes that can be the mental health staff member. It can be us in security. It can oftentimes be that urology tech or orderly that they feel most comfortable with and start talking with, and we certainly let that flow if that's the best way to deal with that person.

But the mental health nurse or case manager, they may be involved more in that developing a unique treatment plan for the patient. They can help call for other resources if needed, provide some more of those services. They can help with transfer to another unit or maybe calling for extra staff. Maybe we do need a sitter on this patient all of a sudden. They're able to better get ahold of the on-call psychiatrist and explain what behaviors they're seeing and what changes need to be made, maybe as it relates to meds or in terms of other interventions that are happening.

Security staff, our role on a B.E.R.T. call, oftentimes we're the first one there because we're already up roving around on the floors nearby, getting there first, determining what other support might be needed there. Certainly we work as part of the team, assist the other team members as needed. If police need to be notified because of something that occurred, we'll help facilitate that contact with law enforcement.

Another thing we do after the incident is we do some extra rounding. After there's been a B.E.R.T. call, we tend to check back in that area with the staff more frequently to see how the patient is doing. We check with staff, see if anything has changed, or if there's any need for us to do anything differently, making sure that staff, again, do feel that support after an incident, as well as documenting the call that occurred on our main pass along border in the security office so that any other staff coming on shift can see where issues have been throughout the day to figure out where there's been problems already, and they can be prepared if they do have to respond to that unit.

A urology tech serves in a very similar purpose. They respond as an extra show of force, extra person there if needed. Again, we have that B.E.R.T. in place and very rarely does it turn out like this, but you already have a team in place. If the situation were to escalate to needing a physical intervention, there's already security there. There's already a mental health staff there, so it gives us those extra staff there.

Some other people that might be consulted during a B.E.R.T. could be a pharmacist. That's definitely someone they can look at as it relates to changing medications. A nursing supervisor might be contacted if a patient needs to be transferred to another unit or just to update them on what's going on. Certainly the primary physician, psychiatrist on-call, those would all be other people to work with or bring in if a B.E.R.T. is called on a patient.

Paul: Our next thing we're going to look at here is our B.E.R.T. calls by shift. We're over a year through our B.E.R.T. call being roll out permanently. One of the hurdles we encountered with the B.E.R.T., and James talked about financial things, when we started rolling this out is whenever we do take a mental health nurse from their unit, we need to replace them with somebody, so we were having to bring a float pool of staff members in.

So for a lot of you that maybe work with mental health or around the mental services know that there's not exactly a lot of money that flows into mental health. So we were running into the problem of our mental health director couldn't really add this into their budget. So it took us, as we talked about earlier, our leadership was very behind this program as far as NCI and PTP. They were very behind this B.E.R.T. team as we started working through and seeing the good change, so we got their approval very quickly, which got us that funding to keep us going as well.

So what we have here [on the slide] is we have our B.E.R.T. calls by shift. Again, we've been breaking this down. We're looking for trends to see if there's something we need to change. During our daytime, 8 to 4, Monday through Friday time, on the floors we have a behavioral health case manager that's already seeing our mental health patients. So again, we're trying to identify if because that person's there, are we preventing B.E.R.T.s from being called? As we've seen, B.E.R.T.s are pretty much universal across the board. There's no specific rhyme or reason. It's not that it's more in the day or more at night. It just flows around, but again, looking at these trends is important to really think about how can we intervene better as we work forward and what's our plan.

Same thing with our B.E.R.T. calls in the days of the week, as we have pulled up, same kind of thing. We do have some more on certain days than others, but there's not really a stand-alone trend of we always have them on a Wednesday or anything like that. So we're trying to look for trends. Originally it was thought we'd maybe have more on the weekends, because we didn't have case managers staff there, and that necessarily wasn't the case either. Sundays were our lowest out of all of them.

James: We looked at calls per quarter from when it started to the most current data we had. You can see the trend is somewhat downward. It's still certainly being utilized. The B.E.R.T. call is being done way more than we have our behavioral situation or anything else. We saw a lot of staff feeling comfortable using that.

I think a couple of reasons it seems to be going down a little bit, I think part of that could be more and more staff have witnessed what the B.E.R.T. team does, how the team responds, and modeling that behavior for the staff on the floors and giving them the idea to see "What are my other resources available?" Letting them know we can call a doc. We can call a psychiatrist. We can think about med changes with the doctor on our unit.

So maybe they feel a little more empowered to manage some of these behaviors before they even need to call a B.E.R.T. Again, not a lot of data points yet to look at in terms of it only being around for about a year, but a slight decrease in its usage. But it's still being used frequently and we've seen a lot of reductions.

This next information we talk about may be the most important one, I think, out of all of them—is the percent of time that staff felt that escalation was prevented or that a Code Green or a security, a behavioral response was prevented. So this is more, a little arbitrary; this is up to the staff's interpretation.

But after an incident they were asked, "Do you think by calling the B.E.R.T., do you think by having this team intervene, we avoided the situation escalating to that physical point?"

And as you can see, it went anywhere from 70 to 100% of the time where staff believe that the response and the intervention that we had at this lower stage with this team prevented a situation from escalating into a physically violent incident. So I think more than anything else, we certainly see in the numbers that we had a lot of decrease in our physical incidents. But just as important is the staff perception that it is getting safer and they're feeling like this response is very beneficial and is helpful.

Looking at this slide you can see our Code Greens over time have decreased, while, at the same time, our calls for security have increased. So we expect to see that, too, because we're telling staff, "Call security; call us." We'd rather walk up there, stand by while you talk to a patient, and have it go well than you not call us and have a situation escalate to a physical incident, and then [we] have to run up there and have that time where there's not extra help there. So we've definitely seen staff calling for security or B.E.R.T. more, and we've seen our behavioral codes go down and our aggressive incidents, higher-level ones, go down as well.

Paul: One thing to note with that Code Green is that was our old name for our security alert, security situation or our behavioral team being initiated—our big, larger 15-person team. So it's a little confusing with the Code Green. That is what our security alerts used to be called. We have moved to the plain language at our hospital. So again that verbiage is still kind of hanging out as we get out of those fiscal years, so we left the verbiage there the same for our staff for when we're dealing with it. But again thinking about that team, we're intervening with that team a lot less, which is good because, again, that's that big disruption at our hospital, as James was talking about.

When we start looking at our next slide here, our security response, and this one is important to look at, and this really models too with our NCI training as well, because again, a big push with our NCI/PTP training is to intervene early, call early. As you guys can see there, our security assist calls, which is the one in that reddish color, have gone substantially up over the years. And we liked seeing that because we'd rather be getting called early, intervening early. That's a big push we have is [to] intervene early. Call somebody early, no matter who it is, getting somebody up there to help. Our security alerts, our Code Greens, our security alerts, our big team, as you can see, they've been going down, trending downward. Again, our behavioral security assist calls have been trending up, which is another good thing as those security alert behavioral situations have been going down.

So again, we are seeing a lot of good response just like we did in our previous presentation. As we're getting more staff trained, we're getting more calls and that's what we definitely want to see happening as well.

James: We'll talk through an example of a B.E.R.T., what it might look like. I had this call occur, for me, a while back. There was a B.E.R.T. call to one of our units, our neuro unit. And myself, another officer got up there. We got there before the whole team was even in place yet. And when we got up there, there was a patient pushing a chair with wheels down the hallway with about four staff around them nearby and following them. The patient was kind of getting agitated. They wanted to walk around, was the situation, and they just grabbed one of the nurse's chairs and started using it as a walker to push themselves around the unit.

In the past, a situation like this, I think, when we would've responded, we would've got up there and staff would've probably been physically trying to restrain or stop this patient. But I think even looking back to the training we've received, when we got up there, staff had gotten a team in place. They'd surrounded the patient a little bit in the hallway, let them have room to walk around, though. They weren't a danger to themselves at that point. They weren't hurting anyone else. Staff were there in place, waiting for a bigger team, waiting to figure out what our best response is. We got up there, started talking with the patient.

A big role, as I've talked to some of our security staff, as I've been involved in some of these, reading reports, a big role in security as well is when we get there, oftentimes a patient may be out of their room. They may be somewhere they're not supposed to be. There may be that initial, difficult behavior. Our role almost initially can kind of be to funnel them back. Let's get them back in the room so that the case manager, so that the mental health nurse can start to talk with them, along with their primary nurse, and come up with a plan.

So on this day, I started talking to the patient, got him calmed down a little bit, found out what his issue was. He wanted to walk around more. He was feeling very cramped in his room, so he decided no one was helping him. He was going to walk around on his own. Eventually, we convinced him to walk back to his room cooperatively. One of the plans going forward from that was staff was to make sure someone got him up every couple of hours and walked him around their unit just to get him out of that room. That was a big concern he had.

That's certainly a minor intervention we can put in place that could prevent this kind of behavior we were seeing from this patient. Certainly, we followed up after the fact with this gentleman as well, but just a simple call like that, it doesn't seem like a lot now, but going back in my mind of how that incident would've been five years ago, we would have shown up with staff, fighting with this patient on the ground trying to drag him back in his room. Maybe injuries occur. Maybe the patient's being restrained. That can definitely be avoided and really determining what do we need to do at this point.

Yeah, the guy is out of his room. Do we need to tackle him? Do we need to grab him then? Well, no. Let's get some more staff there. Let's try to intervene. He was not a danger to

himself. He was not a danger to anyone else. They called the team, we got in place, and we put that plan in place and really had a good successful outcome with that incident.

Terry: Well, thank you guys for that illuminating overview of how B.E.R.T. works at CentraCare in St. Cloud and for all the rigorous work you've done keeping data to show the effectiveness of the training.

James and Paul, thank you first of all for coming today and participating with us. It means a lot to us. If you have a last thought about CPI training, what the impact has been—even though much of what you've said has been about that, I'm going to ask you for one last statement if I could.

James: Sure. I mean, I think, certainly a lot of stuff we talked about, but the integration and getting all staff to the same level and knowing they're being supported. When we started training, we were pretty concerned about maybe training those staff that have been around for 15, 20 years that maybe weren't going to be as willing to accept some of this information and not believe in it, not maybe think it's appropriate or effective.

We found maybe some of the biggest buy-in [came] from those staff, the nursing staff, that have been around for that long, because a lot of them came up to us and said, "This is way overdue. We've been saying this has been needed for a long time. We didn't really realize what was needed, but now that we see that it's out there, we understand how important this is," and that was some of the biggest people we had good responses from, from the staff that have been around for a while, because they'd seen what it was like before and they've seen the changes that were being made, and they knew it was a positive change happening.

Certainly, a big push for our leadership is creating that safe work environment for our staff, and NCI and our PTP training is a big part of that.

Terry: Thank you, James Gulbranson and Paul Ruegemer from CentraCare and the St. Cloud Hospital, and this is Terry Vittone for CPI and the podcast series *Unrestrained* thanking you.

Thank you for joining us today on *Unrestrained*. Tune in again soon for another interview with an expert in behavior management. Until then, this is your host, Terry Vittone, hoping your intention is prevention.