CPI *Unrestrained* Transcription

Episode 65: Deb Fabert and Joe Anderson

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Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, a CPI podcast series. This is your host, Terry Vittone, and today I'm joined by two experts on workplace violence and healthcare. They are Deborah Fabert, the director of behavioral health at Bloomington Hospital in Indianapolis, and Joe Anderson, the director of protective services, and chief safety officer for Indiana University Health, also in Indianapolis. Hello and welcome, Deb and Joe.

Joe: Good morning, Terry.

Deb: Yeah, we're glad to be here.

Terry: Thank you. All right, our interview today is going to focus on a fascinating study co-authored by Deb and Joe titled, "Protecting the Nursing Workforce through an Aggression Prevention Team and Behavior Alert Response." Before we get into the details of the study can you give our listeners an overview of its goals and methodology?

Joe: Well, our listeners might know that the American Nursing Association has petitioned OSHA to require mandatory and comprehensive programs to prevent workplace violence. There's been a Joint Commission Sentinel Event Alert that's been issued around workplace violence and healthcare. We felt at the IU Health that some of our nurses were getting roughed up and we wanted to implement a program to help reduce that kind of violence in our workplace.

Deb: Yeah. So what we came up with was a tiered approach to it. And we'll talk more about this in detail later with some additional questions. But, it's really a tiered approach that starts with prevention, similar to the Prevention First that CPI has recently developed and that of course *Nonviolent Crisis Intervention®* is also part of that prevention de-escalation piece. And then there's a response, and we'll talk in detail about our Aggression Prevention Team response as well as the Behavior Alert response, and then finally, a recovery phase where we provide recovery to any victim or somebody who's shook up when violence happens to them in the healthcare setting.

Joe: And then the good news in this is that we've had really positive outcomes. While the CDC says that violent injuries to nurses has almost doubled nationally, we've seen a reduction, as much as a 12% reduction, in assaults against staff at the Academic Health Center in Indianapolis.

Terry: I see. So you created the Aggression Prevention Team and the Behavior Alert response in response to the dramatic incidents of violence to your nurses? Is that how it came about?

Joe: Well, I think there's dramatic violence and just kind of daily violence. I think with nursing sometimes it's built into the culture to expect that you have to sustain violence as part of your job. And, Deb and I tell a story where we say, "If you were standing in line at the Starbucks to get coffee and someone reached across and smacked the barista, what would you expect to happen next?" Right? You would expect some kind of reaction to that. Well, that was happening pretty regularly to our nurses at our hospitals and we didn't want them to have that be an expectation of their work. We needed to change that culture.

Deb: Yeah. And in addition to that the reason—you know, every time we do this presentation, we ask the audience, "Has anybody witnessed a nurse being abused, or a healthcare worker being spoken to poorly, or cursed at, or something thrown at them?" Every hand goes up. And, our industry and being healthcare workers and nurses in particular, they think it's part of their job because they always are going to give the patient the benefit of the doubt, "Oh, they're sick and it's my job to take care of them." And so, really what we find even when having this process and this response in place, is that nurses are hesitant, and they will always give the patient the benefit of the doubt and tolerate more than they should. And we don't want that culture, going forward. So when you implement a reduction-in-violence program, what you're really doing is changing the culture of the institution. So it's not a quick fix; you can't just drop something in and say, "Oh, this is going to fix it." It's baby steps to get there and, you know, start somewhere.

Terry: So let's give our listeners a sense of the size and the reach of the systems you guys work for—the Indiana University Health statewide system, and the Academic Health Center Methodist Hospital, where the study that you published, that we're talking to today, where you conducted the research and got the results from.

Deb: Yeah. So IU Health is a 17-hospital system right now. It is based, and the mother ship, is the Academic Health Center where Joe and I did this work. It is 3 downtown hospitals, 2 adult hospitals, 1 is Methodist Hospital, about 390 to 420 beds depending on how we stretch the capacity. And then it's attached to another downtown adult hospital, University Hospital, which is associated with the IU School of Medicine and that's the academia part of the Academic Health Center. And then Riley Children's Hospital, and, Joe, I'm not sure how many beds they have at Riley.

Joe: About 200 beds at the pediatric hospital.

Deb: And Riley is pretty much a national and world-renowned children's hospital for exquisite care. So that's the downtown where we instituted this work. I currently work at Bloomington Hospital, which is in Bloomington, Indiana. It's about 50 miles south of Indianapolis and that is the town that Indiana University, the main university is actually located, so it's a college town. And I instituted the same work there and duplicated our process.

There are many other hospitals: we've got Ball Hospital, 17 other hospitals. One's in Muncie, one's up in West Lafayette where Purdue is, Purdue University, and many critical access hospitals, which are very small hospitals, in rural areas, that provide care and then we feed those patients into the mother ship. So it's a big system.

At the Academic Health Center in the ED they see over 100,000 patients in their emergency department. It's a Level 1 trauma center. It's an urban setting, so, a lot of violence, a lot of gangs, those kinds of patients coming in brings a lot of violence; it spills in from the streets.

Terry: So the issues that you're seeing are going to then be comparable to a medical campus at any major city in the country. In other words, if it works where you work, it will work pretty much in any large urban center that has comparable facilities.

Joe: Yeah. It is repeatable.

Terry: Okay.

Joe: As we've rolled it out at other places, we're seeing similar results to ours.

Terry: Great.

Deb: Yeah. In fact, Bloomington Hospital is more of a community hospital. It's a 200-bed, small little community except for when the students are there, the 40,000 students. And I'm not sure if gangs are worse for violence and disruption or students, I'm not sure. But this will serve any hospital, we feel.

Joe: Something to consider is that these problems aren't just happening in urban areas anymore because of the opioid epidemic, because of the lack of behavioral beds and other factors you're seeing the same kind of problems on our suburban communities as we're seeing in our urban communities.

Terry: Put this in a larger context. The American Nurse Association petitioned OSHA to require mandatory comprehensive programs to prevent workplace violence. Could you talk about that in the scope that you work on?

Joe: So I guess what that points to is that this is a national problem. Right? That assaults against staff are happening all over the place and so OSHA has these requirements that they have become known to healthcare through this Joint Commission Sentinel Event Alert. And so there's some expectations of a workplace-violence program and the baseline for us at IU Health is the NCI training that we do through CPI that train folks in de-escalation techniques and to how to keep themselves safe. But then we built this tiered-based approach that provide additional tools for our people. But even that's only one part of a comprehensive program. You need to be considering what your threat protocols are, what your access control is going to be, and what your visitation policies are going to be. So it's really a comprehensive look at what you're going to do to try to keep your workforce safe.

Terry: I see that. So the first steps in putting together the strategic plan for improvement was to do an inventory of what was in place already. And you describe CPI as the cornerstone of—

Joe: Right. So this work starts with a risk assessment, so you have to try to do a risk assessment, identify where you have your gaps and where you need to plug them. And one of the things that we found in doing our research was that while de-escalation training is fairly widespread in healthcare, the incidences of assault against staff were still continuing to rise, and where we identified the gap was that once someone has escalated beyond the

point where you can use your personalized techniques, as you're trained in NCI, you need to remove yourself from that and you need to call for help.

But what happens when you call for help? Right? So, that was where our gap was. We didn't have teams available to respond. We had pieces, right? Security might respond in some instances; social work might respond in other. But what we saw the gap was, we needed this team-based approach that was tiered depending upon what was happening, where the patient was in escalation.

Terry: So even though you had people who had full NCI training, which does include physical techniques, both, you know, disengagement and restraint techniques, you still didn't have a team approach where there was a cohesive code that would call together a group of people that would address the situational violence.

Joe: Correct.

Deb: Yes, that's exactly right.

Terry: And so that's where the, to go back to the title of your study, when you talk about the Aggression Prevention Team, this was essentially the mechanism that you put into place to address these violent incidents that had gone beyond where verbal de-escalation could actually manage them.

Deb: That's exactly correct.

Joe: Correct.

Terry: I see.

Deb: Yeah. Now, one thing I want to add into that is as we did our gap analysis and as we started instituting this Aggression Prevention Team in a more robust fashion where people were being paged, they were designated folks every shift. We realized that even having the Aggression Prevention Team wasn't quite enough. There were two layers to that. Sometimes it was something that could be still de-escalated. But it needed a team approach to it. And other times it was complete flat-out violence occurring. So two different responses, that team may act a certain way if it's just de-escalation that is needed, but then their roles change a little bit. Same team shows up, but the roles change a little bit when it's actual violence happening, and that's the behavior alert. So that's the two-tiered process, but we didn't know that when we started. It's something that we found out as we did our work.

Terry: So this is the differentiation between the Aggression Prevention Team and the Behavior Alert Response, correct? Those are the two. So, the first one being, we can maybe still de-escalate this if we have a show of a team, and [so] then we use a team approach, and Behavior Alert Response, meaning this has already gone into an acting-out situation. Is that's how it works?

Joe: That's correct to say that the differences in APT and BA is, I think, our listeners will understand what a rapid response team is at a hospital, the APT is similar to a rapid response team. It's [when] staff is feeling threatened. They don't think that they have the wherewithal to de-escalate the situation any longer by themselves. They need some help, and so they call for the APT, whatever is occurring with the visitor the patient is obstructing their ability to provide care. That's the APT response. You know, you have a de-escalator, you have security, and you have somebody to support the team member.

At IU Health or at the AHC we use social work, our police department, and chaplaincy to fill those roles. But with the Behavior Alert violence is eminent or violence is occurring. So that's treated more like a code. Right? Overhead page, you know, people running to the scene to intervene, same people are coming, but now it's a security-led event to render the scene safe. The other difference in the behavior alert is we also—that's where we add the clinical.

Terry: Now, do all these team members that come together either for both the Aggression Prevention Team and Behavior Alert response, are all these individuals, do they all have CPI training so that they have a common language when they address what's got to be done?

Joe: Absolutely. They do.

Deb: Yeah. That's a requirement to be on the team. You have to be an expert at it.

Terry: I see, so that helps, because everyone then understands the terminology, the methodology, and so there's no breakdown in communication where the teams come together.

Joe: We were talking about this yesterday about the necessity for everybody to be trained and have that common language and we also had some discussion about the point person, the person that's actually serving as the lead de-escalator, that's intervening with the antagonist in this situation. We were saying it really needs to be an NCI ninja, right? (laughter) They need to be practicing this every— Something that they incorporate in their work on a daily basis. And they're going to use all the techniques from A to Z. But then they have that common language and the others may have to engage their techniques depending on what's occurring. But the person that's at the point really has to be well-trained.

Terry: Interesting. With your permission we may actually make an "NCI Ninja" designation! (laughter)

Deb: I like that idea.

Terry: Yeah, I like it too.

Joe: Maybe you get a sash or something, right?

Terry: There you go. That's right, or the black hoods, you know, guarantee anonymity—

Deb: Yeah, cape and everything.

Terry: All right, so you have what's called an "all-hazards" approach to security and safety responses that you explain in your document detailing your results with your initiative. Why is this all-hazards approach so important? Explain what it is and how it functions.

Joe: Well, for one thing the expectation of OSHA and others is that you're going to have a comprehensive program, right? And the NCI training and the APT BA response is effective in what it's designed to accomplish. But you also have to consider things like active shooter training. I mentioned the Threat Response Protocol so if a disgruntled patient threatens a staff member or there's a spousal relationship that's gone south, and one of your folks are threatened, you have to have some kind of protocols for dealing with those types of situations.

Terry: So I think a lot of our audience will probably, or might be able to answer this, but I would like to get your take on it. Some of the most frequent violent risk factors that you see in your system and in your hospitals.

Deb: Yeah. So when Joe and I do this presentation for folks we always utilize Maslow's Hierarchy of Needs. Now if our audience is someone in healthcare, you know, they're going to be familiar with Maslow's hierarchy. What we know to be true is that patients that come to us that don't have food, don't have water, don't have shelter, don't have jobs, don't have financial support, don't have family support, they're living in the bottom rung of Maslow's hierarchy. And they come into the ER now on top of all of that. They're sick in some way—that's why they're coming to us. So they're at the end of their rope and anything that we take away from them, anything that disrupts their idea of normalcy. Example, you come into the hospital, we're not going to let you smoke. So that's a big one. You come into the hospital, you know, we are going to kind of tell you what your food is going to be. You may feel like you need pain medicine. The doctor is not thinking that you need another dose of pain medicine right now.

So there are a lot of things that could potentially push a patient who's already at the end of the rope completely over the edge. And not only that, as healthcare workers, when we do registration and people come into our facility, we know they're in the bottom rung of Maslow's hierarchy. And so there's a red flag right there, we need to be identifying these patients ahead of time because they are the ones that have those risk factors to not be able to cope with one more difficult thing.

In addition, we know that if healthcare workers can meet at least one need—just look at their needs. They're cold, they're hungry, they're dirty, you know, they need pain medicine. If we can gain a relationship with that patient, a helping relationship, "Gosh, Mr. Smith, I am so sorry that you look cold, can I get you a warm blanket?" Or "It's going to be a little bit before the doctor comes in and I know you know that you're okay to have something to drink. Would you like some water? Can I get you a nice warm cup of coffee?" They are going to be way less likely to lash out at a healthcare provider who is providing them some help, meeting a need in some way. So the number one way that a healthcare worker can protect

themselves in an environment like this is to meet a patient's needs. And what we know from research through the VA and other sources is that if you meet one need the chance of violence decreases by 50%. If you meet two needs it decreases by 70%. They're not crazy.

So that being the case, gain a relationship and meet a patient's needs, which is what healthcare workers want to do anyway. But sometimes when somebody comes in and they're being difficult from the minute they walk in the door, it's hard to really like that person and want to reach out in that way. So it's getting through that barrier.

Joe: Deb and I have been referring to this as social triage, so that when that person comes to the ED there's going to be triage for their medical issue that they're there for. But we need to be taking a closer look at what some of their social needs might be. Because we know someone who has a history of violence, or who has certain mental health disorders, or the social stressors that Deb talked about, relationship problems, legal action, financial loss, those kinds of issues. Or they can even have a diagnoses or physical metabolic issues such as head injury, addiction, dementia, that could be the underlying factors in this.

So, sometimes it's not really the grievance that's the issue, right? You can't smoke a cigarette, and there's this overreaction to that. It's not that they can't smoke the cigarette, it's these underlying violent risk factors that you could identify through some kind of social triage. And as Deb mentioned, you take care of anyone of them, you've now reduced that chance for violence by 50%.

Terry: So, if you practice this first step of meeting a basic social need with some rigorous training and then with the rigorous practice you can really eliminate a dramatic amount of violence.

Joe: Yes, and you're going where we see some of this work going, if we can train more of our staff in that awareness level of training, you know, the CPI is looking at this awareness product for folks. But if we can do that then we reduce the use of the APT and BA teams in the hospital. We have a unit at Methodist Hospital where the nursing manager there had just trained all of her team members in NCI training. Everyone on there has trained.

Prior to that she had significant turnover in her nursing staff and a lot of acting out that was happening on that since she rolled this out because they are early practitioners and they can gauge at the point of grievance, and deal with these social factors successfully with their patients, they started using APT and BA quite a lot, but now they're not using it anywhere near as much because, that patient-centered care happening at the point of nurse contact with the patient has already resolved those situations.

Terry: Sort of a prevention-first approach.

Joe: Prevention-first approach, exactly right.

Deb: Sure. I want to add to that. On this particular unit to paint this picture for our listeners, this is the unit where this excellent work has happened is the trauma step-down unit. So, again, we're in an urban hospital in downtown Indianapolis, we're a Level 1 trauma center,

we're talking stab victims, gunshot victims, gang members that have been injured are routinely on that unit. And they hardly ever have to call the response team because their staff recognizes ahead of time what's going on. And it's not a normal med surge unit where—or surgical unit where people are coming in for appendectomies. These are people who have been though a violent situation and have a violent lifestyle. A lot of drugs going on. I mean that's a crazy unit, but yet that prevention first and recognizing and developing that relationship has still been able to protect our staff. So that's worth noting.

Terry: You talk about something in your report, the effective pathway to violence process, could you break that down?

Joe: Yeah. I discovered this work. I saw a nice presentation that some people from the VA Hospital were doing and they referenced some research by Calhoun and Weston that had been done where they talked about this pathway to violence. And these researchers they identified that there were two types of violence, affective and predatory. Affective is an emotional response. It's, you know, to fear or anger, it happens very quickly in the moment. Predatory is a non-emotional response. They both have the same sequential series of events that lead to the violent act, but in the predatory violence there's more planning and preparation. They may even go through or drill themselves to see how they're going to do. The shooting in Las Vegas would be an example of a predatory—

Terry: So a lot of premeditation.

Joe: Yeah, it's a lot of premeditation. But what we see more often at our hospitals is this affective violence that—and so some kind of grievance occurs, you know, the patient is a—we tell the patient that they're a fall risk so they can't get out of bed on their own to go to the restroom and they're wanting to get up and they're being restricted, or they can't go outside and smoke, or they're just feeling disrespected, not getting their pain medication on time. Right? So at that point, the grievance has occurred and if you're not using your training to recognize that early and intervene then that person will go through some ideation and that—we all go through ideation, right? That's where we start to consider, if I act in a certain way maybe I'll have my needs met.

Most of us know that the way that we need to act is calm and collected and ask, use our words to ask for what we need. But in some cases people will think, "If I raise my voice, if I move forward aggressively, if I use profanity, I'm going to get what I need." And it's at that point where you could start to use your NCI training or your personal training to try to de-escalate that technique, make sure that you're in a safe position.

But if it's not de-escalated at that point then they move to breach. Breach is where they are raising their voice, they are acting aggressively, and that's the point where staff will start to feel threatened, and they need to recognize "It's time for me to remove myself from this situation and call for help." For us that's—

Terry: And maybe the APT.

Joe: For us that's the APT.

Deb: Exactly.

Joe: Now if the APT team isn't effective or we've let it go beyond breach without calling for the APT team, well, the final stage of that is attack. That's the violence is occurring. And so for us, that's where we use the behavior alert code. So Deb and I were very gratified when we discovered this work because we thought this aligns with our tiered-based approach perfectly and we can really use it as a teaching tool for how to use your personalized, you know, your NCI training, your APT, and your BA skills and tools.

Terry: Is that—and when you talk about the three-tiered approach to safety that's essentially what you're speaking to, right?

Deb: Yes. He just described that to you. So in our tiered-approach the prevention is the early recognition of a grievance that Joe just talked about, meeting the patient's needs, Maslow's hierarchy, and the de-escalation techniques, the *Nonviolent Crisis Intervention*®, the CPI training. Okay? Response to tiered-aggression prevention, which is when the event is escalating but it's not to the point of violence yet, and then the behavior alert which is that eminent threat of violence or actual physical violence happening. The final of the three-tiered approach, the final tier is recovery. And what we know is that after an event, more often than not, after the event of the behavior alert where someone has actually been in a head lock or pinned against a wall, you know, the staff member—when you show up to respond to that you have two victims: you've got the person who's acting out that someone needs to lead and de-escalate, but you also have the healthcare worker who has been injured or frightened so much that they're really shook up. So that recovery phase is very important.

What we have found at the Academic Health Center as well as at the Bloomington campus is that someone needs to attend to that person, it's part of our process. But in addition, many times folks need employee assistance counseling. Thereafter, individual counseling. They end up afraid to come to work thinking this is going to happen again, so they need to feel very supported and sometimes depending on how violent the situation might have been there are bystanders on the unit that are watching what has happened, and you might need a team approach or a team counseling which we call our Critical Incident Response team or Critical Incident Debriefing. And out listeners will be familiar with teams like that, when, you know, unfortunately in healthcare we see a lot of a very tragic things and it affects us.

And so, having those debriefings as a team where we support each other and have therapists help support us, or chaplains help support us as well, is really important. Important part of recovery when you've been a victim.

Terry: Yes. That secondary trauma is critical—stage four of our *Crisis Development Model*℠ is Therapeutic Rapport, and sometimes one might consider that the rapport is more focused on the patient or the acting-out person. But as you just so articulately described, the person that deals with the person with the crisis is going to need to establish their own Therapeutic Rapport with their team, you know, with themselves and kind of regroup and to get

themselves whole again before they engage. And so that's a really important part of the process. It's really exciting to hear that talked about and to be defined as a process that needs to be in place for the healthcare worker.

So, CPI de-escalation training clearly fits into your Aggression Prevention Team and you just described some of that, but you also talked about, in our pre-interview, why a training module might be required for bedside-patient care staff. What would that be exactly?

Joe: I think that's the witness awareness piece.

Terry: Okay.

Joe: That's this piece where bedside staff are recognizing that there are patient needs that aren't being met, or a grievance is happening that isn't being met, and that they can then—to which they can intervene. It may be a little bit, that blends together with the social triage piece, right? And the bedside people also need to know then, from that, when they need to disengage and get appropriate help.

But we found that, as we mentioned, about the one unit and the one nursing leader that by having all of their staff trained they're able to take care of a lot of different issues at the point closest to the patient. And, Deb and I talk a lot about this program. It can seem somewhat transactional to people, but we feel that it's very patient-centered. And the reason that we feel that way, that it's patient-centered is because, as we said these things start with patient grievances. And what we're trying to do is successfully resolve whatever that patient or visitor grievance might be, as close to where the grievance actually occurs, and to solve for that problem.

Terry: That person has a really unique position to prevent, don't they?

Joe: That's right. They're in the space where they can do preventative, by the time you've called for the APT team, that group—and what we find in a lot of places that really need to roll this out is that staff have allowed whatever this behavior is, to be repeated and grow and get really out of hand, before they call for help. Which kind of restricts our ability to be able to successfully de-escalate.

Terry: Well, you're continually in a reaction mode.

Deb: Right.

Joe: You're exactly right.

Terry: And that's going to leave a lag between, so that I think that—sorry, Deb.

Deb: No. I just want to add in there that when a patient is difficult to deal with from the minute they walk in the door, it's really hard to get that relationship going. And then, once that adversarial thing is going on what happens is, the healthcare worker instead of being

able to go in and address the need, they don't want to go into the room. They avoid that patient that's cursing.

Joe: When you set boundaries and expectations early, you're going to be much more successful.

Deb: Right. So that prevention piece is really important to recognize, red flag, red flag, this guy is homeless, you know. Or, he didn't have anybody come in here with him and he's just at the end of his rope already—recognize that early on instead of making it us and them.

Terry: You know, these human considerations, I was interviewing a woman from Australia and she said, "Oh, some of my patients just need their 'cupa.'" And they use that C-U-P-A meaning "cup a tea" or "cup a coffee" (laughter) but it's something as simple as a 'cupa' just putting your hands around something warm, "Somebody gave me this." You could see that as a preventative step where maybe your adrenaline is up because you hear somebody cursing, but if you've got that strategy and you've been trained to think that way, well, maybe if I give them a 'cupa' or I listen to them—I mean just basic things, but trained things that people can learn through repetition, like you said that they might not think of otherwise, because we're already to another stage.

Deb: Sure. Yeah, so it's not uncommon when the APT team shows up to address this, that one of the things the key team leader de-escalator says to the patient is, you know, "Nancy Nurse out here is afraid to come in here and take care of you because you frightened her. So we can't have that relationship if we're going to help you. So what's really going on here that we can address and help you with? And then let's bring Nancy in and all get on the same page."

Terry: Is that part of the who, why, and what of your response before violence?

Deb: Yes, it is. (laughter)

Terry: Talk about that a little bit.

Deb: Yeah, I will. Okay, so part of our strategic plan for this, we've talked about it already. Is to make our caregivers feel safe in caring for the patient but it's also to meet the patient's need. So it's really, you know, meets both of those requirements and, you know, then the tiered response and all. We pulled together a multidisciplinary team to devise the process and come up with a very 360 look at what we needed to be bringing to the table. So, it's risk management, quality folks, chaplains, social workers, nurses, bedside staff, nurse leaders, you have to have your chief nurse or your C-suite as we call it, the chief nurse, chief operating officer, chief executive officer in support of this because it is multidisciplinary. It's not just nursing.

These violent acts happen in our cafeteria, they happen in our parking lots, they happen to physical therapists and occupational therapists and down in radiology. So it's not just about nursing although nurses are the biggest group of healthcare providers so the stats show

that it's nurses. Well, it's all healthcare providers. And meeting those patients' needs is a big piece.

So we pulled together this multidisciplinary group and we devised a process for the APT that is on Joe's pathway to violence between ideation and breach: I recognize I need some help. I call this team, but violence isn't happening at that moment, okay? It's just on the pathway to that. So this team for APT is paged, it's not overhead. They are paged, its assigned every day throughout the system, so 24/7 coverage for people to respond. The staff that are on the team have 10 minutes to arrive. So, basically, we're pulling staff away from a job they're already doing. So, if a social worker is dealing with another patient, they're going to have to stop that interaction and leave, if they're on the team.

So, 10-minute arrival, the team shows up and the first thing that we have them do to huddle with the person who's called. So say Joe is the bedside caregiver and I'm the team lead that shows up, I would say, "Hey, Joe, what's going on with this patient? How can we help you?" And it has to be that kind of approach. It can't be "Well, why did you call us?" because that comes across as, you know, "Couldn't you handle this yourself?" You know, you want it to be, "We are here to help you, what's going on and how can we help you?" because now we got a caregiver that's kind of at the end of their rope, that's afraid to go into the room. So we need to address Joe first. Find out what it is he feels he needs, and then, you know, it might be the story he's ripping his telemetry patches off, he wants to go out and smoke, he says, "If I come in there, again, he's going to punch me in the face." You know, so you figure out what's going on.

Three people show up that are key to this team. So we have that lead de-escalator which, at the Academic Health Center, is the social worker. We have a security person and the security person is there to render the area safe, and sometimes that means standing by, not even going into the room. So Joe can talk more about the security person's role because it's very different in an APT and a BA and I'll let him take that since he's our security expert. And then the other person is, at the academic health center is a chaplain, and that chaplain is here to support Joe. So you've got that lead de-escalator who's the expert in *Nonviolent Crisis Intervention®*, and he's going to own the patient and that's typically a social worker. Then the chaplain for Joe, and then security are standing by.

They go in, the lead de-escalator goes in, finds out what's the issue with the patient, they already know from the nurse's perspective, they have a conversation and they set boundaries around what's going to happen; that's a big piece of what our team does. We call it a care contract, it's not actually a written contract, but it is documented in the electronic medical record.

If the patient is cursing and throwing things or whatever, or say there's a visitor and every time mama comes to visit there's a difficulty between the patient and the mom. Then there maybe visitor restrictions. It's boundary setting around what the patient is doing or what the situation is. Saying, "You can't be cursing at the nurse anymore because now she's afraid or Joe is afraid to come in. He's afraid to come in here and take care of you. So what needs to happen? What's really going on?"

Terry: So you set some limits on the patient's behavior.

Deb: Exactly. And that gets documented in the record so that there's consistency because that's an important piece of it also. Then after the patient has been calmed down, Joe's been talked to by the chaplain and, you know, we're going to have a little post-huddle, and we may even bring Joe into the patient's room; that's not uncommon for that to happen. And then the conversation and they're all on the same page, "Here's the plan we're going to use to meet your needs, Mr. Smith, and for Joe to still be your nurse and take care of you. Okay?" So everybody is on the same page, it gets documented if need be. Sometimes the first time they call the APT on a patient, they won't document it in the chart and make real strict interventions, but sometimes that's necessary. So certainly the second time an APT is called on a patient it may be, "We're going to restrict visitation for 24 hours for your mom because every time she comes there's another blow up." Does that make sense?

Terry: Totally, yeah.

Deb: Okay, and that post-huddle piece is really important because it gets everyone on the same page with that contract, or care plan. Care plan for this patient is better nomenclature.

Joe: I would add to that that the de-escalator role is also the person that leads the group and does the documentation at the end. They have to have that, as I said, that NCI ninja mentality. The police officer or security piece on an APT, they have to do an assessment, and their assessment is whether my presence is going to help calm the situation or whether my presence is maybe escalating the situation, and then position themselves appropriately. And then the piece that I would add about the chaplain piece in our place, or the team member support piece is that de-escalator is very micro, right? They're focused on the antagonist and on what's right in front of them. The support person has to be more macro in their approach. Right? So they're looking at this team member to make sure this team member is okay, but they also have to be aware of the other folks on the unit, and whether other people are being adversely impacted by being close to what's taking place here, or even visitors. Or whether there might be a young child that's there and what's occurred is dad has smacked mom. So that they have to kind of have a more macro look at what's taking place and then bring the right resources.

Terry: Boy, you can really see that when you have a team that functions like that, and someone that looks for that, you can see how culture change really starts to happen because you know that that assessment is happening in real-time in every scenario. Who's being impacted here? What are the unique contributing factors? Who's in the unique environment? Is the person who's with the person who's acting out, the one that has the best rapport with them? I mean, there's this continual re-evaluation of the scenario. I mean that's got to be a huge culture change on the floor.

Joe: You know they say that—and I'm not sure how you get to this figure—but they say that only 30% of assaults that occur against healthcare workers are reported. That it's a widely under-reported event. I feel pretty comfortable that with this system that we've made that

culture change where our assaults are not going under-reported because, we have this response team that's coming to those events and recording those events.

Terry: So, a benefit that maybe wasn't designed in, but happened as a result of the steps that you took.

Joe: Yes.

Terry: Fascinating.

Deb: You know Terry, what you just said about the culture change piece I think that's really the beauty of the fact that we have that multidisciplinary team. You know, sometimes you need to tag out and let somebody else, you know, take over, and that's really what we're allowing that healthcare worker to do. But the team that shows up isn't just one person it's really that group think. It's that chaplain who's going to see this with one lens, the social worker who will see it with another. You know, another nurse, the charge nurse, it's a different group of people that can see a clearer picture of what's really happening, so that's the beauty of it, you describe that really well. So, yeah.

The other thing I want to say about the APT is that we're talking about social workers and chaplains and security officers. Our APT and BA response is really very flexible in the way that these roles don't have be filled by those specific disciplines as long as you have a person onsite 24/7 who is that, and I'm going to use that ninja term, that *Nonviolent Crisis Intervention*® ninja that can meet that role. It doesn't have to be a social worker.

In fact at Bloomington Hospital where I rolled this out we don't have social workers and chaplains 24/7. So part of when we developed the team at Bloomington hospital for IU Health we had to look at who is available 24/7. And we realized that we have a nurse administrator that's there, and they're usually handling a lot of these problems anyway. So we trained them to be that ninja for us. And so it doesn't have to be a social worker, although if those folks are available that that's kind of their wheelhouse, their swim lane, so it's good. But if they aren't there, there are other people who can be trained to help, and still have this response. No matter if you're a critical access hospital, a small community hospital, or a big academic call center. You don't have to have the resources. You need the roles for each of these. The de-escalator, the person who's going to help your staff member, and then the security presence for safety.

Terry: So it's a flexible team depending just on people understanding their unique role within the team.

Deb: Correct.

Joe: And we talk to, when we're helping people to roll this out about it's the—what the steering groups need to do is they need to look at what resources they have to fill these roles and if there are any gaps in their training and what they might have to do to fill those gaps too. Not only to identify the appropriate resource but to see that that resource is appropriately trained.

Terry: So you can build in that flexibility by doing a training inventory and determine who has and hasn't had it.

Joe: Yes.

Deb: Exactly. And you know what? I anticipate, and we've instituted this at the three hospitals in the Academic Health Center when I took it to Bloomington Hospital, it's the response teams are completely different. Almost every hospital, I think where we go to, would have a different story to tell, which is why it's really important to do that initial gap analysis and resource allocation piece. But I feel, in fact, I know this to be true, that it's very, very flexible and that is as long as you have that training for these folks. Do they know how to do *Nonviolent Crisis Intervention*®? You know, can they see that macro picture of what's happening on the unit? You can train people to do those things. So I think it's very adaptable, which is beautiful.

Terry: My next question it seems, maybe, obvious but I think there's a deeper answer here. The majority of assaults on nurses—are they intentional? I mean do people mean to do them or is it—?

Joe: No, the majority are non-intentional, in fact, and as we look at our statistics and data around that, as much as 65% to 70% of our assaults are non-intentional. The reason is patient diagnoses. Right? You have patients who have dementia, you have autistic children in the pediatric healthcare community. You have traumatic brain injury folks. Now, if you're the nurse on the other end of the smack, it doesn't necessarily make a difference to you whether it was intentional or non-intentional. You just want the violence to stop.

Where this is taking us in our work, going forward, is whether we need to have a differentiated response or differentiated de-escalation techniques, based upon patient diagnoses, and we're finding it to be true. I think CPI has a space where they're trying to work with de-escalation with demented patients, right?

Terry: Yes, we do. We have a Dementia Care Specialists division.

Joe: So we're not quite there in our work yet, but I can see a point where we would have a defined behavioral assessment and treatment plan, more based upon diagnoses so that it's more focused for a particular patient.

Terry: So you may do yourself out of a lot of these kind of reactionary incidents of violence, if you have that in place beforehand because you will have anticipated—because you understand the diagnosis associated with the patient.

Deb: Correct.

Joe: Exactly, right. And this is really important to your security piece of this as well. One of the main ways that hospital security, or hospital police department in my cases, differs from municipal policing is the majority of people that you're going to encounter have an inability

to comply, based upon diagnoses, right? So you can't continue to be aggressive with them to try to get them to comply. They have an inability to do that based upon their diagnosis.

Terry: And so the caregiver understands that going in, what an advantage they have, in the way that they can both anticipate and then react to patient behavior.

Joe: Right.

Deb: Absolutely. And really, many, many hospitals, our listeners I'm sure will agree with this, they hire ex-police officers, so they have people who are police officers and they part-time work at the hospital. So it's a complete mind shift for a security officer in a hospital to view what they do as being part of a healthcare team and a healthcare provider as opposed to, "I'm supposed to render everything safe and have that compliance piece." And so it's very, very hard for security officers to realize their role difference.

It's something that Joe and I feel is very much an opportunity in healthcare to put special training together for security officers that are in healthcare environments because, their role is really different. We're expecting them to do something completely different. Sometimes we need them to be that police officer. In a behavior alert, we certainly want them to come in and know how to do that and they're excellent with that. But they need to mind shift a little bit when it comes to what Joe just described about compliance, versus, you know, just being supportive.

Terry: And the lessons that through proper training could be internalized pretty quickly I would bet.

Joe: Yes.

Deb: Yes, they can. But, again, that's part of that culture change.

Terry: So let's say a behavior alert has been called and there's violence occurring. What's the response? Is it an archetypical response to this or is it too varied to—I mean what happens?

Deb: Well, actually the team for Behavior Alert and the team for the Aggression Prevention Team are the same players. They're the same people that day who are going to be on call. Okay? But their roles are different when they show up. Okay, so what they do is different. First of all for a Behavior Alert violence is occurring we don't have that 10 minutes for anybody to show up. They have to drop what they're doing just to exactly like a code blue or a medical alert. When it's a medical problem and it's going to be announced overhead, three times just like you do, "Code blue, room 4422" whatever, same kind of thing. So, it's announced overhead, and people drop what they're doing immediately, and they run to the scene. Security, in this situation, because violence is occurring, they aren't going to stand back and huddle, there's no pre-huddle that happens with a behavior alert. We can figure out what's happened after we make the scene safe. So, security dives right in and makes the scene safe.

Terry: It's more hands-on for the security.

Deb: Definitely, a good way to say it. The de-escalator is still going to do that role but after the scene is safe and things have calmed, the de-escalator will still be that lead, goes in, and figures out what's going on with the patient. The chaplain, or that role of supporting the caregiver that has been assaulted, or frightened, or whatever, hopefully not injured, will take that on, that situation on and support the staff member.

It's also very important that as things calm down, you know, we need to consider part of what we talk about with this patient is going to be a clinical piece. What we really find is that behavior alert brings in the clinical, is this patient a traumatic brain injury patient that had impulse control problems. Is this patient psychotic? Did they miss their psychotic medicines because they're on a medical floor and nobody was really addressing that? Is this patient going into withdrawal? Many behavior alerts that we see are alcohol withdrawal patients that we didn't recognize they were going into withdrawal ahead of time. So, we haven't medicated them, and they don't even know what they're doing when they're delirious from alcohol withdrawal.

So, again, recognizing this is starting to ramp up sometimes requires that clinical input. So, in a situation with the behavior alert it's almost always the case that the nurse involved with that patient will need to call the physician and will also need to maybe involve a psychiatric consult if that's available. We also realize that our multi-disciplinary team of having pharmacy help us plan for this behavior alert.

What we did at the Academic Health Center is we had pharmacy as part of our group, because we realized sometimes when you show up and it's a situation and this person is acting out because of withdrawal, we don't have the meds we need to treat this patient with, without ordering them, having to wait 15, 20 minutes for them to show up.

So we automatically have certain drugs put in our auto-dispensing that can be overridden by any nurse. So if you need Ativan, if you need Librium, you know, if you need Xanax, they're available and you could take them out at any—so the nurse, all they have to do is get a verbal order. We're not waiting for transport person to bring us a drug. And that is really how behavior alerts are handled that's almost always a clinical piece. Do you want to add to that Joe or—?

Joe: No, other than to say that that's right, the behavior alert is treated as a code so that's the difference. Violence is occurring and this is where we now get the clinical person involved to help us solve that problem.

Deb: Yeah. And really the post-huddle still happens with the behavior alert, certainly no time for the pre-huddle and we could figure that out after. But the post-huddle is really important because it's not uncommon after a behavior alert for the patients care plan to dramatically change with medication administration. Sometimes the patient is actually removed from that floor and taken to a critical care or a progressive care or to a behavioral unit.

Terry: And let me stop you there, Deb, because you're really—and just to let you jump in again you're answering my next question which was, why is the debriefing and the form that's filled out and submitted to the unit manager, why is that step so important? That I think you're kind of detailing the benefits of what filling out this aggression-prevention behavior alert pre/post debriefing form as you called it. That's a mouthful but very useful and for the reasons you're describing.

Deb: Yeah, absolutely.

Joe: Yeah. And to lead you into that another way that a behavior alert is similar to a code is we audit all of these. We follow up and do audits just like they would do an audit of a code blue.

Deb: Right. So really if you pull and use the debriefing form the APT BA, and it can be used for either. It really lays out the process as it should happen. This form has gone through, I don't know, probably 15 renovations, 15 different—

Joe: Lots of different iterations.

Deb: Yes, because we want to know who called it. We want to be able to follow up afterwards and make sure that we've crossed every t and dotted every i. So who was caring for the patient? Who showed up? Because sometimes the person who is doing the role of the de-escalator for the day may have been involved in something that couldn't really be pulled away for, from that APT. So someone else on the team that shows up is going to fill that role. But maybe somebody didn't show up and we need to investigate why because the last thing we want to do is have our staff call a behavior alert or an APT, and then the team doesn't respond appropriately.

You've got to have a response here and that needs to be looked into, if it doesn't happen right. The pre-huddle is precipitating events and usually we hear, "Oh, this guy has been ramping up for three days, you know?"

"Well, don't wait so long next time to call us." And, then what was the caller's concern? "How can we help you deal with this patient?" And then, the post-huddle is going to be, "What's their plan of care?" Lots of interventions can happen, sometimes it's the care contract we talked about, sometimes it may be medications needed. Sometimes it's restraining the patient. We don't want to do that. We can use every other intervention beforehand but sometimes that is necessary.

Maybe the patient leaves against medical advice, you know, again, we don't want that. We want the patient to stay and allow us—

Joe: It happens with smokers a lot.

Deb: Yeah. They sign out AMA (against medical advice), go smoke their cigarette then come back to the ED 15 minutes later. It's crazy. But if that's what they need to do, then they have that right. Sometimes we find that we maybe really missed that this patient was in

withdrawal, and they need to be medicated and taken cared of for that. So their whole care plan changes, with that multidisciplinary team of the physician and nursing staff being involved. Sometimes we have to put them on a 72-hour hold maybe they're dangerous to themselves or someone else. Maybe we put them on a one-on-one observer. I mean these are all outcomes.

So, that's why it takes this big team of responders to help figure out what are we really dealing with here and how we can best help this patient and keep our staff and ourselves safe.

Terry: So very much a living document that becomes prescriptive as people learn how to correctly fill it out.

Deb: Right.

Terry: Or we rigorously fill it out. I mean it sounds like it has to be. Again, part of culture change is a document like that.

Deb: Sure. And then we want to notify the primary care physician so that they're aware this has happened with their patient, as well as the manager. If it's 3:00 in the morning that manager wants to come in first thing in the morning and know, "Hey, there was trouble in this room last night. I need to have my eye on that today to help the staff." And then, if somebody is injured all of those things, we want to know if there were injuries, we want to be sure that person gets help and then we also want to be sure that recovery piece happens. You know, do we need to send somebody to counseling? Was something so egregious that happened on this floor such that we need to do that critical incident trust debriefing for the team?

So it ties a bow around the whole process, to make sure that we don't miss anything that really still needs to be addressed. The final piece of this is that we always ask staff, "How did you feel about our response? Did we miss something?" Which is why this debrief form and why the process has really evolved over time because, it's continuous improvement as we go. If we miss something that staff member will tell us and they're the best, they're the expert on that. What could we have done better in this response? So it's an excellent tool to help us improve our process.

Terry: And you're also indemnified by the documentation, which is another benefit.

Joe: This documentation together with trending your metrics, Deb touched on is what leads you towards continuous improvement in this process. Just as a quick example, in the pediatric realm most of our responses aren't patient generated, they're parental, visitor generated. And so sometimes the follow-up or the consequences of what we have to do there, is we do a 24-hour cooling-off period for the parent where we ask the parent to leave and come back. That's different in the pediatric realm. But one of the things we identified is we were doing this work through these documents and the trending was that where there were patients involved, they were autistic children. And we had to have a more specific plan for how to de-escalate with autistic children. And we were able to connect those people in

our pediatric hospital who knew how to work with autistic kids, together with the staff members who are treating them for things other than their autism, to put good behavioral-care plans together. And that came out of this documentation work and trending.

Terry: Otherwise you wouldn't have known to ask the question.

Joe: We wouldn't have known to ask the question.

Deb: Exactly, and that's the beauty. And I can't stress this enough to our listeners about multidisciplinary approach because our process will continue to evolve as we come across additional situations that we haven't dealt with before. And so, it will just continuously improve as time goes on. Another example of how we change this process is early on at the Academic Health Center when Joe and I were doing this work, we had the APT and the response would happen, and we stated getting feedback from the staff that—so, say Joe is the caregiver, he's the nurse for the day. This team would show up, they knew the room number of the APT. The de-escalator would go in and talk with the patient, find out what the grievance was. Try to meet that need and sometimes, sometimes maybe not afterwards come out and talk with the nurse. Talk with Joe and say, "Hey, Joe, I went in and took care of this." Well, if Joe was busy with three other patients or there's a code, medical code down the hallway and Joe is involved in that, then the de-escalator and this team would leave, and Joe would not know what had happened.

So the pre- and post-huddle were added to the response team, I don't know, six months to a year after we launched because we didn't realize we weren't meeting the need until the staff said on this debrief form, "I guess they came. I'm not sure what happened." So "Oops, we got a communication problem. We need to do this better." So that's what created the pre- and post-huddles as a very deliberate part of the team to make sure everybody is on the same page with the new care plan. Yeah?

Terry: Well, let's start to talk about some of the results. What are the statistical trends for reduction in assaults since APT responses increased? First of all, why do you think there's a higher percentage of assaults now being reported? I think we've talked about that a little bit, but we can reiterate it, and why do you think violent injuries to nurses are increasing?

Joe: Nationally?

Terry: Yes.

Joe: Because violent injuries to nurses within the Academic Health Center in Bloomington are decreasing as a result of this work that we we're doing. Yeah, we've tracked a reduction in assaults from 2016 through 2017 by as much as 12%.

Terry: I'm sorry, I misspoke, decreasing.

Joe: No, that's fine.

Terry: Okay.

Joe: You gave me a chance to really jump in there with my response.

Terry: Good deal, all right. My face is less red now. (laughter)

Joe: We're doing great work. And, in fact, this reduction has happened as I mentioned earlier while the CDC has found violent injuries have doubled nationally, that's why I said you're correct. Nationally, they have increased, but as a result of this work we've seen a decrease in assaults overall. The other good trend in this work is even though—we've rolled this out several years ago. I think we started in 2013 with our initial plans and our initial processes. But from that time to currently we continue to see this upward trend of APT responses. And what that tells me is that folks are identifying these patient grievances and I look at every one of these APT responses as an opportunity to help a patient.

Whatever that patient is having an issue we're responding a team to resolve that patient issue and we're doing it without it getting to a violent act. So, we have APT's trending up. We have assaults trending down and I just think that that's a wonderful dynamic, and I'm happy that this has happened over the series of years because it shows me that's its sustainable.

And, I believe that one of the reasons that it is sustainable is the work that we just talked about. Right? The continuous improvement in communication and training so that this work continued to be sustained over a period of time, as long as you're keeping your eye on it.

Deb: Yeah.

Terry: So you're almost seeing an inverse relationship between calling the APT—as those increased the behavioral incidence went down.

Joe: Exactly, right. And we're hoping the evolution of this that at some point maybe if we do a better job of more broadly rolling out the awareness training, and getting more of the bedside folks trained appropriately, that maybe we'll see the APT go down because they're able to do that work without engaging the team.

Deb: I actually, you know, having been in nursing for almost 40 years, I really think that I don't see APT is really ever going away or going down a lot and then—

Joe: It's trending differently.

Deb: Yeah. And the reason being, as nurses come into our profession and we've got an aging nursing workforce, you know, so as new nurses come in to our profession, as you're developing as a nurse, you're interested in taking care of those medical things. And I know because I was there that you're interested in making sure I don't miss a vital sign that's going south in the early stages, or, "I'm not quite sure how to work this pump," or, "I need to make sure that I'm giving the right dose of the medication here." So, you're very task-oriented at first. And to deal with a difficult patient and see that bigger vision, as a new nurse, they're really not able to do that yet. They haven't developed that skillset.

So, you need a couple of years to practice and with the help of your colleagues, the leaders that mentor you on your unit, to see that. But in the meantime when that patient is creating a difficult environment for you to care for them and they're starting an adversarial relationship with you, you're going to have to call for help which is great because then, that at-the-elbow coaching of that interdisciplinary expert response team can help you learn that skill. So, I think it'll always be necessary but hopefully fewer behavior alerts because we're recognizing it sooner.

Joe: Yeah, you raised a really good—made me think about a good point as you were saying that Deb, and that is that feeling threatened can be a subjective thing. Right? So we see it in healthcare, I mean a seasoned emergency room nurse is not going to be threatened by a loud voice and profanity, right.

Deb: I could speak to that.

Joe: That they're dealing with that. Conversely, though a nurse who's on the maternity ward, you know, that an OB nurse that might, if the husband of the mother begins to escalate in that same way, they may feel very threatened by that.

Deb: Yeah.

Joe: So those responses will be there, and we have, and as advice to anybody that's rolling this out, you have to be careful about chiding anybody for calling, that based upon that subjective, "If I feel threatened, I feel threatened." And I've got to let you own that and still be there to help you in that moment. Now you can do a little at-the-elbow coaching about, "Maybe this wasn't a behavioral alert when you got that dirty look, but I'm glad you called for help."

Terry: It's a confidence builder for someone with relative experience. It's a great outlet to know it's there.

Deb: Sure. One of the things that Joe and I know, having rolled this out in four or five hospitals is, that one of the questions we always get asked by the staff that don't know the difference between an APT, haven't seen them in action yet, is "How do I know which one to call?" And the beauty of our process is that you don't have to know, it doesn't matter, the same team is going to show up.

Joe: And they'll know that.

Deb: They'll know. They'll know if it's a behavior alert or an APT, and then after they do that at-the-elbow coaching, you'll know. So it doesn't matter, call. Just call for help and we'll figure it out when we get there.

Terry: But you also have something in place called an APT/BA decision tree that a hospital staff might be able to internalize. Describe what that form looks like.

Dev: Yeah. Okay, so I'm very visual so I'm—unfortunately with our listeners, I can't share this like I'd like to. But basically what we did was, because that question was asked so often, we developed a visual that at the top says, you know, "Do I call an Aggression Prevention Team or do I call a Behavior Alert?" And then it has, kind of, on the far left it's a patient with dementia. Do you call an APT? Absolutely. Because this team is going to help you even if it is dementia or traumatic brain injury or autism, we can still put a plan in place. But the response will be a little bit different for a patient with dementia than it is for someone who's intentionally screaming and yelling and cursing because you're not going to put a care contact on Nana who's demented. But you most certainly are on a patient who, you know, is throwing things in the room.

So the response is a little bit different but, again, just call for help. And then, of course, if imminent violence is happening then that's the behavior alert. So it's just kind of a visual for staff that aren't familiar. We put this in our emergency—every nursing unit, most nursing units have the emergency response, like, if there's a fire flip to that page and it tells you what to do. If there's a bomb threat flip to that page and it tells you what to do. That's where this APT decision tree goes. So that staff can easily access this information and, kind of, get in their mind, "Well, I think this might be an APT, let's call that." Okay?

Terry: All right. So let me wrap today by asking you kind of what's next for APT? And how can your findings help inform CPI training, for instance social triage and healthcare? How does that fit in with CPI's awareness training?

Joe: Well, we very much see two pieces to this work as being the evolution to this work. We've talked about social triage quite a bit in this, but sometimes we even refer to that as tier zero. We've got our first tier, second above, but we're thinking maybe we need to be concentrating a little bit more in this prevention area, in this tier zero. And in that realm, I think it ties in very closely to the awareness-level training that CPI can evolve.

On the other end of this we talked a little bit about trying to customize our de-escalation techniques based upon diagnoses and trying to work in a behavioral plan with the rest of the treatment plan for particular patients.

And as we said then, CPI lives a little bit in that or not a little bit, they live in that space of how to do that with dementia patients. And we see that becoming a little broader because there are plenty of areas to focus on and maybe the greatest one is addictive behavior.

Deb: Yes.

Joe: Right? So, in that realm. So that's where I see some of these growing and I see our partnership with CPI and CPI training growing as well. The last thing that I would say is Deb and I are very passionate about this program. We've seen the results within our own organizations, and we've seen less nurses being assaulted, less team members being assaulted. And, we've seen people just feel safer and more supported in the workplace and we'd like to see this work just rolled out much more broadly that's why I'm very gratified to be here today, talking about this because we would like to see this become the standard for folks all across healthcare to keep their people safe.

Deb: That really speaks to the workplace violence Sentinel Alert that the Joint Commission, we talked about early on, you know. Violence is increasing in every healthcare facility across the nation. And this alert came out to make everyone aware and there are going to be regulations that require hospitals to put into place prevention teams like this. Okay? And the beauty of what Joe and I have done here with this work is the fact that it is duplicatable and I know that because I took it from the Academic Health Center to a small community hospital where I work now, at Bloomington, and some of the outcomes that we have seen are very similar to what Joe has seen.

We started the work in November of 2017 and in a little over a year we have had a 52% decrease in assaults with injury, and a 43% decrease in our violent restraint use. That's amazing. That is just amazing to me.

Terry: Restraint reduction, we love it.

Deb: And I'm trying still in the process over a year's time the culture is not in place to really have these dramatic results, but just the fact that we have the response team has created those results. So, we still have with those debriefing forms, are still working on fine-tuning what our process looks like at Bloomington Hospital. However, we're still having very, very good success and culture change takes time. So I anticipate that, and we know for sure that as our APTs and BAs go up, these assaults and restraint use go down and that this is duplicatable. Any hospital in the country could take this program with assistance in the customizable piece of it, for who's going to play the roles, and see good results. So, it's pretty exciting work. We're obviously excited about it and still happy to be able to share it today.

Terry: Well, thank you. I mean more than promising, it sounds necessary too, after you lay it out. It's like with this, when you've got restraint reduction, you've got stats like you've got, and you've got this process in place that is making facilities safer both patients and staff alike. That's an essential curriculum I think or a process for any healthcare facility to consider and put into place. Thank you very much both for joining me today. My guests have been Deborah Fabert, is that—

Deb: Fabert, that's right.

Terry: Good, I had it right then.

Deb: Thank you Terry.

Terry: I didn't get that beforehand but I'm going to leave that in that's fine. Deborah Fabert She's the director of behavioral health at Bloomington Hospital in Indianapolis and Joe Anderson, kind of hard to mess that one up, the director of protective services, and the chief safety officer for Indiana University Health also in Indianapolis. Thank you, Deb and Joe, so much for joining us.

Deb: Thank you Terry for having us today.

Joe: Thank you for having us.

Terry: And thank you all for listening.