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Episode 73: Susan Driscoll

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Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, a CPI podcast series. This is your host, Terry Vittone. Today I'm joined by Susan Driscoll, the president of CPI. Hello and welcome, Susan.

Susan: Thank you, Terry.

Terry: Thank you for joining us. Now, I understand that you were recently in San Antonio, Texas, giving a presentation at Relias Impact Nation, a national healthcare conference. Your presentation titled "Workplace Violence Prevention: Seven Steps to Success" offered solutions to what could rightly be called a crisis in healthcare today. I'd like to ask you why addressing workplace violence in healthcare settings has become such a pressing imperative, along with some specifics about the content of your presentation, including the introduction of CPI's new *Verbal Intervention*™ Training program. So, let's begin. In a recent CPI press release, you are quoted as saying, "We are experiencing an unprecedented time of workplace violence in healthcare." Can we start today, Susan, by having you first define workplace violence and then explain the market research and stats that support the statement?

Susan: Absolutely. So, workplace violence is any sort of either verbal or physical escalation that leads to, you know, harm, either psychological harm or more likely, physical harm. In healthcare, it's always been acute. It's now becoming more...people are becoming more aware of the issue. So, for example, healthcare workers are four times more likely to be the victims of workplace violence than any other profession. Seventy-five percent of all incidents of workplace violence happen in a healthcare setting. Ninety-five percent of healthcare workers report being physically or verbally abused at some point. The statistics are staggering.

Terry: Indeed. I mean, when you talk about almost nearly 100% of the workforce at some past point had either a verbal or a physical threat or something they perceived as violence in their workspace.

Susan: Absolutely. And it's always been part of the nursing profession. Nurses feel that, you know, it's part of their job to be abused. And the American Nursing Association is finally standing up against it and saying, "You don't have to take this. It's not part of the job. It's not normal. You need to start reporting incidents and we need to make this a bigger national issue."

Terry: Well, I guess it's very timely, you know, with things like the Me Too movement, things like that. One wonders, why nurses being, I think in the past or at least perceived to be, but probably demographically, too, to be so often women and that somehow, it was okay for women to suffer this abuse and then not talk about it. I think part of the really energizing thing about this coming to the forefront rather than letting it just depress us or wipe us out, like, "Oh my God, we can't combat such a big problem." We can at least say, "The door is open for dialog."

Susan: Absolutely. And I think it's not just the fact that it's violence against women. Nurses in particular and healthcare workers just assume that either it's part of the job, or more likely that the person who is being violent doesn't know any better. You know, either they have a mental illness, or dementia, or some cognitive challenge that makes them act out. And so, it's just part of the job. In fact, it's not part of the job and it should...you know, the incident-reporting and making people aware can actually lead to better care. And I think that's the number one message to get home.

Terry: You know, along with all this violence, my second question, along with the urgency of addressing workplace violence with the human suffering involved, in your presentation, you talk about some of the staggering costs that are associated with the effects of this violence. **[00:04:00]** Why don't you talk, if you would, about the real costs associated with workplace violence.

Susan: So, the American Healthcare Association released a big study in 2017 and their research showed that $2.7 billion was spent in 2017 in proactive and reactive response efforts to workplace violence. So, it is very, very expensive, closer to, you know, down into the individual facility. An average workers' comp claim is about $16,000. And if you're a victim of violence, you're more likely to, you know, have a workers' comp claim, days lost from work. What I've really been focusing on is the impact of workplace violence on turnover, and especially turnover with nurses. There was a study that was actually just released last year that made a definitive correlation between incidents of violence and nurse turnover and not only the cost of replacing a nurse to the healthcare facility, but also the cost of being understaffed and what that can do to quality of care. So, when you just think of all those different aspects, it's just an enormous problem that has to be addressed.

Terry: I think that, you know, those figures that you quoted as astronomical as they are, you would think that preventative, an ounce of prevention here, I think one would spend much less. I wonder what the training budget to prevent violence is compared with the money spent after the fact to try and address the effects of violence. I suspect it's a much more modest number.

Susan: I would agree, although I do think that's changing. So, 22 states now have requirements that all healthcare workers have to have some sort of preventative training. There's legislation in the works at the federal level. So, I think, you know, people are becoming aware of the problem and the cost and trying to stop it before it gets out of hand.

Terry: You know, that's interesting with turnover, too, I mean, sometimes good people just leave the profession and then you're left even more in the lurch because you've got the lag between, then, the new training that it takes to get the person in there. So, a lot of the impact from what one's outburst or a strike could have, you know, on a whole system is just staggering to kind of imagine the repercussions that violence has in the healthcare system. Even though, in our next question, training could potentially de-escalate the often highly emotional and troubling situations before they spiral out of control. According to market research, a vast majority of workers don't receive workplace violence prevention training. So, Susan, what are some steps organizations and groups committed to change can take to make violence prevention training a reality where they work?

Susan: Sure. So, I think it's most...the first point is making it an issue. You know, there's certainly enough in the news, in the press now about the problem, but again, I think it's, you know, many people in a healthcare facility think it's just part of the job. And I think there needs to be a recognition, an internal recognition that we're not gonna stand for this anymore. You know, speak up, make it an issue, let leadership know that it's a problem. I think that's the first step. Second, and I think this goes with the lack of incident reporting, there needs to be much more of an emphasis on reporting incidents. And I would say that starts with having a policy of what an incident actually is. A lot of the research shows that incidents don't get reported because workers don't know how to define an incident. You know, if it's somebody who's under the influence of either drugs or alcohol and they lash out, is that an incident? They're not aware of what they're doing. If they were, you know, completely sober, they wouldn't be doing it? It still is an incident. You know, if it causes any sort of physical or even psychological impact to the staff worker, it's an incident and should be reported. And I think when facilities and individuals make it more purposeful to record the incidents, then they'll really see the true number of events because most of them go unreported today.

Terry: So, this is really some very rudimentary framing of what the behavior is and when and how it needs to be recorded or interpreted.

Susan: That's right. And again, I think that for a nurse, in particular, looking at it as if you report the incident, you are actually giving somebody some insight that could lead to better care. There might be a trigger there that you weren't aware of. But when someone else sees a pattern with an individual patient, they'll recognize, "Oh my gosh, you know, maybe there's trauma in their background. Maybe there's some other factor." So, it can actually lead to better care. It's not punitive. It's actually, I think, a form of caring.

Terry: You know, a former CPI employee who was a clinician told me in a podcast that I did with her, woman named Kendra Stea, she said that…she was emphatic. She said debriefing is the most important part of this process, probably.

Susan: Absolutely.

Terry: That is, reviewing an incident with your peer group after it's happened, that just what you spoke to for those healthy...the healthy exchange of, well, you know, everybody gets to contribute their experience to learn from what happened. You know, maybe a solution is closer at hand or, you know, just growing cohesion among a group of people who then are no longer afraid to speak out.

Susan: Exactly. So, it's recording the data on an individual patient level, recording the patterns and then, you know...that will lead to an increasing recognition of the problem and then, you know, de-escalation training becomes a natural next step, I think.

Terry: So, how do people go then from, "Okay. We've got this stack of papers and they show something dramatic and negative happens here on a regular basis. We're all getting hit or spit on or assaulted in some way," how do they start a training initiative?

Susan: Well, I think it starts with, you know, wanting to address and solve the problem. What I think is so powerful about CPI training and the programs that we offer is that we teach staff members that they can change their behavior, they can change their approach in very subtle ways, and it can actually de-escalate that person. You know, the crisis prevention model [*Crisis Development Model*℠] with the four stages of the crisis and what somebody can do at each stage once they recognize those stages and once they, you know, develop the muscle memory for how to, you know, react rather than letting what I call the amygdala hijack, you know, when someone is truly in control because they've practiced our techniques, they can recognize, you know, the stage of a crisis and know exactly what to do. And it makes a huge difference. We hear that every day.

Terry: I was first trained by Dan Lonigro, and it was a revelation to learn the *Crisis Development Model*℠ and just to this huge "Aha!" ... not just how to think about more kind of, I guess, dramatic situations, but I brought it back to my own family, and some members of my family who would challenge on a certain basis. And I thought, "You need to de-escalate instead of engage." And I mean, so there was this light from this behavioral model, and I think I could see a lot of other people in my class that had that same [impression], "This is gonna be with me the rest of my life."

Susan: That's right. And I trained with Jeff Schill when I joined CPI and I had that same aha moment, but what's also powerful about the training is hearing the stories of the staff people who've been through the training and, you know, who are Certified Instructors and the incredibly powerful results that they've achieved from the training. It's just, you know, it makes me just so grateful to be working for this organization and to be able to do the good that we're doing.

Terry: Hear, hear. So, there comes a point after they develop a training plan where they then would want a strategy in place with…this was part of your presentation, I think. And how would that strategizing…what kind of steps would people [interested in bringing training to their organization] take?

Susan: So, I think the most important thing is just to start somewhere.

Terry: Just to begin.

Susan: Just to begin. You know, I think the cost, or the perceived cost of the training can be overwhelming to an organization. So, it's important to start somewhere. It might be, you know, giving all of the employees some sort of orientation training, like our *Prevention First*™ product. It might be taking the highest risk area, like the emergency department, and immersing them in skills. We have some clients who have behavior response team. So, their way of initial implementation is to have trained staff who can be called in in the event of a crisis. So, there's no one way to start. I would encourage a facility just to start with wherever their greatest problem is or where the voices are the loudest that we need help. Then I think it's measuring the effectiveness. And those people who've gone through the training, speaking up about the value that it has and then, you know, rolling it out over whatever time period is appropriate.

Terry: I see. And we do see a dramatic…when people like Sally Gillam down at Saint Austin's in Texas, I mean, their emergency violence dropped...I mean, it's just incredibly dramatic how big a change is, calculating ROI, just to think about something like that $16,000 average workman's comp claim. I mean, what if you spent, you know, a tenth of that and trained them?

Susan: Absolutely.

Terry: I mean, that preventative, there it is, that preventative math going into place again.

Susan: And it goes back...I'm gonna go back to turnover because the number one reason, the number one benefit that people say they get out of our training is confidence. They feel confident that they know how to act in an escalating situation. Just the peace of mind, you know, that it gives employees and the control, the empowerment that it gives them that reduces turnover. But it also just leads...you know, I think when people are confident and feel happy, they deliver better care. So, it's just affects every aspect.

Terry: And in tandem with other workers that have the sense of burgeoning confidence, their cultures start to change is what they all relate back.

Susan: That's exactly right.

Terry And I mean that's powerful because then you have a new worker coming in and saying, "I can speak up here. People are empowered." And in fact, they're downright confident and that's contagious as much as fear and, you know, the sort of outburst mentality, if you will, because you don't know better how to manage your own thinking about something that's traumatic to you.

Susan: That's right. Your own fear and anxiety takes control. And even though you may know better, you can't help yourself in the moment. That's why the training and especially the practice,

you know, practice is a huge...classroom practice is a big component of the CPI training. And it's because you have to get that muscle memory, you know. You can't just go through an online training course and expect that you're gonna be ready to go in a crisis moment.

Terry: So, if I'm a hospital administrator and I hear this and I think, you know, "Prevention First, you know, what is that? Maybe I should make all of my employees aware first." I mean, for a really nominal kind of a number, they can make their staff aware that violence prevention is encouraged and of the methods that are effective that can help them.

Susan: And there's another important element there and that is having a coordinated vocabulary and a coordinated approach. So, when there is a crisis, if there are different forms of training or people aren't trained, they don't know how to act, and they don't know how to coordinate. And in healthcare, coordinated action is what it's all about, you know. So, having a consistent vocabulary, being able to say this person is in the defensive mode and escalating fast, and having everybody else know what that means, makes a difference.

Terry: Well, you can see how that fidelity of training between departments, so the security guy knows exactly what you mean, so does the charge nurse, you know, so does someone in housekeeping.

Susan: That's right.

Terry: They all understand how urgent this situation is because of this standardization of terminologies.

Susan: And I think it's most especially important when you're talking about security versus clinical. The clinical staff, the nurse wants to, you know, work as hard as possible to de-escalate the person even if it takes hours. The security person comes in and wants to get it over with fast, you know, "Let's end this incident." And I call it sort of the Mars and Venus phenomena. By them understanding, again, having the same vocabulary, having the same principles, I think it can actually just make for a much better-coordinated experience with no doubt a better outcome.

Terry: We'll get into this tiered training, a suite of training solutions: "In response to the crisis and violence in healthcare settings, CPI has developed a new *Verbal Intervention*™ Training program. It's part of a larger suite of CPI training programs that provide a customizable solution for organizations serious about stopping workplace violence." Susan, can you describe who the training program was described for that is *Verbal Intervention*™? And speak to some of the key features and benefits of *Verbal Intervention*™ program.

Susan: Sure. Sure. So, *Verbal Intervention*™ was designed primarily for nurses and other healthcare workers in more general settings. Our full *Nonviolent Crisis Intervention*® training includes what we now call restrictive practices, which are holds or restraints that are designed to keep somebody safe, but much more physical. The core of our training has always been on teaching the nonrestrictive practices, which are really, you know, verbal intervention skills, what I

call a kind of a de-escalation toolkit. And the *Verbal Intervention*™ program really focuses on those early skills at the earlier stages of a crisis.

Terry: So, that would be the understanding paraverbals…

Susan: Exactly. Exactly. So, if you go back to our *Crisis Development Model*SM, understanding, you know, the escalation of someone through the four stages from Anxiety to Defensive, potentially Risk Behavior and then, you know, Tension Reduction, and then specifically what to do in a nonrestrictive way at each of those stages. Being Supportive in response to Anxiety, being Directive in response to the Defensive stage, knowing the right safety approaches based on your organization's policies and procedures at that risk-level stage. And then it's all about tension reduction and, you know, re-establishing the relationship. If it's a long-term care setting, there's more of a restorative component to it.

Terry: So, short of the hands-on element of CPI training, which might take place at the top of a risk pyramid, the *Verbal Intervention*™ [Training] would give somebody all the skills that CPI training does up into and including disengagement skills, but no hands-on physicals for restraint. Is that accurate?

Susan: That's absolutely accurate. Disengagement is a nonrestrictive practice. It's, you know, if somebody is grabbing you, or pulling your hair, or biting you, how to get free in a way that keeps you and especially the other person safe. So, absolutely.

Terry: I think if I went into a hospital myself personally, and I felt that confidence in that staff, I would feel safer myself just as a family member or a patient.

Susan: Absolutely. And, and once you're trained in CPI, you can see a crisis happening and you can see when somebody is escalating it. You know, we talk about the Integrated Experience that, you know, the staff person's behavior, if they're not calm and consistent and in control, their behavior can actually escalate the patient. And you see that all the time. Now I see videos on TV, situations and you can just see it happening and you can…you wanna say, "Oh my gosh. If you'd only had our training, if you only knew, you wouldn't be doing this."

Terry: Yes. Yes. I found myself even recently in my past thinking, "If you only would have remembered the training, you wouldn't be in the fix you're in right now." So, it does well to refresh on this.

Susan: Yeah. Well, it does. It does. And nobody's perfect. But again, that's part of the debriefing at the end. (laughter)

Terry: Yes! So, *Verbal Intervention*™ sounds like it's really well-designed for a crisis that's happening now. It could be an excellent addition or a way to change culture and reduce violence without committing to a full-on physical training for a group of people or those that it might not be perfect for.

Susan: That's right. Physical...not everyone in the organization needs physicals. Everybody needs a consistent coordinated approach and a consistent vocabulary.

Terry: So, say you've got advocates for the workplace, they've heard about *Verbal Intervention*™ and they want to show return on investment to leadership in the organization to get that going. What are some strategies that motivated employees can use to make that happen?

Susan: Yeah. I think it's understanding the realities of, you know, the leadership and what they're facing. They have limited budgets. They need to deliver quality care and they have to make choices about how best to spend the money. So, I think, again, it goes back to data. Starting with reporting, you know, better record-keeping of incidents and then pre- and post-training, what happens? Actually, what we find is that when an organization initially starts implementing CPI, the number of incidents, reported incidents goes up, but it's because people are reporting it where they once didn't and then we see that it, you know, almost rapidly goes back down.

Terry: In a traumatic or aggressive situation or a violent situation, denial can sometimes be the first things that people who are being victimized hide behind. And this teaches them to be not afraid to speak and to record what's happening. So, that's a good start to lead into things where you make people aware of the problem and it's, as you said, people feel more free to report, but then you've got the debriefing steps and the techniques that are ultimately going to send those numbers plummeting as we have seen.

Susan: That's right. And again, I think it's just like you and I spoke about the power of the stories when you're in one of our training sessions. The staff members need to tell leadership what's happening. Like, you know, just those stories are so powerful, and I think that, you know, individuals have much more power than they think they may have. They just need their voices, they need to get their voices out, they need to collectively have their voices heard. And I think that leadership, when they hear these stories, and start to see the results, and then understand that it's not really that significant an investment, you know, it's what? Twenty dollars an employee for the cost of our training. In the grand scheme of things, it's not that significant in terms of their other expenses and especially in terms of the risk mitigation.

Terry: Right. I mean, I talked to two gentlemen from CentraCare Health in Minnesota, did a podcast with Paul and James and they kept really, really diligent records about workmens' comp claims. And after our training, I'll put a link to that so you can see the reduction. After they started reporting that, CentraCare was all in on CPI training because of just how much less money they were paying per quarter, per annual year. I mean, it was staggering the amount of money that they saved. And I mean, when you have a couple...again, two employees that really believed in CPI training and techniques really made themselves and the whole hospital environment they work in safer, so.

Susan: Absolutely. It just takes speaking up and being an advocate and not being afraid to let other people know any chance you get.

Terry: So, I just mentioned a little bit of that, but I'll pose the question to you. How do you feel healthcare organizations can sustain and benchmark success after they've implemented a training initiative aimed at better confronting and decreasing workplace violence?

Susan: I think that you can't just...one of the dangers, I think, is an organization or a facility that says, "Okay, we're gonna train everybody. Okay. They're all trained, we're done." You know, one-and-done does not work. It requires practice. And that's why we think the certified instructor model is so important because those people are embedded in the organization. They can keep it going. They can, you know, provide coaching on the job, they can do drills and practice. That's fundamental to really making the change. You know, having a group come in, no matter how great the training is, if it's just, you know, again, one-and-done training, it's not gonna have, it's not going to be effective. Those are just basic adult learning principles.

Terry: Yeah. I mean, the train-the-trainer model, I remember Jeff Schill was teaching that and he asked the question, "Why did we go to that?" And there was some murmuring, and no one really offered an answer. And as he said, "Well, we went to that because the person who is there understands the environment and the situations that happen better than we ever could. So, we're going to bring them these tools and these behavioral models, but they implement because they know their people, they know business and the environment that they're in." I never forgot that. It's like, you know, this isn't just so that, you know, you have to have somebody come and visit. You want this person on staff because again, this precludes the one-and-done trap that you might fall into. I mean, that person is on staff, they get their training refreshed. I mean, they energize them over and over again as they bring these concepts back to life again and again.

Susan: That's right. And little drills, you know, little staff meeting drills, little techniques. Just keep it fresh and keep it top of mind and build that muscle memory so that people are prepared when a crisis happens.

Terry: So, I guess we've gone over a lot of what we wanted to talk about today, Susan. Thank you. I'm wondering if you had any last thoughts today on CPI's unique role in helping healthcare facilities deal with the problems of workplace violence.

Susan: You know, I think that there's a great emphasis, too much emphasis almost, on one-time horrible events like an active shooter or, you know, somebody who's out of control and out of their mind and stabs somebody. Those are horrible events. We like to think that, you know, if we could catch those people earlier before they get to that stage, maybe that would've been prevented in the first place. But every day, there are people in distress in a healthcare setting. They're fearful, they're anxious, they're ill, they're exhausted. Just those life's daily crisis moments can impact the whole culture and actually impact the staff members. You know, the staff members give their hearts and souls and all their energy to do better for the people that they serve. And I think giving them...our giving those people the skills to do it better and to be more confident and to be more in control is just a gift an organization can give to their staff.

Terry: So, do it for them.

Susan: Do it for them. Absolutely.

Terry: You know, I've heard that phrase and I think, you know, it applies to so many people. When you do it for your staff, do it for your patient, do it for the world at large that these people impact. I mean, it is an ever-widening circle as you look at the benefit that can come from this program.

Susan: And as you know, at CPI, we believe that we do it for all of them, that we are in this mission...it's a mission for us to help people care for others and especially care for those in need. It's just a wonderful company, it's a wonderful mission, and it is all about doing it for them.

Terry: Nicely said. Thank you. My guest today on *Unrestrained* has been the president of CPI, Susan Driscoll. Thank you so much, Susan.

Susan: Thank you, Terry.

Terry: Thank you. And thank you all for listening.