CPI *Unrestrained* Transcription

Episode 45: Sara Holland

Record Date: 9/21/17

Length: 32:56

Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone, and today I'm joined by Sara Holland, a nurse educator with Virginia Mason Memorial Hospital in Yakima, Washington. Hello and welcome, Sara.

Sara: Hi, Terry. Thanks for having me.

Terry: You're welcome. Thanks for being with us. Let me tell you a little bit about our guest. Sara Holland began her nursing career well before college, serving for six years as a certified nursing assistant in a locked dementia care unit. She completed an associate's degree in nursing at the Yakima Valley Community College in 2002, and eventually, Sara earned both her Bachelor of Science and Master of Science in Nursing degrees. She began her career at Virginia Mason as a safety coach in the hospital's acute inpatient psychiatric care unit. She started the hospital's first shared governance council on psychiatry, and was asked in 2007 to become a professional assault crisis trainer, Pro-ACT®, which she taught for three years.

In 2009, Sara spent two months as a nurse manager of Two Rivers Landing, a children's inpatient psychiatric facility in Yakima, but she quickly returned to adult psychiatry, and eventually began to feel restless in her role as a nurse. That changed in 2015 when she became a certified CPI *Nonviolent Crisis Intervention*® trainer. With the blessing of her nurse manager, Sara began training with two other coworkers in January of 2016.

Today, she facilitates CPI training across the Virginia Mason Memorial Family of Services. In addition, Sara writes curriculum for psychiatric-specific education and interdisciplinary plans of care, as well as acting as a point-of-care reference for all things psychiatric and restraint-related.

Our interview today is going to focus on the impact of CPI training at the hospital and how it helps to manage challenging behavior in both patients and visitors, as well as the way CPI training is facilitated through both online and traditional classroom methods.

All right, Sara, so then after all that, let's begin. Let's talk about why Virginia Mason Memorial selected CPI training. I know in our pre-interview, we talked about what you described as a skyrocketing number of assaults that you had happening.

Sara: We did. We were experiencing a lot of assaults throughout the services, on medical floors, not just what you would think would be, you know, legitimate [places], like psych or ER. We were seeing it on a lot of medical, neurological floors. There were higher levels of patients with dementia, very acutely ill, drug-related delirium, all those kinds of things that you'd see on medical floors. And people were getting injured, both patients and staff. And we took a look at the programs available. Pro-ACT® was not something that we were going to go back to, and that is where CPI reared its head in our system. We looked at the CPI values, and looked at our values and how closely they were aligning, and obviously, you know, decided to go with your program.

Terry: I see. And what specifically in a value structure would you say agreed between CPI and Virginia Mason Memorial?

Sara: So, with CPI, we have our *Care, Welfare, Safety, and Security*℠. We actually had safety as a value until we felt that we had reached that. I've been here for 11 years. And so when I first started, safety was one of our values. It has now been replaced with stewardship because we have accomplished safety. When we look at *Care, Welfare, Safety, and Security*℠, we have Memorial's respect and accountability and teamwork and innovation and stewardship. And if you look at your definition, they line up amazingly.

And when I teach, I actually bring that to the forefront for the people I'm teaching because they want to know why are we doing this program. “What does it mean to me? How does it fit with my daily work?” And, you know, you can tell them, "Well, we want to teach you how to keep yourself safe and keep your patient safe and how to talk to people and how to restrain if absolutely necessary." But it also goes in line with what our beliefs are and how we reach out to our community and how we treat others.

Terry: I see. Now, I know in our pre-interview also, you mentioned that you had trained Pro-ACT® for three years but that you decided not to renew, I think, back in 2010. So you had this gap between 2010 and 2015 where there wasn't—when these all started to skyrocket. Can you kind of paint that picture for us there with what happened with Pro-ACT® and how you came around to training verbal de-escalation training again?

Sara: Yes. So I was teaching Pro-ACT®. It was considered a psychiatric-specific training for the locked unit here in Washington. And so I was teaching it to our psychiatric staff, and then we did incorporate some of the emergency room people, but then we would have things happen like with home health, somebody answers the door with a gun, and things—for Children's Village, there were a couple outlying programs that needed some support, some help, and so I did that. Well, they decided not to renew my credentialing in 2009 and instead took portions of Pro-ACT® and had several—one of our security officers at the time, one of our ER directors at the time, just kind of—they kind of broke it apart, and they just taught components of what they thought was important when they would do onboarding.

And as you know, these programs, regardless of what it is, they grow. They are layered programs. You have to figure out things about yourself before you can figure out things about others and then you move on. And so, just to pull a piece of that chunk out wasn't effective and it wasn't reaching everyone, and it wasn't, you know—everyone is looking for that "why." "Why am I doing it this way?"

And we were just seeing more injuries and more L&I's [Labor & Industry claims.[If you are injured at work or develop an occupational disease and your claim is accepted, workers' compensation (L&I or your self-insured employer) pays for medical care directly related to your accident or illness. I'm sorry I don't have stats for L&I claims, but it was an ongoing problem. And when it came around that, hey, you know, it's one of those things where it starts to kind of talk to you. You start hearing talk here and talk there, and it comes up in a meeting, "Why don't we have anything for this?" And then pretty soon, it was like, "Oh, hey. Here's this crisis prevention. I was doing some research, and I came across this, and it aligns. And would you be interested in getting involved again?" And I was like, "Oh, yes. Yes, please pick me!" So, here we are.

Terry: I see. So what staff and departments did you train?

Sara: Currently, with *Nonviolent Crisis Intervention®* [training], we initially opened it out to the hospital, and it became very evident that this was going to go across Memorial Family Services. And one of the reasons that we chose to do that was because at any given time, people are in and out of the hospital. And there may be an issue where someone from the lab will have to step in and help someone from the emergency room and the waiting room, or you might get someone from one of the outlying clinics who's here for training and comes across this situation where now they can step in and help out. We wanted everyone to have the same skills, to have the same opportunity to learn at the same level because, as you know, if you've got two people who don't have the same training and they try to help, somebody can get hurt. It gets actually worse than not having any training at all.

Terry: So you're finding that by having, like you said, CPI training across the family of services, that you can have staff from different departments assisting in the same intervention with an understanding of the methodology that they're going to use.

Sara: Yeah, and a common language and, you know, what comes next and who should be talking, and the whole situation and how realistically at the core is the patient safety and how we're going to get them where they need to go.

Terry: Now, I think when you started in the pre-interview, you offered employees a selection of the one-day, two-day, or the Flex training option. And could you explain how that evolved and kind of what worked out to be the best solution for Virginia Mason?

Sara: Right, right. So initially, we didn't have Flex. Flex came later. We offered one-day training for the people who did not have direct patient access. Then we offered the two-day training for people who in fact did have frontline access to the patient, so people like ER, psych, med floors, nursing staff, clinical, that kind of stuff. The Flex training came later when we were trying to limit the hours in which we were actually in training, and we actually had someone else go and certify to teach the Flex.

What we were noticing is during our conversations with people in class—and I'm a big proponent of bringing people into class into a forum, not just online, because that's when you get to process information and you get input from other people and you build the team. And you don't build the team on just online components.

And so we started recognizing that the issues weren't just patients. The people are saying, "Well, you know, I've had doctors get confrontational and screaming at me. I've had people follow me into the elevator. I had a nurse back me up against the wall."

So it was workplace violence, too. And it wasn't just about the patients anymore. And we realized that we were basically handicapping people who really needed to take this full class to keep themselves safe. On top of that, we were coming across some areas like nursing assistants who are on our front lines doing one-to-one care with aggressive patients or in restraint. They were not being allowed to take the full two-day class because they couldn't be pulled away that long.

Terry: I see.

Sara: And we decided that we were going to take that away from—we were going to pull that option. Everybody was going to get the same training. Everybody was going to get an opportunity to have hands-on.

Terry: I see.

Sara: It actually has gone pretty well, I have to say. Just because you're not sitting in front of a patient doesn't mean you might not come across a situation where there is an aggressive person.

Terry: I see. So do you see that as—is blended learning pretty much the standard then, part online and part classroom, for how you offer CPI training?

Sara: Right now—so what we're doing right now is they do a three-hour—well, it's two to three hours, comparatively, whoever is working on it there. And they do the online portion. And then we pull them into class for an entire day. And we do refreshers throughout the entire morning, and then in the afternoon, everybody gets the same restraint.

Terry: But it's great. So they don't have to make a two-day commitment, but they get to go online and to internalize and to sort of take their own time and then to come into the classroom situation and share and talk about what they've absorbed and get further instruction to really drive home the training, if you will.

Sara: Yes, and it's been really nice because, you know, people learn in different ways. And so you have someone who might just be a reader, and that's all they need and it made sense to them. But some people have a really hard time visualizing what it would look like until they've actually come into class and they've practiced it.

And so, as an educator, the more chances someone has to say something, the more it's going to sink in, especially if you can show them in real time what does that look like. We do a lot of the role-playing, and we get people up, and I actually have them teach each other when we're doing our refreshers. So I break it down into components and we focus on what I consider our biggest main areas, our, you know, *Crisis Development Model*℠ and the alternative to behaviors. We have them teach the other class members. And so not only are they reading it, they're hearing it, they're teaching it.

Terry: So a truly multimodal kind of approach. That's great. And so how many staff members at Virginia Mason have had CPI training, do you think, so far?

Sara: So far? So our class average is 22. And in the beginning, so the first year, we did two classes a month, so two 2-day classes a month. And then as the time had gone by, we added one-day classes and we added six classes. And now we are back to three 1-day classes a month. And so, my gosh, I'd say probably at least half of the Memorial Family Services in two years have gone through that.

Terry: Okay, so you're about 50% trained then?

Sara: We're adding new people, you know, we're adding new staff members all the time.

Terry: Right. Is your goal 100%?

Sara: It would be 100%, but there is always going to be an ongoing turnover.

Terry: Could you talk about some of the ways CPI training has helped you to better manage patient and visitor behavior, and how that relates to your customer service model? We talked about that in our pre-interview.

Sara: Yes. So the really awesome part is that moment when you see someone have this light bulb and their eyes get big and they go, "Oh, I can think of it that way," or, "I've been doing it wrong," or, "I never thought about that." I'll give you a couple of examples.

We have a gal who is one of those bubbly people who is just happy all the time, and she did registration for ER. And so she would go into the emergency room and, "Hi, my name is so and so, and I'm here to do your paperwork," and she's just a happy person. Through this training, she realized that she needs to check her tone, turn down her volume, and kind of bring it down a notch because not everybody in crisis can tolerate that personality, in order to not create the environment which would—could possibly engage hostility.

She has a moment of, okay, walking into the room, bring her voice down, bring her tone down, pull her voice down so that she can better interact with the crisis because, you know, no one comes to the ER when they're having fun and not having issues. So she was able to check that about herself.

There was another situation with one of my—actually one of the night shift psychiatric nurses when we talked about re-engaging patients after crisis and how—I always teach everyone. We are the professional. We are responsible for their *Care, Welfare, Safety, and Security*℠. It is our job to re-engage with the client, the patient who has been in crisis.

And he just said, "Oh my gosh. All this time I just wait for them to come up to me." And it's like, "Oh, yeah. That doesn't work so well." And so that was an aha moment for him. We had another psych nurse who was like, "I didn't realize so much about myself and how my attitude contributed to outbursts in patients to aggressiveness to, you know, escalations." And so when they recognize that situation—

Terry: The Integrated Experience, essentially.

Sara: Mm-hmm. Yeah, exactly. A lot of people talk about how recognizing the CPI *Crisis Development Model*℠ and the *Verbal Escalation Continuum*℠, and how—I take that and I pull it apart and I say, "This is not the time for a code grey. What is the time for a code grey?" That's our emergency response where everybody comes running. You know, a person is screaming and yelling at the desk. Is that dangerous? What's the level of dangerousness here? How do we respond?

And so a lot of times you get injuries from code greys called inappropriately and little, old people getting tackled because they won't stay in their beds. And that's not appropriate. Teaching people the skill of recognizing what is dangerous or what is just scaring you and then looking at our matrix [CPI's Decision-Making Matrix] and going, "Oh, this is this behavior, but it doesn't mean I have to react like this because it might not turn out like, you know, like it happened last time," and really weighing those risks.

Terry: It's great to hear that you're using the Decision-Making Matrix in such a hands-on or sort of practical way, that you really use this model to provide context to what you see happening in front of you. I also think it's really interesting that, you know, usually when we talk about paraverbals, about tone and volume, we're talking about not mirroring back the frustration and the sort of escalation that happens when people start to get into

heated conversations. It's really interesting that you had to train that nurse who was so bubbly to instead take a more sober sort of paraverbal tone with people so that her exuberance didn't inflame the situation. I've really never heard of that before, but it makes total sense now that you bring it up.

Sara: Yeah. And it's a reality check for a lot of people when they go, "Oh. My attitude is going to affect what's going on in front of me, how I'm behaving." I see people getting into power struggles all the time with patients and, "No, you're going to talk to me. I'm your nurse. This is how it's going to work." It's like, "Why are we fighting this uphill battle?" Find some common ground here. Let's find—see what the need is and how we can facilitate that because at the end of the day, we're here to serve our customers, whether that's each other or the patients that come in or the family members of the patients. We're just—it's customer service.

Terry: Right. Excellent. And Sara, could you share a story about how CPI training helped you successfully de-escalate challenging behavior? I know that we had talked previously about a patient who was having some issues with her radio.

Sara: Right, right. So I have spent 10 and a half years on psychiatry and I've trained a lot of people and we've always had a lot of, you know, movement there as far as employees. And as many different employees as we have, we have the same number of repeat psychiatric patients. And so you build rapport and relationships with patients.

And one of the days that I was working, I had a gal who was actually not my patient but I had worked with her many times before. And she always kind of ran that line right around very aggressive and angry and irritable. She was usually, you know, coming down off of something that she had ingested or smoked or something.

Terry: I see.

Sara: So I came back from lunch that day and there she is at the front desk, screaming, cussing, yelling, demanding to see me. And I was not her nurse, but sometimes the patient picks you. It's not about who's assigned but who might have the best rapport with the patient. So I asked her to meet me in her room to get her away from the audience and away from the front desk where she's been screaming and yelling. And I said, "I'm going to check in, clock in. I'll meet you down there." And she knew because I was consistent with what I would tell her that she could trust that from me.

And I went down and I got her version of things, which is really important because we don't always know how they see, how the client in crisis sees the situation. And a lot of misconceptions can be cured if you just stop and listen to the patient for a second.

Terry: Excellent.

Sara: So I went down there. I got her version of things. She was feeling very powerless, very—as if there was nothing about her environment she could control. She just wanted to listen to some music. We'd had issues in the past where things had been thrown; the music she wanted to listen to was inappropriate. So I got her version. I had to come back out and I had to do treatment planning with her staff members, the doctors, and say, "This is what we've come up with. She's willing to agree to these terms."

Terry: So you set limits for her?

Sara: Yep, absolutely. "Is there any reason we can't see if this will work?" So we actually adjusted her treatment plan to allow her some time to listen to the radio outside by herself, away from other people because her music was not the general public's desired listening.

Terry: Fair enough.

Sara: Yeah, and she was able to follow those limits and respect them as they were time-sensitive and had not become escalated and not become assaultive, which in the past wasn't always something we were able to manage.

Terry: That's a striking example of how this de-escalation model—First of all, you really listened to her, and then you set effective limits. And not only did it de-escalate the situation that day, but it really affected the culture and the approach to the patient in a more holistic and ongoing sense. That's powerful.

Sara: Yeah, yeah. It's always nice when you get to the end of a situation and no one got hurt.

Terry: Mm-hmm. Do you guys put special emphasis on debriefing after every incident?

Sara: We do. So, in the past, there was this real push to "Okay, let's get together," and, "What went wrong? How can we fix it?" But we've changed the focus a bit to “What went really well and what can we improve on it?” So we're trying to spin our positives versus focus on, you know, what didn't work or what failed. And I'm actually going to be heading here soon to a conversation, a collaboration effort between security and psychiatry using the CPI model and our customer service, and really focusing on what our goals are and how to best facilitate safe interaction between the two departments when it comes to patient advocacy and patient crisis. So I'm very excited about that. It's in its baby stages, but I talked with my manager this morning and she authorized it, so yay.

Terry: You mentioned code grey is your code for emergency response. Do you have any stats about code greys and restraint reduction since CPI training was onboarded?

Sara: I actually do.

Terry: Uh-huh [laughs].

Sara: I do. So we started—I got certified in 2015. And so our first full year was 2016 and then ongoing [since then]. What I've done is kept stats for all of 2016, but I stopped it as of the end of August because I wanted to make sure that they were even. So in comparison with August—excuse me, 2016 through August, we had 50 code grey incidents. This year, from January to August of 2017, we've had 20 [a chart from Sara shows 22 in this period].

Terry: Wow.

Sara: So we've definitely decreased our code grey calls overhead. Now, I would like to think because I haven't been able to, like, go back and say, "Well, what are some instances that you felt like you normally would've called code grey but you didn't?" I would love to know what the situation is there. But I had one of my guys run some reports for me regarding restraint application. And in 2016, we had 28 behavioral restraints, and in 2017, we've had only 19, thus far.

So then look at, for a second, med-surg [medical-surgical] restraint because we—I was able to flip behavioral versus med-surg, and this is what got really interesting to me. So in 2016, we had 1,358 med-surg restraints. In 2017, thus far, we've had 551.

Terry: Wow, that's dramatic.

Sara: And so the people that are getting put in med-surg restraints are people on ventilators. That's kind of an ongoing thing that you do. So I was not able to pull that out, but we have things like dementia, issues with delirium, alcohol withdrawal, high ammonia levels, things that would cause confusion, disorientation of patients. And so they would be in med-surg restraint. Otherwise, you know, the behavioral ones would kick in. I think it was behavioral related. So to me, people are obviously, very obviously managing behaviors, managing interactions better. And this is happening on, like, med-surg floors.

Terry: People are internalizing a hands-off approach then?

Sara: Mm-hmm.

Terry: Well, the stats certainly seem to bear that out. And I can sort of feel in the tone of your voice that you're convicted that the reason that this is happening is because people are being trained with things like the *Crisis Development Model*℠ and how to utilize that rather than letting something escalate to the point of a restraint being needed or used.

Sara: Right, yes, absolutely. We’re intervening early, recognizing triggers and symptoms. And, you know, if you have dementia patients, to me it's not rocket science, but people don't stop to think. If you have a dementia patient, the sundown is at 5:00. Let's get meds on board at 3:30. Avoid the whole issue. You know what I mean?

Terry: Mm-hmm.

Sara: How do you talk kindly? You're not arguing with people. We have something called "AIDET®," which is our customer service model here and how to talk to people when you interact with them. And it's something I really pull into—

Terry: Would you repeat the name for me, Sara? I didn't quite get it.

Sara: It's called "AIDET®."

Terry: Okay.

Sara: It's an acronym. It stands for—it's A-I-D-E-T. It stands for Acknowledge, Introduce, Duration, Explanation, and Thank you. So you walk into a room. You acknowledge everyone who's in the room, if they have guests, if they have family there. You introduce yourself and your credentials. You let them know how long you're going to be involved and what's going on. And you explain the procedure or what you need to do. And then you thank them, and you ask them if there's anything else you can do for them.

When I ask the people that are working, I say, "Okay. You're going to go in and do an assessment on somebody. Tell me what you do." They don't even knock, you know, half the time. So they're just blowing through the door, making adjustments, giving meds. There's never a conversation happening. There's not, "This is what I'm doing. This is what you can expect." We live in a culture of go, go, go, go, go. It's our enemy. And I have to remind people that time is relevant. We have to slow it down to get it right.

Terry: When things start to become routine, you somehow feel that other people can intuitively know what you're doing, when in fact you need to communicate it to them verbally, because they can't read your mind. And I think I can see where working through that acronym is just a way to remind yourself, this is a human being. They're not going to know like I know that I've got a lot to do, but like you said, time is a relative thing. And what's more important—I mean just the perfunctory task that you need to perform in the room, or actually making sure that the patient feels a sense of well-being? And I mean it must improve accuracy, too, to have people actually deliberately think of those steps.

Sara: Yeah, and the other thing is that when we go into a patient's room, when we interact with them and we don't tell them what's going on, their cognition—we know if you're in pain, if you're sedated, if you are delirious, you're not in contact with reality—your cognition is lowered based on the, you know, level of crisis you're in. So it takes even longer to reach some people. How are you going to react if somebody comes in and rips the covers off when you're delirious? You know, I'd start swinging, too. So it's just about respect and caring about how someone feels and how do we interact with them.

Terry: Excellent. Now, mentioning these statistical reductions in code greys and restraints, how would you say that the impression of the administration is of CPI training? Is the value of the program getting through, do you feel?

Sara: You know, I do. I think that we have had—so we have new leadership, not new to our hospital, but new as in they just stepped into these positions just a couple of years ago. When we have older people retiring, we've got newer ones in. And so it's kind of fresh eyes on what's going on. And one thing our nurse manager and CSO tells us is that the injuries that staff are getting are no longer acceptable. So she kind of drew a line in the sand, and she said, "We're not going to allow this to happen. It's not okay." And so I take that and use it for my training.

It's not okay to be hurt. When you are debriefing the patient, when you are going through re-engaging, it's not okay to say, "It's okay" [for a staff member to be hurt] if a patient comes up to apologize to you. "It's okay. I'm all right. We're fine." It's not okay. Don't tell people it's okay. And so our senior leadership is really backing people up on protecting yourself and, you know, this is a big thing. This is big across the family of services movement, and they supported it.

Terry: That's great. Well, Sara, to close today, I'm going to ask you something that we didn't talk about before, and that's—I'm wondering what the biggest source of joy is for you in your work there at the hospital.

Sara: My biggest source of joy is educating people. It's teaching people things they didn't know and then watching them use it successfully. I love to do that. I did that on psychiatry. I precept a lot of students. I teach all across—you know, all disciplines. I'm a provider educator for the hospital. So I really enjoy helping people become successful in their environment.

Terry: Excellent, excellent. Well, I want to thank you, Sara. My guest today has been Sara Holland. She's a nurse educator with Virginia Mason Memorial Hospital in Yakima, Washington. Thank you so much.

Sara: You're very welcome, Terry. Thank you.

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