Commentary: Barriers to a Sustained Restraint-Free Environment

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ABSTRACT. A restraint-free culture is becoming a standard practice in the provision of long-term care services for older people, a standard by which licensure and accreditation agencies evaluate providers. Although most health care providers initiate restraint-elimination processes, many fail to achieve the intended result or sustain the practice because of a variety of barriers. Faltering organizations find themselves faced with monumental changes in administrative and supervisory staff, substantial recruitment and retention crises, and inadequate attention to a culture of continuous learning, teamwork, and leadership skill building. This article informs policy makers about the barriers to achieving and sustaining a restraint-free environment and suggests public policy agendas and processes to improve conditions for the aging population.

KEYWORDS. Restraint-free, physical restraints, barriers, regulation, approach to care, quality

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Journal of Aging & Social Policy, Vol. 20(3) 2008
Available online at http://jasp.haworthpress.com
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doi:10.1080/08959420802050462

THE BARRIERS

The elimination of physical restraints is relatively easy for organizations committed to upholding the older person's freedom, individuality, and self-worth. Administrators dedicated to these basic concepts and steadfast in modeling these behaviors over time can make this paradigm shift a reality. The change process to establish a restraint-free approach becomes complicated when administrators themselves, or one or more of their department heads, are firmly stuck in traditional thinking that restraints are necessary, convinced that it is more important to keep people physically safe than emotionally secure. However, there is nothing in the literature that suggests this previously held conviction is true. The following discussion addresses key barriers that thwart the restraint-free potential that lives within all long-term and acute-care facilities.

Administrative Barriers

Administration has the responsibility and authority to lead staff in the provision of care in accordance with the mission and structure of the organization, federal and state mandates, and legal guidelines. It sets the facility's direction through established policies and procedures from which staff is trained and resident care flows. Unfortunately, the process is doomed when there is a lack of attention and accountability, poor communication, or, in other words, ineffective organizational leadership (Blakeslee, Goldman, & Papougenis, 1990). Poor leadership from the top of the organization evokes failure to adopt a new program or sustain an improved delivery of care system (Kinlaw, 1991).

Another administrative failure to implement effective restraint-elimination programs takes the form of inappropriate deployment of resources. Health care administrators listen to voices of disgruntled department heads or line staff about the lack of time or human resources to provide care and services. Their negativity soars when a new program or idea is being launched. Staff fears change (Kinlaw, 1991), preferring the status quo, even if it results in poor quality and inefficiencies.

Supervisory Barriers

While good leadership and support from administration is essential, research suggests that staff feel most closely connected to their direct supervisors (Sheridan, White, & Fairchild, 1992; Spector & Takada, 1991). However, as Jervis explains (2002), the hierarchical system in

nursing often creates a tension and lack of trust between licensed nurses and certified nursing assistants. Nurses feel that poor hands-on care provided to residents is largely due to nursing assistants who are dealing with personal family issues, often leading to tardiness and absenteeism. Conversely, nursing assistants feel underappreciated by their supervisors for the hard physical and mental challenges they endure in caring for the aging population. They also feel undervalued and ill-informed when they are not included in the care planning process for the residents for whom they provide care. In general, nurses are not taught the necessary management and human resource skills to supervise a staff of mostly nursing assistants who need mentoring, support, praise, and discipline (Shepard, 1989). All of these skills require training before a nurse is placed in a management or leadership position.

Restraint elimination also is challenging for nurses who have been inadequately prepared in gerontology. In fact, in 2002, fewer than 1% of employed registered nurses were certified in geriatrics (Kovner, Mezey, & Harrington, 2002). Nursing students are taught to complete patient assessments, but few are educated about assessments specific to the geriatric population and how to develop appropriate, individualized care approaches. They also lack the knowledge to determine suitable care approaches instead of using physical restraints (Wilson, 1996) and rely on their earlier training and dogma that restraints are necessary. Nurses also fear liability or loss of their licenses if a resident falls or is injured without a restraint.

Since the average age of nurses in long-term care has reached an all-time high, there is a degree of resistance by nurses when faced with regulations and care practices that are inconsistent with their earlier training. For example, they were taught to secure elderly people with tied restraints if they had attempted to rise from a chair. The paradigm has shifted, but some are not willing to accept it or are not convinced that it is in the best interests of the people for whom they care.

Staffing Dilemmas

The high turnover rate of nursing assistants today is quite alarming, but facilities are experiencing another, possibly more significant, turnover among administrative personnel—both types are extremely disruptive to successful implementation of a restraint-reduction initiative. This is costly for an organization from financial and systems perspectives, as shown by a 7% higher restraint rate in freestanding nursing homes that experienced administrative turnover (Castle, 2001).

Inadequate Training and Resource Allocation

Inadequate staff training (Strumpf, Patterson, Wagner, & Evans, 1998), revolving staff assignments, and lack of resources (Molasiotis, 1995) can negatively impact a restraint-elimination program. Although some organizations meet only the minimum education requirement for certified nursing assistants, others go beyond the requirement, offering timely, unit-based training and encouraging staff to attend outside conferences. These organizations believe education is vital to keeping staff updated on best-care practices.

Revolving staff assignments is a practice that leads to inconsistency in care and delay in identification of potential physical and psychological changes in residents' conditions, yet most providers continue to schedule staff in this manner. Nursing assistants' assignments are rotated on a monthly, weekly, or even daily basis, with little regard for the best interest of the residents (Goldman, 1998). This is often the approach directors of nursing use to offset excessive tardiness and absenteeism or make up for the lack of available caregivers.

The argument that additional resources are necessary to achieve and maintain a restraint-free environment has been expressed frequently but has not been substantiated. Studies indicate that it actually takes more staff resources to care for a restrained resident, so the fear of dramatic cost increases is misplaced (Phillips, Hawes, & Fries, 1993).

External Barriers

There are a few other barriers to sustaining restraint-free care worth mentioning here. First, some physicians are still ordering restraints based on their personal standard practice, nurse requests, or family insistence. Sometimes, uninformed family members demand that the facility keep their loved one free from harm and feel empowered to "order" restraints as an intervention without knowledge of their potential adverse effects.

Health care providers also view state surveyor expectations, rising liability insurance rates, and possible lawsuits as additional barriers to removing restraints. Some believe restraints are necessary interventions for providing safe environments and satisfying surveyors when, in fact, surveyors are required to determine if least restrictive methods are being tried, and ongoing assessment is continuing until restraints are eliminated (Centers for Medicare and Medicaid Services, 1990). Liability insurance companies have been alerted to the issue of restraints and make

determinations regarding coverage based on risk and the facility's previous experience with an injury or death of a physically restrained patient.

Although this article is not about the legal implications regarding the use or nonuse of physical restraints, and no litigation against a long-term care facility has been resolved in favor of restraint use (Kapp, 1991), some providers continue using "safety" as the rationale for tying people to beds and chairs and fear legal ramifications if they fail to apply a restraint (Nay & Koch, 2006). Families may insist that restraints be used to keep loved ones safe (Palmer, Abrams, Carter, & Schluter, 1999) and may threaten to sue the facility, but decisions regarding restraints and their removal must be made on an individualized basis according to the combined professional assessment of the health care team. The likelihood of a lawsuit is greatly reduced through good communication among the care team, the patient or resident, and the family (Nay & Koch, 2006).

PUBLIC POLICY ISSUES

The barriers that conflict with a successful restraint-free process raise a number of public policy issues.

Management and Leadership Training Programs for Administrators, Nurses, and Other Supervisory Personnel

The basic requirements for nursing home administrators' training include global education on regulations; however, those requirements do little to educate administrators about implementing change in organizations and the resistance to restraint reduction that will occur. Even though some states mandate leadership training as part of ongoing education for administrators, many do not have such a requirement. Therefore, more stringent management and leadership requirements would better prepare supervisory personnel to identify problems, such as high use of restraints, and develop sustainable, alternative processes. Requirements for long-term care administrators should include, at a minimum, specific instruction about physical restraints. Failure to do so perpetuates the use of these devices, leading to poor care for the frailest nursing home residents.

Nursing schools need to add supervisory and management training to their clinical components. Directors of nursing report that they never received formal training to become supervisors and certainly not to become directors. Some gained the role simply because they were the

only registered nurses on the shift, while others became directors of nursing with the understanding that the preceding person would train them, only to find that the predecessor was not returning for the orientation. For many, the job of a nursing supervisor or director of nursing is extremely stressful, and the individual does not feel adequately prepared with leadership and supervisory skills (Carpenter, Goldman, & Proenca, 2004).

Nurses often express dissatisfaction with the responsibility of supervising nursing assistants, counseling staff performance, and delivering performance evaluations. A pilot project was conducted in a newly built retirement community (Goldman, 1998) with these factors taken into consideration. Licensed nurses were hired as primary caregivers, responsible for all hands-on care, documentation, medication, and care coordination for a specific group of residents. No nursing assistants were hired. Only one-third of the nurses interviewed were excited by the opportunity to utilize their expertise to its fullest. They saw the benefits: consistency in caring for residents, improvement in communication with residents and families, the opportunity to detect small changes and intercede early with appropriate treatment, and the ability to be proactive in their care. With this coordinated approach, meaningful and appropriate interventions were applied and physical restraint use was never considered. Unfortunately, while this staffing model has tremendous potential and the cost was below that of the more common hierarchical model (contrary to common myth), without committed leadership and mentoring of this concept, the facility eventually returned to the traditional nursing model.

Gerontological Education for All Health Care Providers, Particularly Nurses, Caring for the Elderly

Caring for an older population is a specialty that requires focused education and expertise by nursing academicians and the long-term care provider arena. Financial incentives need to be available for students entering health care fields, as well as structures to support change-of-career applicants entering health and human services academic programs. A strong gerontology curriculum must be created as a core course for all students planning on caring for older people.

The Value of Nursing Assistants or Direct Care Workers

Nursing assistants provide daily care to patients in long-term and acute-care environments. Their importance as health care team members is recognized, but not necessarily valued adequately. Lack of respect is

often the reason nursing assistants leave an employer to work at a neighboring facility for only a minimal difference in pay.

Organizations are unable to expect consistency and quality in care with high nurse and nursing assistant staff turnover. The costs are enormous, with recruitment and training expenses and the unquantifiable costs of disruption and low morale that occur among staff, residents, and families. There are many pilot projects under way to determine the best approach to recruit and retain staff. However, simple but key elements often are missing that could lead to job satisfaction and reduction in staff turnover. The first element is supervisory training, as mentioned previously. The second, and probably more important, is the implementation of primary or permanent nursing assignments. Imagine coming to a job each day having to learn quickly about a new group of people—to understand everything about them so you can appear knowledgeable about their preferences in sleep habits, meals, bathing, and other activities of daily living, as well as know about their family support and involvement. That is what nursing assistants are expected to do with an assignment of 8 to 12 residents or more each shift. Primary nursing assignments provide consistency in caregiving that eases the burden on the caregiver, comforts the resident and family, and simplifies the role of management. Therefore, valued nursing assistants must be included in care conferences as critical components of each person's health care team.

Training Requirement for All Levels of Health Care Personnel to Include Mandatory Education About Restraints, Their Adverse Effects, and a Process to Develop More Humane Approaches to Care

A major failure in health care, particularly in the long-term care environment, is the lack of commitment to education and training and the failure to recognize a need for lifelong learning. Many long-term care nurses and other care providers tend to believe that once they have received training and obtained licensure, their education is over. This attitude is reflected in nurses' resistance to seek new approaches and learn about advances in research, particularly in the area of restraint elimination.

Although health care professionals may have good clinical expertise (this is debatable, however, because of poor training on assessments of the elderly), they clearly lack knowledge regarding restraints and the development of creative, individualized care plans. They need ongoing education to successfully train, implement, and oversee a quality improvement process with their respective staffs.

Initiating a Public Policy Campaign

Until a national public policy campaign is initiated, organizations will continue to feel consumer pressure to apply physical restraints as a means to keep older people safe. Once consumers become informed about the adverse effects of restraints and the alternatives that can be implemented to achieve a more optimal result, they will be more accepting of, and even willing to embrace, the restraint-free approach to care.

CONCLUSIONS

The public policy agenda needs to be directed at changing the culture of health care organizations toward initiating and sustaining a restraint-free approach to care. Address the perceived organizational and individual barriers through public education and caregiver training to deepen understanding and support for raising the acceptable standards of care for frail elderly people. National public policy guidelines should be focused on restraint elimination and not on restraint reduction. It is time to strengthen this national initiative for the well-being of older people presently receiving care in our country's facilities and for future recipients of acute- and long-term care services.

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RECEIVED: 02/06
REVISED: 04/06
ACCEPTED: 05/06