PerformCARE®	Policy and Procedure
Name of Policy:	Restraint and Seclusion Monitoring
Policy Number:	QI-CIR-003
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement Department
Related Stakeholder(s):	All Departments
Applies to:	Providers/Associates
Original Effective Date:	04/01/17
Last Revision Date:	03/18/24
Last Review Date:	06/30/25
OMHSAS Approval Date:	06/30/25
Next Review Date:	06/01/26

Policy: PerformCare Providers are required to develop written policies and procedures for restraint and/or seclusion reporting with a focus on reduction efforts. This policy sets forth the PerformCare guidelines for the reporting and tracking of any Provider use of restraint or seclusion for a PerformCare Member.

Purpose: To ensure appropriate and timely reporting of restraint and seclusion to PerformCare by Providers in order to monitor for high volume trends within the PerformCare network. Through the monitoring process, the objective is to reduce the use of restraint and seclusion. PerformCare Providers are expected to comply with all federal and state laws, regulations, departmental guidance and bulletins pertaining to the use of restraints and seclusion, including but not limited to OMHSAS-02-01 "The Use of Seclusion and Restraint in Mental Health Facilities and Programs."

Definitions: **Blocking Equipment:** Soft cushioned pads or shields used by staff to assist in maintaining member and staff safety during times of aggression for the purpose of de-escalation.
Chemical Restraint: A medication used to control acute, episodic behavior that is not the standard treatment for the consumer's medical or psychiatric condition and is intended to significantly lower the individual's level of consciousness and restricts the movement of a consumer. A medication ordered by a physician as part of the ongoing individualized treatment plan for treating the symptoms of mental, emotional, or behavioral disorders is not a chemical restraint.

Escort: An intervention that does not restrict the movement or function of the member in any way where the member does not resist and is used to assist in activities of daily living.
Injury: A physical condition that requires treatment greater than first aid.
Manual Restraints: A physical, hands-on technique that restricts the movement or function of the consumer's body or portion of the consumer's body. Prompting, escorting, or guiding a consumer who does not resist in assistance in the activities of daily living is not a manual restraint.
Mechanical Restraint: A device used to control acute, episodic behavior that restricts movement of function of a consumer or a portion of a consumer's body. Mechanical restraints do not include measures to promote body positioning to protect the consumer and others from injury, or to prevent the worsening of a physical condition.
Prone Position: A manual restraint during which a child is held face down on the floor. A prone position manual restraint is prohibited by *MA Bulletin 3800.21(b)* (relating to manual restraints) because it applies weight or pressure on child's respiratory system.
Restraint: Any **chemical, mechanical,** or **manual** technique used for the purpose of restricting movement.
Seclusion: Restricting a child/adolescent/adult in a locked room and isolating the person from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door closed, preventing the individual from leaving the room. Seclusion does not include the use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.
Time-out room: An unlocked room used to remove an individual from the individual's immediate environment to reduce stimulation and assist the individual to regain self-control. Use of a time-out room constitutes a potential alternative to the use of seclusion and restraint.

Acronyms:
CIR: Critical Incident Report
BH-CCM: Behavioral Health Clinical Care Manager
QOCC: Quality of Care Committee
QI/UM: Quality Improvement/Utilization Management

Procedure:
1. A Report of Restraint or Seclusion Form (*Attachment 1*) shall be submitted via fax to PerformCare for the following:
   1.1. Restraint or Seclusion without Injury
      1.1.1. The Report of Restraint or Seclusion Form shall be completed by the Provider for all restraints or

seclusions used during the course of treatment funded by PerformCare.

1.1.2. Report of Restraint and Seclusion Form shall be submitted by the Provider within 24-hours of the occurrence of the restraint or seclusion without injury.

1.1.3. A separate form must be completed for each occurrence.

1.1.4. Form submissions will be data entered and reviewed by PerformCare Administrative Support Staff to ensure appropriate category identification and completeness based on information provided.

1.2. Use of blocking equipment as a manual restraint

1.2.1. Use of blocking equipment as a de-escalation technique is not considered a restraint unless the blocking device restricts the movement or function of the Member. If this criterion is met, then Provider shall follow manual restraint reporting guidelines.

1.3. Use of escort interventions as a manual restraint

1.3.1. If the use of a safety position, including escorts, assists and any other physical intervention, restricts the movement or function of the member in any way and/or the member is resisting the physical intervention, then it is considered a restraint, and Provider shall follow the manual restraint reporting guidelines.

2. A CIR report shall be submitted to PerformCare in accordance with policy QI-CIR-001 *Critical Incident Reporting* if:
   2.1. The restraint or seclusion results in an injury to the Member requiring treatment greater than first aid.
   2.2. Inappropriate restraint techniques are utilized.
   2.3. The Member is restrained in a prone position Provider completes Critical Incident Report and submits to PerformCare within 24 hours of the incident as outlined in Policy *QI-CIR-001 Critical Incident Reporting*.
3. Restraint Report in conjunction with a CIR:
   3.1. A Restraint and Seclusion Form shall be completed in addition to a CIR form when a restraint or seclusion occurs and CIR category criteria is met, such as an allegation of abuse involving a restraint.
4. Data collected from The Restraint and Seclusion Form and Critical Incident Reports related to restraint and seclusion will be reported as follows:
   4.1. To the Quality Improvement and Utilization Management (QI/UM) Committee on a semi-annual basis.

4.1.1. Based on the recommendation of this committee, follow up will occur as needed with providers related to the use of restraints and seclusion.

4.2. To the Member Safety and Quality Committee led by the PerformCare Medical Director on a quarterly basis.

4.2.1. Based on the PerformCare Restraint and Seclusion Monitoring Provider Follow Up Process (*Attachment 2)*, follow up will occur as needed with providers related to the use of restraints and seclusion.

4.3. All data collected will be distributed in accordance with applicable provisions in the HealthChoices contracts.

5. High Volume Restraint Monitoring: PerformCare defines High Volume Restraints as any Member with 10 or more restraints reported in the same quarter.

5.1. BH-CCMs are informed at the close of each month when a Member has reached the High-Volume Restraint threshold.

5.2. BH-CCMs are also informed at the close of Month 1 and Month 2 of the quarter of any Members determined to be At-Risk for reaching the High-Volume Restraint Threshold. A Member is considered to be At-Risk for HV Restraints if they have 5-9 restraints reported in the first two months of the quarter.

5.3. BH-CCMs utilize High-Volume Restraint reporting to guide follow up with Providers during treatment team meetings, continued stay reviews and provider outreach.

5.4. Clinical information about each Member on the High-Volume Restraint Report is reviewed during the Member Safety and Quality Committee on a quarterly basis.

6. The use of restraint and seclusion is discussed with Providers by the PerformCare Behavioral Health Clinical Care Manager (BH-CCM) in continued stay reviews and in regular team meetings.

6.1. CCM follow up on restraint and seclusion reports is determined by the PerformCare Restraint and Seclusion Protocols (*Attachment 3*).

6.2. If the BH-CCM identifies Quality of Care Concerns related to the restraint or seclusion of a Member, a referral will be made to the Quality-of-Care Council (QOCC) for further review.

6.3. The CCM will consult with a PerformCare Psychiatrist or Psychologist Advisor, as needed, and Peer-to-Peer reviews will occur with Provider as clinically indicated.

Related Policies: *QI-004 Internal Documentation, Review, and Follow-Up of Quality-of-Care Issues*

QI-CIR-001 Critical Incident Reporting

Related Reports: None

Source Documents and References: *OMHSAS-3800-09-01 "Strategies and Practices to Eliminate the Use of Unnecessary Restraints"*
OMHSAS-02-01 "The Use of Seclusion and Restraint in Mental Health Facilities and Programs"
OMHSAS-3800-09-02 "Prone Restraints in Children's Facilities"

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 Report of Restraint or Seclusion Form*
Attachment 2 Restraint and Seclusion Monitoring Provider Follow Up Process
Attachment 3 PerformCare Restraint and Seclusion Protocols

Approved by:

Primary Stakeholder

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Restraint and Seclusion Monitoring Provider Follow Up Process

PerformCare completes Restraint and Seclusion Monitoring on a quarterly basis as part of the Member Safety and Quality Committee process. Restraint and Seclusion trends across the previous quarter are reviewed by Level of Care, Provider, Restraint Type, Restraint Duration and High Volume (10 or more restraints per quarter for any one Member).

When a provider demonstrates an increased percent difference in restraint or seclusion incidents for a given quarter as compared to the previous quarter (via the *Incidents by Provider – Restraint, Current and Previous Quarter Chart* in Tableau) the Member Safety and Quality Committee will determine if specific outreach to the provider is necessary. The Member Safety and Quality Committee may determine that no outreach is necessary based on factors impacting the percent difference such as the overall volume of restraints for the provider in both quarters, members with high volume restraints admitted to that provider, the size of the percent difference and existing outreach to the provider that relates to restraint or seclusion incidents.

The Quality Department Staff that presented the Restraint and Seclusion data or a designee will complete outreach to providers determined by the Member Safety and Quality Committee to require follow up for restraint and seclusion increases. Outreach will take place by phone and documentation of discussion will be within the Member Safety and Quality Committee notes. PerformCare can provide information about the percent difference as well as any other provider level data that may be helpful for the consideration of restraint or seclusion trends such as data regarding incident type (*Manual Restraints by Type –Provider* and/or *Restraints by Type -Provider*), time of day (via *Incidents Occurrence by Time of Day* in Tableau), location (*Incidents Occurrence by Location at the Provider Facility* in Tableau) or duration (*Restraint or Seclusion Incidents Duration > 1 hour*).

Formal written outreach can be done if the provider does not respond to phone outreach or if discussions with the provider does not result in an appropriate outcome.

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PerformCare Restraint and Seclusion Protocols 2025

The use of restraint and/or seclusion are to be the last intervention utilized in a member's treatment and treatment plan. Restraint and/or seclusion are traumatic experiences and should be used as the last resort to protect a member from self-harm or harm to others. Protocols to reduce the use of restraint and/or seclusion are required whenever restraint and/or seclusion are utilized, as well as a re-examination of reduction protocols after every use.

Quality Department

1. PerformCare completes Restraint and Seclusion Monitoring on a quarterly basis as part of the QOCC sub-Committee process. Restraint and Seclusion trends across the previous quarter are reviewed by Level of Care, Provider, Restraint Type, Restraint Duration and High Volume (10 or more restraints per quarter for any one Member).

2. When a provider demonstrates an increased percent difference in restraint or seclusion incidents for a given quarter as compared to the previous quarter (via the Incidents by Provider – Restraint, Current and Previous Quarter Chart in Tableau) the QOCC sub-Committee will determine if specific outreach to the provider is necessary. The QOCC sub-Committee may determine that no outreach is necessary based on factors impacting the percent difference such as the overall volume of restraints for the provider in both quarters, members with high volume restraints admitted to that provider, the size of the percent difference and existing outreach to the provider that relates to restraint or seclusion incidents.

3. The Quality Department Staff that presented the Restraint and Seclusion data, or a designee, will complete outreach to providers determined by the QOCC sub-Committee to require follow up for restraint and seclusion increases. Outreach will take place by phone and documentation of discussion will be within QOCC sub-Committee notes. PerformCare can provide information about the percent difference as well as any other provider level data that may be helpful for the consideration of restraint or seclusion trends such as data regarding incident type (Manual Restraints by Type –Provider and/or Restraints by Type -Provider), time of day (via Incidents Occurrence by Time of Day in Tableau), location (Incidents Occurrence by Location at the Provider Facility in Tableau) or duration (Restraint or Seclusion Incidents Duration > 1 hour).

4. Formal written outreach can be done if the provider does not respond to phone outreach or if discussions with the provider does not result in an appropriate outcome.

5. Per QI-CIR-003, Restraint and Seclusion Monitoring, PerformCare providers are required to develop written policies and procedures for restraint/seclusion reporting with a focus on reduction efforts.

6. Providers notify PerformCare of a restraint or seclusion via the submission of the Restraint or Seclusion form. This form is to be submitted within 24 hours of the restraint.

6.1. If the restraint or seclusion resulted in an injury, the provider would instead submit a Critical Incident Report in accordance with QI-CIR-001, Critical Incident Reporting (CIR). All CIRs that resulted in treatment greater than first aide are referred for QOCC review.

6.2. All data collected regarding restraints and seclusions is reported at QI/UM on a semi-annual basis and committee recommendations for follow-up are completed as needed.

7. The use of locked seclusion is only permitted for MH IP Level of Care (LOC). Any use of seclusion in another LOC will be sent to QOCC.

8. Inappropriate use of restraint such as use of a non-approved techniques, use of restraint by staff not trained in use of an approved model for physical intervention, use of restraint or seclusion not permitted in that level care or use of chemical restraint also result in referral to QOCC.

Clinical Department

1. PerformCare Clinical Care Managers (CCM) are made aware of restraints and seclusions in a multitude of ways: during treatment team meetings, during a reauthorization request or continued stay review, via phone calls from the provider, and through a weekly internal Restraint/Seclusion report sent to all CCMs, CCM Supervisors, Clinical Manager and Director of Clinical Services.

2. MH IP/PHP and SUD Rehab/PHP Levels of Care (LOC)

2.1. The CCM will obtain details regarding what led to the restraint and/or a seclusion when made aware of a restraint and/or seclusion during a continued stay review (CSR) or treatment team meeting. The CCM will discuss any changes that have been made to the member's treatment plan regarding restraint and/or seclusion reduction protocols in an effort to reduce the need for future restraints and/or seclusion. If changes are clinically indicated for restraint and/or seclusion reduction protocols, the CCM will request that the members' treatment plan be updated. (The use of seclusion, mechanical restraint and chemical restraint is only permitted for MH IP LOC). Any use of these restrictive procedures in another LOC will be submitted to QOCC).

2.2. The CCM will follow up at the next continued stay review for any restraint and/or a seclusion from the Weekly restraint and/or a seclusion notification report that was not previously reported to the CCM. The CCM will discuss any changes that have been made to the member's treatment plan regarding restraint and/or seclusion reduction protocols in an effort to reduce the need for future restraints and/or seclusion. If changes are clinically indicated for restraint and/or seclusion reduction protocols, the CCM will request that the members' treatment plan be updated.

2.3. The PA will determine if a PA peer to PA peer consult is needed on a case-by-case basis. The CCM and PA will both document consults in member's Electronic Medical Record (EMR). The

CCM will implement the following guidelines for a CCM consult with a PerformCare Psychiatrist Advisor (PA).

2.3.1. When use of Intramuscular (IM) medication as part of the restraint and/or seclusion even if it is a prn order and LOC provider does not consider the use a chemical restraint.

2.3.2. When the duration of restraint and/or seclusion for more than one hour.

2.3.3. When no other behavioral interventions tried before restraint and/or seclusion.

2.3.4. When any use of unacceptable, inappropriate restraint techniques and/or seclusion are used.

2.3.5. When a restraint and/or seclusion is utilized more than 3 times in one week.

2.3.6. When the member's treatment plan was not updated per the CCM request regarding restraint and/or seclusion reduction protocols.

2.3.7. Note: manual restraints for the purpose of CCM follow up is defined as a manual restraint that restricts a member's movement. It does not mean a manual hand escort from one place to the other. These are still reportable as restraint but do not in and of themselves require CCM follow up.

3. RTF/CRR/FBMHS/IBHS LOC

3.1. The CCM will obtain details regarding what led to the restraint when made aware of a restraint during a treatment team meeting. The CCM will discuss any changes that have been made to the member's treatment plan regarding restraint reduction protocols in an effort to reduce the need for future restraints. If changes are clinically indicated for restraint reduction protocols, the CCM will request an updated treatment plan to be submitted to PerformCare within 2 weeks. (The use of seclusion, mechanical restraint and chemical restraint is only permitted for MH IP LOC.) Any use of these restrictive procedures in another LOC will be submitted to QOCC).

3.2. The CCM will review the treatment plan when a CCM is made aware of a restraint while reviewing a reauthorization request and determine if changes have been made to the member's treatment plan regarding restraint reduction protocols in an effort to reduce the need for future restraints. If changes are clinically indicated for restraint reduction protocols, the CCM will request an updated treatment plan to be submitted to PerformCare within 2 weeks.

3.3. The CCM will follow up on any restraint identified on the Weekly restraint notification report within 5 business days, unless the restraint was previously reported to the CCM. The follow-up can occur in the context of a team meeting or 1:1 with the provider. The CCM will discuss any changes that have been made to the member's treatment plan regarding restraint reduction protocols in an effort to reduce the need for future restraints. If changes are clinically indicated for restraint reduction protocols, the CCM will request that the members' treatment plan be updated.

3.4. The PA will determine if a consult with a PerformCare Psychiatrist Advisor is clinically indicated, as well as the PA will determine if a PA peer to PA peer consult is needed on a case-by-case basis. The CCM and PA will both document consults in member's EMR. The CCM will implement the following guidelines for a CCM consult with a PerformCare Psychologist Advisor (PA):

3.4.1. When the use of IM medication as part of the restraint, even if it is a prn order and RTF provider does not consider it as use of a chemical restraint. (Note: follow up with PerformCare Psychiatrist Advisor is required for medication or use of chemical restraint).

3.4.2. When the duration of restraint for more than one hour.

3.4.3. When no other behavioral interventions were tried before restraint.

3.4.4. When any use of unacceptable, inappropriate restraint techniques occurred.

3.4.5. When restraints were utilized more than 3 times in one week.

3.4.6. When the member's treatment plan was not updated per the CCM request regarding restraint and/or seclusion reduction protocols.

3.4.7. Note: manual restraints for the purpose of CCM follow up is defined as a manual restraint that restricts a member's movement. It does not mean a manual hand escort from one place to the other. These are still reportable as restraint but do not in and of themselves require CCM follow up.

4. CCMs will complete follow up per protocol guidelines if restraint/seclusion occur in any LOC not indicated in # 2 and 3 above.

5. Additional Clinical Monitoring.
   5.1. Clinical Manager and Clinical Director will participate in QOCC Sub Comm quarterly restraint/seclusion review meeting.

   CCM Supervisors will review weekly restraint/seclusion notification report on weekly basis and complete follow up with CCM if trends with specific Member or Provider CCM/CCM Supervisor will complete follow up with Provider and CCM will follow PA Consult guidelines as needed.

   5.2. CCM Supervisors will complete restraint/seclusion follow up with CCMs in 1: 1 supervision as needed regarding trends with specific Member or Provider. CCM Supervisor will discuss what PA Consult guidelines were followed by CCM and if additional interventions are needed for Provider outreach.

6. References:
   PerformCare Expectations and Best Practice on the Use of Restrictive Procedures
   https://pa.performcare.org/providers/resources-information/expectations-and-best-practices-restrictive-procedures.aspx

   OMHSAS Bulletin -02-01: Use of Seclusion & Restraint in Mental Health Facilities & Programs
   https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/formsandpubs-omhsas/d_005714.pdf