兒童權利小組委員會

因應 2017 年 1 月 17 日會議席上所作討論而須採取的跟進行動一覽表

本文件列出當局就委員在 2017 年 1 月 17 日兒童權利小組委員會會議所提事項的回應。

跟進有關無醫療需要兒童滯留醫院事宜及其被約束的情況

(a) 醫院管理局分別在 2016 年 6 月及 12 月進行調查，發現有 61 名及 43 名兒童因非醫療原因逗留醫院，當中分別有 38 宗及 36 宗個案因輪候宿位而滯留醫院。經社會福利署(社署)了解後，現提供下列資料：

(i) 滯留醫院原因；

以下表列出兒童滯留醫院的原因：

原因	兒童滯留醫院的數目	
	六月份的調查	十二月份的調查
兒童等候宿位安排	38	36
兒童等候進行多專業個案會議或福利計劃評估	18	5
兒童等候家訪或寄養服務	2	-
兒童等候進行社會評估	1	-
母親等候接受育兒培訓	1	-
兒童等候醫療報告	1	-
兒童等候更改監護人的法律文件	-	1
母親等候進行心理評估	-	1
總數:	61	43

(ii) 滯留醫院的兒童是否已獲安排宿位；

因輪候宿位而滯留醫院的兒童數據表列如下(截至2017年2月7日)：

	2016年6月進行調查所發現38名兒童因輪候宿位而滯留醫院個案	2016年12月進行調查所發現36名因輪候宿位而滯留醫院個案
已獲安排宿位	33宗	19宗
正等候宿位	1宗[註1]	14宗
最後改由家人照顧[註2]	4宗	3宗
總數：	38宗	36宗

註1:該名兒童已於2017年3月23日獲安排入住兒童院舍。

註2:經社工的輔導及支援下，兒童的父母照顧兒童的能力得到改善或獲得其他親友的支援而無須安排宿位。

(iii) 滯留醫院的兒童是否曾被留宿幼兒中心拒絕安排宿位；如是的話，原因為何；

(iv) 滯留醫院的兒童父母是否曾拒絕任何宿位安排；如是的話，原因為何；

輪候宿位的兒童曾被拒絕或其父母曾拒絕任何兒童住宿照顧服務宿位安排的數據及有關原因表列如下(截至2017年2月7日)：

	2016年6月進行調查所發現38名兒童因輪候宿位而滯留醫院個案	2016年12月進行調查所發現36名因輪候宿位而滯留醫院個案
輪候宿位的兒童曾被兒童住宿照顧服務拒絕安排宿位	0宗	0宗
輪候宿位的兒童父母曾拒絕任何兒童住宿照顧服務宿位安排	2宗 (父母選擇兒童住宿照顧服務的地區)	0宗

(v) 滯留醫院的時間及出院計劃。

以下表列出「滯留日數」。「滯留日數」的計算方法為「實際出院日期」減去「病情適合出院日期」。

原因	六月份的調查		十二月份的調查	
	範圍 (日數)	平均數 (日數)	範圍 (日數)	平均數 (日數)
兒童等候宿位安排	12 - 242	94	2 - 310	65
兒童等候進行多專業個案會議或福利計劃評估	6 - 141	45	3 - 18	13
兒童等候家訪或寄養服務	6 -66	36	-	-
兒童等候進行社會評估	3	-	-	-
母親等候接受育兒培訓	9	-	-	-
兒童等候醫療報告	37	-	-	-
兒童等候更改監護人的法律文件	-	-	1	-
母親等候進行心理評估	-	-	88	-

上述個案的離院計劃已轉介相應的醫務社工、社會福利署轄下的綜合家庭服務中心和保護家庭及兒童服務課跟進。

(b) 一名 13 歲男童及一名 8 歲女童，在醫院需要使用安全約束背心作身體約束的兩宗個案的進一步詳情；以及有關規管在醫院使用身體約束措施的指引全文；及

個案 1

本個案兒童 13 歲，確診患有輕度智力障礙、過度活躍症及對抗性反抗症，於 2016 年因在就讀的特殊學校內打傷老師而被社工送入院。

入院後，該兒童屢次因其要求沒有被即時滿足而情緒不穩定，在醞釀期間沒有任何先兆，主治醫生需要使用藥物去控制兒童

的焦燥不安及暴怒行為。於同年，經臨床評估認為適合出院後，其醫療團隊決定安排他到緊急安置的兒童之家繼續照顧。

在等待安置期間該兒童發生了 7 次以上的情緒不穩定，包括擊打紅十字會的老師、攻擊另一名兒童並導致牙齦出血、及扔擲其他兒童的早餐盤等。在大多數情況下，病房護士會安慰該兒童，幫助他冷靜下來。在其中一次，該兒童沒有平靜下來，所以護士安排他到一個沒有病人的房間，讓他冷靜下來。亦有一次，該兒童與母親電話交談後，情緒變得非常激動及不穩定，拔去護士站的電話線，其後護士需要使用安全背心及肢體約束帶固定在床上 10 小時。

及後，該兒童被安排到另一所醫院的兒童精神專科醫生照顧。在等待緊急安置期間，該兒童由兒科醫生繼續照顧。

個案 2

本個案兒童 8 歲，在 2016 年發現被遺棄，由警員送入醫院。該兒童患有多發性先天異常及生長遲緩。該兒童沒有說話能力，而且因下肢問題需要靠支撐才能站立。

為防止兒童跌倒受傷，護士升起床邊的欄杆及安排兒童穿上安全背心。護士有時候需要用肢體約束帶去防止該兒童撕爛尿布放進口裡。

在住院期間，醫護人員發現該兒童經常感到口渴，其尿液呈嚴重稀釋，處於脫水和電解質不平衡的狀態。該兒童亦曾因嘔吐而需要以靜脈注射來補充流失的水份。為拯救該兒童的生命，醫護人員需要維持一個無阻的輸液系統去補充水份和電解質，因此護士使用肢體約束帶防止該兒童誤拔去輸液的導管。

該兒童原於 2016 年便可出院，但由於需時安排該兒童入住一所可照顧失能兒童的寄宿院舍，最終於 2017 年出院。

醫院管理局有關使用約束物品的守則載於附件一(只備有英文版本)。

檢討多專業個案會議及兒童福利計劃

(c) 每三個月召開覆核會議的多專業個案會議所佔百分比。

根據「處理虐待兒童程序指引-- 2015 年修訂版」，負責跟進個案的成員應協助執行保護懷疑受虐待兒童多專業個案會議（多專業個案會議）的決定，如無法執行多專業個案會議議決的行動，或因情況有變，以致即將需要／已採取涉及有關兒童及其家人的後續行動，便應通知主責社工。視乎個別個案的情況，跟進個案的專業人士會以不同的方式及相隔不同的時間互相溝通。然而，主責社工會視乎需要和依據個案會議的協議，在議定的時間（例如在個案會議舉行後的三個月）之後，以書面形式通知個案會議的成員福利計劃的推行進展。

根據保護兒童資料系統，2016 年共有 786 宗個案召開了多專業個案會議。同年，社署保護家庭及兒童服務課處理的個案中，有 10 宗個案曾在多專業個案會議內建議需提交進度報告，以監察有關福利計劃的推展情況，視乎個別個案的情況，所提交的時段在個案會議後 1 至 6 個月不等。至於那些不需要提交進度報告的個案，一般來說，所擬訂的福利計劃簡單直接、父母／照顧者合作、有關兒童具有相當好的自我照顧能力、家庭有可靠的支援網絡等。

醫院管理局
社會福利署
2017 年 3 月

Guidelines for the Use of Physical Restraint

Version	Effective Date
1	28 August 2008
2	01 March 2016

Document Number	HAHO-CC-GL-Q&S-004-v02
Author	Working Group for Guidelines for the Use of Physical Restraint
Custodian	Patient Safety & Risk Management Department
Approved By	Committee on Quality and Safety
Approved Date	18 February 2016
Distribution:	CCEs, HCEs, medical, nursing and allied health staff

Guidelines for the Use of Physical Restraint

1. Introduction

The guideline was first produced by the Central Committee on Quality and Risk Management in 2008. It specifies the general principles for frontline medical and nursing staff to develop their own operational instructions appropriate to their specific clinical settings. Guideline review was done with extensive consultation in 2015.

2. Purpose

This document serves as a guideline for respective COCs and hospitals to review the current practice and develop operational instructions in applying physical restraint to patient to minimize / reduce the risk of injury or death.

3. Scope

This guideline applies to patients requiring physical restraint.

4. Definition

Physical restraint is the use of a physical or mechanical device to limit or prevent movement of the whole or a portion of the patient's body as a means of controlling his or her physical activities.

This guideline DOES NOT refer to the use of physical restraint in the following circumstances:

- Use associated with medical, dental, diagnostic, or surgical procedures when such use is based on standard practice for the applicable procedure.
- Devices used to meet the assessed needs of a patient who requires adaptive support or medical protective devices.
- Devices used by law enforcement officials for security purposes.

5. General Principles and Strategies for Reducing Risk

Decision and application of physical restraint are shared care processes by doctors and nurses. The decision to restrain patients, other than what is necessary for the treatment of specific medical conditions, should be justified on grounds of preventing patients from harming themselves or others. The safety of the patient requiring physical restraints should be ensured.

Restraint should only be used when alternatives are deemed inappropriate or ineffective. As such, health care professionals must carefully weigh the benefits against the risks of using restraint in each particular case, to ensure the least amount of restraint is used, and to limit usage to what is strictly required.

The use of restraint should be judged with the balance of patient's safety and benefits by competent staff. In principle, use the least amount of restraint for the least duration that is necessary, and afford as much dignity to the patient as the situation allows. Choose a restraint measure / device appropriate to the patient's condition and apply correctly and safely by competent staff.

Written instruction specifying the duration and circumstances for restraint application is recommended. Regular review and document the need for restraint, at least once per shift, is necessary.

6. Assessment and Documentation

a. The reason to restrain a patient must be adequately documented, (and whenever possible, be explained to the patient as well as family members accompanying the patient or via phone) including:
   - Assessment, which should be a team approach done by doctor and nurse
   - Date and time of the initial application and subsequent reviews of restraint
   - Reasons for the initial restraint, intended duration and indications for which the restraint is needed.
   - Verbal or phone order received from the doctor and must be followed with a written order signed by the doctor concerned
   - Secondary review of the need for restraint within a reasonable time period by a senior nurse or doctor
   - Reasons for continual application of restraint beyond the initial intended duration.
   - Type of restraint measure / device.
   - Patient's condition.
   - Additional care / precautions taken as a result of the restraint.
   - Discussion / explanation with the patient and / or family members and / or significant others.
   - Date and time of removal the restraint, and the patient condition.

b. Observe the patient regularly, for:
   - Change in the condition indicating restraint, vital signs, state of circulation (e.g. skin temperature, colour, oedema and capillary refill), mental state, skin integrity, restraint position, body movement and range of motion of restrained part(s), condition of restraint device and risk of restraint asphyxia.

   - The need to continue restraint. If restraint is prolonged, attend to patient's activity of daily living (ADL) including personal hygiene, nutrition and hydration status, as well as psychological needs such as dignity and privacy. Patient's comfort must always be attended.

A flow chart for the assessment and documentation for the patient with the use of physical restraint is appended in Annex 1 for reference.

References

1. The Geriatric Subcommittee. Coordinating Committee in Internal Medicine. Clinical Guidelines on the Use of Physical Restraints in Adult Setting. Hong Kong: Hospital Authority; 2005. Available from: http://ha.home/visitor/view_content.asp?content_id=34737&lang=ENG

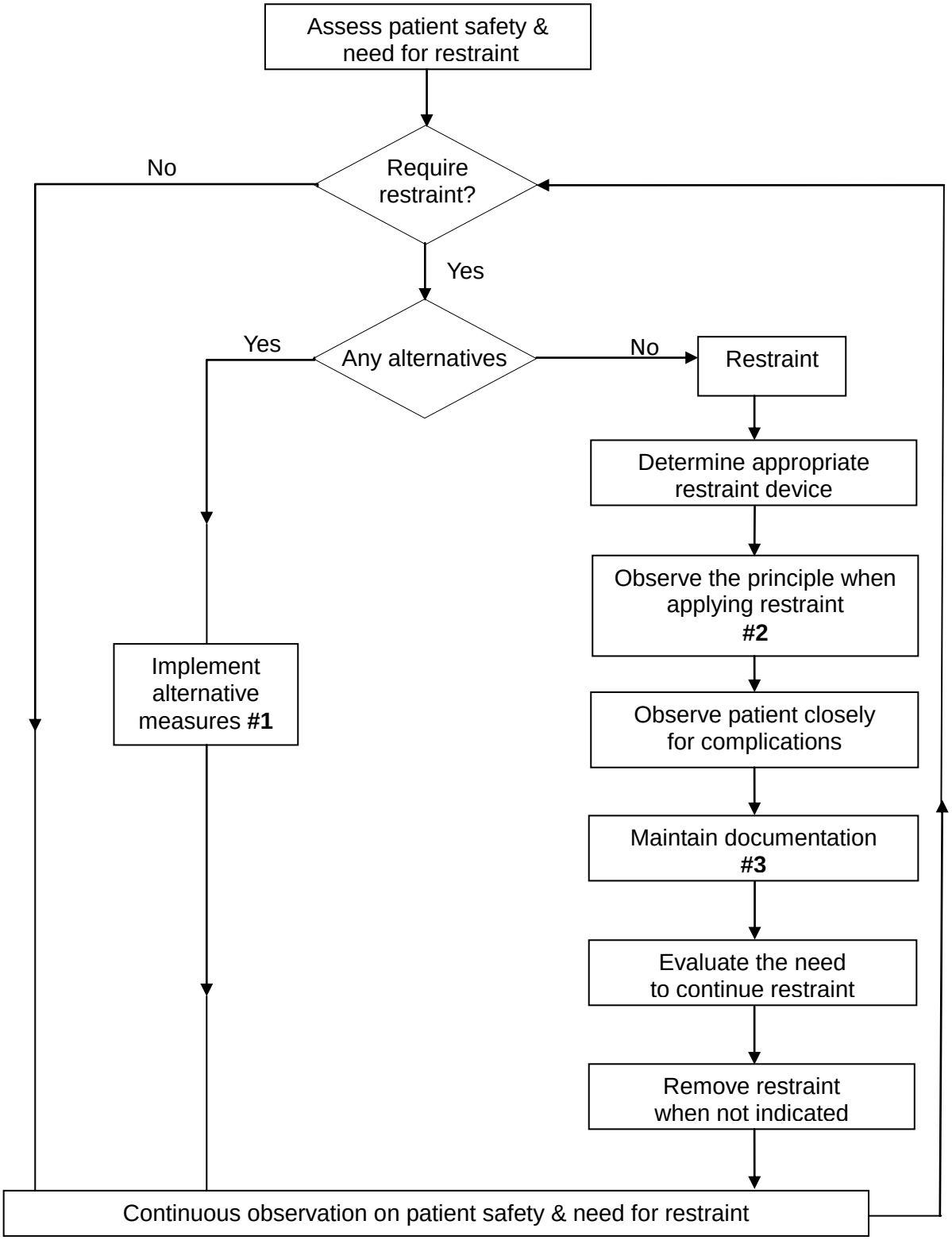
2. Coordinating Committee in Nursing. HA COC(N) Paper: Documentation on patient on physical restraint. Hong Kong: Hospital Authority; 2001. Available from: http://nursenet.home/Coordinating%20Committee%20%20Grade%20Nursing%20Approved%20Pap/Nursing%20Quality%20and%20Safety/Guideline/Documentation%20of%20Patient%20on%20Physical%20Restrain.pdf

3. Nursing Quality and Safety Subcommittee. Nursing Standards for Patient Care: Physical Restraint of Patient. Hong Kong: Hospital Authority; 2015.

4. Professional Development Committee of the Nursing Council of Hong Kong. Guide to Good Nursing Practice: Physical Restraint. Hong Kong: Nursing Council of Hong Kong; 2008. Available from: http://www.nchk.org.hk/filemanager/en/pdf/physical_restraint_e.pdf

Flow chart for the Use of Physical Restraint

Annex 1



1: Alternative measures must be attempted before application of restraint such as:

- Reality orientation
- Medication review
- Facilitation / assistance to toileting
- Provision of call bell
- Accompany care
- Diversional activities

2: Observe the principles when applying restraint

1. Intention to do good
2. Appropriateness to patient condition
3. Respect patient dignity
4. Observation on safety issues to prevent injury

3: Maintain documentation

1. Reason(s) for or against restraint / for or against alternative measures
2. Date / time of restraint / removal
3. Patient condition after restraint / removal
4. Plan of actions
5. Explanation with patient / relatives / significant others

Annex 2

Membership of the Working Group for Guidelines for the Use of Physical Restraint

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