Subcommittee on Children's Rights

List of follow-up actions arising from the discussion at the meeting on 17 January 2017

The Subcommittee has requested the Administration to provide the following information –

Follow up on issues relating to children without medical needs overstaying in hospitals and their conditions of being restrained

(a) The Hospital Authority (HA) had identified 61 children and 43 children overstaying in hospitals without medical needs according to the surveys conducted in June and December 2016 respectively. Among which, 38 children and 36 children were found overstaying in the hospitals due to waitlisting of residential placement. The Social Welfare Department (SWD) has looked into these cases and relevant information is provided below:

(i) reasons for overstaying;

The following table sets out the number of children by reasons of overstay.

Reasons	**Number of Children**	
	June Survey	**December Survey**
Child waiting for placement	38	36
Child waiting for MDCC / Case Conference / Social Welfare Plan	18	5
Child waiting for home visit/ pending for foster parents	2	-
Child waiting for social assessment	1	-
Mother waiting for child care training	1	-
Child waiting for medical report	1	-
Child waiting for legal document for the change of guardianship	-	1
Mother waiting for psychological assessment	-	1
Total:	**61**	**43**

(ii) whether placement offer(s) has been arranged to the overstaying child;

No. of children overstaying in hospital due to waitlisting of residential placement is tabulated as follows (as at 7.2.2017):

	Among 38 children overstaying in hospitals due to waitlisting of residential placement *(Survey conducted by HA in June 2016)*	Among 36 children overstaying in hospitals due to waitlisting of residential placement *(Survey conducted by HA in December 2016)*
With residential placement arranged	33 cases	19 cases
Still waitlisting residential placement	1 case [Note 1]	14 cases
Changed to be taken care by family members [Note 2]	4 cases	3 cases
Total :	38 cases	36 cases

[Note 1] : The child concerned has been admitted to residential home for children on 23.3.2017.

[Note 2] : Upon counselling and support from social workers, the child care abilities of parents concerned have been strengthened or the parents received support from relatives that the arrangement of residential placement is not required.

(iii) whether the overstaying child has been rejected by residential child care centre(s) for placement; if yes, the reasons for that;

(iv) whether parents of the overstaying child have rejected any placement offer; if yes, the reasons for that; and

No. of children waitlisting of residential placement having been rejected by residential child care service or their parents having rejected the placement offered and its reasons are tabulated as follows (as at 7.2.2017):

	Among 38 children overstaying in hospitals due to waitlisting of residential placement *(Survey conducted by HA in June 2016)*	Among 36 children overstaying in hospitals due to waitlisting of residential placement *(Survey conducted by HA in December 2016)*
No. of children waitlisting residential placement but being rejected by residential child care service for admission	0 case	0 case
No. of children waitlisting residential placement and their parents rejected the	2 cases (Parents had location preference)	0 case

placement offered		

(v) the length of overstay and the discharge plan.

The number of days for unnecessary hospitalization is calculated by subtracting the "medically fit for discharge date" from the "actual discharge date" and is set out in the table below.

Reasons	**June Survey**		**December Survey**	
	Range (Days)	**Average (Days)**	**Range (Days)**	**Average (Days)**
Child waiting for placement	12 - 242	94	2 - 310	65
Child waiting for MDCC / Case Conference / Social Welfare Plan	6 - 141	45	3 - 18	13
Child waiting for home visit/ pending for foster parents	6 - 66	36	-	-
Child waiting for social assessment	3	-	-	-
Mother waiting for child care training	9	-	-	-
Child waiting for medical report	37	-	-	-
Child waiting for legal document for changing guardianship	-	-	1	-
Mother waiting for psychological assessment	-	-	88	-

(b) further details of the two cases in which a boy aged 13 and a girl aged eight were physically restrained with safety vests in hospitals; and the full version of the guidelines governing the use of physical restraints in hospitals; and

Case 1

A 13-years-old child, born with mild mental retardation, hyperactivity, and oppositional disorder, was brought to the hospital in 2016 by a social worker because of hitting a teacher in a special school.

After admission, the attending doctor had controlled the child's agitation and aggressive behaviors with medication. Despite that, the child showed repeated episodes of temper outbursts that usually occurred when his requests were not entertained immediately by other children or staff. The clinical team decided that the child would be discharged for emergency placement to a "small group home" for continuing care.

While waiting for the placement, the child had 7 more episodes of temper outbursts involving, but not limited to, hitting a teacher, a nurse and other staff, hitting another child which resulted in gum bleeding, and throwing other children's breakfast, phone, locker etc. In most situations, the ward nurses comforted him and helped him to calm down. On one occasion, the child failed to calm down and he was therefore placed in a separate room for him to calm down. In another occasion, the child became very agitated with outburst of temper after talking with mother on phone. The child pulled off the ward phone lines and was subsequently restrained in bed with safety vest and limb holders until he was able to calm down.

The child was discharged to another hospital and placed under the care of a child psychiatrist while waiting for emergency placement in the same year.

Case 2

An 8-year-old abandoned child was brought into the hospital by the Police in 2016. The child was born with multiple congenital abnormalities and growth retardation. The child, who had no speech and lower limb deformities, could only stand with support.

To prevent the child from injuries, a safety vest was used with bedside rails up. Limb holders were occasionally used to prevent the child from tearing the diaper to pieces and putting them into mouth.

During hospitalization, the child was found to have excessive thirst and excretion of large amounts of severely dilute urine, and was in the state of dehydration and electrolytes imbalance. Also, the child had an episode of vomiting requiring intravenous replacement of fluid during overstay. The maintenance of an effective infusion system to ensure unobstructed free flow of fluid and electrolytes for rehydration and prevention of dislodgment of the intravenous catheter were needed in order to preserve the child's life. Hence, in both situations, the use of limb holders would assist in the patient's compliance with medical treatment and prevent him from pulling off the catheter.

The first discharge decision was made in 2016. However, the child was discharged in 2017 as more time was required for arranging an institution for long term disability care.

The Guidelines for the Use of Physical Restraint of Hospital Authority (in English only) is enclosed at **Annex**.

Review on Multi-disciplinary Case Conference ("MDCC") and welfare plans for children

(c) The percentage of MDCC that conducted review conferences in every three months.

According to the Procedural Guide for Handling Child Abuse Cases (Revised 2015), members who follow up the case should assist in carrying out the decisions made in the Multi-Disciplinary Case Conference on Protection of Child with Suspected Abuse (MDCC). They should inform the key worker if the actions as decided in the multi-disciplinary case conference cannot be implemented or there are any changes in the circumstances that subsequent action is to be/has been taken concerning the child and his/her family. While the communication among professionals following up the case can be in different formats and in different intervals based on individual case merits, subject to the need and agreement in the MDCC, the key social worker will inform members of the MDCC in writing the status of the implementation of the welfare plan in an agreed period of time, say 3 months after the MDCC.

According to the Child Protection Registry, MDCCs have been conducted for 786 cases. In the same year, 10 progress reports for cases handled by the Family and Child Protective Services Units of SWD are required by the MDCCs to monitor the implementation of the welfare plan formulated. The date of submission ranges from 1 to 6 months after the MDCC based on individual case merits. For those cases in which progress reports are not required, in general, the welfare plans formulated are straightforward, the parents/carers are cooperative, the children concerned have substantial self-care ability, the families have reliable support network, etc.

Hospital Authority
Social Welfare Department
March 2017

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
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Distribution:	CCEs, HCEs, medical, nursing and allied health staff

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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.

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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.

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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.

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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

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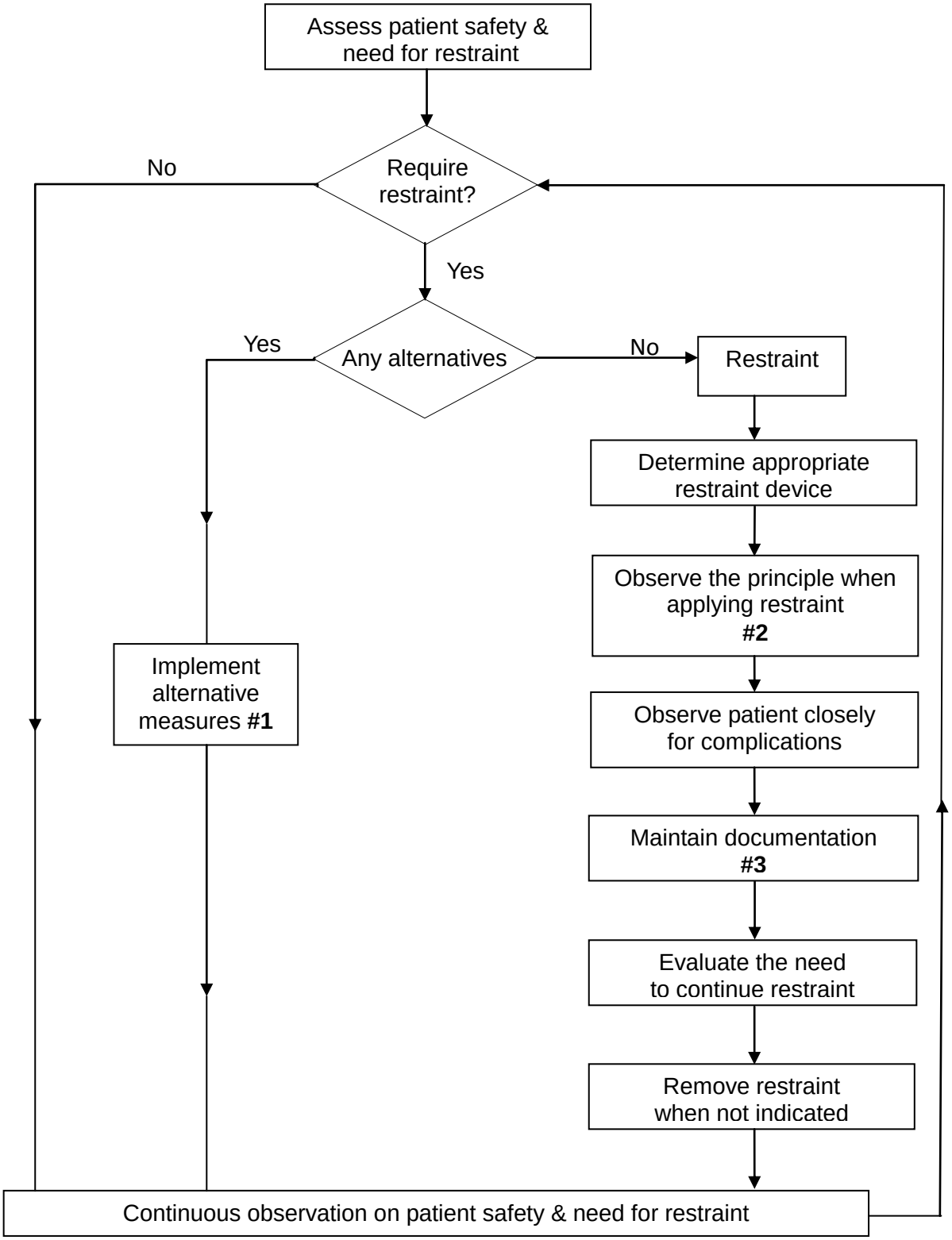
Flow chart for the Use of Physical Restraint

Annex 1



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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

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Annex 2

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

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