Failure to resuscitate disabled resident and to respond to deteriorating condition (14HDC01280, 17 June 2016)

Registered nurse ~ Enrolled nurse ~ Residential home ~ Disability ~ Active resuscitation order ~ CPR ~ Adverse symptoms ~ Adequate advice ~ Care plans ~ Falls risk assessment ~ Delegation of care ~ Right 4(1)

An elderly man with an intellectual disability and diabetes lived in a residential home. He required assistance with mobility, and used a wheelchair. The man's resuscitation status had been discussed with his general practitioner, who was recorded as stating that the man was to have active resuscitation.

The man's progress notes document unexplained bruising and an unwitnessed fall. An undated incident report was completed for the unwitnessed fall.

At approximately 1.50am a few days later, an enrolled nurse (EN) reviewed the man and observed that he was in discomfort. She took a full set of observations and then contacted the registered nurse (RN) on duty. The EN relayed the man's observations and told the RN that the man's breathing was laboured, his skin was clammy, and he was not responding to commands. The RN told the EN to give the man paracetamol elixir in accordance with his prescription, following which the man was put into bed and the EN remained with him.

The EN sat with the man for approximately 20 minutes, at which point she believed he appeared more settled and less agitated. The EN then saw the man's legs rise and gently fall and noted that he appeared to have stopped breathing. At approximately 2.40am the EN checked the man's pulse and recognised that he had died. The EN did not commence CPR. She contacted the RN and told her that she could not find the man's pulse, and that he appeared not to be breathing. The RN told the EN that she would come to the rest home immediately. She arrived a short time later, and called the Police.

It was held that the RN did not take prompt and appropriate action when the EN advised her that the man had symptoms of laboured breathing and clammy skin and so breached Right 4(1). Adverse comment was made in respect of the RN with regard to the lack of detailed instruction listed in the man's care plan.

It was also held that the EN should have ensured that active CPR was commenced and emergency services were contacted when the man stopped breathing, and so breached Right 4(1).

Adverse comment was made in respect of the rest home regarding the actions taken following the man's unwitnessed fall and his resuscitation status.