Care of a disabled person in a residential care home (14HDC00007, 4 December 2015)

Disability service provider ~ Caregiver ~ Standard of care ~ Care planning ~ Monitoring ~ Hours worked ~ Cerebral palsy ~ Obstructive sleep apnoea ~ Epilepsy ~ Rights 4(1), 4(4)

A 20-year-old man lived three nights per week in a residential care home and required 24-hour care because of his acute obstructive sleep apnoea, cerebral palsy and epilepsy. He was unable to walk and used a wheelchair. The other four nights per week he lived at home with his parents.

One night, the man was cared for overnight by a sole caregiver at the care home who was also caring for three other clients with complex needs. The caregiver on duty was to remain awake during the night, and complete client and household duties during the shift.

On the night in question, the caregiver's shift started at 11pm. At approximately 11.10pm, the caregiver transferred the man to his bed. The man's night-time care plan contained information about his medication regimen and sleep system. The caregiver was required to check the man frequently, and record on an hourly checklist that he had done so.

At approximately 3am, the man woke up. The caregiver left the man on his back in bed for 10–25 minutes before transferring him to his wheelchair. At approximately 5am, the caregiver transferred the man from his wheelchair back to bed, with the bed raised at the head end, in order to perform his personal cares. The caregiver said that he went to the ensuite bathroom to wet a flannel and, when he came back, the man had moved so that he was diagonal on the bed, and he was struggling to breathe. The caregiver said that he tried to move the man back into position (lying straight on the bed), but the man's breathing became more difficult, and he stopped breathing.

At 5.21am, the caregiver called 111 and spoke to a call handler. The call handler was advised that a male was unconscious and not breathing. Under the guidance of the call handler, the caregiver performed CPR until two ambulances arrived at 5.33am. The man was taken to hospital, where he died at 8am.

It was held that the caregiver failed to comply with the man's night-time care plan, in that he did not attach the man's shoulder harness after transferring him into his wheelchair, or place a pillow under his head and shoulders after transferring him back to bed to perform personal cares. For these reasons, the caregiver did not provide services to the man with reasonable care and skill and breached Right 4(1).

It was also held that the residential care home did not provide services to the man with reasonable care and skill, as its care planning for the man did not meet the accepted standard. Information and training was provided at house meetings but the care home did not have an adequate system in place to verify whether the caregiver had accessed or received the information and training provided when he missed house meetings. For these reasons, the residential care home breached Right 4(1) of the Code.

In addition, the hours the caregiver was allowed to work following a disciplinary process put at risk the clients he cared for, including the man. Accordingly, the care home failed to minimise the potential harm to the man and breached Right 4(4).

Adverse comment was made about the residential care home’s monitoring of the caregiver’s performance.