

**Implementation of care plan and documentation of
patient non-compliance
(12HDC00915, 30 June 2014)**

Rest home ~ Registered nurse ~ Manager ~ Implementation of care plan ~ Documentation ~ Informed consent ~ Diabetes ~ Restraint ~ Patient non-compliance ~ Rights 4(1), 4(2), 6(1), 7(1)

A 70-year-old woman was admitted to a residential care unit (RCU) at a rest home after fracturing her hip. She was an insulin-dependent diabetic with a complex medical history and was under the care of a number of external clinicians through the regional diabetes service. Her daughter held an enduring power of attorney (EPOA) as to the woman's care and welfare, which had not been activated.

There were numerous issues with the implementation of aspects of the woman's care plan by RCU staff, including in relation to her diabetes management, wound care, falls and mobility assistance, and infection control. The woman's care was also complicated by her non-compliance with some aspects of her care plan. The daughter was concerned that "specialist recommendations" were not being fully implemented into her mother's care.

The woman had fifteen falls during her residency in the RCU including one which resulted in a further hip fracture, following which she was transferred to a public hospital. While the woman remained in hospital, the RCU manager met with the woman's daughter, who signed a restraint plan as her attorney under the EPOA. The restraint plan was not signed by the woman. A short-term care plan was also documented.

After the woman returned to the RCU, there were further issues with the implementation of her care plan. Her daughter attended various meetings with RCU staff and made numerous written complaints. The woman was then transferred to another rest home, where she continued to reside as at the time of this investigation.

It was held that the RCU manager breached Right 4(1) in that she overlooked and failed to follow up on aspects of the woman's care plan. It was also held that the RCU manager breached Rights 6(1) and 7(1) with regard to aspects of the woman's treatment and restraint plan.

It was held that the rest home breached Right 4(1) in that various staff members failed to implement aspects of the woman's care plan appropriately, and Right 4(2), in that its documentation was suboptimal.