

Final Inspection Report

Dutch Village Trust Inc.

Date of inspection: 25 May 2010

RELEASED UNDER THE
OFFICIAL INFORMATION ACT

HealthCERT
Quality & Safety
Regulation & Governance
Ministry of Health

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Undertaken: 25 May 2010
File Ref: W DU01
Provider: Dutch Village Trust Inc.
Contact Person: Mr XXX XXX
Premise: Ons Dorp Care Centre
36 McLeod Road
Henderson
WAITAKERE

Executive Summary

History

The Dutch Village Trust is currently certified to provide rest home level care and hospital level care (Geriatric).

The Ministry of Health has received a number of complaints over the last 10 months about the level of care provide by Dutch Village Trust - Ons Dorp Care Centre. Complaints have also been made to the Office of the Health and Disability Commissioner. Waitemata District Health Board has also conducted an onsite investigation into the concerns received. A number of on-going concerns do not appear to have been resolved to date.

Investigation

In response to the phone contact and complaints of 20 November 2009 the Ministry contacted Waitemata District Health Board (WDHB). WDHB visited the Care Centre with a Gerontology Nurse Specialist and identified that the level of care provided was satisfactory. The Trust also undertook to undergo a full audit for recertification due to the significant changes and concerns that existed.

The complaints could not be substantiated

On 30 November 2009 the Ministry wrote to the Trust requesting the proposed internal audit become a full audit for certification, resulting in the Trust recertifying early. This letter was copied to the Designated Auditing Agency (DAA), so that they were aware of the request, and to Waitemata District Health Board.

The scheduled full audit for certification did not occur as requested. The Ministry sought clarification from the DAA as to why this did not occur. It was identified that the DAA only conducted an internal audit. The DAA identified they did not receive a copy of this letter, and the Trust did not present a copy at the time of the internal audit nor request a certification audit.

The internal audit represented an issue as the independence of the certification audit scheduled for completion by September 2009 could not be verified as the auditor had identified areas of improvement prior to the recertification audit.

In the February 2010 revision of the DAA Handbook, it is no longer permissible for DAAs to provide both internal audits and certification audits of the same facility.

Ministry officials consider it best practice for any internal audit to be done independently of the DAA responsible for the standard certification audits.

A certification audit was carried out on 29 March 2010 by a Ministry audit team thus ensuring an independent audit.

The last certification audit of September 2007 resulted in 3 partially attained criteria and 3 continuous improvements, with the surveillance audit (at mid point of the certification period) resulting in 8 partially attained criteria.

This current certification audit resulted in 101 partially attained criteria and 19 standards not being met. Of these criteria 7 were risk rated as high (advanced directives; care planning; medication management; evacuation scheme; and infection control) and 45 risk rated as moderate.

This change indicated failure of systems within the providers service, even with clinical oversight from the DHB. This may in part be due to a large turnover of senior staff and/or a change in auditors. However given that the DAA internal audit also found 64 partially attained criteria the latter is the less likelihood.

The auditors confirmed that the change in configuration increasing hospital bed numbers within the service is currently on hold.

The provider is required to carry out corrective actions and submit progress reports at 1 month and 3 month intervals, all other partially attained criteria will be reviewed at the next audit. HealthCERT will carry out on-site verification of progress.

A six month period of certification for this provider was issued.

Nature of current complaint

The Ministry of Health has received an anonymous complaint on 21 May 2010 about the standard of care provided by the Dutch Village Trust at Ons Dorp Care Centre. If substantiated, such concerns may be in breach of the Dutch Village Trust's obligations as a certified provider under the Health and Disability Services (Safety) Act 2001 ("the Act").

The complaint relates but is not limited to the following Health and Disability Services Standards (2008):

- 1.2.1 Governance
- 1.2.2 Service Management
- 1.2.3 Quality and Risk Management Systems
- 1.2.7 Human Resource Management
- 1.2.4 Adverse Event Reporting
- 1.3.3 Service Provision Requirements
- 1.3.4 Assessment
- 1.3.5 Planning
- 1.3.6 Service Delivery Interventions.

Service Description

The Dutch Village Trust Inc. provides Aged Residential Care Hospital (Geriatric) and Rest Home care services. The occupancy and capacity is outlined below:

Area	Occupied	Capacity
Hospital	20	24
Rest Home	18	20
Dementia	0	0
Total	38	44

Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by The Dutch Village Trust Inc. are being provided in compliance with section 9, Health and Disability Services (Safety) Act 2001, that is a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under section 9 of the Health and Disability Services (Safety) Act 2001 (the Act) to provide services:

- (a) *'while certified by the Director-General to provide health care services of that kind; and*
- (b) *While meeting all relevant service standards;*
- (c) *in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and*
- (d) *in compliance with this Act.'*

The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor HealthCERT, and XXX XXX, Senior Advisor HealthCERT, under the delegated authority of the Director-General of Health.

Methodology

The inspection was conducted to investigate the complaint made to the Ministry of Health that may have resulted in systems failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted utilising the following methods:

- Interview with Manager
- Interview with Registered Nurse (Clinical Leader)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff

- Document and policy review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

Limitations

The scope of the inspection was limited to the issues raised in the complaint.

Entry Meeting

Present: XXX XXX, Senior Advisor HealthCERT; XXX XXX, Senior Advisor HealthCERT; XXX XXX, Village Manager.

The introduction meeting covered the following points:

A copy of the letter of introduction addressed to XXX XXX was provided to him. XXX was given an opportunity to respond to the letter.

A proposed agenda for the day was discussed and included:

- a request to interview any relatives or health professionals visiting the facility during the course of the day
- whether one or more trustees (Trust Board Members) could be contacted to see if they were available to be interviewed.

The inspection commenced with a tour of the facility.

Summary of Inspection findings

Summary of findings where non-compliance to the Health and Disability Services Standards has been identified specific to the complaint and inspection.

Organisational Management - Standard 1.2

1.2.1 Governance

1.2.1.1 Partial attainment

Trust members confirmed there had been decision making occurring by individual board members and the previous management without authorisation by the board as a whole. This had resulted in the appointment of management staff under a structure that had not been approved by the board.

Corrective Actions:

The Trust shall clearly identify, the roles and responsibilities of Board members in respect to any individualised decision making. The Trust shall identify an agreed organisational structure that is supported by strategic planning and business planning consistent with their philosophy.

1.2.1.2 Partial attainment

Trust members confirmed that they have not received sufficient information about the operation of the service to ensure service delivery is consistent with the values, scope and

strategic direction of the service. For example, the Board were unaware that palliative and terminal care was being delivered within the service. The recent decision by the Board to change the organisational management structure was made without full consideration of the impacts of this change as supporting documentation had not been developed that considers how new roles will interface with each other and where responsibilities for clinical management lies.

Corrective Actions:

The Trust shall ensure that there are effective communication systems and that reporting to them occurs in relation to service delivery. The organisational structure shall include supporting position descriptions and delegated authorities.

1.2.1.3– Partial attainment

There has been appointment of staff working in management positions where alignment of roles and responsibilities of those managers has not occurred. This has resulted in conflict between the two managers and confusion of staff working within the service as to direct reports, roles and responsibilities. The recently appointed village manager did not have full credentialing completed. The situation where the current managers are not working in full cooperation and collaboration has contributed to a culture of blame within the organisation.

Notification to Ministry of Health re these changes as per conditions of certification did not occur.

Corrective Actions:

The Trust to ensure that the organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of service. Notifications to the Ministry occur in accordance to conditions of certification.

1.2.2 Service Management

1.2.2.2– Partial attainment

There is insufficient planning of services to meet the specific needs of consumers as evidenced by a lack of documented plans across all levels of the organisation to guide service delivery.

Corrective Actions:

Ensure organisational planning occurs across all levels of the organisation.

1.2.3 Quality & Risk

1.2.3.1– Partial attainment

Quality and Risk Management Plan & Policy remain as per certification audit, not in place;

There is no current Quality Plan and the Quality Action Plan requires updating. Policies are incongruent in the timeframe for updating Quality Actions. Develop Quality Plan and mechanism for updating quality objectives.

Corrective Actions:

Develop Quality Plan and mechanism for updating quality objectives and implement accordingly.

1.2.3.2 – Partial attainment

No documentation of consumer participation / consultation was found within resident files.

Corrective Actions:

Ensure key stakeholders, including consumers/family/whanau of choice are consulted on service provision and quality improvement and risk management activity, and a written record of their participation is held.

1.2.3.3– Partial attainment

The majority of policies are overdue for review - review dates ranging from 2006 with the majority due 2009 (including clinical policies). The risk management policy states a 2 year review interval will be used. Policy and procedure (forms etc) some now written/ revised but not assessed, and evaluated and are not yet in practice

Corrective Actions:

Review out dated policies and procedures to ensure they align with current good practice and service delivery. Implement service changes consistent with revised policies and procedures and ensure outcomes are measured.

1.2.3.4– Partial attainment

The Risk Management policy outlines timeframes for policy review as being 2 years unless indicated an earlier review is required. A number of the policies had a review date of 2009 (and earlier). There were a number of duplicate policies - e.g. Complaints, Cultural Information - Maori. The latter had 2 unique ID references - C005 and C008. Some policies did not have a unique identification (e.g. Informed & Voluntary consent, Sexuality & Intimacy etc). The use of Standard Operational Policies provided a good visual representation of policy content. New Manuals have recently been developed.

There is not a specific document review policy, although this is now being addressed but not yet fully functional – staff yet to be informed of changes and new policy/procedures.

Corrective Actions:

Develop a document control system to effectively manage and control documents including the timely review and monitoring of documents.

1.2.3.5– Partial attainment

Key components are not linked to quality improvements-

- a) Event reporting is under reported as per progress notes verses incident accident reporting. This included a fall by a palliative care patient where no onward action was taken in respect of that fall as it was not reported.

- b) Complaints- register is in place and forms are by the entrance although they are part of many other forms on display and not obvious for consumers.
No staff are completing these forms when receiving verbal complaints or re staff concerns/complaints.
- c) Infection control- newly appointed RN coordinator with no training expertise (training via DHB commenced today) thus not fully functional, policy has been written.
- d) No reports given at sporadic staff meetings.

Corrective Actions:

Establish and implement a programme that links key components to the quality management system

1.2.3.6– Partial attainment

Quality Data is not discussed at staff meetings, and not fully reported to Board meetings.

Corrective Actions:

Analyse quality data after collation identifying trends and risk minimisation/elimination strategies, and ensure that these results are communicated to service providers.

1.2.3.7– Partial attainment

There is no process to measure achievement of Quality and Risk management is in place. There is no current Quality Plan. The Quality Action Plan provided had not been updated since mid 2009.

Corrective Actions:

Develop a process to identify and measure achievement of quality and risk management objectives

1.2.3.8– Partial attainment

There is no process for addressing corrective actions is in place. No corrective action planning, timeframe or person responsible was sighted.

Corrective Actions:

Establish a mechanism to ensure corrective action planning is undertaken, monitored and closed out

1.2.3.9– Partial attainment

Risks are not monitored/ nor corrective actions evaluated. There is no evidence of ongoing monitoring and review of organisational risks. The hazards on the register are not dated. There are 2 hazard reports seen for 2009, nil 2010. Where residents have repeated falls a 'high falls risk' sign is placed on their door requiring increased monitoring.

Corrective Actions:

Update the hazard register and establish regular updating and monitoring of hazards.

1.2.4 Adverse Events

Policy developed, staff not always completing forms, however they have recently had training on this, the form does not prompt staff to look at measures to prevent recurring falls /skin tears etc or review care / medication etc. No evaluation/ root cause analysis, not followed through There is no evidence of risk minimisation strategies. Recently developed form as per above comment. Apart from new form in use, no change from what was found at the certification audit.

1.2.4.1– Partial attainment

Reporting of incidents /accidents is not fully checked and analysed before becoming an integral part of the management system. Forms reviewed had information missing - e.g. manager signature, further action required.

Corrective Actions:

Analyse incident report data to identify trends and link to the quality management system.

1.2.4.2– Partial attainment

The Village manager and Care manager lack knowledge of the Health & Disability Services Standards and certification conditions regarding reporting i.e. need to report to MOH changes in management and Board changes.

Corrective Actions:

Clarify reporting requirements in respect of relevant legislation and regulation.

1.2.4.3– Partial attainment

Not all events documented, thus quality improvements are not developed and risks not managed. There is no evidence of trending against individual residents to identify those residents most at risk of future untoward events which would enable a minimisation strategy for individuals to be developed.

Corrective Actions:

Develop trending of incidents against residents to inform clinical care.

1.2.7 Human Resources

1.2.7.1– Partial attainment

The full position description for the Care manager was not available for audit. The Care manager and Clinical Team Leader identified three staff who had been under performing. It

was alleged that one staff member may have taken medications for their own use and this coincided with missing medications. This had not been investigated thoroughly through a performance management process. Other instances of rough handling of residents and disrespectful behaviour of staff towards other staff had not been fully documented and a performance management process had not been formally implemented.

Corrective Actions:

Implement a performance management process in accordance with human resource practice.

1.2.7.4 - Partial attainment

Recently employed staff that were interviewed reported they had not received an orientation consistent with the policy at the service and non had it included coverage of essential components of service delivery

Corrective Actions:

Ensure all new staff receive an orientation consistent with relevant policy, and an internal process is in place for evaluating if the service provider is competent to perform the role.

Continuum of Service Delivery - Standard 1.3

1.3.3 Service Provision

Care plans reflected very little change from the last audit. New assessment tools are in files but residents have not been assessed or care plans updated.

Policy is now written but not yet in practice

1.3.3.2 - Partial attainment

No documentation of family/EPOA or resident involvement in care planning.

Corrective Actions:

Ensure all client records evidence of family/EPOA or resident involvement in care planning and service provision.

1.3.3.4 - Partial attainment

Handover between shifts is carried out but not all staff attend these i.e. the RN Team Leader does not attend the morning handover

Corrective Actions:

Ensure the service promotes a multidisciplinary approach, and that there is continuity of service and cooperation between providers.

1.3.4 Assessment

1.3.4.1– Partial attainment

There were a number of assessment tools available: pain, restraint, Mini Mental Score Examination (MMSE), Waterlow pressure risk assessment, wounds, behaviour management. A policy is in place to support the use of these. In all of the 8 client files reviewed, assessments tools were incomplete, or not commenced. For example, a consumer with identified continence issues had no continence assessment completed. This was also noted for a consumer with identified pain. Assessment tools do not indicate who completes the assessment, no designation is recorded. New assessment tools are now developed but as yet not fully implemented

Corrective Actions:

Assessments are completed for all consumers as a basis to plan care requirements relevant to their individual needs.

1.3.4.2– Partial attainment

This process is in place but there is a need to ensure goal/outcomes are clearly stated and evaluated. Goals are not identified in all the consumer files reviewed and the completed assessments are not used as a basis for care needs.

Corrective Actions:

Document consumer needs and goals at initial assessment and where needs change.

1.3.4.4– Partial attainment

Communication with consumer or family is not documented

Corrective Actions:

Communication should be delivered in a manner that is understandable for the consumer/ EPOA and clearly documented.

1.3.5 Planning

1.3.5.1– Partial attainment

Service delivery plans are individualised, however need updating as acuity changes and post evaluation. Care plans were prepopulated with a circle or tick area identifying needs.

Interventions were documented but were not specific to guide care delivery.

Assessments tools available were not always used to guide planning, for example, where a client had a high waterlow score, interventions for reducing pressure area risk are not noted on the care plan.

One file pain was identified as a need on the assessment, but this was not reflected in the care plan interventions to guide service delivery.

Corrective Actions:

Ensure Care plans are current, individualised and accurate specific to the resident needs.

1.3.5.2– Partial attainment

Ongoing assessment not completed in all plans. The care plans provide some information. The level of detail is not robust enough to provide consistent care delivery. Desired outcomes are not recorded.

Corrective Actions:

Ensure care plans describe the required support and interventions for consumer needs.

1.3.5.3 – Partial attainment

No consumer/ family involvement documented, interdisciplinary team is involved and well documented.

Corrective Actions:

Ensure that consumers and where appropriate their family/whanau of choice are informed of treatment and support options available.

1.3.6 Service Delivery / Interventions

1.3.6.1– Partial attainment

Process is in place for this to be achieved however without, assessment and evaluation and reporting of concerns occurring interventions do not always occur to achieve desired outcomes.

The interventions for service delivery do not provide enough detail for individualised and consistent service delivery. Of the files reviewed, assessments were incomplete, care plans that identified some areas of need, did not have corresponding interventions consistent with the assessments undertaken. For example, a consumer with a high waterlow score did not have specific interventions for reducing pressure area risk noted on the care plan.

Corrective Actions:

Care plans record intended outcomes and interventions to provide consistent services.

Summation meeting

A summation meeting was attended by XXX XXX, Senior Advisor HealthCERT, XXX XXX Senior Advisor HealthCERT; XXX XXX, Village Manager; XXX XXX, Care Manager ; XX, XX, XX(Trust Board Members)

XXX thanked the facility for their participation and approach to the inspection recognising that this was unannounced. It was reiterated that the scope of the inspection was narrow and that the purpose of the inspection had not been to verify progress against partially attained criteria from the previous audit. It was noted that relatives interviewed had been complimentary to the service, and that staff were approachable but concerned about the

culture of blame that existed at the service. She confirmed that there would be findings against the Health and Disability Services Standards.

Key issues raised at summation were:

Relevant to complaint;

- There is not clear delineation of roles between management. This is causing confusion for staff. Some staff have taken this opportunity to be divisive and this has negatively impacted on resident care and efficient and effective day to day service operation.
- There has not been adequate performance management of staff where there are recognised performance issues that warrant further investigation and management.
- The trust has not received adequate information about the operation of the home and have recently moved to change the organisational structure without full information that considers the full impact of the change including delegated authorities and relationships between roles
- Policy and procedure being addressed but not yet functional
- Quality and Risk management plan not in place or developed
- Under reporting of events
- Culture of "blame and shame" rather than one of quality improvement
- Key components are not linked to quality improvement
- Quality data is not analysed evaluated and reported on fully
- Complaints process yet to be fully developed
- Assessment , planning, provision of service and evaluation now written but not yet in practice
- The new organisational structure is not supported by necessary documentation including but not limited to position descriptions and delegations.

Not relevant to complaint;

- Infection prevention and control procedures

It was concluded that the Dutch Village Trust will be required to take corrective actions to improve compliance against the Health and Disability Services Standards. The Ministry of Health noted they would be speaking with the District Health Board to determine the best approach to ensure the service received the assistance needed to address the issues verified through this inspection. The Ministry would be recommending either a statutory manager or other assistance to be provided to the Dutch Village by the District Health Board to make the necessary changes. It was also strongly recommended that the Dutch Village stop accepting palliative and terminal care patients as it was apparent that the service lacked the necessary skills to safely deliver this level of service.

On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

Conclusion

The Dutch Village Inc., will be required to take the above corrective actions to improve compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board.

Additional Conditions

Additional conditions to be placed on the Certification Schedule:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.2.1.1; 1.2.1.2; 1.2.1.3; 1.2.2.2; 1.2.3.1; 1.2.3.2; 1.2.3.3; 1.2.3.4; 1.2.3.5; 1.2.3.6; 1.2.3.7; 1.2.3.8; 1.2.3.9; 1.2.4.1; 1.2.4.2; 1.2.4.3; 1.2.7.1; 1.2.7.4; 1.3.3.2; 1.3.3.4; 1.3.4.1; 1.3.4.2; 1.3.4.4; 1.3.5.1; 1.3.5.2; 1.3.5.3; 1.3.6.1; as identified in the Inspection Report must be submitted to the Director-General by 12 August 2010.
2. HealthCERT may elect to carry out a verification audit in relation to these corrective actions
3. The Director-General may impose any further condition, or vary any condition, where the Director-General thinks it is necessary or desirable to do so in order to help achieve the purposes of the Act.

Summary for Publication

The Ministry of Health received a complaint on 21 May 2010 about the care provided to residents at Dutch Village Trust Inc.

The purpose of the unannounced inspection was to determine whether health care services being provided at Dutch Village Trust Inc., were being provided in compliance with section 9, of the Health and Disability Services (Safety) Act 2001. That is, a person providing health care services of any kind must do so whilst meeting all relevant standards.

The complaint was found to be substantiated in relation to governance; service management; quality and risk management; adverse event management; human resources; service provision; assessment; planning and service provision/intervention.

Dutch Village Trust Inc., is required to undertake corrective actions to comply with Health and Disability Services Standards criteria that were found to be partially attained at this inspection.

Ongoing monitoring will be undertaken by the Ministry of Health in conjunction with the District Health Board including the submission of reports to the Ministry by 12 August 2010 and the requirement to have the actions verified by the Ministry.

Organisational Management:

- The Trust shall clearly identify, the roles and responsibilities of Board members in respect to any individualised decision making.
- The Trust shall identify an agreed organisational structure that is supported by strategic planning and business planning consistent with their philosophy.

- The Trust shall develop a written quality and risk management plan which may be separate or included in service/strategic/business plans, including statements about quality activities.
- The Trust shall ensure that there are effective communication systems and that reporting to them occurs in relation to service delivery. The organisational structure shall include supporting position descriptions and delegated authorities.
- The Trust to ensure that the organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of service. Notifications to the Ministry occur in accordance to conditions of certification.
- Ensure organisational planning occurs across all levels of the organisation.
- Develop Quality Plan and mechanism for updating quality objectives. Review out dated policies and procedures to ensure they align with current good practice and service delivery. Implement service changes consistent with revised policies and procedures and ensure outcomes are measured. Develop a document control system to effectively manage and control documents including the timely review and monitoring of documents
- Ensure key stakeholders, including consumers/family/whanau of choice are consulted on service provision and quality improvement and risk management activity, and a written record of their participation is held.
- Establish and implement a programme that links key components to the quality management system. Analyse incident report data to identify trends and link to the quality management system. Clarify reporting requirements in respect of relevant legislation and develop trending of incidents against residents to inform clinical care.
- Implement a performance management process in accordance with human resource practice. Ensure all new staff receive an orientation consistent with relevant policy, and an internal process is in place for evaluating if the service provider is competent to perform the role.

Continuum of Service Delivery:

- Ensure all client records evidence consumer or family involvement in care planning and service provision.
- Assessments are completed for all consumers as a basis to plan care requirements relevant to their individual needs. Document consumer needs and goals at initial assessment and where needs change and ensure Care Plans record intended outcomes and interventions to provide consistent services.

Appendix 1: Documents requested

- Staffing and skill mix policy
- Rosters (last month and this month)
- Clinical Assessment Tools in current use
- Staff orientation policy and process
- Staff training records and in-service training programme
- List of staff with current first aid certification
- Quality and risk management plan
- Emergency Response Policy
- Incident and accidents records for the last two months
- Minutes of staff meetings
- Minutes of quality meetings
- Resident files
- Completed resident satisfaction survey
- Quality & Risk Management Plan
- Business/ Management / Operational Plan
- Quality Improvement reports/ corrective action plans
- Complaints register
- HR advice received by an external consultant to the Dutch Village regarding the disestablishment of the Care Manager position
- Position descriptions, curriculum vitae's and employment contracts for the Village Manager, Care Manager and Clinical Team Leader
- Job advertisement for the newly established Nurse Manager position
- Draft minutes of the last Trust Board Meeting
- Confirmed minutes of previous Trust Board Meeting (April 2010)
- New organisational structure as approved by the Trust Board
- Minutes of the last two resident meetings
- Position description for the newly advertised position – Nurse Manager (not available)
- Delegated authorities and processes that support the revised organisational structure (not available).