

# Shalom Court Auckland Incorporated - Shalom Court Rest Home

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Shalom Court Auckland Incorporated

**Premises audited:** Shalom Court Rest Home

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 27 April 2021 End date: 28 April 2021

**Proposed changes to current services (if any):** The service plans to decrease the total number of beds from 32 to 29 by decreasing the use of three apartments previously used for rest home level residents. Rest home level residents currently reside in three of the apartments in the apartment block which is connected to the care facility by an airbridge. This will reduce to two once residents move into the facility.

**Total beds occupied across all premises included in the audit on the first day of the audit: 25**



# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Shalom Court rest home provides rest home and hospital level of care for up to 29 residents. On the day of the audit there were 25 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observation, and interviews with residents, the resident advocate, staff, management, board members, and the general practitioner.

Shalom Court is a not-for-profit organisation that is governed by a board of governance, and a separate Trust Board. The service is managed by the executive officer (non-clinical) and has been in her role for two years and is supported by the clinical operations manager (registered nurse) and a team of registered nurses and healthcare assistants. The residents and community visitors spoke highly of the service, including the provision of a supportive cultural and spiritual environment based on Jewish values and beliefs.

The service was awarded a continued improvement rating around community involvement.

Areas for improvement were identified around neurological observations and care plan interventions.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Shalom Court provides an environment that supports resident rights. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Shalom Court has fully implemented its quality and risk management system. Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training plans are documented. The executive officer is supported by a clinical operations manager who is a registered nurse who is on site five days a week and is on call when not on site. They are supported by a team of RNs.

There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. External areas are safe and well maintained with shade and seating available. All the rooms are single rooms and each has it's own private en-suite. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receives training in restraint minimisation and challenging behaviour management. On the day of audit, the service had two residents using restraint and one resident using an enabler.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There was one outbreak in 2019. This was well managed and appropriate authorities were notified.



## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	42	0	2	0	0	0
<b>Criteria</b>	1	90	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Shalom Court staff ensure that all residents and families are informed about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There are posters displayed in visible locations throughout the facility. Policies around the Code is implemented, and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (one executive officer, one clinical operations manager, five healthcare assistants, three registered nurses, and one diversional therapist) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (one rest home and four hospital). Discussions with staff confirmed that they are familiar with the requirement to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. Family stated that informed consent was sought on admission and residents interviewed agreed with this.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff interviewed could describe the role of the advocacy service and where the leaflets could be located around the facility. Advocacy service training occurred 2021.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	CI	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The clinical operations manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Since the previous audit, there has been one complaint in 2019, four complaints in 2020 including one DHB complaint which was resolved, one complaint received through the advocacy service, and one previous complaint received through the Health and Disability commissioner which was closed off in 2020. There were no further recommendations required for any of these complaints. There have been two complaints in 2021 (year to date).</p> <p>All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. As a result of complaints training was provided to staff around meaningful communication, and continence management. Call bell audits have been implemented regularly.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrances to the facility.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The registered nurses discuss aspects of the Code with residents and their family on admission.</p>

rights.		Discussions relating to the Code are held during the resident/family meetings. The five residents (three hospital and two rest home) and one relative (hospital) interviewed, reported that the residents' rights are being upheld by the service.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The personal privacy, dignity and autonomy policy is documented. Staff were observed interacting with residents throughout the audit. All interactions were respectful and evidenced residents are treated with dignity and respect. Residents and the relative interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured, and independence is encouraged. Staff interviewed described how they maintain resident privacy. Staff sign a code of conduct declaration on employment.</p> <p>Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and Shabbat services are held. There is a policy on abuse and neglect and staff have received training in 2019 and 2021.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a Māori health plan and culturally safe policy to guide staff in the delivery of culturally safe care. The Māori health plan identifies the importance of whānau. There were no residents identifying as Māori on the days of the audit. While the service currently has no official linkages with Māori groups, the management team reported they would be able to access this through the DHB and can access the local marae. Staff interviewed were knowledgeable around the principles of Māori health requirements.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Shalom Court identifies the residents' personal needs and values from the time of admission. This is achieved in partnership with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the residents' plan of care, which included the identification of individual values and beliefs. Care plans reviewed included the resident's social, spiritual, cultural and recreational needs. Shalom Court continues to build on the previously awarded continuous improvement around providing a service centred around Jewish religious values and beliefs by facilitating new Jewish community gatherings at the facility.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff Code of Conduct/house rules is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Registered nursing staff are available seven days a week, 24-hours a day. There is a general practitioner which provides continuity of care for residents.</p> <p>The GP for each resident, reviews residents identified as stable rest home level of care every three months. Hospital level residents have monthly visits with more frequent visits for those whose condition is not deemed stable. Physiotherapy services are provided for eight hours a week over two days. A podiatrist visits on a regular basis, the dates the podiatrist is visiting is posted on resident noticeboards around the facility.</p> <p>The service has links with the local Jewish community and encourages residents to remain independent within the community. The service has a strong resident centred focus. The resident advocate (interviewed) visits the residents on a weekly basis and facilitates the monthly resident meetings. The resident advocate talks with the residents and conveys any concerns they have. The resident advocate is also involved in the event management sub-committee who meet monthly to discuss activities including (but not limited to); the activities programme, planning for upcoming celebrations/birthdays/happy hours, and discussing suggestions to introduce new activities for residents.</p> <p>The chairperson of the board and a board member interviewed described visiting the facility regularly, popping in to chat with residents and being involved in the happy hours, fundraising and celebrations held at the facility. Each board member has a 'portfolio' including health and safety (member of the health and safety committee), finances, residents and relatives and human resources (HR).</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. Education is provided through attending in-services held at Shalom Court and through an online education platform. Staff are encouraged to complete NZQA. The clinical operations manager is a member of the palliative care education committee and has a strong relationship with Mercy Hospice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Twelve accident/incident forms reviewed (from April 2021) identified family are kept informed.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. The relative interviewed stated that they are kept informed when their family member's health status changes.</p> <p>Residents have the opportunity to provide feedback through the resident advocate and the monthly resident meetings.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. There were three non-English speaking residents residing at Shalom court on the day of the audit. Staff described learning basic words in the resident's language to be able to communicate. Family were utilised to interpret new information, and flash cards were used to aid communication. The staff interviewed described getting to know each individual resident, learning about resident preferences and being able to pre-empt the needs of the residents. One resident has an iPad and watches television programmes and movies in their own language.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Shalom Court Boutique Home and Hospital is a faith based not-for-profit organisation and governed by a board of eight governors. A separate Trust board of three trustees own the buildings and plant. The executive officer and clinical operations manager report monthly to the board of governors, who then report three-monthly to the Trust board.</p> <p>Shalom court provides rest home and hospital care for up to 26 residents in the care centre and rest home level care up to three residents in the cottages (the service has decided to decommission three of the six cottages certified to provide rest home care). This reduces the total number of residents from 32 to 29 overall certified beds.</p> <p>The main facility (Phillip House) has 14 dual purpose beds and there is a hospital wing (Albert House) of 12 beds with a separate entry and an internal corridor link between the two buildings.</p> <p>On the day of the audit there were 25 residents: 7 rest home level and 15 hospital level and 3 rest home residents in cottages. All residents are under the age-related residential care contract. There were no respite residents.</p> <p>The executive officer has been in her role for two years and has previous experience as the operations manager at Shalom Court and office management for a religious organisation. She is supported by the clinical operations manager (registered nurse) who has extensive experience in aged care management and clinical management. They are supported by registered nurses and a team of long-</p>

		<p>standing experienced healthcare assistants.</p> <p>The strategic 2019-2022 strategic plan has been implemented. The plan includes goals, including (but not limited to) Jewish occupancy, and introducing the community to Shalom Court, and looks at future goals and ambitions while adhering the vision, mission and philosophy of the service.</p> <p>The executive officer has attended education sessions including (but not limited to) the quarterly New Zealand Age Care Association (NZACA) branch meetings, the aged care managers conference, leadership and development programmes.</p> <p>The clinical operations manager attends the annual NZACA conference, attends the aged care managers conference, attends district health board (DHB) aged care forums. The executive officer has strong relationships with Jewish organisations and is a board member on two boards.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the executive officer, the clinical operations manager provides management oversight of the facility with support from the board. The registered nurses provide clinical oversight when the clinical operations manager is on temporary leave including the on-call requirement.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Shalom Court implements a quality and risk management programme which has been purchased from an external consultant. Monthly data collated around incidents, accidents and infections is well documented and analysed with look back periods for previous months, and the previous years. Remedial actions as needed are implemented. There are monthly combined quality/staff meetings and clinical meetings. Infection control and health and safety meetings are held three-monthly. Staff interviewed reported good communication is maintained, discussions around quality data collated in the monthly quality and risk management report is reported to staff at handovers. Internal audits are completed, and corrective action plans have been developed and signed off by the clinical operations manager once complete. The infection control coordinator and the health and safety representative provide monthly reports to the clinical operations manager, and reported they discuss results at meetings.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is</p>

		<p>in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff at staff meetings and staff sign once they have read the policy.</p> <p>Annual satisfaction surveys are held. The 2020 resident meeting evidenced an increase in respondents who were overall satisfied. The relatives' satisfaction survey had low response rates, but evidenced satisfaction with the service. Areas of low satisfaction were investigated and opportunities for improvement were implemented where possible.</p> <p>The health and safety committee are representative of the facility and includes the Clinical Operations Manager and a member of the board. The health and safety representative and Board Member have completed external training around hazard and risk management. A health and safety system is in place, goals are included in the strategic plan and the quality plan. Hazard identification forms and an up-to-date hazard register is in place which was last reviewed in March 2021. Staff interviewed were knowledgeable around minimising and reporting of hazards. All staff are competent in the use of hoists and manual handling techniques. Health and safety is included in orientation of new staff. Fall prevention strategies are individualised for residents at risk of falling, including the use of sensor mats. Fall prevention training was last completed in 2019 and again in 2021. Registered nurses and healthcare assistants work closely with the physiotherapist and the Tai Chi master to complete exercises to prevent falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Twelve resident related accident/incident forms were reviewed (five rest home and seven hospital). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. There was evidence in the resident file around relative notification of incidents. Incidents are analysed for trends; however, neurological observations were not always documented for unwitnessed falls as per policy. All incident reports were reviewed and signed off by the clinical operations manager. Interventions such as increased monitoring was recorded and fall prevention strategies were implemented.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. One retrospective section 31 notification has been completed as there have been changes to both the Trust board and the board of governors. There have been no outbreaks since the previous audit.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (two RNs, two HCAs and the diversional therapist) evidenced implementation of the recruitment process, employment contracts, completed orientation</p>



<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>and annual performance appraisals. A register of practising certificates was maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: restraint, manual handling, hand hygiene and medication).</p> <p>An annual education and training plan has been documented. The service has implemented an online education platform for staff to access education as they wish. The healthcare assistants undertake aged care education NZQA. Education and training for clinical staff is linked to external education provided by the district health board. Eleven staff have current first aid certificates, and staff who administer medications have current medication competencies. All staff have completed hoist and manual handling competencies in the last year.</p> <p>Healthcare assistants are encouraged to gain a New Zealand Qualification Authority (NZQA). Currently there are four HCAs with level 4 and nine HCAs with level 3 NZQA in health and wellbeing. There are six registered nurses (including the clinical operations manager), three are competent in interRAI. Syringe driver competencies are completed annually by the registered nurses through Mercy Hospice.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a staffing rational and policy, staffing levels meet contractual requirements. There is a total of 25 staff including casual staff. The management team includes: the executive officer and the clinical operations manager Monday to Friday. The clinical operations manager is on call after-hours with other registered nurses.</p> <p>Staffing includes:</p> <p>Six registered nurses; morning shift -; 2x 7 am to 3 pm. Afternoon - 1x 3 pm to 11 pm. Night shift - 1x 11 pm to 7 am.</p> <p>Healthcare assistants:</p> <p>Albert wing: Twelve beds, nine hospital level residents</p> <p>Morning shift has two HCAs from 7 am to 3 pm. Afternoon shift has two HCAs; 1x 3 pm to 11 pm, and one HCA from 3.30 pm to 9 pm. There is one HCA overnight.</p> <p>Philipp wing: Fourteen dual purpose beds with 10 residents (six hospital and four rest home), staff also supervise the three rest home residents in the apartment block (cottages).</p>

		<p>Morning shift has three HCAs; 2x 7 am to 3 pm and 1x 7 am to 2 pm. Afternoon shift has two HCAs; 1x 3 pm to 11 pm and 1x 3 pm to 9 pm. There is one HCA overnight.</p> <p>Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely.</p> <p>Residents' files demonstrated service integration. Entries were legible, timed, dated and signed by the relevant healthcare assistant or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the yellow envelope system. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are standing orders and these meet medicine guidelines and legislative requirements.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs (in hospital) and senior medication competent HCAs (in rest home) administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication fridge</p>

<p>guidelines.</p>		<p>and room temperature is checked daily, recordings evidenced temperatures are maintained within expected ranges. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is contracted. The kitchen is not kosher, but every effort is made to adhere to kosher requirements as much as possible. There is a small kosher kitchen on site for the Jewish community to utilise. There is a kitchen manager who works 40 hours a week and a weekend chef who works sixteen hours. There are catering assistants who cover seven hours a day, seven days a week. All staff have food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in the dining rooms from bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available.</p> <p>On the first day of audit, meals were observed to be hot and well-presented, and residents stated that they were enjoying their meal. All kitchen records are electronic. There is a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. Residents and family members interviewed were satisfied with the meals. The food control plan is due for renewal on 30 January 2022.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to prospective residents should this occur and communicates this to prospective residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition, pain and continence.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions overall documented support needs and provided detail to guide care, however not all interventions were documented to support all assessed needs. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and physiotherapist. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this.</p> <p>Resident falls are reported on incident/accident forms and written in the progress notes. Neurological observations are not always completed for unwitnessed falls (link1.2.4.2).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently three wounds being managed. Monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age,</p>	<p>FA</p>	<p>There is a diversional therapist (DT) who works 20 hours a week. On the days of audit, rest home and hospital residents were observed participating in exercises with the physiotherapist, playing bingo, having manicures and doing Tai Chi.</p> <p>There is a weekly programme in large print on noticeboards and residents have a copy in their rooms. Residents have the choice of a variety of activities in which to participate, and every effort is made to</p>

<p>culture, and the setting of the service.</p>		<p>ensure activities are meaningful and tailored to residents' needs. There is an art club. The DT plays the ukulele and the guitar.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>Shabbat Kiddush is held every Friday. Residents do not have to be Jewish to attend. There is a monthly lunch with the Rabbi.</p> <p>There are monthly van outings. There is a hospital dog and volunteers also bring in dogs.</p> <p>There is a monthly happy hour with entertainers or speakers. Special events such as birthdays, Anzac Day, Queens's birthday and many Jewish celebrations are recognised and celebrated.</p> <p>There is massive Jewish community involvement with many volunteers assisting the DT. Silver Club is held monthly. There is a speaker and morning tea. Rosh Hodesh celebrates the first day of the Jewish month and volunteers serve wine, cheese and crackers. There are visits from Kadima school and Bnai Akiva (scouts). One resident goes out to bridge.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly, and residents and the relative were complimentary around activities during interviews.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Five care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Written evaluation is completed that describes progress to meeting goals. Where the evaluation reflects a change in health status or usual activities this is updated in the care plan. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six- monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the gerontology nurse, the mental health team and the hospice. Discussion with the registered nurse identified that the service</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building's hold a current warrant of fitness which expires 8 December 2021. There is a maintenance person who works 37.5 hours a week. There is a contracted lawn mowing person, but the maintenance person does the gardens. Electrical and plumbing contractors are available when required.</p> <p>There is a preventative and reactive maintenance schedule. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. All wings are carpeted. Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There are lifts between floors and there is also an air bridge between the care facility and apartment block (cottages). The external areas and gardens were maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured</p>	<p>FA</p>	<p>All rooms have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are signs on all shower/toilet doors.</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	In all wings there are large and small communal areas. The larger areas are used for activities and the smaller areas are for residents to read, entertain visitors or just have quiet time. The dining areas are part of the lounges but there is ample space.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All laundry is done off site. All cleaning is contracted. There is a cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning services are monitored. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms are kept closed when not in use. Cleaning trollies are locked in a cupboard when not in use.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire evacuation drills take place (last in February 2021). There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are emergency folders with specific information held in each nurse's station and civil defence supplies centrally located. Emergency food stores are kept in the kitchen. There are adequate supplies in the event of a civil defence emergency including a 750-litre water tank. The service has BBQs and access to a generator in the event of a civil defence emergency. Emergency lighting is installed throughout the facility. Emergency management is included in staff orientation. A minimum of one person trained

		<p>in first aid is available at all times.</p> <p>A pager call bell system is in place and indicator lights are installed above resident bedroom doors. There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The building is secure after hours. When the apartments (cottages) are checked at night two staff attend. They carry a torch and a phone. Security gates have recently been installed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. The older area is heated by gas radiators and the new area has underfloor gas heating. Staff and residents interviewed stated that both are effective. The facility is smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. An infection control coordinator (RN) is responsible for infection control across the facility. A job description outlines the role and responsibilities.</p> <p>The programme is set out by management and the infection control committee. The programme is reviewed annually.</p> <p>All visitors and contractors are required to sign in. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management cupboard and ample stock of personal protective equipment.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed online DHB and Bug Control education. This is updated annually. During Covid-19 there has been regular information from the DHB and the MOH.</p> <p>The facility has access to an infection control nurse specialist through the DHB, public health, GPs, local laboratory and expertise from Bug Control.</p>



<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are comprehensive infection control policies that are current and reflect standards, legislation and good practice. These policies are developed by management and the infection control committee and reviewed annually. There is resource information and plans around Covid-19 from the DHB and the MOH.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. There is no evidence of infection control training except for Covid-19 (link 1.2.7.5). All staff complete hand hygiene audits. In-services have been provided around PPE and outbreak management and there has been particular emphasis on this since Covid-19. Any new communication regarding Covid-19 is relayed to staff meetings, noticeboards and at handovers.</p> <p>Resident education occurs as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed with the care manager. The infection control coordinator provides surveillance data which is included in the monthly quality and risk management reports discussed with staff at handovers and on staff notice board. Trends are identified, and analysed, and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility. There is no infection control benchmarking. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the</p>

of restraint is actively minimised.		staff confirmed their understanding of restraints and enablers.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were two residents using bedrails which had been documented as an enabler. Risk assessments were completed, and consents had been signed by the next of kin for the use of bedrails. Two hourly checks were documented as instructed by the care plan.
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## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	There was evidence of follow-up of all resident incidents by a registered nurse. Relatives were notified and opportunities to minimise risks (where possible) were identified and implemented. Neurological observations were not always documented for unwitnessed falls.	Six of seven unwitnessed falls (hospital level) did not have neurological observations completed following unwitnessed falls.	<p>Ensure neurological observations are completed for all unwitnessed falls as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve</p>	PA Low	Care plans reviewed were individualised and resident focused. Three of five care plans included interventions to support all identified	Two of five care plans did not have interventions documented to support all assessed needs; (i) One hospital resident with behaviours that challenge did not include de-escalation techniques to support staff in managing the	Ensure care plans include interventions to support all assessed

<p>the desired outcomes identified by the ongoing assessment process.</p>		<p>assessed needs.</p>	<p>behaviours; and (ii) one hospital resident did not have interventions to support the resident's interests/social activities</p>	<p>needs and resident interests/social activities</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.1 Consumers have access to visitors of their choice.	CI	Shalom Court identified an increase in resident acuity and frailty, and identified that residents are generally living longer, therefore less able to get out to the community to join groups and religious celebrations. A goal in the business plan is to broaden the scope of the Jewish community and look for ways to invite the Jewish community into the facility so residents can retain their spiritual and religious connections.	<p>Due to the increased frailty of residents, Shalom Court embarked on a quest to -bring community groups to Shalom Court in order for our residents to remain included in community activities.</p> <p>A monthly Rabbis Kosher lunch is held. Volunteers lead the weekly sabbath and festival services. Three Rabbis provide spiritual support on request. A Memorial Service is held for Jewish all residents who pass away at Shalom Court.</p> <p>Additionally, in line with Jewish custom, prayer services (minyanim) are held at Shalom Court for Jewish residents as well as community members who passed away. This is a new initiative to enable our residents to attend prayers as many of our residents are too frail to attend funerals. Minyanim are held after sunset according to Jewish Law and this poses an additional impediment for residents wishing to attend these when held offsite. The Prayer Services (Minyanim) are actively supported by the Jewish Burial</p>

			<p>and Benevolent Society, spiritual leaders and the greater community.</p> <p>Jewish youth groups visit the residents, and the young women prepare gift packages for each resident in celebration of Jewish festivals. Representatives from the Jewish organisations perform the candle lighting ceremony for the eight-days of Chanukah.</p> <p>Shalom Court was the first facility to host New Zealand's 'Challah bake' in November 2019. This is a global event where members of the Jewish communities come together to observe the Sabbath and enjoy meals together. The residents were involved in braiding the ceremonial bread for the function. The function was well received by the residents. The attendance went from 75 attendees in 2019 to 110 in 2020. The function was held in the local bowling club due to Covid-19 risks; all residents were supported to attend. The function was a great success with letters and emails of appreciation received from people who attended.</p>
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End of the report.