Performance

Report

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| Name of service: | Mayflower Brighton |
| Service address: | 7 Centre Road BRIGHTON EAST VIC 3187 |
| Commission ID: | 3075 |
| Approved provider: | Mayflower Brighton |
| Activity type: | Assessment Contact - Site |
| Activity date: | 27 June 2023 to 28 June 2023 |
| Performance report date: | 1 August 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Mayflower Brighton (**the service**) has been prepared by N Eastwood, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary

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| Standard 4 Services and supports for daily living | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 26 April 2022 and 28 April 2022.

At the time of the Site Audit the service was unable to demonstrate meals were of a suitable quality, quantity, or temperature.

The service has implemented several effective actions in response to the identified non-compliance including the purchase and use of heated trolleys and incremental serving of foods which may cool quickly.

At the site visit of 27 and 28 June 2023, the service demonstrated how they have worked with consumers and representatives to enhance the menu and ensure individual consumers needs and preferences are met. Most consumers and representatives confirmed their satisfaction with the food served, although some suggested there could be more variety. Management outlined plans for further upgrades to the dining and food service areas which have been costed and are awaiting approval. The Assessment Team observed the meal service to be efficient, alternate choices available and adequate staff to assist consumers requiring assistance.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 26 April 2022 to 28 April 2022.

At the time of the Site Audit the service was unable to demonstrate that appropriate action was taken in response to complaints and an open disclosure process was used when things go wrong.

The service has implemented several effective actions in response to the identified non-compliance including the review and strengthening of the feedback and complaints process as well as the open disclosure policy and implementation of an electronic feedback and complaints system which will soon be updated further.

At the site visit of 27 and 28 June 2023, consumers and representatives confirmed they are able to raise concerns with the team leader in the unit and expressed confidence in the leadership team to address concerns and the ability to escalate as needed. Staff were able to describe their role in incident management and open disclosure and confirmed the process to report any incident or complaint to their team leader. The Assessment Team reviewed the complaints register and noted the new strengthened processes are followed. A review of incident reporting documentation supported that open disclosure was well embedded in practice and occurs as routine practice.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was previously found non-compliant with requirements 7(3)(a), 7(3)(b) and 7(3)(e) following a Site Audit performed between 26 April 2022 to 28 April 2022.

At the time of the Site Audit the service was unable to demonstrate:

* there were sufficient staff to meet consumer care needs,
* interactions between consumers and the workforce are kind, caring, and respectful of consumers identity, culture, and diversity,
* performance of staff was regularly assessed, monitored, and reviewed

The service has implemented several effective actions in response to the identified non-compliance including roster review and recruitment, call bell response time monitoring, communication to staff regarding expected standards of behaviour and implementation of a formal appraisal process.

With regard to requirement 7(3)(a) the service was able to demonstrate at the site visit of 27 and 28 June 2023 there were sufficient staff to provide quality care to consumers with most consumers providing positive feedback and confirming they receive the care they need. Management described the changes to staggered start times which were not effective and the addition of staffing relevant to the complexity of and increased care needs of consumers. Daily call bell response time monitoring is carried out with further investigation implemented with response times greater than 9 minutes. Management explained there are further roster reviews underway to ensure compliance with required care requirements. The Assessment Team reviewed staff rosters for the previous fortnight which demonstrated most shifts were filled. The Assessment Team noted call bell response times are responded to on average within 4 minutes and adequate staffing to consumers during mealtimes.

With regard to requirement 7(3)(b) the service was able to demonstrate at the site visit of 27 and 28 June 2023 that interactions between staff and consumers were respectful. Consumers and representatives expressed satisfaction with relation to their interactions with staff, staff were able to describe the ways they demonstrate respect to consumers and the Assessment Team observed respectful interactions between staff and consumers. The Assessment Team reviewed procedures and policies and noted the organisation has a suite of policies that outline behavioural expectations for employees including an employee code of conduct.

With regard to requirement 7(3)(e) the service demonstrated performance appraisals with staff had been completed. Where staff were unable to commence the performance appraisals, management had taken reasonable action in an attempt to monitor their performance. Most staff confirmed they have completed a performance appraisal in the previous 12 months, staff who have not been employed for 12 months were aware their appraisal was pending. Management explained they have commenced conducting performance appraisals on a yearly basis and completed 142 appraisals since the previous site audit.

As a result, and with consideration to the implemented actions and available information I find these requirements now compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 26 April 2022 to 28 April 2022.

At the time of the Site Audit the service was unable to demonstrate there were effective governance systems in place related to information management regarding staff training records and effective systems in place for recording and management of complaints and feedback and plans for continuous improvement.

At the site visit of 27 and 28 June 2023 the service has implemented several effective actions in response to the identified non-compliance including transition to electronic information feedback and complaints management and training record systems.

The Assessment Team noted that mandatory training is completed by staff through an online portal, staff receive notifications through the platform which alert them of mandatory training requirements. Management can access and extract mandatory training completion data and use it to analyse and monitor training completion. Management assisted the Assessment Team to access the current Plan for Continuous Improvement explaining that the current electronic system has contributed to an inability to close completed items, the software is currently being reviewed and the Assessment Team noted only one outstanding item for closure. The Assessment Team reviewed the service’s mandatory training records and noted for 2023, 25 staff have one or more outstanding mandatory training modules. Mandatory and optional face-to-face training attendance is recorded manually by the services learning and development staff and monitored through local spreadsheets. A review of the complaints and feedback register demonstrated all complaints and feedback were captured and recorded within the electronic register along with actions taken for resolution.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)