COMMITTEE	**AUDIT AND GOVERNANCE COMMITTEE**
DATE	**30 NOVEMBER 2017**
TITLE	**REPORT OF THE CONTROLS IMPROVEMENT WORKING GROUP**
PURPOSE OF THE REPORT	**TO REPORT ON THE MEETING HELD ON 23 OCTOBER 2017**
AUTHOR	**COUNCILLOR JOHN BRYNMOR HUGHES**
ACTION	**TO ACCEPT THE REPORT AND CONSIDER THE RECOMMENDATIONS**

---

1. INTRODUCTION

1.1 A meeting of the Working Group was held on 23 October 2017 with the Vice –chair of the Audit and Governance Committee, Councillor John Brynmor Hughes, Councillors Angela Russell, Cemlyn Rees Williams and Dewi Wyn Roberts, Luned Fôn Jones, Audit Manager and Manon Beatson, Senior Auditor present.

1.2 The reports that the Working Group addressed were:

TITLE	DEPARTMENT	AUDIT OPINION
Tan y Marian	Adults, Health and Wellbeing	C
Plas Maesincla	Adults, Health and Wellbeing	B
Plas Ogwen	Adults, Health and Wellbeing	C
Care Homes – General	Adults, Health and Wellbeing	n/a

2.3 Officers attended to discuss the individual reports and the following were present throughout the meeting:

- Gareth Roberts - Cabinet Member for Adults, Health and Wellbeing
- Aled Davies – Head of Adults, Health and Wellbeing Department
- Amanda Roberts – Plas Ogwen Manager

2.4 Tan y Marian

2.4.1 The main findings of the audit were as follows:

A report, dated 30 January 2017, was published by the CSSIW (Care and Social Services Inspectorate Wales), which noted: "Overall, we found that people receive a good service at Tan y Marian where they have positive relationships with the staff and are cared for in a warm, relaxed manner." Although the scope of the internal audit overlapped the CSSIW inspection, audit tests were not reduced and we took advantage of the opportunity to verify the actions against the recommendations proposed by the CSSIW. The main findings that arose from the audit can be seen below:

The 'Statement of Purpose' has been included in the Home's 'Service User's Guide'. The statement was verified to ensure that the contents coincided with Appendix 1 of the Care Homes (Wales) Regulations2002. The content was found to be appropriate, but some information was not included, such as details about room sizes - although it is accepted that this is not completely practical and that the opening paragraph (Aims and Objectives) refers to the 'elderly'.

A sample of residents' Care Plans were verified and found to be very comprehensive. However, it was found that the periodic reports (namely the daily, monthly, 3 monthly and 6 monthly notes) were not up-to-date.

There are no contracts in place between the Council and the residents who have been in residence at the home for a long time.

The CSSIW report stated that the frequency of supervision sessions appeared to be inconsistent, and suggested that care workers should receive formal supervision at least once every two months and staff appraisals every twelve months. Whilst verifying the supervision records of a sample of workers, it was found that they were not conducted every two months, but that there were steps in place to address this.

An example of a mistake on one worker's holiday card was seen, where the holiday total had been incorrectly calculated following a holiday application. The mistake had not been corrected although two later occasions were recorded on the card. The mistake meant that the worker had an additional 10 hours of holidays.

Following a discussion with the Manager and the clerk, it was found that it would be beneficial if these officers had read-only access to the ledger. This will mean that the home would have access to their budget and details of expenditure without having to depend on the Finance Unit.

A sample of 13 invoices were selected, and it appears for five of them that order had been created following receipt of the invoice.

A sample of E11 forms were selected, namely 'Record of Residents' Finances' for three of the Residents. It was found that no witnesses had signed the E11 on several occasions, and there were no receipts to support all the expenditure. The arrangements of recording residents' finances is the subject of a separate audit in the 2017/18 Audit Plan and Internal Audit will re-visit Tan y Marian's arrangements in due course.

During the visit, it was found that the entrance door and the external door from the kitchen and staff room were held open on a hook. The risk of keeping doors open was discussed with the Manager, not only to restrict residents from leaving, but to restrict unauthorised individuals from entering. The Home believes that there is a need to move away from risk-averse systems and that the individual's rights overcame any acceptable risk. It was expressed that there had not been any cases of unauthorised access, neither of any missing residents.

The CSSIW's report (30 January 2017) states: "we saw a spray bottle containing disinfectant in the two bathrooms which was in easy reach of the residents. We brought this to the attention of the registered manager who said she would lock them away." On the day of the Internal Audit, the toilet chemical cleaning material was seen to be in easy reach of the residents in the toilets.
It was found that the temperature of the medication room records were inconsistent. The temperature had not been recorded for five of the 22 days in June up to Internal Audit's visit. It was seen at times that the room's temperature could ('generally') exceed the maximum of 25 degrees as is stated in the Policy.

2.4.2 Selwyn Lloyd Jones, Disability Serviced County Manager was welcomed to the meeting to discuss the audit findings in the absence of Bethan Davies, Tan y Marian Manager.

2.4.3 The Audit Manager provided a summary of the audit findings. The Audit Manager stated that contracts had not been established between the Council and the residents despite the fact that they have been residing at Tan y Marian for a number of years.

2.4.4 The Audit Manager explained that staff supervision arrangements were not acceptable and fail to meet the expected standards. In respect of residents' monies and the relevant records, it was explained that deficiencies had been found and that a specific audit was carried out on the records of residents' monies.

2.4.5 The Audit Manager expressed disappointment that chemicals had been found within reach of the residents on the day of the inspection, despite the fact that this was highlighted in a report on Tan y Marian published by the CSSIW in January 2017. Furthermore, she stated that temperature of the medication room did not comply with requirements which may pose a risk to the residents.

2.4.6 A Member expressed concern regarding the fact that the doors of the home were open and that the Tan y Marian Manager accepted this risk. The Disability Service County Manager referred to the "Alder" report that claimed that Gwynedd Council was risk averse and explained that the Council was trying to move away from closing doors in the homes as it does not provide residents with a homely atmosphere. The Audit Manager agreed with this comment and explained that without a DoLS award, the Council has no right to keep any person locked up. A Member proposed that a risk assessment should be compiled as it is not practicable to keep the door closed at all times. The Disability Service County Manager agreed to arrange for a risk assessment to be drawn up and sent to the attention of the Audit Manager. A Member suggested that consideration should be given to the creation of a policy but the general belief was that this would restrict some individuals as arrangements vary from home to home.

2.4.7 The agreed actions were discussed and it was found that positive steps had been taken since the release of the final report such as the ordering of a cabinet with a lock to keep chemicals. It was also explained that the Manager had established a supervisory program and that she intends to check a sample of care plans periodically to ensure their accuracy and that the Property Unit will be installing a fan in the medication room as there is no window in the room.

2.4.8 The Disability Service County Manager was thanked for attending the meeting and for explaining the operational steps taken to mitigate the risks identified during the audit.

2.5 Plas Maesincla

2.5.1 The main findings of the audit were as follows:

There is a homely and friendly feel to the home and good controls exist but the following aspects need to be tightened:
Not all Service User Plans are updated every month in accordance with the National Minimum Standards for Care Homes for Older People, which notes, "the service user's plan is reviewed by care staff in the home at least once a month". The Manager was aware of this, and was in the process of updating them following a busy period at the home.
A sample of the staff supervision records were verified and it was found that not everyone had received supervision within the last two months in accordance with the National Minimum Standards, "care staff receive formal supervision at least once in every two months". The Manager has been having difficulties supervising casual staff who only work a small number of days during the week.
Orders are not signed on every occasion.
Invoices are not dated and stamped as 'received', which makes it difficult to identify the tax point in order to complete the TR252 slip.
Up to £40 is being kept in a drawer without a lock in the office. There is a keypad on the office door but every staff member is aware of the code. This was discussed during the visit; the Manager and Clerk were happy with this arrangement and were aware of insurance requirements.
An evacuation exercise has not been conducted since February 2015.
A sample of the Home's generic risk assessments were verified and it was found that they had not been reviewed since February 2016.
Whilst verifying the Home's training spreadsheet, it was found that the Manual Handling and Safeguarding of Vulnerable Adults training of 8 members of staff was not up-to-date. It was explained that the Manual Handling Trainer had confirmed a number of training sessions for the near future. Places on the Safeguarding of Vulnerable Adults courses are scarce but the home had notified the Learning and Development Service about the staff members who needed training in this area.
There is a keypad on the door of the medication room, however, during the visit, it was discovered that the door was not tightly shut. The Manager was notified of this and the door was tightly shut immediately.

2.5.2 Susan Thomas, Plas Maesincla Manager and Gwen Hughes, Area Manager – North were welcomed to the meeting.

2.5.3 The Audit Manager explained that despite the fact that the report had received a category "B" opinion, it was the decision of the Audit and Governance Committee at its meeting held on 28 September 2017 to discuss the report at the Controls Improvement Working Group.

2.5.4 The Audit Manager outlined the main findings of the audits which included:

- Failure to update residents' care plans
- Lack of supervision
- Evacuation drills have not been carried out since 2015
- Generic risk assessments not reviewed
- Training out-of–date
- The door of the medication room not tightly closed

2.5.5 The Manager explained that Plas Maesincla is a care home for residents with dementia and that finding time to hold staff supervision and training sessions could be difficult and that this was a problem across the Service. She explained that training sessions filled up quickly or that following organising the training, the member of staff could be off work on sick leave or required to be at the home due to staff shortages.

2.5.6 The Head of Adults, Health and Wellbeing Department stated that supervision could take place in many ways and that it isn't always carried out formally, e.g. experienced staff share advice with new staff and that it may be a weakness that these informal supervision sessions are not recorded. The Manager stated that staff had to be removed from the house to carry out supervision which is impractical in times of staff shortage. The Area Manager – North stated that the Manager had put in place arrangements whereby the Assistant Manager and Senior Care Assistant assist with the formal supervision of staff.

2.5.7 A Member enquired who was responsible for conducting the training sessions and why more of them could not be held. The Area Manager – North responded that they were working with the Learning and Development Service to develop e-learning modules so that training can be done in the workplace or on a mobile device which will reduce the need to release staff for the day.

2.5.8 It was asked what progress had been made since the final report was released. Confirmation was received from the Manager and Area Manager – North that all agreed actions had been properly addressed and that the evacuation exercise has now been carried out.

2.5.9 The Plas Maesincla Manager and the Area Manager – North were thanked for providing the Working Group on the developments since the release of the final report and the arrangements in place.

2.6 Plas Ogwen

2.6.1 The main findings of the audit were:

There is a homely and friendly feel to the home and good controls exist but the following aspects need to be tightened:
The home's Statement of Purpose was not entirely up to date, however, we were informed that it was already the subject of a review when the audit was being undertaken.
The staff do not receive formal supervision every two months, which is an expectation set in the Care Homes (Wales) Regulations and the National Minimum Standards. It was confirmed that it was difficult to find time to supervise night and casual staff.
Invoices are not dated and stamped as 'received' on all occasions. This makes it difficult to identify the tax point required in order to complete the TR252 slip. A stamp was bought for the kitchen following the publication of the draft report, in order to date the invoices received.
The TR34 forms were not checked and certified by a second officer.
Every member of the home's staff has access to the safe, this was discussed further with the Manager, and she was happy with the arrangement.
The Officer in Charge is responsible for the home's keys including the keys to the medication room. The keys are transferred to the next Officer in Charge at the end of every shift. There is an expectation that they keep the keys on their person throughout the shift. However, on the day of the visit, it was found that the keys had been kept in a drawer in the office as they are heavy to carry. Evidence was received following the publication of the draft report that the Manager had ordered aprons and chains in order to facilitate carrying the keys.
Following a resignation, a new Key Worker is needed for one of the residents, as a risk assessment had not been carried out for over six months, where they should be completed monthly. The Manager was already aware of this and was in the process of arranging to conduct a new assessment.
Risk assessments have not been sent with the HS11 forms (Accidents and Incidents Report) when reporting accidents. It was agreed that this would be done from now on.
Although there is an existing copy of the Safeguarding Children and Adults Policy and Guidelines available to staff, there is no evidence the workers have read them. Following the publication of the draft report, evidence was received by the Manager confirming that all members of staff except for one had by now read the Policy.
Whilst verifying the Home's training spreadsheet, it was found that several members of staff had not completed the 'Safeguarding Vulnerable Adults' training for several years, including one member of staff who had not completed the training since 2001. However, the Manager confirmed that training had been arranged for 9 members of staff within the next 4 months.

Medication competence tests have not been completed annually, and many have not been completed since 2013. Also, the record of who is permitted to administer medication is not up-to-date, as one member of staff no longer works for the home. Following the publication of the draft report, the Manager confirmed that the record of staff who are permitted to administer medication has been updated, but no evidence was received to support this.
Although a copy of the Medication Policy was available in the Medication room and in the office, evidence shows that only the Assistant Manager had read the policy since 2016. Following the publication of the draft report, evidence was received confirming that all members of staff had now read and understood the Policy.
A sample of 5 MAR's (Medication Administration Record) were checked and it was found that two members of staff had not signed to confirm receipt of medication in every case. Whilst verifying the arrangements for returning/disposing of medication, two instances were found where only one member of staff had signed the 'Destroyed or Returned Medication' form where two signatures are required. The Assistant Manager was notified of these shortcomings during the visit, she was aware of the Policy's requirements. The Manager confirmed that she had conducted a supervision session with these members of staff following the publication of the draft report to remind them of the importance of two different members of staff signing the form when receiving and disposing of medication, no evidence was received to support this.
Work has commenced to meet the requirements of "The Quality Dashboard" following a poor Audit of the home's Site Management. A negative report was also received recently following an audit of the home's menus; the Manager confirmed that these would be the subject of a review in the near future.

2.6.2 Amanda Roberts, Plas Ogwen Manager was welcomed to the meeting.

2.6.3 The Audit Manager stated that the same themes appear repeatedly in residential homes, but due the weaknesses in respect of the administration of medication, Plas Ogwen received a category "C" opinion. The Audit Manager outlined that the main findings included:

- Lack of supervision
- All staff with access to the safe
- One resident without a key worker
- Failure to send risk assessments with accident reporting forms (HS11)
- Out-of –date training
- Staff not receiving medication competence tests annually
- Medication administration records out dated
- MAR sheets not signed as required.

2.6.4 The Manager explained that Plas Ogwen is a residential home but that some of the residents have dementia or similar conditions.

2.6.5 It was explained to the Manager that the greatest concern was regarding the arrangements with medication. The Manager explained that they had now acted on the agreed actions and that appropriate arrangements were in progress. She also stated that Plas Ogwen faces the same problems as Plas Maesincla in terms of staff training and hoped that the e-learning modules will be of assistance.

2.6.6 A Member stated that the report identifies problems that can be resolved instantly as they were not intense.

2.6.7 Members queried why the same problems arise repeatedly and whether the officers considered this to be acceptable. The Head of Adults, Health and Wellbeing stated that is takes time to establish arrangements and that they were trying to streamline arrangements, and if a concern or problem rises more than once, then specific cases will need to be reviewed.

2.6.8 The Plas Ogwen Manager was thanked for attending the meeting and update the Working Group of the steps taken following the release of the final report.

2.7 Residential Homes – General

2.7.1 In its meeting held on 28 September 2017, the Audit and Governance Committee resolved "that the Cabinet Member for Adults, Health and Well-being and the Head of the Adults, Health and Well-being department attend the Working Group to consider the themes that are often highlighted in Residential Homes' audits, and invite the relevant officers to the meeting."

2.7.2 The Chair of the Audit and Governance Committee, Councillor Richard Medwyn Hughes joined the meeting for this item and Catherine Ellis, Area Manager – South was welcomed to the meeting.

2.7.3 The Audit Manager presented a document highlighting the risks identified in the Council's residential homes over the past three years. The Audit Manager explained that the audit programme has been revised since April 2016 so that there was a greater emphasis on the care component rather than administrative arrangements.

2.7.4 It was generally seen that there were weaknesses with medication. It was explained to the Working Group that medication training had been carried out by a pharmacist but that he has since retired and that the Learning and Development Service had arranged that other pharmacists visit the homes to conduct this essential training.

2.7.5 The Area Managers explained that the Care Home Managers usually have a rota detailing when supervision sessions will be held but matters arise on the day which results in a failure to carry out formal supervision. The main factors that can affect the arrangements are sickness, which means that the member of staff is required on the house floor. The Area Manager stated that problems exists with releasing staff to attend training.

2.7.6 An observation was made by a Member that Plas Hafan had received an "A" opinion category and it was asked if there were lessons that could be learned from Plas Hafan's home to improve the performance of other homes. The Area Manager - North stated that much was dependent on the Manager and the commitment of the team. The Area Manager explained that sickness absence was lower at Plas Hafan compared to other homes which meant that supervision and training sessions could be held.

2.7.7 The Area Managers expressed that the risks identified were administrative rather than lack of care. The Audit Manager responded that a lack of proper arrangements in relation to the administration of medication is a high risk and any failure could be disastrous.

2.7.8 It was explained to the Working Group that staffing levels at the homes remained the same although the needs of residents has intensified. It was explained that grant funding had been received and that they had bought special beds that would release staff time. However, it was expressed that this will not solve the problem altogether. It was explained that the Private Sector also compete for the same staff that are already scarce and that not as many have been applying for jobs recently. In addition, all residential home staff will be required to register with the CSSIW which can lead to a further reduction in staffing levels.

2.7.9 The Head of Adults, Health and Wellbeing Department stated that 7 out of 11 of Gwynedd Council's homes have received comments or recommendations from the CSSIW in terms of their staffing levels. 2 out of the 7 are a lack of conformance. It is expected that 10 out of the 11 will receive comments in respect of their staffing levels – the only exception is Plas Maesincla.

2.7.10 The Working Group's proposal was that the Cabinet Member for Adults, Health and Wellbeing and the Head of Adults, Health and Wellbeing Department would report back to the Working Group following a review of the care homes' staffing levels. A discussion was held on the training of new staff, and the Audit Manager stated that the Department could take advantage of the Apprenticeship Schemes offered by the Llandrillo Menai Group.

2.7.11 The Cabinet Member for Adults, Health and Wellbeing, the Head of Adults, Health and Wellbeing and the officers were thanked for attending the meeting and for the open discussion and plans for improvement.