COMMITTEE	**AUDIT AND GOVERNANCE COMMITTEE**
DATE	**28 SEPTEMBER 2017**
TITLE	**OUTPUT OF THE INTERNAL AUDIT SECTION**
PURPOSE OF REPORT	**TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 15 SEPTEMBER 2017**
AUTHOR	**LUNED FÔN JONES – AUDIT MANAGER**
ACTION	**TO RECEIVE THE REPORT, COMMENT ON THE CONTENTS AND SUPPORT THE ACTIONS THAT HAVE ALREADY BEEN AGREED WITH THE RELEVANT SERVICES**

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1. INTRODUCTION

1.1 The following report summarises the work of the Internal Audit Section for the period from 1 July 2017 to 15 September 2017.

2. WORK COMPLETED DURING THE PERIOD

2.1 The following work was completed in the period to 15 September 2017:

Description	Number
Reports on Audits from the Operational Plan	10

Further details regarding this work are found in the body of this report and in the enclosed appendices.

2.2 Audit Reports

2.2.1 The following table shows the audits completed in the period to 15 September 2017, indicating the relevant opinion category and a reference to the relevant appendix.

TITLE	DEPARTMENT	SERVICE	OPINION	APPENDIX
Training New Members	Corporate Support	Democracy	B	Appendix 1
Death Grants	Finance	Pensions and Payroll	A	Appendix 2
Leisure Centres' Direct Debit Payments	Economy and Community	Leisure	B	Appendix 3
Arfon Tennis Centre	Economy and Community	Leisure	B	Appendix 4
Pavillion Leisure Centre	Economy and Community	Leisure	B	Appendix 5
Glan Wnion Leisure Centre	Economy and Community	Leisure	B	Appendix 6
Plas Maesincla	Adults, Health and Wellbeing	Residential and Day	B	Appendix 7
Plas Hafan	Adults, Health and Wellbeing	Residential and Day	A	Appendix 8
Plas Ogwen	Adults, Health and Wellbeing	Residential and Day	C	Appendix 9
Tan y Marian	Adults, Health and Wellbeing	Residential and Day	C	Appendix 10

2.2.2 The opinion categories within the reports affirm the following:

Opinion "A" Assurance of financial propriety can be expressed as the controls in place can be relied upon and have been adhered to.

Opinion "B" Controls are in place, and partial assurance of financial propriety can be expressed as there are aspects where some procedures can be strengthened.

Opinion "C" Assurance of financial propriety cannot be expressed as the controls in place cannot be relied upon, but losses/fraud due to these weaknesses were not discovered.

Opinion "CH" Assurance of financial propriety cannot be expressed as acceptable internal controls are not in place; losses/fraud resulting from these weaknesses were discovered.

3. FOLLOW-UP WORK

3.1 New arrangements have been established for follow-up audits. In 2016/17, a total of 205 actions were agreed to be undertaken before 31 March 2018. Now, rather than carrying out a follow-up on only "C" opinion reports, all agreed actions will be addressed by requesting the unit/service/establishment to provide evidence to prove implementation. On 15 September 2017, there was acceptable implementation on **26.83%** of the agreed actions.

4. WORK IN PROGRESS

4.1 The following work was in progress as at 16 September 2017.

- Disposal of Confidential Waste – The Use of Red Sacks and Shredders *(Corporate)*
- Obtaining References, Proof of Identity and Evidence of Qualifications *(Corporate)*
- Safeguarding Arrangements – Field Workers' Awareness of Policy *(Corporate)*
- Safeguarding Arrangements - Establishments *(Corporate)*
- Proactive Prevention of Fraud and Corruption *(Corporate)*
- Information Management - Establishments *(Corporate)*
- National Fraud Initiative *(Corporate)*
- School Uniform Grant *(Education)*
- Pupil Deprivation Grant *(Education)*
- Education Improvement Grant for Schools *(Education)*
- Awareness of the Whistleblowing Policy – Primary and Secondary *(Education)*
- Health and Safety – Primary Schools *(Education)*
- Schools - General *(Education)*
- Bro Ffestiniog Leisure Centre*(Economy and Community)*
- Victoria Dock *(Economy and Community)*
- Supporting People Grant (Part 2) *(Adults, Health and Wellbeing)*
- Depots *(Highways and Municipal)*
- Garden Waste Collection *(Highways and Municipal)*
- Smallholdings *(Regulatory)*
- Housing Waiting List *(Housing)*

5. RECOMMENDATION

5.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 1 July 2017 to 15 September 2017, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

Appendix 1

TRAINING NEW MEMBERS
CORPORATE SUPPORT

1. Background

1.1 Section 7 of the Local Government Measure (Wales) 2011 states that local authorities are required to ensure that reasonable training and development opportunities are provided to its members, in addition to providing members with the opportunity to receive an annual review of their training and development needs.

1.2 The 'Development Framework for Councillors in Wales' outlines the essential skills and information for local authority councillors in Wales to fulfil their duties. The framework was formed as part of a continuing professional development programme for councillors, and corresponds with The Wales Charter for Member Support and Development. Gwynedd Council is eager to submit an application to the Welsh Local Government Association (WLGA) to attain this 'Members' Charter' during the second half of 2017.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that appropriate arrangements had been established in order to achieve the training needs of Gwynedd Council's new members. In order to achieve this, the audit included assessing the procedure of identifying and providing training to members elected in May 2017 in accordance with their needs and the requirements of the Local Government (Wales) Measure 2011.

3. Main Findings

3.1 It was found that the Council's arrangements were in accordance with the requirements of the Local Government (Wales) Measure 2011. The minutes of the Democratic Services Committee and Full Council show that thorough preparatory work had been done for the 2017 election in order to ensure a complete and relevant training programme for the new Members. Ffordd Gwynedd has influenced the process of identifying the needs of Members, with some aspects intertwining with the application for the Members Charter. The arrangements are elaborated upon below.

3.1.1 Specific Role Descriptions have been suggested by the WLGA; Gwynedd has recently adopted and adapted these in order to comply with the principles of Ffordd Gwynedd and to reflect the duties that are to be achieved as Members of the Council's Committees.

3.1.2 A Training Programme for the year has been planned and shared with the Members on paper, via the Outlook calendar, and e-mail, and a current copy is available on the E-Learning Portal. The programme will be updated if there is any additional training, or if requests for specific training are received, either from the Members or the Council's staff. Learning and Development and the Democratic Service are eager to take advantage of available technology to facilitate the process for Members by making the most of the 'MS Surface' tablets and the Integrated Learning and Development System (SIDD). Input by Heads of Department, the Learning and Development team, the Democratic Service and feedback from Members have been considered whilst drawing up the Programme, and extensive discussions about the contents have been held by Committees such as Democratic Services.

3.1.3 Specific induction sessions and 'stalls' were held in May 2017, and this is considered as part of the induction process. New Members' first six months are considered as 'Induction', and is part of the '5 year cycle' where the Learning and Development Team identify the needs annually. The specific induction sessions included a taste of what is available to Members in addition to necessary training that must be completed at the beginning (e.g. Conduct, Information, Committees/Democracy etc).

3.1.4 In accordance with the Ffordd Gwynedd mindset, Members are expected to contribute to the training process by highlighting their own needs, rather than adhering to a specific programme. In addition to training via courses and e-learning, one-to-one sessions are offered to the Members by the Corporate Support Department to discuss and review their needs. Members were notified on the induction 'stalls' that they had an opportunity to receive Coaching by a Qualified Coach. This is a new step, and there appeared to be much interest amongst Members.

3.1.5 Members have the right to request to attend additional external training, and criteria is in place in order to consider whether the requests are worthy or not, and whether they offer value for money to the Council. A specific leaflet is not currently available, but there is an intention to publish and share it on the E-Learning Portal so that Members can access them.

3.1.6 All training is carefully considered before it is offered; value for money and the location are considered. Members are contacted to gauge the interest in the subject and how convenient is the timing and the location. The majority of training is mainly held in Penrhyndeudraeth and Caernarfon due to the available resources there, in addition to the fact that Penrhyndeudraeth is fairly central.

3.1.7 20 of the 24 new Members attended all of the five induction 'stalls' held on 9-10 May 2017, with one Member attending four 'stalls', and one Member attending three 'stalls'. Only two Members failed to attend any 'stalls'. These stalls were not restricted to new Members elected in May 2017, 27 re-elected Members also attended the stalls. All the material presented during the stalls are available on the members' portal to give members an opportunity to browse through them or remind themselves of the content.

3.1.8 The Report of the Pension Fund 2015-16 explains that *"Specific training (LAPF Trustee's Basic Training) was attended by three Members, whilst two others attended in 2016"*. The five have now completed the Training. Four newly elected additional Members to the committee have received an induction from the Head of Finance and a Specialist Consultant, and will be receiving the training (LAPF Trustee's Basic Training) between October and December 2017. Every Member of the Board has access to the on-line 'Pensions Toolkit'.

4. <u>Audit Opinion</u>

(B) Partial assurance can be expressed of the propriety in the arrangements of Training New Members as there are controls in place, but there are aspects where some arrangements could be tightened. The services have committed to implement the following steps to mitigate the risks highlighted:

- Complete and share a specific leaflet for Members to request additional training and draw up and share a Criteria leaflet to assess their requests.

- Move forward with the arrangements to win the Charter (Members' Charter).

Appendix 2

DEATH GRANTS
FINANCE

1. Background

1.1 Gwynedd Council are responsible for providing a local government pension service for itself, Isle of Anglesey County Council, Conwy County Borough Council, statutory employers, Community Councils and other optional towns, in addition to the right to accept other bodies which conform to the provisions of the regulations. From the first day a worker joins Gwynedd's pension scheme, a death grant which corresponds to three times their annual salary is payable if they were to die whilst in service and were younger than 75 years old.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that adequate internal controls are in place in the accounting arrangements and administration of death grants payments. In order to achieve this, the audit included auditing a sample of death grant payments recently made, ensuring they were appropriate.

3. Main Findings

3.1 A sample of 'death grant' payments were selected from the ledger, and the supporting paperwork was checked. The sample covered payments made during 2016/17 and included workers from a variety of organisations which are a part of the Gwynedd Pension Fund.

3.2 All workers do not submit a 'death grant expression of wish form', which informs the Pensions Service of who would receive the death grant if they were to die in service. If a form has been received, the Pensions Service must conclude that the information continues to reflect the wishes of the deceased, however, they do have the right to go against the form if they have an adequate reason to do so. In every case within the sample, a proof of relationship between the deceased and recipient was seen. Some cases within the sample included a will/probate rather than a grant declaration form.

3.3 Whilst checking the payments, an appropriate audit trail was seen for the calculations and that independent checks were also included in the process. Evidence such as certificates was also seen in support of every payment made.

3.4 Interest is calculated daily at a rate of 1% higher than the Bank of England's basic rate from the date of death (not the date the Pensions Service is notified). Interests on late payments are added to any payments made one month later than the date of death. From the sample, it was seen that interest costs could be high, such as £1,538 in one case and £480 in another case. However, it was seen that delays were mostly as a result of external bodies' failure to provide essential information or documentation required to release the payment.

4. <u>Audit Opinion</u>

(A) An assurance of propriety can be stated in the administration arrangements of death grants as it is possible to depend on the internal controls that are in place

and that these have been followed.

Appendix 3

LEISURE CENTRES' DIRECT DEBIT PAYMENTS
ECONOMY AND COMMUNITY

1. Background

1.1 Gwynedd Council Leisure Centres are part of the Healthy Communities service, within the Economy and Community Department, and they all offer a service that can be paid for through direct debit. Every direct debit application is processed at the Arfon Tennis Centre in Caernarfon.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that appropriate controls were in place for the administration and processing of Leisure Centres direct debits, in accordance with the IMS/FIN/02 guidelines, namely the Direct Debit procedure handbook. In order to achieve this, the audit included verifying that adequate arrangements were in place for processing and monitoring direct debit applications, requests to change or freeze an account, corporate discount applications, and cancelled/missed direct debits, by ensuring that a recovery process is in place.

3. Main Findings

3.1 It was generally seen that there are appropriate internal controls for processing direct debit applications, but that the following aspects need to be tightened in order to mitigate the risks highlighted.

3.1.1 It was found that some of the prices sent to the Business & System Support Officer to be input on the Gladstone system (Leisure's financial system), were different to what was approved by the Cabinet. However, confirmation was received that the prices were verified before being input on the system, in order to ensure that customers were charged the correct price. The Senior Business and Performance Officer was notified of these errors via e-mail. An updated price spreadsheet was received confirming that the errors had been rectified.

3.1.2 There are no arrangements in place to verify applications to the Corporate Discount Scheme. The scheme requires that a payslip from the past two months must be received in order to join, and annually thereafter to confirm their employment with the company registered with the scheme. The Terms and Conditions of the Direct Debit Packages Application Form notes that *"A payslip from the last two months is required and must be updated annually."* Although evidence is received for initial membership, there was no case where a payslip had been seen a year after that. It was confirmed that a lack of resources and time made it difficult to achieve this. This was highlighted to the Healthy Lifestyles Centres Manager, whom agreed to investigate different options, such as that members employed by Gwynedd Council paid the fee directly from their salary.

3.1.3 The terms of the Corporate Discount Scheme confirms that the registered company could be asked for a list of staff members who have left their employment in the past year, in order to identify any members who are not eligible to take advantage of the scheme. Similarly to the above, a lack of resources and time means that it is impossible to achieve this. This was discussed with the Healthy Lifestyles Centres Manager. It was agreed to investigate options for corresponding with the companies to request confirmation of members' employment.

3.1.4 There is no process in place to recover income from anyone who has taken advantage of the corporate discount when they are not eligible to do so. It is impossible to identify these members without any monitoring of the discount.

4. Audit Opinion

(B) Partial assurance can be expressed of the propriety in the administration of leisure centres direct debits as there are controls in place, but there are aspects where some arrangements could be tightened. The service has committed to implement the following steps to mitigate the risks highlighted:

- Investigate and trial different options to mitigate the risk.
- That a process is in place to recover money from any customers who have benefited from the discount without being eligible to receive it.

Appendix 4

ARFON TENNIS CENTRE
ECONOMY AND COMMUNITY

1. Background

1.1 Gwynedd Council Leisure Centres are part of the Healthy Communities service which is within of the Economy and Community Department. There are four Area Managers who are responsible for managing the Centres under the Authority's control. The Arfon Tennis Centre provides a number of services for the public, including tennis courts, fitness/weights room and fitness classes.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that secure arrangements were in place in the Leisure Centre in order to control and reduce risks appropriately, and to ensure conformity with the Council's internal procedures and other relevant acts.

2.2 The audit involved visiting a sample of four Leisure Centres unannounced in order to ensure that appropriate arrangements are in place for managing various risks which could exist in the areas of collection of income, budgetary control, procurement, storage of goods and health and safety.

3. Main Findings

3.1 It was seen that robust internal controls are in place at Arfon Tennis Centre, but that the following aspects need to be tightened:

3.1.1 A stock check of the vending machine was last carried out in May, the machine has been out-of-order until very recently, but it is now operational and therefore the stock record/check should be up to date. A monthly stock check is also carried out on the equipment sold at the centre, a sample of records was selected to be checked and it was found that three out of four of these records were correct.

3.1.2 The centre's risk assessment has not been reviewed annually.

3.1.3 Whilst going around the centre, only one poster notifying the public not to take photographs was seen and this was in the weights room. The Duty Manager had said that they had some on the toilet doors but they were not on display on the day of the inspection. He believed that these might have been removed to prepare for the doors to be painted.

4. <u>Audit Opinion</u>

(B) The Audit opinion is that partial assurance can be expressed of the propriety in the Arfon Tennis Centre as there are controls in place, but there are aspects where some arrangements could be tightened. The establishmente has committed to implement the following steps to mitigate the risks highlighted:

- Remind staff of the need to correctly carry out stock checks every month.
- Review the risk assessments.
- Ensure that there are posters notifying the public not to take pictures on display at all times.

Appendix 5

PAVILION LEISURE CENTRE
ECONOMY AND COMMUNITY

1. Background

1.1 Gwynedd Council Leisure Centres are part of the Healthy Communities service which is within of the Economy and Community Department. There are four Area Managers who are responsible for managing the Centres under the Authority's control. The Pavilion Leisure Centre provides many services to the public, including a sports hall, fitness room and sauna.

2. Purpose and scope of the Audit

2.1 The purpose of the audit was to ensure that secure arrangements were in place in the Leisure Centre in order to control and reduce risks appropriately, and to ensure conformity with the Councils internal procedures and other relevant acts.

2.2 The audit involved visiting a sample of four Leisure Centres unannounced in order to ensure that appropriate arrangements are in place for managing various risks which could exist in the areas of collection of income, budgetary control, procurement, storage of goods and health and safety.

3. Main Findings

3.1 Generally, it appears that the Pavilion Leisure Centre has appropriate internal controls in place, but there is a need to tighten controls on the following aspects in order to reduce the risks identified.

3.1.1 The vending machine isn't emptied at least once a month in accordance with IMS Vending Machines Guidelines. The Duty Manager confirmed that this area was already the subject of discussion with the Business and Systems Support Officer An agreement was reached to empty the machine every two months due to the minimal income it generates. However, evidence was seen proving that the machine has not been emptied for 4 months. Following the release of the draft report, both the Area Manager and the Duty Manager confirmed that the vending machine would be emptied on a monthly basis from now on. Evidence was received confirming the machine was emptied recently.

3.1.2 The expected reports are not produced, checked and certified on a monthly basis. It was seen that the reports relating to 'Point of Sales Transactions', 'Point of Sales Transactions Cancelled', 'Record Refunded' and 'log in log out' had not been produced for the last two months. The Duty Manager confirmed that a long leave of absence had made it difficult to cope with the workload. The reports for June were produced on the day of the audit, with assurance that May's reports would be produced soon. Evidence was received following the release of the draft report confirming that the reports have since been produced.

3.1.3 It appears that no fire evacuation route tests have been performed since 2015. The Duty Manager confirmed that he performed these tests daily, but had not documented them. Following the release of the draft report, evidence was received confirming the tests are now performed and documented on a weekly basis.

3.1.4 Many of the risk assessments present on the Health and Safety database have not been reviewed in the last year. However, these assessments are no longer relevant, as the activities are no longer provided at the Centre.

3.1.5 A new member of casual staff has not received an induction. The Duty Manager confirmed that it is difficult to find the time provide induction as casual staff only work minimal hours. The Duty Manager stated that he will attempt to undertake the induction training in the near future.

3.1.6 The Duty Manager's First Aid training has recently passed its three year validity. The Area Manager has confirmed that training will be arranged in the near future.

3.1.7 COSHH sheets aren't reviewed regularly in accordance with IMS/HS/09.1.4. Evidence was received following the release of the draft report confirming that new COSHH sheets had since been received at the Centre and that they have been checked and signed by the Duty Manager. The next review is due in 2018.

4. <u>Audit opinion</u>

(B) The Audit opinion is that partial assurance can be expressed of the propriety of the Pavilion Leisure Centres arrangements, as there are controls in place, but there are some aspects where arrangements can be tightened. The establishment has committed to implement the following steps to mitigate the risks identified.

- Ensure the vending machine is emptied at least every two months.
- That the expected reports are produced, checked and certified monthly.
- Perform and document weekly evacuation route test.
- Ensure that all COSHH sheets are reviewed regularly.

Appendix 6

GLAN WNION LEISURE CENTRE
ECONOMY AND COMMUNITY

1. Background

1.1 Gwynedd Council Leisure Centres are part of the Healthy Communities service which is within the Economy and Community Department. There are four Area Managers who are responsible for managing the Centres under the Authority's control. Glan Wnion Leisure Centre provides a number of services for the public, including tennis courts, fitness/weights room and fitness classes.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that secure arrangements were in place in the Leisure Centre in order to control and reduce risks appropriately, and to ensure conformity with the Councils internal procedures and other relevant acts.

2.2 The audit involved visiting a sample of four Leisure Centres unannounced in order to ensure that appropriate arrangements are in place for managing various risks which could exist in the areas of collection of income, budgetary control, procurement, storage of goods and health and safety.

3. Main Findings

3.1 It was generally seen that appropriate internal controls are in place at Glan Wnion Leisure Centre, but that the following aspects need to be tightened in order to mitigate the risks highlighted.

3.1.1 It was found that occasional errors were made when completing the TR34 forms when banking, which results in the Income Section amending the totals by making use of the surplus/deficit account code. This results in the Centre not being aware of all the use made of this account code.

3.1.2 It was found from Gladstone system reports that many small debts had been deleted because staff had entered the incorrect member details into the system. This is likely as a result of a member requesting a service without presenting a membership card, whether it be over the phone or at the reception, and the request is processed on the account of a member with a similar name.

3.1.3 It was found that some customers attended sessions without paying on the day, and there was no evidence that the debts are paid promptly. It was explained to the Auditor that it was not possible to accept money on Sundays and that card payments had a minimum of £5. As a result, the Centre permit reliable/regular members to use the facility on the condition that they pay on their next visit.

3.1.4 A comprehensive inventory is kept of items within the Centre although only items over £100 need to be recorded. It appears that the information on the IMS documents are misleading with regards to this as it notes that only items with a value of up to £100 should be recorded.

3.1.5 The stock change arrangements were verified and an arithmetic error was discovered on one occasion on the Lucozade machine's sales spreadsheet. In addition, it was found from the records that a number of bottles had been disposed

from the storeroom as they were out of date, whilst some of them were for sale in the machine at the time.

3.1.6 It was found that some orders had been created on the e-procurement system after the Centre had received an invoice which suggests there is no certification and separation of duties when ordering goods on all occasions.

3.1.7 A tablet and the Legend system is used to conduct daily/weekly/monthly etc. tests at the Centre. It was seen from the system that a number of the tests were not being completed or not always recorded, and occasionally that some of the tests were also recorded on paper in accordance with the previous procedure.

3.1.8 The Centre uses three forms to record the required training for inducting new contracted staff whilst casual staff receive training as the manager sees it necessary.

3.1.9 The staff were not aware of the safeguarding poster/pamphlets/ card and the processes that should be followed. The procedure was explained to the manager whilst highlighting the relevant links on the pamphlet. The staff were not clear about the safeguarding training that must be completed. It was found that some had accepted the Safeguarding Children and Adults Policy in the Policy Centre, and that two members of staff had completed the Safeguarding and Protecting Children module on the E-Learning Portal. None of the staff have completed the Safeguarding Adults Module.

4. <u>Audit Opinion</u>

(B) The Audit opinion is that partial assurance can be expressed of the propriety in Glan Wnion Leisure Centre as there are controls in place, but there are aspects where some arrangements could be tightened. The Manager has committed to implement the following steps to mitigate the risks highlighted:

- Ensure that the required tests are undertaken and recorded in a timely manner on the 'Legend' system and reduce the cases where the work is unnecessarily duplicated on paper.
- Tighten arrangements in ensure that the banking forms TR34 and bankings are completed correctly before being sent to the Income Section.
- Ensure that official orders are created before procuring goods and that there is separation of duties involved with the process.
- Ensure that all members are aware of the payment system, in relation to paying for every session before accessing the centre's facilities.
- The Centre to receive and display Safeguarding posters in order to raise awareness amongst staff of the procedures and processes which are in place.
- The Centre's staff to complete the Safeguarding and Protecting Children Module and

  and Safeguarding Adults Module on the E-Learning Portal.

Appendix 7

PLAS MAESINCLA
ADULTS, HEALTH AND WELL-BEING

1. Background

1.1 Plas Maesincla, Caernarfon is a residential home for older people who have been diagnosed with dementia. The home has been registered for 23 residents.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the management and maintenance arrangements of Plas Maesincla Residential Home are appropriate and in accordance with relevant regulations and standards. In order to achieve this, the audit included verifying that the home's arrangements were sufficient in terms of administration and staffing, budgetary control, procurement of goods and receiving income, health and safety, and monitoring performance along with ensuring that the service users and their property are safeguarded.

3. Main Findings

3.1 There is a homely and friendly feel to the home and good controls exist but the following aspects need to be tightened:

3.1.1 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.

3.1.2 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.

3.1.3 Orders are not signed on every occasion.

3.1.4 Invoices are not dated and stamped as 'received', which makes it difficult to identify the tax point in order to complete the TR252 slip.

3.1.5 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.

3.1.6 An evacuation exercise has not been conducted since February 2015.

3.1.7 A sample of the Home's generic risk assessments were verified and it was found that they had not been reviewed since February 2016.

3.1.8 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.

3.1.9 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.

4. Audit Opinion

(B) The Audit opinion is that partial assurance can be expressed in the management and maintenance arrangements of Plas Maesincla as there are controls in place, but there are aspects where some arrangements could be tightened. The service has committed to implement the following steps to mitigate the risks highlighted:

- Update the Care Plans of the Service Users every month in accordance with the National Minimum Standards for Care Homes for Older People.
- Dedicate time for staff supervision at least every two months in accordance with the National Minimum Standards for Care Homes for Older People.
- Ensure that every order is authorised and signed by the relevant officer.
- Use a 'received' stamp on every occasion from now on.
- Ensure that an evacuation exercise is carried out annually.
- Ensure that risk assessments related to the home are reviewed annually.

Appendix 8

PLAS HAFAN
ADULTS, HEALTH AND WELL-BEING

1. Background

1.1 Plas Hafan, Nefyn is a residential home for older people. The home has been registered for 32 residents.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the management and maintenance arrangements of Plas Hafan Residential Home are appropriate and in accordance with relevant regulations and standards. In order to achieve this, the audit included verifying that the home's arrangements were sufficient in terms of administration and staffing, budgetary control, procurement of goods and receiving income, health and safety, and monitoring performance along with ensuring that the service users and their property are safeguarded.

3. Main Findings

3.1 It was found that there is a homely and friendly feel to the home. It was also found from the audit that the home's management and maintenance arrangements were appropriate, and this is reinforced by a recent report by the CSSIW in addition to the internal monitoring arrangements of the Adults, Health and Well-being Department.

3.2 The 'Statement of Purpose' has been included in the 'Service User's Guide' document. The statement was verified to ensure that the contents coincided with Appendix 1 of the Care Homes (Wales) Regulations 2002. The content was found to be appropriate, but some information was not included, such as a record of staff's qualifications, and details in respect of room sizes, although it is accepted that this is not completely practical.

3.3 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.

3.4 In relation to ordering and paying for goods, it appears that some official orders are created after the invoice date.

3.5 It was found that workers attended training appropriately. However, it was found that the training record spreadsheet was not completely up-to-date and did not coincide with the training database. Work is already being undertaken to update this spreadsheet.

4. <u>Audit Opinion</u>

(A) The Audit opinion is that assurance of propriety can be stated in the management and maintenance arrangements of Plas Hafan Residental Home as it is possible to depend on the internal controls that are in place and that these have been followed. The service has committed to implement the following steps to mitigate the risks

highlighted:

- Update the training records of the Home's staff in order to keep this information up-to-date and facilitate the process of monitoring skills gaps.
- Manager and Clerk to enquire with the Finance Unit in order to receive 'read-only' access and training on the ledger to proactively monitor payments and their budget.
- Ensure that orders are created and certified in the order book before the goods or service are supplied.

Appendix 9

PLAS OGWEN
ADULTS, HEALTH AND WELL-BEING

1. Background

1.1 Plas Ogwen, Bethesda is a care home for older adults. The home has been registered for 27 residents.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the management and maintenance arrangements of Plas Ogwen residential home are appropriate and in accordance with relevant regulations and standards. In order to achieve this, the audit included verifying that the home's arrangements were sufficient in terms of administration and staffing, budgetary control, procurement of goods and receiving income, health and safety, and monitoring performance along with ensuring that the service users and their property are safeguarded.

3. Main Findings

3.1 There is a homely and friendly feel to the home and good controls exist but the following aspects need to be tightened:

3.1.1 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.

3.1.2 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.

3.1.3 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.

3.1.4 The TR34 forms were not checked and certified by a second officer.

3.1.5 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.

3.1.6 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.

3.1.7 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.

3.1.8 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.

3.1.9 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.

3.1.10 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.

3.1.11 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.

3.1.12 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.

3.1.13 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.

3.1.14 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.

4. <u>Audit Opinion</u>

(C) The Audit opinion is that assurance cannot be given in the arrangements at Plas Ogwen as the controls in place cannot be depended upon, but no losses / fraud

resulted from control weaknesses. The Home has committed to implement the following steps to mitigate the risks highlighted:

- Ensure that time is dedicated for one-to-one staff supervision at least every two months, and that formal records are kept in accordance with the National Minimum Standards for Care Homes for Older People.
- Send the relevant risk assessments with the HS11 forms from now on.
- Ensure that medication competence tests are carried out annually.
- Update the list of staff who are qualified to administer medication.
- Two members of staff to sign the MAR forms when accepting medication in every case.
- Two staff members to sign "Return of Medication" forms when disposing medication.

Appendix 10

TAN Y MARIAN
ADULTS, HEALTH AND WELL-BEING

1. Background

1.1 Tan y Marian Home, Pwllheli is a residential home which provides care for up to nine young adults with learning disabilities.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the management and maintenance arrangements of Tan y Marian Home are appropriate and in accordance with relevant regulations and standards. In order to achieve this, the audit included verifying that the home's arrangements were sufficient in terms of administration and staffing, budgetary control, procurement of goods and receiving income, health and safety, and monitoring performance along with ensuring that the service users and their property are safeguarded.

3. Main Findings

3.1 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:

3.1.1 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'.

3.1.2 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.

3.1.3 There are no contracts in place between the Council and the residents who have

been in residence at the home for a long time.

3.1.4 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 moths, but that there were steps in place to address this.

3.1.5 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.

3.1.6 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.

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

3.1.8 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.

3.1.9 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.

3.1.10 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.

3.1.11 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.

4. <u>Audit Opinion</u>

(C) The Audit opinion is that assurance cannot be given in the arrangements at Tan y Marian Home as the controls in place cannot be depended upon, but no losses / fraud resulted from control weaknesses. The Home has committed to implement the following steps to mitigate the risks highlighted:

- Conduct periodic reviews of the Care Plans.

- Continue to work towards establishing a routine where care workers receive formal supervision at least once every two months and a staff appraisal every twelve months.
- Verify that the total on the holiday cards are correct when approving holidays.
- Manager and Clerk to enquire with the Finance Unit in order to receive 'read only' access and training on the ledger in order to proactively monitor payments and their budget.
- Ensure that orders are created and certified in the order book before the goods or service are supplied.
- Move toilet chemical cleaning material to a safe area.
- Record the temperature in the medication room daily.