Report to:	**AUDIT COMMITTEE**
Relevant Officer:	Nick Henson – Head of Adult Care and Support
Meeting	15 September 2022

INTERNAL AUDIT FOLLOW-UP – CARE AT HOME

1.0 Purpose of the report:

1.1 To consider a progress report on the recommendations made in the internal audit report of the Care at Home Service (internal provision) issued on the 11 October 2021.

2.0 Recommendation(s):

2.1 To consider the actions being implemented to address the audit recommendations relating to the Care at Home Service (internal provision) audit.

3.0 Reasons for recommendation(s):

3.1 To enable Audit Committee to consider an update and progress report on the audit recommendations.

3.2 Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.3 Is the recommendation in accordance with the Council's approved budget? Yes

4.0 Other alternative options to be considered:

4.1 N/a

5.0 Council priority:

5.1 The relevant Council priority is;

- Communities - Creating stronger communities and increasing resilience

6.0 Background information

6.1 The Care at Home service form part of the Care and Support Division within Adult Services, they provide care in the community for a number of situations, these include:

- Primary night care for planned and emergency response,

- Long term palliative care for terminally ill service users remaining in their home,
- Enablement services for hospital discharges,
- Homes Best service to ensure a service users house is clean and safe for returning to home or preventing a hospital admission and emergency rapid response.

The majority of care provided is on a short term basis however there are some long term service users that are supported by Care at Home due to the complexity of the needs that external providers have been unable to support. Typically care is provided between two and six weeks, though this can be as little as one day for bridging care and up to eight years for palliative care.

6.2 The scope and assurance statement of the audit was as follows:

Scope

The scope of the audit was to ensure that adequate and effective controls are in place to minimise business risk by undertaking compliance testing on the following:

- Referral process are robust;
- Care plans are up to date and fit for purpose;
- Policies and Procedures are in place and up to date;
- Health and Safety Manual and Risk Assessments are in place and up to date;
- Robust quality assurance arrangements are established;
- Suitable security arrangements are in place and being complied with;
- Stock control records in place and maintained;
- Staff rotas are in place and operate safe levels of cover;
- Staff mandatory training is up to date and a suitable log is maintained; and
- Enhanced DBS checks are undertaken for relevant staff.

Assurance Statement

Overall, we consider the controls in place to be adequate with several changes necessary, however we do acknowledge that a number of improvements have already been identified by the service, with some early plans to address some of these issues. However, we are particularly concerned around ensuring staff have both received the required level of training and training records are complete and therefore have assessed this element of the scope as inadequate.

6.3 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 **Appendix 5(a)**: Internal Audit Recommendations and Agreed Actions.

8.0 Financial considerations:

8.1 The controls being implemented will be done so within current budget constraints.

9.0 Legal considerations:

9.1 Risks need to be effectively managed in order to comply with relevant legislation.

10.0 Risk management considerations:

10.1 To enable the Audit Committee to gain assurance that risks are being effectively managed.

11.0 Equalities considerations:

11.1 Where equality analysis is appropriate these will have been undertaken whilst making decisions relating to the subject.

12.0 Sustainability, climate change and environmental considerations:

12.1 Any matters relating to sustainability, climate change and environmental considerations will be considered when making decisions relating to the subject.

13.0 Internal/external consultation undertaken:

13.1 The progress report has been prepared in conjunction with the relevant Head of Service and Chief Officer.

14.0 Background papers:

14.1 N/a

Appendix 5(a) - Agreed Action Plan

Recommendation		*Priority*	*Agreed Action*	*Responsible officer*	*Target Date*	*Progress*
R1	We recommend a consistent standard of service user packs is maintained with all necessary information obtained and stored on file with robust arrangements to review and sign off necessary records.	3	Agreed. All service user packs are under review to ensure they are in line with the medication policy and CQC requirements.	Service Manager	31st January 2022	The service user packs have been reviewed and updated to ensure consistency. Care and Support workers are allocated to first visits and a more uniformed and consistent approach has been adopted to assessing and completion of all documentation. Further information below in regards to medication.

Recommendation		Priority	Agreed Action	Responsible officer	Target Date	Progress
R2	We recommend a systematic method for carrying out quality reviews on service user packs and medication records commences to ensure consistency in quality and recorded information.	2	Agreed. The review of current service user packs and procedures will driving in developing a suitable quality assurance programme.	Service Manager Team Leader	31st December 2021	All Primary Night Care reviews have been undertaken by the Care and Support Worker's and a quarterly rolling review schedule has been implemented. This approach will be developed further and extended to include all service users' packs using a 'sampling' approach.

Recommendation		Priority	Agreed Action	Responsible officer	Target Date	Progress
R3	We recommend the Medication Action Plan outstanding actions are followed up and required changes incorporated into service delivery.	2	Agreed. New standard operating procedures are being developed by Operational Leads, once this has been published further work can take place against the Medication Action Plan. A medication policy statement is due to be signed off and circulated to all providers, internally and externally, for action to be taken to ensure compliance with the Council's standards.	Service Manager Team Leader	31st January 2022	New Standard Operating Procedure for the Division currently in draft form awaiting final revisions and approval. Operational procedures reviewed and changed as follows: Medication first visit checklist is now in place to ensure all the required information is available. This also helps to identify any additional risk areas that require follow up by a manager. Monthly Medication Administration Record (MAR) 'preparation' procedure has been implemented to ensure consistency of approach. MAR Quality Assurance Audits are being undertaken monthly.

Recommendation		*Priority*	*Agreed Action*	*Responsible officer*	*Target Date*	*Progress*
R4	We recommend the review of procedures takes place to ensure they are updated and monitored using a document control to manage document review dates.	3	Agreed. The Operational Coordinator commenced their role on 1st October 2021 and will be reviewing the current procedure documents.	Service Manager Operational Coordinator	31st March 2022	Support received from Provider Support Hub to review and update the Standard Operating Procedures. Daily office procedures have been reviewed and updated to include the daily 'Huddles' and procedures to input onto the system a Package of Care and end a Package of Care. Document Control processes in place.

Recommendation		Priority	Agreed Action	Responsible officer	Target Date	Progress
R5	We recommend a record is produced to evidence all employees are aware of the health and safety manual and risk assessments, and know how to access the information.	2	Agreed. A signature list has been produced and all staff are being asked to sign to confirm the awareness of the information and how to access it. This will form part of the induction process for new members of staff.	Service Manager	30th November 2021	Completed Monitored by the management team.
R6	We recommend advice is sought from the Corporate Health and Safety team in conjunction with reviewing the Health and Safety Manual and risk assessment process, to ensure all relevant activities are captured and up to date and confirm date of next Health and Safety audit.	2	Agreed – the Corporate Health and Safety Team will be consulted with as part of a review of risk assessments and associated papers, however a date for Health and Safety audit to take place could not be confirmed due to the Health and Safety team's limited audit programme.	Service Manager Team Leader	30th November 2021	Quarterly Meetings agreed and arranged between Care at Home and Health and Safety Team where particular risk areas can be identified/followed up and/or support offered.
R7	We recommend a review of the KPI data reporting is reviewed with consideration to introduce a set of KPI targets to report progress on a quarterly basis.	3	Agreed. Consideration will be given to producing a set of local KPIs for the service.	Service Manager Operational Coordinator	31st March 2022	Key Performance Information submitted to Head of Service on a quarterly basis.

Recommendation		Priority	Agreed Action	Responsible officer	Target Date	Progress
R8	We recommend training logs are updated as a matter of urgency and monitored on an ongoing basis, to ensure arrangements are in place to schedule renewal training prior to the lapsing.	1	Agreed – Issues have been raised concerning refresher training completed on iPool that does not generate a new certificate or update the date of completion. Medication Competency assessment completions were restricted due to Covid however nobody was assigned to administer medication that was not trained. Work is underway to revise the mandatory training requirements for the service, whether virtual or classroom training is required and these will be RAG rated on the training matrix for clarity. Team leaders are now required to update training logs for their team members on a weekly basis. Close working continues to take place with OWD to creatively ensure all employees are able to access relevant training whilst continuing service delivery.	Service Manager Team Leader (DBC)	30th November 2021	The training log is updated daily by the Duty Manager. This ensures that it is current and up to date. Funding has been agreed to provide additional Moving and Handling training sessions to enable the service to catch up following the Covid pandemic. (Currently 75% completion/up to date with the remaining staff booked or will be once they return from sick leave) Allocated Team Leader has overall responsibility for monitoring training and Operational Governance on a quarterly basis. Staff provide manager a screen shot of the completed ipool training where no certificate is issued

Recommendation		*Priority*	*Agreed Action*	*Responsible officer*	*Target Date*	*Progress*
R9	We recommend Team Leaders are made aware of the DBS check requirement when assigning hours to Casual employees that may not have worked for the service for three months or more.	3	Agreed. The management team have been notified by email. A process will be linked to the process of checking timesheets to highlight any casual employees that have not worked for the service for 2 months. In the past, the Head of Service received a list of all casual employees that had not been employed for more than three months however this is no longer issued.	Service Manager	Completed	Completed Monitored by the management team.