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Castle Craig Hospital
AUDIT REPORT

Re-certification - Remote

Report issued at 12:44 GMT on 28-Apr-2022

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Castle Craig Hospital AUDIT REPORT

Client ID#:	CMPY-041564
Client/Address:	Castle Craig Hospital Blyth Bridge, West Linton, Peeblesshire EH46 7DH Smarmore Castle Private Clinic Ardee, County Louth (Lú), A92 YY22, Ireland
Audit Criteria:	ISO 9001:2015
Audit Activity:	Re-certification - Remote
Date(s) of Audit:	Castle Craig Hospital West Linton, United Kingdom: 11-Apr-2022 to 12-Apr-2022 Smarmore Castle Private Clinic Ardee, County, Ireland: 13-Apr-2022 to 14-Apr-2022
Auditor(s) (level):	Deborah Camotta (Lead Auditor, Castle Craig Hospital, West Linton, United Kingdom) Deborah Camotta (Lead Auditor, Smarmore Castle Private Clinic, Ardee, County, Ireland)
Scope of Audit and Scope of Certification:	**Overall Scope** **ISO 9001:2015:** Provision of mental health care within a private psychiatric hospital for the treatment of service users with substance abuse dependency and gambling - related addiction ***Site: Castle Craig Hospital, West Linton, United Kingdom*** **ISO 9001:2015:** Provision of mental health care within a private psychiatric hospital for the treatment of service users with substance abuse dependency and gambling - related addiction **ISO 9001:2015:** The provision of residential treatment for alcohol and chemical dependency ***Site: Smarmore Castle Private Clinic, Ardee, County, Louth (Lú), Ireland*** **ISO 9001:2015:** Provision of mental health care within a private psychiatric hospital for the treatment of service users with substance abuse dependency and gambling - related addiction

OVERALL RESULT: No Action Required

The management system was found to be fully effective. (no nonconformities issued)

EXECUTIVE SUMMARY

The client's system is mature with no non-conformities/observations raised. The audit was conducted via Teams and documentation and records were sent via email – zipped folders. Staff were available throughout the audit via teams, phone and/or email. It was therefore confirmed that there were no unacceptable remote audit risks and that an effective audit could be carried out using "Teams" based discussions, interviews and screen sharing. Patient plans are due their nature confidential, so details were limited in this area. Technology used to conduct the remote audit all worked as planned. The system continues to work very well, good levels of detail within the documents and records sent. There were no areas for concern.

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SWOT ANALYSIS

Strengths	mature system, positive management involvement
Weaknesses	none evident
Opportunities	none identified
Threats	none identified

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INTERTEK MATURITY MODEL

The score descriptions are generic to all management systems and cannot be customized by the auditor, thus allowing for the consistency of interpretation and standardization of audit results worldwide. The scores provided to your organisation are for benchmarking purposes only and are based on the audit team's evaluation.

Management

Mature

Consistent evidence of management commitment, customer and/or interested party satisfaction, knowledge/awareness of policy and objectives being demonstrated by the majority of staff. Responsibility and authority is evident and supported via data, trends and related KPI's. Management reviews are complete and demonstrate support by the majority of personnel. Records are complete and demonstrate positive trends in improvement and lessons learned.

Internal Audits

Meets Intent

Internal audits are being performed at planned intervals and are based on status and importance of the Management System. Data is being collected on regular basis. Audit teams are trained, impartial and objective in their approach. Audit reports are clear, concise with respect to content. Actions are being taken as a result of audit findings and timely responses are provided.

Corrective Action

Meets Intent

The corrective action process meets the minimum requirements as defined by the standard. Data does exist from such sources such as customer and/or interested party complaints, internal audits, warranty analysis, defects, internal metrics and supplier performance. The process includes a review of the effectiveness of the actions taken. There is evidence of problem solving tools being used to support the process.

Continuous Improvement

Meets Intent

Data streams are being used as sources to drive continual improvement over time. These may include management system policy, objectives, and audit results, analysis of data, CAPA and management reviews.

Operational Control

Mature

Operational Controls are planned and developed. Planning of operational controls is consistent with all other Management processes. Objectives, process requirements, needs for appropriate additional documents and resources, verification and monitoring activities and records requirements have been determined, as appropriate. Processes and activities run consistently. Data is collected, and reviewed to verify the effectiveness of operational controls with evidence of significant improvement trends. Some evidence linking to some key business factors.

Resources

Mature

Resources required for the effective maintenance and improvement of the management system have been defined and deployed. Improvements have been noted in areas such as customer and/or interested party satisfaction, continual improvement, process variation. Levels of competency have been defined and documented within the existing management system.

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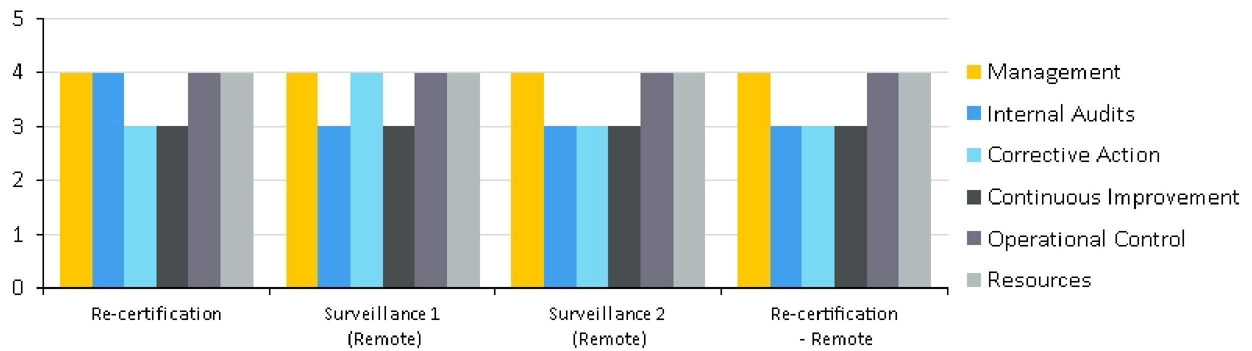

Rating: 5=Benchmark | 4=Mature | 3=Meets Intent | 2=Beginning | 1=Not Evident

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FINDING SUMMARY

	Minor	Major
Issued during current activity	0	0

Opportunities for improvement have been identified

No

STATUS OF PREVIOUS AUDIT FINDINGS

Follow-up on findings issued at previous audit:

Prior assessment resulted in no non conformities.

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EVIDENCE SUMMARY

The state of the management system is summarized below:

Conclusion of Client's Processes/Functional areas audited including KPI/Metrics

8 Operations

CC – Patient Files
Patient – SOR. Contents, photograph on day of admission. Create mission- assessment, background, mobility, family, substance use history, pre-treatments, violence, allergies, disorders, suicidal/ self-harm. Medical history. Arrived to site, covert tested before. Sign release of information- contents, confidentiality. Discharge- agreed to stay commitment. Number of days off stay agreement. Sign permission to obtain GP records/ contacts. Medical admission- observation checklist completed, positive indications and add photographs, next of kin. Doctor-drugs history, past medical history, allergies, medical/ psychiatric, general discussion with client. No known allergies. Therapist notes from sessions. Nursing care plan written. PEEPS - Personal emergency egress plan- fire- RAG. clinical notes/ daily and discussed at shift handover. Continuing care plan. Medical disclosure summary- sent to patients GP.
Patient-AL. contents same as the previous file. This patient was discharged on the 13th of April 2022. Treatment summary. Linked cardex/ medical- prescriptions day today. Completed by doctor and reviewed by doctor. First cardex- detox- ID medicines. Separate prescription. Second discretionary medications- by nurses- paracetamol. No known allergies.

Therapeutic activities-music. Therapeutic art is held every second week. Plan of activities was evidenced, programme has been developed.

SM –
Patient JS – DOB 15/02/1963. Emergency contact details. Alcohol substance misuse. Family history. Medical checklist- allergies, asthma on Ventolin inhaler. Psychiatric history. File signed and dated.

CC – Maintenance
Fire safety audit – Scottish Fire and Rescue Service, letter dated 12/07/2021 – some areas for improvement, inadequate fire risk assessment. Fire risk assessment submitted 12/07/2022.
Fire drill dated 05/11/2021.
Fire extinguisher and alarm service dated 03/11/2021, by Tweedale Fire Services.
Last Rentokil visit dated 04/04/2022, routine inspection, no current live infestation.
Weekly call point tests recorded on the spreadsheet – all areas.

SM –
PAT 29/03/2022.
Fire extinguishers dated 23/03/2022, by Advanced Fire Protection.
Fire alarm serviced 15/03/2022

Smoke alarm serviced 15/09/2021.
Emergency lighting serviced 15/09/2021.
Pool checks conducted daily – Chlorine. Maintained by Dalco Engineering.
Gas safe cert dated 06/04/2022
Fixed wire dated 10/04/2017, expires 5 years.

Kitchen – CC and SM
Fridge and freezer temperature checks are recorded for AM/PM, daily. Cooking and cooling temperature log 82°C or above. The temperature probes are checked in boiling water and ice and recorded on the sheet. Incoming delivery checks record – date, time, supplier, product description, food temperature, product date, condition of food item, condition of packaging, condition of tinned product – signed. Cleaning rotas were seen for daily, weekly and for either the chef of kitchen assistant. HACCP in place. The food hygiene policy was displayed in the kitchen. There is a 4-week rolling menu in place, which is seasonal. Certs available for deep clean of extractor fans.
Special diets are catered for, with a range of options available. Daily menu order reviewed which identified all residents and their meal choices for the day.

Purchasing/Receipt of Goods – CC and SM
SM – PO dated 11/04/2022, order for 1 x box blue nitrile small.
Order for cleaning of canopies, job number16752.
SLA for waste, every 4 weeks

9 Performance Evaluation (customer satisfaction, management review, internal audits)
Management review, QE objectives, Customer Satisfaction, Internal Audit Schedule, Internal Audits, Supplier Evaluation and Performance.
Customer satisfaction – both 100% positive feedback

CC – Quarterly meetings are held. Weekly reports of the controlled drug stock and register are completed by the Senior Nurses in Kirkurd and Castle Medical Units and forwarded to the QA Department for monitoring purposes and collation into a quarterly report as required by the Hospital Manager. Meeting held on the 11/01/2022, agenda covered areas such as – review of impacts on family visitors. Incident forward accident report. Fire safety report. Water safe to report. Training on compliance. Review of policy. Any urgent matters-health and safety report and action plan. Patient use of upkeep. The last meeting was held on the 01/03/2022. The agenda covered COVID-19 review and update. Kurkud, recovery gardens community update. The castle community update. Visitors. Isolating patients. Isolating stuff. Medicines management reports and Ashton's reporting. Controlled drugs report. Incident report. MRHA warnings. Infection control update. Policy review plan for 2022- 3. Review of policy.

SM – Meeting held March 2022, areas discussed - number of admissions, patient stay in treatment. Complaints- no complaints for the period. Incidents-there have been 12 incidents reported six were accidental/ environmental and forward behaviour with two clinical incidents, one remains open. COVID-what outbreak of coping 19 in January with two patients confirmed positive. Staff and patients were segregated and observations increased. Admissions were

paused for one week and services resumed fully after that. Public health was satisfied with the measures taken to contain the outbreak. A nursing training summary was available from December 2021 two February 2022. Staff nurse inductions from December to February 2022, there have been five new staff nurses inducted into the service. Additional support sessions for- introductions to policies protocols and procedures, fire evacuation planning, communication systems, medications competences observation assessment, treatment planning and multidisciplinary team liaison, infection control procedures, and management of attendance. Training requirements highlighted 2 ongoing appraisals. No issues to the administration department and no recruitment required. Policies were discussed.

Internal audits – both sites
Internal audits are conducted at planned intervals and are based on status and importance of the Management System. Data is collected on a regular basis and results analysed. Audit teams are trained, impartial and objective in their approach. Audit reports are clear, concise with respect to content. Actions taken as a result of audit findings are completed in a timely response.

10 Improvement (non-conformance, corrective action)
Complaints, Non-Conformances and Corrective Actions (including root cause), Q/EMS effectiveness check, continual improvement,
CC – Improvements
Psychoeducation
All lectures, DVDs and YouTube presentations have been evaluated by the patients, resulting in a number of outdated DVDs being removed and well-received YouTube presentations being increased. Live therapist lectures have all been rebranded, reviewed and updated. There is a clear increased in satisfaction for psychoeducation.

Fitness
Fitness has improved from 91% to 100% (Good/Very Good/Excellent), reflecting the promotion of a Fitness Manager, who is implementing new equipment and different fitness options.

Accommodation
This field also includes maintenance. The maintenance team has recently been increased by two, therefore improving response times. Patients have been given the facility to report issues directly to the maintenance team using the Upkeep programme.

SM –
Review and update documentation.
Maintenance of various areas has been scheduled.

Review and conclusion of client performance trends since last certification/recertification (at recertification audit and last surveillance audit prior to recertification)
The QMS has been functioning effectively over the last certification cycle

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Conclusions regarding risk assessment/risk treatment processes

Lucy Haden
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Conclusions regarding context of the organization

The internal context, within which it seeks to achieve its objectives, has been evaluated and documented, considering, the organisational structure, roles and accountabilities. Policies, objectives and the strategies that are in place to achieve them. Capabilities, in terms of resources and knowledge. Information systems, process flows and decision-making processes. Organisational culture. Standards, guidelines and models. Contractual relationships. The external and internal context is reviewed at least annually and the documentation updated accordingly. A SWOT and PESTLE has been documented and has been discussed at the management review.
CC – The interested parties that are relevant to the Quality Management System are defined as: healthcare improvement Scotland, company bankers, solicitors, auditors, payroll, insurers, HMRC, information commissioner's office, Intertek, HSE, KIPU systems limited, Ashton's hospital pharmacy Scottish Borders Council General Medical Council, nursing and midwifery council, independent healthcare providers network, Home Office, disclosure Scotland, clients, families/ carers of patients, employees, Castle Craig Netherlands, Smarmore castle private clinic, CATCH Recovery, peoples pension therapeutic professional bodies, ISCAS, Scotmas, CDAO Working Group, LIN.
SM – as above but includes Irish Medical Council, Irish nursing and midwifery board, Irish vetting service, Bank of Ireland possessions, pest proof limited, Boyne Water.

The significant requirements of these interested parties include: The consistent provision of services which meet patients' requirements. The continual enhancement of customer satisfaction. A safe and pleasant working environment. Adherence to legal and regulatory requirements.
The scope is '' The Provision of mental health care within a private psychiatric hospital for the treatment of service users with substance abuse dependency and gambling - related addiction''.

Impact of Significant Changes (If Any)

None

Additional information/unresolved issues

None

Communication/Changes during the visit (if applicable)

None

References to appendices:

Audit plan (as executed)

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Have all shifts been audited:

Yes

The audit has been performed according to audit plan meeting audit objectives, scopes and duration (on-site and off-site) as given within the audit plan

Confirmed

Extent of use and effectiveness of Information and Communications Technology (ICT).

ICT was used for 100% of this audit.

ICT used was effective in achieving the audit objectives.

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LEAD AUDITOR RECOMMENDATION

Lead Auditor's Recommendation for ISO 9001:2015

The management system is in conformity with the audit criteria and can be considered effective in assuring that objectives will be met. Continued certification is therefore recommended.

OTHER OR ADDITIONAL LEAD AUDITOR RECOMMENDATION

N/A

CLIENT ACKNOWLEDGEMENT

Client Representative Name and Mailing Address:	Lucy Haden l.haden@castlecraig.co.uk
Acknowledged By:	Lucy Haden l.haden@castlecraig.co.uk

This report is based on a sample of evidence collected during the audit; therefore the results and conclusions include an element of uncertainty.
This report and all its content is subject to an independent review prior to a decision concerning the awarding or renewal of certification.