Castle Craig Hospital

AUDIT REPORT

Surveillance 2

Report issued at 10:02 GMT on 03-Apr-2024

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:	Surveillance 2
Date(s) of Audit:	Castle Craig Hospital West Linton, United Kingdom: 01-Feb-2024 Smarmore Castle Private Clinic Ardee, County, Ireland: 21-Mar-2024
Auditor(s) (level):	Deborah Camotta (Lead Auditor, Castle Craig Hospital, West Linton, United Kingdom) David Holroyd (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 residential setting for the treatment of service users with substance abuse dependency and process addictions. ***Site: Castle Craig Hospital, West Linton, United Kingdom*** **ISO 9001:2015:** Provision of mental health care within a residential setting for the treatment of service users with substance abuse dependency and process addictions. ***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

Castle Craig Hospital **AUDIT REPORT**

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-conformity/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.

SWOT ANALYSIS

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

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

Outstanding

Strong evidence of management commitment, customer and/or interested party satisfaction, knowledge/awareness of policy and objectives being demonstrated consistently by all members of the organization. Responsibility and authority is evident and supported fully via data, trends and related KPI's. Management reviews are completed as scheduled and attended regularly by all required personnel. Records are complete and demonstrate positive trends in improvement and lessons learned. Senior management is fully engaged in supporting all aspects of the System.

Internal Audits

Outstanding

Internal audits are being performed at planned intervals and are based on status and importance of the Management System. Data is being collected analyzed and reviewed by senior management on a regular basis. There exists a strong link between the internal audit results and the overall health of the organization. Audit teams are fully trained, impartial and objective in their approach. Audit reports are clear, concise and demonstrate a correlation to the overall strategic plan. Actions taken as a result of audit findings have demonstrated significant and measurable improvements over time. Senior management is actively involved in the corrective action process ensuring timely implementation and overall effectiveness of resolution.

Corrective Action

Outstanding

The corrective action process has demonstrated to be fully effective in practice. Data from sources such as customer and/or interested party complaints, internal audits, warranty analysis, defects, internal metrics and supplier performance are used to drive improvement in the applicable processes. The process includes a thorough review of the effectiveness of the actions taken. Strong evidence of problem solving tools in use may include; Pareto Analysis, 5 why, 8D, fishbone and mistake proofing.

Continuous Improvement

Outstanding

All streams of data are being used as sources to drive continual improvement over time. These include management system policy, objectives, audit results, analysis of data, CAPA and management reviews. Advanced tools such as Lean, Kaizen, 5S etc. are implemented and understood at all levels in the organization. There is a clear linkage between actions taken and the financial contribution of the various projects. There is strong evidence of a reduction in variation and known failure modes over time.

Operational Control

Outstanding

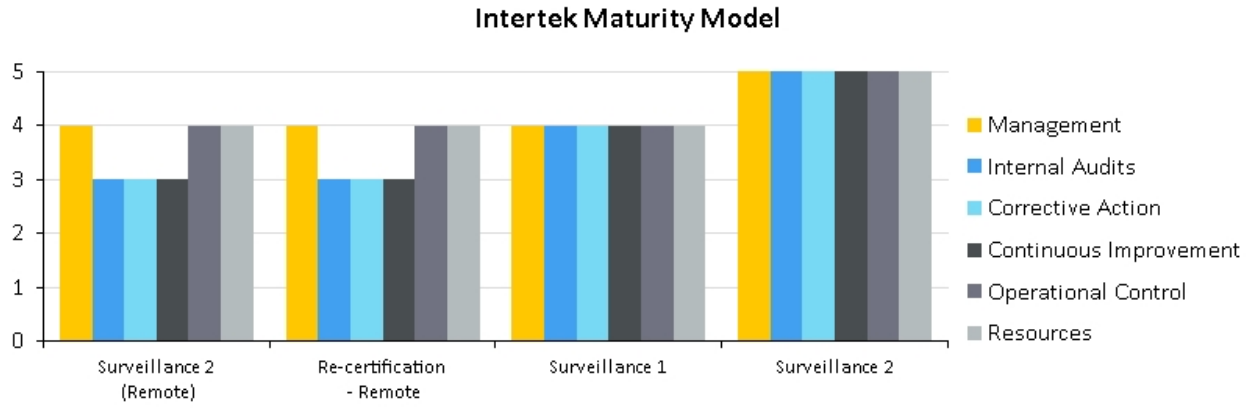
Operational Controls are planned and developed. Planning of operational controls is consistent with all other Management processes. Objectives, process requirements, needs for appropriate additional documents and resources, verification and monitoring activities and records requirements have been determined, 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. Strong link to all key business factors. Best Practices (Lessons Learned) are

shared throughout organization.

Resources

Outstanding

Resources required for the effective maintenance and improvement of the management system have been defined and effectively deployed. Existing resources have been utilized effectively. Evidence to support this is noted in efficiency metrics, customer and/or interested party satisfaction, continual improvements, and reduced variations. Levels of competency have been defined and demonstrated effective in practice throughout the organization. Lesson learned and best practices are used regularly to determine resource requirements.



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

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.

EVIDENCE SUMMARY

The state of the management system is summarized below:

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

5 Leadership

Top Management interviews – Q Policy, business plans linked to quality objectives, roles and responsibility/authority, management commitment and provision of resources, customer focus – applicable statutory or regulatory requirements understood and met

The Quality Policy includes a commitment from management to develop and improve the Quality Management System by: Communicating throughout the company the importance of meeting customers' requirements, communicating throughout the company the importance of meeting all relevant statutory and regulatory requirements, establishing the Quality Policy and its Objectives, commitment to continuous improvement, conducting Management Reviews, ensuring the availability of resources, promote the use of risk-based thinking, ensure that the Quality Management System performs as intended, support other relevant management roles with regard to their delegated responsibilities. The quality operational procedure is hyperlinked (alphabetical index)

CC – The Quality Policy – effective date July 2008, reviewed September 2023, version 10.

6 Planning (Risks, opportunities, objectives)

Risk based planning for continual improvement / Changes Business, Management meetings to discuss IMS – targets & objectives and changes which cover who, what, why and how to achieve.

Wherever risks and opportunities are identified and is documented on a Quality Risks and Opportunities Register and implemented. All risks identified are open and ongoing status. Dated Feb 2022, last reviewed January 2024.

When made, all changes are reflected in the Quality Manual and communicated to relevant interested parties.

A SWOT analysis has also been produced highlighting strengths and weakness within the company, appendix 5. Staff to be aware of internal weakness and consider ways to improve these.

CC – Quality Objectives – last reviewed September 2023. Objectives for 2024

Hospital risk register regularly updated to ensure that contingency plans are regularly reviewed.

Oversight and assessment of effectiveness of Services Manager and their departments.

To achieve and maintain a fully staffed therapy team allowing staffing capacity for the use of all 82 available registered beds.

Recruit, induct and support a stable workforce and increase staff retention in key areas (Therapy, Catering and Nursing) to establish >3-year retention for staff in these areas.

Weekly HR recruitment and staffing updates.

Prepare for regulatory inspection, expected in 2024.

To continue to support the long-term recovery of patients by working closely with CATCH and partners with the aspiration for 100% of those patients positively discharged from CCH to continue to be abstinent at 3 years post discharge.

7 Support (Competence, awareness, communication)

Infrastructure, Calibration & Maintenance of Equipment, Resources such as external providers, Training, competency and awareness, Documented Information with control of documents and records and version control.
The company has determined what resources both internal and external (and what people) are necessary to implement, operate, maintain and continually improve the effectiveness of the QMS and has provided such resources as are necessary to achieve those aims.

Resources, Roles, Responsibility and Authority

The organisations management team and in particular the management representatives for health, safety and quality have clearly defined roles and responsibilities in relation to the management systems and operational controls. Interface reviewed and provides good evidence of committed approach to continuous improvement and legal compliance.

Competency, Awareness and Training

CC –

Each department has own mandatory training.

E learning thoughout the year. Health care workers – fire, life support, overdose prevention, manual handling, safe guarding, food hygiene, anaphylaxis, COSHH, mental capacity. Therapists have 100% training completed. Admin completed majority of training for rolling twelve months. Overall training compliance for nurses during 2023 was 100%. Training plan – structure of the nursing team.

NMC Registration Record – seen for – TB, KD, DD, DD, LD, RG, GH, VK, SL, AM, LP, ER, LS, KW, AW and NG.

Communication, Participation and Consultation

The company has determined what resources both internal and external (and what people) are necessary to implement, operate, maintain and continually improve the effectiveness of the QMS and has provided such resources as are necessary to achieve those aims. The importance of achieving customer satisfaction by fulfilling customer requirements is paramount to the success of the business and this is widely understood within the company.

8 Operations

CC – Patient Files held on Kipu EMR System.

Patient AT, admission date 05/1/2023. Contact details completed. No known allergies. Pre-admission completed 13/11/2023. Admitted – 3 separate – nursing, therapeutic and medical. Details uploaded onto the HIPU system. Meds on admission, benzo detox. Will be staying in Recovery Gardens. Therapist assessment – signed by patient at each stage. Each assessment is scored. Therapist plan set up. Drug and addiction issues, relapse prevention. Detailed progress notes. Discharge – therapist summary, 15/1/2023. Medical discharge notification. Discharge letter.

Patient – AD armed forces patient. Send weekly reports to Tricare. Admission on the 12th of December 2023 until the 8th of January 2024, based in Portugal. No known allergies. Contacts added, assessed on the 24th of November 2023. Medication information dated the 24th of November 2023. Permissions have been signed by the patient. Alcohol

dependent. Therapist screening tests completed. Free treatment plan dated the 14th of December 2023. Treatment plan created, signed by the patient. Progress notes. Discharge- therapists summary, nursing completed discharge letter signed on the 9th of January 2024.

Patient – ND that makes it on the 14th of November 2023, discharged on the 6th of January 2024. Through private insurance. Allergies-lippiprotein transfer. Assessed on the 2nd of November 2023, approved on the 3rd of November 2023 by the medical director. 2 treatments. Admission- consents signed by the patience. This charged on the 6th of January 2024-with support-CATCH sears, provides continuing therapy/ care. Continuing case management.

Customer property- patients possessions tracker base implemented.

Castle Craig handover notes held on the system for each patient.

Duty of Candour Annual Report – 1st of April 2022 – 31st March 2023. No incidents where duty of candour has been evoked in accordance with Castle Craig's national policy.

Maintenance
CC –
PAT continuous, completed internally. Cert of PAT dated Nov 2023 by White Testing Ltd.
Fire extinguishers dated Nov 2023, due Nov 2024 by Tweeddale Fire Protection Ltd.
Emergency lighting serviced annually – Nov 2023, due Nov 2024
Fire Evacuation Primary Medical Centre dated 19/01/2024 taking 8 mins. Recovery gardens 25/09/2023, taking 7 minutes.
Fixed wire dated –
House 7 certificate number SSC 188641, dated the 4th of March 2021.
House 8 certificate number EICR 241043, dated the 15th of March 2021.
Castle Craig various EICR 23807, dated the 25th of august 2020.
House 1 EICR 241036, dated the 3rd of June 2021.
House 4, EICR 241055, dated the 22nd of April 2021.

Check escape routes twice a month.

Kitchen – CC
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 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 for daily, weekly and for the chef and kitchen assistant. HACCP in place. The food hygiene policy is displayed in the kitchen. There is a seasonal 4-week rolling menu in place. 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.

Unannounced Inspection Report dated 20-21 September 2022. Overall rating – Good.

9 Performance Evaluation (customer satisfaction, management review, internal audits)
Management review, QE objectives, Customer Satisfaction, Internal Audit Schedule, Internal Audits, Supplier Evaluation and Performance.
Patient satisfaction – Patient Satisfaction Summary Report October 2023. 20 consecutive surveys from September and October were analysed. 100% of patients graded their Individual Therapist Care, Overall Treatment Programme, Therapy Programme, Admission and Treatment at Kirkurd Unit and Catering as Good, Very Good or Excellent.

CC –
Board report dated 15/10/2023 – areas reviewed patient satisfaction, recruitment and retention, internal audits, admissions performance.

Internal audits – CC
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. Infection control audit summary, dated 24/08/2023.
Infection control 23/09/2023 and 03/12/2023.
Nurse training report – ongoing, Jan 2024
Patient satisfaction report, now held electronically, October 2023.

Medicines Management Monthly Report dated September 2023 and November/December 2023. Training meetings held for anaphylaxis on the 14/11/2023.

10 Improvement (non-conformance, corrective action)
Complaints, Non-Conformances and Corrective Actions (including root cause), Q/EMS effectiveness check, continual improvement,
CC – Improvements
Provided a staff photoboard in both units.
Checked and upgraded the educational reading materials.
Adds removed from YouTube.
The volleyball court has been rolled and resurfaced.
Transport provided for religious attendance.
Facilitated a gardening group every week.
Four new PCs have been installed for patient use.
Provide more Pilates, resistance training and yoga equipment.
The fitness team are providing guided afternoon walks.
Four hill walks scheduled per week.
Replaced and upgraded 25% of duvets and pillows.

Improved the gym equipment, bought £6,000 of new equipment in the last three months.

Incident Report Log 2023 –
Report number – 1/23 – boiler at Kirkurd not working – fixed 29/12/2023 but broke again the next day. Recommend that boiler is serviced 6 monthly.

Complaints Log 2023 –
Ref no 6 – helpdesk, patient sent 17-point compliant, 07/5/2023. Full response sent 15/05/2023, no response received, considered closed. Compliant not upheld.
Ref no 9 – patient alleged victimisation by CCH and that he had been unfairly issued a contract for inappropriate behaviour. Patient discharged a week early. Acknowledgment sent 16/11/2023. Response sent 14/12/2023, no response received by 09/01/2024, considered closed.

Review and conclusion of client performance trends since last certification/recertification (at recertification audit and last surveillance audit prior to recertification)

The management system has proved to be effective and compliance with the standard throughout this certification cycle with no non conformances reported.

Conclusions regarding risk assessment/risk treatment processes

Wherever risks and opportunities are identified and is documented on a Quality Risks and Opportunities Register and implemented. All risks identified are open and ongoing status. Dated Feb 2022, last reviewed January 2024.
When made, all changes are reflected in the Quality Manual and communicated to relevant interested parties.
A SWOT analysis has also been produced highlighting strengths and weakness within the company, appendix 5. Staff to be aware of internal weakness and consider ways to improve these.

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. Last updated

03/01/2024.

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''.

Additional information/unresolved issues

None

Communication/Changes during the visit (if applicable)

None

References to appendices:

Audit plan (as executed)

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

Have there been any changes to Scope?

No

Have there been any changes to Headcount?

No

Have there been any Address Changes?

No

Have there been any Sites Added / Removed?

No

Have there been any Other Changes?

No

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

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