Unannounced Care Inspection Report
4 October 2016

Cornfield Care Centre
Green Lane and Castle Lane Suites

Type of Service: Nursing Home
Address: 51A Seacoast Road, Limavady, BT49 9DW
Tel no: 028 7776 1300
Inspectors: Lyn Buckley and Heather Sleator

1.0 Summary

An unannounced inspection of Cornfield Care Centre took place on 4 October 2016 from 09:50 to 17:00 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

The registered manager and staff spoken with demonstrated the knowledge and skill necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding. Patients and relatives spoken with confirmed that they were assured and confident of the staffs' ability to care and they trusted staff to "always do the right thing".

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated to a high standard, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

During discussion with the registered manager concerns were raised regarding the wearing of jewellery by one staff member and the policy on visiting arrangements in accordance with best practice in dementia care. The registered manager gave assurances that these matters would be addressed. Refer to section 4.3 for further details.

There were no requirements or recommendations made.

Is care effective?

Care records reviewed accurately reflected the assessed needs of patients, were kept under review and, where appropriate, adhered to recommendations prescribed by other healthcare professionals. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate.

Relatives spoken with stated that they "trusted staff" to care for their loved ones and that "staff were loving, kind and attentive to all patients". Relatives also stated they had confidence in the staff to deliver the right care at the right time to ensure the best possible outcome for their loved one. Patients were confident of the ability of staff to meet their need effectively and in a timely manner. Patients confirmed that the registered manager was available to them.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to

be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities.

A recommendation was made regarding the displaying of patient information on 'whiteboards' viewed in dining rooms and nursing offices, which had the potential to compromise patient confidentiality.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in section 4.4 patient and relatives were positive in their comments regarding the staffs' ability to deliver care and respond to needs and/or requests for assistance. The attitude and actions of staff were commended.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients and relatives confirmed that this knowledge also ensured that staff provided assurance and comfort when needed. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

It was evident that the home provided a varied and comprehensive programme of activities which was considerate of various levels of participation. Patients and relatives spoke highly in relation to the activity therapists.

In addition to speaking with patients, relatives and staff, RQIA provided 10 questionnaires for staff and relatives and eight patient questionnaires for distribution by the registered manager. At the time of writing this report seven relatives and eight staff returned their questionnaires. Refer to section 4.5 for further details.

There were no requirements or recommendations made.

Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patient and relatives spoke in positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents and accidents.

However, it was evident that a more robust method of recording the analysis and outcomes of audits was needed to clearly evidence the action taken by the registered manager in response to the audit's findings. A recommendation was made

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives.

Based on the inspection findings detailed in the body of the report which included: review of records, systems and processes; comments from patients, relatives and staff, it was evident that Cornfield Care Centre (Green Lane and Castle Lane) was well led. The registered manager demonstrated how she manages and leads her team to ensure delivery of safe, effective and compassionate care as part of her day to day operational control of the home.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Heather Moore, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent finance inspection

The most recent inspection of the home was an announced finance inspection undertaken on 16 June 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Cornfield Care Centre	**Registered manager:** Mrs Heather Moore
Person in charge of the home at the time of inspection: Mrs Heather Moore	**Date manager registered:** 26 August 2015
Categories of care: NH-I, DE, PH, PH(E) and TI A maximum of 23 patients in category NH-I; one patient in category NH-TI; one patient in category NH-PH; one patient in category NH-PH(E) and a maximum of 26 patients in category NH-DE. The home is also approved to provide care on a day basis to two persons.	**Number of registered places:** 52

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

During the inspection the inspectors spoke with 11 patients individually and greeted others in small groups, seven care staff, four registered nurses, two catering staff, three members of staff from housekeeping, one staff member from the laundry service, five relatives and the diversional therapist.

In addition questionnaires were provided for distribution by the registered manager; 10 for relatives, eight for patients and 10 for staff. Seven relatives and eight staff returned their questionnaires within the timescale specified. Details of their responses can be viewed in section 4.5.

The following information was examined during the inspection:

- seven patient care records
- staff roster from 26 September to 9 October 2016
- staff training and planner/matrix for 2016
- staff supervision and appraisal planners
- competency and capability assessment for nursing staff left in charge of the home
- one staff recruitment record
- records relating to registration checks with Nursing and Midwifery Council (NMC) and the Northern Ireland Social care Council (NISCC)
- complaints record
- incident and accident records
- record of quality monitoring visits carried out in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- records pertaining to consultation with staff, patients and relatives
- audit and governance records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 June 2016

The most recent inspection of the home was an announced finance inspection. The completed QIP was returned and approved by the finance inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next finance inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 23 February 2016

There were no requirements of recommendations made as a result of the last care inspection.

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subjected to regular review to ensure the assessed needs of the patients were met. A review of the staffing rota from 26 September to 9 October 2016 evidenced that the planned staffing levels were adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. New staff were supported through their induction by a dedicated mentor. Review of one staff member's induction evidenced the record to be completed in full and signed/dated by the inductor and inductee.

Review of the training planner/matrix 2016 indicated that training was planned to ensure that mandatory training requirements were met. Staff confirmed that they were required to complete mandatory training. Discussion with the registered manager and review of records evidenced that a robust system was in place to ensure staff attended mandatory training.

We were informed that care staff had completed a training course on dementia care for healthcare assistants. The content of the training included topics such as understanding dementia, communication and responding to behaviours that challenge staff and the service. We observed staff responding to a patient who was distressed. Staff were sensitive to the needs of the patient and their response to the patient calmed and diffused the situation. This was evidence of good practice and of the knowledge gained, through training being embedded into practice.

A planner was in place to manage staff supervision sessions and annual appraisals. Discussion with staff and the registered manager confirmed that supervision sessions were meaningful and relevant to their role and function in the home.

The registered manager and staff spoken with demonstrated the knowledge and skill necessary to fulfil their role, function and responsibilities in general and specifically in relation to adult safeguarding and the management of restraint. Receipt of information post inspection confirmed that any patient subject to restraint, such as a lap belt, had their care appropriately monitored and reviewed.

Staff described their role and responsibilities with enthusiasm and said that they were enabled to deliver “excellent care”. Patients and relatives spoken with confirmed that they were assured and confident of the staffs’ ability to care for their loved ones and that they ‘trusted’ staff to always do the right thing.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC). Safety and medical alerts were reviewed on a regular basis and relevant notices were ‘actioned’ and/or disseminated to staff as required.

Review of seven patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of records pertaining to accidents, incidents and notifications, forwarded to RQIA since the last care inspection on 23 February 2016, confirmed that these were managed appropriately. Audits of falls and incidents were maintained, which provided an account of the number, timing and outcome of accidents occurring in the home. This information also informed the responsible individual’s monthly monitoring visit in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A recommendation has been made under ‘is the service well led’ domain regarding the evaluation and analysis of audit outcomes. Refer to section 4.6 for details.

A review of the home’s environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm, well decorated to a high standard, fresh smelling and clean throughout. Housekeeping staff were commended for their efforts. Stores observed evidenced that staff had access to ample supplies such as bed linen, towels, wipes, gloves and aprons. Patients, relatives and staff spoken with were complimentary in respect of the home’s environment.

As previously stated both Castle Lane and Green Lane suites afforded a high standard of accommodation and comfort to patients. Both suites had spacious lounge areas for the patients to enjoy with the seating arranged around the walls. The seating arrangements were discussed with the registered manager as the current arrangement did not promote or enable a more domesticated and homely appearance, or facilitate communication between, and companionship amongst, patients. In Castle Lane suite we were informed that visitors are encouraged to either use the patient's bedroom or the smaller quiet lounge when visiting. Staff stated this was to protect the dignity of a patient/s, in the lounge, should they display a behaviour which may be challenging. Whilst staffs response was understandable the registered manager was advised to review the policy on visiting arrangements in accordance with best practice in dementia care.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

One member of staff was observed not adhering to the home's uniform policy and basic infection prevention and control measures, by wearing nail polish. This was discussed with the registered manager and RQIA were assured that the matter would be addressed immediately.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments informed the care planning process and both were reviewed as required. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. Care records reviewed, accurately reflected the assessed needs of patients, had been kept under review and, where appropriate, adhered to recommendations prescribed by other healthcare professionals such as speech and language therapist (SALT) or dieticians. Registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records. Relatives confirmed that they were kept informed of any changes in their loved ones' care and were complimentary regarding the level of communication they experienced. One relative was pleased that the registered manager knew them and was aware of their loved one's needs.

Relatives spoken with stated that they "trusted staff "to care for their loved ones and that "staff were loving, kind and attentive to all patients". Relatives also stated they had confidence in the staff to deliver the right care at the right time to ensure the best possible outcome for their loved one.

Electronic supplementary records such as repositioning/food and fluid intake records evidenced that these records were maintained in accordance with best practice guidance, care standards and legislative requirements. Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records. However, a recommendation was made regarding the displaying of patient information on 'whiteboards' viewed in dining rooms and nursing offices. This information could easily be read by a member of the public and it contained specific and confidential patient information.

Observations evidenced that call bells were answered promptly and patients requesting assistance in one of the lounge areas or their bedrooms were responded to in a calm, quiet and caring manner. Patients were confident of the ability of staff to meet their need effectively and in a timely manner.

Staff confirmed that they were kept informed of changes or concerns regarding patients' needs through the handover reports at the beginning of their shift. Staff also confirmed that regular staff meetings were held, that they contributed to the agenda and that minutes were made available. Staff meetings for registered nurses and care assistants were held quarterly. The review of the minutes of staff meetings evidenced that the registered manager also held frequent meetings with specific grades of staff, for example; housekeeping staff and catering staff. This was good practice. Review of the minutes evidenced that the registered manager listened to the contribution of staff and had implemented the suggested changes.

Staff stated that there was 'effective teamwork'; this was evidenced through discussion and observation of interactions throughout the inspection process. Staff stated they were 'proud' to be a part of their team and to 'make a difference'. Each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with the nurse in charge or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with the patients, with their colleagues and with other healthcare professionals.

Effective communication with patients and their relatives was evident on a one to one basis as recorded in the care records and through observations of interactions. Patients confirmed that the registered manager was available to them on a daily basis.

There was information available to staff, patients, representatives in relation to activities, the availability of reports and additional information regarding various medical conditions and support services available.

Areas for improvement

A recommendation was made regarding the displaying of patient information on 'whiteboards' viewed in dining rooms and nursing offices.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. As stated in section 4.4 patient and relatives were positive in the comments regarding the staffs' ability to deliver care and respond to needs and/or requests for assistance.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Patients and relatives confirmed that the details known by staff also ensured that staff provided assurance and comfort when needed. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. For example, patients, relatives, visitors to the home and staff were invited to provide feedback on an ongoing basis by speaking with staff and with the registered manager on a daily basis. The registered manager confirmed that she operated an 'open door' approach and "that anyone could come to speak with her at any time".

All patients and relatives spoken with commented positively regarding the care they received and the staffs' caring and kind attitude. In particular the registered manager was mentioned for her calm, quiet, and professional attitude and for the changes she had implemented since her appointment. It was evident good relationships had been developed and that there was a high level of confidence in the staffs' ability to deliver care and to address concerns effectively. Patients spoken with said that staff "made a difference to their life in the home"; and that staff knew what to do when "something wasn't right". The attitude and actions of staff were commended.

It was evident that the home provided a varied and comprehensive programme of activities which was considerate of various levels of participation. Patients and relatives spoke highly in relation to the activity therapists.

In addition to speaking with patients, relatives and staff RQIA provided ten staff and relatives and eight patient questionnaires for distribution by the registered manager. At the time of writing this report seven relatives and eight staff returned their questionnaires.

Comments and outcomes were as follows:

Patients: There were no patient questionnaires returned.

Relatives: Comments recorded included

- ''Staff are kept very busy."
- "I believe my … is well cared for here. I also believe the staff are excellent and always have time for me if I want to discuss anything about my … care."
- "Staff appear to be rushing most of the time. Always to a schedule but get the task done regardless."
- "I am very content that my … is in a safe environment with compassionate and friendly carers."
- "Staff appear to be very busy and are often under pressure…"

All but one relative indicated that they were very satisfied with the care provided in all areas questioned. The one relative indicated that they were satisfied and, as with others, did comment regarding staffing levels as detailed above. However, as discussed in section 4.3 review of duty rotas, observation of the delivery of care and discussion with staff evidenced that patients' needs were met by the levels and skill mix of staff on duty.

Staff: respondents indicated that they found the care provided was very satisfactory in relation to each the four areas/domains questioned. There were no additional comments recorded.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff confidently described their role and responsibility in the home. In discussion patients were aware of the roles of the staff in the home and to whom they should speak to if they had a concern. Patient and relatives spoke in positive terms in relation to the registered manager and their confidence in her leadership skills. Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients/representatives confirmed that they were confident that staff/management would address any concern raised by them appropriately.

Staff were knowledgeable of the complaints and adult safeguarding processes commensurate with their role and function. A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately. Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events, complaints, and/or potential adult safeguarding concerns were reported to RQIA or other relevant bodies appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, care records, infection prevention and control, environment, complaints, incidents/accidents. However, it was evident that a more robust method of recording the analysis and outcomes of audits was needed to clearly evidence the action taken by the registered manager in response to the audit findings. For example, while the audit of accidents occurring in the home indicated the time, place and number of falls, there was no clear evidence that the registered manager had reviewed the data in relation to patterns or trends emerging or of any action or direction she had given staff following the audit. RQIA were assured that these processes had been undertaken to ensure identified improvements were embedded into practice. However, as previously stated there was no clear record of this process evidenced a recommendation was made.

Review of reports and discussion with the registered manager evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and Trust representatives. It was good to see that the person carrying out the visit on behalf of the provider reviewed the previous action plan to ensure actions were addressed. Any action not completed in full was stated again for review during the next visit. This is good practice.

The registration certificate was up to date and displayed appropriately. A valid certificate of public liability insurance was current and displayed.

Discussion with the registered manager and observations evidenced that the home was operating within its registered categories of care.

Based on the inspection findings detailed in the preceding domains, review of records, systems and processes; and comments from patients, relatives and staff it was evident that Cornfield Care Centre (Green Lane and Castle Lane) was well led. The registered manager has demonstrated how she manages and leads her team to ensure delivery of safe, effective and compassionate care as part of her day to day operational control of the home.

Areas for improvement

It was recommended that audit records clearly evidence that the results of audits have been analysed and evaluated; that appropriate actions were taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Heather Moore, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** immediate action necessary.	The registered provider should ensure that patient information is stored securely and confidentially. For example, patient information on whiteboards should not be accessible to the general public. **Ref: Section 4.4** **Response by registered provider detailing the actions taken:** Patient information on whiteboards has been removed and is not accessible to the general public.
Recommendation 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that audit records clearly evidence that the results of audits have been analysed and evaluated; that appropriate actions were taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice. **Ref: Section 4.6** **Response by registered provider detailing the actions taken:** The accident audit template has been reviewed and updated to ensure that appropriate actions were taken to address any shortfalls identified to evidence that the necessary improvements had been embedded into practice..

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower
5 Lanyon Place
BELFAST

BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews