Willow Ward
Address: Bluestone Unit
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ

Dates of Inspection Visit: 26 - 28 July 2016

Names of Inspectors: Alan Guthrie, Dr Brian Fleming, Patrick Convery

This report describes our judgement of the quality of care at Willow ward. It is based on a combination of what we found when we inspected and from a review of all of the information available to The Regulation and Quality Improvement Authority (RQIA). This included information given to us from patients, the public and other organisations.

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in this service. The findings reported on are those that came to the attention of RQIA during the course of this inspection while assessing the four stakeholder outcomes under this year's theme of Patient Centered Care. The findings contained in this report do not exempt the Trust from their responsibility the Mental Health (Northern Ireland) Order 1986 and the Department of Health (DoH) standards. It is expected that the areas for improvement outlined in this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Contents

1.0 Details of Ward

Willow Ward is a twenty bedded ward which provides psychiatric assessment, care and treatment to male and female patients aged 65 years and over. The ward can also accommodate five patients aged 50 - 64 years. On the days of the inspection the ward was at full capacity. Three of the patients had been admitted to the ward in accordance with the Mental Health (Northern Ireland) Order 1986. Patients were supported by three consultant psychiatrists and a multi-disciplinary team (MDT) that included: nursing staff, an occupational therapist, domestic and catering support staff and advocacy services.

Patients could also access social work, psychology, physiotherapy, speech and language therapy and dietetics through referral.

2.0 Summary of this Inspection

This inspection focused on the theme of Person Centred Care.
This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

RQIA noted that Willow ward was a well maintained and welcoming ward. Inspectors found that ward staff provided compassionate care to patients. This was evidenced through patients' and relatives' comments and through assessment of the ward's environment. Patients and relatives stated that the care and treatment they had received was to a high standard. Patients were also positive regarding their relationships with staff and complimentary regarding the manner in which staff supported them and their relatives. The ward's environment was very therapeutic and ward staff maintained the ward's gardens to a very high standard. The ward was clean and the atmosphere was calm with patients presenting as being at ease and comfortable in their surroundings. Patients who met with an inspector stated that they felt safe on the ward.

The leadership and management within the ward were of a high standard. This was evidenced through review of the ward's processes, the experience of patients and the views of staff. All staff appeared to work well together and staff described the MDT as effective and inclusive. Staff reported that they enjoyed working on the ward and that the quality of care and treatment provided to patients was of a high standard.

One priority one area for improvement has been made. This concerns the completion of patient care records on the Trust's PARIS electronic patient information system. Two priority three areas for improvement have been made. These relate to the availability of occupational therapy staff and the review and updating of two Trust policies.

Follow up on Previous Inspection Recommendations

Eight recommendations were made following the most recent inspection on 29 July 2015. All of the recommendations had been implemented in full.

1. The ward was equipped with twenty profiling beds. Each of the patient recovery plans reviewed by inspectors evidenced continued assessment of risk in relation to the use of a profiling bed with the patient. Recovery care plans were individualised and reviewed on a weekly basis.

2. Inspectors reviewed the ward's ligature and environmental assessment and management tool. An up to date assessment had been completed on 30 June 2016. The assessment included reference to patient beds. Comments, actions required and recommendations for management of beds were noted to be appropriate and commensurate to the needs of the patient group.

3. Patients' care plans reviewed by inspectors evidenced that each patient's care and treatment had been reviewed and updated in accordance with Trust policy and professional guidelines. Patient continuing care records reviewed by inspectors evidenced that decisions made by the MDT were shared directly with the patient.

4. Patient care records reviewed by inspectors evidenced that patient participation and progress in therapeutic activities was recorded. These records were up to date and available on the Trust's PARIS electronic patient information system.

5. Patient recovery plans examined by inspectors included a therapeutic and leisure activity section. This section assessed the patient's strengths and needs and an action plan to support the patient's progress. Recovery plans were reviewed on a weekly basis by nursing staff and the MDT.

6. Records reviewed by inspectors evidenced that the Occupational Therapist (OT) had completed an assessment of each patient's circumstances. Continuing care records, care plan reviews and MDT reviews evidenced that patient involvement in therapeutic and recreational activities was continually reviewed and recorded. This included a record of when a patient may have declined to participate in an activity.

7. Inspectors evidenced that restrictive practices implemented as part of a patient's care and treatment plan were recorded in the patient's recovery care plan. The use of a restrictive practice was clearly documented, continually reviewed by nursing staff, and the wider MDT, and discussed with the patient.

8. Inspectors reviewed three sets of patient care records. Patient assessments, risk assessments, care plans and continuous care records were all recorded on the Trust's PARIS system. Records evidenced that all clinical staff updated patient progress on the PARIS system.

3.0 How we Carried Out this Inspection

RQIA's programmes of inspection, review and monitoring of mental health legislation focus on four specific and important key stakeholder outcomes:

Is Care Safe?
Is Care Effective?
Is Care Compassionate?
Is the Service Well Led?

What the inspector(s) did:

- reviewed a range of information relevant to the facility sent to RQIA before the inspection. This included policies and procedures, staffing levels, ward aims and objectives and governance protocols;
- talked to patients, carers and staff;
- observed staff working practices and interactions with patients on the days of the inspection;
- reviewed other documentation on the days of the inspection. This included care records, incident reports, multi-disciplinary procedures and staff training records; and
- reviewed progress since the last inspection.

At the end of the inspection the inspector(s):

- commended areas of good practice;
- shared the inspection findings with staff; and
- highlighted areas for improvement.

4.0 What People Said about this Service

Patients Stated:

During the inspection inspectors met with ten patients. Five of the patients met with an inspector on a one to one basis and completed a questionnaire. Patients informed the inspector that the staff were helpful and supportive. Patients stated that they were involved in their care and treatment and that they had felt better since being admitted to the ward.

Patient involvement in their care and treatment was witnessed during interactions observed by the inspector. Patient involvement was also detailed in patient care records. All of the patients who spoke to the inspector stated that ward staff treated them with dignity and respect.

Patients Said:

“Staff are nice people”.

“It’s o.k.”.

“Foods good”.

“There’s activities”.

“It’s a good place here”.

“The facilities and staff are good”.

“The staff could not have treated me any better”.

“The service is good…beds are comfortable and the emergency button is handy”.

“The staff pulls together”.

“Excellent… couldn’t say anything else”.

“This is the most modern bedroom I have ever seen…staff are excellent”.

During the inspection patients’ relatives were invited to meet with an inspector. Five relatives met with an inspector. Relatives were complimentary regarding ward staff approach, attitude and support. Relatives stated that they were involved in patient care and ward staff listened to their views and kept them up to date regarding patient progress. Relatives reported no concerns regarding their ability to meet with members of the ward’s MDT.

Relatives Stated:

“Wonderful staff team….they lift patients and really care for them”.

“**** has made excellent progress. The staff really know what they are doing”.

“We have good communication with the ward sister”.

“We have found staff helpful and easy to talk to”.

“I feel as valued as my relative. This has helped me through a very difficult time”.

Inspectors left a number of questionnaires with the ward manager to distribute to relatives/representatives as required. Two questionnaires were returned to RQIA. Both questionnaires recorded positive comments.

Staff Stated:

Inspectors met with ten members of the ward’s MDT incorporating the views of both clinical and support staff. Staff told inspectors that they felt the MDT was supportive and effective. Every member of staff stated that they felt the ward put patients first and that the team worked well together. Staff also reported that they enjoyed working on the ward and that they felt their role and contribution to patient care was valued. Staff reported no concerns regarding their ability to access support, supervision, training and appraisal.

Inspectors met with four members of nursing staff. Staff demonstrated understanding of the ward ethos, purpose and policies and procedures. Nursing staff stated that the ward was a positive environment for patients and promoted a recovery culture. Staff reported no concerns regarding their role and responsibilities. It was positive to note that staff stated that they found the ward’s MDT to be inclusive, effective and supportive. Staff were also complimentary regarding the support they received from the ward manager.

Medical staff informed inspectors that the ward functioned well and relationships within the MDT were positive. Staff stated that the nursing care provided to patients was of a high standard and the ward had good occupational therapy input. Staff informed inspectors that relationships with patients’ relatives were very positive. Contact with other clinical specialisms was described as good including access to neurology and general medicine. Staff highlighted the challenges to accessing a geriatrician and in providing highly specialised care to patients suffering from long-term chronic psychiatric conditions.

Clinical staff informed inspectors that the introduction of all records being retained in electronic format remained challenging. Staff cited difficulties to ensure protected time to allow them to update care records in a timely and continuous manner. This concern is discussed in the quality improvement plan accompanying this report. The ward’s Occupational Therapist (OT) provided a range of activities relevant to the needs of the patient group. Inspectors were concerned to note that the OT worked

between two wards providing therapeutic interventions and OT assessments. Subsequently, the OT's ability to provide the range of therapeutic services to both wards was limited. Inspectors were informed that the trust was in the process of recruiting another OT. This issue is discussed in the quality improvement plan.

5.0 Our Assessment of the Four Stakeholder Outcomes

5.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Key Indicator S1 - There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.

Examples of Evidence:

- ✓ Patient care records reviewed by inspectors evidenced patient involvement in their risk assessments, recovery care plans and their occupational therapy assessment.
- ✓ Patient care records evidenced that care and treatment provided to each patient was individualised and based on the assessed needs of the patient.

Area for Improvement:

- ✘ None identified.

Key Indicator S2 - The premises and grounds are safe, well maintained and suitable for their state of purpose.

Examples of Evidence

Ward Environment: Inspectors assessed the ward's physical environment using a ward observational tool and check list.

- ✓ Patients reported that they felt safe on the ward.
- ✓ The ward was clean, tidy and well maintained. The ward was also fresh smelling and configured in a manner appropriate to the needs of the patient group.
- ✓ Environmental risk assessments and a health and safety audit had been completed and were up to date. Appropriate control measures to manage presenting risks had been introduced.

- ✓ A ligature risk management action plan detailed that a number of identified ligature points should be managed by ward staff. The ward manager reported that ward staff had expressed no concerns regarding their ability to manage and review ligature points.
- ✓ Each patient had an individualised risk assessment completed which included an ongoing assessment of risk and the use of a profiling bed.

Area for Improvement:

- ✘ None identified.

Key Indicator S3 - **There are at all times, suitably qualified, competent and experienced persons working in the facility.**

Examples of Evidence

- ✓ Inspectors met with representatives from each profession within the MDT and ward support staff. No member of staff reported any concerns regarding their role, experience or training.
- ✓ Staff had completed up to date mandatory training.
- ✓ Staff supervision and appraisals were completed in accordance to the required standards.
- ✓ Staff informed inspectors that they enjoyed working on the ward and that the MDT worked well together.

Area for Improvement:

- ✘ None identified.

Key Indicator S4 – **Patients are detained appropriately with information provided about their rights and how to make a complaint.**

Examples of Evidence:

- ✓ Inspectors evidenced appropriate arrangements in place to ensure the discharge of statutory functions in accordance to the Mental Health (Northern Ireland) Order 1986.
- ✓ Patients knew how to make a complaint and how to access the advocacy service.

Area for Improvement:

- ✘ No areas were identified for improvement in relation to safe care.

5.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Key Indicator E1 - Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients.
Care and treatment is evaluated for effectiveness. Effective discharge planning arrangements are in place.

Examples of Evidence:

- ✓ Patient care records evidenced that care and treatment plans were based on each patient's individually assessed needs. Plans were reviewed daily by the MDT and comprehensively on a weekly basis during each patient's review.
- ✓ Care records reviewed by inspectors evidenced, when appropriate to the patient's mental health, active participants in their care and treatment planning. Patient recovery care plans were completed in a manner that reflected the patient's perspective.
- ✓ MDT records evidenced that each patient's progress was continually reviewed.
- ✓ Patient care records evidenced that discharge planning commenced upon each patient's admission. Records demonstrated that each patient's discharge was considered on a continuous basis.
- ✓ One patient's discharge from the ward had been significantly delayed. It was positive to note the ward's senior management team continued to implement appropriate steps in relation to the patient's discharge plan. This included providing ongoing comprehensive reviews of the patient's progress and circumstances.
- ✓ Patient care records were centrally retained in the Trust's PARIS patient information system.

Areas for improvement:

- ✘ Protected time for staff to ensure patient care records are appropriately and comprehensively updated on the Trust's PARIS system.

Key Indicator E2 - Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised

Examples of Evidence:

- ✓ The ward was located in a modern purpose built facility which was designed in accordance to best practice guidance.
- ✓ Care records evidenced that the use of restrictive practices was based on each patient's individualised assessed need and presenting risk. Inspectors evidenced that restrictions were used proportionally and as a last resort.
- ✓ The ward promoted a least restrictive practice culture as evidenced by the limited use of restraint, observation and by the continued review of the need for restrictive care interventions.

Area for Improvement:

- ✘ None identified.

5.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Key Indicator C1 - There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.

Observations - Effective and therapeutic communication and behaviour is a vitally important component of dignified care. The Quality of Interaction Schedule (QUIS) is a method of systematically observing and recording interactions whilst remaining a non-participant. It aims to help evaluate the type of communication and the quality of communication that takes place on the ward between patients, staff, and visitors.

Inspectors completed direct observations using the QUIS tool during the inspection and assessed whether the quality of the interaction and communication was positive, basic, neutral, or negative.

- **Positive social (PS)** - care and interaction over and beyond the basic care task demonstrating patient centred empathy, support, explanation and socialisation
- **Basic Care (BC)** – care task carried out adequately but without elements of psychological support. It is the conversation necessary to get the job done.
- **Neutral** – brief indifferent interactions.
- **Negative** – communication which is disregarding the patient's dignity and respect.

Examples of Evidence:

Observations of interactions between staff and patients/visitors were completed throughout the days of the inspection. There were three interactions recorded in this time period. The outcomes of these interactions were as follows:

Positive	Basic	Neutral	Negative
100%	0%	0%	0%

- ✓ Interactions between patients and staff were witnessed by an inspector as being supportive and positive.
- ✓ Inspectors met with five patients. Patients reported that they felt staff were supportive and helpful. Patients were complimentary regarding staff attitude and approach.
- ✓ Patient involvement in their care and treatment was evidenced during interactions observed by inspectors and within patient care records.
- ✓ All of the patients who spoke to inspectors stated that they were treated with dignity and respect.
- ✓ Care records evidenced that restrictive practice interventions had been used appropriately and in accordance to the required standards.
- ✓ Patients and relatives who met with inspectors were complimentary about the ward's design, atmosphere and the support they received from the staff team particularly nursing staff.

Area for Improvement:

- ✘ None identified.

Key Indicator C2 - There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.

Examples of Evidence:

- ✓ Patients who met with inspectors stated that they attended their ward meeting and staff kept them informed about their care and treatment plans.
- ✓ Patients stated that their views were sought and considered.
- ✓ Nursing staff demonstrated appropriate understanding in relation to relevant policies, procedures and evidence based practice.
- ✓ Patients could access the advocacy service as required.
- ✓ The advocate informed inspectors that the ward supported and promoted the role of the advocacy service.
- ✓ Patients stated that they were satisfied with the MDT approach to their relatives/carers.

Area for Improvement:

✘ No areas were identified for improvement in relation to compassionate care.

5.4 Is The Service Well Led?

Effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Key Indicator WL1 - **There are appropriate management and governance systems in place to meet the needs of patients.**

Examples of Evidence:

- ✓ Inspectors met members from each staff group within the MDT. Staff who met with inspectors stated that they understood their role and responsibilities and the actions they should take to safeguard patients and their families.
- ✓ Inspectors reviewed the ward's safeguarding vulnerable adult procedures, child protection procedures and complaints and compliments records. These were noted to be appropriate.
- ✓ Inspectors reviewed all incidents that had taken place on the ward from April 2015. Incidents had been recorded appropriately and included a description of the circumstances and the action taken.
- ✓ Patient care records evidenced that safeguarding referrals were appropriately managed and incidents had been recorded and reviewed in accordance with Trust policy and procedure.

Area for Improvement:

✘ None identified.

Key Indicator WL2 - **There are appropriate management and governance systems in place that drive quality improvement.**

Examples of Evidence:

- ✓ All staff who met with inspectors stated that the MDT worked well and the ward provided a high quality of care and treatment to patients.
- ✓ There were effective systems in place to report and analyse incidents, accidents and serious adverse incidents.
- ✓ Staff evidenced a good level of understanding in relation to relevant policies, procedures and evidence based practice.
- ✓ Patient forum meetings were held on a monthly basis and facilitated by the ward's advocate. The advocate stated that patient concerns were addressed.
- ✓ Staff were proud of the care and treatment provided to patients on the ward.

Area for Improvement:

✘ Two Trust policies relevant to the ward were not reviewed by the required date.

Key Indicator WL3 - **There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.**

Examples of Evidence:

- ✓ Staff who met with inspectors stated that they understood their role and responsibilities within the ward.
- ✓ There was a clear management structure identifying the lines of responsibility and accountability.
- ✓ Staff had received up to date mandatory training, supervision and appraisal.
- ✓ Clinical ward staff who met with inspectors stated they had no concerns regarding the support they received and their ability to access appraisal and supervision.
- ✓ Staff stated that the MDT was supportive, effective and inclusive.

Area for Improvement:

✘ None identified.

Key Indicator WL4 - There are effective staffing arrangements in place to meet the needs of the patients.

Examples of Evidence:

- ✓ There were effective staffing arrangements in place and members of the staff team reported no concerns regarding staffing levels.
- ✓ On the days of inspection there was enough staff on the ward to attend to patient's needs.
- ✓ Staff stated that there were good working relationships between the members of the MDT.
- ✓ Staff were positive about their role and the effectiveness of the care and treatment provided to patients.

Areas for improvement:

- ✘ The ward did not have a full time Occupational Therapist.

6.0 Good Practice Noted

Inspectors evidenced that the MDT worked effectively together to provide good quality care to patients. There was clear objective evidence that patients were treated in a caring and compassionate manner and that care planning was patient centred and inclusive.

The ward's environment and atmosphere was very good and staff ensured that the ward garden was maintained to a high standard.

7.0 Quality Improvement Plan

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide a compliance plan to RQIA detailing the actions to be taken to address the areas identified.

Key areas for improvement were discussed with the ward manager and other staff from the Trust involved in providing care/treatment to patients in this ward as part of the inspection process.

The timescale for action on the areas for improvement commenced from the day of the inspection. The quality improvement plan requires to be completed by the Trust detailing the actions the Trust intend to take to make the required improvement and returning to RQIA within 28 days of receipt.

On return to RQIA the quality improvement plan will be assessed by the inspector.

Areas for Improvement		Timescale for Implementation in Full
Priority 1		
1	Patient care records retained on the Trust's PARIS system should be updated in a contemporaneous and consistent manner. Staff should have protected time to complete their records.	25 August 2016
Priority 2		
	No priority two improvements have been made.	
Priority 3		
2	The Trust's Corporate manadatory Training Policy and the Policy, Procedures and Guidance for Registered Nurses, Midwifes and Specialist Community Public Health Nurses on Safeguarding Children and Young People require review.	28 January 2017
3	The wards Occupational Therapist was not available on a daily basis Monday to Friday nine to five.	28 January 2016

Definitions for Priority Improvements

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

HSC Trust Quality Improvement Plan

WARD NAME	**Willow**	**WARD MANAGER**	**Mary Donnelly**	**DATE OF INSPECTION**	**26 - 28 July 2016**
NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN	MARY DONNELLY	**NAME(S) OF PERSON(S) AUTHORISING THE IMPROVEMENT PLAN**		LOUISE HALL ADRIAN CORRIGAN	

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

The areas where improvement is required, as identified during this inspection visit, are detailed in the inspection report and quality improvement plan.

The completed improvement plan should be completed and returned to team.mentalhealth@rqia.org.uk from the HSC Trust approved e-mail address, by 13 September 2016

Please password protect or redact information where required.

PRIORTY	TIMESCALE FOR IMPLEMENTATION IN FULL
1	This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified
2	Up to **3 months** from the date of the inspection
3	Up to **6 months** from the date of the inspection

Part A

Priority 1: Please provide details of the actions taken by the Ward/Trust in the timeframe **immediately** after the inspection to address the areas identified as **Priority 1**.

	Area identified for Improvement	Timescale for full implementation	Actions taken by Ward/Trust	Attached Supporting Evidence	Date completed
1	***Key Outcome Area – Is Care Effective?*** Patient care records retained on the Trust's PARIS system should be updated in a contemporaneous and consistent manner. Staff should have protected time to complete their records. **Minimum Standard 5.3.3 (a)** This area has been identified for improvement for the **first** time.	25 August 2016	All staff have a professional responsibility to complete care records whether paper or electronic. Staff will be advised that they will be supported in maintaining their daily workload to include sufficient time for record keeping. This will be done through staff meetings and individual supervision. It will also be commenced across all disciplines within the multidisciplinary team. This process will start immediately and will be ongoing.		

Part C

Priority 3: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement. The timescale within which the improvement must be made has been set by RQIA.

	Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
2	***Key Outcome Area – Is Care Well Led?*** The Trust's Corporate manadatory Training Policy and the Policy, Procedures and Guidance for Registered	28 January 2017	Corporate Mandatory Training Policy This has been updated and	

	Nurses, Midwifes and Specialist Community Public Health Nurses on Safeguarding Children and Young People **Minimum Standard 5.3.1 (c)** This area has been identified for improvement for the **first** time.		uploaded on the Trust Intranet. Policy, Procedures and Guidance for Safeguarding Children and Young People This policy requires updating but has been deferred due to the ongoing revision or regional guidance on minimum levels of safeguarding training, ongoing revision of regional safeguarding children supervision policy 2011 and the SBNI child protection policy and procedures as well as the recent publication of co-operating to safeguard children and young people in Northern Ireland. It is envisaged that this policy will be reviewed before the end of 2016.	
3	***Key Outcome Area – Is Care Well Led?*** The wards Occupational Therapist was not available on a full time basis Monday to Friday Nine to five **Minimum Standard 6.3.1 (a)** This area has been identified for improvement for the **first** time.	28 January 2017	This is a consideration that has been raised and reviewed within current resources. There is occupational therapist provision on the ward on a daily basis 9-5. There is a process for prioritising the work that is carried out by the Band 6 OT and the Band 4 technical instructor.	

TO BE COMPLETED BY RQIA

Inspector comment (delete as appropriate)	Inspector Name	Date
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information	Alan Guthrie	14 September 2016
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		

The **Regulation** and
Quality Improvement
Authority

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