Mental Health and Learning Disability
Inpatient Inspection Report
25 – 27 October 2016

Carrick Ward and Evish Ward

Acute Admission
Grangewood Hospital
Gransha Park
Londonderry
BT47 6TF

Tel No: 028 71860261/028 7186 4379

Inspectors: Audrey McLellan, Wendy McGregor and Dr Shelagh Mary Rea

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Assurance, Challenge and Improvement in Health and Social Care

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 service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What We Look For

2.0 Profile of Service

Evish and Carrick are acute admission wards situated in Grangewood Hospital. Evish provides assessment and treatment for female patients aged 18-65 and Carrick provides the same service for male patients aged 18-65. The wards are part of single-system crisis service which includes a crisis response home treatment team and an acute day care service. The service operates as one single seamless team working closely with community teams. This service appears to be a very effective model of care as the average weekly occupancy is 72% and the average length of stay is 10 days.

The wards can accommodate up to 30 patients in single ensuite bedroom accommodation. Each ward has three bedrooms which can be converted into an integrated Psychiatric Intensive Care Unit (PICU).

The wards are supported by a multi-disciplinary team (MDT) including; nursing staff, two consultant psychiatrists, two staff grade doctors, one registrar, 2 F1's, an occupational therapist, a pharmacist and two social workers. There is one ward manager responsible for the management of both wards and the management structure includes four deputy ward managers.

On the day of the inspection there were nine patients on Evish ward and eight patients on Carrick ward. There were five patients on Evish ward and four patients on Carrick ward who had been detained appropriately in accordance to the Mental Health (Northern Ireland) Order 1986.

3.0 Service Details

Responsible person: Elaine Way	**Position:** Chief Executive
Ward manager:	Liam Dunne
Person in charge at the time of inspection: Liam Dunne	

4.0 Inspection Summary

An unannounced inspection took place over three days from 25-27 October 2016.

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.

We assessed if the wards were delivering, safe, effective and compassionate care and if the service was well led

Evidence of good practice was found in relation to the leadership within the wards, the involvement of patients in their care and treatment, patients' access to activities on the ward and in the acute day hospital, the positive working relationships within the multidisciplinary team, the wards relationship with community teams and the promotion of quality improvement projects completed by all members of the MDT. It was good to note that there was evidence that physical interventions were used as a last resort given this ward supports patient who are in crisis. Staff demonstrated a good understanding of restrictive practices and gave examples of how they use de-escalation techniques before any physical intervention.

Areas requiring improvement were identified in relation to the recording of risk management plans, the completion of actions following the fire safety assessment, the collation of vulnerable adult referrals and the absence of clinical psychology within the MDT.

Concerns were raised in relation to the absence of a physical intervention policy and template to record and collate information in relation to physical interventions. However, the trust has developed a new procedure for this and has confirmed that a record sheet will be available for staff to use from 12 November 2016.

The carer advocate from CAUSE raised a number of concerns regarding patients' discharge. This was raised with the ward manager who advised inspectors that the advocate had not informed them of these concerns. The ward manager agreed to speak with the advocate in relation to this.

Patients said:

"Staff are very helpful."

"If there is an altercation or fight staff respond quickly, they support and encourage patients, and make them feel secure. There are no more floors /stairs in Grangewood which is positive for those having difficulty climbing stairs."

"Staff are very supportive dedicated workers. They make you feel so welcome. I am glad I came here."

"Amazing staff made me get well."

"Amazing support ……..sort out medication…….. clean wards……brilliant daycare."

A relative said:

"Carrick ward is an acute assessment unit in the Grangewood complex. The staff including catering and domestic blend well together, to create a trusting and caring relationship."

The findings of this report will provide the service with the necessary information to enhance practice and service user experience.

4.1 Inspection Outcome

Total number of areas for improvement	**9**

Findings of the inspection were discussed with trust representatives as part of the inspection process and can be found in the main body of the report.

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

The escalation policies and procedures are available on the RQIA website: https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

5.0 How we Inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006
- The Human Rights Act 1998
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002

Prior to inspection we review a range of information relevant to the service. This included the following records:

- The operational policy or statement of purpose for the ward
- Incidents and accidents
- Safeguarding vulnerable adults
- Complaints
- Health and safety assessments and associated action plans
- Information in relation to governance, meetings, organisational management, structure and lines of accountability
- Details of supervision and appraisal records
- Policies and procedures

During the inspection the inspector met with nine service users, 12 staff, two visiting professionals and three relatives.

The following records were examined during the inspection:

- Care documentation in relation to four patients
- Multidisciplinary team records
- Policies and Procedures
- Staff duty rota
- Staff supervision templates
- Clinical room records
- Environmental risk assessment
- Health and safety assessment
- Fire safety risk assessments
- Mandatory training records
- Records relation to the monitoring of incidents, accidents and serious adverse incidents
- Records relating to adherence to statutory requirements of mental health legislation
- Records relation to the monitoring of the average length of stay and discharge
- Minutes of patient forum meetings
- Minutes of ward manager meetings
- Minutes of a number of different governance meetings and senior staff meetings

- Safety brief template
- Staff planner record

During the inspection inspectors observed staff working practices and interactions with patients using a Quality of Interaction Schedule Tool (QUIS).

RQIA reviewed the recommendations made at the last inspection. An assessment of compliance will be recorded as met/ partially met/ not met.

6.0 The Inspection

6.1 Review of recommendations from the most recent inspections dated 17 July 2015 in Evish Ward and 28 July 2015 in Carrick ward.

The most recent inspection of the wards were unannounced inspections. The completed Quality Improvement Plans (QIP) were returned and approved by the responsible inspector. The QIP's were validated by the responsible inspector during this inspection.

Recommendations		Validation of Compliance
Number: 1 **Standard:** 5.3.1(c) **Stated:** Second Time	It is recommended that the Trust insures that the Mental Health Services Protocol for the admission, treatment and discharge of children or young persons under 18 to adult wards is updated.	**Met**
	Action taken as confirmed during the inspection: The Mental Health Services Protocol for the admission, treatment and discharge of children or young persons under 18 to adult wards had been reviewed and updated in August 2015.	
Number: 2 **Standard:** 5.3.1 (a) **Stated:** Second Time	It is recommended that the Trust introduces a use of a physical intervention record. This record should record reasons why the intervention was necessary, the details of the staff involved and the outcome. A copy of the record should be retained in the patient's record. A further copy should accompany the associated incident report.	**Met**
	Action taken as confirmed during the inspection: The Trust has produced a new physical intervention policy Management of Actual or	

	Potential Aggression (MAPA). This is currently in draft form however senior representatives within the trust confirmed that the physical intervention record will be available for staff to use from the 12 November 2016.	
Number: 3 **Standard:** 4.3 (b) **Stated:** Second Time	It is recommended that the Trust ensures that policies and procedures requiring renewal are updated.	**Met**
	Policies and procedures relating to the ward were up to date.	
Number: 4 **Standard:** 5.3.3 (a) **Stated:** First Time	It is recommended that the ward manager ensures that information in relation to the multi-disciplinary team, when the ward round is held and the names of all staff on duty is displayed	**Met**
	Information in relation to the multi-disciplinary team, when the ward round is held and the names of all staff on duty was displayed on the wards notice boards.	

Follow up on the implementation of any recommendations made following the investigation of a Serious Adverse Incident	
No: 1 **SAI NO:** SAI 61-15	Based on the review of this incident it is proposed that AMH will progress the development of the Alcohol Liaison Nurse role within the crisis unit to enhance the skills and training of all staff in relation to the treatment and intervention for individuals dependant on Alcohol and Drugs along the continuum of their care needs.
	Senior trust representatives confirmed that a business case has been put forward for the support of an alcohol liaison nurse within the wards.
No: 2 **SAI No**: 61-15	For individuals exhibiting symptoms of Alcohol-Related Brain Damage (ARBD) specialist consultation will be considered as the Trust progresses the ARBD pathway.
	Senior trust representative confirmed that the implementation of this recommendation is in progress.

7.0 Review of Findings

7.1 Is Care Safe?

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

Areas of Good Practice

Patients were actively involved in designing and managing their own risk management plans and safety plan.

Risk management plans were individualised and were reviewed regularly by the multidisciplinary team.

A generic health and safety assessment had been completed in April 2016 with an action plan.

An environmental ligature risk assessment was completed on 23 June 2016 which detailed actions required to manage risks on the wards.

Staff knew who to raise concerns with when necessary.

Staff stated they felt well supported on the ward and that the MDT team worked well together.

Staff confirmed they do not work beyond their role and experience.

There was evidence that patients' rights had been explained to them when they had been detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The frequency of the use of physical intervention to support patients was low. This demonstrated that staff were using de-escalation and diversionary methods to avoid the use of physical intervention. Staff confirmed they worked towards the least restrictive practice.

There was information available on the detention process, patients' rights and how to make a referral to the Mental Health Review Tribunal (MHRT).

Staff were observed gaining consent from patients prior to supporting them with their care and treatment.

Relatives and patients stated they knew how to make a complaint.

Information regarding the complaints procedure was displayed throughout the ward.

Areas for Improvement

Risk management plans were in place in the review section of the template. Concerns were raised regarding this as staff had to review the update section to identify the most up to date management plan.

A fire safety assessment had been completed on 5 September 2016 for Carrick ward and on 19 July 2016 for Evish ward. A number of required actions were assessed as high risk in the Evish assessment but there no evidence that these had been actioned within the timeframe. The ward manager advised a number of these areas had already been actioned but the assessment had not been updated to reflect this. They also confirmed they were working on implementing outstanding actions.

The ward information booklet could be enhanced by adding information regarding the complaints procedure, the patient and client counsel and the carers advocacy service (CAUSE).

Medicine kardexes did not always record the indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line.

Number of areas for improvement	**4**

7.2 Is Care Effective?

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

Areas of Good Practice

Patients' needs were comprehensively assessed on an ongoing basis.

All professionals involved in patients' care documented their involvement in one set of progress notes.

Care plans were updated when patients' needs had been reviewed to reflect the change to their care and treatment.

Care plans were holistic and had been signed by patients. If patients disagree with their care plans this was also recorded.

There was evidence that the care and treatment was delivered in line with current evidence based guidance and best practice standards

Patients had an individual therapy planner which was combined with ward based activities and activities in the day hospital.

Patients were assessed regarding their physical, nutritional and hydration needs.

The multidisciplinary team meetings were attended by all professionals which included occupational therapy, pharmacy, social work, staff from the home treatment team, the consultant psychiatrists, ward doctors and nursing staff.

Appropriate referrals were made to other professionals when discussed and agreed at the MDT meeting.

Patients were offered 1:1 time on a daily basis.

Staff who were interviewed by inspectors confirmed that they always had time to provide patients with 1:1 support.

Staff also reflected how 1:1 support was valuable in supporting patients' recovery and reducing incidents of aggression on the ward.

When patients were ready for discharge a discharge planning meeting was held and patients completed a safety plan.

It was good to note that MDT Meetings (interface meetings) were held on the ward each Monday morning with the community teams to ensure continuity of care for patients when they are discharged.

The ward appeared calm and relaxed, it was clean, clutter free and maintained to a high standard.

It was good to note patients could avail of the acute day hospital whilst an inpatient and could continue to attend this facility for a period of time when discharged.

There was evidence that the MDT reviewed patients detention regularly to ensure patients were experiencing the least restrictive option.

Deprivation of liberty (DOLS) care plans were in place in relation to the swiped access on and of the ward. These care plans detailed the restrictions in place in relation to each patient's individual needs.

Staff demonstrated a good understanding of deprivation of liberty and it was evident that staff worked towards the least restrictive intervention.

The patients' advocate stated that the care on the ward was good and staff were compassionate and had a gentle approach with patients. They stated that staff were calm and do not rush patients

Areas for Improvement

Some of the care documentation was not fully completed:

- The MDT template was completed in each care record to detail decisions agreed, the responsible person for implementing agreed actions. However, when the action was completed this was not always signed and dated.
- The medication on admission template had not signed in two out of the four care records.

- Two out of the four interim care plans not been completed fully.
- The formulation template was not completed in all four records reviewed.

Number of areas for improvement	1

7.3 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.

Areas of Good Practice

All interactions between staff and patients were observed as positive.

Patients who spoke to the inspectors confirmed that they were treated with dignity and respect.

Staff confirmed that they had time to support patients with their emotional needs.

Patients confirmed they were offered the opportunity for one to one time with staff each day.

Patients stated they can have a representative of their choice attend meetings about them.

All patients stated they either felt safe or if they did not feel safe they could speak to staff.

Patients and relatives confirmed they were involved in decisions about their care and treatment and that staff regularly discussed their progress.

There was evidence in the care records that staff had explained to patients the need for the use of any restrictive practice.

Patients and their relatives were satisfied with the care and treatment provided and the way staff treat them from admission to discharge.

An advocate from Foyle Advocacy attended the ward on Monday and Thursday of each week to support patients.

The advocates informed inspectors that staff were compassionate, that the care was good and all staff had a gentle approach and did not rush patients.

Areas for Improvement

The carer advocate from CAUSE did not have a presence on the ward and therefore missed opportunities to meet with patients' families to inform them of their role.

During an observation of a group session in the acute day hospital the inspectors noticed that the session was interrupted unintentionally by two visitors. One visitor came into the day hospital to deliver mail and another had been in a meeting with a staff member from the day hospital. This was noted to distract patients in the session.

Number of areas for improvement	2

7.4 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Staff demonstrated a good understating of their role and responsibility if they have a concern regarding patients' care and treatment on the ward.

Staff were aware of the trusts policy and procedure for managing incidents and accidents.

Governance arrangements were in place to monitor the prescription and administration of medication.

The wards had a full time pharmacist who attended the MDT meetings for patients on both wards.

There were robust governance arrangements in place to monitor the prescription and administration of medication.

Staff were involved in a number of quality improvement projects through the wards weekly micro-systems meetings such as;

- Reviewing staff morale which led to areas identified to improve communication on the wards;
- Analysing the outcome of patient experience questionnaires which resulted in improving communication regarding estimated date of discharge as this had been highlighted by patients as an area they were unclear about, and;
- Reviewing high dosage of medication and combination of antipsychotic monitoring.

Policies and procedures relating to the ward were up to date.

There were governance arrangements in place to monitor patients' length of stay on the ward and any delayed discharges.

Systems were in place to analyse risks, accidents and adverse incidents, serious adverse incidents and complaints so that services could be improved. Trends were analysed and if concerns are raised these were discussed at the micro-system meeting or discussed at team meetings.

The ward manager held weekly staff meetings and minutes of these meetings were shared with all staff. The ward manager also monitored staff attendance at these meetings.

There was evidence that information was cascaded to the ward staff from governance meetings.

A number of audits were completed on a monthly basis by the ward manager.

- Aggression and violence on the ward.

- Absent without leave (AWOL's)
- Medication errors
- Incidents of self-harm
- Outcome of patient satisfaction surveys.
- Average length of patients stay on the ward.

There was evidence that the ward manager analysed incidents on the ward and used the outcomes to improve the safety of patients and staff on the wards.

It was good to note a new process had been implemented to ensure all staff were aware of risks, incidents and concerns on the ward. This was called a 'safety debriefing' meeting which was held each morning and was attended by all staff including the ancillary staff. Staff advised inspectors that the introduction of this meeting helped them to feel safe on the ward.

There was a 'Daily Planner' completed each day to record each staff member's role throughout their shift.

Weekly patient forum meetings were held on the ward

Complaints and compliments were recorded on the trust's dashboard. There had been three complaints over the past year which had been dealt with according to the trusts policies and procedures.

There was a defined organisational and management structure in place. Staff who spoke to the inspectors were aware of this structure.

All staff including the MDT who met with the inspectors confirmed that they had up to date appraisals in place and received supervision as per their professional / governance guidance.

No concerns were raised regarding the level of staff on the ward.

There were some gaps in the staff mandatory training however, the ward manager had an action plan in place to address these deficits.

The inspectors interviewed members of the MDT and they confirmed that the MDT worked well together and that they were well supported by their colleagues

Areas for Improvement

Information was not collated and analysed in relation to vulnerable adult referrals as this could not be recorded onto the DATIX system.

There was no ward based clinical psychologist. Senior management advised that they had completed a business case in relation to this as they had identified this as a gap in the overall service.

Number of areas for improvement	**2**

8.0 Provider Compliance Plan

Areas for improvement identified during this inspection are detailed in the provider compliance plan. Details of the provider compliance plan were discussed at feedback, as part of the inspection process. The timescales commence from the date of inspection.

The responsible person should note that failure to comply with the findings of this inspection may lead to further escalation action being taken. It is the responsibility of the responsible person to ensure that all areas identified for improvement within the provider compliance plan are addressed within the specified timescales.

8.1 Actions to be taken by the Service

The provider compliance plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed provider compliance plan **20 December 2016**.

Provider Compliance Plan Evish Ward and Carrick Ward	
The responsible person must ensure the following findings are addressed:	
Priority 1	
Area for Improvement No. 1 **Stated:** First Time **Standard:** 5.3.1 (a) **To be completed by:** 24/11/16	A fire safety assessment had been completed on 5 September 2016 for Carrick Ward and on 19 July for Evish Ward. A number of actions were assessed as high risk in the Evish assessment but there no evidence that these had been actioned within the timeframe. **Response by responsible person detailing the actions taken:** All actions from Fire Risk Assessments have been completed.
Priority 2	
Area for Improvement No. 2 **Stated:** First time **Standard:** 5.3.1 (a) **To be completed by:** 22/12/16	Risk management plans were in place in the review section of the template. Concerns were raised regarding this as staff had to review these updates to identify the most up to date management plan. **Response by responsible person detailing the actions taken:** As discussed at the Inspection feedback. The team have highlighted the limited functionality within the Epex system where the E-risk is held in the patient record. At this point in time we are unable to change the system set up to show the most up to date Risk Management Plan at the top of this E-Risk form. Adult Mental Health is installing the PARIS to replace the current Epex system with a go-live date set for the 5th June 2017. The Team have been working with system developers to ensure that the current risk management plan will be most prominent in the Risk Management section of the patient record. In the meantime all staff are aware that to access and update the risk management plan within Epex that they will need to scroll to the bottom of the form.
Area for Improvement No. 3 **Stated:** First time	The ward information booklet could be enhanced by adding information regarding the complaints procedure, the patient and client counsel and the carers advocate service (CAUSE).

Standard: **To be completed by:** 22/12/16	**Response by responsible person detailing the actions taken:** The ward information booklet has been updated to reflect the area for improvement recommendation.
Area for Improvement No. 4 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 8/12/16	Some of the care documentation was not fully completed; • The MDT template was completed in each care record to detail decisions agreed, the responsible person for implementing agreed actions. However, when the action was completed this was not always signed and dated. • The medication on admission template had not signed in two out of the four care records • Two out of the four interim care plans not been completed fully. • The formulation template was not completed in all four records reviewed.
	Response by responsible person detailing the actions taken: The MDT Care-plan has been redesigned to incorporate the formulation template, thus ensuring that the formulation is reviewed at least on a weekly basis. The formulation template that was in use has been removed from the Integrated Care Pathway (ICP). The medical staff induction programme has been reviewed in order to highlight the necessity for completion of both the interim care plan and the medication on admission template. It has been highlighted through the Crisis Team Meeting and the weekly Nursing Staff Meeting that the MDT checklist needs to be completed fully, including dates and signatures of those responsible for implementing agreed actions. The Charge Nurse will design an audit tool in order to assess compliance with this recommendation.
Area for Improvement No. 5 **Stated:** First time **Standard:** 5.3.3 (a) **To be completed by:** 8/12/16	The carer advocate from CAUSE did not have a presence on the ward and therefore missed opportunities to meet with patients' families to inform them of their role.
	Response by responsible person detailing the actions taken: The Charge Nurse has had discussions with the CAUSE representative based in Grangewood regarding their role and opportunities to inform patients' families of their service. We have agreed that the CAUSE representative will provide leaflets at the entrance to each ward, that information regarding CAUSE will be included in the Patients' Induction Package, that CAUSE are linking in with the Crisis Team in the production of a Carer's Leaflet and that the CAUSE representative will have a more direct role in providing a link between families/carers and the Charge Nurse of the wards, particularly in cases where families/carers have issues regarding care

	provision/communication etc. There is also an annual Carers coffee morning co-hosted between CAUSE and Mental Health Staff which has improved awareness and relationships.
Area for Improvement No. 6 **Stated:** First time **Standard:** 6.3.2 (a) **To be completed by:** 8/12/16	During an observation of a group session in the acute day hospital the inspectors noticed that the session was interrupted unintentionally by two visitors. One visitor came into the day hospital to deliver mail and another had been in a meeting with a staff member from the day hospital. This was noted to distract patients in the session
	Response by responsible person detailing the actions taken: Banagher has put a system in place to reduce interruptions as much as possible. The entire Crisis Team have been informed of these changes at the Crisis Team meeting. The times for delivery of mail have been discussed and rearranged with support services to ensure delivery does not take place during sessions. A sign is erected on the entrance door to the unit to advise of group sessions taking place and not to interrupt. This has already been noted to have had a positive impact on the delivery of these sessions.
Area for Improvement No. 7 **Stated:** First time **Standard:** 5.3.2 (c) **To be completed by:** 22/12/16	Information was not collated and analysed in relation to vulnerable adult referrals as this could not be recorded onto the DATIX system.
	Response by responsible individual detailing the actions taken: The Charge Nurse has developed a database based on the RQIA pre-inspection template to collate and analyse adult safeguarding referrals for the Crisis Service Admission Unit.
Area for Improvement No. 8 **Stated:** First time **Standard:** 5.3.1 (f) **To be completed by:** 8/12/16	Medicine kardex did not always record the indication for Pro Re Nata (PRN) medication and whether it was to be administered as 1st line or 2nd line.
	Response by responsible individual detailing the actions taken: The Crisis Service Pharmacist, medical staff and Service Managers met to discuss this recommendation. Review of PRN medications is currently undertaken at the weekly MDT meeting. The group agreed that indications for use of PRN medication would be documented in the *special instructions* box on the kardex where appropriate.
Priority 3	
Area for Improvement No. 9	There was no clinical psychologist attached to the wards to form part of the MDT.

Stated: First time **Standard:** 4.3 (j) **To be completed by:** 27/4/17	**Response by responsible person detailing the actions taken:** A proposal to commission dedicated psychology resources for the acute crisis MDT is being developed by the Head of Crisis Service in conjunction with the Lead Psychologist and will be tabled at Adult Mental Health Senior Management Team in January 2017.

Name of person(s) completing the provider compliance plan	Liam Dunne		
Signature of person(s) completing the provider compliance plan	Liam Dunne	**Date completed**	13/12/16
Name of responsible person approving the provider compliance plan	Trevor Millar		
Signature of responsible person approving the provider compliance plan	Trevor Millar	**Date approved**	20/12/2016
Name of RQIA inspector assessing response	Audrey McLellan		
Signature of RQIA inspector assessing response	Audrey McLellan	**Date approved**	22/12/16

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