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Unannounced Care Inspection
of
47 Somerton Road

26 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced care inspection took place on 26 October 2015 from 10.00 to 17:30.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

Overall on the day of the inspection, concerns and areas of improvement were identified and are required to be addressed to ensure that care in the home is safe, effective and compassionate. These areas are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015, relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 Standards until compliance is achieved. Please also refer to sections 5.2 and 6.2 of this report.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 26 February 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	8

The details of the Quality Improvement Plan (QIP) within this report were discussed with Wayne Salvatierra, home manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Somerton Homes Ltd William Trevor Gage	**Registered Manager:** Wayne Salvatierra
Person in Charge of the Home at the Time of Inspection: Wayne Salvatierra	**Date Manager Registered:** Registration pending
Categories of Care: NH-LD	**Number of Registered Places:** 38
Number of Patients Accommodated on Day of Inspection: 34	**Weekly Tariff at Time of Inspection:** £637 per week

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: Communicating Effectively
Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were analysed:
- notifiable events submitted 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 plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report

During the inspection, we observed care delivery/care practices and undertook a review of the general environment of the home. We met with six patients, three care staff, one registered nurse, ancillary staff and two patients' representatives.

The following records were examined during the inspection:
- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- complaints records
- policies for communication and end of life care
- policies for dying and death and palliative and end of life care

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced estates inspection dated 4 August 2015. The completed QIP was returned and approved by the estates inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection

Last Care Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Regulation 19.1 **Stated:** First time	The registered person should ensure that continence assessments are completed for all patients	**Partially Met**
	Action taken as confirmed during the inspection: The review of nursing care records confirmed that a continence assessment had been completed for patients. However, the continence assessment had not been fully completed and did not identify the type of continence product required or the frequency and level of support required for each patient.	
Recommendation 2 **Ref**: Standard 19.1 **Stated:** First time	The registered person should ensure that care plans to manage continence are in place for each individual assessed need	**Partially Met**
	Action taken as confirmed during the inspection: The review of care plans in respect of continence management did not evidence that the care plan identified the type, size or colour of the continence product or the level of support assistance the patient required. Nursing staff had not provided this information following the completion of the continence assessment.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was not available on communicating effectively. A general communication policy was available however; the policy did not reflect the current best practice regional guidelines on Breaking Bad News. Discussion with four staff did not confirm that they were knowledgeable regarding this policy and procedure.

Training records did not evidence that staff had completed training in relation to communicating effectively with patients and their families/representatives. This training should

be arranged and include the procedure for breaking bad news as relevant to staff roles and responsibilities.

Is Care Effective? (Quality of Management)

Nursing care records in the home are computerised. A review of a sample of care records did not evidence that the breaking of bad news was discussed with patients and/or their representatives. Section 5.4 provides further information in respect of nursing care records.

There was evidence maintained in a separate file that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Care staff were consulted and discussed their ability to communicate sensitively with patients and/or representatives. When the need for breaking of bad news was raised, care staff felt this was generally undertaken by nursing staff. However, staff were aware of communication aids/cues, for example, non-verbal cues and gestures. They also felt their role was to empathise and to support patients and their representatives following sensitive or distressing news.

Is Care Compassionate? (Quality of Care)

Discussion was undertaken with staff regarding how they communicate with patients and their representatives.

All staff presented as knowledgeable and had a strong awareness of the need for sensitivity when communicating with patients and their representatives.

A number of communication events were observed throughout the inspection visit which validated that staff embedded this knowledge into daily practice. These observations included staff assisting patients with meals and speaking to patients with a cognitive or sensory impairment. There was a calm atmosphere in the home throughout the inspection visit.

Staff recognised the need to develop a strong, supportive relationship with patients and their representatives from admission to the home. It was appreciated by staff that this relationship would allow the delivery of bad news more sensitively and with greater empathy when required.

Areas for Improvement

A policy on communicating effecting should be written. The policy should reflect the regional guidance on breaking bad news.

A management system should be implemented to verify that staff are knowledgeable of the policy documentation in respect of communicating effectively and palliative and end of life care as per regional guidelines.

Training for staff in respect of communicating effectively should be arranged.

Nursing care records must provide nursing staff with the opportunity to discuss end of life wishes with patients and/or their representatives.

Number of Requirements:	**1**	**Number of Recommendations**:	**3**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

A reference manual, which included the management of palliative and end of life care and death and dying, had been made available for staff. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included information on bereavement counselling.

Registered nursing staff consulted were aware of and able to demonstrate knowledge of the Gain Palliative Care Guidelines, November 2013.

Staff training records regarding palliative and end of life care were unavailable at the time of inspection. However, the information was submitted to RQIA at a later date by the home manager who stated that the training completed by staff was as follows:

Palliative and End of Life Care (3 day Course) by NI Hospice
September 2013
3 registered nurses attended.

Syringe Driver Training
14th February 2014
1 registered nurse attended.

Pain Management
5th June 2014
2 registered nurses attended.

Syringe Driver Training
14th February 2014
1 registered nurse attended

Palliative Care (guidelines)
25th February 2015
2 registered nurses attended

End of Life Care in Nursing Homes
February 2015
2 registered nurses attended
6 care staff attended.

The review of staff induction training records did not confirm that palliative and end of life care was included. It is recommended that this aspect of care should become part of the staff induction training programme.

A review of the competency and capability assessments for registered nurses did not evidence that end of life care was included and that the assessments had been validated by the home manager. Section 5.5.2 provides further information in respect of nursing care records.

There was an identified link nurse in respect of palliative and end of life care at the time of the inspection

Discussion with nursing staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the manager, nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

Specialist equipment, for example syringe driver was in not use in the home at the time of inspection.

Is Care Effective? (Quality of Management)

A review of care records and discussion with nursing staff evidenced that patients' needs for palliative and end of life care were assessed and referrals had been made to the specialist palliative care service. However, the outcome from a review of nursing care records was concerning. Nursing care records are computerised. The system did not afford for a nursing assessment in conjunction with the patient and/or their representative regarding end of life wishes. Where a patient had been referred and assessed by the palliative care team from the Trust, a corresponding plan of care had not been written. The recommendations of the palliative care team were incorporated into other care plans. To ensure a holistic approach to care, including the management of hydration and nutrition, pain management and symptom management, palliative/end of life care plans, should have been developed and care needs monitored and evaluated.

Discussion with the manager, staff and a review of care records evidenced that environmental factors had been considered. Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Patients' representatives were enabled to stay for extended periods of time without disturbing other patients in the home.

A review of notifications of death to RQIA during the previous inspection year, evidenced they were appropriately submitted.

Is Care Compassionate? (Quality of Care)

Discussion with staff evidenced that they were aware of, through discussion with patients and/or their representatives the spiritual preferences regarding care. Staff stated that they had little experience in providing end of life care but felt they would be able to sit with patients, if family members were not available so as no patient passed away with no one present.

The manager stated that it had been a considerable period of time from staff had supported a patient at the end of life and as such a compliments record was not maintained.

Discussion with the manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Staff consulted confirmed that they would be given an opportunity to pay their respects after a patient's death. From discussion with the manager it was evident that arrangements were in place to support staff following the death of a patient. The arrangements included for example, bereavement support and staff meetings.

Areas for Improvement

Palliative and end of life care should be included in the induction training programme for nursing and care staff.

Care plans in respect of palliative/end of life wishes and care must be developed, monitored and evaluated in accordance with the assessed needs of patients. The recommendations of the specialist palliative care team should be reflected in patients' care plans, where applicable.

Number of Requirements:	**1**	**Number of Recommendations:**	**1**

5.5 Additional Areas Examined

5.5.1. Questionnaires

As part of the inspection process, we issued questionnaires to staff and patients representatives. On this occasion, questionnaires were given to patients; we observed care practice and spoke to patients on an individual and/or small group basis.

Staff Views

Eight completed staff questionnaires were returned. The response within four questionnaires was generally positive and staff felt patients were afforded privacy, dignity and respect at all times.

Management should consider and action the following areas where staff expressed dissatisfaction in the returned questionnaires:

Three staff were not satisfied with training in respect of palliative and end of life care.
Three staff were not satisfied that there were supportive systems in place to inform patients and staff of a death.
Two staff were not satisfied with the training available on the management of distressing symptoms at end of life care.
Four staff members were not satisfied with the training available on communicating effectively and breaking bad news.
Three staff were not satisfied that patients received timely support from the multi-disciplinary team e.g. DN, GP, dietician, continence advisor, OT, SALT.
Four staff were not satisfied with the arrangements in place to meet patients' spiritual, psychological and cultural needs.
Three staff were not satisfied there were supportive systems in place to enable staff to pay their respects following the death of a patient.

In discussion with the inspector staff raised concerns in relation to:

- Staff training was not available on a regular basis
- Communication within the home was poor, this included lack of regular staff meetings and limited information made available at the hand over report when commencing duty
- Staffing levels, including staff shortages due to casual sick leave

The manager was made aware of the concerns brought to the attention of the inspector by staff. The manager agreed to address the concerns, as far as possible.

Patients' Views

Four patients completed and returned a questionnaire. Comments were as follows:

Two patients were not satisfied they had access to religious support if required.
One patient did not feel confident that nursing staff listened to them.
One patient did not feel their pain was well controlled.
One patient did not feel they had as much independence as possible.
One patient did not feel their relatives/friends were made welcome by staff.

All patients stated they felt safe in the home, privacy was respected and staff treated them with dignity and respect.

Patients' Representatives' Views

Two relatives took the opportunity to meet with the inspector during the inspection. The representatives expressed their concerns regarding the care and support their relative was receiving from both the National Health Service and the home. The representatives stated they had informed the manager of the home of their concerns and had seen little improvement. It was agreed I would inform the home manager of the concerns which had been brought to RQIA's attention. This was done at the conclusion/feedback of the inspection.

Two questionnaires were completed and returned. Both were positive and the following comment was made:
"I am more than happy with the quality of support my … gets."

5.5.2. Governance and management arrangements

Wayne Salvatierra was appointed as home manager in June 2015 and is being supported in his post by Trevor Gage, responsible person. The importance of governance and management arrangements were discussed with Mr Salvatierra. Mr Salvatierra was advised to implement robust quality assurance/monitoring systems. These systems would include, for example, quality audits of the services provided by the home, regular staff meetings, as a collective team and by job roles and individual supervision. It was also discussed that there may be benefit in arranging a relatives' meeting. Other governance areas which arose during the inspection were the following:

Induction training

Four recent staff induction training records were reviewed. The review did not evidence that induction training had been fully completed by staff, signed and dated by both parties and validated by the home manager on completion. A requirement has been made.

Competency and capability assessment for a nurse in charge

The review of the competency and capability assessment for nurses did not evidence the assessment reflected the role and responsibilities of a nurse in charge of a nursing home. The assessment template was based on a hospital/clinical model and it did not readily translate to a care home environment. Evidence was not present of the signatures of both parties completing the assessment and they had not been validated by the home manager. A requirement has been made.

Nursing care records

As stated in sections 5.3 and 5.4 nursing care records were computerised records and did not afford for discussion in respect of the end of life wishes for a patient. However, the review of nursing care records also did not evidence that all aspects of the assessment schedules were being completed, that information was being transferred to individual care plans and that the content of care plans were being updated as and when patients' needs changed.

A care plan for the use of a restrictive practice did not clearly state the rationale for the use of the restrictive practice or that the continued need for the restrictive practice was being evaluated on a regular basis. The use of restrictive practice must be undertaken in accordance with regional best practice guidance. A recommendation has been made.

Complaints

The complaints record did not evidence the robust recording and management of complaints received into the home. Concerns had previously been brought to the attention of RQIA by a complainant. The concerns had not been registered in the homes complaints record. Any complaint received from whatever source must be recorded and investigated in accordance with Regulation 24, The Nursing Homes Regulations (Northern Ireland) 2005. A requirement has been made.

5.5.3 The Environment

47 Somerton Road is a single storey home providing accommodation for 38 patients. The majority of bedroom accommodation is on a single room basis although there are a small number of shared rooms. There is a large communal area at the entrance to the home and two further small lounge areas in the home. The communal area at the entrance of the home is a designated lounge area and is used by most of the patients. This area does become noisy due to the number of patients present. In discussion with the manager it was advised that consideration should be given to the appropriate use of space in the home so as to meet patients' needs. Patients may prefer a smaller quieter lounge area to relax. Consideration should also be given to the increased use of the other lounge areas in the home.

The carpeting and flooring in areas of the home should be considered for replacement. The identified areas were the carpeting in corridor A and the flooring in the dining room. The carpeting in two patients' bedrooms was also in need of replacement. The manager was informed of the location of the bedrooms.

A number of patients' beds were divan in type. The appearance of the beds would benefit from the use of valance sheets and duvet covers should be ironed after laundering.

There was ample storage for equipment and miscellaneous items in the home. However, storage areas viewed were disorganised and poorly utilised. Storage areas should be kept tidy.

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Wayne Salvatierra, home manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref:** Regulation 16 (1) and standard 32.1 **Stated:** First time **To be Completed by:** 30 November 2015	The registered person must ensure: • information regarding patients end of life wishes, in consultation with patients' representatives, where applicable, is retained in care records • a care plan is written, monitored and evaluated in respect of the palliative or end of life wishes and needs of patients. The care plan should reflect the recommendations of the specialist palliative care team, where applicable. **Ref: Sections 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: 1 The information with regards to the patients end of life wishes, in consultation with the homes patient's representatives is now retained in the patient's care notes. 2 A Care plan for palliative care is formulated and written in conjunction with the recommendations from palliative specialist nurse. The care plans are evaluated monthly and amended where required depending on the patient's/representaives condition and/or wishes. The Palliative/End of life care assessment are now incorporated in the home's Goldcrest Computer System.
Requirement 2 **Ref:** Regulation 20 (3) **Stated:** First time **To be Completed by:** 30 November 2015	The registered person must ensure the competency and capability assessment for registered nurses, in charge of the home, reflects accurately reflects the responsibilities of the role. The competency and capability assessment must be signed and dated and validated by the home manager. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: New competency and capability assessment template has been formulated which accurately reflects the roles and responsibilities of the Nurse in Charge. The competency and capability assessments are signed and dated as well as validated by Home Manager.

Requirement 3 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time **To be Completed by:** 30 November 2015	The registered person must ensure the staff induction training programme s accurately completed, signed by both parties and validated by the home manager. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: Staff induction forms have been amended to ensure that they are accurately completed signed, dated and validated by Home Manager.
Requirement 4 **Ref:** Regulation 24 **Stated:** First time **To be Completed by:** 30 November 2015	The registered person must ensure any complaint received into the home is recorded in the complaints log. Complaints must be investigated in accordance with regulation 24. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: At a staff meeting held on 26/11/15 Nursing Staff were advised that every complaint received in relation to the service we provide is fully documented in the home's complaints book and investigated and responded to in accordance with Regulation 24.
Requirement 5 **Ref:** Regulation 17 **Stated:** First time **To be Completed by:** 31 December 2015	The registered person must ensure that the system/s in place to monitor the quality of services provided by the home is robust. Quality auditing must evidence that the range of services provided and where a shortfall was identified the remedial action taken to address the shortfall. **Ref: Section 5.5.2**
	Response by Registered Person(s) Detailing the Actions Taken: The areas identified under section 5.5.2 of the report have been actioned these include more robust governance arrangements, increased frequency of staff meetings, review of the induction training and its validation, review of the competency and capability assessment for nurses in charge as well as a review of the assessment template used. A patient representatives meeeting/ relatives meeting has been scheduled for the 21st of December 2015, and held on a six monthly basis thereafter.

Recommendations	
Recommendation 1 **Ref:** Standard 19.1 and 32.1 **Stated:** First time **To be Completed by:** 30 November 2015	Policies on Communicating Effectively and palliative and End of Life care should be written, in accordance with best practice guidance. **Ref : Sections 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Palliative and End of Life Care Policy as well as Breaking Bad News Policy is presently in the Home with separate sheet signed and dated by staff showing they have read and understood the policies.
Recommendation 2 **Ref:** Standard 19.6 and 32.1 **Stated:** First time **To be Completed by:** 15 December 2015	A management system should be implemented to evidence staff have read and understood the new policy documentation in respect of communicating effectively and palliative and end of life care. **Ref: Sections 5.3 and 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Palliative and End of Life Care Policy as well as Breaking Bad News Policy is presently in the Home with separate sheet signed and dated by staff showing they have read and understood the policies.
Recommendation 3 **Ref:** Standard 19 **Stated:** First time **To be Completed by:** 31 December 2015	Training in respect of communicating effectively should be provided for staff. The training should include the areas discussed in standard 19. **Ref: Section 5.3**
	Response by Registered Person(s) Detailing the Actions Taken: Palliative/End of Life Care and Breaking Bad News training has been undertaken on 30/11/15 for staff. Management would wish to emphasise that staff are fully supported in all aspects of their training and the negative comments recorded within the Inspection report are not reflective of the dedication and hardwork of the majority of staff.
Recommendation 4 **Ref:** Standard 39.1 **Stated:** First time **To be Completed by:** 30 November 2015	Palliative and end of life care should be included in the induction training programme for registered nurses and care staff. **Ref: Section 5.4**
	Response by Registered Person(s) Detailing the Actions Taken: Palliative and End of life Care has been incorporated in our new staff induction form template.

Recommendation 5 **Ref:** Standard 4.9 and 18.6 **Stated:** First time	Nursing care plans regarding the use of a restrictive practice should be written and regularly evaluated and updated, where appropriate, in accordance with best practice guidance, DHSSPS Deprivation of Liberty Safeguards 2010 and DHSSPS Restraint and Seclusion 2005. **Ref: Section 5.5.2**
To be Completed by: 30 November 2015	**Response by Registered Person(s) Detailing the Actions Taken:** Where restrictive practice is in place in relation to a patient the rationale for its used is clearly stated in the care plan and evaluated on an ongoing basis with respect to its continued need.
Recommendation 6 **Ref:** Standard 43.5 **Stated:** First time	Areas of high noise levels should be monitored and the home should provide and/or utilise smaller more homely lounge areas so as patients have a choice of where they wish to sit. **Ref: Section 5.5.3**
To be Completed by: DD Month Year	**Response by Registered Person(s) Detailing the Actions Taken:** The use of the home's range of lounges and rooms has been reviewed which has resulted in patients in keeping with their wishes being able to maximise use of other areas of the home and reduce the dependence on the main lounge.
Recommendation 7 **Ref:** Standard 46 **Stated:** First time	Replacing the carpeting in corridor A and two patients' bedrooms should be considered. The flooring in the dining room should also be considered for replacement. **Ref: Section 5.5.3**
To be Completed by: 31 December 2015	**Response by Registered Person(s) Detailing the Actions Taken:** The carpets areas identified have been changed and ongoing work is being carried out in relation to the flooring of corridor A and the dining room.

Recommendation 8 **Ref:** Standard 43.6 **Stated:** First time **To be Completed by:** 30 November 2015	To enhance the appearance of patients' bedrooms bed linen should be ironed when laundered. The use of valance sheets on beds would also improve the appearance of the bed and bedroom. **Ref: Section 5.5.3** **Response by Registered Person(s) Detailing the Actions Taken:** The home's bed linen is ironed on a regular basis,laundry staff have been advised both verbaly and via a memo regarding the matter. Additional valence sheets which are available in the home have been placed on the patients beds identified.

Registered Manager Completing QIP	Wayne Salvatierra	**Date Completed**	09/12/15
Registered Person Approving QIP	Trevor Gage	**Date Approved**	09/12/15
RQIA Inspector Assessing Response	Heather Sleator	**Date Approved**	11/12/15

Please ensure the QIP is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address