The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
21 and 22 June 2016

Seapatrick Care Home

Type of Service: Nursing Home
Address: 80 Lurgan Road, Seapatrick, Banbridge, BT32 4LY
Tel No: 028 4062 8289
Inspector: Donna Rogan

www.rqia.org.uk
Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Seapatrick Care Home took place on 21 June 2016 from 10:30 hours to 16:30 hours and on 22 June 2016 from 09:50 hours to 15:30 hours.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of positive outcomes for patients through the competent delivery of safe care. Recruitment and induction practices were evidenced to be well managed and there was evidence of appropriate management of staff registration with their various professional bodies. Staffing levels were maintained and reflected the dependency levels of patients. A review of the training records evidenced that staff training was being well managed. One requirement and one recommendation were made regarding the management of the environment.

Is care effective?

There was evidence of good delivery of care with positive outcomes for patients. Care records were generally well maintained and included assessment of patient need, risk assessments and a comprehensive care plan which evidenced patient/representative involvement. There was also clear evidence of effective team working and good communication between patients and staff. There were two recommendations made in relation to care records.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. All patients spoken with were complementary regarding the staffs' attitude and attentiveness to detail. Patients were complimentary of staff. There was good evidence of patient, representative and staff consultation. Patients were very praiseworthy of staff and a number of their comments are included in the report. A recommendation has been made however, that the negative comments made by staff, patients and relatives during the inspection are investigated by management and actioned as required. There is an activity programme in place, however, records have not been maintained of the activities conducted, and a recommendation is made in this regard.

Is the service well led?

There was evidence of systems and processes in place to monitor the delivery of care and services within Seapatrick Care Home. Compliance with the recommendations made will improve the overall services provided, the experience of service users and leadership within the home.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Clare Doherty, Deputy Sister, on day one of the inspection and Maud Beck, Senior Staff Nurse on day two of the inspection as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent estates inspection

The most recent inspection of the home was an announced estates inspection undertaken on 22 February 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

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

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Maureen Claire Royston	**Registered manager:** Edel McCaughley
Person in charge of the home at the time of inspection: Clare Doherty, deputy sister 21 June 2016 Maud Beck, senior staff nurse 22 June 2016	**Date manager registered:** 18 March 2015
Categories of care: NH-MP(E), NH-I, NH-DE, NH-PH	**Number of registered places:** 60 Total 35 NH-DE 1 NH-MP (E) 2 in hospital 19 NH-I, 1 NH-PH, 2 in hospital

3.0 Methods/processes

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

Prior to inspection the following information was 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
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with approximately 25 patients, eight care staff, five registered nursing staff, three ancillary staff and six 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
- accident and incident records
- notifiable events
- audits
- records relating to Adult Safeguarding
- complaints records
- recruitment and selection records
- NMC and NISCC registration records
- staff induction, supervision and appraisal records
- staff, patients' and relatives' meetings
- monthly monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005
- policies and procedures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 February 2016

The most recent inspection of the Seapatrick Care Home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

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

4.2 Review of requirements and recommendations from the last care inspection dated 04 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 20 (1) (c) (iii) **Stated:** First time **To be Completed by:** 20 March 2016	The registered manager shall ensure that specialised training for staff is provided as soon as possible. The registered manager shall ensure that records of the training is maintained and will confirm to RQIA in the returned QIP that the training has been completed. **Action taken as confirmed during the inspection**: A review of the training records evidenced that specialised training on Mental Health was held on 3 and 4 May 2016.	**Met**
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 21 **Stated:** First time **To be Completed by:** 20 March 2016	The registered manager shall ensure that an ongoing wound care chart is maintained with patients with a wound or pressure ulcer. The registered manager should ensure that the identified care record is updated as a priority. **Action taken as confirmed during the inspection**: A review of two patients care records with wounds/pressure ulcers evidenced that there was an on-going wound chart in place. Both records were maintained in keeping with best practice. The registered manager confirmed in the returned QIP that the identified care record had been updated following the inspection.	**Met**

4.3 Is care safe?

The deputy sister confirmed the planned daily staffing levels for the home and stated that the levels were subject to regular review in order to ensure that the assessed needs of patients were being met. The deputy sister provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients, this included details of patients dependency levels.

A review of the staffing roster for weeks commencing 20 and 27 June 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff staffing rosters it was confirmed that administrative, maintenance, catering, domestic and laundry staff were on duty daily. Staff spoken with were satisfied that there were sufficient staff to meet the needs of patients when all staff turned up for duty. Relatives commented positively regarding the staff and care delivery. However, two relatives commented that they found that there was a large turnover of staff which at times could be problematic in terms of consistency. Details of comments made by patients, relative and staff, are stated in section 4.5.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor signed the record to confirm completion and to declare understanding and competence. The manager also had signed the record to confirm that the induction process had been satisfactorily completed.

A review of two staff records and discussion with the deputy sister confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home.

There were systems in place to monitor staff attendance and compliance with training. Review of staff training records from January 2016 evidenced that the attendance/compliance levels with mandatory training was good. Following discussion with staff it was ascertained that planned training was in place for staff that had not yet completed their training. The deputy sister confirmed that a management system is in place to ensure that staff required to attend training are identified and reminded to complete their training. A training matrix is in place to inform the manager of staff attendance at training.

Discussion with the deputy sister, staff on duty and a review of records confirmed that there are systems in place to ensure that staff receives supervision and appraisal. Discussion with staff and a review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed.

A review of two personnel files evidenced that recruitment processes were in keeping with The Nursing Homes Regulations (Northern Ireland) 2005 Regulation 21, schedule 2.

A review of documentation confirmed that adult safeguarding concerns were managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA have been appropriately notified. The manager had robust systems in place to monitor the progress of safeguarding issues with the local health and social care trust and the PSNI.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with registered nursing staff and review of records also evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that accidents and incidents had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. The manager completed a monthly analysis of falls to identify any trends or patterns.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home smelt fresh, clean and was appropriately heated. Fire exits and corridors were observed to be clear of clutter and obstruction. There were no issues identified with infection prevention and control practice.

One issue was raised in relation to the designated smoking room; it was currently being used as an area to store equipment. Correspondence was received that this was a temporary arrangement and that the registered manager was advised by the estates inspector that they could use this room as storage area if there were no patients who smoke in the home and if the room remained locked. Confirmation was received from the estates inspector for the home, that the manager was advised during an inspection on 22 February 2016 that if used as a store the fire safety precautions for this room would need to be reviewed by the fire risk assessor to determine if the correct type of fire detector has been installed for the intended purpose. If this is to be changed to facilitate a different use it should be changed back if the room is to be returned to a smoking room. The manager was also advised if the room was to be used as a store that it should be remained locked. We observed a patient smoking in the garden area of the home during the inspection. The door to the smoking room was also unlocked on both days of inspection. A requirement was made in this regard. A recommendation is also made that the disused hot trolley should be removed from the identified dining room.

Areas for Improvement

There were two areas for improvement identified under the safe domain they were in relation to the environment.

Number of requirements	1	**Number of recommendations**:	1

4.4 Is care effective?

Review of three patient care records evidenced that initial plans of care were based on the pre admission assessment and referral information. A comprehensive, holistic assessment of patient's nursing needs was completed at the time of admission to the home. As previously discussed a range of validated risk assessments were completed as part of the admission process. The outcome of patient assessments of need and risk assessments were evidenced to inform the care planning process.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and palliative care nurse facilitators. Care records were regularly reviewed and updated, as required, in response to patient need. However, the formal evaluations of care should contain more detail of the outcomes for patients, the term, "all care given" was being used. A recommendation is made in this regard.

Discussion with one visiting professional during the inspection, confirmed that they had a good relationship with staff in the home and that they are appropriately referred and instructions provided are followed and records maintained. Investigation specimen details were not always fully completed. One patient who required a specimen of blood to be taken on 2 June 2016 did not have it taken until 10 June 2016. Registered nursing staff was aware of why the samples were not obtained. However, this information was not recorded. Improvement is also recommended regarding the management of supplementary care records. They were being appropriately completed by care staff, however, there was no evidence that the information was being reviewed or consolidated by registered nursing staff. A recommendation is made in these regards.

Staff demonstrated awareness of the importance record keeping and of patient confidentiality in relation to the storage of records. There was evidence within the care records that patients and/or their representatives were involved in the care planning process. There was also evidence of regular, ongoing communication with relatives. Registered nurses spoken with confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the manager and staff evidenced that nursing and care staff were required to attend handover meetings at the beginning of each shift. Staff were aware of the importance of handover meetings in ensuring effective communication. Staff spoken with confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted with clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff also confirmed that if they had any concerns, they would raise these with the manager.

We discussed how management consulted with patients and relatives and involved them in the issues which affected them. There was evidence of regular meetings being held with patients and relatives with the most recent being held on 6 April 2016. Minutes of the meetings held were reviewed and confirmed attendance and the detail of the issues discussed. A notice board displaying information for relatives was provided at the entrance to the home.

The serving of lunch was observed in all units in the home. Tables were set with cutlery, condiments and napkins. Those patients who had their lunch in the lounges or bedrooms were served their meal on a tray which was set with cutlery and condiments and the food was covered prior to leaving the dining room. Meals were transported from the kitchen in heated trolleys. Registered nurses and care staff were both in attendance to attend to the nutritional needs of patients.

The serving of the lunch was observed to be well organised with all of the patients being attended to in a timely manner. The meals were nicely presented and smelt appetising. All of the patients spoken with enjoyed their lunch.

Areas for Improvement

Two recommendations have been made regarding the management of care records.

Number of requirements	**0**	**Number of recommendations**:	**2**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. We observed numerous occasions when staff offered patients' choice and took time to find out what the patients wanted when it was not always apparent and patients were unable to express their wishes clearly. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable in their surroundings. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner. Numerous compliments letters and cards had been received by the manager from relatives and friends of former patients.

Ten questionnaires were issued to patients; all ten were returned prior to the issue of this report. The patient response indicated that all aspects of care were of a high standard. Two questionnaires returned comments that they felt they did not know who the manager was and two commented that they felt more staff was needed.

Ten relative questionnaires were issued to relatives; five were returned prior to the issue of this report. The comments stated that the delivery of safe, effective, compassionate care were commendable. .

The following comments were provided from patients and relatives during inspection and in the returned questionnaires:

- "There is a high turnover of staff."
- "There have been a lot of staff changes."
- "I couldn't be happier with my relatives care."
- "My …. is in good hands."
- "It's great here and the food is good."
- "the home is much more settled."
- "The manager has made some great improvements."
- "You can sometimes be left waiting to be taken to the toilet."
- "Not sure who the manager is."
- "In the morning sometimes when I buzz staff are long in answering it."
- "I would like a lock on my door for privacy."
- "Need more staff."
- "I have spoken with the manager twice when passing my relatives room. I go to the nursing staff if I have any concerns."

Ten questionnaires were issued to nursing, care and ancillary staff; nine were returned prior to the issue of this report. The responses to the questions were all positive and staff indicated that in their opinion the delivery of safe, effective and compassionate care was of a high standard. All staff stated that the service was well led. All staff spoken with stated that morale was excellent in the home. However, five staff did comment that at times they felt they were short staffed.

A recommendation has been made, that the negative comments made by a number of staff, patients and relatives in the returned questionnaires are investigated by management and actioned as required.

There were a number of activities ongoing in the home. Patients were observed to be involved and there are various opportunities to encourage patients to become involved in the daily activities. Activities were patient led and in accordance with their wishes. Discussion with the activity therapist evidenced that there was enthusiasm by all staff to ensure planned activities were well organised. All staff spoken with stated that the activity programme was varied and reflective of patient preferences. The environment is conductive to dementia care and numerous pets to provide stimulation in various areas of the home. They include a dog, goldfish, a parakeet and hens. A review of activity records do not evidence the volume of activities carried out in the home. A recommendation is made that records are maintained of the activities provided and the name of the person leading the activity and patients' participation.

The home has also introduced a new quality initiative, "The Quality of Life Programme"; this programme enables the manager to seek formal feedback from staff, patients, relatives and visitors to the home. The information is collated to drive improvements in care. The programme seeks to support the home by identifying any emerging issues and providing solutions or resources to manage them. This initiative is to be commended.

Areas for Improvement

There were two areas for improvement identified in the domain of compassionate care during the inspection they relate to patient/relatives comments and the management of activities.

Number of requirements	0	Number of recommendations:	2

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available.

Discussion with staff evidenced that there was a clear organisational structure within the home. Staff spoken with were knowledgeable regarding line management within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the manager was off duty. Discussions with staff also confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Patients and representatives spoken with confirmed that they were aware of the home's complaints procedure. Patients and their representatives confirmed that they were confident that staff and /or management would address any concern raised by them appropriately. Patients were aware of who the registered manager was. Information on how to make a complaint was displayed in the home.

A record of complaints was maintained by the manager. The record included the date the complaint was received, the nature of the complaint, details of the investigation and a copy of the letter sent to the complainant. There was evidence that the manager assessed that the complainant was satisfied with the outcome of the complaint and the level of satisfaction was recorded.

Any contract compliance issues raised by the local health and social care Trust were recorded as complaints. In these instances the Trust informs the manager if the complainant is satisfied with the outcome. Discussion with the manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

As previously stated there were numerous thank you cards and letters received from former patients and relatives. These are displayed throughout various areas in the home.

There are systems in place to monitor the quality of the services delivered and a programme of audits was completed on a monthly basis. Areas for audit included care records, infection prevention and control practices, falls, complaints and the environment. A review of the record of audits evidenced that where an area for improvement was identified and an action plan was developed, completed and the area re-audited to check that the required improvement has been completed.

It was discussed how patients and relatives were involved or consulted with regards to issues which affected them. As previously discussed regular meetings are held with patients/relatives the information is displayed for relatives on dedicated notice boards.

A review of records evidenced that the unannounced monthly visits required under Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any areas for improvement.

Areas for Improvement

Areas for improvement were identified in the previous domains of safe, effective and compassionate care. Compliance with the requirement and recommendations will improve the overall services provided, the experience of service users and leadership within the home.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Clare Doherty, Deputy Sister, and Maud Beck, Senior Registered Nurse, 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 provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

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

5.1 Statutory requirements

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

5.2 Recommendations

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

5.3 Actions taken by the Registered Provider

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

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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 27 (4) (a) and (b) **Stated:** First time **To be completed by:** 30 July 2016	The registered person should ensure the use of the designated smoking room is reviewed. The fire safety precautions for the smoking room are required to be reviewed by the fire risk assessor to determine if the correct type of fire detector has been installed for the intended purpose. If this is to be changed to facilitate a different use it should be changed back if the room is to be returned to a smoking room. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: The smoke room has been cleared of storage items and will be maintained as a smoke room.
Recommendations	
Recommendation 1 **Ref**: Standard 44.8 **Stated:** First time **To be completed by:** 30 June 2016	The registered person should remove the un-used hot food trolley from the identified dining room. **Ref: Section 4.3**
	Response by registered person detailing the actions taken: The trolley is no longer in working order and arrangements have been made for its collection and disposal.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 July 2016	The registered person should ensure that supplementary records are reviewed and consolidated by registered nursing staff. Information regarding patients' specimens should also be recorded appropriately. **Ref: Section 4.4**
	Response by registered person detailing the actions taken: Nurse meeting held on 05.07.16 to address this issue - all nurses reminded to check care files and documentation daily and record same on 24hr shift report. Progress notes should reflect data provided from supplementary records. Specimens to be recorded in appropriate section of patient files when taken and diarised for follow up of results.

<table>
<tr><td rowspan="2">Recommendation 3

Ref: Standard 21

Stated: First time

To be completed by:
30 July 2016</td><td>The registered person should ensure that the formal evaluations of care are meaningful.

Ref: Section 4.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Addressed at nurse meeting on 05.07.16 (minutes made available to all nursing staff) - nurses reminded to make all evaluations patient specific and to include details of care given.</td></tr>
<tr><td rowspan="2">Recommendation 4

Ref: Standard 7

Stated: First time

To be completed by:
30 July 2016</td><td>The registered person should ensure that the negative comments made by a small number of patients during the inspection are investigated by management and actioned as required.

Ref: Section 4.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Staff changes are necessary to ensure a good skill mix when new staff start and it is important that all staff are able to work in all units when required. All staff receive the same training and there should be no effect on continuity or standard of care.

The Home Manager visits each unit at least once daily and speaks to all staff, visitors and residents that she meets - residents in Dementia unit may not remember her as the manager but she is on familiar terms with all residents and most relatives who visit during the day.

The Home Manager has an 'Open Door' policy and anyone with any complaints or issues are encouraged to bring them to her attention so they can be dealt with promptly. Feedback is obtained from relatives, visitors and residents via the Quality of Life programme.

Staffing levels are adjusted according to the number and dependency of residents. All residents are assisted to the bathroom according to their needs. We will monitor feedback received via QOL for any further concerns.</td></tr>
<tr><td rowspan="2">Recommendation 5

Ref: Standard

Stated: First time

To be completed by:
30 July 2016</td><td>The registered person should ensure records are maintained of activities provided and the name of the person leading the activity and patients' participation.

Ref: Section 4.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All residents have activity careplans in place and records detailing their weekly activities. This will be monitored by the Home Manager when auditing care file records.

Photographs will be taken and displayed of any activities undertaken as they happen.</td></tr>
</table>

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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