Inspection Report

23 November 2021

Parkdean

Type of service: Nursing Home
Address: 44 Fortwilliam Park, Belfast, BT15 4AS
Telephone number: 028 9037 0406

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Parkdean **Responsible Individual:** Mrs Emer Bevan	**Manager:** Ms Farah Vergara - Acting
Person in charge at the time of inspection: Ms Farah Vergara - manager	**Number of registered places:** 64
Categories of care: Nursing Home (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 64 patients. The home is located over three floors with patient's bedrooms located on the ground, first and second floors.	

2.0 Inspection summary

An unannounced inspection took place on 23 November 2021 from 9.40 am to 6.30 pm by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led. Since the last inspection there has been a change in the management arrangements in the home and an acting manager is in post. RQIA were satisfied that the manager understood their role and responsibilities in terms of governance.

Patients were happy to share their experiences of living in the home and expressed positive opinions about the home and the care provided. Patients said that staff were helpful and pleasant in their interactions with them.

RQIA were assured that the delivery of care and service provided in Parkdean was provided in a compassionate manner by staff who knew and understood the needs of the patients.

The findings of this report will provide the registered persons/manager with the necessary information to improve staff practice and the patients' experience.

New areas requiring improvement were identified and these are detailed within the main body of the report and in the Quality Improvement Plan (QIP) in Section 7.0. One area for improvement was not met and is stated for a second time.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients, staff and relatives were asked for their opinion on the quality of the care and their experience of living, visiting or working in Parkdean. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

4.0 What people told us about the service

Sixteen patients, seven staff and one relative were spoken with. Two questionnaires were returned with relatives indicating they were happy with the care provided in the home. No feedback from the staff online survey was received within the timeframe for inclusion in this report.

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff.

The relative spoken with was happy with the care partner arrangements and the care their relative was receiving.

Staff acknowledged the challenges of working through the COVID – 19 pandemic but all staff agreed that Parkdean was a good place to work. Staff were complimentary in regard to the home's management team and spoke of how much they enjoyed working with the patients.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 22 September 2020		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 48.6 and 48.8 **Stated:** First time	The registered person shall ensure that evidence is present to confirm all staff have participated in a fire evacuation drill at least once per year.	**Not met**
	Action taken as confirmed during the inspection: Review of records provided evidenced that not all staff had attended a fire drill annually. This area for improvement is stated for a second time.	
Area for improvement 2 **Ref**: Standard 48.1 and 48.9 **Stated:** First time	The registered person shall ensure that there is a current fire risk assessment and management plan available in the home.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 3 **Ref**: Standard 35.7 **Stated:** First time	The registered person shall ensure that the monthly monitoring reports reflect that staff have been consulted during the visit and their comments noted. The commencing and finishing times of the visit should also be in evidence.	**Partially met**
	Action taken as confirmed during the inspection: Review of records evidenced that this area for improvement was partially met. This is discussed further in Section 5.2.5. A new area for improvement is made to ensure accurate records are maintained.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of selection and recruitment records evidenced that staff were recruited safely to protect patients. Staff were provided with an induction programme to prepare them for providing care to patients.

There was a system in place to ensure that nursing and care staff maintained their registration with either the Nursing and Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC). However, review of records evidenced that not all care staff employed were included in the checklist for NISCC and information shared with RQIA on behalf of the provider post inspection evidenced that the NMC register was checked "periodically in the run-up to expiry dates" and that NISCC checks that were completed on an "ongoing basis". An area for improvement was identified to ensure that the system was reviewed to ensure it was sufficiently robust to prevent staff working unregistered.

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty. Review of records confirmed most of the staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so. The manager confirmed the outstanding staff would not take charge of the home until they had completed the appropriate assessment.

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on an annual basis. Staff were able to correctly describe their roles and responsibilities regarding adult safeguarding although not all staff had completed training with regards to Deprivation of Liberty Safeguards (DoLs). To ensure all staff have knowledge of the Mental Capacity Act (Northern Ireland) 2016 and the Deprivation of Liberty Safeguarding Code of Practice, an area for improvement was identified.

Staff said there was good team work and that they felt well supported in their role and the level of communication between staff and management.

Patients spoke highly about the care that they received and confirmed that staff attended to their needs in a timely manner; patients also said that they would have no issue with raising any concerns to staff.

It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner. The relative spoken with expressed no concerns regarding staffing arrangements in the home.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

It observed that information relating to patient care and treatment held on a computer was accessible because staff had not locked the electronic record when leaving the office. This was discussed was discussed with the manager who took necessary action to secure access to the information. An area for improvement was identified.

Patients who are less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly; accurate records were maintained.

Where a patient was at risk of falling, measures to reduce that risk were put in place, for example, use of an alarm mat to alert staff the patient requires assistance. Review of records relating to the management of falls evidenced appropriate actions were consistently taken by staff post fall. This is in keeping with best practice guidance.

At times, some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails. Review of patients' records and discussion with staff confirmed that the correct procedures were not consistently followed if restrictive equipment was used. Review of records for one identified patient confirmed that although an appropriate care plan and consent were in place, a risk assessment had not been completed prior to the use of bedrails. This was discussed with the manager who arranged for this to be completed. An area for improvement was identified.

A number of patients were on bed rest but were unable use the nurse call system due to their cognitive impairment. This was discussed with the manager who agreed to audit the use of the nurse call system to ensure those patients who cannot use the system are appropriately supervised.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need support with meals ranging from simple encouragement to full assistance from staff.

Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and portions were generous. A variety of drinks were served with the meal. Staff attended to residents' dining needs in a caring and compassionate manner and maintained written records of what residents had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

Discussion with staff confirmed that changes to the planned menu were not recorded. This was discussed with the manager who agreed to address this matter with kitchen staff.

Review of patient's records evidenced that these were generally well maintained, however some deficits in recording were noted. For example, gaps were noted in one patient's oral hygiene record and another patient's wound care plan had not been updated to reflect the change in their treatment. In addition, some entries to care records had not been reviewed by registered nurses and some care plans were added to rather than rewritten when there was a change in patient's needs. This had the potential to cause confusion in relation to the delivery of patient care. Details were discussed with the manager and areas for improvement were identified.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and include any advice or recommendations made by other healthcare professionals. Review of care records of a patient recently admitted to the home evidenced that care plans had been developed within a timely manner to accurately reflect the patient's assessed needs.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. There were no malodours detected in the home. Many patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, clean and tidy. Some identified patient equipment required more detailed cleaning. This was discussed with the manager agreed to address this before the end of the inspection.

Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. Lounges were arranged in such a way that patients could safely socially distance. The manager agreed to review the seating arrangements in the dining room to facilitate social distancing where possible.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on the 18 December 2021; all recommendations made by the assessor had been addressed.

Issues were observed which posed a potential risk to patients' health and wellbeing. These included:

- food and fluid thickening agent stored in areas accessible to patients
- cleaning chemicals were stored in an unlocked cupboard allowing potential patient access to substances hazardous to health
- an electrical socket for a nurse call bell in a bedroom had been damaged and exposed wires were noted.

These issues were discussed with the manager who took the necessary action to reduce or remove any immediate risk of harm and an area for improvement was identified.

The manager said that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. The home was participating in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA).

Visitors to the home had a temperature check when they arrived. They were also required to wear personal protective equipment (PPE). There were laminated posters displayed throughout the home to remind staff and visitors of good hand washing procedures.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. While some staff were observed to carry out hand hygiene at appropriate times and to use PPE correctly; other staff did not. Some staff were not familiar with the correct procedure for the donning and doffing of PPE, while others were not bare below the elbow in keeping with best practice. This was discussed with the manager and an area for improvement was identified.

Dripping water from electrical fittings and water staining was observed on the ceiling in a communal lounge during review of the environment. In addition, one of the patient lounge/dining area was being used as a staff dining area. Discussion with the manager confirmed that the leak was recently identified. Details of the care inspectors observations were shared with the home's estates inspector as these areas needed to be followed with the registered person. Subsequently RQIA were notified and assurances were provided that these matters had been addressed.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, some patients told us they liked the privacy of their bedrooms, but enjoyed going to the dining room for meals and choosing where to sit with their friends. Other patients preferred to enjoy their meals in their bedrooms. Patients were observed to enjoy listening to music, reading newspapers/magazines and watching TV, while others enjoyed a visit from relatives.

Patients said there was a lack of activities in the home. One patient said "I don't really get offered any activities, you are left to do your own thing here" while another said "we used to do activities but haven't had anything in a year or more." Discussion with staff confirmed that activities were not planned at present and staff were not allocated to provide activities in the absence of an activity co-ordinator. Staff spoken with confirmed they find it difficult to provide activities due to care duties. This was discussed with the manager and an area for improvement was identified.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff told us they assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Ms Farah Vergara has been the acting manager since 25 October 2021. RQIA were notified appropriately.

Staff were aware of who the person in charge of the home was including when the manager was off duty, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

Staff commented positively about the manager and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

Review of the home's governance systems and processes evidenced a number of areas that required to be reviewed to ensure these systems identified and addressed areas needing to be improved. For example, the recording of accidents and incidents and reviewing these for patterns and trends; auditing of the quality and content of care records; review of the process to ensure the registration of staff; implementation of patient equipment cleaning schedules and planning of staff appraisals.

RQIA acknowledged that the change in management arrangements and the management of Covid -19 had impacted the governance arrangements. RQIA were satisfied that the manager understood their role and responsibilities in terms of governance and needed time to address the areas for improvement identified as a result of this inspection.

There was a system in place to manage complaints although deficits were identified. Examination of two complaints confirmed appropriate follow up actions were not consistently taken. This was discussed with the manager and an area for improvement was identified.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. However, the reports did not state the start and finishing time. This was identified as an area for improvement at the last care inspection.

In response to the area for improvement the responsible individual stated within the returned quality improvement plan, "*no references is made within the standard to the start and finishing times and as such these are not recorded in this report*". Inclusion of the time the home was visited would give RQIA or other relevant stakeholders context and assurance that monitoring visits are being completed at various times in order to meet with a wide selection of staff and visitors to the home. To ensure accurate records are maintained a new area for improvement was identified.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (April 2015) (Version 1.1).

	Regulations	Standards
Total number of Areas for Improvement	6	9*

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Farah Vergara, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 21 (1) (a) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the current system for monitoring staff registration is reviewed to ensure it is robust. This is to ensure no nurse or care staff is working in the home unless they are either in the process of applying to enter the NISCC register; or on the 'live' register for NISCC or NMC. Ref: 5.2.1
	Response by registered person detailing the actions taken: Contrary to the inspector's findings whereby it is stated that the system should be reviewed to ensure it was sufficiently robust to prevent staff working unregistered, a system is currently in place to mitigate against such circumstance and is deemed to be working appropriately. That said, Care Staff may be working unregistered with NISCC for a period of time as they cannot register with NISCC until they are employed in a Care role. Every effort is made to register Care staff with NISCC despite the difficulties in contacting the NISCC team. Nurses' PINs are recorded electronically and checks are made throughout the year.

Area for improvement 2 **Ref:** Regulation 19 (5) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that when staff complete electronic records they log off when leaving the office to ensure patient information is only accessible to those with permission. Ref: 5.2.2
	Response by registered person detailing the actions taken: The importance of locking computer screens has been reiterated once again to all employees. Additionally, screen savers have been introduced to lock after a period of inactivity to mitigate against patient information being accessible.
Area for improvement 3 **Ref:** Regulation 16 (1) (2) (b) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure care plans are reviewed by registered nurses in keeping with this regulation. Ref: 5.2.2
	Response by registered person detailing the actions taken: Every effort is made to ensure care plans are reviewed within the given time frame. Goldcrest assists by flagging the items for review.
Area for improvement 4 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure unnecessary risks to the health, welfare and safety of patients are identified and so far as possible eliminated. This area for improvement relates to the following: • food and fluid thickening agent and cleaning chemicals should be securely stored • damaged electrical sockets should be reported and fixed in a timely manner. Ref: 5.2.3
	Response by registered person detailing the actions taken: The importance of utilising the appropriate thickening agent along with the correct storage of same has been reiterated to all staff. Storing of chemicals has also been addressed. Staff have been advised of the urgent need to report all damage to maintenance. During the inspection there was no damage to electrical sockets identified, instead some nurse call points which have a 12v battery and are therefore not dangerous were noted to be cracked. This is an ongoing issue and these call points are replaced regularly.

Area for improvement 5 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene. Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff receive donning and doffing training from the moment of induction and staff are constantly reminded of the importance of good practice with regard to IPC
Area for improvement 6 **Ref:** Regulation 10 (1) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that robust governance arrangements are put in place to ensure that the deficits identified in the report are appropriately actioned. Ref: 5.2.5
	Response by registered person detailing the actions taken: As the Acting Manager had been in post for only one month at the time of the inspection, attention will be focused going forward on follow up especially in regard to complaints.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Regulation Standard 48.6 and 48.8 **Stated:** Second time **To be completed by:** 31 December 2021	The registered person shall ensure that evidence is present to confirm all staff have participated in a fire evacuation drill at least once per year. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: A fire drill was scheduled for November 2021 but as the Home only came out of Covid outbreak at this time, the fire drills were completed on 13th and 14th December instead.
Area for improvement 2 **Ref:** Standard 39.4 **Stated:** First time **To be completed by:** 31 January 2022	The registered person shall ensure all staff complete training in relation to Deprivation of Liberty Safeguards. Ref: 5.2.1
	Response by registered person detailing the actions taken: DOL's training has been completed by several staff and is ongoing for newly appointed staff.

Area for improvement 3 **Ref**: Standard 18.6 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that an appropriate risk assessment is completed before the use of bed rails. Ref: 5.2.2
	Response by registered person detailing the actions taken: Bedrail assessments, bedrail care plans and consent are completed as a matter of procedure however it appears that one risk assessment had not been completed for one resident. The care the care plan and consent were however in place. All Registered Nurses have been advised that the despite the pressures brought by Covid, staff shortages and outbreaks in the Home, every effort should be made to ensure ALL risk assessments regarding bedrails are updated within the specified time frame.
Area for improvement 4 **Ref**: Standard 6.14 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that any patient that requires oral hygiene has their needs met as planned and accurate records of oral care delivery are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: It is understood that this area is regarding one resident requiring mouthcare as part of their plan of care. This mouthcare was delivered by Night staff on the morning of this inspection and was documented within GoldCrest system. This is considered by Nursing staff to be an ongoing care provision for all patients requiring this level of care within the Home and is regularly addressed throughout the day.
Area for improvement 5 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that patients' wound care plans are updated in a timely manner to reflect any changes in care and treatment and those daily evaluations evaluate the condition of the wound. Ref: 5.2.2
	Response by registered person detailing the actions taken: It is understood that this again was in reference to one resident with a wound care plan in place. The relevant wound care was being recorded in the daily evaluation notes and the wound care plan had been updated and evidenced during the inspection. Although the resident's other leg was being wrapped with compression wraps, there is no wound in place, therefore Registered Nursing staff dispute that a wound care plan is required in this instance. A Lymphoedema care plan however was in place.

Area for improvement 6 **Ref:** Standard 11 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure that the provision of activities in the home is reviewed to make sure that meaningful activities are provided to patients in the absence of an activity co-ordinator. A contemporaneous record of activities delivered must be retained. Ref: 5.2.4
	Response by registered person detailing the actions taken: Due to the Covid pandemic, activities have been scaled back as group activities, which were previously arranged, are no longer appropriate. Whilst the entire focus of the staff has been to maintain the health of the residents given the continuous disruption of Covid, staff have been given an allocation and protected time slot for the provision of activities which residents can choose if they wish or do not wish to partake in.
Area for improvement 7 **Ref**: Standard 40.2 **Stated:** First time **To be completed by:** 31 January 2022	The registered person shall ensure all staff have a recorded annual appraisal and supervision no less than every six months. A supervision and appraisal schedule shall be in place, showing completion dates and the name of the appraiser/supervisor. Ref: 5.2.5
	Response by registered person detailing the actions taken: The process of supervisions and appraisals is well established in Parkdean Nursing Home. However, given the change in Manager and the appointment of new several new staff this process has been interrupted. Appraisals will continue in January 2022.
Area for improvement 8 **Ref**: Standard 16 **Stated:** First time **To be completed by:** 31 December 2021	The registered person shall ensure all complaints are dealt with promptly and effectively. Actions taken, whether the complainant was satisfied with the outcome or not and how this level of satisfaction was determined should be recorded. Patient care plans should be reviewed to ensure the outcomes of complaints are accurately recorded. Evidence should be retained that lessons learned from complaints are shared with staff. Ref: 5.2.5
	Response by registered person detailing the actions taken: Every effort will be taken to ensure all complaints are dealt with promptly and a response given to the complainant in a timely manner. Social workers will be kept involved of the progress as appropriate. Whilst it is not always possible to satisfy the complainant in terms of outcome, the level of satisfaction of response will be recorded where applicable and any impact of patient care reviewed.

	It appears that this Area for Improvement is a duplication of Area for Improvement 6 within The Nursing Homes Regulations section of the report.
Area for improvement 9 **Ref:** Standard 37.3 **Stated:** First time **To be completed by:** 31 December 2021	The registered person shall ensure that monthly monitoring reports accurately reflect the commencing and finishing times of visits untaken. Ref: 5.2.5
	Response by registered person detailing the actions taken: As stated in the previous Inspection report of Sept 2020 and as quoted by the inspector in section 5.2.5 of this inspection report, this Area for Improvement has been addressed previously. Standard 35.7 does not reference **start** and **finish** times within the monthly governance report. Whilst the inspector asserts that inclusion of start and finish times will provide RQIA and stakeholders assurance that a wide selection of staff and visitors to the Home, it is considered that the details of these staff and visitor comments are suffice to evidence this and no requirement of timings are deemed necessary. In keeping with Standard 37.3 the monthly monitoring reports are up-to-date, accurate and available for inspection in the home at all times.

Please ensure this document is completed in full and returned via Web Portal

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