Minster Care Management Limited

Saffron House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Saffron House is a care home supporting people across two floors of accommodation. The service is registered to provide care and accommodation for up to 48 younger and older people, people with physical disabilities and people living with dementia. At the time of our inspection there were 29 people using the service.

People's experience of using this service and what we found
Staff did not consistently follow the provider's procedures for the safe storage, return and disposal of medicines. People's medicine records did not always evidence people had received their topical medicines as prescribed. People's care plans did not include robust guidance and information as to how staff should support a person when they became distressed. Risks around people's distress were not well managed as staff lacked the skills and knowledge to support people safely and effectively.

Systems and processes to ensure good oversight of the service were not being used effectively by the registered manager. Improvements driven by the provider had not been fully embedded in staff working practices. There was insufficient oversight and monitoring of staff to ensure people always received safe care.

Although some improvements had been made around the assessment of people's mental capacity, further improvements were required. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not consistently support this practice.

The provider had made significant improvements to the environment to ensure people were protected from the risk of infections and some improvements were still in progress at the time of our inspection. However, we found improvements were still required around staff awareness of the risk of cross infection.

Most staff felt supported within their roles and told us they received regular supervision and meetings. Staff were recruited safely. Relatives did not always have confidence that staff received the clear direction and guidance they needed from the management of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 1 August 2023) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

We carried out an unannounced focussed inspection of this service on 6 June 2023. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment. safeguarding, consent and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Saffron House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the assessment and mitigation of people's risks and medicines, safeguarding people and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Saffron House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors and an Expert-by-Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Saffron House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Saffron House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well

and improvements they plan to make. We reviewed information we held about the service and spoke with local authority commissioners, responsible for funding care for some of the people using the service. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people and observed support and interactions between people and staff in communal areas. We also spoke with 7 relatives who were able to share their views about the service. We met with 8 staff including the deputy manager, operations manager, housekeeper, maintenance and care staff. We reviewed care plans and records for 5 people and reviewed a sample of medicine records. We also reviewed 3 staff recruitment files, staff training records and other documentation relating to the day to day management of the service, including quality assurance.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question as inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our previous inspection we found the provider failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made improvements to medicine systems and processes but these were not fully embedded and staff did not consistently follow procedures for the safe management of medicines.

● Medicines were not stored, returned or disposed of safely. We found a significant number of unidentified tablets in sharps containers (designated containers for the safe disposal of sharps such as syringes). There was no audit trail to identify why and when these tablets had been disposed of in the sharps containers, or who they were prescribed for. This meant we could not be assured people were receiving their medicines as prescribed.
● The provider had a clear returns procedure for medicines to be returned to the pharmacy for safe disposal, but the registered manager had not ensured staff followed this procedure through their oversight and audits.
● We found gaps in medicine administration records where staff had not signed to confirm they had applied people's topical medicines, such as creams. We could not be assured people had received these medicines as prescribed.
● We observed a member of staff who was administering people's medicines, leave a medicine trolley unattended for nearly one minute in a communal area. There were boxed medicines on top of the trolley which were easily accessible. This presented a risk of people accessing medicines that were not prescribed for them.

Staff were not following safe systems for the management of medicines. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The area manager undertook supervisions with senior staff following our inspection visit to reinforce correct procedures for the destruction and return of medicines.
● The provider had implemented an electronic system to support more robust systems of medicine stock control and administration. We saw this has resulted in improvements in clearer and more detailed protocols for people's medicines.

Assessing risk, safety monitoring and management
At our previous inspection systems were not sufficiently effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements were not sufficient to ensure people were always safe.

● Risks to people's health and safety were not consistently assessed or mitigated against. At our previous inspection, we found care plans lacked information and guidance for staff to provide effective support and intervention when people became distressed. At this inspection, we found care plans continued to lack this information.
● Two people were described as regularly experiencing distress and required staff intervention to keep them safe. Their care plans failed to include any strategies or guidance for staff on known triggers, and ways to support them when they were in an agitated state.
● We observed a person walking in and out of people's rooms without any support or intervention, including rooms where people were vulnerable in bed. The person was known to take objects from other people's rooms. When the person was approached, they were verbally abusive. We raised this concern with staff who told us the person was agitated and better left alone. Their care plan did not have any strategy or guidance in place to support staff in managing this risk to keep the person and others safe. Staff were recording incidents, but records evidenced a lack of consistency in the staff's approach and intervention.
● Care plans and risk assessments included inappropriate terminology to described people when they became distressed. For example, a person's risk assessment referred to them as having 'bad' behaviour and becoming 'fidgety'. This evidenced a lack of understanding and insight into the needs of people who were distressed.
● We observed a staff member supporting a person to eat. The person preferred to eat their meals standing up and this was included in their care plan. The staff member continually guided the person to sit down and began spooning food into the person's mouth at a fast rate. The person stood and used their fingers to extract the excess food from their mouth as this was clearly causing them distress and was a potential choking risk.

There was lack of risk assessment and guidance around the mitigation of risks to keep people safe from harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The area manager told us they would address these concerns following our inspection visit.
● People's care records showed staff were following guidance around mitigating risks associated with people's nutrition and hydration, skin tissue viability and catheter care.
● People had updated personal emergency evacuation plans in place to mitigate known risks in the event of an emergency.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our previous inspection we found systems and processes in place to protect people's human rights were not effective. This was a breach of Regulation 13(4) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found systems and processes to safeguard people were not fully effective and people remained at risk of harm

● Safeguarding systems and processes were not used consistently.
● For example, we found an incident between 2 people that highlighted potential safeguarding concerns. The incident had not been referred to relevant external agencies, including the care quality commission. There was no evidence that risks had been reviewed and action taken to mitigate the risk of further incidents. This meant people were not adequately safeguarded from harm.
● Our observations of a person walking in and out of people's rooms without oversight or staff intervention evidenced people were not consistently safeguarded from the risk of harm. Incidents were not used to learn lessons and inform future responses and interventions to reduce the risk of harm.

People were not consistently protected from the risk of harm. This was a continued breach of Regulation 13(4) Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who we spoke with told us they felt safe in the service, but we received mixed feedback from relatives. Whilst some felt their family member was safe, others felt a lack of staff oversight was a concern. A relative told us, "Sometimes there is a resident who is agitated and there isn't any staff around to support them." A second relative told us, "People go into [Name's] room and they get frightened. Staff put an alarm in the room to alert them, but we often find it is either switched off or it doesn't work."
● The provider had systems in place to support review and analysis of falls and accidents and action was taken to mitigate risks, such as referral to other agencies.

Preventing and controlling infection
At our last inspection we found the provider had failed to protect people from the risk of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice requiring the provider to make urgent improvements.

At this inspection we found the provider had made sufficient improvements to meet the requirements of the warning notice we served at our last inspection. However, further improvements were needed to ensure people were protected from the risk of cross infection.

● The provider had taken immediate action to improve cleanliness and the standard of people's living accommodation. This included replacing mattresses, bedding and furniture. Re-decoration of the premises was in progress at the time of the inspection, however there was no target date for work to be completed.
● We found a heavily stained sink in a clinic room, dedicated to storing and administering medicines. The work top was also damaged, exposing porous wood which meant it could not be thoroughly cleaned or sanitised. This left people at risk of cross infection. The area manager took immediate action and instructed the replacement of the sink and work surface.
● Staff appeared unaware of the risk of cross infection for people in communal areas. For example, dining tables were left laid with mats and cutlery throughout the day. We saw people frequently picking up cutlery, breathing on it and wiping it and putting it back. People later used this cutlery to eat their meals. We also observed a staff member wipe a person's nose with the sleeve of their cardigan.
● Housekeeping staff followed detailed cleaning schedules and procedures. They were able to explain how increased oversight had improved standards of hygiene and cleanliness in the service.

Visiting in care homes

● People were supported to have visitors. The provider's approach to visitors in the care home was in line

with government guidance.
● We observed visitors entering the home throughout the inspection and were seen spending time with their family members in people's rooms and communal areas.

Staffing and recruitment
● Staff did not always receive the supervision and guidance they needed to meet people's needs safely. Since our last inspection, the provider had recruited to staffing vacancies and reduced the use of agency staff. We observed a lack of management oversight and guidance for agency staff who were working in the service which placed people at potential risk of harm.
● People, relatives and staff felt the deployment of staff was not always sufficient to meet people's needs in a timely way. A staff member told us, "People have to wait because sometimes we cannot get to them in time; especially as there are a number of people who need 2 staff to support them." Relative comments included, "Sometimes I walk in and don't see any staff, they are hanging out together and jobs like clearing up after mealtimes is left. I think some staff need to take the initiative and do things," "There is mostly enough staff but at times they are short staffed," and "I have to prompt staff to help [Name] as they are unable to ask for help. I have seen people calling for the toilet and having to wait a long time for help."
● The provider assessed staffing needs through dependency assessments. However, this did not fully assess the impact of the environment and peak times where people required additional supervision. The area manager told us they would review the staffing dependency tool following our inspection.
● The provider followed safe recruitment practices. A check with the Disclosure and Barring Service (DBS) was carried out on all applicants. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating remains requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we found effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made and the provider was no longer in breach of regulations. However, further improvements were required to ensure mental capacity assessments were clearly recorded and sufficiently detailed.

- Mental capacity assessments were not always undertaken consistently. For example, one person had been assessed as having mental capacity to consent to all aspects of their care plan. This contradicted with additional information which described the areas of care the person lacked mental capacity to consent to.
- There was a lack of consistency around recording best interest decisions. People's care plans recorded when best interest decisions were required, but records did not always evidence how, when and who was involved in decision making processes.
- The area manager had identified where further improvements were required and had developed an action plan to ensure mental capacity assessments were sufficiently detailed.
- The provider had improved processes to ensure applications to unlawfully restrict a person of their liberty were made in a timely manner and conditions of authorisations were complied with.

Staff support: induction, training, skills and experience

● Staff completed induction before supporting people and received on-line and face to face training. Staff were positive about training; comments included, "My induction was long enough to help me get to know people. My manager completes spot checks on my work and offers feedback to support my development," and "I have completed a lot of training and there is further refresher training planned. I think we have enough training so support people's needs, for example, people living with dementia."

● Although staff were supported to complete essential training, relatives were not confident all staff were suitably trained and skilled; particularly agency staff. Comments included, "I don't think the agency staff are trained but the regular staff are trained. I saw an agency staff trying to pull a person up out of a chair under their armpit," "Not all staff are responsive to people's needs. For example, there was a person who wanted to go and lie in bed because their back hurt. Staff said they couldn't as it was too early; they didn't provide any reassurance or comfort" and "I think some staff have been allowed by the manager to cut corners, either knowingly or unknowingly."

● We observed an agency staff member failing to follow safe practices whilst supporting a person to eat their lunch. The staff member told us they had only worked 2 shifts prior to our inspection visit but they were not receiving any oversight or support from the senior on duty or permanent care staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed but some care plans still contained conflicting information around people's needs. For example, a person falls risk assessment identified them at medium risk of falls, but their care plan assessed them as at low risk.

● Advice and guidance from assessments by healthcare professionals was included in people's care plans and care records showed this was followed by staff. For example, a person's skin integrity had improved through staff following instructions from district nurse assessments.

Adapting service, design, decoration to meet people's needs

● Re-decorating of the premises was in progress at the time of our inspection. Although we could see some improvements, there remained areas of heavily chipped paintwork and ingrained dirt in doorways and some corridors. The operations manager was unable to provide a completion date for this work at the time of our inspection.

● Where people preferred to stay in their rooms, doors were open which meant other people were able to walk in unsupervised. There was no reference in people's care plans as to their choice for doors to be open or closed whilst they were in their rooms.

● Staff did not always keep areas locked where required. For example, we were told a bathroom was out of order and the room was kept locked at all times. This was supported by a notice on the door. However, we found the door had been left open during the afternoon and no staff were present. There was risk people could access this area despite the room being identified as unusable.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have a choice of meals and provided with a choice of drinks throughout the day. People told us they enjoyed the lunchtime meal.

● Where people were assessed as at risk from poor nutrition or hydration, records showed staff supported them to have sufficient to eat and drink.

● Relatives felt staff supported people to have sufficient to eat and drink. A relative told us, "[Name] needs to be encouraged and prompted to eat and drink, or else they won't do this. The staff who I have seen assisting [Name] are kind."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● Staff supported people to see health professionals such as GP's and nurses to maintain their health and well-being. Advice and guidance was included in people's care plans.

● Throughout our inspection visit, we observed the senior staff on shift communicating with health and social care professionals and ensuring referrals were made to meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found a failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice requiring the provider to make improvements.

At this inspection, we found improvements had been driven by the provider but had not been fully implemented or embedded within the service.

- Systems to monitor and improve the service were not used effectively. The registered manager completed a range of audits and checks but these had not identified the areas or concerns we found during this inspection. Records failed to evidence if target dates for completion of improvements had been achieved. The registered manager had not always ensured effective improvements were made and sustained within the service.
- The registered manager had failed to have effective oversight of the service to ensure improvements were made and sustained. For example, the registered manager had failed to identify staff were not following safe procedures for the return and disposal of people's medicines.
- The registered manager had failed to ensure systems and processes were in place and used effectively to ensure all agency staff received the support, guidance and oversight they needed to provide safe care.
- The registered manager had completed an update of care plans following our last inspection visit. However, we found people's care plans continued to lack sufficient information and guidance where people could experience levels of distress that required staff intervention and support. We also found mental capacity assessments required further work to ensure these were fully in line with the mental capacity act framework.
- The registered manager had failed to ensure timely and effective action was taken in response to actual or potential safeguarding incidents. This put people at risk of harm.
- We received mixed feedback about the responsiveness and effectiveness of the registered manager. Most staff felt the registered manager was supportive, though a staff member told us they felt concerns were listened to but not acted on. Relative comments included, "The [registered] manager is very nice and is approachable and has followed through with issues we have had," "Concerns are addressed but sometimes things take a long while to get sorted out. The [registered] manager treats staff more like friends than staff. They do not seem to have managerial status with staff" and "It seems that [registered manager] have been

allowed to manage the way that they are doing it now. I can get more help from the seniors than the manager."

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made improvements to the environment and staffing since our last inspection. They were able to demonstrate their own audits and checks had identified some of the issues and concerns we had found.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service is legally required to notify us of certain events that happen. We have not always been notified as required. For example, we found a potential safeguarding incident that had not been referred to CQC by the registered manager.
● Complaint records showed the registered manager and provider had been open in where things had gone wrong and gave commitments to putting things right. However, some relatives felt they did not experience timely responses or resolutions to their concerns. A relative told us, "I try to go to the [registered manager] but I haven't had a response from her about a worry I raised a couple of weeks ago." A second relative told us, "Concerns are not always addressed and I don't raise anything now. I feel like the [registered] manager just humours me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People felt involved and consulted in their care. Records showed people, staff and relatives attended regular meetings where they were consulted about the day to day running of the service and information was shared.
● The provider had a closed social media site which enabled relatives to access up to date news and events in the service.
● Staff spoke about positive teamwork and good support from their line managers. Staff comments included, "I feel confident my senior would support me and I can make suggestions in meetings" and "I feel staff are more aware since the last inspection. We have had more learning and training over what goes into care plans and how to record. This improves person centred care."
● A relative described how their family member had improved since moving to the service and receiving positive staff support.

Working in partnership with others
● Health and social care professionals visited the service regularly. Recommendations made to support people to maintain their health and well-
being were implemented and included in people's care plans.
● Records showed staff made referrals to external agencies when they felt people needed extra support. For example, referrals to support people with their movement and mobility and healthcare.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was lack of proper risk assessment and guidance around the mitigation of risks to keep people safe from harm. Staff were not following safe systems for the management of medicines

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not consistently protected from the risk of harm.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to operate effective systems to assess, monitor and improve the service

The enforcement action we took:

Notice of Proposal to cancel registration