Minster Care Management Limited

Woodlands Court Care Home

Inspection report

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Tel: 01942323352

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 June 2017 and was unannounced. At our previous inspection in April 2015 we found no concerns and had rated the service as Good. At this inspection we found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive or well led. The service will be rated as Inadequate and placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Woodlands Court Care Home is registered to provide accommodation for up to 40 people who require assistance with personal care and support. There were 34 people using the service at the time of the inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always being safeguarded from abuse as not all incidents of suspected abuse had been referred to the safeguarding authority for further investigation. Risks of harm were not always minimised following incidents and accidents and staff did not always follow people's risk assessments to keep them safe from harm.

People's medicines were not stored and managed safely and medication audits had been ineffective in ensuring continuous improvement.

There were insufficient suitably trained staff to support people safely. The registered manager was in the

process of recruiting to new positions. New staff were employed though safe recruitment procedures.

Infection control measures were not sufficient to ensure the environment and equipment in use was clean. As a result of this people were not protected from the risk of infection.

Health care advice was gained when people became unwell or their needs changed, however people's health care records were not always up to date and reflective of people's needs.

People were offered choices of food, however when people required their food and fluid monitoring this was not always completed. Some people were at risk of choking as they were being given food and drink which put them at risk of harm.

People were not always treated with dignity and respect and their right to privacy upheld. People were not always receiving care that met their needs and reflected their individual preferences.

People were not regularly asked their views on the service they received. Some people did not know who the registered manager was and who to complain to.

Staff felt supported by the manager to fulfil their roles, however poor staff practise was not being identified and improved through observations of competency.

The systems and audits in place to monitor and improve the quality of the service were ineffective. Action had not been taken to improve the service when areas that required improvement had been identified.

The principles of the MCA 2005 were being followed to ensure that when people lacked mental capacity they were supported to agree to their care and support in their best interests.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service were not being safeguarded from the risk of abuse as not all incidents of potential abuse were being investigated.

People were at risk of harm as their assessed needs were not always being met in a safe way and action was not always taken to minimise their risks.

There were insufficient suitably trained staff to meet the needs of people in a safe way.

People's medicines were not stored or administered safely.

Infection control measures were not sufficient to ensure the environment was clean and people were protected from infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always cared for by staff who were trained and effective in their roles.

Health care advice was sought when people's needs changed, however advice was not always followed to ensure people remained healthy.

People were offered a choice of food and drink. However the provider could not be sure that some people were eating and drinking sufficient to remain healthy as this was not monitored.

The principles of the MCA 2005 were being followed to ensure that people who lacked the mental capacity to agree to their care were supported in their best interests.

Is the service caring?

Requires Improvement

The service was not caring.

People's right to privacy was not always upheld and staff routines disturbed people's sleep.

Consideration to people's personal care needs were not always met to ensure their dignity was maintained.

People's home and equipment was not maintained and kept clean to ensure people lived in a dignified manner.

People's relatives and friends were free to visit.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their individual needs and preferences.

People were not routinely asked their views on the service they received.

There was a complaints procedure but not everyone knew who the registered manager was to complain to.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor and improve the quality of the service were ineffective.

Action had not been taken to improve the service when areas that required improvement had been identified.

People's views on the service were not regularly sought to ensure continuous improvement.

Staff felt the registered manager was approachable and supportive.

Woodlands Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 June 2017 and was unannounced. It was undertaken by two 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.

We reviewed the information we held on the service. We looked at notifications sent to us by the registered manager. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications.

We spoke with seven people who used the service, three visiting relatives, four care staff, two senior carers, the cook, the registered manager, deputy manager and area manager. Some people were unable to talk to us due to their communication needs so we observed their care in the communal areas. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at the care records for eight people who used the service. We looked at staff rotas, training files and two staff recruitment files. We looked at the way in which people's medicines were managed. We also looked at people's daily care records and records of their medication. We looked at the systems the provider had in place to monitor the quality of the service. We did this to see if they were effective.

Inadequate

Is the service safe?

Our findings

At our previous inspection we had no concerns in the safety of the service. At this inspection we found that people were not always receiving care that was safe and people were at risk harm.

The provider had a safeguarding policy and staff had received training in the safeguarding of people. However, we saw care records showed that one person had been recently admitted into the service with bruising and injuries. No action had been taken to refer these injuries to the local safeguarding authority for further investigation. When we spoke to a senior member of staff they told us that it was not their responsibility to report safeguarding's and the registered manager was unable to offer an explanation as to why the injuries had not been reported.

We saw in another person's daily records that they had been found to have bruising to their arm. When staff had asked the person how they had acquired the bruising the person had named another person who they said had pulled them up off the settee. No action had been taken to investigate the cause of the bruising and a safeguarding referral had not been made to ensure the person was protected from future incidents

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as these people were not being safeguarded from potential abuse.

We found that risks of harm to people were not always minimised as staff did not always follow people's risk assessments. One person had been assessed by a speech and language therapist (SALT) as requiring their fluids thickened as they were at risk of choking. We saw the person was given a drink by a carer which was not 'syrup thick' as stated in their assessment. We brought this to the attention of the senior member of staff who stirred the drink and added more thickener. We saw that the thickener being used was not prescribed for the person. There are a number of commercially available thickeners on the market. When thickening foods and fluids it is important that only the scoop provided with the thickener is used as these can vary between different products. Using the correct scoop will enable the correct amount of thickener to be mixed with the correct amount of foods and fluids. This put this person at risk of choking as they were not being given thickener that had been prescribed for them.

We saw another person's nutritional assessment stated they would benefit from a 'soft diet' due to the risk of choking. On the day of the inspection we observed a member of staff giving the person toast and this would have put the person at risk of choking. This person's care records also stated that they were at high risk of sore skin as they were being cared for in bed. Staff told us that they supported the person to reposition themselves every two hours, however there were no records to evidence that this had taken place. Following, the inspection we were informed that this person's nutritional and skin integrity assessments had not been up dated and were not reflective of their current needs. The lack of clarity within the care plans put the person at risk of receiving care that was not safe and did not meet their needs.

One person had been assessed as being at high risk of falls, had experienced several falls and they had been referred to the falls team by their GP. The person's mobility care plan stated that two staff members should

assist the person whilst mobilising. We observed one member of staff supporting the person whilst holding their hands and walking backwards. This did not safely support the person to walk and put the person at risk of falling as they were not supported in accordance with professional advice.

There was a system in place to monitor incidents and accidents. However, not all incidents and accidents were being investigated to reduce the risk of them occurring again. We saw that one person had a skin tear and bruising to their leg and was being treated by the district nurses; however no investigation into how the person had received the injuries had taken place. We saw other incident reports which documented bruising and injuries to people and no action had been taken to identify how the injuries occurred and minimise the risk of them occurring again.

People's medicines were not always being managed safely. We saw that some people were prescribed 'as required' (PRN) medicine to be administered when they experienced a period of anxiety. All of the protocols for the administration of these medicines lacked sufficient personal detail to inform staff when the person should be offered their PRN medicines. We saw one person was being administered PRN anxiety medicines on a regular basis and there were no records as to why the medicine had been given. In this person's care records on the day of the inspection it was recorded that they had been settled, however they had been administered their PRN anxiety medication. A senior carer told us: "We usually give them this medicine in the morning to settle them down". It was unclear why the person had been given this medicine if they had been calm and not anxious.

We looked at the way medicines were stored and found that regular checks were not being maintained of the equipment and environment that medicines were being stored in. Medicine fridge temperatures were not being taken and people's 'insulin' was being stored in it. This meant that the district nurses administering the 'insulin' could not be sure that it was safe for use. The rooms that the medication was being stored in were also not being checked for its temperature and some medicines required storage below a certain temperature. This meant that the provider could not be sure that medicines were safe to be administered.

We checked some people's medication records and found that there were some gaps in the recordings of when people had their prescribed creams applied. The registered manager told us that they had identified this with staff and had been trying to address them not signing to say they had applied the creams. This meant that they could not be sure that people were having their creams applied as prescribed. There was a medication audit being competed, however this did not include a check on the numbers of medicines available. The registered manager could not be sure that people were having their oral medicines as there was no regular stock check of people's medicines.

These issues above show that effective systems were not in place to ensure that people consistently received safe care and support. This constitutes a breach of Regulation12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that the standard of cleanliness within the service was poor. We found soiled mattresses and divan beds in some people's rooms which people were sleeping in. We saw one person's mattress had the plastic cover on that it had been delivered in still on the bed. A member of staff told us: "[Person's name] doesn't sleep on the cover we put a sheet on the top". The plastic cover was not meant to be slept on and put the person at risk of their skin becoming sore as they had continence needs. Some carpets were dirty and there was a malodour in some areas of the building. Some cushions were ripped which compromised the cleaning of them and the table cloths and mats on the dining tables were sticky with grease. People's personal equipment such as a walking trolley and slippers were dirty and required cleaning and this put

people at risk of infection as effective cleaning and infection control measures were not in place.

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2017.

One person who used the service told us: "Sometimes we have to wait for help from staff, the new ones are the worst". Staff we spoke with told us that they felt there were sufficient trained staff to meet people's needs, however we observed that a new member of staff who was on induction and was supposed to be shadowing a more experienced member of staff was left alone to support one person to eat. They were observed to be giving the person something to eat which was contrary to their care plan. This put this person at risk as the staff member did not know the person's assessed needs. We discussed with the registered manager the staffing levels throughout the service and they told us that there were sufficient staff available during the day, however we saw several people who would have benefitted from more support to meet their personal hygiene needs as several people looked unkempt and unclean.

Two people told us that they had been woken after they had gone to bed to have their medicines. A member of staff told us that this was because there was only one senior staff on duty who was able to administer the medicines and if they were busy elsewhere could not always complete the night medicines in a timely manner. A relative told us: "There is never enough staff on. They are down on some days to one staff and one senior. Then sometimes a senior does both floors for medication". The registered manager told us that they were in the process of recruiting to new positions as they had identified that more staff were needed during the evening and night time hours as after 8pm there was only one senior to administer medication. The registered manager had not considered using agency staff to fill this staffing deficiency and people were being disturbed to have their medicines. This meant that there were insufficient numbers of suitably trained staff to meet people's needs.

These issues were a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff who were being recruited by the provider were employed through safe recruitment procedures to ensure they were fit and of good character to work with people who used the service. Pre- employment checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had no concerns in the effectiveness of the service. At this inspection we saw that when people's health care needs changed or they became unwell that the appropriate health care advice was sought. People attended their GP, had support with their mental health care needs from a community psychiatric nurse and were visited by other health care professionals such as district nurses. However, we found that not people's care plans were reflective of their current health care needs and this put people at risk of not receiving the health care they needed.

Staff told us they felt supported by the management through regular supervision and training. There was a regular programme of training available and we saw records that confirmed that staff training was up to date and relevant to their roles. However, we observed that not all staff followed safe practise guidelines in relation to the moving and handling of people and in safely supporting people to eat and drink. We observed one trained member of staff unsafely supporting one person to walk and an untrained member of staff supporting another person to eat and drink in an unsafe manner. Neither of these incidents were seen and addressed by a senior member of staff. This meant that staff were not being effectively supported to fulfil their roles

People told us they generally liked the food and that they had choices. One person told us: "We have three or four choices. If I don't like what's on, I can have something different". Another person told us: "The food is good. Some days are better than others". We observed meal times and saw that people were offered choices and that they were able to eat their meals in an unrushed manner with support from staff if they required it.

Staff we spoke with told us that they not received training in the Mental Capacity Act 2005 (MCA) and the registered manager confirmed this. However, staff demonstrated they understood the principles of the MCA 2005. The 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 Act 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. We saw that people's mental capacity to consent to their care had been assessed in relation to individual decisions. One person had been refusing staff support and not to follow GP advice. We saw that this person had been assessed as lacking the mental capacity to make these decisions and that these choices may be detrimental to their health and wellbeing. We saw that a multi-agency meeting had been held with all the relevant people who were involved in the person's life and decisions to provide care and medication had been made in the person's best interest.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found referrals for people who had been assessed as lacking the mental capacity to agree to being at the service and other restrictions in place had been made. We saw one person had a DoLS authorisation in place with a condition attached to it. We saw that the condition had been met by the registered manager. The meant that the provider was following the principles of MCA 2005

by supporting people who lacked mental capacity to agree to their care at the service and to ensure they were not being unlawfully restricted.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had no concerns in how staff treated and cared for people who used the service. At this inspection we found that although we saw some kind and caring interactions not all interactions between staff and people demonstrated a caring and dignified approach. We conducted a SOFI which is a tool we use to observe people's care. During this process we saw one person who was living with dementia walking up the corridor and pointing towards the toilet. A member of staff came and diverted the person from the toilet saying: "You don't need to go in there, come and sit down", and led them away. As the person was walking away they became incontinent in the corridor as they had required the use of the toilet. This did not demonstrate a caring attitude as the person's needs were not being met and their dignity had been compromised.

We saw a member of staff support one person to another person's bedroom to have a visit from a district nurse. The member of staff did not consider the person whose room it was and respect their right to privacy.

Two people we spoke with told us that on several occasions they had been woken at night to have their medication. One person told us: "It was 11pm one night and I had gone to bed at 9pm. I shouldn't have to be woken up should I?" This did not show respect for people who were sleeping. We discussed this with the registered manager who told us that they were unaware that people were being woken to have their medicines but told us that they were recruiting to new senior positions in the evenings as they had identified there was not enough senior cover at night.

We observed that some people who required support from staff with their personal hygiene looked unkempt and unclean. We saw two people who had faecal matter in their finger nails. A relative of one of these people told us: "Look, the staff don't have time for the little important things, look at their finger nails", as they pointed to the faecal matter. We saw another person who required full support to change their clothes if they became soiled. At breakfast we noted that the person's t-shirt became damp and dirty from where they had unavoidably spilled their breakfast down it. At lunchtime we noted that the person still had the dirty wet t-shirt on and a tissue had been put between the person's skin and t-shirt to avoid them getting wet. We discussed these issues with the registered manager who told us that they did not feel that it was a lack of staff which meant that staff did not have time to care for people. This meant that staff were not treating people with respect and offering them the support they needed to maintain their dignity.

Some people had to sleep on dirty and soiled mattress and divan beds. One person's new mattress had been left with the plastic cover on it and we observed that the quality of some of the bedding such as sheets and pillows were poor. This did not demonstrate a caring and respectful attitude to people who used the service.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered choices about when they got up and when they went to bed and we saw that people

freely moved around the home as they wished. People told us there were no rules and restrictions about how they spent their time.

People gave us mixed views on how they felt they were treated. One person told us: "The girls (staff) are belting, I would tell them anyway if they weren't ". Another person told us: "Some girls are better than others, they help me have a bath and some can be a bit rough". People told us that their friends and relatives could visit them when they liked and we saw several visitors on the day of the inspection.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service. At this inspection we found that people did not always receive care that was based on their individual needs and preferences.

People had an individual plan of care. However the monitoring of people's care was not effective as records relating to specific care tasks were not always up to date and reflective of people's current needs. Some people required support with their anxiety at times and their care plans lacked clear and comprehensive information as to how to support people at these times. Staff did not always follow people's care plans to ensure their safety, for example one person's care plan stated they required two staff members to mobilise and we observed one staff member support the person in an unsafe way.

Some staff did not always appear to know people's individual needs. We saw one person was being escorted into the community with a relative and a member of staff went to get them their shoes. The staff member came back with someone else's shoes which did not belong to them. Another person was offered a drink of coffee and then tea, the person eventually shouted: "I don't like either of them I like milk". We observed a new member of staff supporting a person to eat who they did not know and this had put them at risk of harm.

We saw that people's care plans were reviewed on a monthly basis however people themselves were not involved in this process and they were not being regularly asked their views on the service they received except in occasional resident and relatives meetings. Some people we spoke with did not know who the manager was and had not raised their concerns which they raised with us during the inspection such as being woken at night to have their medicines. One person who used the service told us: "I talk to the girls (staff) if I want anything, I don't know who the manager is".

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to participate in hobbies and activities of their liking and the activity coordinator encouraged people to get involved but respected people's choice not to join in. We observed a game of bingo and there had been some community activities arranged which people told us they enjoyed. The service had some outside space which we saw one person enjoying. One person told us: "I have been to Blackpool and Southport". Another person told us: "I like knitting and dominoes".

We found that when the registered manager did receive formal complaints that these were dealt with appropriately according to the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had no concerns about the leadership of the service. At this inspection we found several concerns and the governance systems were not effective in maintaining and improving the quality of service for people.

The provider had systems in place to monitor and improve the service. However, the monitoring of incidents, accidents and unexplained injuries was ineffective as action was not always taken to minimise risk and improve the quality of care for people who used the service. This included the potential safeguarding incidents which had gone unreported to the local authority. This meant that people were at risk of continuing harm as systems were not in place to ensure lessons were learned and the appropriate action was taken to improve the quality of care for people.

Records of people's individual assessed care were not kept up to date to ensure that staff had the information they needed to care for people safely. There were no food and fluid charts to ensure people at risk of malnutrition or dehydration had sufficient to eat and drink to remain healthy. Records in relation to the repositioning of a person who was at high risk of developing sore skin were not being kept to monitor and ensure that they were receiving the care when they needed it. This meant that the provider could not be sure that people were receiving the care they required.

We saw that several audits were completed however these were not effective in improving the service for people. The medication audit had not identified the issues we found with the balance of stock and the fridge and room temperatures not being recorded and monitored. We saw the audit had noted gaps in staff signatures; however we found that there were still numerous missing signatures on people's topical cream charts. This meant that the medication audit was ineffective in identifying and addressing areas for improvement.

The provider's representative inspected the service regularly and we saw records of these checks. We saw that they had identified that medication stock control was not taking place, however action had not been taken to implement a system. We also saw that the inspection had identified a malodour in the upstairs area of the service and in the lift area and the registered manager had been asked to review the cleaning schedule. At this inspection we found that the malodours were still evident and the standard of cleanliness throughout the service including the equipment people were using was poor.

The service had been a recent infection control audit completed by an external agency and we saw that following the audit the registered manager had introduced mattress checks. We saw these checks were being carried out regularly, however we noted that two mattresses had been recorded as not being fit for use and both these mattresses were still in use. This showed that this audit was ineffective as it had not ensured that the equipment was replaced in a timely manner.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported by the registered manager and that they were approachable. However some people who used the service did not know who the registered manager was and had not been asked their views on the service. We saw that there had been several meetings held for all departments' since the registered manager had been in post. The registered manager and deputy manager told us that they had worked hard to support staff and to change the culture of the service to ensure people were put first. However, we saw that this had not been fully effective as from our observations not all people received a safe, effective, responsive and caring service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving care that met their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect.

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 always safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not being protected from the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by sufficient numbers of suitably trained staff.

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 People were not always receiving care and support that was safe.

The enforcement action we took:

We served a warning notice asking the provider to improve.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the service were not always effective.

The enforcement action we took:

We served a warning notice asking the provider to improve.