Roseberry Care Centres GB Limited

Swiss Cottage Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Swiss Cottage is a care home providing personal and nursing care to 73 people. Most people were living with some form of dementia, some were receiving end of life care. The service can support up to 85 people.

People's experience of using this service and what we found
One person's relative said, "I don't feel [my family member] is safe." Another person's relative told us the same. One member of staff said, "We are pushed to the limit, everyone has their breaking point." We asked one person if there was enough to do to keep them happy and fulfilled. "No, staff are mostly nice, but they don't have time."

People's safety was not being protected and promoted. Two people living with advanced dementia had left the home when it was not safe for them to so and had gone missing. There were failures in the security of the building and processes in place to alert staff and those in charge this had happened. Staff were not updated, and lessons were not always learnt when this and other incidents had happened before.

When people had potentially experienced harm, robust measures were not followed to promote their safety and rights. Safeguarding alerts and referrals to the local authority were not raised when they should have been. People's property in the home often went missing. Systems were not effective in securing people's property.

Staff told us there was not enough staff to always meet people's care needs. Most falls were unwitnessed by staff. Staff did not respond when fire exit alarms were sounded. Staff did not spend time with people to talk, give them comfort, and promote their mental and emotional well-being. Internally arranged events to promote people's interests, were not taking place at the home. The environment was not homely or comforting. One relative said, "The home is very clinical, it looks a bit tired."

There was ineffective leadership at the home. Staff did not feel listened too. When they raised issues with the manager, they said nothing changed. The manager of the home and provider were not effectively testing the quality of the care provided. The manager and provider were not looking at people's experiences to see if improvements were needed. The manager and provider no longer saw the clear shortfalls in people's care in terms of promoting people's safety and seeing what people's daily lives were really like.

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

Rating at last inspection The last rating for this service was good (published on 26 January 2018).

Why we inspected
We received concerns in relation to staffing levels, medicines, people not receiving personal care, staff not responding to a possible head injury, and clothes going missing. As a result, we undertook a focused

inspection to review the key questions of safe, responsive and well led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swiss Cottage on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care, staffing, person centred care, and the leadership of the home 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 rating, 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Swiss Cottage Care Home

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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by three inspectors.

Service and service type
Swiss Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection, the manager had applied to CQC to become registered manager and has since been registered by the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service over the last twelve months. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
We completed observations to understand people's experience of living at the home. We spoke with four people who lived at the home and spoke with 10 members of staff. We also spoke with the manager, deputy manager and the area director. We requested key documents and records to be sent to us safely using a secure e-mail address.

After the inspection
We reviewed a series of documents and sought clarification from senior staff to validate the evidence found. We looked at nine people's care records, staff employment checks, and a recent medicines and IPC audit. The service's action plan and various safety checks completed in relation to equipment used and the building. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the maintenance manager, a further seven members of staff and with eight people's relatives.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The manager told us that a person living with dementia, who needed assistance from staff when outside, had left the home alone without the knowledge of staff and been found by a neighbour.
- On the night of our visit to the service another person left the home without staff knowledge. The manager told us that this person had previously tried to leave the home alone on two occasions. On the latest occasion the person was found by the police nine hours later and needed to be hospitalised. The provider had not taken appropriate action to assess and mitigate the risks to people to allow them to leave the home safely with staff assistance should they wish to. This put people at risk of harm.
- We identified safety risks with fire exits being opened by people living with dementia who could then leave the building without staff available to accompany them. We were told by staff fire exits were used as routine exit and entry points by some staff and alarms were deactivated. We identified an internal coded door did not shut properly. This increased the risk of people leaving the home without the appropriate support from staff.
- Staff told us they understood they were all to go to the activated fire exit door if the alarm sounded. However, staff explained they were often busy assisting people and unable to leave them so hoped someone else would go to the fire exit. The manager did not have a system to ensure the alarm was responded to.
- There were no lessons learnt from previous times when people had left the building without staff knowledge. Robust investigations were not completed and there were no actions shared with the staff team to ensure risks were mitigated. One staff member said they found out about a recent incident through their colleagues talking about it in passing.
- Safe processes were not in place to ensure people's specific dietary needs were always followed by the kitchen staff. The Chef was unaware that one person was on a plan to increase their weight. This information was missing on the record they used. The Chef showed us the record they also used to check people's requirements and we saw that this had not been updated to reflect people's current needs. These shortfalls could put people at risk of choking and further weight loss.
- There were shortfalls in responding to incidents and falls, to try and minimise the risk of it happening again. For example, one person fell from their bed. No action was taken to mitigate the risk of them being injured from a fall in the future. The person then had a second fall and it was only then that the manager sourced equipment to minimise the risks to the person.
- Risk assessments and care plans did not always explore the risks posed to people, and did not give staff sufficient information to prevent the person and others coming to harm.

Learning lessons when things go wrong

All these issues had placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The manager and provider of the home did not have processes to identify and effectively respond to potential harm and abuse.
● The manager and provider had not made safeguarding referrals as required to ensure people were safe. For example, some people had come to the home with pressure sores, unexplained cuts and bruises. No action had been taken to follow this up to identify whether people were at risk of further injuries.
●One person was noted to have had an unwitnessed fall despite being assessed as needing one to one care. There had been no investigation into why the staff providing one to one care had not been present to observe what had happened or to take action to prevent the person falling.
● We found that a non-clinical member of staff had changed a person's wound dressing. We were told this had happened before and the wrong type of dressing had been applied. Staff had not raised this as a safeguarding concern or reported it to the manager.
● People's relatives told us people's clothes went missing. Staff and people confirmed this. We told the manager about this, and we were shown a large pile of clothes that no one knew who they belonged to. The provider did not have an effective system to protect people's property.

Poor staff knowledge and a lack of effective safeguarding systems had placed people at potential risk of harm. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There was not enough staff to promote people's safety. Staff said they were not confident people could be protected from falls. From 23 December 2021 to 28 February 2021 there were 30 documented falls at the home. 27 of these were unwitnessed by staff.
● Some staff told us they did not have time to give people showers. They felt they often had to rush people with their personal care.
● One member of staff said they saw staff rushing, not changing their PPE when entering another person's room. This put people at risk of infection. One staff member explained that they were aware staff did not always use the required equipment needed to reposition people safely in bed. This put people at risk of injury. Staff said they felt "Exhausted" by their third 12-hour shift each week. One member of staff said, "I'm on my knees by the start of the third day and I'm young."
● Staff told us there was not enough staff to spend time with people talking or to offer comfort to people.
● We observed in all areas of the home staff did not spend time engaging with people.
● The manager and provider did calculate how many staff they needed via a dependency tool. But they did not consider specifics such as the layout of the building; ask staff, people and relatives for feedback about staffing levels or observe care being delivered as part of their assessment of staffing levels.

We were not confident there was enough staff to always keep people safe. There was not enough staff to spend time with people and promote their well-being and quality of life. This placed people at risk of potential harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment checks were completed to promote people's safety.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. Relatives had reported to us they had been allowed into the home and into lounges without being given PPE to wear and a lateral flow test being completed.

● We were not assured that the provider was using PPE effectively and safely. We saw examples of staff not wearing their face masks correctly. One member of staff embraced a colleague on their arrival to the home.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. There was not enough staff to consistently keep people safe. We were not confident staff could be effectively cohorted to people with COVID-19.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● We completed a check of some people's medicines and found the correct amount had been administered. We observed a member of staff giving people their medicines in a safe way.
● However, we identified one person's prescribed topical cream had not been applied in line with the prescriber's instruction. This person was at risk of developing pressure sores. They did not have any pressure sores, but this was a potential risk to this person developing them. This medicine issue had not been identified by the manager's audits or by the staff who administered the cream.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was no social stimulation available for people. Staff told us and we observed staff did not spend time with people to enrich their day. Staff did not chat, check in on people and spend time with them, or perform an activity together.
- We saw people staring at blank walls with no stimulation in their bedrooms. Some people spent all their time in their bedroom. No attempts had been made to provide any interest or sensory stimulus for them in their rooms. For example, TV's and radios were not present or on. Dementia friendly techniques such as sound, tactile objects, or sensory lighting was not used or explored with people.
- Staff told us they wanted to spend time with people, but they did not have time to do this. One member of staff said, "Sometimes I sit with someone on my break, otherwise they wouldn't talk to anyone." Another member of staff said, "We don't have time to take people in the dining room to give them a different experience of being in their bedroom all the time."
- We observed and staff told us there were no events taking place inside the home to give people a stimulating or fun experience. One member of staff said, "The activity co-ordinator can't be everywhere, all we do is occasional bingo."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not receive person centred care in terms of their mental health needs and living with dementia. One person became upset and distressed. Several staff responded in a way which distressed this person further. There was no risk assessment or care plan to guide staff in how to support this person when they were distressed. Staff had not received specific training about how to manage this situation in an effective way.
- On two occasions we needed to prompt staff to respond to a person saying they needed assistance to use the bathroom.
- Staff told us they did not have time to give people a shower. We observed and were told by staff, having a facial shave and having people's hair styled was an occasional 'activity' rather than part of their daily hygiene routine. We were not confident people's care preferences were being met.
- Staff told us the kitchen was closed at night so there was no availability of hot snacks and yogurts for people. One member of staff said, "Some residents need to have yogurt to take their medicine, others want something hot, especially if they have slept through supper." We were told some staff shared their own packed lunches and brought in bread for people. They told us this issue had been raised before with the manager, but no effective action had been taken in response to this.

People were not routinely receiving person centred daily care. People's experiences were not being considered to give them interest and enjoyment in their lives. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● One member of staff said, "Relatives are always so grateful when we have cared for their loved ones who are end of life. I always make sure they are well presented when the relative visits after they have died."

● Given the lack of stimulation and time given to people, we were not confident this part of people's lives was being managed in a thoughtful and caring way.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers; Improving care quality in response to complaints or concerns

● This aspect was considered in some people's care planning. When staff did speak with people it was clear and at the person's eye level. However, care plans and assessments were not written in an accessible way.

● There was a complaints process in place. Relative's complaints were responded to.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The manager and provider of the home were not responding to risks to people's safety in a timely and effective way. There were inadequate processes in place to protect people who were living with dementia and at risk of leaving the home on their own. Action was not been taken following incidents to prevent further risks to people from the incident reoccurring.
- Managers and senior staff did not identify the possible signs of abuse or neglect when people presented with wounds, bruises, and cuts, when they first came to the home. They were not upholding people's rights in this area or keeping them safe from potential harm. Systems were not present to identify potential harm and to guide staff of what to do. There were no effective audits into this aspect of people's care.
- Accidents, injuries, and events which made people unsafe, were not robustly investigated, lessons learnt were not shared with staff, processes were not reviewed, or new ones implemented to ensure people were safe.
- The manager and provider of the home were not testing the quality of the care provided. Audits and checks were not being carried out to make sure mattress settings were correct; Whether people's dietary requirements were being met; whether staff knew how to manage situations when people became distressed. There was no analysis of falls to identify why there were a high number of unwitnessed falls. This put people at risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a person-centred empowering culture at the home. We saw and were told by staff that people did not receive care which promoted a good quality of life.
- We found there was not enough staff to spend time with people, to provide a social aspect to people's lives and promote their well-being. Staff saw this as an important part of people's lives, speaking enthusiastically about the people they supported. Staff said they were motivated to provide this support, but they did not have the time.
- Thorough checks on individuals care and quality of their daily experiences were not being completed, to satisfy themselves if the service was good. Audits focused on targets such as training completed but people's experiences were not being considered.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care; Working in partnership with others

● People, staff and people's relatives were not being asked in a meaningful way about their views of individuals care.
● The manager had not engaged with an NHS department about a person's change in need and funding despite numerous attempts from this department to do so. There were times the manager and provider were not accessing support and advice from other parties in relation to people's needs, when they should have done.

There was ineffective leadership at the service. Processes and effective systems were not in place to test the quality of the service and respond to failures and concerns. There was a lack of insight about the standard of care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider has listened to our concerns and feedback of the service. They have produced an action plan in response to our findings. They have told us they have taken action to start rectifying these issues.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care which promoted their interests and mental well-being. 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's physical safety was not being promoted at the home. There were poor processes to protect people. The management oversight and knowledge of what good safe care looked like was inadequate. 12 (1) (a) (b) (d) e

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Indicators of potential abuse and harm were not identified and acted upon. People's property was not protected. 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient levels of staff to meet

Treatment of disease, disorder or injury	people's holistic needs and keep people safe. 18 (1)

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The management and provider were not effective at assessing the quality of the care provided. They were not identifying failures in the service and making plans to resolve these. 17 (1) (a) (b) (c) e

The enforcement action we took:

We asked the provider to correct these failures in a short time frame. We asked them to report to us each month their progress made in monitoring and managing these failures.