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 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

About the service
Swiss Cottage is a care home providing personal and nursing care up to 85 people. The service provides support to adults with long term conditions, most people were living with some form of dementia. At the time of our inspection there were 41 people living at the home. The home was split over three floors, but the provider had recently closed the first floor.

People's experience of using this service and what we found

We found people were still not safe at the home. For example, people who had specialist diets and who were at risk of choking. Whilst the managers acted when we raised these concerns, they required us to direct them as to what action they should take. We later had assurances of the work they had completed to reduce these risks, but we found there was still further work to be completed to make people safe.

The provider and managers auditing systems were not present or effective at meaningfully assessing the standard of care at the home and identifying if action was needed to be taken to make improvements. There were continued issues around the care of people who had poor skin integrity, effective care planning and providing a meaningful social experience.

The cleaning regime and maintenance at the home was not effective, with stained flooring and equipment, some rooms were tired in appearance and some communal spaces were cold. Staff were not following correct procedures for the safe disposal of their personal protective gloves.

Staff were not always respectful of people's bedrooms and their privacy. Some people still felt bored and some said the planned social events did not interest them. Other people spoke positively of the social events, which was an improvement from previous inspections.

People were not 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 support this practice.

People spoke well of the food and drinks, but the dining experience was limited and those who needed support to eat were not always supported well at these times.

There was positive feedback received about end of life care at the home, but further work was needed in the planning and recording of this care for individuals.

Relatives and people felt safe at the home. One person told us, "Yes I do feel safe." A relative said, "At the moment I think that [name of relative] is safe because they [care staff] are all keen and are always being proactive, they [staff] always phone us up if there are any issues." Another relative told us since their relative

moved to the home their health has significantly improved, they said, "I now have my [name of relative] back."

Relatives spoke well of the managers and staff at the home. They had worked hard to make improvements to people's experience of care, but we had not seen significant, sustained and embedded improvements.

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 27 May 2022). The provider completed an action plan and we had continued to impose conditions on their registration at this location. At this inspection we found the provider remained in breach of regulations. This service has been in Special Measures since 11 September 2021.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

Enforcement and Recommendations
We have identified breaches in relation to promoting people's safety, how person centred the care experience was, restrictive practices to people's freedoms, and how effective the leadership was at this time.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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? 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 caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. The service was not well-led.	**Inadequate**

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 Health and Social Care Act 2008.

Inspection team
Two inspectors and an Expert by Experience completed this inspection. 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
Swiss Cottage is a 'care home'. People in care homes receive accommodation, nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Swiss Cottage is a care home with 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 not a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 24 November 2022 and ended on 20 December 2022. We visited the service on 24 November and 8 December 2022.

What we did before the inspection
We spoke with the local authority to gain their views of the home and looked at the information we held about the service. We also reviewed the action plans the provider had sent us. We used the information the

provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time at the home over two days so we could see how people were treated and supported by the staff and the managers of the home. The management team was made up of the nominated individual (the nominated individual is responsible for supervising the management of the service on behalf of the provider), a regional operations manager, acting manager, and peripatetic manager. We completed a check to see people had received their medicines. During the inspection process we reviewed 15 people's care records, assessments, and care plans. We also reviewed staff employment checks, medicine records, incident reports, training records and managers daily check records. We spoke with 7 people, 9 staff, 12 relatives, the provider's operations manager, peripatetic manager and nominated individual. We also requested information to be sent to us via secure e-mail, in relation to risk assessments, care plans, reviews, injuries and safeguarding analysis, incident reports and investigations, fire, building and equipment safety checks. We also spoke with two professionals.

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure people were always safe. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. We also found new issues which contributed to this breach.

- Two incidents of people choking had occurred, whilst people did not experience significant harm, action had not been taken to reduce the risk of further incidents of choking. We required further action to be taken as part of this inspection. During our second visit to the home we found that the action had not been fully embedded into safe staff practice.
- People did not have any pressure damage to their skin which had originated at the home. But some people's pressure equipment was not set correctly which put people at potential risk of harm.
- Key risks had not been identified by managers and staff. For example, one person who was at risk due to how they wanted their bedroom to be maintained and following an identified fire safety risk from an external fire safety company, managers did not take swift action to reduce this risk.
- When some people's needs changed risk assessments and care plans were added to, rather than rewritten, which could cause confusion for the staff following them.
- A person living with dementia who had posed a risk to others, and who regularly wanted to go into other people's rooms, was not always being supported by staff in a safe way to reduce this risk.
- Staff had blocked a fire exit with a piece of equipment. We raised this with the management team to get this removed.

Preventing and controlling infection

- Areas of the home were not clean and well maintained, flooring was stained and dirty, paintwork was chipped in a number of areas.
- Peoples furniture and equipment was in poor repair or not cleaned, one person's armchair was badly stained, a soiled commode lid had been left in the person en-suite, pressure mats were marked and looked dirty.
- Staff were not following safe infection control practices when disposing of their personal protective gloves.

Using medicines safely

● People who were at risk of choking and prescribed thickening agent to be added to their drinks, were at risk of choking due to poor staff practice with how this product was administered. Changes were made to these practices, but these were not fully embedded when we checked this aspect of people's care.
● A person's as required mood controlling medicine, guide for staff to follow, lacked information to ensure this medicine was not given inappropriately. This person's medicine care plan also lacked this information.

Learning lessons when things go wrong
● We found repeat themes when lessons had not been learnt from previous times. For example, pressure care management and ensuring people received their specialist diets.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service which placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe at the home. One person said, "Safe oh yes, no one comes in her unless they are a patient." A person's relative told us, "Safe, oh yes, I don't know exactly why I feel that, but if anything happens to [name of relative] they [staff] always get in touch with me."
● We completed a check on a sample of people's medicines and found these tallied.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to ensure people were protected against potential abuse. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.
● Staff knew what potential abuse could look like and what they must do if they had concerns.
● When people experienced potential harm when they were in hospital, managers appropriately raised these incidents as safeguarding referrals.
● However, the management had still not ensured people's property was always protected. Even when people moved rooms no inventories took place. There was still unclaimed clothing in the laundry room. Some people's relatives told us their relatives did not wear their own clothes, despite labelling them.

Staffing and recruitment
● New staff had DBS (disclosure and baring service) checks in place before they started working at the home.
● Other staff recruitment checks were completed such as obtaining and verifying staff references.
● Enough staff were available to meet people's needs. Staff and people's relatives told us there was now enough staff to support people.

Visiting in care homes
● Relatives were free to visit their loved ones when they wanted to.

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. The rating for this key question has remained 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.
- A person who had capacity was being restricted by staff when they were trying to do something important to them. The management had created care plans promoting this restriction, they and the staff who supported this person had not understood the principles of the MCA and re-assessed this need as circumstances changed.
- The need for regular effective and meaningful reviews had not been identified by the staff and managers.

A person was not being consistently treated in a way to promote their rights in relation to the MCA, this posed a potential risk to others due to staff and managers understanding about this subject. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- Two people were not receiving their specialist diet that was required following a professional assessment.
- People's care plans and risk assessments in relation to food were not always effective in exploring the risk and guiding staff about how to meet this need. Including if someone chose to go against it.
- One person who needed assistance to eat was being rushed and given large spoonful's and not enough time to chew and swallow before the next one. We informed a manager about this because of the potential associated risks, they said they would talk with all the staff about this.

People were not always being supported to receive their specialist diets and food in a safe way. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● For people who were identified at risk of malnutrition, action was taken to help them increase their weight.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● A person repeatedly missed their medicine review held by professionals due the poor management of these appointments by managers at the home.
● For people who needed medicine reviews who were prescribed mood controlling medicines there was no effective system to monitor these reviews had taken place or if other actions were needed to ensure they did.
● We found there were times when staff and managers did not always work effectively with professionals. There were shortfalls and missed opportunities when a professional was asked by the local authority to support people to prevent their limbs from becoming contracted. There was poor communication with staff, care plans and risk assessments were not completed, and the associated equipment could not always be found.
● Nurses contacted health professionals when people were unwell.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some people did not have risk assessments and care plans to identify and explore the risks and support they needed. For example, a person who was living with health conditions, did not have a risk assessment or care plan to ensure staff met these needs.
● Observation records when an incident of choking had occurred were poorly documented and failed to monitor and record any observations following the incident.
● Some care plans and daily notes were handwritten and were not fully legible. The management team were aware of this and had a plan to correct this.

Adapting service, design, decoration to meet people's needs
● In one part of the home, people did not have access to a social communal space which they could access independently. This was not conducive to a social experience.

Staff support: induction, training, skills and experience
● Care staff and nurses told us their training was good, but most were unable to describe what had been good or helpful about the training in relation to their work.
● There were gaps in staff's training, not all staff had up to date training.
● Managers completed clinical competency checks on nurse's knowledge and skills, but most nurses could not tell us what clinical skills had been assessed or provide a view of how effective these assessments had been.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated with respect. A member of staff was supporting a person in their bedroom, they became upset, we heard the member of staff saying in a frustrated way, "Come on!"
- A person told us how they had been, "Told off" for pressing their buzzer three times to seek support to use the bathroom. They also told us when they did receive support they were left in a condition, which they were not happy about.
- One person had photos taken of them to show staff how to position them in bed, these had been placed above their bed on the wall. Other people had posters on their bedroom walls telling staff about their interests and backgrounds. These were also placed in non-discreet places.

Respecting and promoting people's privacy, dignity and independence
- People told us, and staff entered people's bedrooms, without knocking or asking if they could come in. A nurse was seen to enter a bedroom without knocking or even speaking with the person to say what they were doing.
- Generic underwear had been made available in case someone had an incontinence episode, this was not promoting people's dignity.
- Incontinence items were stored in people's rooms in obvious places. Sometimes there was a lot of these items stored in some people's bedrooms and en-suites. A person had someone else's wheelchair stored in their en-suite without their agreement.

People were not consistently treated in a respectful way, which could have a negative impact on people's well-being. This was a breach of regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Alongside these experiences we did see staff treating people in friendly ways when supporting people with care tasks.
- One person said, "I find the girls (staff) are very good and always helpful." Another person said, "[Name of member of staff] took me down for a shower today, that was lovely."

Supporting people to express their views and be involved in making decisions about their care
- One document about people's needs did show people had been involved in seeking people's preferences of care. But people told us they had not been involved in writing their care plans. People's reviews were not written in ways which showed they had been involved in these reviews. Further work was needed here to

involve people when possible in making plans for people and their reviews of care.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

At our last inspection the provider had failed to ensure people experienced a person-centred care experience. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

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

- Most people spoke well of the planned events but outside of these they felt bored with little to do. One person said, I feel weary a lot of the time, it is often quiet, no one comes and chats very often, I think I am just waiting." Another person said, "It does get very quiet here, I would like it to be a bit livelier sometimes." A further person said, "I'm bored a lot of the time really, there is nothing going on for me."
- There were records of one to one time with staff, but these gave no indication of how long this one to one time lasted for. There were missed opportunities to make use of information in people's care plans and in these records to provide events which were tailored to individuals' interests.
- For people who spent a lot of time in their bedrooms or in bed staff did not routinely spend social time with these people. Staff did not demonstrate they knew people.
- Internal doors routinely banged loudly even though people were nearby in their beds resting. The lounge and dining room was routinely cold and on two occasions we needed to raise this for staff to act, by turning the temperature up. The management team were not effectively monitoring this.
- Some parts of the home and some people's bedrooms looked tired in appearance, with stained flooring and marks on the walls.

People were not in receipt of a person centred social and care experience. This placed people at risk of harm in relation to their mental well-being. This was a continued breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

- Relatives and staff had given positive feedback about people's end of life experiences. But the end of life plans, were basic and lacked information. End of life reviews also did not demonstrate meaningful chats or reviews had been attempted about this subject.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care plans, risk assessments, and reviews were not in formats which were accessible to people.
- When staff supported people, they spoke clearly to them. Staff communicated via a white board for one person.

Improving care quality in response to complaints or concerns

- There was a complaints process in place which managers followed. Compliments were also received from relatives when their loved ones had died.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained 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.

At our last inspection the provider had failed to effectively assess the quality of the care provided. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- There continued to be key shortfalls in relation to monitoring pressure equipment, ensuring people received their specialist diets, the hygiene of the home, risk assessments, reviews, effective record keeping, medicine reviews, and checks on whether the MCA was being implemented. These all demonstrated poor quality monitoring by the management team.
- Analysis of injuries and safeguarding events continued to be ineffective. The management were raising a high level of safeguarding referrals to the local authority each month for example in November 2022, 24 referrals were made. However, the management analysis was not robust, looking at each one to consider themes and actions they could take.
- When investigations were completed by manager's they failed to identify the key issue and take the appropriate action. For example, when a person on one to one support fell, a key failure was not identified here, which prevented lessons to be learnt, so it did not happen again.

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

- We still found issues with how people were supported to ensure they had safe and person-centred care. For example, staff were not always thoughtful or respectful towards people.
- The management and provider did not have a good understanding of what person-centred care in relation to promoting people's mental well-being, their interests, and offering people choices looked like. We found issues in these areas which the management had not identified.

Continuous learning and improving care; Working in partnership with others

- The management team had responded to some issues when these were identified to them, for example, risk of choking. But they were not proactive at identifying these issues themselves.
- Issues identified at previous inspections had been repeated, showing lessons had not been learnt, with effective systems put in place to monitor these aspects of people's care.

● There were missed opportunities to work with a professional about a project to help people have an improved daily quality of life. Some staff had embraced this, but there was poor communication from the managers with incomplete documentation, and actions taken to promote the project by the management team.

Systems had still not been established to effectively assess and monitor the quality of care provided which placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The management had made some improvements in relation to people's social experience following this being identified at previous inspections. For example, social activities were taking place and some one to one time was given to people.

● Staff and managers were not completing open and meaningful reviews of people's care to gain their views and consider if more support could be provided. For example, with end of life planning and promoting people's interests.

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

● Managers had failed to communicate fully with us during the inspection. During our first day of the inspection an incident took place which they had failed to tell us about or send in a notification until we prompted this.

● Following one significant complaint the nominated individual had taken action to review this aspect of care and was engaging with the complainant.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	There was not a consistent person-centred culture at Swiss Cottage. Systems had not been established to effectively assess and monitor this aspect of people's lives. This placed people at potential risk of harm in relation to their well-being.

The enforcement action we took:

Due to failures in governance and safety at two consecutive inspections, the CQC took action to remove the location Swiss Cottage from the register, effectively closing the service. The provider Roseberry Care Homes Ltd placed an appeal against our decision to close Swiss Cottage with the first tier tribunal. However, the provider then chose to withdraw their appeal. The CQC's decision to remove the location has now come into effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider was not ensuring people's rights were always being protected in relation to the mental capacity act 2005.

The enforcement action we took:

Due to failures in governance and safety at two consecutive inspections, the CQC took action to remove the location Swiss Cottage from the register, effectively closing the service. The provider Roseberry Care Homes Ltd placed an appeal against our decision to close Swiss Cottage with the first tier tribunal. However, the provider then chose to withdraw their appeal. The CQC's decision to remove the location has now come into effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at potential risk of harm.

The enforcement action we took:

Due to failures in governance and safety at two consecutive inspections, the CQC took action to remove the location Swiss Cottage from the register, effectively closing the service. The provider Roseberry Care Homes Ltd placed an appeal against our decision to close Swiss Cottage with the first tier tribunal. However, the provider then chose to withdraw their appeal. The CQC's decision to remove the location has now come into effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not always receive their assessed specialist diets and those who needed assistance to eat and drink were not always supported in a safe way. This put people at risk of harm.

The enforcement action we took:

Due to failures in governance and safety at two consecutive inspections, the CQC took action to remove the location Swiss Cottage from the register, effectively closing the service. The provider Roseberry Care Homes Ltd placed an appeal against our decision to close Swiss Cottage with the first tier tribunal. However, the provider then chose to withdraw their appeal. The CQC's decision to remove the location has now come into effect.

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	There were key shortfalls with how the provider assessed the quality of the care provided at Swiss Cottage. Robust systems had not been established which were used to effectively assess and monitor the standard of care at the service. This placed people at potential risk of harm.

The enforcement action we took:

Due to failures in governance and safety at two consecutive inspections, the CQC took action to remove the location Swiss Cottage from the register, effectively closing the service. The provider Roseberry Care Homes Ltd placed an appeal against our decision to close Swiss Cottage with the first tier tribunal. However, the provider then chose to withdraw their appeal. The CQC's decision to remove the location has now come into effect.