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 to 49 people. The home is divided into three areas and set in woodlands. Most people who were living at Swiss Cottage were living with some form of dementia. The service can support up to 85 people.

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

People spoke well of the care staff. They said they found them caring and kind. One person said, "It does feel a bit like family here in some ways." Another person said, "There are some nice girls here, they are all very good and I feel safe with them." One person's relative said, "They (staff) do genuinely care for (relative) here, it has improved recently." Another also said, "I think they (management) needed that kick up the bum from last time, they (staff) have been top banana."

Since the last inspection we found improvements had been made, in relation to managing people's specialist food needs, skin and pressure care, and responding to those people who may have left the home in an unsafe way. Staff said communication had improved. Most staff were motivated to want to improve people's experiences of living at the home, to give them enjoyment and pleasure whilst living at the home.

Despite this we found there were still issues with the home. The provider and management team had not created a person-centred culture at the home. Staff were willing to spend time with people and help them to have a social life, but they did not have the time to do this. People told us they were bored, and staff told us people were not interested in the traditional "activities" such as bingo. Some staff had shown independent initiatives to change this, but this was not across the whole home, nor was it led by the managers and provider.

We also found this person-centred aspect of care was missing with food and drinks. Some people did find the food ok, but most did not like the choices. Assessments had not been completed to ensure people were getting their favourite foods and drinks. We were told there were now drinks and snacks available at night, but the provider was not checking this.

Relatives had been complimentary of the care their loved ones had received when they were at the end of their life. Although we did find shortfalls with the planning of end of life care.

Protecting people from potential harm and abuse had improved. But there were still shortfalls in the management systems to respond to bruising and injuries sustained in the hospital or the home. Investigations were not always completed when they should have been. When some people's needs were changing, we were not confident action was being taken to reduce these risks. Actions were taken when something happened, but there was also no consideration or investigation to consider if these events could have been prevented.

The management and provider's audits were not effective at identifying the shortfalls and issues we found. The audits completed to test the quality of the service did not always evidence what the person doing the audits, had done. Nor had they taken the opportunity to test aspects of the care provided when something happened. There was still not a culture of embracing lessons learnt and sharing these with the staff.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 24 May 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

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

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.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and always protecting people from harm, not providing person-centred care and how well led the home was.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always 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 Health and Social Care Act 2008.

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 completed by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Swiss Cottage is a 'care home'. People in care homes receive accommodation and nursing and or personal care as a single package under one contractual agreement dependent on their registration with us. 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

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 spoke with the local authority and reviewed the information we already held about the service. We used all this information to plan our inspection.

During the inspection
We spent time in the home to understand people's experience of living at the home. We spoke with ten people who lived at the home and spoke with nine people's relatives. We also spoke with nine members of staff as well as the operations manager, deputy manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a series of documents and sought clarification from staff to validate the evidence found. We looked at 15 people's care records and checked the medicines for five people. We reviewed three staff employment checks, and various safety checks completed in relation to equipment used and the building, which included fire related equipment. We reviewed audits completed by the management team.

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 robustly assess the risks relating to the safety and welfare of people, which put people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made in this area, but not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- There were shortfalls with how staff and management were responding to changes in people's needs.
- One person had rolled out of bed and experienced an injury. Staff knew this person's needs when they were in bed had changed, but there was no action taken and a new plan was not put in place to manage this risk, before this injury.
- Another person had sustained an injury due to how they were getting into their bed. Staff were aware of this risk, but there was no assessment of this risk and no plan put in place to reduce this risk.
- When a person experienced an injury, actions had been taken at the time of the accident. But we were not confident there was a robust understanding by staff, and effective systems to continuously assess risk and take action, to reduce the risk.

Using medicines safely

- Anticipatory medicines were not always administered according to best practice.
- One person had received a 'as required' medicine to manage distress. Nursing staff had administered the highest prescribed volume of this medicine the first time this person had it. Which had resulted in this person being sedated.
- The nurse did not provide a documented rationale for why they had done this. Nor had their nursing colleagues questioned this or raised this issue at handover or when they had counter-signed for this medicine.

Staffing and recruitment

- The provider was not always ensuring safe recruitment procedures were taking place.
- In a sample of three staff recruitment checks completed, one new member of staff did not have evidence their identity had been verified. We found references were not verified for two members of staff. Staff did not always have a full employment history documented.
- The provider had not ensured those staff completing these checks were doing so in compliance with the

regulations.

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. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People felt safe, but some were not overly confident about feeling safe. One person said, "I am safe here, I trust them (staff)." Another person said, "I feel safe to a certain extent, the carers try their best here."
● Various and regular safety checks on the equipment used and the building took place. This included fire risk assessments and related equipment, such as fire doors.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to robustly protect people against the potential risk of abuse. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made in this area, but not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● There were still shortfalls in the management's safeguarding systems. Potential abuse was not always reported or investigated.
● When one person arrived from hospital with multiple bruising no investigation took place, no safeguarding referral was raised and no conversation with the safeguarding team took place.
● When a person sustained an injury, when being supported to move by two staff, no thorough investigation was completed, nor a safeguarding raised.
● Staff were clear about the potential signs of abuse and said they would report this to the managers. But staff did not always know who they could report abuse to, outside of the home.

Systems had not been effectively established to always protect people from potential abuse which put people at potential risk of harm. This was a continued breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure there was enough staff to keep people safe. This was a breach of regulation 18(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 18.

● On the day of inspection there was enough staff to meet people's physical care needs. But we did not believe there was enough staff to spend social time with people.
● People told us staff responded in a reasonable time when they needed assistance. One person said, "I do use my buzzer, they (staff) are pretty good and come quite quickly." A relative said, "(Relative's) carers are all fine, but I don't think (relative) gets enough stimulation.
● We found staff answered people's buzzers in a short time, but staff did not spend time with people and people confirmed this to us.
● Staff had disclosure and barring service (DBS) checks in place before they started their inductions at the home.

● New staff had references and their 'right to work' status checked.

Learning lessons when things go wrong
● The provider and management team were not effective in learning lessons when things went wrong.
● When mistakes and incidents had been made in the past, the provider's audits did not look at these themes and topics to see if lessons had been learnt. Such as when people went missing, when clothing went missing, and with end of life planning.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 using PPE effectively and safely.

● 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 was making sure infection outbreaks can be effectively prevented or managed.

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

● The provider and management team at the home ensured people's relatives and friends were able to see their loved ones as they wanted. This was in a safe and private way.

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

Staff support: induction, training, skills and experience

- Records indicated staff training was up to date. However, staff struggled to recall what training they had had and what was good about it, or how it had helped them in their work.
- Staff did not have regular supervisions; they could not recall their last supervisions. We noted staff did not have planned supervisions dates. This was corrected, but this was prompted by our inspection.
- Nursing staff did not believe the provider supported them to develop their clinical skills and knowledge. They said they relied on asking visiting professionals for directions on this.
- There was no post training or debriefs to promote staff understanding in complex issues such as dementia care. We also found shortfalls with how changing risks were being identified and managed, how anticipatory medicines were administered, and end of life was being planned for.

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

- Improvements had been made with how the kitchen staff supported people to have their specialist diets.
- Food was now available for people in the night and if they wanted hot and cold snacks.
- We could see people who were at risk of being a low weight had specialist food teams involved. Some people had food and fluid charts which showed they were eating foods and having drinks as recommended by the specialists.
- However, we found shortfalls with these records such as not showing what had been offered but declined. Also, one person was receiving this specialist support but there was no way of monitoring what they were eating and drinking as agreed as they had no food chart. People's specialist food care plans often lacked the details of what the specialist team had recommended.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- One person told us, "This flipping covid is a nuisance, but I've never had anything since being here, not even a cold." A relative said, "If (loved one) needs a blood test or anything, they (staff) phone me, tell me what is happening."
- Improvements had been made with how people's skin and pressure care was being managed. People's pressure mattresses were set to the correct settings. People did not have any pressure damage from their care in the home.
- People had support from health professionals when they needed this, which also appeared to be timely.

● Staff told us what the plans were for helping some people to get better and which health professionals were involved.
● People had assessments in place identifying the key risks which they faced.

Adapting service, design, decoration to meet people's needs
● Work had been made in some areas of the home to make the environment calm and friendly for those living with dementia.
● Attempts had been made to reduce the institutionalised appearance of some parts of the home. But more work was needed here.

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.
● Staff had a clear understanding of the importance of offering and promoting the choices available to people. Staff also understood what mental capacity meant in practice.
● When a 'best interest' process was needed this took place. Although we found some shortfalls with the records of these processes, lacking detail in who was consulted with and what was said at these conversations.

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, when we rated this key question, we rated it good. At this inspection the rating has changed to 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 spoke well of the care staff and we saw some staff treat people in kind and caring ways. However, we were also told issues with how some people were being treated in the home. Some people felt isolated and bored. We saw staff not talking to or involving people in their care. The provider had not ensured that people's individual preferences, interests, and likes were being prompted at the home.
- Some people were not always treated and supported in a safe way when their needs were changing or if they experienced an injury or arrived at the home with bruises.
- One person told us, "I am quite happy, the girls (staff) look after me." Another person said, "Some of the young ones are lovely, there are some nice girls, they are very good." A person's loved one said, "I can't fault any of the carers, the care is consistently good, the home is spotless, our one to one is marvellous."

Supporting people to express their views and be involved in making decisions about their care

- Staff spoke with us about how they did this with key decisions of the day, such as what people wanted to wear and what the food options were.
- Some staff had developed their own ways of doing this, to promote choice. One member of staff said, " I make sure I have two meals ready to give, so I can show people who have dementia what the options are, as they may not understand if I tell them, or they may just prefer to see what it (meal) looks like."
- However, we also found examples when people were not involved in their care planning. When their likes, dislikes, and interests were not being considered.

Respecting and promoting people's privacy, dignity and independence

- One person said, "I don't like having male carers, and they (staff) respect that." Staff were respectful when assisting people to eat and drink. We heard a member of staff say to a person before lunch was served, "We will use this (clothes protector) to protect your blouse."
- Doors were closed when people needed personal care and staff knocked on people's doors to enter, but they did not wait to hear if the person was ok with them coming in.
- One person had significantly improved their mobility since moving to the home. Staff said it was because they supported this person to walk about the home.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

At our last inspection the provider had failed to ensure people received positive social experiences at the home. 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.

● Some staff had looked at creative ways to make people's time at the home a social and enjoyable experience. They had planned some events. We saw one of these events and staff got involved, to make it fun for people.
● However, most people in other parts of the home were often left on their own, with no interaction, chatting, or with staff doing something of interest with them.
● We found staff did not have time to do this because they did not have enough time. Some staff said they saw this as part of their job, but often would try and fit this into their tasks. Other staff did not provide this support to people at all because they lacked the skills to. We saw this when staff sat and watched TV with some people and did not speak with them and when some staff gave people their meals without saying anything.
● One person told us, "The days can be very repetitive here." Another person said, "I am bored here, there is nothing to do." Someone else said, "If you don't find someone to chat to, it's a very long day."
● Staff told us how they did not think the 'activities' on offer did much for people. They said people found these boring. Staff did not feel listened to by management when they shared these views.
● The provider had not created a person-centred culture where staff spent time with people and tried to find ways to make people's experiences happy and enjoyable.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● There was still no planning of personalised care, to explore people's current interests, or what they were interested in before they moved to the home.
● There was no attempt from the provider to check this was happening for people and if staff had the time and skills to do this.
● Some people had reviews of their care, but these often did not involve the person, even when they could contribute.

● One person was living with advanced dementia, staff said this person needed more one to one time with staff, but this was not happening. Nor had specialist dementia advice been sought to try and make life more enjoyable for this person.
● Some people were not happy with the food. We were also not confident people were regularly eating and drinking what they liked, their favourites and what made them happy. This was not being considered when planning this part of people's care. The provider was also not testing people enjoyed what they ate and drank.

End of life care and support
● People did have end of life plans in place, but these were basic and not personalised. Even when some people had indicated they had spiritual wishes and beliefs. These plans lacked information and practical details to support staff to meet these needs.
● Key aspects of one person's end of life plans were absent, even though staff knew this person was dying.

There was not a consistent person-centred culture at Swiss Cottage. Systems had not been established to assess and monitor this aspect of people's lives. This placed people at potential risk of harm in relation to their well-being and mental health. This was a continued breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's relatives had sent cards of thanks to the staff for looking after their loved ones when they were dying.

Improving care quality in response to complaints or concerns
● There was a complaints process in place. Related documents showed complaints had been responded to, with contact made with the complainant.
● However, the provider was not checking, when complaints had been raised and lessons identified, that lessons had been learnt in practice.

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.

● When staff talked to people they spoke clearly and directly with people. Sometimes getting close and at their eye level. This also included writing on a white board for one person.
● One member of staff said when supporting a person to drink, "Ok, are you ready, I will tip it up a bit. Is that ok?"
● Staff explained to us how they spoke with people when they were providing care to them, to help them understand and be involved with this.

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 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 robustly assess the standard of care provided at the service to ensure people lived safe and fulfilling lives. 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

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

- Improvements had been made in some areas, such as protecting people who may leave the home in an unsafe way, ensuring people had their specialist diets and their pressure care was well managed. Staff told us managers had improved, how information was shared with them. However, there were still key failures.
- The provider and management team had not ensured there was a person-centred culture at the home. They had not created systems to promote this, nor were they assessing this aspect of the care provided. They had not considered if they had the staffing for this.
- There was still not a culture of learning lessons when something goes wrong. Despite some key failures at the last inspection and following the inspection, the provider was not testing these lessons had been learnt. They had not created systems to do this and share these lessons with staff.

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

- When the provider had completed audits, these often-lacked evidence to show the audit had been robust.
- There were missed opportunities to investigate and test the quality of care provided and respond to potential risks. Such as when a person acquired a bruise when staff were supporting them. Or when there was an increase in falls at a particular time of the evening.
- Investigations into injuries and accidents did not consider if staff were not responding to the emerging risk for these individuals. It only focused on responding to the new risk and injury.
- The audits had not identified shortfalls in recordings. There was a continuous theme of poor documentation in reviews, care re-evaluations, and care plans. There was a lack of evidence, rationales or recorded actions taken when nursing staff had made clinical decisions, and when people had fallen.
- The provider was not meaningfully assessing the competency of staff and the training they were providing. Nursing staff felt they were not being supported to develop their clinical knowledge. There were no attempts to build on the training provided and develop a culture of continuous learning.

There were still 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. 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; 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; Working in partnership with others

- Attempts had been made to do this, seeking feedback from relatives. Some staff had asked people about their views of the social life at the home. But the provider had not prompted this.
- There was not a culture of involving people in planning and reviewing their care. Considering if the care was person centred and seeking feedback about all aspects of their care.
- The provider had responded to complaints raised by relatives.

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

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been effectively established to always protect people from potential abuse which put 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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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.