Roseberry Care Centres GB Limited

Swiss Cottage Care Home

Inspection report

Plantation Road
Leighton Buzzard
Bedfordshire
LU7 3HU

Tel: 01525377922
Website: www.roseberrycarecentres.co.uk

Date of inspection visit:
09 August 2023
17 August 2023

Date of publication:
30 October 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Swiss Cottage is a residential care home providing personal and nursing care to up to 85 people. The service provides support to older people, some of whom are living with dementia. The home consists of 4 units, of which 2 were used. At the time of our inspection there were 30 people using the service.

People's experience of using this service and what we found
People were not always protected from abuse and improper treatment. People did not always receive safe care as individual and environmental risks were not always well managed. Learning could not always occur from incidents and accidents or when people experienced emotional distress due to a lack of reporting. There were shortfalls in infection prevention and control. Topical medicines and thickening agents were not always safely managed. There were enough staff deployed, however they did not always work effectively to meet people's needs. Relatives felt staffing levels had improved. People were able to receive visitors without restriction.

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. Although, the policies and systems in the service supported this practice, they were not always operated effectively.

People did not always have their health needs met or well monitored and were at greater risk of weight loss due to unmet nutrition needs. Food was not always appetising, and people were not always offered choice and variety in what they ate. Staff had received training and supervision, but this had not resulted in safe practices.

People were not always treated with dignity and respect. For example, personal information was displayed on people's walls, which informed passers-by of confidential information about their needs. People's gender preferences about who supported them with personal care were not always upheld.

Records showed people's hygiene preferences were not maintained. Care plans did not always contain person-centred information about people's past histories and preferences. People did not receive regular support to take part in meaningful activities.

Systems and processes continued to be ineffective and did not ensure people received a quality service. The provider did not always follow their own policies relating to areas such as infection prevention and control, falls management and safeguarding. There was not an effective system to review and ensure care plans were accurate. The provider had not submitted all required notifications to CQC. However, relatives were kept up to date. People, relatives and staff felt the registered manager was approachable.

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 22 February 2023). 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
We have found breaches in relation to people's safety, safeguarding, person-centred care, dignity and respect, nutrition, handling complaints and good governance.

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 of 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 3 inspectors, a medicines inspector and 2 Experts 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 9 August 2023 and ended on 31 August 2023. We visited the service on 9 August 2023 and 17 August 2023.

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 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 spoke with 9 people who used the service and 15 relatives about their experience of the care provided. We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service.

We spoke with 22 staff including domestic staff, maintenance staff, kitchen staff, care staff, nurses, the registered manager and the regional operations manager.

We reviewed 17 people's care records. We looked at 3 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, quality assurance reports and accidents and incidents.

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.

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.

Assessing risk, safety monitoring and management;

- The provider failed to always manage safety risks in relation to people's mobility. For example, 12 people's care plans did not guide staff about their type of sling or which loops should be used to promote their best positioning, comfort, and safety. We also found incorrect information in care plans about equipment people could use and how many staff needed to support them to mobilise. For example, a person's care plan stated they could use a standing aid when they can no longer stand. This increased safety-related risks to people.
- Risks to people with swallowing difficulties (dysphagia) were poorly managed. Staff had failed to lock thickening agents away, this posed a risk to people living with dementia who may accidently ingest the thickening agent, resulting in asphyxiation. Despite having a secure staff room, staff's food and drink were left accessible in communal areas; these foods were unsafe to consume by some people. Dietary prompt cards, which listed how to prepare people's food safely, were not always present. Staff on duty were to carry dietary prompt cards but had not signed these in or out since June 2023. A person's care plan contained conflicting information about their risk of choking. This increased choking-related risks to people.
- We observed that people did not always have their call bells within reach. This meant staff had not always ensured people could call for assistance. This increased safety-related risks to people.
- People's care plans did not always contain accurate information about the measures required to mitigate known risks. One person's care plan contained conflicting information about when they should wear mitts to prevent them from harming themselves.
- Risks relating to fire doors were not always well managed. We observed staff had held a fire door to a lounge open with a chair and placed 2 people who could not mobilise independently in this room. In addition, we found a fire door did not close as it should on an unsecured bedroom used as storage. This increased fire-related risks to people.
- Environmental risks were not always well managed. We found freestanding furniture in communal areas was not always secured to walls. This increased risks that people could pull this furniture on top of themselves if they fell. There was an additional risk to one person at greater risk of falls, who was known to move furniture. Scissors were left unsecured in a nursing station, increasing the risk of injury from sharp objects. A light in a store cupboard for hazardous substances had not been working, making it difficult to see and collect products safely.
- People were at risk of burns from uncovered radiators. We found Swiss Cottage to be uncomfortably hot

on the first inspection day, we identified several radiators in communal areas and people's bedrooms needed to be covered or replaced with a more suitable type.

Learning lessons when things go wrong

● While reviewing care notes, we found a person had choked while eating 2 days before our inspection. As the staff member had not completed an incident or accident form, the registered manager was unaware of this concern until we highlighted it. Not completing accident and incident reports increases the risk of actions not being taken to manage risks to people.

● Antecedent Behavioural Consequence (ABC) charts were not completed for a person who experienced frequent emotional distress related to their mental health. ABC charts help to identify themes, trends and best support practices when people experience emotional distress. This meant themes and trends could not always be reviewed to inform care plans and manage risks relating to the person's well-being.

Preventing and controlling infection

● There were shortfalls in managing infection risks relating to food preparation. The area where kitchen staff changed into uniforms, had an excess build-up of dirt, dust and cobwebs. We also observed that a chef wore a wristwatch and an unclean apron that had not recently been washed. On the first inspection day, we were not asked to wear aprons or overcoats before entering the kitchen. The failure to follow food hygiene measures meant people were at increased risk of infection.

● Not all areas could be cleaned effectively due to these areas requiring refurbishment or replacement. We found communal bathrooms with chipped paint, excessive panelling gaps behind sinks and toilets, and a rusty handrail. A person's bedrail bumper was excessively dirty and ripped. Additionally, a communal lounge had excess dirt and dust on the floor and skirting boards. These concerns increased the risk of infection harbouring.

● Safe infection prevention control practices had not always been followed for disposable gloves, as we found these had been disposed of in a person's waste bin.

● People were at increased risk from Legionella, a group of bacteria which can be found in water. Care homes must ensure water temperature is managed to prevent a build-up of Legionella, which can cause Legionnaires' disease, a type of pneumonia. We found concerns relating to water temperatures since January 2023. This increased health risks to people.

Using medicines safely

● The provider did not ensure topical medicines administration records (TMAR) were always in place or prescribers' instructions specified where people needed these medicines to be applied. This increased the risk of people not receiving their medicines correctly.

● Risks relating to people who could experience constipation was not well managed. We found 2 people were prescribed laxative medicines. However, staff had not followed care plans to record bowel movements to ensure they were not experiencing constipation. This meant people were at increased risk of constipation.

● Some people were prescribed medicines such as pain-relief, laxatives, and inhalers to be taken on a when required (PRN) basis. Guidance in the form of PRN protocols were in place, however they did not always have enough information about the person to help staff give these medicines consistently or if a person should receive a higher or lower dose of variable dose medicines.

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

● Medicines including controlled drugs (CD's) were stored securely and at appropriate temperatures.
● Some people living at the home were given medicines covertly. The staff had carried out the necessary assessments to give medicines covertly safely. Covert administration is when medicines are administered in a disguised format hidden in food or drink.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from abuse and improper treatment.
● The provider had not submitted a safeguarding referral for an allegation of abuse against a staff member which had resulted in disciplinary action. This was discussed with the provider during the inspection, however following the inspection the local authority informed us they had still not received a referral. This meant the concern could not be independently reviewed to determine if it needed further investigation by the local safeguarding authority. As a result, CQC made a safeguarding referral.
● People's personal hygiene needs were neglected by staff. We found evidence a person had not been supported to wash or was washed with cold water. Records showed hot water supply issues in some bedrooms for over a month. We checked taps identified in records and found them to be cold. The registered manager told us staff filled washbowls with warmer taps. However, this person's washbowl was completely dry when records showed this person received a wash. Records showed other people without hot water had also washed. However, we did not observe staff carrying washbowls of water during our visits. Records also showed broader issues affecting the hot water supply from January 2023. However, the provider had failed to take reasonably practicable steps to record water temperatures to ensure people did not receive improper treatment.
● People were left without access to their mobility equipment and people's mobility equipment was used inappropriately. We observed staff had placed other people's drinks on a person's walking frame, leaving them in another room without their mobility aid. Inspectors highlighted this risk to the nurse, who reunited the person with their walking frame. However, this lack of regard for this person's mobility and safety needs increased the risk of the person falling.
● A person's skin care needs were neglected by staff. A person's care plan stated they should not be repositioned onto their left side, but records showed staff had done this. People are repositioned to prevent pressure sores. The registered manager investigated these concerns and informed us this person could not be repositioned on to their left due to their mobility, and staff were apologetic for recording this. They assured us they would continue to monitor repositioning records. However, we followed this up and found continued concerns. The provider failed to make immediate and sustained improvements to meet the person's repositioning needs. We shared these concerns with the safeguarding team.

The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse and improper treatment. This was a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed responses when asking relatives if they felt people were safe. Overall, relatives did feel people were safe, but some made references to particular incidents. For example, a relative said, "Yes, [Person] is in [their] room right outside the nurse's office so no one disturbs [Person]. The only thing is things go missing from [Person's] room. I don't know if it's the staff or residents. I brought [Person] a brand-new radio and aftershave, and they have gone. I am very happy with the home and the standard of care [Person] receives. I'm very, very happy."

Visiting in care homes
● We observed people were free to receive visitors without restriction. Although relatives told us they felt free to visit, they also told us it could be difficult to access the building on weekends. A relative told us, "The

only thing is, you ring the doorbell, and you wait 15 minutes. You ring the landline, and still no answer. Numerous times I've had to go home because no one's answered the door to let you in."

Staffing and recruitment

● Staffing deployment did not always result in people's well-being needs and preferences being met. This is covered in other parts of the report. However, our observations of staffing levels and review of staff schedules indicated enough staff were deployed to keep people safe.

● Overall, relatives felt staffing levels had improved. A relative told us, "Well, it certainly has improved. There are more people around. When [person] was upstairs, there never seemed to be much staff. You had to go looking for them, but it's not the case now."

● Staff were recruited safely. This included ensuring staff had the right to work in the UK and Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

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

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

At our last inspection we found people's rights were not promoted in relation to the MCA. This was a breach of regulation 11 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 11.

● A person continued to be restricted by staff. At our last inspection, we found a person was prevented from doing something they enjoyed, as staff did not always give them the support they needed. This had not improved, and records showed days when they received no support at all to meet this need. The person said, "I have to wait for them (staff). They are very busy. You just exist here."

The provider did not always ensure they treated people in line with the principles of the MCA. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A person's alcoholic drink was restricted and locked away by staff. We presented this concern to the registered manager, who told us this was to prevent the person from drinking too much alcohol. However, they could not evidence any historical concerns, or a mental capacity assessment undertaken about this

decision. This person was being unlawfully deprived of their liberty.

The provider was depriving a person of their liberty without lawful authority. This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection, we found people were not always supported to receive their specialist diets and food in a safe way. This was a breach of regulation 14 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 14.

● People at increased risk of weight loss were not supported to have additional sources of nutrition in line with care plans. For example, a person's care plan stated they should be offered 3 cups of milkshake daily. However, records consistently showed this was not achieved. We also found similar concerns for 3 other people at risk of weight loss. In addition, a chef told us they only prepared milkshakes 3 times per week. This put people at increased risk of malnutrition.

The provider did not ensure people's specific nutritional needs were always met. This was a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Food was not always appetising. Chefs prepared people's lunches before 11:00am each day so they could attend a daily team meeting. People's food was hot stored and wrapped in clingfilm until 12:30pm when it was served. This caused the food to sweat and become soggy. A person told us, "I find most of the food and the lunches unappetising. Sometimes, I think it would be so lovely to have an omelette."
● A chef told us people who ate pureed food did not get offered choices in what they ate. They also said leftover food from the previous day was pureed for that day's lunch. A person's records showed they had received a meal of chicken, broccoli, carrots and mash 6 times on one week and 8 times on another week. This meant there was a lack of choice and variety in people's diets.
● The chef told us they prepared 8 cooked breakfasts daily, and "it would be down to staff to mediate" if a 9th person wanted a cooked breakfast.
● When we asked a person if they were enjoying their Weetabix they said, "Very sparing with the milk. I have told them, but they take no notice. I put my tea in it.".

The provider did not always have enough regard for people's wellbeing needs in relation to nutrition. This was a breach of regulation 9(3)(I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed some positive findings in the support people received while eating. For example, we observed lots of positive laughing and joking when a staff member was encouraging a person to eat. Furthermore, we observed another staff member checking if a person's food was warm enough and gave them plenty of time to swallow and enjoy their food. This person appeared very relaxed in the staff members presence.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People did not receive the support they required to ensure their health needs were monitored.
● Monitoring for people who used a catheter was not always safe or effective. For example, a person's records showed a gap of approximately 23 hours between monitoring. People's urinary output should always be monitored where catheters are required to ensure there are no blockages or health concerns.
● One person's care plan stated they should be supported to have their blood pressure monitored weekly due to hypertension, records show this was not consistently carried out . This increased health risks to this person, who had previously had a stroke.

The provider did not always ensure risks to people's health were well managed. This was a breach of regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported to access health care services such as GPs, dentists, dieticians and chiropodists. There were systems in place to monitor when people were last seen by health professionals.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed, but these did not always result in people's care plans containing information about people's past histories and what was important to them.

Staff support: induction, training, skills and experience
●Staff had received training, but this did not always lead to good and safe practice. For example, staff had received Mental Capacity Act training but did not recognise they were unlawfully depriving a person of their liberty. Some staff members were moving and handling trainers, and other staff had received this training. However, people's mobility needs were not always safely met.
● Records showed, and staff confirmed they received regular supervisions, but this did not always lead to staff practice issues being identified. A newer staff member told us they received an induction and was assigned a mentor to support them through this process. We also found appraisals and probationary reviews were held.

Adapting service, design, decoration to meet people's needs
● Whilst some people's rooms were decorated to reflect their interests, such as football or pictures of their relatives, we found some people's bedrooms lacked personalisation.
● The provider positively responded to relatives' feedback about needing more communal spaces. Due to closing 2 upstairs units at Swiss Cottage, relatives had commented lounge areas were getting smaller due to people moving downstairs. As a result, the provider created 2 additional lounge spaces by using unoccupied bedrooms.
● We observed people appeared to enjoy spending time in an area of the home that was designed to resemble a sweetshop. This area was close to the reception area and office, where people could interact with staff and visitors coming and going throughout the day.

Inadequate

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. At this inspection the rating for this key question has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

At our last inspection, we found people were not consistently treated in a respectful way. This was a breach of regulation 10 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 10.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

● People had personal information on display in their bedrooms without considering if this was respectful or dignified. For example, a person had the size of the continence pad they needed stuck on their wardrobe. This was visible from outside their bedroom and anyone passing by their bedroom would know they wore continence pads. Another person had 4 handwritten pieces of paper stuck to their wall, which included the information, "[Person] your bottom is very red."
● On several occasions, when we were talking to people, we observed staff walked into people's bedrooms without knocking. A person told us, "Sometimes people (staff) just walk in."
● We observed staff put a jumper on a person with a significant rip in the sleeve. This person's care plan stated they liked to look smart and well-presented.
● People's wishes and views were not always respected. A person's care plan stated they preferred female staff to support them with their hygiene needs. Despite this and staff schedules showing female staff on duty, records showed a male staff member had supported them on 4 separate days with their hygiene needs.

The provider had not ensured people were always treated with dignity and respect. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback about how caring the staff were. A person said, "I don't like that one female carer she is rude, although I don't think that she feels that she is rude, there is no need for her to be so brusque." However, a relative told us, "[Staff member] works for an agency but has such a good rapport with [Person], [Staff member] often walks with [Person] and always cares, I honestly don't think [Person] would still be here (alive) without [Staff member's] care."
● A relative told us how the provider had made additional efforts to support a person to celebrate their 100th Birthday. They recounted to us how the service made the day special and how much it was enjoyed.

Inadequate

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. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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.

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

- People did not have their hygiene preferences met. For example, a person's care plan stated they liked to have a bed bath twice per week, however records showed this preference had not been met from 14 July 2023 to 15 August 2023. Another person's care plan stated they liked to have a weekly shower, but records showed they had not been supported to have a shower from 1 July 2023 to 15 August 2023.
- There was not always person-centred information available in people's care plans about their past histories and likes and dislikes. This increased risk of people's identity, values and beliefs not being understood by staff.

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

- People did not always have consistent support to participate in activities and pursue their interests. We found more mobile people had more opportunities to participate in activities such as baking or going out. However, we did not observe any notable activities for people cared for in bed.
- Eight people's 'my day so far' records showed significant gaps in daily records to evidence people received regular interaction and could participate in activities. Peoples' care plans relating to activities did not always contain information on meeting their activity needs or interests.
- We observed a staff member had brought an electronic tablet to a person and told them they would play a film of a golf tournament; however, after the member of staff struggled to get this working, they departed without interaction. We checked the screen a few moments later to find it was blank. Furthermore, we observed staff throwing a beach ball to a person, which lasted for approximately 2 minutes, after which they were left sitting alone in silence, holding the beach ball.
- A person told us, "I would like to see a newspaper, but I have never even seen one copy here, ever. No one ever comes to discuss what I might want".
- A relative told us, "The only thing I would say there is not enough stimulation, they do put on some activities every day. [Person] is declining but when we take [Person] out you see the difference because [Person] is stimulated. When [Person] is in the home there is just not enough stimulation, that's not down to

their care. The care is good, there's just not enough stimulation."

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.

● Although the provider had signed off an action plan relating to pictorial food menus, we did not observe any of these in use on either day of our inspection. This meant the provider had not ensured they sustained improvements to enable people to make food choices.

People did not always receive person-centred care to reflect their choices and preferences. People did not receive regular opportunities to take part in activities that were meaningful to them. This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not provided with information to help them find their way around the home as there was very little dementia-friendly signage. Dementia signage helps people to orientate their surroundings and can help prevent falls. A staff member told us, "When new people come, they find it really hard to get about. People need a proper tour of the place and proper signs to help them understand what is happening."
● As the provider had recently started to use electronic care plans, these were not yet available in accessible formats.
● Staff used whiteboards to facilitate communication with 2 individuals.

Improving care quality in response to complaints or concerns
● Complaints were not always well managed or responded to effectively.
● Relatives and Residents meeting minutes showed complaints and concerns had been raised in relation to water being too cold in a person's bedroom, being able to get into the care home on the weekend and staff conduct. Although the provider could describe actions they had taken, these complaints had not been recorded in the provider's complaints folder or electronic records. This meant the provider had not ensured they always operated an effective system to receive, record and handle complaints.

The provider did not always operate an effective system to record complaints. This was a breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● Care plans evidenced the provider had sought information from people and their relatives about their preferences for the end of their lives, such as if they had funeral arrangements in place or any religious beliefs they would like observed. People's care plans also specified if there were decisions in place around if there should be attempts to resuscitate them.

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

- The provider had failed to implement sufficient governance and oversight to ensure their policies and procedures were followed by staff. This resulted in the numerous shortfalls and concerns identified in relation to safeguarding, complaints, infection control, falls management, environmental safety and medicines management.
- People's care plans contained other people's names, wrong use of gender and conflicting information. This meant systems to review care plans to ensure they were of good quality and accurate were ineffective and increased the risk of people's safety and care needs being unmet.
- Lessons had not been learnt from previous inspections. This was the fourth consecutive inspection where the provider failed to comply with person-centred care, safety and good governance regulations.
- The provider's quality assurance arrangements, which included monthly visits by a senior manager and undertaking a mock inspection, had not been effective at identifying concerns we found during this inspection and the improvements needed.
- Action plans had been signed off by the provider relating to behavioural monitoring, safe use of thickening agents, pictorial menus and care plan audits. However, we found the provider had not sustained or evidenced improvements they had made to ensure continuous improvement and quality care.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider failed to submit all required statutory notifications to CQC. Providers are legally required to submit statutory notifications to CQC for allegations of abuse, or utility failure. We use this information to monitor services and assess risk, which helps inform us of when to inspect a service or action we should take to seek assurances. We will follow this up.

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

● Relatives felt the registered manager was approachable. A relative said, "Oh, definitley, definitely. If you go to [registered manager's] office with a problem, [registered manager] will sort it out straight away and there is no comebacks. I've got every confidence in them."

● The provider kept relatives up to date with any changes. A relative said, "We get telephone calls to keep us updated. My [relative] suffers with bruising due to age, but they always inform us." Relatives' meetings were also held, those unable to attend received minutes. A relative said, "Yes, they do have relatives' meetings, but I don't go, they are not held at a good time for me I'm afraid, but we get the minutes so I do feel I get feedback." Relatives also told us they were asked to complete surveys.

● All staff spoke positively about the registered manager. A staff member said, "[Registered Manager] is very caring about the residents and is a supportive manager." Another staff member said, "I love our manager at the minute. It's been hard and we have had so many managers. It's really hard to find someone to trust, [Registered Manager] is brilliant."

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 had policies to promote them meeting their legal responsibilities to act on the duty of candour.

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 The provider had not ensured people's care met their needs and preferences.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were always treated with dignity and respect.

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 The provider had not ensured people were treated in line with the MCA.

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.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not always protect people from abuse and improper treatment.

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 The provider had not ensured people's specific nutritional needs were met.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not always operate an effective system to record complaints.

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	The provider had failed to implement and operate effective systems to ensure the quality and safety of the service.

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.