Marie Paterson, Care Inspectorate, Compass House, 11 Riverside Drive, Dundee DD1 4NY.

1. I am employed by the Care Inspectorate as the Chief Inspector Adults. I hold the following qualifications: - Preliminary Certificate in Social Care, Diploma in further education and teaching of adults with a mental handicap, Diploma in Social Work, Degree in Social Work, Open University, Regulation of Care Award, Anglia Ruskin University, Management of Health and Social Care Award, Open University, Local Authority Management Award, and a Diploma in Executive Business Coaching.

2. Prior to coming to work in the Care Commission, the legal entity responsible for the regulation of social care services, including care homes, prior to the creation of the Care Inspectorate, I worked in local government social work departments. My last post was Residential and Day Care Officer with line management responsibilities for adult day care centres and residential care homes across South Lanarkshire Council for adults. Previous posts I held were Care Home Manager, Depute Manager and various other social care and social work posts.

3. I joined the then Care Commission in 2002 as an inspector and was promoted to the post of Team Manager. I transferred to the new organisation, the Care Inspectorate, in 2011 as team manager for a multi professional team of inspectors. Since 2011, I have held various posts including Team Manager, Dementia Practice Lead, Methodology Lead, National Complaints Manager, Acting Head of Quality and Improvement, Service Manager Adults, and my current post of Chief Inspector Adults with responsibility for adult regulated care teams and the national complaints team.

4. The Care Inspectorate is the independent body in Scotland for the scrutiny and regulation of care services. Please refer to the previous statement provided by Kevin Mitchell Executive Director of Scrutiny and Assurance at the Care Inspectorate for the remit, legislation, and role of the Care Inspectorate. The response from Scottish Government to Covid-19 was led by the Chief Medical Officer (CMO) and Public Health Scotland as the pandemic was a public health emergency.

5. The Coronavirus (Scotland) Act 2020 received Royal Assent and came into effect on 7 April 2020. The Act introduced temporary changes to the way essential public services operate and are regulated during the pandemic. Provisions included various

temporary extensions to prescribed deadlines for freedom of information requests, child protection measures and placements, and guardianships and treatments in relation to adults with incapacity.

6. The Coronavirus (Scotland) (No.2) Act 2020 received Royal Assent on 26 May 2020. This brought in further legislative changes including specific duties for the Care Inspectorate.

7. Malcolm Wright, Chief Executive of Health and Social Care, wrote to all Health Board and Local Authority Chief Executives, Directors of Public Health (DPH) and Chief Officers on 17 April 2020. The letter advised that the First Minister and Cabinet Secretary for Health had requested that DPH take immediate action to deliver an enhanced system of assurance around the safety and wellbeing of care home residents and staff.

8. Following this letter DPH put in place monitoring and visits to services and risk assessed services – graded either green, amber or red, using a "traffic light" risk assessment system. We worked to support the DPH providing information and intelligence and, where requested, we did joint visits with public health teams which were either virtual or onsite, as put in place by DPH.

9. On 20 April 2020, John Connaghan CBE, Chief Performance Officer for NHS Scotland and Director of Delivery and Resilience, wrote a follow up letter (from that sent on 17 April) to health board / local authority chief executives, DPH and chief officers. The letter detailed further requirements around assurance and the need for visits to services and the need for DPH to work closely with Health and Social Care Partnerships (HSCP) and the Care Inspectorate.

10. On 17 May 2020, Scottish Government issued a directive that arrangements must be made to ensure appropriate clinical and care professionals across HSCP take direct responsibility for the clinical support required for each care home in their board area. Directors of Nursing in each Health Board area were given responsibility for clinical care and oversight.

11. Health boards and local authorities provided support through the Care Home Clinical and Care Oversight Groups, of which the Care Inspectorate was a member. The

names, and how these were organised, varied over health board areas, and they were led by the NHS.

12. Assurance visits to services began and the oversight groups began to hold daily discussions about the quality of care in each care home in their area. These were the so-called daily “huddles.” We took part in these meetings, and this enabled team managers and inspectors to use the intelligence gathered from oversight groups to inform the planning of our scrutiny visits. We also played an important role in providing intelligence and information to the oversight groups.

13. The Care Inspectorate had to respond rapidly to the pandemic, and to supporting people, as well as meeting the additional duties placed on it by the new legislation. We had to put in place new methodology to undertake visits as we were not inspecting in normal times but in time of a pandemic, something that we had to take into account. I would refer you to the previous statement provided by Kevin Mitchell Executive Director of Scrutiny and Assurance on changes to our practice and changes to methodology that were undertaken.

14. As well as taking part in daily huddles and local oversight groups we put in place enhanced intelligence sharing on the outcome of scrutiny visits and inspections. Where we issued a Letter of Serious Concern or issued an Improvement Notice, we would send a copy to NHS Directors of Nursing and Local Authority lead of huddle groups to enable support to be given to services. I would refer you to the previous statement provided by Kevin Mitchell Executive Director of Scrutiny and Assurance on what is a letter of serious concern and an Improvement Notice.

The outbreak at Redmill Care Home in West Lothian in October 2020

15. Redmill Nursing Home is registered to provide care to 68 older people. It is based in East Whitburn, West Lothian. The provider is HC - One Limited.

16. The home had not had an outbreak of Covid in the first wave. We received 81 notifications for confirmed/suspected Covid-19 from Redmill in October 2020. There were also three suspected cases on 26 September 2020. The first notifications in October were on the 1 October 2020 and were all confirmed cases. Of the notifications we received in October 2020; 44 were for people using the service, 35

were permanent staff and two were agency staff. We received 22 death of a service user notifications in October 2020. Of these 17 were notified as confirmed or suspected to be related to Covid-19. Of the remaining five, one was initially reported as due to respiratory infection, but the update notification stated it was an error and cause was unknown. It was an expected death, and the cause of the other deaths was unknown at that point.

17. We had regular contact with the service, at least weekly. These contacts were in addition to the inspection visits and contact regarding inspection. They were to discuss outbreaks, infection prevention and control practice, staffing, PPE, and outbreak management.

18. The Care Inspectorate team manager took part in the daily care home huddle meetings and weekly oversight group with HSCP, Directors of Public Health (DPH) and NHS Nursing Colleagues. The DPH had assessed Redmill as amber, this means that weekly contact would have been maintained with the home by public health staff. Meetings of the Problem Assessment Group (PAG) and Incident Management Team (IMT) led by public health professionals were taking place to monitor the outbreak and we took part in these alongside representatives from the care home, DPH, testing and HSCP colleagues. The local oversight teams provided assistance to the home to support staffing and educational support for the staff. The DPH provided weekly watching briefs on the outbreak management and support for Redmill and this was sent to us and informed our intelligence and decision making around inspections.

19. In relevant meetings we had wanted to undertake a Covid-19 inspection, however given the outbreak and the support being provided by external partners the DPH felt an inspection would have been an additional burden to the home at this difficult time and felt this was unnecessary. It was felt by professionals that the home should focus on outbreak management and that Public Health would support them. While we agreed with this initially - and with no other intelligence to go on - we reviewed this following a complaint from an agency worker submitted to the Care Inspectorate on 12 October 2020. The complaint related to standards in the home including: staffing, dealing with people after death, care of residents and management and leadership. Agreement was reached with DPH and others for us to undertake a Key Question 7 inspection and to report findings back to the relevant oversight groups including PAG, IMG and local huddle groups. I would refer you to the statement provided by

Kevin Mitchell Executive Director of Scrutiny and Assurance as to what a Key Question 7 inspection included.

20. The complaint related to night duty on the 9 October 2020. When we shared this intelligence with the NHS Chief Nurse, they revealed that they had also had a concern raised by an NHS Lothian bank carer on the same shift (Friday 9 October 2020). The NHS Lothian bank nurse escalated her concerns to the nurse in charge of the shift, but the information was not passed to the manager of the care home. The bank nurse escalated her concerns to NHS Lothian bank co-ordinator and the HSCP staff went into the care home the following day, 10 October 2020. The Chief Nurse stated that they had worked with Redmill Regional Manager and things were improved and being monitored by them. However, NHS Lothian had not shared this intelligence, and the complaint, with the other oversight partners including the Care Inspectorate. The nurse had come to us with their complaint as the nurse was not satisfied that improvements had taken place. Our information was that they were still working in the home.

21. We carried out an unannounced inspection of the care home with Healthcare Improvement Scotland and a representative from NHS Lothian. This inspection was done over four days, 21, 22 and 27 October, and concluded on 28 October. While staff were providing care, staffing levels (particularly at night) meant staff were not able to be responsive to people's changing care and support needs. Additional support for people living with dementia who could not follow isolation rules and walked around the home, was not always available. End of life support for people also needed to improve.

22. We identified serious concerns with the cleaning of the environment, staff infection prevention and control practice (IPC), management of waste, and staffing numbers. We issued a letter of serious concern to the provider on 21 October 2020 which detailed immediate action to be taken [CI/60- INQ000335477].

23. When we visited on the evening of 22 October and during the day on 27 October, all areas identified in the letter of serious concern had improved. Staff were able to respond to people's needs and support people to socially distance. The home was tidier and cleaner but there were still improvements needed.

24. We informed West Lothian health and social care partnership of our findings, and they provided support to the home in terms of staff training, additional staff, and clinical oversight. We also provided the HSCP and the Director of Nursing with a copy of the letter of serious concern when we issued this to the service.

25. The outcome and evaluations/grading for the inspection were: -

    Overall evaluation for key question 7 'How good is our care and support during the COVID-19 pandemic?' - Weak

    Quality indicator (QI) evaluations:
    QI 7.1 People's health and wellbeing - Weak
    QI 7.2 Infection prevention and control practices - Weak
    QI 7.3 Staffing arrangements – Weak

26. We also undertook a monitoring visit of the service on 11 November 2020 to support improvement and ensure the service was on track to make improvements. We discussed outbreak-ending, observed a deep clean of the environment being undertaken and observed residents' wellbeing. We provided advice and links to good practice. We noted that the NHS had supported the home by a Hospital Manager visiting to provide support and guidance to housekeeping staff and processes to support good IPC.

27. Along with Healthcare Improvement Scotland and a representative from NHS Lothian, we completed a further inspection of the home on 19 November 2020, to follow up on the improvements required from the inspection carried out in October 2020. The improvements related to IPC, staffing and care practices. The inspection included two visits to the home.

28. We found that some progress had been made on all the areas required. The home was cleaner and maintenance work had started to improve IPC. Staff IPC practice had improved, and PPE stations were easily accessible to staff. End of life care, supporting peoples' nutritional needs and care for people who walk with purpose had improved.

29. There were enough staff to care for people, but the use of dependency tools to

determine the number of staff required, and to provide the right support for people, needed to be improved. This would facilitate better deployment of staff. Further work was needed on all the above areas to fully meet the improvements required. We extended the time for these to be completed.

30. We informed West Lothian HSCP of our findings. We did not amend the evaluations/gradings for the service because there were still some improvements required. We planned to do a further visit to monitor progress.

31. The outcome and evaluations/grading for the inspection were: -

    Overall evaluation/grading for key question 7 'How good is our care and support during the COVID-19 pandemic?' – Weak

    Quality indicator (QI) evaluations:
    QI 7.1 People's health and wellbeing – Weak
    QI 7.2 Infection prevention and control practices – Weak
    Q1 7.3 Staffing arrangements – Weak

32. We carried out a further inspection of the service on 21 January 2021 with Healthcare Improvement Scotland, to follow up on the improvements that were required. We found that the required improvements had been made. The environment was improved, and repairs and painting completed. There were sufficient staff to ensure responsive care for people. We saw improvement in how staff used PPE and IPC practices were safer. We reminded managers about appropriate hand washing practices and the need for regular audits to make sure improvements are sustained.

33. We informed West Lothian HSCP of our findings.

34. We reviewed the evaluations/gradings for the home based on our findings at this inspection. The updated evaluations/grading are set out below: -

    Overall evaluation/grading for key question 7 'How good is our care and support during the COVID-19 pandemic?' – Adequate

    Quality indicator (QI) evaluations: -

QI 7.1 People's health and wellbeing – Adequate

QI 7.2 Infection prevention and control practices – Adequate

QI 7.3 Staffing arrangements – Adequate

35. All of the published inspection reports can be found on our website.

36. We laid three reports before parliament which referred to Redmill on 11 November 2020, 9 December 2020, and 9 February 2021.

37. Following each inspection, we maintained regular contact with the home providing advice, guidance and support for improvement and discussing the actions required following the outcomes from inspection and action taken by the service. We also provided support to the home in how to support staff with trauma and directed them to resources available via Scottish Government.

38. In October 2020 we received two complaints regarding Redmill. As outlined above, the first was from the agency nurse, regarding concerns about practice. This complaint led to the inspection of the service. This was in line with our Gold Command Decision on 31 March 2020 that any visit to a service would be an inspection using Key Question 7 to ensure we inspected the care home's response to Covid-19. The second complaint was received on 26 October from a family member who was concerned over the outbreak and how this could be happening if the provider was adhering to guidance. They had not been in the home and their concern was understandably for their loved one. We provided support and information. Between February and October 2020 we had received 4 complaints - one in February and 3 in March. The first concern related to odour and concern over cleanliness in the home. This was sent to the provider for investigation. The provider investigated the complaint in February and provided us with a copy of this. Of the other three in March, one was anonymous, that was limited in nature and mainly about staffing, and two were from the same person about care of their loved one. These complaints were passed to the inspector as intelligence to inform risk assessment and monitoring of the home.

39. In October 2020, the Cabinet Secretary for Health and Sport commissioned a rapid review of recent Covid-19 outbreaks in care homes; the primary aim of the review was to ensure that areas for improvement are identified, focussing on systems analysis and opportunities to enhance the support available for the delivery of care

in the care home sector. The aim, as detailed in the terms of reference for the review, was to 'collate and evaluate local level experiences and responses to the resurgence of Covid-19 outbreaks within care homes and to support learning and practice across the sector through the sharing of learning identified and approaches to improvement.' This review focussed on four care homes which, in October 2020, had outbreaks involving a high number of positive cases of Covid-19. Redmill Care Home was one of the homes selected for the review. We provided information on notifications, contact and interaction with oversight teams. At the time of our first submission, we had not yet inspected but had this planned. We subsequently provided the review team with the information on the outcome of the inspection. The finalised report published by Scottish Government is produced [CI/62-INQ000335479].

The outbreak at Caledonian Court care home in Larbert in November 2020

40. Caledonian Court is registered to provide care for 72 older people including 30 people with dementia. It is based in Falkirk, Stirlingshire. The provider is Care UK Limited.

41. We received 51 notifications of suspected / confirmed cases of Covid-19 throughout November (starting on 3 November 2020) - 19 for people living at the services and 32 staff members We had previously received 27 confirmed / suspected cases between 26 – 30 September 2020.

42. We received 24 death notifications for people who lived at the care home. Of these 20 were notified as confirmed or suspected to be related to Covid-19. Of the remaining 4, one was also marked as "Covid-related" on the death certificate and the other 3 unknown at that point.

43. We had been told that the outbreak was initially localised to the downstairs memory care unit but had then spread upstairs. A number of staff were tested positive and had to isolate and not attend work. The provider had put contingency plans in place to support staffing and the HSCP was assisting and identifying bank staff to assist.

44. We had regular contact with the service at least weekly. These contacts were in addition to the inspection visits and contact regarding inspection. They were to

discuss outbreaks, infection prevention and control practice, staffing, PPE, and outbreak management.

45. We took part in the daily care home huddle meetings and weekly oversight group with HSCP, DPH and NHS Nursing Colleagues. The DPH had assessed Caledonian Court as amber, this means that weekly contact is maintained with the home by public health staff. The meetings for the Problem Assessment Group and Incident Management Team led by public health professionals were taking place to monitor outbreak as well as NHS Forth Valley Care Home Strategy Group Meeting focussing on Caledonian Court. We took part in these alongside representatives from the care home, DPH, testing, HSCP colleagues from Falkirk HSCP, Stirling, and Clackmannanshire HSCP. The local oversight teams provided support to the home with staffing, educational support for the staff and provided clinical oversight/support.

46. We shared intelligence at the relevant groups with other professionals. This included complaints received - we had received three complaints related to Covid and these were managed in line with our Gold Command team decision of 19 March 2020 that providers would be asked to be the first line of resolution to resolve complaints.

47. We also knew that the home had no manager and a new depute manager had commenced in post. We received various complaints about the depute manager and also about the rota for staff. Some of these were not within our remit. All were managed in line with our Gold Command team decision of 19 March 2020, that providers would be asked to be the first line of resolution to resolve complaints, or that the information was used as intelligence to inform risk assessment and monitoring of the home.

48. Given the management concerns, the outbreak and the three complaints we received, we made the decision to carry out an inspection. This was in line with our Gold Command Decision on 31 March 2020 that any visit to a service would be an inspection using Key Question 7, to ensure we inspected the care home's response to Covid-19.

49. At the NHS Forth Valley Care Home Strategy Group, Public Health and NHS colleagues had concerns about an inspection, as normal practice is not to enter a home when it had an outbreak and this practice had been adopted during Covid-19

for hospitals. However, we had assessed the intelligence and believed that an inspection was required.

50. We carried out an unannounced inspection of the care home on 9 and 10 November 2020, along with Healthcare Improvement Scotland. We found that people living there were supported by staff to maintain contact with family and friends using technology and regular phone calls. Staff were kind, caring and attentive towards residents and there were enough staff available to support people. Personal plans had sufficient information to enable staff to meet people's health and care needs, but could have been more person-centred. We could not see how people's needs were being met in relation to anticipatory care planning. We found the home was clean and tidy. Enhanced cleaning schedules were in place; however, more attention was needed to ensure that equipment and furnishings were sufficiently clean. We identified some areas where maintenance was needed to enable more effective cleaning. Improved quality assurance measures would have been helpful. Staffing arrangements were sufficient and feedback from families was positive.

51. We informed Forth Valley health and social care partnership of the findings, and they agreed to provide support to the home. We planned to undertake a further visit to follow up on areas that needed to improve.

52. The outcome and evaluations/grading for the inspection were: -

    Evaluations/grading Overall evaluation for key question 7 'How good is our care and support during the COVID-19 pandemic?' – Adequate
    Quality indicator (QI) evaluations:
    QI 7.1 People's health and wellbeing - Adequate
    QI 7.2 Infection prevention and control practices - Adequate
    QI 7.3 Staffing arrangements - Adequate

53. We completed a further inspection on 15 December 2020 to follow up on the improvements that were required. We found improvements had been made. Good standards of infection control practice had been implemented. The home had some refurbishments completed and it was clean and tidy. Staff had received training and were knowledgeable about Covid-19, the use of PPE and infection prevention and control. Personal plans had been reviewed and were more person-centred. We informed Forth Valley HSCP of our findings.

54. As this was a follow-up inspection to check improvements had been actioned and the home had evaluation/grades of adequate we did not change the evaluation/grades at this inspection.

55. We laid two reports before Parliament which referred to Caledonian Court during this period.

The outbreak at Grandholm care home in Aberdeen in January 2021

56. Grandholm Care Home is registered to provide care for up to 79 older people. The provider is Holmes Care Group Scotland Ltd. The provider registered with the Care Inspectorate on 30 July 2020. While this was a new registration, the service was in operation before this date as a care home and the new registration was due to a change of provider identity.

57. We were notified of a confirmed case of Covid-19 on 21 December 2020. This was a staff member who tested positive following routine testing in the home. There were no further detected cases in the home until 15 January 2021 when a number of staff and residents tested positive during routine testing. In total, we were notified of 85 people having Covid-19 at the home. Of these 32 were staff and 53 were people living in the home.

58. The home struggled to complete notifications to us and did not follow the guidance by putting a number of confirmed cases into one notification, when these should have been submitted individually.

59. We had regular contact with the service at least weekly. These contacts were in addition to the inspection visits and contact regarding inspection. They were to discuss outbreaks, infection prevention and control practice, staffing, PPE, and outbreak management.

60. We took part in the daily care-home huddle meetings and weekly oversight group with HSCP, DPH and NHS Nursing Colleagues. The meetings of the Problem Assessment Group and Incident Management Team led by Public Health professionals were taking place to monitor outbreaks as well as the HSCP. We took part in these alongside representatives from the care home, DPH and HSCP

colleagues. The local oversight teams provided support to the home with staffing, educational support for the staff, and they provided clinical oversight/support. There was concern regarding the management of the outbreak and Public Health made regular visits to the home to support them, and further clinical oversight support was given by NHS. Despite this, the Public Health Nurse raised further concern about practice in February 2021.

61. There have been two complaints made to us since registration in July 2020. One related to infection prevention and control (IPC) and the other to well-being. Both were allocated for intelligence, which means that the information is passed to the case-holding inspector to note and use as intelligence in any risk assessment and monitoring of the home. Where these related to outbreaks or IPC, the case-holding inspector would make contact with the service. The second complaint related to Covid-19 and was received in December 2020. It related to staff not wearing PPE and issues with visiting guidance. We contacted the service to discuss both issues and shared with partners. This complaint was used to inform our risk assessment and decision to carry out an inspection. This was in line with our Gold Command Decision on 31 March 2020 that any visit to a service would be an inspection using Key Question 7 to ensure we inspected the care home's response to Covid-19.

62. We carried out an unannounced inspection of the care home on 25 and 26 February 2021 with Healthcare Improvement Scotland. We issued a letter of serious concern [CI/61 – INQ000335478] to the provider on 26 February which detailed immediate action that the home must take in relation to infection prevention and control practice, including cleaning of the environment, mattresses, and care equipment. We continued our inspection on 2 March with Healthcare Improvement Scotland.

63. Staff were better informed about hand-hygiene and their practice had improved. PPE supplies were good and readily available throughout the home. Staff wore and disposed of PPE safely.

64. Improvements were limited in relation to cleaning and cleaning products. Staff were not clear about their roles and responsibilities in aspects of cleaning equipment and the environment. This contributed to poor IPC practice. Leadership and enhanced governance required to be strengthened in order to put in place the necessary improvements.

65. People living in the home were supported by care staff who were familiar with their choices and preferences. We observed kind and compassionate interactions between staff and service-users. People's healthcare needs were met but were compromised by poor IPC practice.

66. Visiting was supported and in line with guidance. People maintained contact with family and friends using technology. A system was in place to update families about their relative's care.

67. We planned a further visit to monitor progress and ensure improvements were made.

68. Overall evaluation/grading for key question 7 'How good is our care and support during the COVID-19 pandemic?' – Weak

    Quality indicator (QI) evaluations: -
    QI 7.1 People's health and wellbeing - Weak
    QI 7.2 Infection prevention and control practices - Weak
    QI 7.3 Staffing arrangements - Weak

71. We immediately informed Aberdeen City HSCP of our findings and they agreed to provide support to the home. We also sent copies of the letter of serious concern to them and the Director of Nursing at NHS to enable support to be given to the home.

72. We completed a further inspection on 16 April 2021 to follow up on the improvements that were required at the previous inspection.

73. The provider had appointed a new manager to the service.

74. There were sufficient staff on duty to meet the needs of the people living at the service, and staffing numbers had changed in response to clinical need. Staff spent time with people, engaging in meaningful activities.

75. Significant improvements in IPC practices were observed. Staff had completed relevant training and robust systems were in place to track and ensure their knowledge of and competency in infection prevention and control.

76. Intensive decluttering and cleaning had been completed throughout the building to support ongoing effective cleaning and decontamination. Safe systems had been put in place for the management of laundry, waste and substances used for cleaning and decontamination. Staff demonstrated good knowledge of these systems.

77. A programme of indoor visits had commenced within the home, with a plan to further increase the number of visits, in accordance with guidance.

78. We informed Aberdeen HSCP of our findings.

79. We reviewed the evaluations for this care home based on our findings at this inspection. The updated evaluations are set out below: -

    Overall evaluation/grading of key question 7 'How good is our care and support during the COVID-19 pandemic?' – Adequate
    Quality indicator (QI) evaluations: -
    QI 7.1 People's health and wellbeing – Adequate
    QI 7.2 Infection prevention and control practices – Adequate
    QI 7.3 Staffing arrangements – Adequate

80. We laid two reports before parliament which referred to Grandholm at the time of the outbreak dated 17 March 21 and 28 April 2021.

81. I declare that the contents of this statement are, to the best of my knowledge, true and accurate.

Personal Data

18 December 2023