Witness Name: NR

Statement No: 1

Exhibits: None

Dated: 21st May 2025

UK COVID-19 ENQUIRY MODULE 6

WITNESS STATEMENT OF NR

I, NR, of I&S, provide this statement as an employee of I&S I&S regarding my knowledge and experience within I&S, Edinburgh, during the period from March 2020 to June 2022. The following account outlines relevant details about the service, staffing, resident admissions, infection prevention, personal protective equipment, visiting restrictions, and overall reflections on the impact of the COVID-19 pandemic in response to Annex A: Matters to be addressed.

Background to the Care Home

1. The Company:
   a. owns the operations relating to the Care Home.
   b. is privately owned for profit.
   c. is party to a lease relating to the Care Home property.

2. The Care Home:
   a. property was purpose-built in I&S consisting of two floors with combined living and dining areas. All bedrooms are equipped with en-suite toilets and washbasins.
   b. is a registered service provider with the Care Inspectorate of Scotland with service number I&S
   c. is registered to provide care to a maximum of 29 older people being over the age of 65 and one named person who is under the age of 65.
   d. accepts admission of residents who are either socially and/or privately funded.
   e. service supports individuals across residential, nursing, and dementia care categories.

3. On or around March 2020:
   a. the Company employed fifty-five colleagues to work solely in the Care Home, specifically:
      i. One Care Home manager;
      ii. One deputy manager,
      iii. Four nurses;
      iv. One bank nurse;
      v. One activity co-ordinator;

vi. Two administrative staff;
vii. One beautician;
viii. Four catering staff;
ix. Five domestic staff;
x. Six senior carers; and
xi. Twenty-nine carers.

b. the ethnicity of those employees employed by the Company was as follows:
   i. two colleagues were of African ethnicity;
   ii. one colleague of Asian ethnicity;
   iii. five colleagues of white polish ethnicity; and
   iv. forty-seven of white ethnicity.
c. external agency staff was used on an ad-hoc basis to cover absences and holidays.
d. there were twenty-eight residents living within the Care Home and receiving care services.
e. At the end of June 2022 there were twenty-eight residents living within the home.

Discharges from Hospital

4. During the first wave of COVID-19:
   a. three residents were admitted to the Care Home from I&S / I&S Each admission was a new resident to the Care Home.
   b. the notice period for hospital discharges varied, and records of initial enquiries were not maintained between March and May 2020.
   c. NHS staff provided updates on residents' COVID status, confirmed isolation periods, and facilitated pre-discharge testing.
   d. all residents admitted to the Care Home completed necessary isolation for 14 days upon admission to the Care Home.
   e. the Care Home did not experience external pressure to accept hospital transfers.
   f. the Care Home did not refuse any hospital admissions throughout the period from March 2020 to June 2022.

Infection Prevention and Control (IPC)

5. The Care Home informed staff about changes in IPC Guidance through daily flash meetings.
6. The Company's wider group shared up to date government guidance reviewed by senior managers through daily briefings and infection control audits.
7. Any residents contracting COVID-19 were required to isolate in their room and observed social distancing.
8. The Company reconfigured parts of the Care Home property to create partitions to facilitate safe visits by residents' family and friends.

9. No third parties were allowed to enter the Care Home property. All deliveries of supplies to the Care Home were left externally with staff members taking precautions to bring supplies in the property.
10. The Care Home faced challenges in relation to:
    a. the division of staff due to limited changing and staff room space despite implementing social distancing measures in accordance with government guidelines, including assigned number limits for lifts and break areas.
    b. ventilation due to window restrictions imposed by health and safety regulations.
    c. certain residents would occasionally refuse to be tested. Generally staff and residents would agree to be tested on regular basis.
11. During outbreaks:
    a. the Care Home followed government guidelines issued by public health professionals
    b. Enhanced infection control measures, staff cohorting, and shielding arrangements were implemented for vulnerable residents.

Personal Protective Equipment (PPE)

12. The Care Home:
    a. received appropriate PPE from the local hub and directly sourced additional supplies when necessary.
    b. did not experience PPE shortages or receive inappropriate equipment. However, mask fit testing was not conducted, and staff felt hospital colleagues had access to higher-grade masks.

Visiting Restrictions

13. The Care Home:
    a. informed resident's families of visiting restrictions via phone, email, and social media updates.
    b. facilitated end of life visits under strict hygiene protocols.
    c. arranged window, garden, and visitor room visits via a booking system.
    d. Implemented the use of Facetime and telephone calls to ensure residents maintained contact with loved ones.

14. When homes initially locked down, this had significant impact on residents and their loved ones, whilst staff spent time with residents and showed kindness and compassion, residents and relatives missed the emotional connection that could be derived from a visit or embrace.

15. During Covid, the local GP, attended the Care Home in emergency situations or when there was a serious resident deterioration. The GP also supported the team readily by telephone. All other external professionals offered phone support.

End-of-Life Care

16. Two residents of the Care Home died between March 2020 and May 2020, neither were related to covid.
17. In the period March 2020 to June 2022:
    a. there were thirty-three deaths, one of these deaths was covid related, the resident affected by covid died in hospital.
    b. there were no staff deaths during this period. Staff coped well during the period.
18. The rate of deaths over the 26-month period was in line with rate of deaths in previous years.
19. The Care Home did not use the reSPECT tool from March 2020 to June 2022. The team within the service monitored residents for soft signs of deterioration and assessed vital signs. All concerns or changes were discussed with the GP when necessary. The team put short term care plans in place where residents experienced a decline which gave guidance to the staff on how to monitor and manage symptoms.
20. The Care Home did not have concerns about DNACPR decisions. The local GP arranged DNACPR forms where required in collaboration with the team at the Care Home and with residents and relatives where appropriate.
21. Residents who died during the pandemic continued to have access to appropriate end of life medicines, the GP was particularly good at providing ACP medicines quickly. Essential visits were arranged for families to support their loved ones.

Provision of data

22. During the period from March 2020 to June 2022, the Care Home was required to:
    a. complete Turas care management safety huddles daily;
    b. make weekly notifications to the Care Inspectorate regarding staff absences;
    c. notify the Care Inspectorate when the home experienced outbreaks; and
    d. notify the Care Inspectorate at the end of outbreaks.
    e. notify the Care Inspectorate of each resident confirmed to have contracted Covid.
    f. log covid tests for all staff twice weekly.

Staffing

23. The Care Home staff worked in a flexible way to ensure they could continue to provide care at a safe level. During times of outbreak, staff offered to work extra hours where they could.
24. During times of staff shortages, the Care Home relied on the use of staff overtime and external agency workers.
25. The Care Home team:
    a. managed well during the pandemic, as a small service the team were fortunate to not experience a positive resident case of covid until the vaccines were in roll out.
    b. were proud that they managed to keep covid out of the Care Home for a significant period.
    c. worked well together and supported each other.
    d. received regular calls from our Care Inspectorate officer as a means of support.
    e. received covid test kits and uplift of them was swift.

26. The Care Home purchased PPE regularly and received supplies from local hubs. Public health provided support daily by telephone during outbreaks to offer advice and guidance.

Overall Reflections

27. Anne's law has been a beneficial learning from the pandemic. Whilst the Care Home did not face any covid positive discharges from hospitals, should we face a pandemic in the future, a more protective discharge approach would be beneficial to ensure testing and appropriate isolation periods prior to discharge.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: NR Personal Data

Dated: 21st May 2025