Witness Name: Name Redacted

Statement No.: 1

Exhibits: 0

Dated:29th April 2025

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF Name Redacted

I, Name Redacted **registered manager of** I&S I&S will say as follows: -

Introduction:

I am the registered manager at I&S care home for older people. We are a private company, providing care and accommodation for persons who require nursing or personal care for up to and not above 27 residents aged 65 years and over.

Background to the care home:

1: I&S is a privately owned residential care home for older people. The home is located in the I&S and provides personal care for 27 residents. Any nursing care is accessed from within the community.

2: We pride ourselves on providing exemplary care and meeting the individual requirements of our residents for over 40 years. Independence is carefully nurtured and encouraged through our team of highly skilled carers.

3: Although not purpose built, we have a well-maintained home built originally as a bungalow in 1975, we have extended several times with the last extension completion in 2013.

4: We are comprised of 26 bedrooms, catering for 27 residents. All rooms are unique to suit every requirement, a mixture of ensuite, cloakroom or shared bathroom facilities. We have a communal bathroom with spa bath and hoist plus a communal shower room. The vast majority of our rooms are ground floor, enjoying views of our wrap around garden. We also have 7 first floor rooms, serviced by a large, glass fronted, fully lit passenger lift.

5: We were contracted to three councils during the pandemic. The councils commission beds to enable them to place funded residents from I&S Council, I&S Council and I&S Council during the period of pandemic, that covers the enquiry. The majority of our residents are and have always been self-funding.

6: As of March 2020, we had 33 staff including myself working in the care home. All were female workers, and we had 1 polish nationality and 5 of an African descent. Four of these staff were management/directors and focused on ever changing legislations and policies and procedures, and the safe running of the home, including making necessary changes to the care home, and ensuring that staffing levels were filled. Making sure that testing was completed and sent off and results were looked at in a timely manner and actioned. They made sure that all families of residents were kept informed and all staff and residents. Implemented training and observations on staff. One was administrator who supported in the clerical side and filling out forms and the ordering of items. We had two cooks who worked only in the kitchen making fresh home cooked meals and cakes and ensuring that health and safety and infection control measures were implemented. Four domestic staff were employed, one of which being the head housekeeper. Their duties included ensuring that all areas were cleaned properly and appropriately and that all chemicals were used in the correct manner. The laundering of bedding, clothing etc and following infection control procedures. We had one activity and wellbeing co-ordinator who ensured that all residents were mentally fulfilled and exercised. We employed eight senior carers whose tasks included medications, overseeing care staff and assisting residents with all aspects of their personal care and daily living. They also liaised with medical professionals and outside agencies, and family members and friends of residents. We also had employed 13 care staff who assisted residents with all aspects of their personal care and daily living tasks. All staff implemented infection control policies and procedures. We had no staff on a zero-hour contract, and none that worked in other care homes. We block booked agency staff from two trusted agencies, so that they would not work in other homes as to reduce the risk of infections.

7: As of March 2020, we had 25 residents living in our care home. In June 2022 we had 26 residents living in our home. We had two residents due to move into vacant rooms, which were cancelled because of the lockdown. At one point we had ten vacancies before becoming fully operational in June 2022. We used one bedroom as our testing station, and another as our staff changing room, our hair salon became our main PPE and handwashing station. One of our lounges had a visiting pod built around the patio doors. All other rooms were left unoccupied because the risk of infection was too high for people moving in, or on advice from Public Health England, to not take admissions because of internal outbreaks and isolation.

Discharges from hospitals:

8: In wave one of the covid-19 pandemic, (March 2020 – May 2020) we had three residents taken to hospital. One resident was taken to hospital twice in March 2020, not admitted, and returned directly to the care home. The first time was following protocol of seeking medical advice following a fall resulting in a head injury. The second time 111 sent an ambulance due to the same resident having symptoms of a chest infection. She was returned to the care home with suspected covid-19 at 03:00am to isolate and receive full barrier nursing care. There was no communication with the hospital to say she wasn't being admitted or that she was on her way home. The ambulance crew informed us of her covid-19 status upon arrival back at the home, and that she should be treated as having covid-19. This was the first time any resident with these symptoms had been considered covid positive. The second resident was admitted to UHCW to be treated for infection, between 18.04.2020 and 21.04.2020. This resident was

frequently admitted due to having recurrent infections and history of delirium. She wasn't tested for covid-19 but returned from hospital presumed not to have covid-19, to isolate and receive full barrier nursing care. The third resident was admitted to UHCW with suspected covid-19 on 04.05.2020 to the 16.05.2020. She returned home to complete her isolation period after consultation about what equipment and precautions to take to minimise the risk of spread. She returned to I&S once we were in receipt of a hospital bed with pressure relieving mattress. She did not leave her room and subsequently died of covid-19 on 03.06.2020. We were in agreement with the hospital that she should return to us for end-of-life care. This was the only resident who was tested for covid-19 prior to discharge from hospital, and we were informed that she had been isolating and had to complete the isolation period of fourteen days, upon her return home. She resided in a single room with own en-suite, so isolating wasn't a concern.

9: We didn't take any new admissions from hospital at all. From memory I don't recall receiving requests to take any new admissions from hospitals, so wasn't in a position to feel pressured to do so.

Infection control and prevention:

10: At the start of the covid-19 pandemic we widened our lines of communicating with our staff, to include setting up a WhatsApp group. Emails, posters and signage, set up pin boards and observed staff practice.

11: WhatsApp – a staff WhatsApp group was set up as the fastest way to communicate information, legislation, cover shifts and share worries and concerns. We found this very supportive and widely used which helped with staff moral and wellbeing.

12: Emails – testing results, policies and guidance and information from ASC, IPC training were communicated by email. It offered more privacy than a shared group. We found that this better met with GDPR and confidentiality.

13: Posters and signage – The front gate to the home remained closed with clear signage, providing clear instructions of the IPC measures in place and expected from everyone entering our premises. This signage continued into the car park and gardens, asking to maintain a safe distance of 2 meters apart, to wear masks. The front door had a poster which changed frequently giving further advice on the status of the home, and measures in place to keep all safe. On entering the building there were more instructions on how to take and record your temperature, a checklist of symptoms to look out for, and of how to get tested. This led you to more posters in the main handwash station, situated near the entrance, which displayed the correct handwash techniques, donning and doffing of PPE, and how to manage clinical waste. Social distancing signage was displayed throughout the building, posters on chairs indicating which you could sit on and which you couldn't, doors displayed infection status and isolation dates. The laundry room displayed posters on safe handling of linen and clothing. The utility room displayed posters on how to dispose of clinical waste as did bathrooms. Handwashing and PPE posters were also displayed in all bedrooms, bathrooms and the utility room. The kitchen displayed safe entry and safe use posters, as did the domestic room, giving instructions on how to manage chemicals and disinfections. We found that this served as visual and written instructions, reminders to all staff at the point of performance. We appreciated there was a lot that was fast changing and a lot to take in, with no room for error.

14: Staff pin board – We set up a covid-19 pin board to display the business plan and government documents cascaded to us by our councils around symptoms, isolation periods, testing, notifications and who to contact, when and why. It was a centralised go to for policies, procedures and protocols including Public Health. We found that this provided us with the facts of what to do at the time needed, rather than cascading information for each staff member to remember what to do in the event of. Keeping up with the fast-changing advice from the government was challenging. By the time you were sharing information with staff from the gov.uk website it was already changing. Instructing staff to go to the pin board and phone a manager was far safer and effective.

15: Observing staff practice – We observed all staff demonstrate good hand wash techniques and donning and doffing on a regular basis. In fact, we all observed each other to ensure that corners were not being cut, we were not becoming complacent and forgetting sequences.

16: It was reassuring to have contact numbers and email addresses to Public Health England, IPC nurses, I&S Council to interpret government guidance. They were heavily relied upon by us to ensure we understood what was being asked of us.

17: Another challenge we faced was reconfiguring the care home to separate covid–19 residents from non-covid-19 residents while adhering to the practice of social distancing. There are no communal rooms on our first floor, and residents were discouraged from entering other people's rooms. The ground floor is predominantly open plan, which allowed for social distancing comfortably. Our second lounge contained a visiting pod accessible from a patio door. We felt the safest way to separate those testing positive, was for them to remain isolated within their own room. In order for them to exercise or socialise, staff were allocated to them and only them while on shift. They were given separate time slots to be able to leave their room with masks on in areas where they wouldn't be encountering other residents. Weather permitted they could walk round the grounds. We opted to have designated staff care for positives and non-positives using full PPE.

18: We were fortunate to have lots of patio doors in communal areas, which could be opened routinely to improve ventilation. We also had air purifiers wall mounted in our dining room and both lounges. We had a mobile one which we could take into bedrooms and move around, which helped with air filtration. To further assist with purifying the air we invested in a machine that sanitised rooms. We found this very beneficial.

19: Once testing was implemented, we felt a sense of relief, however it was time consuming and challenging in many ways. We provided transport for staff to come in on their days off at least once weekly, for PCR testing. They took time to do, package and process for both residents and staff. Performing the tests were very distressing for some, and triggered nose bleeds, sore throats, cold sores and mental anxieties. The results came through at any time day or night, to our mobile devices. The manager received all residents and staff results. It was an anxious time waiting for results, and a distressing time taking action and sharing results without delay. This process was worsened when testing was increased following an outbreak to opening back up following whole home isolation.

20: We had mixed views and mixed responses when LFT testing was introduced alongside PCR testing. You couldn't guarantee you would have a full complement of staff, for any given shift, and at short notice had to find cover. Some staff without symptoms tested positive, some staff

with symptoms tested negative. Everyone worked day to day under stress of not knowing what was coming.

Personal Protective Equipment (PPE)

21: We were fortunate enough to never experience short supplies or lack of PPE. In our home we have always provided hand soap, hand towels, gloves and aprons in all of our rooms. We also stock face masks and visors for any kind of outbreak, as well as keeping additional supplies of all PPE, chemicals and hand wash, hand sanitiser, toilet rolls, laundry products, to ensure good supplies ahead of any winter pressures. It is good practice to have a full order in house throughout the winter months so if there is any disruptions caused by bad weather, you remain fully stocked. This was further aided when free PPE was provided by the government. PPE is provided in various sizes at I&S as normal. Our only concern regarding PPE was that some of our supply could maybe be taken to someone with short supply.

Visiting restrictions

22: During the pandemic we made good use of communicating with visitors by email. This allowed our phone lines to be well managed. We asked residents to nominate a main source of contact who we emailed on the understanding they would share information with other friends and family. We kept our residents fully informed of the fast-changing guidance around the severity of the pandemic, and the impact it was having on the world, the country and the care homes. We were open and honest and that included restrictions around visiting to minimise the risks. We felt that our residents were really understanding. With regards to accommodating visitors, we were very much led by the guidance, so there were times when no visitors were allowed in at all, and times where we had telephone calls, video calls, window visits, pod visits, social distance visits, garden visits and indoor visits, sometimes visitors tested before visiting on the premises or wore PPE. Once it was permitted, end of life visits were facilitated. We used mobile devices, iPad, email and a private Facebook to share recorded messages and photos of activities taking place. All staff including activity and wellbeing staff were able to facilitate contact with loved ones.

23: At the start of the lockdown when the home was fully closed, and no visits were permitted, it was heartbreaking to sit with residents at the end of their life with their loved ones on the end of a mobile device. Witnessing the distress caused to family and friends by not being able to visit took a toll on us all.

24: It was upsetting to have the priest give last rites over a facetime call. It was more upsetting that Dr's were not coming into the home to assess unwell residents. We were taking basic observations of blood pressure, pulse, temperature and blood oxygen levels to relay to Dr's, but we were not able to listen to someone's chest, a key observation in diagnosing a chest infection. I feel if residents were properly assessed, they may have been diagnosed, treated and recovered. I can't praise the district nurses enough. They were first in and worked over and above any of the other health services that we came across. Like carers, they always turn up.

Deaths and end of life care

25: Over the course of the relevant period, we were fortunate to not lose any members of staff to covid-19. Many resigned from their positions or went off sick due to overwhelming fear and anxieties. This led to one member of staff taking their own life in 2023. She developed health anxiety which overtook her mental health and felt that she couldn't cope anymore. This had and

continues to have a massive impact on both staff and residents who were privileged to know and work with her. The care home provided counselling and continues to offer counselling to all members of staff as an ongoing resource since then.

26: However, we did lose 20 residents, four of which had covid-19 included on their death certificate, only one had a confirmed test. The majority of our residents had a RESPECT form or an DNACPR in place prior to the pandemic. We continue to discuss resident choices and preferences with GP's now.

27: Sadly, we experienced difficulties accessing end of life palliative medications and saw resident's distressed and agitated in their final stages. We had access to health professionals primarily nurses, but drugs were in short supply. We had one resident who passed away in March 2020 at the age of 100. She had recently had a new battery in her pacemaker, her death was very distressing, as the pacemaker was making it difficult for her to pass away. When seeking advice, I was put through to a Dr, who specialises in pacemakers. I was asked if I had a magnet to place over her pacemaker to make it stop working, which would therefore allow her to pass away. This was a wake-up call to the severity of the impact on the care homes.

Provision of data

28: The only data that I remember having to fill in was the capacity tracker, and PPE form which was for I&S Council. These forms were filled in by myself and I was supported by admin staff.

Staffing

29: Staffing is the key to any successful business. Care homes included. It was important to us to put measures in place to keep our staff working and caring for our residents. We had good communication and kept them aware of how we were going to stay safe. Initially there was a lot of fear among staff, which resulted in some deciding to leave work and stay at home with their families. Some were unable to provide childcare, some were given instructions to shield, others were off due to illness. We provided transport to enable our staff to get to and from work safely without using public transport, we provided them with additional uniforms that could be laundered within the workplace, we increased training and educated each other on safe working practices and living safely with our families in our community. We showed empathy to how staff were feeling, we gave lots of praise and encouragement and developed an in it together culture. There were times when we helped source key worker nursery placements to enable some to remain in work. To help us continue to provide safe staffing numbers we devised an on-call rota, shared with more staff than in normal circumstances, as a group we became more flexible in working more hours and patterns, we block booked staff from two agencies which meant they weren't going into numerous homes, they were just coming to ours.

30: Covering shifts often meant staff who were well, worked more than usual without a day off. In response to that, those returning to work following illness, worked overtime to allow others to take consecutive days off to rest and recover. Unoccupied bedrooms could be used for staff to rest in between shifts if needed, we provided meals and shower facilities to those working longer shifts. This helped to show how much we were all appreciated, and we became more than colleagues. This helped staff morale. The WhatsApp group also helped with staff morale, we felt comfortable to show our emotions and voice our fears. Our residents also helped with

staff morale, with many comparing the pandemic to worse experiences in the last world war. We joked and said we had never had as many people offer to work New Years Eve. We could have a party here! On a serious note, we cried when our residents chose to go and join the rest of the country in clapping for us and the NHS.

31: Throughout the pandemic we received gifts from our community, messages of praise from local nurseries, endless support from the local authority, we also received financial support from various grants and funds. These enabled us to make necessary changes within the care home to support both residents and staff. The money was spent on a whole variety of things including washable chairs, electronic devices, a visiting pod, transport, wages paid for testing on days off, disposable medication pots, observation equipment, a staff changing room to which we were very grateful of. Our administrator would know a lot more about this.

32: We were fortunate that we had a full staff team who were pro-vaccine and were happy to travel to wherever necessary to receive vaccinations. So, when the policy of compulsory vaccination for staff in care homes was implemented, we didn't lose any staff, and staff morale wasn't affected. Had I have had staff who were anti-vaccine I would have had serious staffing concerns. I personally feel that this law should not have been implemented within the care sector. It holds no legitimate benefit if not implemented in other sectors. I started work in a care home at the age of 14 as a Sunday laundry assistant and have dedicated my whole working life to working in care homes. I am trained to degree level and have been a manager for the last 23 years. The impact on the home and my family, and my life would have been devastating had I of not been pro-vaccine. I no longer choose to be vaccinated.

Overall reflections

33: The overall support shown throughout the pandemic from ASC was outstanding. Anyone we spoke to showed interest and did all they could to help us. Without any judgement, they sought advice, interpreted legislation, listened to our experiences and showed appreciation. We had many difficult yet comfortable conversations that were emotional. Without them we would have had a much more negative experience of the pandemic. We built trusting relationships, and I don't feel that much would need to change in the event of a future pandemic.

34: On the flip side of this I felt very let down by the Health Secretary, Matt Hancock, who blatantly lied about the situation with the care homes. There was no blanket of protection, we were left to sail our own ships. He wasn't heartfelt and he had no understanding or appreciation of the challenges care home face, pandemic or not. It felt like we were the sacrifice, a cull of older people who could no longer contribute to society. Decisions about social care services were made based on the crisis and cost within the sector. It demonstrated exactly what the government thought of the social care work force. We were seen as underappreciated, under achievers, not academic enough to work within the health sector. This was proved by forcing a law that we vaccinate or end our careers, which was never the same law within the health sector. How many health workers strike? How many care home workers strike?

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: Personal Data

Dated: 29th April 2025