Witness Name: I&S

Statement No: 1

Exhibits: 0

Dated: 2 June 2025

UK COVID-19 INQUIRY – MODULE 6

WITNESS STATEMENT OF I&S

I, I&S will say as follows: -

I am replying on behalf of I&S

I&S

I own and operate I&S Care Home since 2005. I was a Registered Nurse by profession and have worked in the Nursing Home Sector since 1984 to date.

I have extensive experience as a senior executive having held the position of Chief Executive in the largest privately owned nursing home group in the UK (42 Nursing Homes and a Private Hospital). During my time as a Senior Executive, I lead the Groups through significant change management, acquisitions and managed a large group for the I&S

I&S The homes achieved Investor in People status: European Modules of Excellence & were award winning nursing homes in the UK across categories of care in mental health, functionally mentally ill, physically disabled, frail elderly, terminal illness, and community care services.

Background to the Care Home

1. I&S Care Home is a Registered Nursing Home with 41 Nursing Beds – Registered with Regulation Quality and Improvement Authority. The Care Home operates within the Western Health and Social Care Trust geographical area. All residents admitted are from Western Health and Social Care Trust area.

I&S Care Home is a purpose-built facility with thirty-nine single bedrooms and one double bedroom ensuite. Some of the single bedrooms are ensuite. The home has many large and small lounges plus dining room spaces. Bath and shower facilities plus utility, kitchen, and laundry rooms. The home has two beautiful conservatories front facing the main road which was of great significance during Covid-19, as one became our isolated visiting room for families with the residents. I&S also has lovely, landscaped gardens both enclosed for safety, privacy and enabling residents to get outside for fresh air to enjoy colours and smells. The home is situated on a busy main road, at the front of the care home residents can be walked

on the paths, with staff, to see the neighbouring countryside and enjoy the smells of the environment. The front of the home has many seating areas for residents with families to rest and talk together.

I&S was first opened in I&S. The home is privately owned by myself and all residents are funded weekly via contract with Western Health and Social Care Trust for services. The home is modern and meticulously maintained and has won many awards for its environment, quality and specialism of services provided.

The home on 20th May 2025 employs 83 staff (Home Manager, Nursing Sisters, Registered Nurses, Senior Health Care Assistants, Care Assistants, Head Cook, Assist Cook, Kitchen Assistants, Domestic Assistants, Laundry Assistants, Social Therapists, Maintenance Officers, Administration staff).

The Home is Registered for categories:

Maximum number of approved Places – 41 Categories of Care. A Maximum of 14 patients in Dementia care category and 27 beds for frail elderly, physical disability and terminal illness. The home is also approved to provide care on a day basis for 4 persons. Code number of Registration: I&S

The patients age group ranges from 35 years old to 95 years old.

I&S Care Home is unique in Northern Ireland as it provides daily care services linked to the local General Practitioners that "prevents admissions to hospitals" I&S I&S The residents' conditions are frail elderly, young physical disability, chronic ill health, dementia, terminal illness – a sizeable percentage of the residents have complex and complicated care needs. Many of the residents have their care delivered by enhanced staffing, provision of 1:1 staffing twenty-four hours per day.

2. As at March 2020 the staffing was as listed at appendix A I have never used Agency staff in any care home where I was the Responsible Officer. At I&S Care Home we have never used Agency staff since I took ownership September 2005.
   During this period 1st March 2020 to 28th June 2022 no staff worked in any other care home only I&S Care Home.

3. As at March 2020 the number of residents living in I&S Care Home was as listed at appendix B.
   This appendix illustrates the number of residents living in I&S on 1st March 2020 (41 residents) and the same on 28th June 2022 (41 residents). Please note I&S Care Home achieves 100% occupancy every month and has done so since 2005. An empty bed is occupied by Western Health and Social Care Trust within a 48-hour period.

Discharges from hospital Wave 1 (1st March 2020 to May 2020)

4. The number of Residents discharged from Hospital 1.

   The number of returning residents was 0.

   The number of new admissions was 2

From the 1st of March to the 28th June 2022.

Number of residents discharged from hospital was: 16
Number of residents returning from hospital was: 3
Number of new admissions was: 35

5. In relation to hospital discharges to I&S Care Home:

   a. Good notice was given and an agreed date with hospital staff was planned – we had no concerns in this area
   b. We would always have been told of their Covid status, and this would have been questioned thoroughly by the Home Manager and or Nursing Sisters at I&S – we had no concerns in this area
   c. Yes, we had asked for all residents coming into I&S from the hospital setting to be tested prior to transfer and all had a negative result.
   d. If positive result prior to discharge from hospital or elsewhere patient would have had isolation period before admission to I&S.
   e. We had the ability to isolate the resident in a single room for 14 days with high infection control protection and the same staff on a 12-hour shift providing the safe and quality care.
   f. We never had any pressure placed on us by Western Health and Social Care Trust staff – we had an excellent working relationship with all liaison persons both at the acute hospitals and it was only the Home Manager or Nursing Sisters I&S dealt with such matters. We believe strongly that the excellent communication and relationships that were established carried us through such challenging times.

6. We had NO hospital discharges that we declined to admit.

Infection prevention and control

7. Prior to the Covid – 19 pandemic I&S was always well advanced in Infection Prevention and Control processes and systems of work. Procedures were strictly in place and regular audits for compliance were in place by home management. I&S would have had an exceptionally low percentage of infections and outbreaks – it was a rare occasion. The Home Manager was always the Champion and Lead for Infection Prevention and Control, and staff were trained to high levels of excellence. A low turnover of staff helped maintain such strong compliance. The home always used Antichlor for cleaning which is proven for preventing infection and outbreaks. So, our baseline to start with was an extremely high one.

All staff in every grade received a twice daily handover outlining clearly what was expected of each and the enhanced Infection Prevention and Controls and cleaning schedules. In between handover reports at least three hourly "huddles" were held with all staff to keep each informed of the updated situation. Copious masks, gloves, aprons (all Personal Protective Equipment) were provided by the Home Owner long before we received Personal Protective Equipment supplies from the Public Health Agency (Western health and Social Care Trust) – this Personal Protective Equipment was placed in every suite of bedrooms, kitchen, laundry, communal areas. Sanitizers were placed in frequent locations throughout the home. On arrival to the care home at the entrance all staff had to sanitize their hands, pass a scanner for temperature and body control and if wearing personal protective equipment or not before entry. Staff all changed into their uniform in the care home – no staff travelled to and from work in their uniform. This was a forbidden practice. All staff were provided with free meals for their breaks to avoid extra travel into town for food. The government guidance plus Public Health Agency plus Western Health and Social Care Trust plus Regulation Quality Improvement Authority – all these departments were sending endless emails with attachments. There was far too much repetition and far too much detail much of which was hard to understand. It was extremely time consuming. However, the Home Owner and Home Manager many times per day read the emails to ensure this was followed as per requirement.

8. It was never possible to isolate Covid residents in one area. The layout of the home has 7-9 beds in each suite. Each resident had their own bedroom. Staff were allocated to work in these areas in pairs (2/3 staff per suite). Excellent signage was in place for social distancing and new practices were put in place for staff handovers to ensure distancing was practised – the large entrance hall allowed for this. Staff meal breaks were taken at various times to allow small numbers to rest and eat in different areas (we provided extra space along with the staff room, we had four extra places plus the staff room). Social distancing for staff was professionally managed, and staff were complimentary of this plus their free meals.

A. Visitors/ Staff – immediately at the start of Covid-19 we decided to use one of the front conservatories for visitors. This room had opening front doors out to the car park, and it allowed visitors to arrive at this door and wait to see their relative. An impressive glazed and wooden frame was made to divide the visitor from the resident. Yet the resident could be seen clearly. Staff accompanied each resident to this seating area and then allowed with dignity the visit to go ahead. This conservatory was the most significant and important part to having visitors see their loved one. We had a visiting warden commence this role and she cleaned the room after every visit to Infection Prevention and Control Standards. Temperature of visitor was taken, records and signatures maintained of each visit. Lovely music played in the background. Visitors were only permitted in this area. However, on every occasion when a resident was deteriorating their next of kin visited them in their bedrooms under strict infection prevention and control. We never had any relative viewing through a window. We never turned any relative away

I&S

I&S

I&S We had at any given time up to twenty "Care Partners" (This was a Department of Health request/Western Health and Social Care Trust)

B. We had no challenges in relation to ventilation in the care home. We always had lots of windows open for visiting and other meetings with staff and health professionals.

C. We honestly did not face many of these challenges we ensured good systems and practices were in place and staff with families had to follow the plans for everyone's safety. Strong leadership and excellent communication by the Home Manager and Registered Nurses on duty was pivotal to this and crucial information sharing.

9. Covid-19 testing for residents and staff commenced at I&S on 03/08/2020. Testing was weekly for staff and every 28 days for residents. We would have carried out other specific /ad hoc testing schedules as advised by Public Health Agency or if symptomatic residents. This regular testing did allow for early identification of Covid, especially in asymptomatic residents/staff. The ordering and supply of tests were good and readily available. Close monitoring of supplies and expiration was required.

In relation to testing, staff required to be trained to ensure adequate technique and errors did occur due to illegible writing or incorrect personal details, however the video issued by Public Health Agency helped to facilitate this. The testing process was time consuming for residents, many of whom who could not cooperate or had difficulty tolerating the initial guidance of swabbing both the throat and nasal cavity. Extra staffing was therefore required and this had great implication on resources that were already overstretched. An allocated testing area was required to manage the sheer volume of testing to reduce the risk of cross infection.

The courier collection service was prescheduled and collected at the door, however there were multiple instances when the tests were not collected on time, up to 12 hours late. This meant the home manager then had to spend valuable time sourcing contacts to arrange urgent collection.

Results were often slow to return, filtering in over a period of days, causing delays in identifying problem samples that required repeating and commencement of Infection Prevention and Control policy procedures for positive residents/staff/care partners.

10. The Home Manager liaised closely with the Public Health Agency and consulted up to date government guidance, the Western Health and Social Care Trust, Regulation and Quality Improvement authority, Care Home Support Team and implemented Infection Prevention and Control precautions as per I&S own policies which were of an exemplary standard. Trust Infection Prevention and Control support visit, 31/08/2021(just after our 2nd outbreak).

11. Steps taken in response to the outbreak:

- Robust and continuous implementation of guidance
- Isolation/cohorting of staff

- Infection Prevention and Control – Personal Protection Equipment, hand hygiene, enhanced cleaning schedules, ventilation in the home
- Social distancing
- Testing
- Monitoring of residents social and emotional wellbeing considering social isolation throughout the pandemic
- Communication/coordination of shared information through frequent staff huddles/handover
- Management of footfall in the home/Visiting schedules
- Supportive management of staff/sharing personal fears and worries/teamwork and provision of a staff rainbow room

Personal Protective Equipment

11 A. This was an extremely stressful and challenging time in the early months, until we started to receive Personal Protective Equipment from Western Health and Social Care Trust late April 2020, as many of our suppliers of Personal Protective Equipment has reduced stocking levels resulting in the Home experiencing shortfalls. Management had little option but to ask local businesses, schools and skilled people within the community to make masks and face protection. The Home Owner travelled hours to collect gloves, masks, aprons from many other homeowners who grouped together and sourced such supplies and then we had a meeting point. The Home Owner stressed on many occasions in the early days to the Trusts that the community and care homes were extremely vulnerable and needed personal protective equipment first to prevent spread. This never happened the acute settings of hospitals all seemed to get first before the care homes. However, this did not prevent Infection prevention and control strict procedures taking place. The Home Owner bought many personal protective equipment supplies from a variety of sources. Local businesses were so supportive and left supplies at the care home front door. Once Western Health and social Care Trust started to supply personal protective equipment, we ordered weekly. Initially it was limited to specific amounts, but this improved as the situation worsened.

B. We did not encounter problems with ill-fitting Personal Protective Equipment. Nor did we receive any expired Personal Protective Equipment; some supplies had short expiration however the Western Health and Social Care Trust Care Home Support were closely monitoring and rectifying this situation. As time improved with supply of Personal Protective Equipment, we received adequate and necessary Personal Protective Equipment supplies to meet I&S needs.

C. All our Registered Nurses and a few key senior healthcare staff attended promptly for fitting of the Filtering Facepiece 3 masks, to allow for safe management of Aerosol-generating procedure as x1 resident was prescribed Continuous Positive Airway Pressure Therapy at night. Some staff did require to be fitted multiple times for the Filtering Facepiece 3 masks; however, they did receive the appropriate mask within a reasonable time frame. Refitting was facilitated 2 yearly.

D. Staff were exhausted wearing Personal Protective Equipment – the wearing of masks constantly was never a pleasant experience. Staff were told the importance of frequent breaks,

drinking lots of water, getting outside for fresh air. Staff were fearful of going home and taking infection to their families. Staff coped in numerous ways, many were resilient managed well while others were fearful and anxious. The Home Manager and Registered Nurses provided excellent daily support.

Visiting restrictions

12 A. Family's – the next of kin were always communicated with about visiting normally via email, or mobile phone numbers. The administration team and visiting warden provided enormous support in this aspect. Visiting schedules were planned. When visiting was not permitted families were spoken to. But we never stopped next of kin visiting extremely sick relatives and always visited when a resident deteriorated or was in the final stages of life. We had NO resident die from Covid -19 as the primary cause. We had NO resident die alone families were always present under strict Infection Prevention and Control, but we did encourage families when someone was extremely ill to remove their face mask and gloves to enable touch this was vital for us as staff – love care and attention was never missed. We believed strongly that families had the right to be with their loved one when extremely ill – we worked tirelessly to enable this and honestly no harm or increased infection happened as a result.

B. Always management and Registered Nurses facilitated end of life visits – always.

C. Daily visits took place in the visiting lounge with screen in place facilitated by a booking system and visiting warden in place to support. Open windows were essential and not ever an issue. This visiting area was all glass with opening windows to outside. Residents were supported to talk per telephone mobile and landline/ relatives had WhatsApp conversations/ video links via iPad – good communication existed, and families were complementary of this. During the Covid-19 period we continued to have our relative's forum (not held in the home) but to enable social distancing we used the local school large assembly hall to facilitate distancing and numbers. We had always good attendances from families. This was a useful source of engaging in meaningful information. We had no difficulties in allowing families to visit. We encountered no problems and had no complaints many compliments for the ease of visiting and for the excellent communication. Families visited daily from 10am to 6pm on a structured appointment process. No one was ever turned away or not able to be facilitated.

D. We had no problems in this area – as we the Home Owner and Home Manager believed strongly that our residents must see their families and therefore put in place a system for visiting safely with strict Infection Prevention and Controls. Families all adhered to this with the very odd person who questioned this. Any difficulties where quickly overcome.

3. The restrictions were far too rigid, and the public did not understand the "whys" behind this. Families and staff could have linked into the Public Health Agency guidelines for the "whys" but hard to understand. Whilst we all understood the spread of infection and its relevance there had to be some common sense. Telling a family, they could not see a loved one dying (not a covid death) never happened in I&S . This was shocking not to be able to spend time with their loved one in their last hours. This should have been accommodated – the trauma that this has left behind for many families is shocking. As the Home Owner of I&S Care Home with the Home Manager we agreed how this would work under strict Infection Prevention and Control standards – we wanted our residents to have their families with them in their dying

hours. We had NO resident die from Covid-19 as a primary cause of death at I&S Care Home.

14. Health professionals were limited in visits to I&S this was because they were not allowed to visit by their Employing Authority. Many telephone calls took place instead or online meetings. General Practitioners visited occasionally when very much needed. I understand this – these professionals were afraid of spread of infection to their homes and other working places. The risks were high. This did impact residents the lack of visits, but management overcome this by establishing phone connections and photography via social media.

Deaths and end of life

15. We had NO deaths from Covid-19 as the primary cause of death during the pandemic. A total of 31 residents died from other illnesses. No staff member died. The death of a resident is a sad time in a care home and for all staff involved they get upset but good support was and is always provided by the Registered Nurses. It was pleasing on every occasion when a resident died their family was present if they chose to be.

16 A. Due to the complex health of our residents, many of whom were living with the consequences of chronic conditions which had debilitating effects on their health and general well-being, I&S had well established processes to ensure all new residents had an Advanced Care Plan discussion with them (if appropriate), their Next of Kin and General Practitioner. This set out an individual plan of care for each resident, including decision on resuscitation status, ceiling of care/for hospital admission.

I&S had a strong team of dedicated registered nurses and care staff and had been recognised over the years for its proactive work, forward thinking and ongoing initiative to prevent unnecessary hospital admissions. I&S I&S I&S The homes vision was always to ensure individual residents experienced a good quality of life and when they reached the end phase of their life, that they were shown compassion, dignity and comfort in death for both the individual and their family. We did not want this to change during the Covid pandemic.

Do not attempt cardiopulmonary resuscitation notices were already considered, with a large percentage of our residents having a recognised palliative care requirement resulting in a Do not attempt resuscitation status, and for hospital admission only on medical advice or for clear benefits following their Advanced Care Plan discussion.

B. We never encountered throughout the pandemic period concerns about Do not attempt cardiopulmonary resuscitation – this never happened in I&S Care Home.

17. For a short period of time General Practitioners visits were reduced/stopped due to staff shortages/self-isolation within the local General Practitioner practice. In liaison with the General Practitioner, we developed new ways of working including the use of video consultations with the nurse recording observations and performing the examination and providing feedback to the General Practitioner to make clinical decisions. This was possible due to our Registered Nurses having a broad breadth of knowledge, skills and experience and were therefore equipped to recognise the deteriorating resident. Registered Nurses were

attuned to assessing the need for anticipatory prescribing of end-of-life medications and the use of the 'pandemic pack' of medications that we, in I&S found to be invaluable and was utilised widely. However, feedback received from many out of hours General Practitioners indicated that other care homes may not have utilised their pandemic stock as we did. Western Health and Social Care Trust Extension of Community Health Care outcomes training to staff was also reported by the Registered Nurses to be of significant value.

Provision of data

18. It was endless requests daily Monday to Friday. As the Home Owner for the full period of the Covid -19 pandemic I had to (including weekends) complete a template to Regulation Quality and Improvement Authority this was meant to be shared with Western Health and Social Care Trust and Public Health Agency – I often asked myself was it shared as for example many times per day Western Health and Social Care Trust/Public Health Agency would ask for the same information. When we did have a Covid-19 outbreak first time in July 2021 (we had managed from 1st March 2020 to July 2021 never to have a staff member or resident positive testing) the number of calls from Western Health and Social Care Trust and Public Health Agency were far too much. These were phone calls asking questions and "must dos" did they bring reassurances or support rarely. In the Care Home sector, you were alone as the Home Owner (I carried this burden of care and safety for my residents and staff twenty-four hours per day). It never left me I never had a break from it – it was my responsibility as the Responsible Person (Regulation Quality and Improvement Authority), but it did take its toll. Many times, I was lost in the paper chase after 5pm and weekends who was there to ask very few. I had to always provide the support care and attention to my residents and staff.

There should have been a much clearer format of data collection as time went on for what was really required to inform and make changes for safe Infection Prevention and Control outside of the care home. Too many people involved.

Staffing

19. Staff at I&S went beyond the call of duty – undertook extra shifts were supportive to colleagues. Provided excellent care and attention to colleague's residents and families.

20. We were never short of staff. We used NO agency. We had a full complement of staff in every department. Even when large numbers of staff were off with Covid-19 we still managed to cover all shifts – this was a tremendous achievement, and it was the staff who made I&S a safe place to live and work.

21. We had an independent helpline for support. One was also provided by Western Health and Social Care Trust. No doubt staff were stressed and exhausted going home to their families. We strived to ensure staff had at least two days off every seven days shift pattern. We provided free meals for staff. Staff morale was good and each one looked after each other. The few staff that needed extra help received this from management. The Home Owner provided financial support as required in a confidential manner.

22. Financial support from the Western Health and Social Care Trust via Department of Health /Public Health Agency came far too late. The expense to the Home Owner was enormous yet services and Personal Protective Equipment had to be provided to the highest standard. When financial support did arrive, it was an extremely complicated process to seek reimbursement for. Endless hours for administration staff it was unreal the evidence requested. The Western Health and Social Care Trust/ Department of Health at its most senior level should have

decided much earlier financial support was required plus have an amount per resident to cover such costs for Personal Protective Equipment /Infection Prevention and Control necessities. A round figure should have been agreed from day one. Not itemised each area – this is what happened – some financial support was a lump sum but the amount of work to get any money was an unreal ask on a single Homeowner. Yet I am grateful for what financial help I received but it never covered the full expenses encountered and the human cost. My honest opinion was who really cared for the Home Owner we just had to get on with it and suffer the losses – my greatest priority was to ensure safe staffing and high quality of serve provision.

Overall reflections

23. What worked well:

Was the outstanding leadership of our Home Manager as a leader and champion for Infection Prevention and Control. It was her steadfastness, resilience, and ability to manage such huge daily changes that had the specific results seen at I&S Care Home. To have had 16 months (March 2020 to July 2021) in the first wave of Covid-19 with NO residents or staff testing positive was an incredible achievement and deserved recognition. I have no doubt that the quality outcomes can be attributed to the high standards of care and Infection Prevention and Control interventions delivered to our residents, was all down to the leadership of this person and the ability for all grades of staff to follow this direction. This is I&S success story. Also, importantly to the culture and values of the management staff at I&S to be I&S allowed our many next of kin to continue to visit their loved ones. This is our second success story, and we were highly commended for this. This "Care Partner" initiative took a lot of the visiting warden's time and a dedication above measure. I&S were exemplary in our visiting/ staying connected with all next of kin and families during all this wave – WhatsApp/ daily phone calls/ video links/ a protected and isolated visiting room with separation Infection Prevention and Control see through partition all was so extraordinarily successful. At I&S we had NO deteriorating or dying resident not seeing family members face to face and holding of hands and touch – all so crucial for palliative care and end of life journey. We worked tirelessly twenty-four hours per day to ensure this happened.

NO resident died from Covid – 19 as their primary death cause. It was the huge commitment of our staff made this success story.

What could be different in the event of a future pandemic:

- Much better information sharing by Department of Health/Western Health and Social Care Trust/Public Health Agency in simple language easily understood that can be shared with all staff and families. The LINKS send via email were far too detailed and hard to understand. Families needed greater education and understanding of their individual responsibilities to protect residents/staff to control outbreaks within the care home setting.
- Much better practical and financial support early in a pandemic is essential – not just phone calls and emails. With Personal Protective Equipment and especially finance coming late to the process. When finance was approved the complication of presenting this detail requests back to Western Health and Social Care Trust was enormous workforce pressures.

- Much better preparedness for Personal Protective Equipment and financial support – in early at the beginning with the most vulnerable groups in society.
- Proper face to face visits to show support and offer help. Not distanced away after 5pm and at weekends. Persons to visit and offer help who understand what it is like to work and care for residents in a care home?
- Data that is requested and collected – should be meaningful and that this is shared across all Agencies without repetition of requests. Asking the question what value will such information add to help support and protect people.
- The Independent Sector has the most complex and vulnerable groups of residents and needed the immediate support for Personal Protective Equipment and other example pandemic drugs (to be held in the care home) – the supplies all came too late at the beginning of this wave.
- More helplines for staff to utilise for counselling. How could staff be better supported for their own mental health?
- Even at today's date meetings held via video links whilst good in some instances need to change to face to face visits / meetings.
- Multidisciplinary Teams and General Practitioners reviews and visits would need to improve, often difficult to contact, reluctancy to enter the home or communicate via other means. In a small number of cases there was lack of support/guidance for the home staff to manage care needs of resident's especially Social Workers who had not been supportive to conduct Care Management Reviews. We were fortunate to have highly skilled Nurses and supportive families.
- Pandemic stock – a wider range of antibiotics and comfort medicines for end of life would have been beneficial. Pandemic stock utilized well within the home and prevented delays in residents care with prompt delivery.

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: PD

Dated: 02.06.2025

Appendix A

I&S Care Home, I&S Western Health and Social Care Trust

Staff Template, Period between 1st March 2020 and 28th June 2022

KEY: 1. Total on Payroll Active
2. Leavers
3. Female
4. Male
5. Northern Irish
6. International
7. Indian
8. Hungarian
9. Sri Lankan
10. Covid +
11. Additional Information

Month/Year	1	2	3	4	5	6	7	8	9	10	11
Mar-20	75	0	68	7	69	6	5	1	0	0	
Apr-20	78	0	70	8	72	6	5	1	0	0	
May-20	78	0	70	8	72	6	5	1	0	0	
June-20	78	2	70	8	72	6	5	1	0	0	
Jul-20	80	4	73	7	74	6	5	1	0	0	
Aug-20	79	2	72	7	70	5	4	1	0	0	
Sep-20	78	0	71	7	74	4	4	1	0	0	
Oct-20	79	2	72	7	74	5	4	1	0	0	
Nov-20	79	0	73	6	75	4	3	1	0	0	
Dec-20	83	3	77	6	79	4	3	1	0	0	
Jan-21	82	0	76	5	78	4	3	1	0	0	
Feb-21	82	1	76	5	78	4	3	1	0	0	
Mar-21	84	2	78	5	80	4	3	1	0	0	
Apr-21	84	1	78	5	80	4	3	1	0	0	
May-21	84	1	78	5	80	4	3	1	0	0	
Jun-21	86	0	80	5	79	7	5	2	0	0	
Jul-21	89	1	82	7	82	7	5	2	0	3	
Aug-21	94	5	86	8	87	7	5	2	0	26	1 staff member pursued a career in Nursing, 1 moved to Australia and the other 3 took up new posts. (2nd Outbreak of Covid)
Sep-21	89	3	80	9	82	7	5	2	0	0	
Oct-21	88	1	79	9	82	6	4	2	0	0	

Nov-21	92	1	83	9	85	7	4	3	0	0	
Dec-21	96	2	88	8	85	11	4	3	4	5	
Jan-22	94	2	87	7	83	11	4	3	4	3	
Feb-22	94	4	87	7	81	13	7	2	4	4	
Mar-22	95	4	89	6	80	15	7	2	6	2	
Apr-22	91	1	87	4	76	15	7	2	6	0	
May-22	92	1	88	4	76	16	6	2	8	0	
June -22	91	1	86	5	74	17	6	2	9	0	

Appendix B

[redacted] Care Home, [redacted] - Western Health and Social Care Trust

Number of Registered Nursing beds = 41 Residents template

1st March 2020 to 28th June 2022

KEY:
1. Actual Occupancy
2. Number of Admissions
3. Number of discharges to the community
4. Number of expected deaths not related to Covid
5. Number of deaths with Covid-19 as the primary cause
6. Number of transfers to Hospital
7. Number of transfers to other care homes
8. Number of admissions back from Hospital with no positive Covid-19
9: Number of admissions back from Hospital with positive Covid - 19
10: Additional information

Month/Year	1	2	3	4	5	6	7	8	9	10
March - 2020	41	1	0	0	0	0	1	0	0	1 Admission, Covid negative on Admission. 1 Discharge to another Care Home, Covid negative on discharge.
April - 2020	41	0	0	0	0	0	0	0	0	
May - 2020	41	1	0	2	0	0	0	0	0	1 admission, Covid negative on admission. 2 expected deaths not Covid related, fragility of old age.
June - 2020	41	4	0	3	0	0	0	0	0	4 admissions, all Covid negative on admission. 3 expected deaths not Covid related, fragility of old age.
July - 2020	41	1	0	1	0	0	0	0	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age.
August - 2020	41	1	0	1	0	0	0	0	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age.
September - 2020	41	0	0	0	0	0	0	0	0	

October - 2020	41	1	0	2	0	0	0	0	0	1 Admission, Covid negative on admission. 2 expected deaths not Covid related, fragility of old age.
Month/Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
November - 2020	41	2	0	1	0	0	0	0	0	2 Admissions, both Covid negative on admission. 1 expected death not Covid related, fragility of old age.
December - 2020	41	0	0	0	0	0	0	0	0	
January - 2021	41	0	0	1	0	0	0	0	0	1 expected death not Covid related, fragility of old age.
February - 2021	41	0	0	0	0	0	0	0	0	
March - 2021	41	0	0	1	0	0	0	0	0	1 expected death not Covid related, fragility of old age.
April - 2021	41	2	0	2	0	1	0	0	0	2 Admissions, both Covid negative on admission. 2 expected deaths not Covid related, fragility of old age. 1 Hospital admission due to acute mental health review/Covid negative when transferred
May - 2021	41	3	1	2	0	0	0	0	0	3 Admissions, all Covid negative on admission. Discharge from respite stay back to the community, Covid negative on discharge. 2 expected deaths not Covid related, fragility of old age.
June - 2021	41	1	0	1	0	0	0	0	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age.
July - 2021	41	1	0	1	0	1	0	0	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age.

										Hospital admission due to exacerbation of respiration level 2/Covid negative when transferred.
Month/Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
August - 2021	41	3	0	5	0	0	0	1	0	3 Admissions, all Covid negative on admission. 5 expected deaths not Covid related, fragility of old age. Resident returned from hospital/Covid negative when re-admitted.
September - 2021	41	4	0	2	0	1	0	0	0	4 Admissions, all Covid negative on admission. 2 expected deaths not Covid related, fragility of old age. Hospital admission due to acute mental health review/Covid negative when transferred.
October - 2021	41	1	0	0	0	1	0	1	0	1 Admission, Covid negative on admission. Hospital admission due to aspiration pneumonia/Covid negative when transferred. Resident returned from hospital/Covid negative when re-admitted.
November - 2021	41	1	0	1	0	1	0	0	0	1 admission for temporary stay 1 expected death not Covid related, fragility of old age. Hospital admission due to exacerbation of respiration Level 2/Covid negative when transferred
December - 2021	41	1	0	1	0	0	0	1	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age. 1 Resident returned from hospital/Covid negative when re-admitted.
January - 2022	41	2	1	1	0	0	0	0	0	2 Admissions, both Covid negative on admission.

										Discharge to the community, Covid negative on discharge. 1 expected death not Covid related, fragility of old age.
Month/Year	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
February - 2022	41	2	1	2	0	0	0	0	0	2 Admissions, both Covid negative on admission. Discharged from temporary stay back to the community, Covid negative on discharge. 2 expected deaths not Covid related, fragility of old age.
March - 2022	41	1	0	0	0	1	0	0	0	1 Admission, Covid negative on admission. Hospital admission due to raised C reactive protein (blood test) , unknown origin/Covid negative when transferred to Hospital
April - 2022	41	0	0	0	0	0	0	0	0	
May - 2022	41	1	0	1	0	0	0	0	0	1 Admission, Covid negative on admission. 1 expected death not Covid related, fragility of old age.
June - 2022	41	1	0	0	0	0	0	0	0	1 Admission, Covid negative on admission.