COVID Paper II

Examining the Impacts and
Response in Residential
Mental Health Services

mhc
coimisiún meabhair - shláinte
mental health commission

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Abbreviations

CAMHS – Child and Adolescent Mental Health Service

CHO – Community Healthcare Organisation

DSS – Decision Support Service

DOH – Department of Health

HSE – Health Service Executive

HPSC – Health Protection Surveillance Centre

IPC – Infection Prevention Control

LTRC – Long Term Residential Care

MDT – Multidisciplinary Team

PPE – Personal Protective Equipment

Executive Summary

The COVID-19 pandemic has required residential mental health services to respond and adapt to a rapidly evolving risk environment on an unprecedented scale. From the outset of the pandemic, mental health services have shown a capacity for change and resilience which helped them in the prevention and treatment of COVID-19. The response and actions taken by services has not only ensured that service delivery has been sustained but has also prevented the spread of illness and saved lives.

The characteristics of mental health services mean that they are faced with unique challenges in any pandemic situation. The purpose of this paper is to seek an understanding of how the sector responded, identify emerging best practice and identify lessons that can be learned to safeguard residents into the future.

Approach and methodology

This is the Mental Health Commission's (MHC) second paper on the topic of COVID-19 in residential mental health services. Like all organisations, the MHC has had to change and adapt its work practices in order to continue to uphold the rights of people who use services and to provide assurance in respect of resident safety. As a result, there have been changes to the inspection and monitoring practices. The MHC also has a role in promoting high standards and supporting the sector. The MHC has done this by gathering detailed data sets about COVID-19 in services and using this information to identify where residents were at risk. In this way, the MHC helped to identify areas where targeted interventions were needed. The MHC, Health Service Executive (HSE) and the Department of Health (DOH) collaborated to protect residents and staff, using real-time data to inform responses.

In April 2020 the MHC began monitoring residential mental health services in respect of COVID-19. The team responded to each centre where cases were identified and escalated issues where indicated. A defined and accelerated escalation pathway to the HSE was put in place to facilitate this response. This meant that where additional risks were identified, such as access to PPE or staff resources, there has been a targeted response and the MHC sought additional assurances and evidence that action was taken. This in turn has served as an additional safeguard to ensure that vulnerable residents have been protected.

Analysis and findings

Through these monitoring activities, the MHC has built up a significant amount of COVID-19 related data. Some of these data and observations will be presented in this paper to help inform our understanding of how residents can be protected now and in the future.

The main findings are as follows:

1. Disease progression trends

National COVID-19 cases graphed against confirmed cases in mental health services from April 2020-April 2021 showed three distinct 'waves' of the virus were evident with a slight lag between national case peaks and residential mental health service peaks.

2. Resident impact

The demographic with the most reported cases was females between the ages of 81 and 90; this subgroup accounted for 16% (n=24) of all confirmed resident cases during the initial monitoring period, March to July 2020. 52% (n=79) of cases were among male residents, 48% (n=74) were female residents. 88% (n=134) of residents fully recovered from the virus, 10% (n=16) of residents died and the outcome was unknown in 2% (n=3) of cases.

3. Staff impact

Of 269 individuals who acquired COVID-19 during the initial monitoring period, March - July 2020, nursing staff accounted for over half of the cases at 55% (n=148).

4. Geographic spread

Dublin and surrounding counties reported higher numbers of confirmed cases. This correlates with community incidence rates in these areas.

5. Risk management

The MHC undertook a detailed updated risk assessment with services in early 2021. This followed similar assessments in 2020. Services reported high risk preparedness and outlined risk management measures including: staffing contingency plans, collaboration with public health, the provision of staff education and training, and the formation of dedicated COVID-19 response teams.

6. Innovative practices

Services were provided with an opportunity to outline innovative practices introduced in response to COVID-19. Responses demonstrated the implementation of a variety of new practices, particularly in the areas of resident wellbeing, information sharing and advancements in service use of technology.

Recommendations and policy observations

In total, seven high level recommendations have been made with the aim of supporting further learning from the COVID-19 pandemic and ensuring that service users are better protected into the future.

The **recommendations** can be categorised as follows:

- Governance and leadership
- Premises
- Guidance
- Staff training and support
- Ongoing risk management and collaboration
- Further research opportunities
- Learning and service implications

Acknowledgement

The MHC wishes to take this opportunity to specifically acknowledge the very distressing impact the pandemic has had on residents, their families, and friends, as well as the impact on the staff and management of services. The MHC extends its sincere condolences to all those who have lost loved ones as a result of this disease.

In compiling this paper, the MHC has learned of numerous examples of how staff in mental health services worked extremely hard to support and protect residents who have been impacted by the pandemic. This work was supported at national level by the HSE Mental Health Unit. It is also evident from our findings that frontline staff in mental health services accounted for a considerable number of COVID-19 cases. The MHC wishes to acknowledge the sacrifices and tireless work of frontline staff in protecting residents.
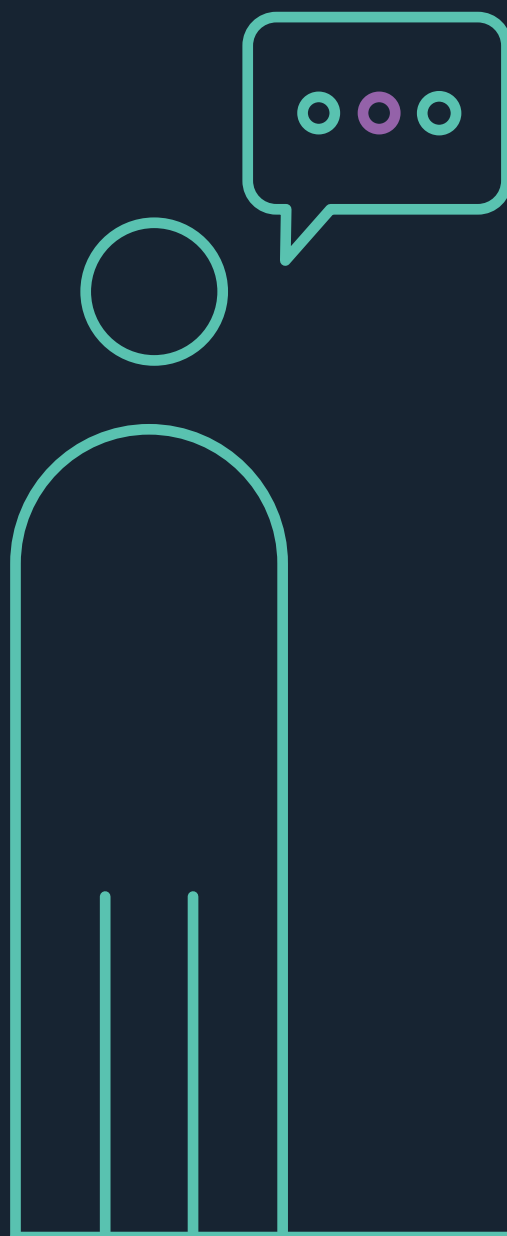
1. Introduction

Background

The purpose of this paper is to understand the impact of the COVID-19 pandemic on Irish residential mental health services; to outline actions taken to mitigate risks and support resident wellbeing; and to report on disease progression within and between those services. The paper will also expand upon the preliminary observations as outlined in *COVID-19 Paper 1: Supervising, monitoring, and supporting Irish residential mental health services during COVID-19* (24 September 2020).

The MHC has used this paper as an opportunity to analyse additional data collected in respect of disease progression between March 2020 and April 2021. The paper also provides detail of innovative practices introduced by services in response to the pandemic and resultant changes in work practices.

The MHC has been engaging with residential mental health services throughout the pandemic. We commend services across the country for their resilience in the face of extraordinary stress and uncertainty. Both approved centres and community residences demonstrated an unwavering commitment to protecting residents and staff in a profoundly uncertain service context.

Our team have heard of the introduction of innovative practices across the country, which we are pleased to be able to outline at a high level in this paper. We have also spoken to staff from all levels and service types and have noted their in-depth knowledge in respect of COVID-19. Health Protection Surveillance Centre (HPSC) guidance was under near-constant review during the early months of the pandemic, yet staff demonstrated a clear understanding of their role in tackling disease progression and protecting the most vulnerable.

In publishing this follow-up paper, the MHC is seeking to share learnings and developments to reflect the quality of work undertaken in mental health services during the pandemic. We are also disseminating same in order to ensure that services are as well prepared as possible for any further surges of COVID-19, related variants or future pandemics.
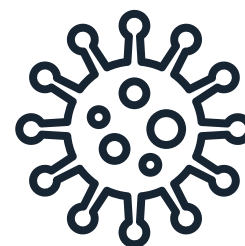
COVID-19

COVID-19 is associated with acute respiratory illness, and clinical evidence indicates that a proportion of patients become seriously ill, requiring respiratory support and admission to an acute hospital for intensive care treatment[1]. While the disease is relatively mild for most, the severity rises primarily with age, being potentially severe for the over-70s cohort, as well as with some medical conditions.

While the entire population is vulnerable during a pandemic, mental health service users resident in acute settings and long-term residential care units may be particularly susceptible to developing COVID-19 and experiencing negative health outcomes. There are a number of reasons for this. Many residential mental health services are still located in multi-occupancy, outdated buildings. A recent report by the Inspector of Mental Health Services, Dr Susan Finnerty, outlines same and notes that 'many buildings have been designed to address safety concerns, such as fire, self-harm, and violence, but not infection prevention and control'[2]. Individuals receiving care and treatment for mental health issues, particularly those with acute needs, may be less able to readily comply with Infection Prevention and Control (IPC) recommendations or instructions. The nature of mental healthcare delivery necessitates close care and co-location with other healthcare settings which can increase contact numbers, as can frequent admissions into services. The age profile of residents and the prevalence of co-morbidities also increases the risk of negative COVID-19 outcomes. There is emerging evidence of the increased risk of adverse outcomes in residents and patients in such settings.[3]

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1   Department of Health (2020). Ethical Considerations Relating to Critical Care in the context of COVID-19.

2   Dr Susan Finnerty, A Report on Physical Environments in Mental Health Inpatient Units, Mental Health Commission, 2021

3   N Basrak et al, "Risk of adverse outcome of COVID-19 among patients in secure psychiatric services: observational cohort study" 2021 BJPsych Open

However, mental health services also have distinct strengths in terms of their ability to respond to public health risks. They often have strong and established links with IPC specialists and public health teams. Their staff teams are made up of trained professionals with experience of responding to and managing communicable diseases. Clinicians are directly involved in service oversight and the provision of care. Ongoing professional development and training are accepted working requirements and staff are experienced in responding to emergent risks and crises.

MHC regulatory scope

The MHC is an independent statutory body that was established in April 2001 and is the regulator for mental health services in Ireland. The regulatory functions and process for independent review of involuntary admissions came into effect following full commencement of the Mental Health Act[4] (the **2001 Act**) in November 2006.

The MHC's mandate is to promote, encourage, and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the 2001 Act. In 2015, the MHC welcomed the establishment of the Decision Support Service (DSS) within the MHC under the Assisted Decision-Making (Capacity) Act 2015[5]. The DSS extends the remit of the MHC beyond mental health services to include all adult relevant persons in Ireland who may require support in decision-making.

Under the 2001 Act, the statutory scope of mental health regulation is limited to in-patient services (approved centres) which are estimated to make up <1% of mental health services in Ireland. 90% of mental health services are delivered in primary care settings. These include the above approved centres but also include 24-hour nurse staffed community residences, which are unregulated.

A wide range of services are provided within mental health residential facilities, including: acute adult mental health care, continuing mental health care, psychiatry of later life, mental health rehabilitation, forensic mental health care, mental health care for people with an intellectual disability, child and adolescent mental health care (CAMHS) and specialist eating disorder services.

The Health Service Executive (HSE) provides the vast majority (92%) of residential mental health services. A small number (7%) operate as private and independent services and 1% are funded by the HSE as Section 38 organisations, which amount to agencies contracted to provide services for the HSE.

MHC COVID-19 response

The MHC response to the COVID-19 pandemic is outlined in greater detail in Paper 1 of this series. In short, on 1 April 2020 the MHC was tasked with risk assessing mental health services by the Department of Health. Detail in respect of this process is provided in the Methodology section below. The MHC then developed a sustainable weekly monitoring process in respect of disease progression and risk in residential services. The monitoring team configuration has changed in response to national disease progression trends and in anticipation of surges.

At the time of drafting, the MHC was monitoring 66 approved centres nationally, comprising 2,647 beds. There were 118 24-hour nurse staffed community residences nationally, comprising approximately 1,270 beds. As community residences are not subject to the same regulatory controls as approved centres and are subject to regular reconfiguration, it is difficult to provide an exact figure in relation to community residence beds. Furthermore, it should be noted that the number of approved centres and beds fluctuated over the course of the year-long monitoring period as services were registered, reconfigured and closed to facilitate building works.

The MHC COVID-19 monitoring processes were completely distinct from our usual inspection, compliance, or enforcement processes. The MHC committed to working with and supporting services to protect residences and staff.

It is important to note that data collected as part of the MHC COVID-19 monitoring process was not primarily intended to facilitate research and analysis. The MHC's main concern in collecting COVID-19 information was to inform its understanding of existent or potential risk in residential mental health services and to escalate such risks accordingly in the interests of the safety and welfare of service users.

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4   Mental Health Act 2001 (2001).
5   Assisted Decision Making (Capacity) Act 2015 (2015).

2. Methodology

Data sources

The following data sources are detailed and analysed in this paper and explained further below.

- Reported weekly data about suspected and confirmed cases for the period April 2020-April 2021
- Detailed data about suspected and confirmed cases provided for the period March-July 2020 (the initial monitoring period)
- Updated risk framework responses
- Innovative practices responses

It should be noted that one limitation of the above data sources is that none specifically centre on the voice of residents or service users. This is a considerable constraint and recommendations in this regard are included in Section 4 below.

Reported weekly data

The MHC has been conducting weekly monitoring calls with mental health services since April 2020. A set of standard questions is used to elicit information in respect of disease progression and risk management. This information is recorded in service-specific Excel sheets. Collated data in respect of disease progression is then recorded in a master log. This is a live spreadsheet which is updated daily as the MHC is notified of suspected or confirmed cases.

Each Friday morning a point in time report is compiled detailing active cases of COVID-19 as notified to the MHC. This includes the number of suspected and confirmed staff and resident cases and is circulated to relevant stakeholders in the DOH and the HSE. The data from these weekly reports were compiled into one spreadsheet and internally validated.

The collated data spans the timeframe from April 2020 to April 2021 and provides a high level, point in time overview of weekly disease progression trends in residential mental health services. The data is not a cumulative figure for the week, rather it represents the number of active reported cases at a point in time.

The data was analysed to provide the trend analysis detailed in Section 3.1 below.

Detailed data from initial monitoring period

In order to undertake a more detailed assessment of disease progression, mental health services were asked to provide additional detail in respect of confirmed staff and resident cases that occurred during the initial monitoring period. While it is not possible to review all confirmed cases in this level of detail, the below analysis provides an insight into the experience of mental health services during the first wave of the COVID-19 pandemic. From July 2021 onwards, the MHC collected only the data it needed to inform its ongoing risk assessment processes in order to ensure that residents were safe.

Data collected as part of the weekly monitoring calls were collated onto Excel spreadsheets and cleaned by MHC staff to ensure no duplicates were recorded. Formatted spreadsheets were sent to each Community Healthcare Organisation (CHO) or service area, separated out into approved centres and long-term residences. Services were asked to verify the above referenced records as to whether the service had reported COVID-19 cases via the weekly monitoring calls. Additional detail was requested in respect of all confirmed staff and resident cases from the first known instance up to the date the request was issued, 30 July 2020. Respondents were asked to provide the following anonymised information. No identifiable data was requested or collected.

In respect of staff, at a CHO-wide level:

- Profession
- Reason for testing
- Date of testing
- Date results received
- Whether working across facilities

In respect of residents, at a service-wide level:

- Date of birth
- Gender
- Reason for testing
- Date suspected
- Date of testing
- Date resulted received
- Whether transferred to hospital
- Outcome
- Whether underlying medical conditions

Once received, data was collated onto a single spreadsheet and analysed according to the variables listed above. This analysis is detailed in Section 3.2 below.
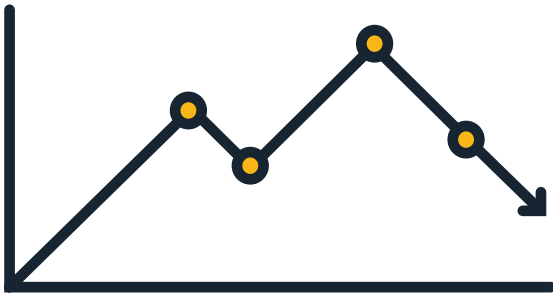
Updated risk framework

In April 2020, the MHC undertook a rapid review of available national and international guidance in relation to long-term care provided in residential settings and developed a risk framework to objectively assess and record the level of risk in mental health services. Services were initially assessed against the framework in early April 2020 and were reassessed against the same standard in early May 2020. The initial average risk score calculated for the services was 79.87%, with an updated average of 85.44%, an improvement of 5.57%. This information was provided to the HSE and the outcomes informed ongoing risk monitoring by the MHC. Further detail about the process can be found in our initial COVID-19 paper[6]. Condensed weekly risk assessments, as detailed above, continued for the remainder of 2020.

Following national disease progression trends and in anticipation of an expected increase in cases in early 2021, the MHC undertook a detailed updated risk assessment with services. The updated framework was issued to services on 18 December 2020 and consisted of a combination of 'Yes/No' questions and open text questions. Services were given four weeks to complete this. The binary responses were used to calculate an updated risk score for each mental health service. These questions are reproduced in Appendix 1.

Once returned, updated risk framework responses were logged in a master spreadsheet and a risk score was calculated for each service using the below calculation. Details of the responses and updated risk scores are outlined in Section 3.3 below.

> Total 'Yes' responses
> --- x 100 Total
> # Risk framework assessment questions asked

Innovative practices data

The MHC was also eager to capture information about innovative practices and emerging best practice at a service level in response to COVID-19 and rapidly changing organisational and operational requirements. A questionnaire was devised to elicit this information and this was issued to services alongside the updated risk framework above. Completing the innovative practices questionnaire was voluntary and the MHC acknowledged that services may not have the capacity to do so. The questionnaire consisted of 'Yes/No' questions relating to the following innovative practice areas and open text boxes to allow the provision of more detailed information.

- Contact with friends, family and the outside world
- Providing information and guidance
- Communication and networking
- Multi-disciplinary team involvement
- Changes to service design
- Use of technology
- System collaboration
- Innovative practices in Infection Prevention and Control (IPC)
- Innovative safe staffing practices
- Wellbeing of residents and people using services

Responses were collated and qualitative analysis was undertaken to categorise the detail provided. This analysis is outlined in Section 3.4 below.

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6   Mental Health Commission, COVID-19 Paper 1: Supervising, monitoring, and supporting Irish residential mental health services during COVID-19 (24 September 2020)

3. Analysis & findings

3.1 Disease progression trends

As outlined in Section 2, the MHC has been collating weekly point in time reports in respect of current COVID-19 cases as notified by services. A margin of error is necessarily noted; the data is compiled as reported by services and the potential exists for false positives in the testing programme or duplication in the reporting of cases. However, the weekly data reflects the understood disease progression at that point in time.

The below graphs illustrate trends in reported COVID-19 cases in mental health services from April 2020 to April 2021. Figure 1 below shows newly identified national COVID-19 cases, reported weekly by the HPSC, graphed against confirmed active cases in mental health services from April 2020-April 2021. The graph should not be understood as a comparison between two distinct data sets. Rather, it illustrates relevant peaks and troughs in disease progression. The three distinct 'waves' of the virus are evident in the below as is the slight lag between national case peaks and residential mental health service peaks.

Figure 1: COVID Case Mapping
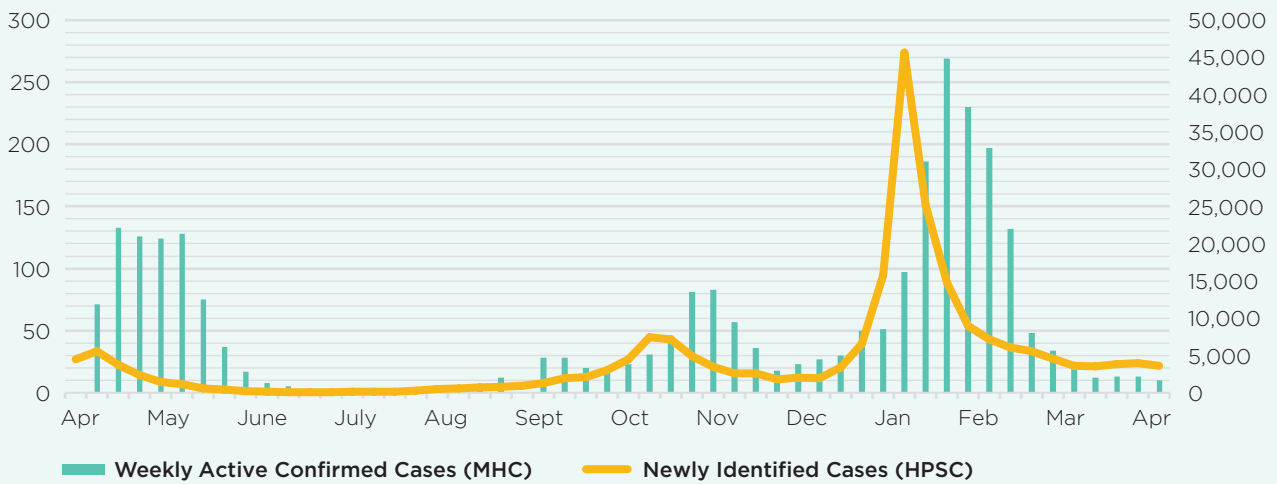
The graph below shows trends in the number of services reporting suspected and confirmed staff and resident cases each Friday. Again, the three 'waves' are evident.

Figure 2: No. of Services Affected
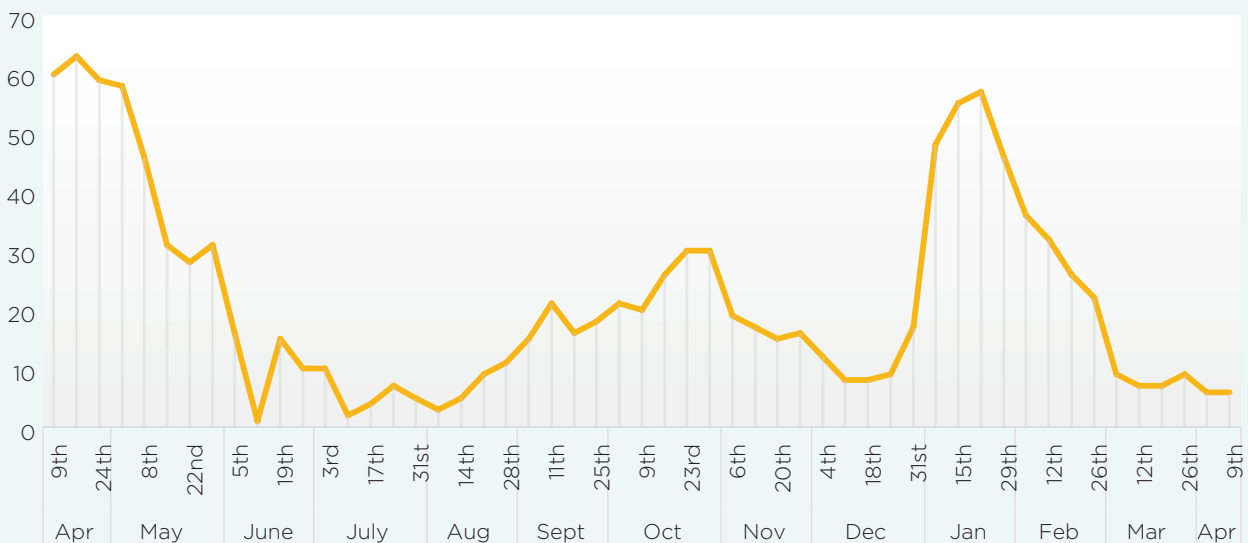
The below graph shows the number of confirmed and suspected cases detailed in the weekly reports. Considerably more suspected cases were notified in the earlier stages of the pandemic. The reduction in notifications is likely a reflection of increased knowledge in respect of virus symptoms and improved access to testing. A considerable surge in confirmed cases is evident in early 2021.

Figure 3: MHC Confirmed vs Suspected Cases

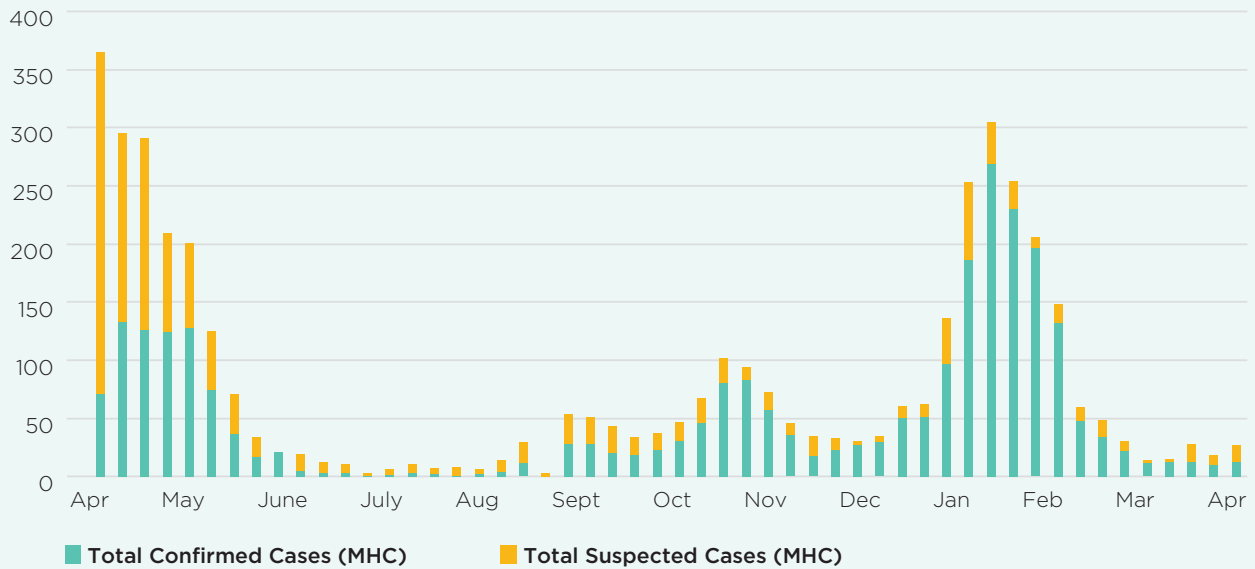■ Total Confirmed Cases (MHC)   ■ Total Suspected Cases (MHC)

Figure 4 below outlines trends in the number of confirmed staff and resident cases of COVID-19 from April 2020 to April 2021. Figure 5 illustrates the combined number of cases reported each Friday.

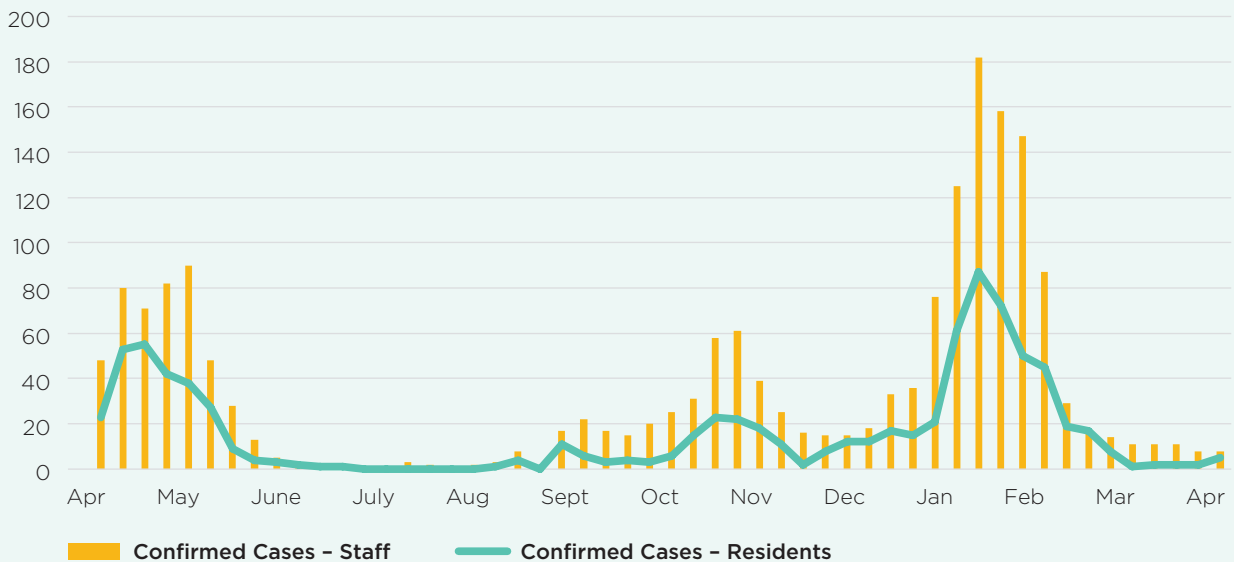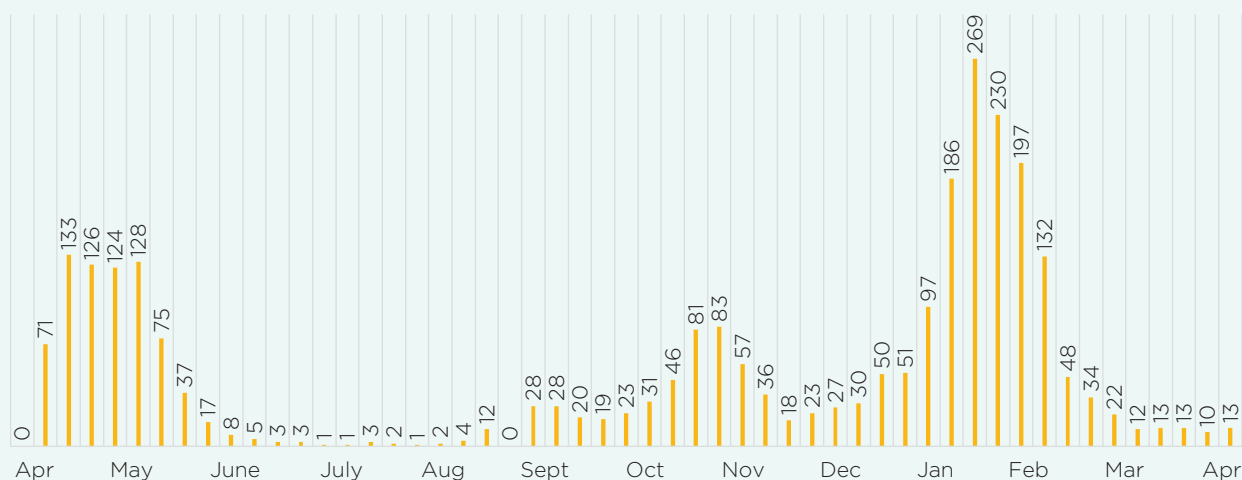**Figure 4: Confirmed Cases – Staff vs Residents**

■ Confirmed Cases – Staff   — Confirmed Cases – Residents

Figure 5: Confirmed COVID Cases (MHC) Apr 20-Apr 21


3.2 Initial monitoring period analysis

Disease progression

The detailed data submitted by services in respect of the initial monitoring period (9 March 2020 to 30 July 2020) provides the following confirmed case numbers:

- 269 confirmed staff cases
- 153 confirmed resident cases

Disease progression over the initial monitoring period is mapped on the below graph. Figure 6 shows that cases were highest in late April and early May with the number of staff cases generally higher than resident cases.

Figure 6: Disease Progression
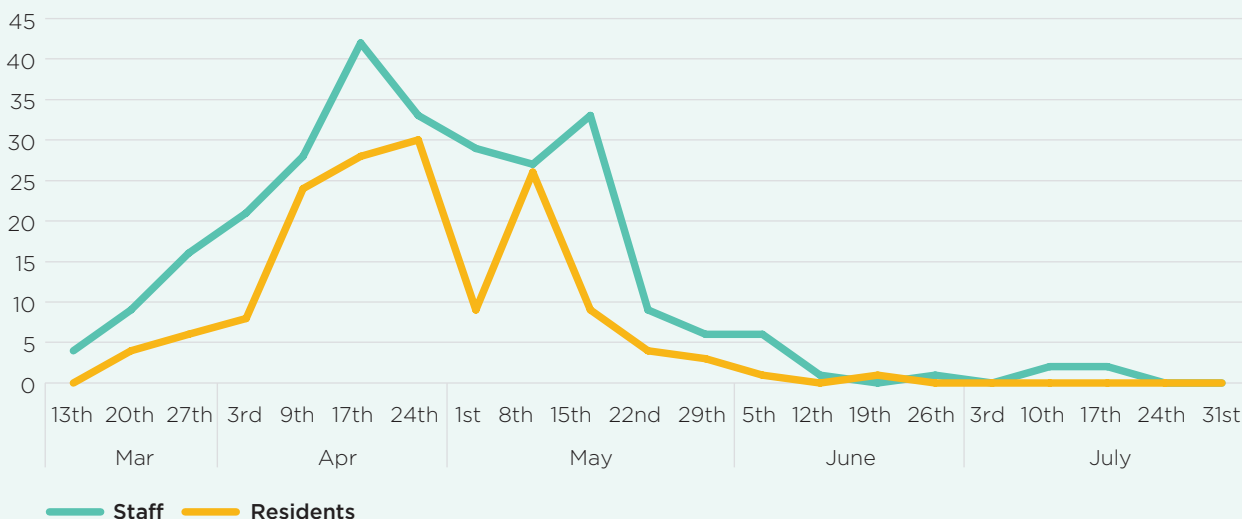
The detailed data was compared with national data trends compiled from the weekly HPSC reports[7]. The aim was to identify any trend similarities between national cases and those in residential mental health services. The graph below shows this comparison and corresponding increases in cases. Please note that HPSC data prior to 9 April 2020 is unavailable.

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7   Health Protection Surveillance Centre Weekly report on the epidemiology of COVID-19 in Ireland. https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/epidemiologyofcovid-19inirelandweeklyreports/. Week 15 2020 – Week 14 2021.

Figure 7: HPSC Cases vs MHC Cases

Legend: Overall cases (HPSC) — Cases(MHC)
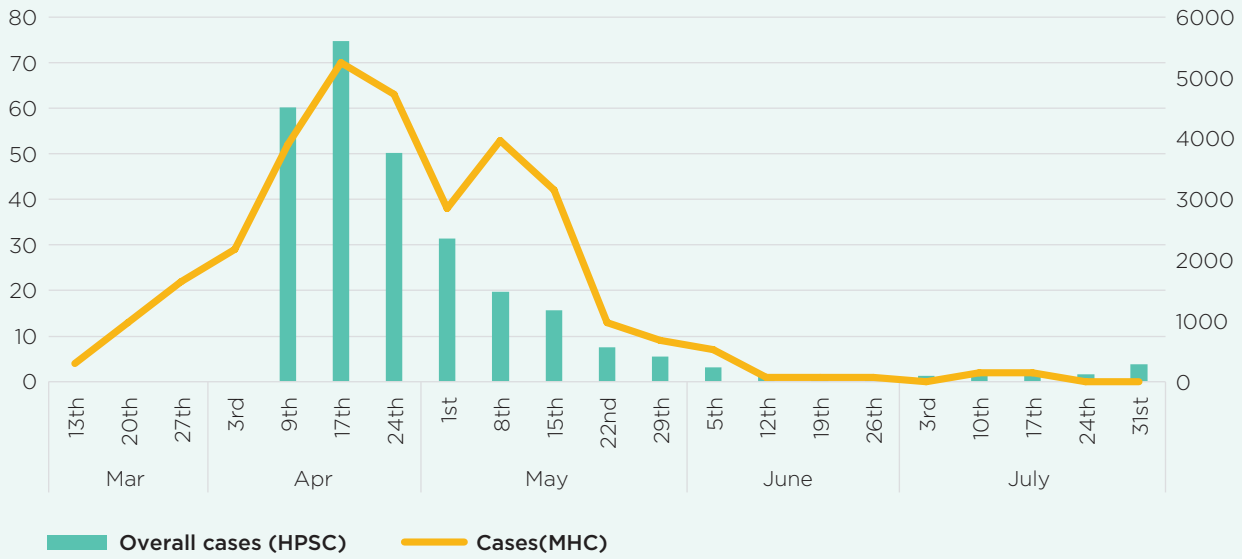
Resident impact

The detailed data provided by services allowed for more comprehensive analysis of the demographic characteristics of residents who acquired COVID-19 and their outcomes. The information provided to us from services regarding resident cases allowed us to consider age, gender and underlying conditions as factors when analysing outcomes and hospital transfers of residents.

No. of confirmed resident cases reported by approved centres	135
No. of confirmed resident cases reported by community residences	18

The graph below shows the number of confirmed COVID-19 cases mapped against age and gender. The demographic with the most cases was females between the ages of 81 and 90; this subgroup accounts for 16% (n=24) of all confirmed resident cases during the initial monitoring period. 52% (n=79) of cases were among male residents, 48% (n=74) were among female residents.

Figure 8: COVID-19 Cases by Age/Gender

Legend: Male — Female
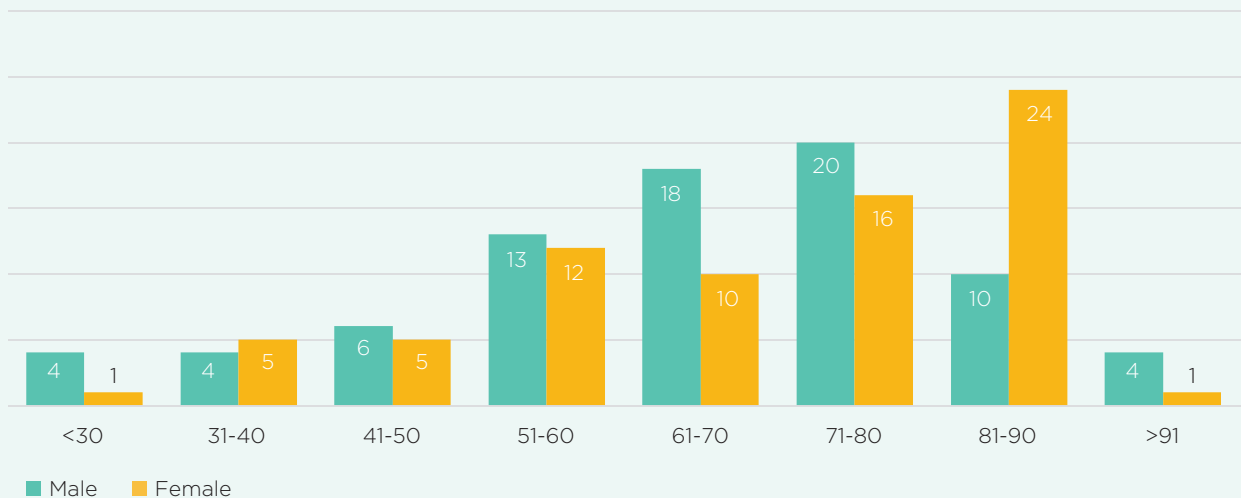
Services provided information in respect of the outcome in confirmed COVID-19 cases. This information is graphed below according to age group. 88% (n=134) of residents fully recovered from the virus, 10% (n=16) of residents died and the outcome is unknown in 2% (n=3) of cases.

Figure 9: Outcome by Age Group

	<30	31-40	41-50	51-60	61-70	71-80	81-90	>91
Death	0	0	0	0	2	6	7	1
Recovered	5	9	11	24	26	29	26	4
Unknown	0	0	0	1	1	0	1	0
Mortality rate	0%	0%	0%	0%	7%	17%	21%	20%
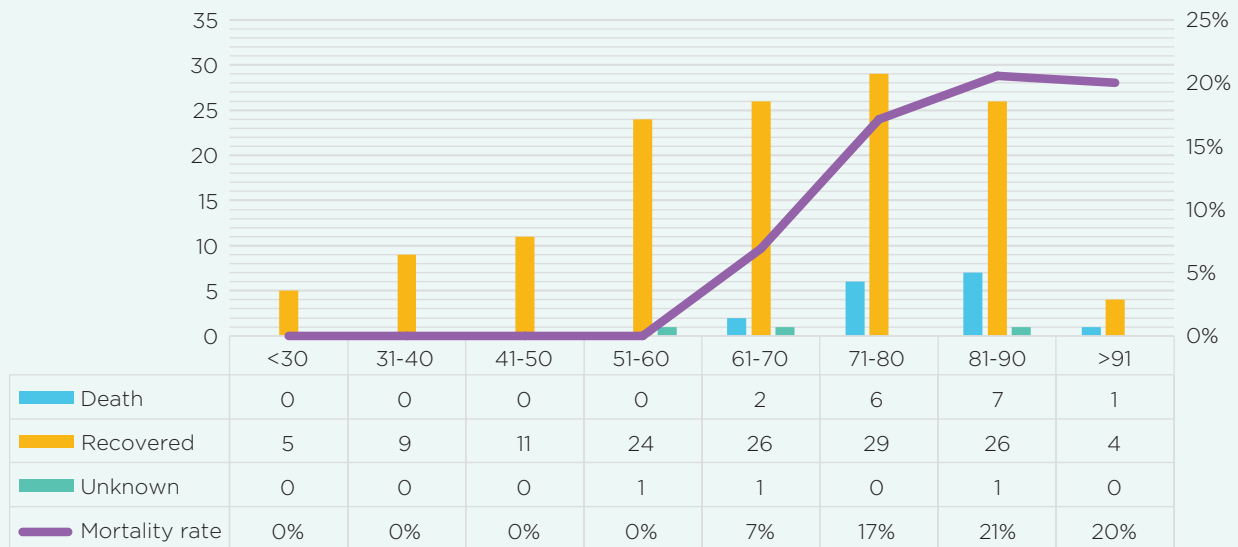
Services were asked to detail whether residents who acquired COVID-19 had any of the following underlying conditions: cardiovascular disease, chronic respiratory disease, cancer and diabetes. 69% (n=11) of those who died had one or more of the above underlying health conditions while 31% (n=5) did not.

45% (n=69) of the confirmed resident cases were transferred to hospital for treatment. Of these, 78% (n=54) were over the age of 70. Of those transferred to hospital, 23% (n=16) had underlying health conditions.

Staff impact

Services provided information in respect of the specific professions of the 269 individuals who acquired COVID-19. This detail is provided in the table below. Nursing staff account for nearly half of the cases at 55% (n=148). The lowest numbers of reported cases concerned centre-based pharmacists and teachers.

Table 1: Staffing Impacts by Profession

Profession	No. of staff	% of staff
Nursing	148	55%
Medical	35	13%
HCA	38	14%
Teacher	2	1%
Occupational Therapist	9	3.3%
Pharmacist	3	1%
Support Staff	22	8.2%
Administrative/Management staff	8	3%
Social Work	4	1.5%

The MHC also sought information in respect of the reason for staff and resident testing in mental health services. Responses are outlined in the chart below. The majority of tests were conducted after the individual became symptomatic.

Figure 10: Reasons for Testing for Staff and Residents
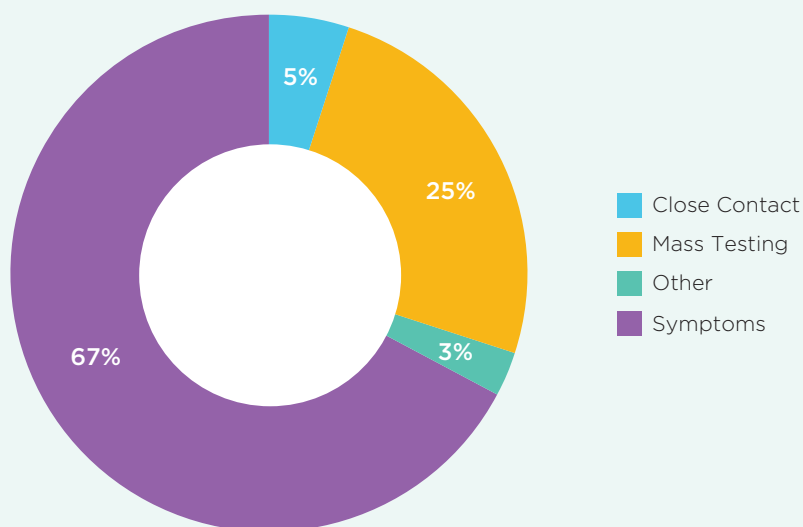
Geographic spread

The below table details the numbers of staff and resident cases per HSE Community Healthcare Organisation (CHO). CHOs covering Dublin and surrounding counties reported higher numbers of confirmed cases; this correlates with community incidence rates in these areas.

*Independent service providers are included in the below table. Combined, independent services reported a total of 173 confirmed cases of COVID-19 during the initial monitoring period. However, it should be noted that four of the 12 independent services monitored provide in excess of 100 beds and the group as a whole accounts for 720 beds. The number of cases reported must be viewed in that context.

Table 2: Reported Incidence by CHO

Area/Service	Geographical Area	No. Res cases	No. Staff Cases	Total Cases
CHO1	Cavan, Donegal, Leitrim, Monaghan, and Sligo	8	9	17
CHO2	Galway, Mayo, and Roscommon	3	14	17
CHO3	Clare, Limerick, and North Tipperary	9	5	14
CHO4	Cork and Kerry	4	7	11
CHO5	Carlow, Kilkenny, South Tipperary, Waterford, and Wexford	0	5	5
CHO6	Dun Laoghaire, Dublin South East and Wicklow	1	9	10
CHO7	Dublin South City, Dublin South West, Dublin West, Kildare, and West Wicklow	15	20	35
CHO8	Laois, Longford, Louth, Meath, Offaly, and Westmeath	25	18	43
CHO9	Dublin North City & County	11	44	55
IND*	IND (Independent service provider)	65	108	173
NFMHS	NFMHS (National Forensic Mental Health Service)	0	10	10
NIDS	NIDS (Nationally Intellectual Disability Service)	12	20	32

3.3 Updated risk framework analysis

Building on the risk assessment work undertaken in April and May 2020, in late 2020 the MHC developed an updated risk framework with additional questions pertaining to prevention and management plans, staffing and workforce arrangements, governance and resources. While all monitored services were issued the updated risk framework, only approved centres were required to complete and return same. 30 community residences also returned the information. The details of the update risk scores calculated are below.

Table 3: Updated Risk Scores

Average updated risk score for approved centres	93%
Average updated risk score for community residences	97%
Average combined risk score	94%

In addition to binary questions used to calculate the above risk score, a number of qualitative risk questions were posed and analysis relating to these is detailed below.

Contingency planning

Just as the risk assessment framework was updated to provide a clearer picture of the developing COVID-19 situation in Irish mental health services, many approved centres reported updating their contingency plans in line with changing national restrictions and in anticipation of a third wave. This constitutes evidence of responsive governance by these services.

Amongst the detail provided, many approved centres listed the formation of dedicated COVID-19 response teams which met several times a week to proactively manage the COVID-19 situation. By far the most common element of contingency plans was anticipating staffing issues. The majority of services described detailed staffing plans including:

- Well-established line management structures
- The implementation of resource levelling within and between units
- Overtime
- Redeployment of staff
- The use of agency staff
- Remote working plans

Capacity to isolate

Services were asked about their ability to provide isolation facilities in the context of a suspected or confirmed case of COVID-19. 42% of approved centres reported that they had the facilities to isolate all or the majority of residents. 49% of approved centres reported the ability to isolate some residents and noted that this was dependent upon factors such as:

- The ratio of confirmed cases to residents without the virus
- The ability of residents to comply with self-isolation instructions
- The number of single en-suite rooms and the capacity to cohort confirmed cases in multi-bedded rooms
- Recommendations by Public Health

Risk management measures

All services detailed extensive risk management measures and compliance with the HSE risk management policy. Detail of risk management measured included:

- Collaboration with Public Health IPC specialists.
- Staff undertaking IPC specialist training provided by HSE or third-level institutions.
- Creation of COVID-19 risk registers
- Reduction of shared bedrooms
- Testing upon admission
- Increased cleaning staff
- One-way systems in common areas
- Wall mounted wipes in common areas
- Use of temporary accommodation scheme through HSE HR
- Remote and staggered working facilitated for staff
- Temperature checks
- Hand hygiene workshops, donning/doffing PPE, IPC training, cough etiquette
- Barrier nursing systems

Staffing management

The majority of services noted a reliance on redeployment in the context of an outbreak and staffing pressures. Other management methods referenced include:

- Barrier nursing
- Overtime
- Change of shift patterns
- Cancellation of annual leave
- Additional cleaning staff
- Ensuring staff familiar with individual residents are present on each shift to ensure continuity of care and familiarity with the individual needs of each resident

Education & training

Answers provided in respect of education illustrate the breadth of training provided to staff. Topics covered include:

- Hand hygiene
- Donning/doffing PPE
- IPC training
- Blended learning (in person workshops and online tutorials/webinars)
- Circulation of updates to HPSC and HSE Guidance
- Staff upskilled to undertake COVID-19 swabbing and as peer flu vaccinators

3.4 Innovative practice findings

The innovative practices questionnaire was sent to the 183 services that were being monitored by the MHC at the time of dissemination (66 approved centres and 117 community residences). Overall, a total of 21 responses were received (approximately 11.5% of the total number of services). The MHC asked that any feedback provided be submitted on a voluntary basis, dependent on a service's capacity to engage with the survey in the context of increasing COVID-19 cases nationally.

The MHC welcomed detail of any innovative practices i.e. the introduction of any new or original practices which services believed improved their ability to manage COVID-19. The focus of the questionnaire was to identify best practices used (individually or in collaboration with other services) with the purpose of sharing these innovations among mental health services in order to aid disease regression, as well as enhancing conditions for both residents and staff within different aspects of a service.

Of the 21 responses received, 19 supplied written qualitative answers. 7 out of the 19 answers were identical in content as they related to CHO-wide practices. All the responses reported the introduction of innovative practices and developments in their services. Many of these were location and service specific.

The responses constitute self-reported evidence from services and have not been systematically verified by the MHC, although a number of the referenced practices were noted as part of ongoing monitoring and inspection processes.

Four areas of innovation that appeared to be the most common to all services are detailed below. Within these areas are specific innovative practices that work at a service- and CHO-wide level to improve service provision.

COVID-19 governance and management response

Several services described improved oversight and information gathering arrangements to support improved governance and management responses to the pandemic. Services reported the introduction of resident screening for COVID-19 on admission as well as regular staff testing. Services reported increased training for staff. One service reported engaging a trained nurse as an IPC Link Nurse to provide support and guidance to other staff members.

Services have established 'COVID Team Leads' responsible for the implementation of COVID-19 management and the resolution of any IPC issues that arose. Weekly COVID-19 management meetings were introduced, and frequent reviews of COVID-19 policies were undertaken.

Increased cleaning of wards and services was introduced to reduce the risk of virus transmission and health and safety assessments were undertaken on a more regular basis. Of the services who provided responses, a number increased the display of relevant HPSC, HSE and IPC guidance for both residents and staff.

Some services collaborated with others in their CHO to share information and knowledge throughout the pandemic. Services also worked together on joint COVID-19 projects, such as the 'CHO 1 Return to Work' protocol, which provided staff in CHO 1 with a step-by-step guide on returning to the workplace.

Resident wellbeing

Services reported implementation of several changes during COVID-19 to ensure resident wellbeing remained a priority.

Services reported the increased use of technology for residents, particularly in the area of communication technologies. While the MHC is aware of some instances in which residents did not have adequate access to such technologies, some services reported increased WiFi quality and the provision of smart phones or tablets for residents to enable them to have video interaction with family or advocacy support workers. Some services introduced SMS systems to text the families of residents in order to engage and update them on current circumstances such as visiting hours or outbreak status.

For entertainment purposes, additional televisions were provided and steaming services, such as Netflix and Spotify, were introduced. These services were found to be of particular benefit if the resident was confined to isolation due to COVID-19.

Activities for residents were also moved online and many services reported the ability to introduce new activities for residents as a result of this shift. For example, online courses were provided and virtual museum tours were attended. Religious services were also made available to residents on devices.

Information sharing

A number of services reported introducing COVID-19 newsletters or leaflets which were published on a weekly or monthly schedule. These were circulated to residents to keep them informed about pandemic developments and any changes being introduced in the service as a result of COVID-19.

One service implemented weekly meetings between staff and residents where the group could discuss any questions or concerns they had regarding COVID-19.

Advancements in service use of technology

A significant number of services reported advancements in their use of technology. Services reported moving the majority of work and meetings to online platforms, which in turn enabled the following:

- Easy access to information and resources, allowing for remote working through the application of Telehealth and Telehealth policies

- Online meetings, both internal and external

- Assessments or consultations with patients using services such as 'Attend, Anywhere'

- Rapid informing of staff of any COVID-19 updates to the services, e.g. an outbreak

- Access to online platforms to attend webinars or access to HSE-Land to educate staff members regarding COVID-19

- Online services being utilised to conduct individual and group therapy sessions

- Collation of information resources to a service website

Another innovative practice reported in the technology setting was the introduction of services providing "home based or virtual treatment programmes". These programmes have full MDT involvement and allow individuals who cannot or do not wish to attend a service during the pandemic to receive treatment for an acute general adult mental health issue without the risk of infection.

4. Recommendations

Collaboration

The MHC COVID-19 response was primarily concerned with identifying emerging risks in mental health services. A key component of this response was collaboration with the HSE and the Department of Health (DOH) in the interests of ensuring timely responses that would protect residents. Risks were escalated to the HSE and/or DOH as appropriate and largely concerned issues such as significant shortages of staff; an outbreak or cluster in a service; difficulty accessing testing or shortages of PPE. A tripartite governance forum between the MHC, HSE and DOH was also established to oversee this process. As a result of this collaboration there were improved arrangements in place to support services and protect residents in residential mental health services.

Services demonstrated responsive governance arrangements, resilience, and flexibility during the pandemic. This is evident in the risk responses and innovative practices information provided to the MHC and from weekly monitoring communications and ongoing engagement with services over the past year. Services engaged readily with the monitoring processes and many provided updates and assurance reports in excess of those requested by the MHC. It was also noted that the staff in services who engaged with the MHC COVID-19 team demonstrated a high degree of knowledge and awareness of IPC guidance.

The HSE Mental Health Division must also be commended for their timely action in respect of risks identified by the MHC, as well as the work they undertook internally to ensure services had the resources required to mitigate risk in the first instance. CHO COVID-19 response teams provided support to Public Health outbreak teams who in turn supported mental health services reporting multiple cases.

Regular communications and defined weekly reporting promoted collaboration and transparency regarding the identified concerns which were escalated by MHC. The HSE were highly responsive to escalated concerns; issues relating to services accessing PPE and delays in testing were responded to immediately and were either resolved or information was provided.

Recommendation: The collaboration, reporting and escalation protocols which have been implemented by the MHC should be retained in order to provide assurance to all stakeholders involved in risk responding and to ensure that relevant risks to residents are mitigated in a timely manner.

Recommendation: At service level, staff training in emerging IPC best practice should continue to be prioritised as essential to preventing and managing future outbreaks.

Risk mitigation

Assurances provided by services to the MHC demonstrate that, in general, key risks were considered and steps were taken to mitigate same. Services were able to provide detail about risk mitigation measures and there was considerable consistency across services and CHOs.

The average risk score calculated in April 2020 was 80%, with an updated average of 85%. The score calculated in early 2021 was 94%. While the latter cannot be compared directly to the earlier scores as the same framework was not used, the current score indicates that services, on the whole, continue to report high levels of risk awareness and mitigation.

In our first COVID-19 paper, the MHC noted service confusion in respect of which HPSC-issued public health guidance they should be following. At the beginning of the monitoring period, all mental health services were advised to follow the various long-term residential care facilities guidance published by the HPSC. However, difficulties were noted in the application of this guidance to acute settings. In June 2020, a specific section on acute mental health facilities was added to the HPSC 'Acute Hospital Infection Prevention and Control Precautions' guidance document[8].

While this provided clarity, some services reported difficulty determining which guidance to follow given a mixed care setting. In December 2020, the HSE Mental Health Operations team notified the MHC that an audit had been undertaken to categorise facilities into acute hospital settings or long-term residential care settings. The MHC welcomed this exercise and the clarity provided and noted that as part of the updated risk framework assessment, 97% of services were able to state which guidance they were following and all respondents reported having arrangements in place to ensure that the relevant HPSC guidance was being implemented.

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8   HSE & HPSC, Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting, Version 1.2, June 2020

> **Recommendation:** National guidance, developed in response to emerging risks, should be proofed at the outset to ensure its relevance to all mental health service types and to ensure parity between mental health and physical health services. Clarity must be readily available to services in respect of which guidance they should follow, particularly when multiple guidance documents are available.

Disease progression

Residential mental health services experienced disease progression that was largely in line with community incidence of COVID-19. Reported confirmed cases of the disease in mental health services were highest in January and February 2021, corresponding to a considerable national surge.

During the three most noticeable waves of disease progression, staff cases were higher than resident cases. A slight lag was noticed between national trends and rates in mental health settings. Considerably more suspected cases were notified to the MHC in the earlier stages of the pandemic; this is likely a reflection of increased knowledge in respect of virus symptoms and improved access to testing as time progressed. It should be noted that even with demonstrable risk management systems in place, mental health services reported a significant increase in cases in early 2021. Further, more detailed analysis of this time period would be required to identify any additional learnings.

The detailed data provided by mental health services in respect of the initial monitoring period, provides an insight into the impact of COVID-19 on staff and residents in residential mental health settings. The demographic with the most cases was females between the ages of 81 and 90; this subgroup accounted for 16% (n=24) of all confirmed resident cases during the initial monitoring period. Nursing staff accounted for over half of the staff cases at 55% (n=148). Further research is required to determine whether similar impacts were experienced in the third wave of disease progression (January 2021).

It is difficult to assess whether the incidence of COVID-19 in mental health settings has to date been comparable with trends in other jurisdictions or in other care settings. This is because we do not have cumulative data on demographics and outcomes for the entirety of the pandemic. It would be useful to have access to aggregate public health data in respect of confirmed cases, outbreaks, and clusters in both acute and LTRC mental health settings. This would enable a more holistic assessment of disease progression and would allow for comparisons to be drawn.

> **Recommendation:** Further detailed analysis is needed in respect of latter COVID-19 waves in mental health services. Such research should utilise aggregate public health data in respect of outbreaks and clusters in order to better understand the impact of this disease in mental health services.

Vaccination

In early January 2021, the MHC added an additional question to our weekly monitoring calls in respect of vaccination roll-out. We subsequently raised concerns about the lack of a vaccination schedule for mental health services, particularly in respect of residents over 65 years of age in long-stay accommodation.

In late January, the MHC met with the HSE Mental Health team and received an update on the planned roll-out of vaccinations. On 28 January 2021, the MHC contacted a sample of services to assess progress against the stated schedule. The evidence obtained demonstrated that the HSE was adhering to the planned roll-out policy and the MHC was satisfied as to progress being made.

The MHC have continued to monitor vaccination rollout and the broadening of eligibility in line with the Government's prioritisation plan. Considerable progress has been made in the vaccination of residents and staff. The MHC acknowledges the responsiveness of the HSE to concerns raised and commends the roll-out of vaccinations to vulnerable individuals and staff in congregated care settings.

> **Recommendation:** Contingency vaccination plans should be developed in anticipation of the need for future programmes to account for emerging variants. Mental Health Services should be considered in parallel to physical health services in relation to all future vaccination plans.

Premises

As noted in the first COVID-19 paper, an early risk was identified in relation to mental health facilities with shared bedrooms and limited ability to isolate residents. Rapid service reconfiguration was undertaken in many areas, including temporary closures and the use of alternative facilities. Other services decreased their bed occupancy in order to provide for single-room accommodation.

Since the outset of the pandemic, the MHC has expedited the registration of four modern IPC compliant facilities with single rooms. The purpose of these expedited registrations was to move residents out of inappropriate and outdated accommodation and to support the HSE in their COVID-19 contingency plans.

However, considerable concerns remain in respect of the accommodation in some units. In the most recent risk framework responses, only 42% of respondents reported that they had the ability to isolate all or the majority of residents. A recent report by the Inspector of Mental Health Services, Dr Susan Finnerty, provides an overview of concerns in respect of the physical environments in some mental health units[9].

The report states: *'The COVID-19 pandemic has demonstrated that, in Ireland, some mental health buildings are not fit for purpose, both across the community and in-patient estate. Many buildings have been designed to address safety concerns, such as fire, self-harm, and violence, but not infection prevention and control. It is paramount that mental health services prevent transmission of the virus in in-patient settings, as well as preventing the spread in the community.'*

The MHC has sought more robust regulations on premises in order to ensure that all residential and in-patient mental health services are in modern, fit-for-purpose buildings, which comply with IPC standards. A more robust regulatory framework will help to ensure that residents are not only provided with the surroundings and premises that have been proven to be best suited to their mental health care provision, but also to help protect against the risk of future infection of COVID-19, and in the case of other, future pandemics.

Recommendation: Investment is required as a priority to ensure that mental health buildings are fit for purpose. More robust legislation should be developed to ensure that all residential mental health settings meet best practice in terms of IPC standards.

Learning and implications for wider service delivery

Mental health services demonstrated a strong capacity to respond to the grave and immediate challenges presented by COVID-19. Across all levels of management and staffing it was evident that there was a cohesive and targeted response in the interests of protecting residents and patients who were very vulnerable to this disease.

Services demonstrated a number of characteristics and notably a capacity for change which enabled them to reorganise and reposition services in the rapidly evolving risk environment. It was also evident that services had exceptionally strong support from their staff throughout this process. There is an opportunity for mental health services to take the learning from operating during a pandemic and apply this learning with the aim of generating wider service transformation in the context of national mental health policy objectives.

Recommendation: Mental health services should closely review their responses to COVID-19 to gain learning which can be applied to other challenges facing the sector. In particular, services should apply this learning in the context of implementing the transformational objectives contained in *"Sharing the Vision: A Mental Health Policy for Everyone"*[10].

Further research recommendations

In addition to research recommendations above, the MHC recommends that the Department of Health considers commissioning the following research projects:

1. Research into the experience of residents, patients and service-users of mental health services during COVID-19. Such research should centre the voice of such individuals and should include an examination of the impact of restrictions of wellbeing.

2. A case-study examination of the experience of different services and service types in respect of COVID-19 outbreaks. In particular, such research should seek to identify learning in respect of causal and mitigating factors.

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9   Dr Susan Finnerty, A Report on Physical Environments in Mental Health Inpatient Units, Mental Health Commission, 2021
10   Government of Ireland, "Sharing the Vision: A Mental Health Policy for Everyone" 2020

Appendix 1

	Updated COVID-19 Risk Framework
1	Are there arrangements in place to ensure that the relevant HPSC guidance on IPC for your service is being implemented?
2	Are contingency plans in place to manage a COVID-19 outbreak?
3	Have these plans been communicated to all relevant staff, and do they understand them?
4	Are the contingency plans kept under regular review?
5	Have they been validated to ensure that they will work in the event of an outbreak?
6	Are plans concerning the allocation of resources during an outbreak in place?
7	Are deputising arrangements in place to ensure the ongoing effective management of the service in the event of sudden staff shortages?
8	Are isolation facilities available in the service?
9	Are risk management arrangements in place to identify, manage, review, and address and learn from infection prevention and control (IPC) risks and outbreaks in the service?
10	Is there an expert in IPC available to the service?
11	Does the service have contact details for their local department of public health?
12	Where you have identified deficiencies in any of the above, do you have an improvement plan in place to address them?
13	Are staff being provided with education and training in IPC and in relation to the relevant HPSC and HSE COVID-19 guidance?
14	Are processes in place to oversee and check that the HPSC guidance is being followed?
15	Is there a person with overall responsibility for the management of IPC?
16	Are roles and responsibilities of staff clearly defined? Do staff understand their responsibilities?
17	Do staff know how to escalate IPC related risks?
18	Are arrangements and reviews in place to ensure that sufficient levels of IPC equipment are available in the service at all times?

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More information

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