Mental Health Services
Covid-19 – Response to Outbreak Control

Paper presented to NPHET 17 June 2020

Covid-19 Data

- The number of confirmed and suspected Covid-19 cases in residential mental health facilities has decreased significantly, from 354 on 9 April to 21 on12 June.
- The number of reported deaths in mental health facilities is 17. No deaths have been reported since week ending 15 May.

Introduction

There are 65 approved centres (57 are HSE facilities, the remaining eight are independent providers) and 116 24-hour staffed community residences providing residential mental health services.

An approved centre is a hospital or other inpatient facility for the care and treatment of people with mental illness or disorders. 24-hour community residences provide residential care for individuals with a mental illness, particularly long-term. Some residential units serve as respite facilities for individuals who require support at different times.

The HSE manages and funds the majority of approved centres and all 24-hour residences. Three approved centres are operated by independent section 39 organisations and are part-funded by the HSE. The HSE also buys placements from eight other independent centres. The Mental Health Commission inspects all approved centres under the 2001 Mental Health Act. The Commission also inspects the 24-hour community residences, although these are not regulated under the Act.

Residential Mental Health Facilities	
Mental Health Approved Centres	**Mental Health 24-hour Residences**
2,673 total beds in 65 approved centres	1,252 total beds in 116 centres
40 average beds per approved centre	11 average beds per centre
32 median beds per approved centre	10 median beds per centre

Covid-19 Preparedness

The Department of Health has:

- introduced emergency legislation which enables the Mental Health Commission to conduct mental health tribunals with limited personal interaction.
- introduced secondary legislation to allow the transfer of nine patients from the Central Mental Hospital Dundrum (CMH) to new facilities in Portrane, so that other at-risk patients can be appropriately treated at the CMH.
- announced funding of €1.1 million to increase online mental health supports, to address potential demand from the public, frontline health professionals and people with new or existing complex mental health needs. A further €1.1 million is anticipated from *Sláintecare* to continue these supports for the rest of the year.

- received Government approval for the refreshed mental health policy, *Sharing the Vision* and was launched by Ministers Harris and Daly on 17th June.
- approved the release of €0.485 million new development funding for a mental health hub at the reconfigured Rosalie site in Roscommon, including two day hospitals and a telepsychiatry project - CAMHS Connect.

Since 7 April, the Mental Health Commission has been conducting risk assessment of all residential mental health facilities, through a Covid-19 Risk Framework. It has undertaken a survey with all facilities to assess their disease progression, environment and staffing, among other risk factors.

HSE Mental Health Operations has a comprehensive, cross-sectoral service response, within the HSE, to address infection risk in mental health settings and manage cases arising in individual approved centres and community residences.

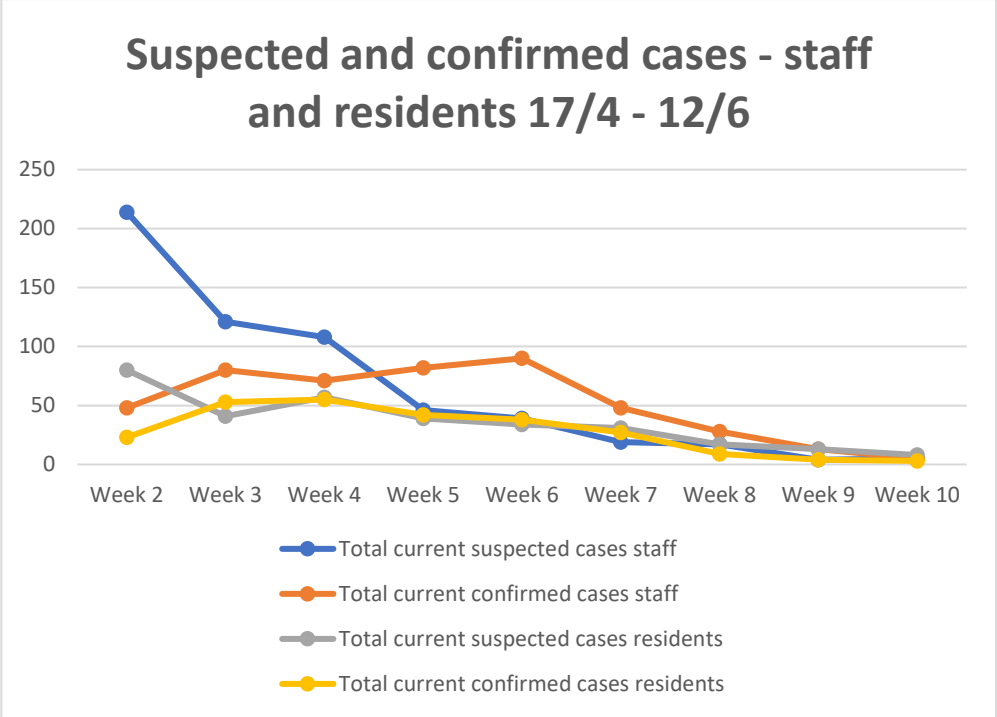
The HSE Mental Health response is guided by NPHET public health advice. It involves continuous engagement with HSE public health officials, Section 39 organisations, community mental health teams, community residential units, approved centres including acute units, emergency departments, specialised rehabilitation units and forensic mental health services and the national forensic hospital on mental health service requirements for Covid-19. The HSE is also progressing a psychosocial response to Covid-19.

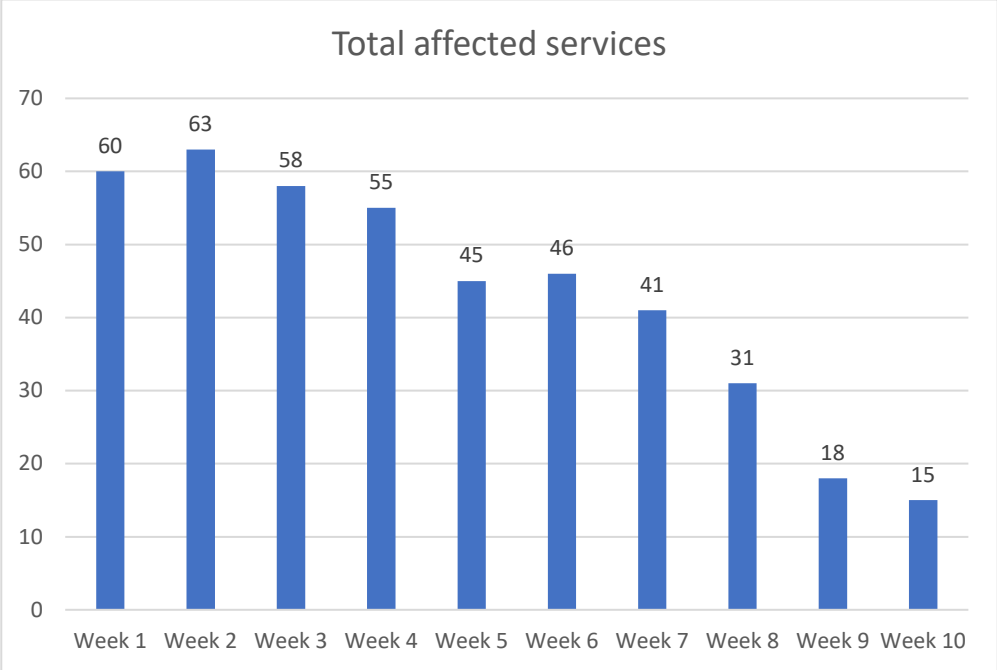
Mental Health Commission (MHC) Risk Assessment

MHC Approach

The MHC uses a strong pro-active risk assessment process, examining preparedness, environment and disease progression among residents and staff in all operating approved centres and 24-hour residences, and it notifies the HSE of space, systems and staff issues that need to be addressed (see Appendix 1). Data on each centre is analysed and a risk score allocated, with a weekly report provided to the HSE and Department. Daily calls take place with the HSE to escalate issues occurring between reports.

This approach has been very successful. There has been a significant decrease in confirmed and suspected cases, in staff and residents, over the ten weeks from 9 April to 12 June. In the last week, the number of cases decreased from 34 to 21 (see chart below). The MHC methodology and risk rating has supported HSE Mental Health Services in Covid preparedness, by identifying high risk areas and enabling it to focus resources on facilities with a high percentage of at-risk patients. There has been a continual reduction in cases since week two at 15 April, when 63 facilities had confirmed, or suspected cases, compared to 15 facilities at 12 June.





There has been rapid service reconfiguration in many CHO areas and the HSE has undertaken to inform the MHC of changes to facilities and the transfer of residents into appropriate accommodation under Covid-19 contingency plans, while the MHC has expedited registering of new facilities. Three new approved centres have been registered since the pandemic began, including Portrane (see above).

<u>High-Risk Facilities</u>

The MHC has risk-rated facilities, including structural risk from the layout of premises. To reduce risk, the HSE has, through contingency plans, restructured high-risk facilities to

reduce patient numbers in risk situations, including shared accommodation. Subsequent risk reassessment showed a significant decrease in risk following these changes.

Public Health Advice and Admissions

The MHC has reported that facilities are responsive and engaged and awareness and adherence to public health advice has increased significantly. However, there continues to be confusion, particularly in approved centres in acute hospitals, on use of the *Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Unit* for admissions. The HSE advises that a guide is being developed with the HPSC to address issues.

There remains a lack of clarity for services, particularly with recent changes in requirements for admissions of new residents.

Services following the guidance for residential care facilities must test every new admission and isolate them for 14 days. In the case of an outbreak, the facility will be closed to new admissions. Residential care facilities without current cases were able to commence visiting processes from Monday 15 June.

Services following the guidance for acute hospitals are not required to test and isolate every new resident. They do not have to close to new admissions in the case of an outbreak. New guidance for visits does not apply to these facilities.

Testing

Testing was a major concern for the MHC, with delays contributing to staff difficulties. The MHC has observed a major mobilisation in staff testing across mental health services, but while testing has been completed it remains a concern.

Placements

The MHC previously highlighted its concern about the longer-term appropriateness of placements. Several resident transfers have taken place to reduce risk from shared or dormitory style accommodation. While such transfers may be appropriate in the short term, over the medium and long term they must be reviewed to ensure all residents are in appropriate care facilities in line with their assessed needs.

Community Mental Health Services

Facilities previously reported concerns to the MHC that ongoing limitation of community mental health services would increase inpatient admissions, and this may have flow-on effects for the risks highlighted. However, now that community services are recommencing, challenges identified include social distancing, space required for respite care, the 14-day isolation policy for new admissions and the risk of overcapacity.

The MHC has previously noted the need for careful consideration of facilities with temporary or ad hoc arrangements for resident accommodation, in particular risks to residents if they are moved back into shared accommodation. The MHC recognises that lifting restrictions will be subject to public health advice, but clear guidance must be provided to services.

HSE Mental Health Operations Response to Covid-19

In response to the MHC weekly risk assessment, the HSE completes a high-level risk review and reports on controls and protocols in place to address all issues, particularly identified high-risk facilities.

High Risk Facilities

The HSE has confirmed that all CHOs have reconfigured high risk facilities to eliminate multi-occupancy bedrooms, reducing the risk of cross-infection. The Outbreak Control Framework (see Appendix 2), with planned actions, was agreed between the Department and the HSE as a basis for reporting, with a focus on high-risk settings and subject to amendment as agreed with MHC and the Department.

Public Health Advice

Mental health services are provided in community facilities and acute units in acute hospitals. Community facilities follow the *Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units.* However, acute hospitals follow the *Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting* guidelines.

To ensure all mental health facilities follow the same protocols and guidelines, National Mental Health Services and the HPSC are developing guidance specific to acute inpatient units. At present, for a conflict in an acute inpatient unit over which guidance to follow, particularly for long term care residents, clinical judgement may be necessary to ensure the best decisions and needs of the patient are addressed at a particular time.

Admissions

National Mental Health Services are working with HPSC to provide further clarity for acute inpatient units. This will include admissions. Currently all new admissions are isolated in single rooms.

Testing

National Mental Health Operations advised that it is in regular communication with the senior project specialist responsible for testing, to ensure that all mental health facilities where outbreaks have occurred have been tested. It has confirmed to the Department that all staff in residential mental health facilities have been tested.

Testing in facilities is guided by the HPSC. Baseline testing has been completed in all mental health facilities in all nine CHOs. Currently, there is no guidance on repeat testing. Services have active monitoring in place, which includes monitoring residents for symptoms of respiratory illness or changes in their baseline condition and symptomatic residents are tested. Staff are monitored daily. Control measures are implemented if there is any suspected case in a facility and outbreak control teams are in place as required.

Placements

Resident placements and transfers during Covid-19 will be reviewed as part of HSE Mental Health Services business continuity planning.

National Mental Health Operations

National Mental Health Operations currently has visibility of preparedness plans in all nine CHOs. Information received from MHC is integrated with weekly information received from Directors of Nursing, Executive Clinical Directors and Heads of Mental Health Services.

HSE Mental Health Operations has contacted all CHOs to discuss centres of concern highlighted by MHC. The HSE has assured the Department that plans are in place to address identified risks and that all facilities contacted have preparedness plans.
Visiting protocols will continue as per HPSC guidance as restrictions are reduced. This will be continually reviewed and risk assessed whenever further guidance provided. Visiting restrictions have been addressed through access to telecoms, including mobile phones and video calls. In CAMHS inpatient approved centres, every effort is made to maintain contact between the young people concerned and their families.

Resumption of Normal Mental Health Services

Inpatient and community residential facilities have stayed open through the pandemic and patients have continued to receive services, albeit at reduced numbers in some settings to ensure patient and staff safety. Public health advice continues to guide this situation as services return to a more comprehensive provision. In community settings, essential services continue on a face-to-face appointment system as required, with further services delivered remotely through telecoms. However, mental health service improvement activity has been reduced or paused in some circumstances during Covid-19.

As services are reintroduced, enhancement of community services to deliver mental health care is key to delivering the right care in the right place at the right time. The response to the Covid-19 pandemic has accelerated Sláintecare's goals and the launch of the refreshed mental health policy, *Sharing the Vision,* ensuring a basis for services to continue to adapt and re-design patient pathways to support this model of care.

Dr Colm Henry (CCO) and Dean Sullivan (DDG) are overseeing the development of a business continuity plan by Community Operations for a phased approach to returning to full service. Each CHO is outlining services still operating and services that have been stepped down, as well where staff have been reassigned to support Covid-19 work. Additionally, each Head of Operations is determining actions under each service for a phased approach to normal service resumption.

HSE Mental Health is also considering ways to improve services in acute units, community residential settings and community teams in a safe way. Telehealth technologies will be enhanced and expanded with the reintroduction of a more comprehensive service. Further engagement with NGO partners will take place to maximise delivery through SLAs. The HSE will continue to support this work and to integrate it into its service provision.

HSE Mental Health Services have been providing online services for over two years. It is noted that online health interventions have been particularly suited to remote access to supports during the Covid-19 outbreak. Adoption of technology has formed part of the psychosocial response to the pandemic and will aid the reopening of mental health services by allowing the HSE to manage patients safely, effectively, and in a timely manner. Online

interventions will augment existing services, providing a wider reach, and changing how people with mild to moderate mental health needs will be treated in the future.

The HSE National Office for Suicide Prevention is similarly working with partners to address suicide prevention during and after Covid-19. NOSP and the National Suicide Research Foundation have been working with colleagues in Scotland undertaking a literature review on public health emergencies and suicidal behaviour. It is hoped to provide the HSE with some research-based intelligence about the likely impact of the current Covid-19 pandemic on suicidal behaviour.

Mental Health Unit

Department of Health

June 2020

Mental Health Commission

1. COVID-19 risk assessment framework

The Department of Health has requested that the Mental Health Commission undertake a risk rating exercise as part of enhanced public health measures for COVID-19 disease management for the purposes of liaising with national and regional governance structures to support services.

The Commission has developed a risk framework to contact and assess services in terms of their preparedness, environment and disease progression. This is not an inspection, compliance or enforcement process. The Commission is committed to working with and supporting services as part of this risk assessment process.

PLEASE NOTE: The Commission will be contacting services (by phone in the first instance) to complete this framework. Services are not being requested to complete and submit the template. Any questions in relation to this framework should be sent to Compliance@mhcirl.ie

EDIT 14 April 2020: An appendix of focused follow-up questions to allow for the ongoing monitoring of services was added on 14 April 2020.

Risk statements

*Risk will be assessed against the following **risk statements**, each of which includes a number of criteria and corresponding lines of enquiry. These risk statements relate to the resident cohort and the four pillars of 'SPACE', 'SYSTEMS', 'STAFF' and 'STUFF' (Crisis Standards of Care (IOM)).*

1. The resident cohort does not include at-risk populations
2. Residents are not accommodated in shared accommodation
3. The physical environment is able to facilitate separation and cohorting of residents
4. The service maintains a schedule of cleaning
5. There are clear protocols for communications relating to Covid-19
6. Protocols have been established for visitors
7. The service is able to provide general health, emergency and palliative care services
8. Protocols have been established for the admission and transfer of residents
9. The service has access to staff with appropriate expertise
10. Staff have access to relevant training
11. Staff are not working across services
12. There is a plan for staffing contingencies
13. The service has a baseline stock of PPE
14. The service has contingency plans with suppliers

Risk criteria

The service will be asked a number of questions in order to determine whether or not the risk statement is relevant and applicable. While these questions are structured for yes/no answers, it is likely that many services will be somewhere in the middle. Where this is the case, additionally commentary and specific examples will be sought.

DISEASE PROGRESSION

We are currently aware of <<number>> of suspected or confirmed cases of COVID-19 in the service. Could you please confirm whether that is correct or has changed?

Current suspected or confirmed cases – residents *Including residents transferred to or from service*
Current suspect or confirmed cases – staff *Numbers of staff self-isolating*
Current number of tests or results awaited *Timeframes for testing or results*

Are you the nominated COVID-19 lead for the service? *If not, please provide below:*	Yes ☐	No ☐
COVID-19 lead name		
COVID-19 lead role		
COVID-19 lead contact details		

RESIDENT PROFILE

1. The resident cohort does not include at-risk populations					
1.1	There are no residents over 60 years of age? *If there are, how many?*	Yes	☐	No	☐
Comments:					
1.2	There are no residents with underlying medical conditions? *Cardiovascular disease, Chronic respiratory disease, Diabetes, Cancer*	Yes	☐	No	☐
Comments:					

SPACE

2. Residents are not accommodated in shared accommodation					
2.1	Do all residents have a single room with ensuite?	Yes	☐	No	☐

Comments:

3. The physical environment is able to facilitate separation and cohorting of residents					
Currently, how many separate wards/units in the service?					
Comments:					
3.1	Are residents able to practice social distancing?	Yes	☐	No	☐
Comments:					
3.2	Can the service be reconfigured to isolate 1x resident?	Yes	☐	No	☐
Comments:					
3.3	Can the service be reconfigured to isolate 2x or more residents? *Can a ward/section of a ward be separated?*	Yes	☐	No	☐
Comments:					
3.4	Would the isolated resident(s) have access to separate living and dining spaces and bathroom facilities?	Yes	☐	No	☐
Comments:					

4. The service maintains a schedule of cleaning					
4.1	Is a regular schedule of cleaning maintained?	Yes	☐	No	☐
Comments:					
4.2	Is the frequency of cleaning increased for a suspected or confirmed case of Covid-19?	Yes	☐	No	☐
Comments:					

SYSTEMS

5. There are clear protocols for communications relating to Covid-19					
5.1	Is there a person in the service responsible for collecting and disseminating information and updates in relation to Covid-19 to staff and residents?	Yes	☐	No	☐
Comments:					
5.2	Are there regular communications to staff about Covid-19?	Yes	☐	No	☐
Comments:					
5.3	Are there regular communications to residents about Covid-19? *Including information on preventative measures*	Yes	☐	No	☐
Comments:					
5.4	Are there regular communications to families about Covid-19? *Including information on preventative measures*	Yes	☐	No	☐
Comments:					
5.5	Is there a protocol for notifying suspected/confirmed cases of Covid-19? *Are staff aware of their public health contact?*	Yes	☐	No	☐
Comments:					

6. Protocols have been established for visitors					
6.1	Are there restrictions on visitors? *Protocols have been updated*	Yes	☐	No	☐

Comments:					
6.2	Are there clear exceptions for residents receiving end of life care? *Protocols have been updated*	Yes	☐	No	☐
Comments:					
6.3	Have new visiting procedures been communicated to residents and their families?	Yes	☐	No	☐
Comments:					
6.4	Are communications facilitated through other means, i.e. phone, Facetime etc.	Yes	☐	No	☐
Comments:					

7. The service is able to provide general health, emergency and palliative care services					
7.1	In normal operating conditions would the service provide medical treatment within the service? (i.e. would not transfer the resident) For comments: Has this changed / have any issues arisen?	Yes	☐	No	☐
Comments:					
7.2	In normal operating conditions would the service provide end of life care within the service? (i.e. would not transfer the resident) *For comments: Has this changed / have any issues arisen?*	Yes	☐	No	☐
Comments:					

7.3	In normal operating conditions would the service manage a medical emergency within the service? (i.e. would not transfer the resident) For comments: Has this changed / have any issues arisen?	Yes	☐	No	☐
Comments:					
7.4	Residents deemed as a 'close contact' are checked 4x per day for Covid-19 as per public health guidance? See 5.2 HSE Guidance	Yes	☐	No	☐
Comments:					
7.5	All residents are regularly monitored for symptoms of Covid-19?	Yes	☐	No	☐
Comments:					

8. Protocols are established for the admission and transfer of residents					
8.1	Does the service have a protocol for checking and recording symptoms prior to an admission or transfer?	Yes	☐	No	☐
Comments:					
8.2	Does the service have a protocol for admitting or transferring a resident with Covid-19 symptoms?	Yes	☐	No	☐
Comments:					

STAFF

9. The service has access to staff with appropriate expertise					
9.1	Does the service have access to Infection Prevention Control (IPC) expertise?	Yes	☐	No	☐
Comments:					

9.2	Does the service have access to palliative care expertise?	Yes	☐	No	☐
Comments:					
9.3	Is one member of staff or more trained to collect a sample for testing for Covid-19? *Does the service have access to testing for Covid-19*	Yes	☐	No	☐
Comments:					

10. Staff have access to relevant training					
10.1	Do staff have access to IPC information and training?	Yes	☐	No	☐
Comments:					
10.2	Are all staff are trained in all aspects of IPC practice relevant to their role? *Do they know signs and symptoms of Covid-19*	Yes	☐	No	☐
Comments:					
10.3	Are staff trained in the proper use of PPE?	Yes	☐	No	☐
Comments:					
10.4	Are cleaning staff are trained in additional cleaning and disinfecting requirements?	Yes	☐	No	☐
Comments:					
10.5	Do staff have access to palliative care information?	Yes	☐	No	☐
Comments:					
10.6	Do staff have access to palliative care training?				

Comments:					
10.7	Is there a person with responsibility for identifying training needs and accessing appropriate training?	Yes	☐	No	☐
Comments:					

11. Staff are not working across services					
11.1	Does the service have dedicated nursing staff that are not working across services?	Yes	☐	No	☐
Comments:					
11.2	Does the service have dedicated medical staff that are not working across services?	Yes	☐	No	☐
Comments:					
11.3	Does the service have dedicated healthcare assistants (HCAs)/ multi-task attendants (MTAs) that are not working across services?	Yes	☐	No	☐
Comments:					
11.4	Does the service have dedicated health and social care professionals (HSCPs) that are not working across services?	Yes	☐	No	☐
Comments:					

12. There is a plan for staffing contingencies					
12.1	Is there a person responsible for reviewing staffing levels and needs daily?	Yes	☐	No	☐
Comments:					

12.2	Is there a register maintained of staff caring for residents with Covid-19?	Yes	☐	No	☐
Comments:					
12.3	Are staff temperatures checked twice daily?	Yes	☐	No	☐
Comments:					
12.4	Is there an escalation protocol for staffing shortages?	Yes	☐	No	☐
Comments:					
12.5	Is there a plan for staff cohorting? *Care for a resident who has tested positive is delivered by a single nominated person on each shift to the greatest extent possible*	Yes	☐	No	☐
Comments:					

SUPPLIES

13. The service has a baseline stock of PPE					
13.1	*(Where there are **no** current cases)* Do you have enough PPE for 1x positive (suspected or confirmed) Covid-19 patient for 3 days?	Yes	☐	No	☐
Comments:					
13.2	*(Where there are current cases)* Do you have enough PPE per positive (suspected or confirmed) Covid-19 patient for 3 days?	Yes	☐	No	☐
Comments:					

14. The service has contingency plans with usual suppliers					
14.1	Do you have access to palliative care medications?	Yes	☐	No	☐
Comments:					
14.2	Do you maintain access to a pharmacy as per normal operating conditions?	Yes	☐	No	☐
Comments:					
14.3	Do you have access to oxygen?	Yes	☐	No	☐
Comments:					
14.4	Do you have access to the usual supplies of food and catering equipment? *Any issues arisen*	Yes	☐	No	☐
Comments:					
14.5	Do you have access to usual supplies and cleaning services for linen? *Any issues arisen*	Yes	☐	No	☐
Comments:					

Additional comments:

2. Appendix 1: Follow-up monitoring questions for MHC COVID-19 Risk Framework

1.	**RESIDENT cases**
1(a)	Current number **confirmed** cases RESIDENTS? *This includes residents subsequently transferred*
1(b)	Current number **suspected** cases RESIDENTS? *This includes residents subsequently transferred*

1(c)	Recovered RESIDENTS?
1(d)	Location of RESIDENTS? *Are they in the facility? Where in the facility?*
2.	**STAFF cases**
2(a)	Current number **confirmed** cases STAFF?
2(b)	Current number **suspected** cases STAFF? *This is suspected based on symptoms (i.e. not based on close contact)*
2(c)	Recovered STAFF?
2(d)	Number of staff currently self-isolating?
5.	**Current access to PPE?** *Do they have current stock? Do they have defined access?*
6.	**Any delays in testing?** *How long are they waiting on average for tests?*
7.	**Additional information to provide from original survey?**
8.	**Any other concerns or issues?**

Appendix 2

HSE Risk Report – reporting template on outbreak control

	HSE Comments/Updates	HSE Actions
Establish/update guidance and assure actions in the context of disease management		
Centres to provide data, on a weekly basis, on rate of infection amongst staff and among residents who acquired COVID-19 following admission	All new outbreaks, suspected or confirmed cases are notified to MHC. Data entered onto NIMS.	Ongoing assessment of weekly data provided to inform mitigating measures. Data is provided to national testing to ensure all testing has taken place where required. Concerns are raised with the HSE by MHC if they arise between reports.
Risk rate all MH settings	MHC risk-rating being performed, primarily based on premises.	HSE ongoing actions on identified risks. HSE discusses risk ratings with Head of Service in weekly call, any themes emerging are discussed. Individual CHO issues followed up.
Suite of actions in line with risk rating		
RESIDENT PROFILE		
Does the resident cohort include at-risk populations?	In some centres, there are residents over 60 years of age and some with underlying medical conditions.	Ongoing priority monitoring of at-risk cohorts. Preparedness plan in place in each CHO. Management teams meet daily to discuss issues and changes required.
SPACE		
Are residents accommodated in shared accommodation?	In some centres, residents are in shared accommodation, with limited ability to separate residents.	Significant work undertaken to reconfigure premises, to reduce beds and provide single rooms where possible. Many units are running on up to 50% less capacity. Others have been divided into possible Covid and non-Covid areas. Social distance measures have been implemented as per HPSC guidance.
Does the facility maintain a schedule of cleaning?	Yes.	Schedule reviewed as risks may be identified. Routine and terminal cleaning are provided. Staff refer to the HPSC guidance regarding additional cleaning.
SYSTEMS		
Are there clear protocols for communications on Covid-19?	There is a person responsible for collecting and disseminating information and updates on Covid-19 to staff and residents. A lead person has been identified in each service. There is regular communication to staff/residents/families about Covid-19. There are protocols for notifying suspected/confirmed cases of Covid-19. Communication issued from HSE national operations as required through heads of service.	Ongoing priority.

Have protocols have been established for visitors?	There are restrictions on visitors, with exceptions for residents receiving end of life care. The new visiting procedures have been communicated to residents/families via phone, social media etc.	Ongoing priority. The HSE will continue to adhere to HPSC guidance for visiting and as restrictions are reduced, all visiting will be risk-assessed and based on further guidance provided.
Is there a regular testing programme in place for residents and staff?	There is a process to test all suspected staff and service users, MH Units are regarded as long-term residential care settings and are prioritised for testing. Frequency depends on public health requirements and local needs.	Overall HSE target of 100,000 tests per week. Testing has been completed in all mental health facilities in all nine CHOs. Currently there is no guidance on repeat testing. HSE will follow all HPSC guidance on testing and reporting of suspected cases.
Is the service able to provide general health, emergency and palliative care services?	Service provides palliative care but not emergency care. Patients/service users have access to general health care. In community setting all service users have a GP. If condition deteriorates they access appropriate health services as required. Facilities follow public health advice on checking residents for symptoms of Covid-19.	If public health advice changes, services will comply.
Are protocols established for the admission and transfer of residents?	There are protocols for checking and recording symptoms prior to an admission or transfer, in line with public health advice. There are protocols for admitting or transferring a resident with Covid-19 symptoms.	Protocols will be kept under review in line with public health advice. The Code of Practice on Admission, Transfer and Discharge (MHC, 2009) is followed. HSE Mental Health is working with HSE Public Health to provide further clarity for acute inpatient units on admissions. Currently, admissions are isolated in single rooms.
STAFF		
Does the service have access to staff with appropriate expertise?	The service has access to infection prevention control (IPC) and palliative care expertise and healthcare as required. There are staff trained across mental health services to test for Covid-19 in suspected staff and service users.	MH staff will work closely with testing services. There is a lead person in the CHO responsible for testing coordination.
Do staff have access to relevant training, including training in the proper use of PPE?	Staff have access to IPC information and training, palliative care information & training and are trained in the use of PPE. Cleaning staff are trained in additional cleaning and	Work is in progress to ensure that all staff are trained in all aspects of IPC practice relevant to their role. Additional webinars have been provided for mental health staff on IPC, and the management of an

	disinfecting requirements (as per HACCP). The person in charge of the discipline is responsible for identifying training needs in each centre and accessing appropriate training (on a multi-disciplinary basis).	outbreak. Further support can be provided as required.
Are staff working across services?	In some cases, dedicated nursing/medical/ HCAs/HSCPS staff work across services.	Arrangements in place to limit cross-contamination where staff move between services to reduce risk of cross-infection. Service areas are zoned and staff allocated to areas to work as much as possible. As per HPSC guidance, daily monitoring in line with preparedness plans.
Is there is a plan for staffing contingencies?	A person is responsible for reviewing staffing levels and needs daily. There are escalation protocols for staffing shortages. As part of overall roster, there is a register maintained of staff caring for residents with Covid-19. Staff temperatures are checked twice daily as advised by Public Health. Depending on staffing levels, care for a resident who has tested positive is delivered by a single nominated person on each shift to the greatest extent possible.	Staffing continuity to be maintained through backfilling and replacement as part of overall workforce planning, within available capacity. If public health advice changes re temperature checks, services will comply. Necessary protocols to be put in place to ensure safety and infection control for staff managing positive cases.
SUPPLIES		
Does the service have a baseline stock of PPE?	PPE baseline stock is available in all services and as required. The service has a contingency plan with usual suppliers.	Constantly monitored