Building a Better Health Service

CARE COMPASSION TRUST LEARNING

Mental Health Services

COVID-19 and the Mental Health Services

1.

Building a Better Health Service

CARE COMPASSION TRUST LEARNING

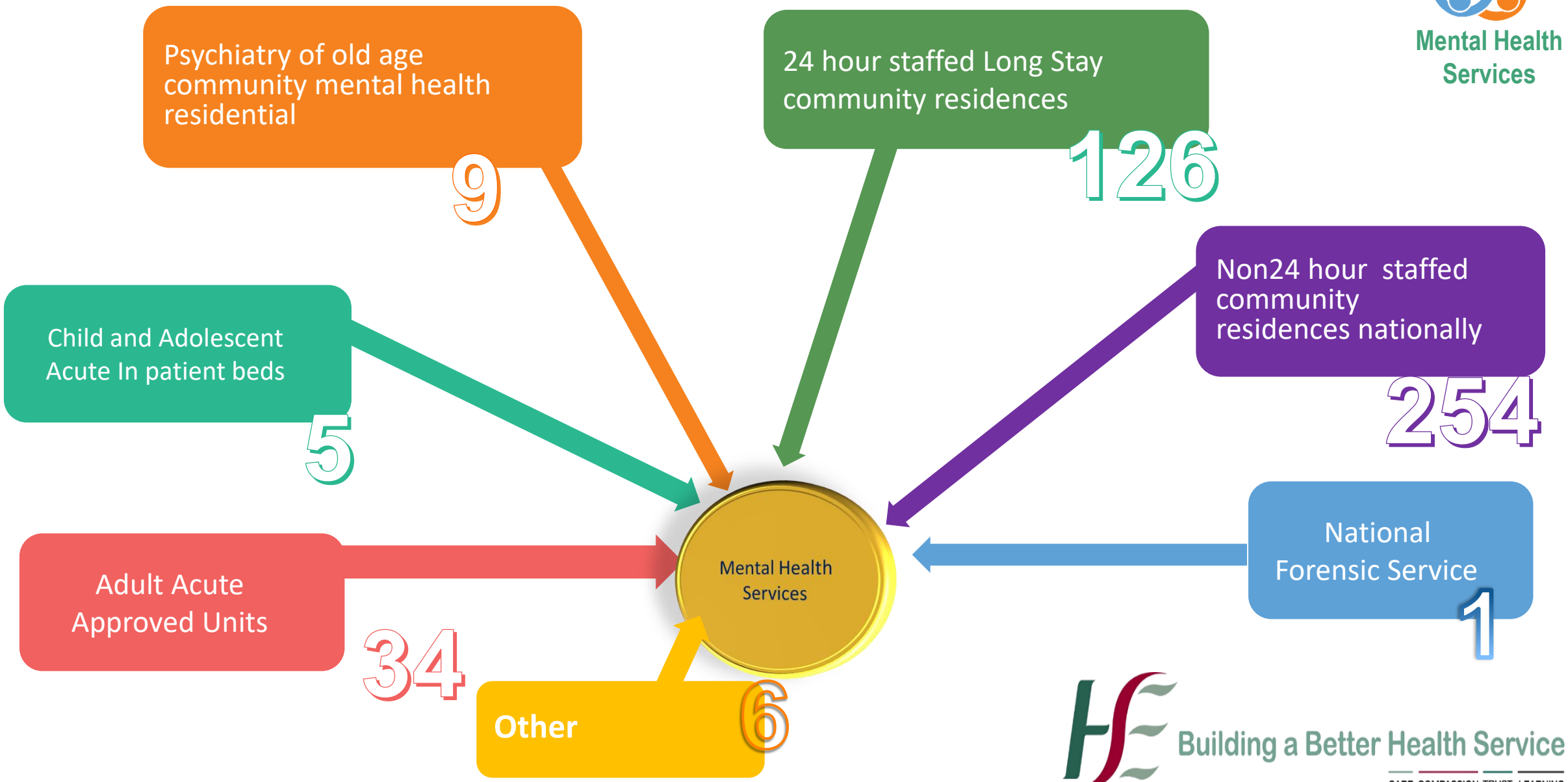
Mental Health Services

1. Setting the scene

Dr Mary Cosgrave -Covid 19 pandemic 2020

Mental Health Services Residences 2020 (based on list compiled March 2020)

Mental Health Services



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Bed capacity nationally (source MHC reports)

Mental Health Services

- Acute 1,050
- Acute POA 56
- 24 hour residences 1,318
- Adult non acute 719
- Forensic 103
- Child 98
- St Patrick's and St Edmunsbury 241 and 52
- SJOG 159
- Bloomfield 151
- Highfield 112

Bed Capacity Nationally (source MHC reports on bed capacity 2020 and inspection reports)

Mental Health Services

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Mental Health Settings

Mental Health Services

- Acute Units
- High Observation Units
- Phoenix Centre
- Rehabilitation wards
- Hostels
- Single rooms versus Multi bedded rooms
- Different lay outs ability to divide the unit
- Staffing levels, skill mix and staff members' skillsets
- Equipment available: diagnostic, treatment, oxygen points, PPE
- Level of care possible

At Risk Groups

Mental Health Services

- Age Profile in Mental Health Settings

- Almost 5 3% of patients resident in psychiatric hospitals/continuing care units were aged 65 years or over on census night and 39% in independent private and private charitable centres,

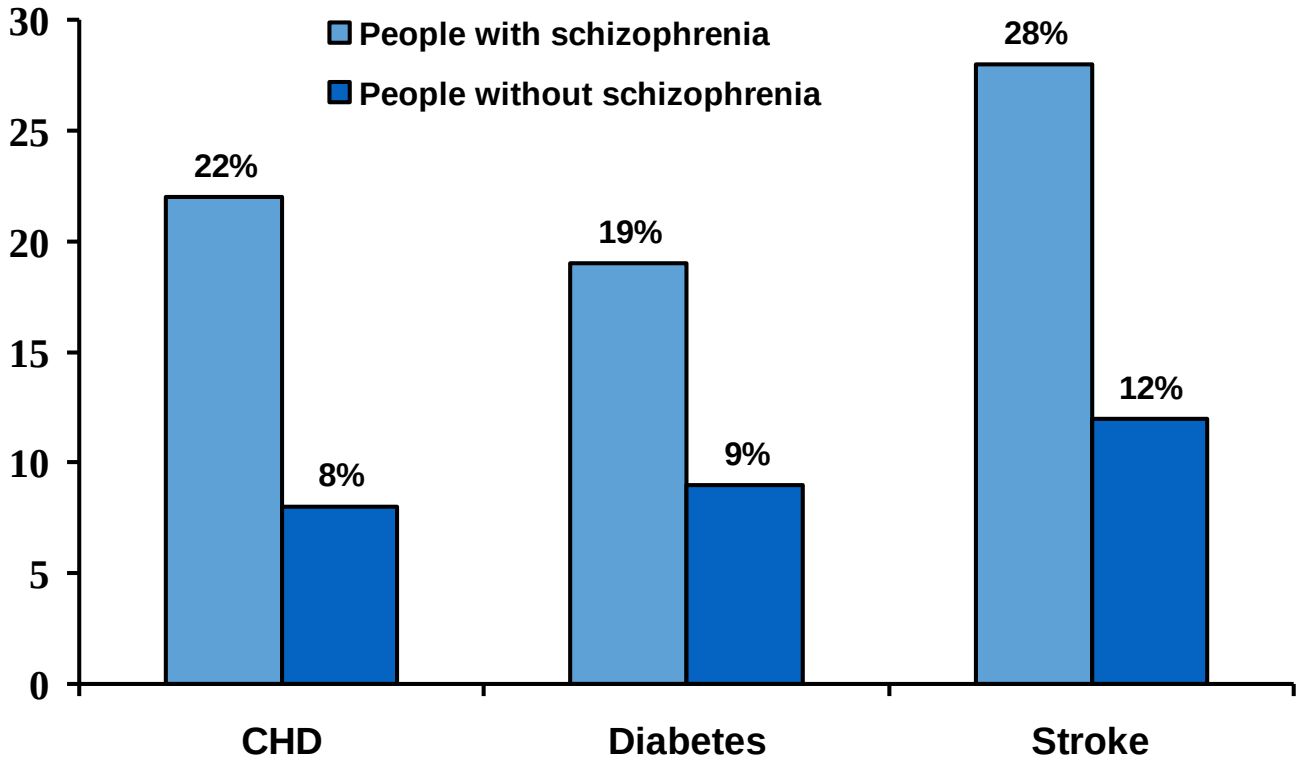
- Over one-quarter of patients in psychiatric hospitals/continuing care units and 20% in independent/private and private charitable centres were 75 years and over on census night. This compares with almost 6% in general hospital psychiatric units

Irish Psychiatric Units and Hospitals Census 2019 Main Findings www.hrb.ie

High rate co- morbidities in people who have mental ill health

Mental Health Services

Five-year (non) survival rates



Hippisley-Cox J et al (2006) A comparison of survival rates for people with mental health problems and the remaining population with specific conditions.
Disability Rights Commission. Equal treatment: closing the gap, July 2006

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Usual medical services

Mental Health Services

- GP: yes or no
- Blood taking and access to acute hospital system
- IV placement
- Ability to give subcutaneous fluids
- Observations/knowledge of NEWS or ISBAR
- Cover to ward/unit on call

Testing and escalation currently mental health services

Mental Health Services

- If COVID-19 is suspected, the doctor will arrange testing through the National Ambulance Service or a trained staff member
- If the clinical condition does not require hospitalisation, they should not be transferred from the facility on infection prevention and control grounds
- Residents with confirmed COVID-19 will require appropriate healthcare and social support, including access to medical management of COVID
- Residents with confirmed COVID-19 infection should remain in isolation on contact and droplet precautions until 14 days after the first date of onset of symptoms and they are fever free for the last 5 days.

Priority groups for testing

Mental Health Services

Priority will be given to symptomatic people in the following groups :

- Close contacts of a confirmed case
- HCWs who are front facing/ have regular patient contact
- Groups most at risk of severe infection such as persons with diabetes, immunosuppressed , chronic lung disease, chronic heart disease, cerebrovascular disease, chronic renal disease, chronic liver disease and smokers.-
- Household contacts of at-risk groups above
- Staff & residents of NHs and other residential care settings including MH and those in direct provision, the homeless, Roma and travelling community settings where symptom management is difficult
- Prison staff and inmates where it may be difficult to implement self-isolation advice
- Pregnant women to ensure they can be managed safely in hospital, minimising the risk of spread in the maternity hospital.

Residential care setting referral - COVID 19 test

Patient has symptoms

Remote/ In-house medical assessment of patient

COVID 19 Test required?

No

Exit process

Yes

Access to Healthlink?

Yes

HEALTHLINK

Referral via Healthlink

No

This part of process is still in development

Person in Charge at Residential Care Setting fills out the Patient Referral Form in Excel

Email referral to CHO Residential Care email address

HEALTHLINK

CHO Referrals Coordinator submits referral in Healthlink

Referral added to relevant CHO unassigned list in Swiftqueue

Test may be assigned to a number of options:

National Ambulance Service (NAS)

Staff at Residential Care Setting

CHO Staff Trained in Testing

This is available in a limited number of areas at present.

Test Completed at Residence

Note: NAS delivers all their swabs to nearest hospital microbiology lab at end of the day

Sample taken to nearest CHO test clinic to be included in their daily lab transport batch

Lab analyses swab sample

Test results are communicated via Healthlink

CHO Referrals Coordinator sends results to the Person in Charge at the residential care facility

GP receives results

This part of process is still in development

Drafted by: Conor Lantry for Primary Care Community Operations, HSE.
Date of version: 02 April 2020 and will be reviewed and updated as required in response to changing procedures as directed by HSE.

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Mental Health Services

2. Experience of an affected unit
Mairead Kelly

ADON Jonathon Swift Clinic St James

Overview of the Jonathan Swift Clinic

Mental Health Services

Three wards:

- 22 Bedded Acute Admission ward
- 16 Bedded Step Down ward
- 9 Bedded PLL ward
- Acute Day Hospital

Our Covid 19 Story

Mental Health Services

Staff

12/03/20 – 1 staff member + **24/03/20:** 41 staff in self isolation

- 34 staff tested
- 13 staff tested +
- 8 Members from the same team
- 30% of staff in self isolation

Patients

- 7 Patients tested +
- 6 PLL Patients tested +
- 5 Transferred to medical Hospital
- 1 Remained in JSC
- All had good outcomes
- JSC Currently Covid free

Lessons Learned

- Social Distancing
- Isolate Early
- No Visiting
- Patients leave status
- Closed to admissions
- Monitoring Symptoms
- General Hospital
- Rationalising of staff
- Information Overload
- Seek Advise
- Reduced bed capacity
- Clinical Governance
- Staff Information
- New methods of working

Mental Health Services

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Mental Health Services

3. Practical Advice for staff working in mental health settings

Dr Rory O'Donnell
Respiratory Consultant St James

COVID-19 interim case definition

Mental Health Services

A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease e.g., cough, shortness of breath)

OR

A patient with any ARI & having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset

OR

A patient with severe ARI (fever and at least one sign/symptom of respiratory disease e.g., cough, shortness of breath AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Mental Health Services

- Incubation up to 14 days
- May be asymptomatic
- Flu like sx, cough, headache, fatigue
- Atypical symptoms, GI, loss of taste
- In IDS patients (Not himself, delirium, drowsy, poor form)
- Majority have benign course
- Severe cases get pneumonitis

Clinical Presentation

Mental Health Services

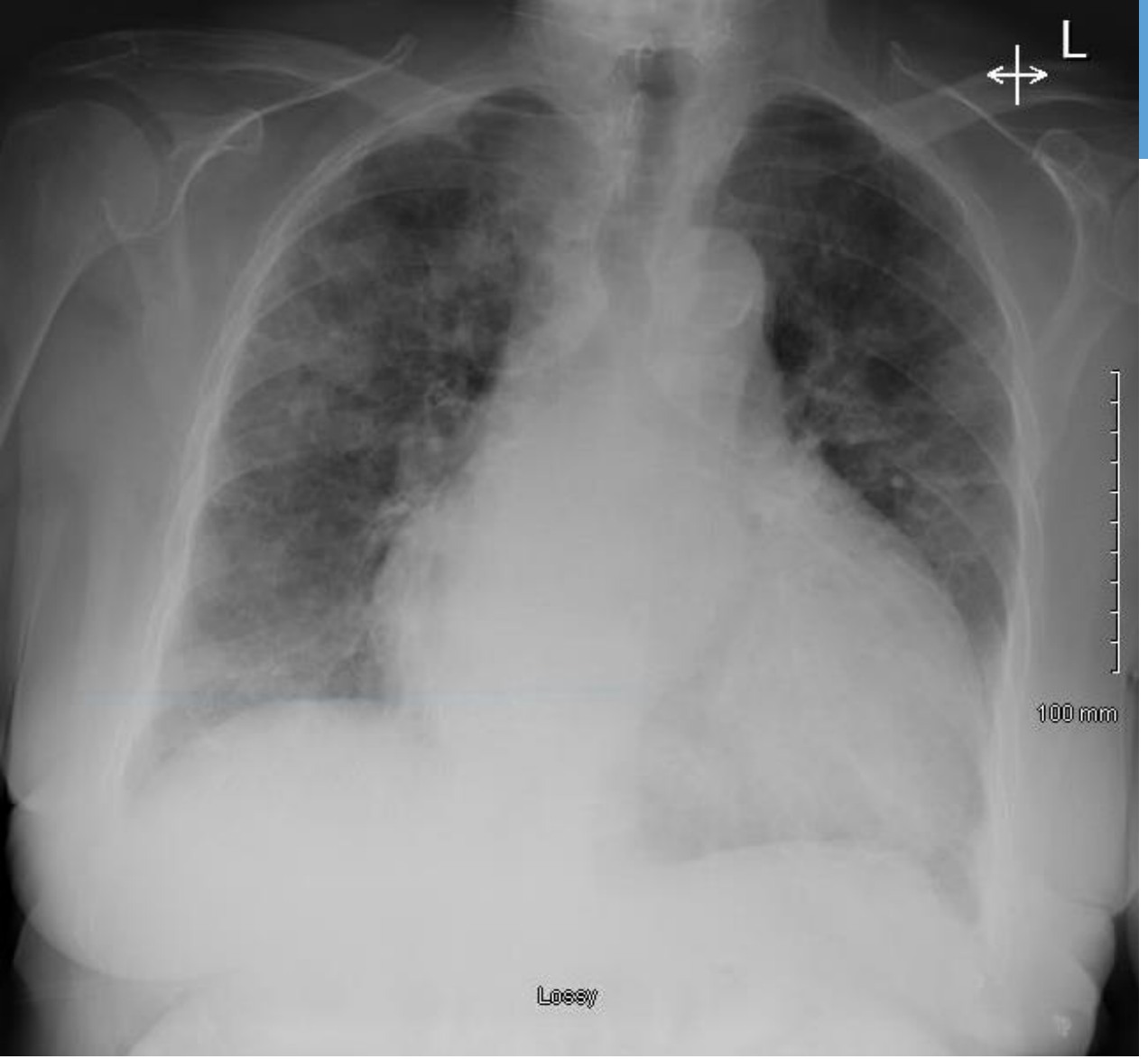
MOST COMMON SYMPTOMS

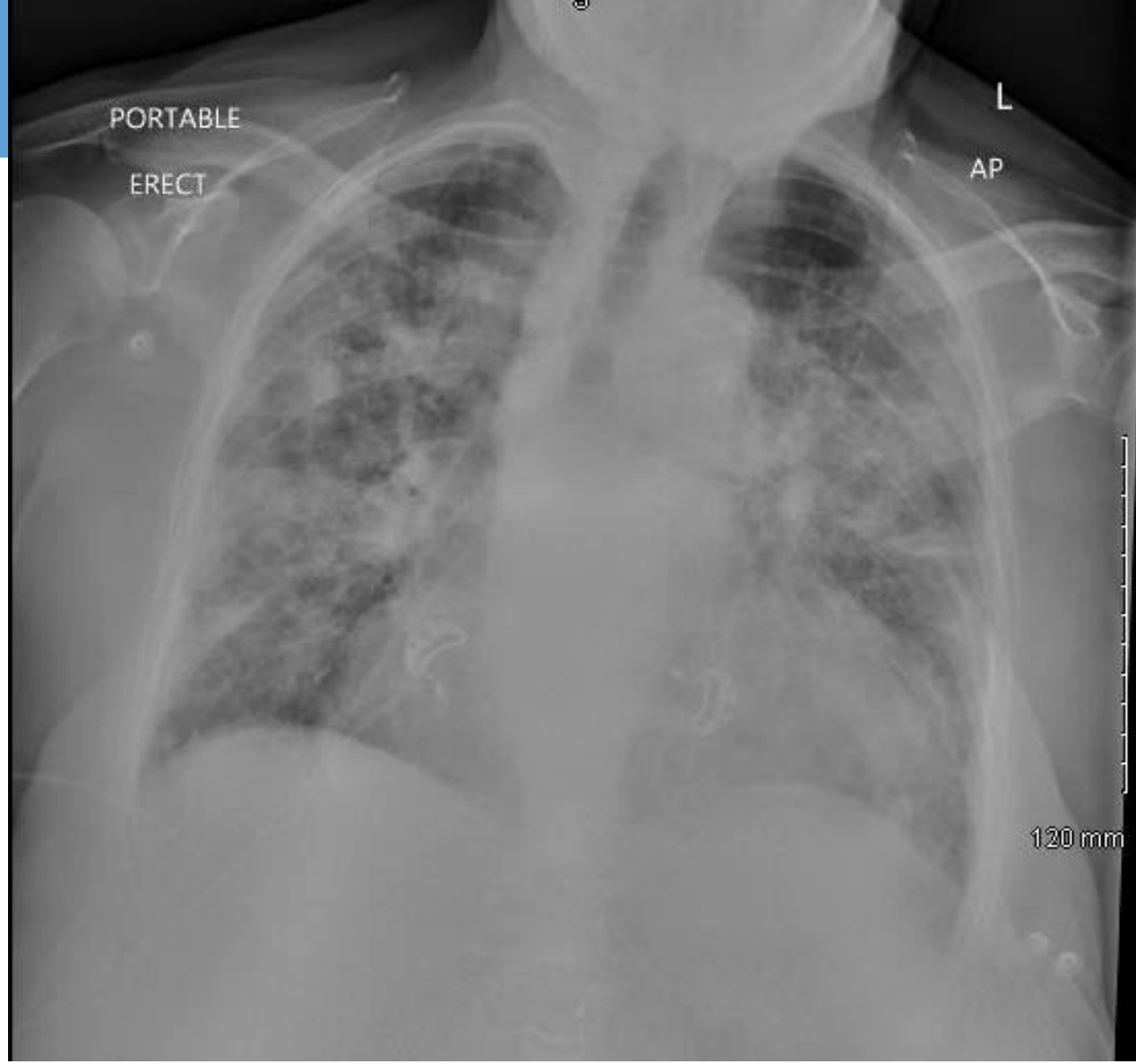
- Cough
- Dyspnoea
- Myalgia
- Fatigue
- Fever

LESS COMMON SYMPTOMS

- Anorexia
- Sputum production
- Sore throat
- Confusion
- Dizziness
- Headache
- Rhinorrhoea
- Chest pain
- Haemoptysis
- Diarrhoea
- Nausea/vomiting
- Abdominal pain
- Conjunctival congestion.
- Loss of taste or smell

(BMJ Best Practice)





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(BMJ Best Practice)

Progression

Mental Health Services

- 20% cases severe
- Can be a significant lag between onset and SOB
  - Median 8 days
- Unforgiving (don't "sleep on it")
- Myocarditis
- Sepsis syndrome
- Renal failure

COVID Patient Pathway: Respiratory Management

THE SINGLE MOST VALUABLE THING YOU CAN DO IS ADHERE STRICTLY TO INFECTION CONTROL + PPE

Discharge Criteria

1. Screened positive for COVID
2. Fit for discharge
3. Age < 65 years
4. Initial oxygen sats > 97% and RR < 20
5. Absence of infiltrate on CXR
6. Absence of significant co-morbidity: COPD, asthma, previous Type 2 respiratory failure, CCF, DM (discretion required) – if previously hospitalized for comorbidity, will likely need admission
7. Able to self-isolate at home

Discharge with Pulsoximeter

1. All of the above, but sats > 95%
2. Patient has SMART phone and email address
3. Living in catchment area
4. Patient felt to be cooperative, reliable and sensible (no current drug/alcohol use)
5. No nail-varnish

PRECAUTIONS

2. Admit to ward: Check O2 sats

Sats > 94%

NOT HYPOXIC
(no supports required but does not meet criteria for dc)

-**Isolation room**
-Obs check 6hrly

Note: patients with COVID may develop cardiomyopathy + deranged LFTs also

Sats < 94%: Do an ABG

HYPOXIC
(COVID pneumonitis causing resp compromise)
-**Isolation room**
-Target sats >94%
-Obs check minimum 6hrly (or more often)
-Establish ceiling of care
1. Nasal prongs (up to 6L/min): droplet precautions
2. Venturi: aerosol precautions
3. CPAP via non-vented mask *while awaiting ICU rv*
Peep 10cmH20, FiO2 0.4 & titrate
Monitor for increasing RR, increasing work of breathing, increasing FiO2 to guide ICU review

HYPERCAPNIC
(COPD patients with exacerbation secondary to COVID)

-**Isolation room**
-Target sats 88-92%
-Obs check minimum 6hrly (or more often)
-Establish ceiling of care

1. Nasal prongs: droplet precaution
2. BiPAP (with respiratory team input): aerosol precautions

Monitor for increasing RR, work of breathing, FiO2 to guide ICU rv

3. Refer to ICU

Please strive to establish ceiling of care early for all COVID patients (baseline function and comorbidities at time of admission)

1. Respiratory Failure
  - Early intubation recommended
  - FiO2 > 40 - 60%
  - Increasing resp rate/work of breathing
  - pCO2 rising / > 7 (nb in non-COPD patients)

2. Other Organ Failures
  - Patients with comorbidities may decompensate with other organ failures and warrant ICU discussion as per standard practice

COVID-19 Assessment and testing pathway for symptomatic resident in Residential facilities (RF) and Long Term Care Facilities (LTCF)

Mental Health Services

Isolate the resident in his/her room. Resident's GP or Medical Director to perform risk assessment

A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath);

OR

A patient with any acute respiratory illness **AND** having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset;

Clinical judgement should be employed when assessing these criteria.
Clinicians should be alert to the possibility of atypical presentations in older patients and those who are immunocompromised, for example low temperature rather than fever.
A higher index of suspicion is needed if there is a COVID-19 positive case or contact in the RCF/LTCF.

Criteria not met:
Resident has some symptoms of respiratory tract infection but doesn't meet the above criteria

Unless assessment at hospital is indicated, the resident should remain isolated from other residents within the facility for a **minimum of 14 days** from symptom onset, the last 5 of which they should be without fever.

Please refer to information leaflets on patient self-isolation.

Meets criteria

Check if there are any other residents with COVID-19 symptoms (i.e. outbreak) in the RF/LTCF

No other cases

Arrange COVID-19 testing:

A. If resident can attend a community testing site, they should be referred by a GP via Healthlink, as per Telephone assessment and testing pathway for patients who phone GP and healthcare settings other than receiving hospitals

B. If resident is unable to attend a community testing site, testing should be managed according to National Ambulance Service document on: **COVID-19 Testing in Residential Settings**

Unless assessment at hospital is indicated, isolate the resident, **pending results:**

- **If positive**, advise resident to self isolate for a **minimum of 14 days** from the onset of symptoms, the last 5 days of which should be without fever.
- **If not detected:** Advise resident to self isolate until **48 hours after resolution of symptoms.**

Adopt Infection Prevention and Control precautions as per Preliminary COVID-19 IPC Guidance including Outbreak Control in Residential Care Facilities and Similar Units.

Yes other suspected cases

Testing should be managed through NAS according to the NAS document on **COVID-19 Testing in Residential Settings.**

- If multiple residents / potential cluster are identified within a unit, this should be identified within the referring email to NAS
- **Notify** Public Health of outbreaks within unit as per Preliminary COVID-19 IPC Guidance including Outbreak Control in Residential Care Facilities and Similar Units
- Following confirmation of a COVID-19 positive diagnosis within the unit, it is assumed that all residents presenting with symptoms are COVID-19 positive. Multiple re-referrals to NAS for potential COVID cases should be avoided

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Reviewed and approved by COVID-19 Expert Advisory Group: 27/03/2020

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Some Key Points

Mental Health Services

- Is the patient sick?
- What would you normally do?
  - If its talk to GP or refer to Hospital then do so
- Is the patient a risk to others?
  - Are others exposed to them
- Is the patient capable and reliable
  - Will they self isolate effectively
- Have end of life decisions been made?
  - What would those decisions be in absence of COVID
- Every case is individual, there are no blanket ressussitation rules
- Seek advice

Some Key questions about each patient
RED = Consider hospital referral

Mental Health Services

Suspected COVID 19

(common sense, is there another explanation eg cellulitis)

Well vs sick

Reliable vs Not reliable

No Medical co-morbidities vs Medical co-morbidities

Agreed End of life care plan vs No End of life care plan

Treatments

Mental Health Services

- Supportive, Oral fluids, paracetamol
- Oxygen
  - No precedent or evidence base for community O2 in this setting
  - Sat monitors are required
  - Oxygen delivery options limited
  - Hi flow, high FiO2 not an option
- Palliative options

Guidance

Mental Health Services

- Check list for Acute Adult Approved Centres (AAAC) -
- Check list for High Support Community Residence/Hostels and POLL Services
- Check list for Low and Medium Support Community Residences/Hostels
- Guidance on the use of Irish National Early Warning System (NEWS) in Acute Mental Health Services
- 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 https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Preliminary%20RCF%20guidance%20document.pdf