Critical that mental health service providers show they can identify and manage risk, says Mental Health Commission

Recognising and understanding weaknesses will help slow possible future progression of Covid-19

September 10th, 2020: The Chief Executive of the Mental Health Commission says that it is critical that providers of mental health services across the country demonstrate that they are capable of quickly identifying and managing risks to protect residents against future progression of Covid-19.

While the entire population is vulnerable to the virus, it is accepted globally that mental health service users resident in acute settings and long-term residential care units may be particularly susceptible to developing Covid-19 because of pre-existing medical conditions and other factors.

Two inspection reports published today by the Commission identified six moderate-risk non-compliance ratings at two in-patient mental health units. However, despite the fact that the inspection were undertaken in February and March - and before the Commission temporarily suspended its inspection process - the Commission's Chief Executive said that the evidence and compliance levels in both centres indicate a clear capability on behalf of the providers to protect their residents.

"It is critical that providers of mental health facilities - such as the two centres in these reports - provide the evidence of an ability to identify and manage risk," said John Farrelly. "High levels of compliance with the regulation on risk management indicate a provider that recognises and understands both the strengths and weaknesses of their service. Crucially, this enables action to halt - as much as is possible – any possible future progression of Covid-19 in their centre."

While the approved centres - located in Mayo and Galway - both had an overall compliance rating of 87% for 2020, this was a fall of 10% from a 97% rating for both centres in 2019.

The Inspector of Mental Health Services, Dr. Susan Finnerty, said that staff training was an area that the Commission would continue to scrutinise in an effort to ensure that staff in all approved centres are supported to provide care and treatment in accordance with best contemporary practice.

"This is especially important when centres, such as those referenced in today's reports, cater for patients who are resident for more than six months in an approved centre," she said. "For example, the inspection report for both centres noted that not all staff were trained in fire safety and the prevention and management of violence and aggression. It is important that centres ensure that all staff are appropriately trained to deal with the needs of any patient in their care and to deal with any potential risks to their safety."

An Coillín is a single-storey building near Mayo University Hospital in Castlebar, County Mayo that accommodates 22 residents at full capacity. At the time of inspection, there were 20 residents living there for more than six months. Residents were accommodated in a combination of single en-suite bedrooms and shared dormitories.

The report for the centre found 14 regulations rated as excellent; while it was found to be moderately non-compliant on four regulations relating to staffing, administration of medicines, the use of physical restraint, and admission, transfer, and discharge.

With regard to staffing, the report found that the appropriate staffing resources were available to meet the needs of residents with the exception of psychology. In addition, not all healthcare staff

were trained in fire safety, basic life support and the prevention and management of violence and aggression. Fire safety training levels were concerning as only 33% of nursing staff had up-to-date training. In an effort to improve staff mandatory training attendance, the approved centre rolled out 'mental health service training days' to incorporate numerous training sessions within the same day.

The approved centre was non-compliant with the code of practice on the use of physical restraint. This was down to the fact that a medical examination of a resident in one episode was not completed no later than three hours after the start of physical restraint. Three episodes of physical restraint were inspected. These indicated the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others.

The clinical file of one resident was examined in relation to the admission process. The resident's admission was on the basis of a mental illness or disorder. A key worker system was in place within the approved centre. An admission assessment was completed and included the current mental health state of the resident, as well as a risk assessment and full physical assessment. However, the admission assessment did not include the presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, nor any other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

Creagh Suite is located on the grounds of St. Brigid's Hospital, Ballinasloe, Co. Galway and occupied part of a building constructed in the 1930s which was previously the hospital admission unit. It operates as a continuing care facility for residents with dementia under the care of the Psychiatry of Old Age team. The centre is registered for 14 residents but at the time of this inspection accommodated six residents.

The report for the centre found 16 regulations rated as excellent; found that there was moderate non-compliances with two regulations related to the use of mechanical restraint and staffing; while it received two low non-compliant ratings for food safety and privacy.

The report also found that not all health care professionals were trained in fire safety, the prevention and management of violence and aggression, the Mental Health Act 2001, and Children First.

Three episodes of mechanical restraint were examined during the inspection process. In one of the episodes, there was no documented evidence that mechanical restraint for enduring risk of harm to self or others was used to address identified clinical need and when less restrictive alternatives were unsuitable. In this episode, mechanical restraint was not ordered by a registered medical practitioner under supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf. In relation to that same episode, the clinical file did not specify that there was an enduring risk of harm to self or others; that less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which the mechanical restraint was applied; the duration of the restraint; the duration of the order; and the review date.

Notes to the Editor:

An Coillín: https://www.mhcirl.ie/File/An-Coillin-IR-2020.pdf

- Overview of centre:
    - Location: Castlebar, County Mayo
    - Beds: 22 beds
    - Care: Continuing Mental Health Care/Long Stay
- Conditions:
    - There were no conditions attached to the centre
- Compliance:
    - 87% overall (down from 97% in 2019)
    - 27 compliant; 4 non-complaint; 8 non-applicable
    - 2020 risk ratings (for the 4 non-compliances)
        - 4 moderate
- 2020 areas rated as excellent:
    - 14 (identification of residents; food and nutrition; food safety clothing; residents' personal property and possessions; recreational activities; religion; visits; communication; care of the dying; general health; privacy operating policies and procedures; mental health tribunals)

Creagh Suite: **https://www.mhcirl.ie/File/Creagh-Suite-IR-2020.pdf**

- Overview of centre:
    - Location: Ballinasloe, County Galway
    - Beds: 14 beds
    - Care: Continuing Mental Health Care/Long Stay and Psychiatry of Later Life
- Conditions:
    - There were no conditions attached to the centre
- Compliance:
    - 87% overall (down from 97% in 2019)
    - 27 compliant; 4 non-complaint; 8 non-applicable
    - 2020 risk ratings (for the 4 non-compliances)
        - 2 moderate
        - 2 low
- 2020 areas rated as excellent:
    - 16 (identification of residents; food and nutrition; residents' personal property and possessions; recreational activities; religion; visits; communication; care of the dying; individual care plans; therapeutic services and programmes; transfer of residents; general health; provision of information to residents; use of CCTV; privacy operating policies and procedures; risk management procedures)