

Reducing harm from ligatures in mental health wards and wards for people with a learning disability



National Mental Health and Learning
Disability Nurse Directors Forum

*Influencing and advancing care in
mental health and learning disabilities*

This guidance was developed by [the Mental Health and Learning Disability Nurse Directors Forum](#) in collaboration with experts by experience and the Care Quality Commission.

[Overview: Reducing harm from ligatures in mental health wards and wards for people with a learning disability](#)

The 5 key factors that staff should look at to reduce harm from ligatures.

[The built environment: Reducing harm by ligature in practice](#)

The key themes that the Mental Health and Learning Disability Nurse Directors Forum has identified for ligature harm risk management in the built environment.

[Ligature point risk assessment template](#)

The Mental Health and Learning Disability Nurse Directors Forum's ligature point assessment template has been designed to support staff in identifying and recording ligature risk points, controls and actions required to mitigate risks associated with the built environment.

It has been developed with support from 40 different mental health and learning disability trusts, including private sector organisations, along with experts by experience and people who use services.

[Tiers and mitigating controls](#)

Guidance on levels or 'tiers' of risk and factors for mitigating controls for ligature point risks.

Overview

Foreword

The notable aspect of this guidance, which has been developed in collaboration with members of the Mental Health and Learning Disability Nurse Directors Forum, Experts by Experience and the Care Quality Commission, place an emphasis on therapeutic engagement.

As a nurse myself, I know how easy it is to concentrate on the measurable aspects of a risk or difficulty. You can easily create a tick box form to say you have door handles that can't be used as ligature point; in this you feel as a healthcare worker you can demonstrate you have reduced the risk, which feels like a job well done.

However, as a person who has suffered from severe mental illness and used mental health services, I have learnt from my own lived experience that the interventions that are not so easily measurable, like therapeutic engagement, more often than not were the factors that reduced my risk of using a ligature.

To give an example, while I was sectioned under the Mental Health Act and was a patient in an acute mental health hospital for my own safety, I became emotionally distressed and started to try to harm myself. The response by the team caring for me was to put me in seclusion, a room with nothing in it apart from a plastic mattress. In this isolation, devoid of any human contact my suicidal thoughts increased and my mind increasingly focused on how I could physically end my life. In the limited resources I had in the seclusion room, I managed to create a ligature. I passed out and the next thing I knew were that people were surrounding me after the ligature had been cut from around my neck.

I share this distressing personal story to demonstrate that a ligature can be found, even in the most barren of places, particularly when a person becomes so desperate to stop the emotional distress. So what did help me in my distress?

Therapeutic engagement – human connection – someone sitting with me and acknowledging my suffering, so I didn't feel alone in my overwhelming emotional distress.

Therapeutic engagement is spoken about first in this guidance for a reason: from my experience it was a massive factor that not only in a moment stopped me from actively trying to take my own life, but it ultimately lead to me managing my distressing thoughts without self harming.

All parts of the guidance, including the recording template, are important but I would urge people using them not to fall in the trap that, as healthcare professionals, we can so easily fall into; that of only focusing on the measurable aspects of this comprehensive guidance, because the less measurable outcomes, like therapeutic engagement, can be the most powerful tool we have to reduce someone even thinking about creating a ligature.

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Introduction

This guidance is written for staff with responsibilities for:

- caring for patients on mental health wards, and on wards for people with a learning disability
- assessing and managing risks to patients in the inpatient care environment
- those buying, installing and maintaining fixtures and fittings for mental health wards and wards for people with a learning disability.

The main focus is on removing or reducing the risk of patients taking their own lives or harming themselves using a ligature, particularly in combination with an anchor point. However, the practices covered will have wider benefits for patients and staff.

A ligature is anything, like a cord or other material, that could be used for the purpose of hanging or strangulation. A ligature anchor point is anything that could be used to attach a ligature. Ligatures do not necessarily need to be attached to a ligature anchor point.

Staff working in inpatient services should be aware of the potential harm that can be caused by use of a ligature in the ward environment, and work hard to identify and reduce risks.

Inpatient care environments, patient populations and relative risk of harm will vary by context and over time, so there can be no standardised approach to assessing ligature risk. It is also important to acknowledge that risk cannot be completely eliminated and that some risks may be difficult or even impossible to predict.

Removing or reducing the means and opportunity for people to harm themselves is only one aspect of managing risks in this area.

We have identified 5 key factors that should be considered in working to reduce harm from ligatures:

- **Therapeutic engagement:** A vital part of supporting patients' recovery is the quality of the interaction between staff and patients, which can positively influence the effectiveness of safety plans. These plans should be person-centred and created with the patient to plan how to manage times of distress that may result in causing harm to themselves. In this guide we use the term 'therapeutic engagement' to describe this positive relationship between patients and those trying to help them.
- **The built environment:** Controlling the built environment reduces opportunities for a patient to use fixtures, fittings, or furniture or their personal items (such as clothing) as ligatures or ligature points to cause harm to themselves or attempt suicide.
- **Staffing and skills:** Good therapeutic engagement relies on having the right staff with the right skills and support and – critically – the time to spend with patients to build trust and rapport. Engaging staff in robust training and cohesive and effective teamwork can improve the outcomes for patients. It can also improve staff effectiveness and job satisfaction. Wards with lower staff turnover have fewer deaths by suicide, and so retaining staff and supporting them well (including through training) leads to safer care.
- **Technology:** This can increasingly play a part in keeping patients and staff safe by, for example, enabling staff to remotely observe patients who need a high degree of supervision to keep them safe, without having to continually disturb them.
- **Procurement:** How services buy and bring into use furniture, fixtures, fittings and equipment (sometimes called 'procurement and implementation') can also help keep people safe, by making best use of the money available, buying the right things, and using them to best effect.

After each of the 5 key factors listed in this section, we set out some key considerations that services may want to consider and ask themselves.

Therapeutic engagement

Effective therapeutic engagement is viewed as a partnership relationship between staff and patients, with shared decision-making and recovery-focused goals.

The relationship is based on mutual trust, respect and negotiation, enabling patients to solve problems and enhance their coping capacity with the aim of building a meaningful life.

Understanding individual needs and preferences, through meaningful effective engagement and relationships built on trust, is important when considering the impact that mental health staff have on patients' experiences of self-harm and suicidal behaviours while they are in mental health wards and wards for people with a learning disability. The [therapeutic engagement questionnaire \(TEQ\), developed by Kingston University London](#), is designed to support staff in their therapeutic engagement activity and understand how it is experienced by people who use services.

The dynamic on mental health wards and wards for people with a learning disability can be complex and difficult. This can lead to difficult relationships between staff and patients that can be obstacles to effective therapy. A review of literature on inpatient self-harm in 2011 identified staff-related issues linked to self-harming behaviour, including use of bank and agency staff, low levels of qualified staff, and increases in staff absence.

The review also looked at research into nursing staff experiences. The authors noted that staff found managing self-harm challenging. They often felt uncomfortable with interventions such as observations or restrictive practices.

Staff also described experiencing negative emotions towards patients who self-harmed, and a fear of suicide. These difficult emotional responses resulted in more distant nurse/patient relationships. Poor understanding of self-harm and a lack of support when working with self-harm was also highlighted as a problematic factor. Staff need access to supportive supervision and the opportunity to engage in reflective practice.

Barriers to therapeutic relationships included:

- lack of choice of nurse (for example, gender of nursing staff)
- communication issues (including language, both due to differences in first language and use of jargon)
- absence of regular ward staff and reliance on temporary staff
- poor staff attitudes.

These reviews suggest that values are intrinsic to safe care and a supported workforce is essential to manage and reduce self-harm, including by ligature, on mental health wards and wards for people with a learning disability. Further research into workforce implications and ligature harm reduction on inpatient wards is required.

Psychological safety

Creating a psychologically safe culture offers direct benefits to staff and the health care it provides. Psychological safety can be broadly defined as 'a climate in which people are comfortable expressing themselves'. It has importance in mental health in empowering staff, patients and families to voice their suggestions, concerns and anxieties.

When we consider the importance of candour and a learning culture among the workforce to improve learning and reduce ligature associated risks, the importance of psychological safety becomes clear.

Inpatient health care can be a high-risk environment. Staff rely on interprofessional and interdisciplinary relationships to manage risk effectively in environments where errors can result in significant harm or even death.

Despite the seemingly obvious benefits of psychological safety, a culture of blame and fear is still prevalent in far too many healthcare organisations. This in turn is detrimental to patient experience, staff morale and organisational safety.

In today's healthcare organisations NHS England describes the importance of workplace compassion at all levels, from strategic planning, policies and procedures through to the way words are used in everyday conversations across organisations, and the importance of kindness and compassion in all settings.

Therapeutic engagement and relationships play an important role in helping to create a psychologically safe culture and environment where staff and people using services can feel able to speak up and ensure maximum involvement in their care.

Key considerations

Do we build a sense of collaboration and co-production with the patient, by considering the following:

- How do we take steps to understand the ligature risk for each individual?
- What are their individual triggers?
- What are the individual early warning signs?
- Understanding what is helpful and unhelpful for supporting each patient?

Do we develop a shared sense of safety planning with that individual among the team?

- How do we clearly communicate a shared responsibility of safety planning and expectations around this to our staff?
- When is the right time to have a conversation to work towards expectations/shared responsibility for safety planning?
- For example, during enhanced observations, when a patient is stable, or during 1:1s
- How is this knowledge and information concerning individual safety plans conveyed across the team to ensure a consistent approach to supporting patients?

Do we understand the times when building a therapeutic relationship is beneficial?

- How is the latest evidence and learning from incidents used to update training to build therapeutic relationships?
- Do we have a shared understanding of how to utilise physical environments to enhance psychologically safe practice?
- How is this embedded in risk assessments?
- How do we foster and encourage the use of 'safe quiet spaces' to build relational security, for example sensory rooms, de-escalation, outside spaces, where possible.

For example:

- How do we maximise the supportive aspects of enhanced observations? Communicating why they are on observations and what we hope to achieve from being on observations? Is the level of observation reviewed in respect of the location (see tiers for built environment)?

- How do we utilise this build a shared sense of what is needed to support a patient after using restrictive practice?

The built environment

This section covers how to minimise harm associated with the use of ligatures in the care environment for inpatients, which is often described as the 'built environment'.

As ward or care environments vary, this guidance should be adapted to local contexts. And because environments change – with new items being brought in and others removed or damaged – risk assessments need to be reviewed continually. Organisations should have a consistent approach to the task.

Ligature harm reduction needs to balance providing a care environment that is as safe as possible with maintaining people's privacy and dignity to aid their recovery. It needs to go hand in hand with other aspects of mental health care, including workforce planning, supportive observation and engagement, and therapeutic relationships between patients and staff.

The built environment should also be considered with other forms of risk assessment to reduce ligature harm risk. The [National Institute for Health and Care Excellence \(NICE\)](#) recommends collaborating and agreeing on individual risk assessments with patients, instead of using risk assessment tools and scales to predict future suicide and treatment.

What we mean by the built environment

We define the built environment as the structure of the inpatient care environment (the buildings and wards) along with fixtures, fittings and furniture. It includes the surrounding areas that patients could access, such as communal reception areas, gardens and other outside spaces.

Patients' possessions and items that could be used as ligature material or to provide ligature anchor points are also included.

Why the built environment is important

Controlling the built environment reduces opportunities for a patient to use fixtures, fittings, furniture or their personal items (such as clothing) as ligatures or ligature anchor points to cause harm to themselves or attempt suicide.

Examples of safety interventions include:

- collapsible furniture
- reduced ligature fixtures and fittings (that make it difficult to attach a ligature)
- the removal of fixed ligature points where possible.

Current guidance already requires the use of some vital measures to reduce ligature harm risk in mental health inpatient settings.

For example, providers must use collapsible shower and curtain rails. Any incident involving a rail that does not conform to this is reportable as a [Never Event](#).

Mental health inpatient services must also regularly assess ward areas to identify and remove ligatures and ligature anchor points, where possible.

The care environment is important in the context of harm reduction and recovery-oriented practice by:

- providing a safe space to aid recovery

- enhancing opportunities for patients to build therapeutic relationships with staff and peers
- providing opportunities for therapeutic risk-taking
- affecting the extent to which patients experience privacy and dignity (for example, opportunities to have their own space).

Ligature types

Patients use a variety of materials as ligatures in attempts to harm themselves.

Clothing and other items commonly available in hospital wards and in the home are the main materials used.

Most items are not dangerous in everyday use and, as a result, services should avoid taking a blanket approach to restrict items associated with ligatures risks. Individual risk assessments (discussed below) should be carried out to determine the extent to which items that are capable of being used for self-harm are removed from the patient. This should be regularly reviewed and monitored. What may be a protective factor or positive risk for one patient will not be for another. Services should only deny patients access to items of clothing as a last resort.

Services need to keep risk assessments under continual review because risk factors will vary over time, even sometimes during a shift.

People with lived experience of self-harm should be involved in developing policies to help prevent or reduce the likelihood of harm in inpatient care.

Ligature points

Patients may use a variety of ligature anchor points to secure ligatures. Some ligatures and anchor points are obvious and easily accessible; some are less obvious and less easy to reach. As a result, it is vital that ligature risk assessments include both known and new forms of ligature points.

In all cases and contrary to previous guidance, low-lying ligature points **should not be judged as low risk and should be removed where possible.**

Staff should remain vigilant for all forms of ligature risk when assessing the care environment. Environmental risk assessments should include seeking out new ligature points or those that have been manipulated or subject to wear and tear, which may introduce new risk factors.

Where there are limited environmental controls or these impinge on the patient's care, privacy and dignity, staff should ensure that both individualised and system controls reduce ligature risk.

Controls include a level of observation and supervision based on individualised risk assessments, combined with processes that support these controls (for example, multidisciplinary team working and sharing of risk information in handovers and huddles).

Ward layout and design

Ward design and how well staff are able to observe patients are contributory factors for a proportion of suicides. An ideal ward design provides maximum opportunity to observe patients. Locations with a good line of sight reduce the need for restrictive intrusions and support a non-institutional 'home-like' environment.

Private spaces are important for providing patients with a greater sense of control, identity and dignity. They can also help improve people's wellbeing and positive behaviour, and can play a significant role to their recovery journey.

Some patients, for example autistic people, may benefit from space to avoid bright lights, noise and physical contact.

However, research has shown that almost all deaths by suicide happen in places where patients have privacy in bedrooms and bathrooms (with a minority of 8% happening in shared or communal areas).

Safe and effective mental health care relies on a careful balance between safety, privacy and dignity, ensuring individual patient needs are met in line with the Equality Act 2010 and patients' Human Rights.

As a result, services need to make sure that they have appropriate systems and controls in place to keep people safe while balancing the need for privacy.

Therapeutic environment

It's not just about the ward layout, but about the whole environment. Creating a therapeutic environment focuses on the balance between patient safety, privacy and dignity. It maximises opportunities to focus on strengths-based and recovery-oriented practices. Well-designed environments also aid in fostering enhanced therapeutic relationships between patients and staff, and contribute to patients' feelings of safety and control.

In contrast, ward designs that have an overly strong emphasis on patient safety foster more institutionalised restrictive environments. This can lead to negative behaviours, patients feeling disempowered, and increasing the risk of self-harming behaviours.

Positive features in the ward design, such as artwork and landscapes, can reduce stress levels and symptoms of mental ill-health.

Outdoor spaces, such as gardens and the integration of nature-based activities, provide several benefits to patient experience and outcomes.

People with lived experience of self-harm, including carers, can help services understand the challenges of creating the right environment for therapeutic care. Environments should always be co-designed with them.

Observations

In its [2021 annual report](#), the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) found that 41% of patients who died by suicide were cared for using medium or high-level therapeutic observations.

Factors associated with an increased risk of suicide during observation include staff attending to multiple duties, poor ward design, lower staff levels, and observations by less senior or experienced staff and by those unfamiliar with patients.

When supportive levels of therapeutic engagement and observation are required, the extent to which these are therapeutic is vital to patient recovery and managing ligature harm risk.

Dynamic approaches to engagement during observations (for example, judged distance) are essential and support patients to feel safe.

Observations are a skilled intervention that should be carried out by skilled staff who are familiar to the patient and encourage therapeutic, recovery-oriented approaches.

Individual risk assessment

Predicting suicide risk through verbal disclosure and using predictive tools is difficult and unreliable. Many patients that die by suicide deny or do not explicitly indicate having suicidal thoughts before death. Tools to assess risk in a non-individualised way have poor predictive values.

Risk formulation should consider more dynamic and individualised approaches, such as psychosocial forms of assessment that are collaborative with patients and carers and that build therapeutic relationships.

During individualised risk assessments, several factors should be considered, such as demographics, clinical features, personal circumstances and patient history.

Data from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) further supports these findings. This found that 67% of people who died by suicide in an inpatient setting (on the ward) from 2008 to 2018 were deemed as having no or low risk at last contact, and 31% were judged as having low or no immediate long-term risk.

Clinical messages

NCISH have set out some [key clinical messages for personalised risk assessment](#) in mental health services:

1. Risk assessment tools should not be seen as a way of predicting future suicidal behaviour.
2. Risk is not a number, and risk assessment is not a checklist. Tools, if they are used (for example as a prompt or a measure of change), need to be simple and accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.
3. There is a growing consensus that risk tools and scales have little place on their own in preventing suicide. This study suggests ways in which clinical risk assessment processes might be improved. The emphasis should be on building relationships, and gathering good quality information on (i) the current situation, (ii) past history, and (iii) social factors to inform a collaborative approach to management. Staff should be comfortable asking patients about suicidal thoughts.
4. Risk assessment processes are an intrinsic part of mental health care, but they need to be consistent across mental health services. Staff should be trained in how to assess, formulate and manage risk. Ongoing supervision should be available to support consistency of approach. There is little place for locally developed tools.

5. Families and carers should have as much involvement as possible in the assessment process, including the opportunity to express their views on potential risk. The management plan should be collaboratively developed. Communication with primary care may also be helpful.

6. Managing risk should be personal and individualised, but it is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and onward referral are all managed safely.

Patient pathway

Inpatients are at high risk of suicide, but individual level of risk varies depending on where they are in the patient pathway.

Approximately 25% of all suicide behaviours (typically ligature harm) occur during the first week of admission, and 21% of patients who completed suicide on the ward from 2008 to 2018 died within the first 7 days of admission.

Further on in the admission, 48% of deaths occurred in the first 4 to 5 weeks and 31% of deaths after 10 weeks from admission date.

Further considerations are required as patients move towards discharge to ensure that they have the right level of preparedness when transitioning from a relatively safe environment to a less controlled one.

It is vital to understand risk indicators alongside the patient history and to maximise engagement through therapeutic relationships. It informs individualised risk assessment to support staff in managing potential ligature harm risk.

Key considerations

- Can I identify potential ligature points and risks to safety?
- Is the layout sufficiently documented (for example, annotated ward layout, photos of areas, photos of ligature points)?
- Are there mitigations to minimise or eliminate potential areas of risk?
- Would I be happy/comfortable staying here (in other words, will the environment aid recovery)?
- Have I collected feedback from patients, experts by experience, staff, families and carers on the therapeutic value of this built environment?
- Are all staff familiar with their environment, aware of ligature points and how these may change over time (for example, because of wear and tear or damage) and aware of the mitigating controls (for example, collapsible furniture)?
- Are staff aware of the ligature risk of each patient in the context of each room or areas accessible by patients? Is this assessed, documented, and communicated within the team through individualised risk assessment and management plans?
- Are staff considering differing areas or rooms when assessing and assessing risk and responding to this by subsequent care planning (for example, differing levels of therapeutic engagement and observation dependent on the patients and the location)?

For the built environment, we have developed [specific guidance](#) that includes an recording template that you can use to help identify ligature risk points and take action to mitigate these depending on the level of risk and the areas to which they might apply.

Staffing and skills

The importance of an appropriately skilled and resourced workforce to minimise the risk of harm is not a new concept, but one that is enshrined in both regulatory and quality improvement requirements.

There are relatively few studies of patient safety in a mental health inpatient context, particularly those concerned with workforce and the impact on risk reduction in ligature-related harm.

Developing and retaining a confident, competent and psychologically robust workforce are key enablers of the interventions described in this guidance.

To understand the importance of the relationship between workforce issues and reducing ligature risks in built environments, we must first understand the broader challenges of workforce development.

In 2017, the Health Education England report *Stepping forward to 2020/21* estimated that NHS organisations lose 10,000 staff each year from mental health services. Staff leaving is often associated with poorer quality of care, which in turn may lead to an increase in self-harm, including ligature-related incidents.

Health Education England published competence frameworks for self-harm and suicide prevention in adults and older adults, and for children and young people, recommending skills and knowledge for professionals across a broad range of backgrounds and experiences, including professionals and volunteers who work in mental health, physical health and social care.

Skill mix

In 2016 the National Quality Board highlighted the importance of evidence-based staffing skill mixes in mental health settings.

Defining the ratio of both registered and unregistered staff to patients, other professionals (for example, psychologists and occupational therapists), and other team members (such as peer support workers and physicians' associates) and the wider multidisciplinary team (MDT) input are key to successful workforce skill mix.

Staffing numbers need to be agreed based on current acuity, environment, enabling access to specific treatments, infection prevention and control (IPC) requirements, time of day, and increased risk and/or observation levels in addition to bed numbers.

Education and training

There is little literature focusing on ligature risk but there has been some work on education and training in relation to suicide risk reduction.

The [2019 National Enquiry into Suicide and Safety in Mental Health Annual Report](#) noted that staff awareness was essential in reducing risk. The implication was that training would be the medium to do this.

It would appear from the literature that education and training is one element that can increase staff awareness of self-harm and suicide risk, including by the use of ligatures.

For senior clinical and estates team members, advanced ligature training would improve understanding of the anti-ligature environment and enable safer decision making.

The [Mental Health Staffing Framework](#) provides online resources to help develop leaders' awareness of the importance of, and practicalities involved in, developing local systems for ensuring appropriate skill mix and staffing levels.

Health Education England's [New roles programmes](#) may be beneficial in covering vacancies and reducing the need for use of agency staff, which is associated with improved patient experience.

Key considerations

Do we have processes that inform us of the safe staffing ratios and skill mix as a minimum, and in response to changing needs such as acuity, infection prevention and control measures and increased risks and/or observation levels?

- How do we review the skills, knowledge, and training needs of staff in response to particular areas of work?
- How do we know the skill mix and experience of our staff in response to the areas that they work?
- What are our agreements for minimum training, skills, and standards with temporary staffing providers?

Do we have the appropriate and relevant training for managing ligature harm minimisation with our workforce?

- What training do we offer staff in relation to the management and minimisation of ligatures?
- Which staff do we offer ligature minimisation and management training to and why?
- What training do we offer staff to identify risks, behaviour, potential triggers that may indicate a person may utilise ligatures?
- What training do we offer staff in relation to responding to a ligature event?
- How frequently do we require this ligature training to be carried out? Is it mandatory? Is refresher training mandatory?
- What induction awareness ligature training do we require temporary staff to do?

- How do we ensure that these skills are embedded and maintained in practice? How is this supported with the following activities:
- How is learning from incidents shared and actioned in new ways of working?
- How does learning from practice and incidents inform ligature training?

What is the available support for the wellbeing of staff following any incident involving ligatures that may have caused harm?

- What is the available support for the wellbeing of patients following any incident involving ligatures that may have caused harm?
- How, when, with and by whom are debriefs carried out?
- How do we include the management and minimisation of harm from ligatures within clinical supervision sessions?

Do we have a shared sense/standard procedure of how to carry out environment assessments to assess ligature risks and how to action these? ([see the section on the built environment.](#))

- How do we equip/train staff how to carry out ligature assessments with the environment?
- How do we communicate the findings of environmental assessments and the required responses and actions, including the reasons why, with our staff?
- Do we know areas where ligature events may more frequently occur from our incident data? How do we clearly communicate this with staff and temporary workers?

- Do we have appropriate expertise via a champion in the team or the service? How does this person(s) interact with the workforce to provide supervision and support?

Do we actively promote and maintain a psychologically safe culture through respect, mutuality, and person-centred care? Is this promoted in the following areas:

- Actively sought in recruitment at all levels and the selection process?
- How is this included in mandatory training?
- How is this included in career monitoring and development?
- How is this included in expectations for disciplinary procedures?
- How is included in the aim and ambition of the team? How is this monitored or appraised? How do we people know about it?
- How do our processes and procedures support staff and equip staff to raise concerns, potential hazards, and risks in relation to ligature harm?

Technology

Technology is now a central component in everyday living, and it is also developing quickly in health care. We should consider how we can use technology to help us with the challenges we face when trying to maintain patient safety.

It makes sense for us to use all available resources to understand and manage self-harm better. An individualised approach must be the priority because patients' needs and motivations differ.

Digital technology gives us new opportunities to provide inpatient services differently. With strong clinical leadership to embed a positive culture to support the use of technology, this can complement the therapeutic relationship, the most important element of patient safety.

Use of technology must be subject to checks on safety, accuracy, effectiveness and suitability. Other important considerations are the absence of much research on the benefits of technology and concerns about how using it can affect patients' privacy and dignity. Use of vision based technology should take into account a patient's need for privacy, and used only with the patient's consent or in their best interests as agreed as part of a recognised process.

Services must take care not to rely on technology as an alternative to direct staff involvement with patients. For example, personal involvement might identify risks or signs of distress that technology cannot. Any concerns could then be dealt with before the patient reaches a crisis.

Ward-based clinical staff may benefit from training on new products. This could be via a service level agreement by product providers or internal sessions. This would be in addition to regular ligature training.

There is more information about [Technology in care](#) on CQC's website.

Key considerations

Have all the steps in the guiding principles for procurement been followed?

Is there a shared understanding of the purpose of the technology – why are we considering the use of technological resources?

- Have we fully considered its impact on safety vs privacy and dignity for patients and is it being used with their consent? (see Therapeutic environment in the built environment chapter)
- How have we communicated the purpose to those who will operate/utilise the resource/equipment in the context of ligature risk?
- Have we fully considered and communicated to all staff the limitations/constraints of the technology concerning minimising ligature risk?
- Are there any implications relating to consent, confidentiality and/capacity?
- Does the resource/equipment require a maintenance program/review to monitor that it is fit for purpose in context of ligature risk?
- Is a contingency plan required should the resource/equipment fail to operate for managing ligature risk?
- Where relevant, how have we communicated the use of resource/equipment with patients and carers to ensure a shared understanding of purpose and use in practice?
- How does the resource/equipment impact on patient experience in creating a home-like environment?

Procurement

Service providers should:

- Increase collaboration between NHS providers on learning, evaluation and procurement of anti-ligature fixtures, fittings and furniture.
- Encourage agreement of national NHS standards in anti-ligature fixtures, fittings and furniture.
- Ensure that they follow manufacturer's instructions in maintaining and testing anti-ligature fixtures and fittings.
- Optimise confidence in using new products through training and measuring effectiveness using key performance indicators.
- Involve subject matter experts in procurement to enable scrutiny of any proposed product.
- Involve people who use services in procuring new types of products and technologies

(Although these recommendations were written for NHS trusts, they may also be applicable to independent providers of mental health care.)

Procurement staff should have ligature risks at the forefront of their thoughts when drafting a specification. Regional NHS Procurement hubs can help support trusts by sharing best practice from other regional and national organisations. Additional information can also be found on the online [NHS Estates Team Collaboration Hub](#) and in NHS England's [Estates Technical Guidance](#).

Guiding principles

Key considerations

Are we clear why we require to procure this/these items?

Is the procurement essential – could we look at different ways of working?

- What is the intended purpose of the equipment/resource? Is this understood across the team?
- Is this introducing new equipment?
- How does the selected equipment/resources comply with any national guidance/best practice? Contact your Estates department for the latest guidance.
- Has this been considered against possible ligature risk? Has it been reappraised against the procurement requirements?
- If a replacement, was the equipment/resource involved in any ligature events? (consider reviewing incident data to inform your answer)
- What does the incident records tell you about its use?
- How has this been considered against the previous questions?
- How has this been reappraised against the procurement requirements?
- Could the equipment/resource be used creatively as a component to contribute to a ligature event? E.g. using an item in a different way/context than it is intended. For example, a waste bin could be upturned and used as a stool to potentially reach a ligature anchor point.
- Service providers could consider asking manufacturers to have their products BRE tested before purchasing products

Have we considered the impact on patient experience in creating a home-like environment? (see the therapeutic environment in the built environment section)

- Has the range of options been risk assessed and considered in the context of potential ligature harm vs patient experience and therapeutic benefit?

- Where relevant and possible, have we consulted patients and carers regarding the proposed equipment/resource?

Bibliography and further reading

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The built environment: Reducing harm by ligature in practice

We have identified 4 key themes for ligature harm risk management in the built environment:

- **Co-design evidence-based approach ligature harm reduction planning:** Incorporate local expertise through collaborations with staff and experts by experience when reviewing ligature harm risks.
- **Therapeutic environment:** Consider the balance of safety versus privacy and dignity when assessing and controlling for potential ligature harm, including the extent to which restrictions may impact on patient recovery.
- **Individualised risk assessment:** Focus on individualised approaches to risk assessment rather than tools to predict future suicide risk and treatment. Minimise use of blanket restrictions to manage known risks to aid reduction in institutional dependence.
- **Integration into other aspects of treatment and care planning:** Consider the role of other aspects of treatment and support (for example, levels of observations) and how risk assessment should be integrated into care planning and therapeutic risk assessment and co-produced safety planning, where possible.

Further detail on these 4 themes is given below.

The figure below provides a systematic method for assessing ligature risk based on the identified themes.

We have also developed a recording template that can help you to identify ligature anchor point risks and take action to mitigate these depending on the level of risk and the areas to which they might apply.

As the built environment is only one facet of ligature harm reduction, it should be considered alongside the other elements of the overall guidance.

Figure: Assessing ligature risk

1. Collaborate with expert stakeholders

- Form a group with representation from clinicians, estates and experts by experience
- Add links out to senior leaders and commissioners

2. Understand the risk

- Identify themes in national and local data; staff experience and expertise; patient expertise
- Use the following factors to consider risk

2a: System process factors

- Current policies and procedures supporting staff
- Resource requirements (for example, additional staffing for higher level of therapeutic observation)
- Rapid induction process for agency/temporary staff

2b: Person-centred care factors

- Assess and plan care and risk in response to an individual's needs

- Consider the local ward environment
- Consider recovery-oriented practice and positive risk taking within a managed ward environment
- Balance risks and respond to individual privacy and dignity
- Co-produce activities and care plans

2c: Environmental factors

- Consider local design and identify challenges (for example, limitations to clear lines of sight)
- identify ligature material and anchor points
- Mitigate controls to restrict patient access to supervised/staff only areas
- Manage items brought on to the ward

Establish governance and assurance systems

- Instigate planned and ad hoc reviews of the built environment
- Created tiered and systematic risk assessment
- Develop policies and procedures that support staff to identify, monitor and manage risks
- Design clear systems to escalate risks and challenges that need immediate action (for example, maintenance work)

Disseminate and embed

- Disseminate current risk factors and approach to ligature harm reduction
- Establish a clear understanding of constant vigilance among all staff

- Focus on therapeutic and individual approaches to safety planning
-

Further guidance for the 4 themes

Co-design evidence-based approach ligature harm reduction planning

- Inpatient care environments, patient populations and relative ligature harm risks will vary by context and over time so there can be no standardised approach to assessing ligature risk.
- Providing the best approach to ligature harm reduction requires planning and should use a systematic approach that incorporates current understanding at a national level, local intelligence (incident data), and co-design that draws on the local workforce's experience.

- Practical steps towards this approach might include:
 - Creating a working group consisting of relevant staff and experts by experience to discuss local environments, and to influence the creation and review of local policy and local procedures. These activities could include ward walkarounds specifically to consider fixtures, fittings, and furniture in the context of safety and therapeutic value.
 - Discussions focusing on current data from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), shared learning from the National Mental Health and Learning Disability Nurse Directors Forum and local incident reports to understand areas for learning opportunities and environmental changes.
 - Discussions that actively consider the holistic impact of the built environment when managing ligature harm risk (for example, therapeutic environment – see below).

Therapeutic environment

- A therapeutic environment considers the extent to which the physical environment aids and facilitates privacy, recovery, and patient wellbeing. Therapeutic environments also affect staff efficacy and satisfaction, which influences therapeutic relationships, patient experience and staff retention.
- In this context we are referring to the therapeutic environment primarily as the structural features of a ward, how patients and staff interact with them, and how they may enhance patient recovery and experience.
- As described above, both intent and opportunity to self-harm inform the extent to which institutionalised or ‘home-like’ approaches should be considered.
- Services should be aware that potential new ligature risks might be introduced into the environment by the use of equipment necessary to support individual needs – for example, disability aids.

- Where possible and feasible, outdoor spaces should be incorporated into patient activities, providing opportunities to engage with nature as part of the therapeutic environment ([Health building note HBN 03-01](#)).
- Due to the diverse nature of outdoor spaces, these require special consideration for where they sit in the four tiers described above.
- Wherever possible, all ligature points must be removed or environmental control measures used. If this is not possible, individualised and process/system controls should be implemented (see the [guidance on tiers and mitigating controls](#) for examples).
- Technology may play a part in balancing patient safety with privacy and dignity. Use of vision-based technology should take into account a patient's need for privacy, and used only with the patient's consent or in their best interests as agreed as part of a recognised process. It should not be used alone but rather support therapeutic interactions and nursing observations.
- Devices that electronically monitor private spaces may appear less intrusive and disruptive than staff repeatedly entering a patient's space. Sometimes simpler solutions such as well-placed mirrors may provide methods for observing blind spots.
- In all instances, selected fixtures, fittings, and furniture should have a residential appearance and appear home-like as much as possible. For example, fluorescent strip lighting may be the choice for many inpatient settings but give the feeling of an institution. Other examples, such as adapted or boarded up fixtures, may also have similar effects.
- More generally, the use of colour, texture and natural materials provide a more residential appearance. Wherever possible, providing access to natural light and opportunities to view outside space is also beneficial. In areas where risks are known, and mitigation options are limited, wards should still consider options that offer a home-like feel, where possible ([Health building note HBN 03-01](#)).

- As described above, both intent and opportunity to self-harm inform the extent to which institutionalised or de-institutionalised approaches should be considered. Deciding the degree to which areas of a ward could focus on more institutionalised or de-institutionalised approaches can be aided by considering the 4 different tiers.

Personalised risk assessment and safety planning

- Wards should avoid generalised approaches to predicting suicide risk and provide a more individualised holistic approach to identifying indicators when considering patients' suicide risk.
- Assessments should include the broader aspects of a patient's life, including support provided by partners, families and/or carers, and how this may impact individual suicide risk.
- These assessments should consider patient history and markers that may increase suicide risk – for example, individuals with a history of self-harm, suicide attempts, and substance misuse alongside protective factors.
- It is vital that assessments consider the current mental state of the patient and, more importantly, encourage candid conversations through psychologically safe practice concerning any suicidal ideations they have.
- These assessments should occur frequently, and a dynamic approach should be applied to how the patient is managed during their stay.
- As much as it is important to consider their safety (and possibly increase restrictive practice), it is equally important to practise therapeutic risk-taking to encourage recovery.
- Therapeutic risk-taking should consider the extent to which patients have access to 'home-like' settings that act as a therapeutic environment and the impact of over-restrictive practices.

Integration into other aspects of treatment and care planning

- Managing ligature harm risk should be part of a wider process aimed at reducing patients' dependence on the relatively safe inpatient environment.
- Patients should have as much access as possible to a 'home-like' physical environment plus opportunities for person-centred activities and access to outdoor spaces, where possible. Where possible, discussions about risk and safety should include people that know the person best – for example, their carers and/or family members.
- When considering access to activities or outings, consider the therapeutic value and impact of the intervention alongside potential risks and how using risk-reducing controls can support the patient to take part in the activity.
- Practical steps such as bed allocation (for example, consider the bed location and lines of sight), accessibility, and ease of observation should be considered at the point of admission and reviewed during the patient stay and considered as part of the risk assessment and management plan.
- The therapeutic environment and interactions in it are especially important where patients are nursed using levels of supportive therapeutic observation. Observations, regardless of the level, should be viewed as an opportunity to engage with patients as appropriate, build trusting relationships and become familiar with the patients' routine, likes/ dislikes and personal needs and requirements.
- This is a skilled intervention and requires staff to use techniques such as active listening, empathy, discussing the patient's thoughts and feelings, and responding to non-verbal cues, as well as maintaining a therapeutic presence.
- Observations should also be used to re-evaluate risk frequently and to increase understanding of patients' feelings and motivations to aid risk assessment and care planning.

Ligature point recording template

This ligature point recording template has been designed to support staff in identifying and recording ligature risk points, controls and actions required to mitigate risks associated with the built environment.

It has been developed with support from 40 different mental health and learning disability trusts, including private sector organisations, along with experts by experience and people who use services.

The template is designed to be used in all areas where patients may be present. It is not designed to be used in areas such as the staff office or restroom that are not accessible to patients. These areas should already have management controls in place to stop patients coming into these areas.

This recording template should be used in conjunction with the supporting [Tiers and mitigating controls guidance](#).

Levels of risk

To support staff in identifying ligature risk points, risks are categorised into 3 levels or 'tiers':

- **Tier 1 (more of a residential feel/therapeutic focus):**

Areas where patients have high supervision and patients are not typically left alone for long periods.

- **Tier 2 (more of an institutional feel/safety focus):**

Areas where patients may spend time with minimal supervision; these will typically be freely accessed or open areas.

- **Tier 3 (more of an institutional feel/safety focus):**

Areas where patients may spend a lot of time alone with minimal or no supervision.

Ligature risk points identified in tiers 2 and 3 areas should be removed where possible. In some limited cases, for example if a ward or service is supporting patients to return to the community, it may be appropriate for the ligature point to remain. However, assessors should consider if the risk outweighs the need for a therapeutic environment, and may wish to include the rationale and/or mitigating controls in the assessment.

[See Tiers and mitigating controls guidance for full details.](#)

Mitigating controls

To support staff in taking appropriate actions to mitigate risks, for each level or 'tier' of risk, there are 3 risk mitigation control categories:

- **Environmental** – factors that surround the local design of the environment, patient access to different environments, staff awareness of their environments and consequent risks, and management of ligature material and anchor points.
- **Individualised** – factors relating to patient risk and care planning, level of therapeutic observations and engagement, recovery orientated practice, appropriate staffing levels/ skill mix.
- **System/process** – current policies and procedures that support staff to manage risk based on individualised assessment and support appropriate actions and resource requirements.

Each level or 'tier' of risk has specific factors to consider for each category of mitigation control, but please note that this is not an exhaustive list.

[See Tiers and mitigating controls guidance for full details.](#)

How to use the recording template

Part 1: Pre-assessment review

Aim: To help staff identify and understand local risks for individual wards/service areas before starting a visual ligature risk assessment.

Action:

- Carry out a desktop review of a variety of sources including, for example, previous incident data and ligature risk assessments, to identify risks and any trends in the data.
- Record whether these areas have been considered before.
- Review and record information about staff training, how ligatures are managed on the ward/service area, and how information is shared with staff, including flexible workers.

Part 2: Ligature point risk recording template

Aim: To identify and record any potential ligature anchor point risks, and record the controls and actions required for each risk.

Action:

- Carry out a visual inspection (walk around) of the ward/service area to review and assess ligature point risks.

- For every risk assessment, record:
 - Type of service (e.g. PICU, Older Adult)
 - Ward/unit/ area name
 - Ward/ unit/ area location
 - Ward/team manager
 - Date ligature point risk assessment completed
 - Date of last ligature point risk assessment
 - Names and roles of assessor(s)
- For every ligature risk identified, record:
 - Room/area name/identification code
 - Room/area description
 - Tier
 - Location of identified
 - Ligature anchor point
 - Description of ligature point
 - Existing controls/mitigating controls
 - Recommendation from assessment
 - Action required
 - How will actions be taken forward

Part 3: Local Information guide

Aim: To give an overview of the risks, controls and mitigations for the individual ward/ service area. This includes how to respond to a ligature event and how to report new ligatures risks.

Action: Using information from the desktop review and visual inspection, use this template to record:

- Specific identified risks and controls to minimise harm
 - Availability of items that may be used as a ligature and controls
 - How to respond to a ligature event:
 - Location/type of ligature cutters (include pictures if helpful):
 - Location of resus equipment:
 - Incidents debrief/ support/ learning arrangements staff and patients:
 - How to report a potential ligature risk e.g. damaged room/ area, new risk identified following a ligature event
-

Download the recording template

Ligature point recording template (Mental Health and Learning Disability Nurse Directors Forum)

[202311_MHForum_Ligature-point-recording-template.xlsx](#)

File title

Ligature point recording template (Mental Health and Learning Disability Nurse Directors Forum)

Tiers and mitigating controls

This guidance on levels or ‘tiers’ of risk and factors for mitigating controls for ligature point risks should be used in conjunction with [the ligature point risk recording template](#).

Tier 1

Low privacy/less opportunity to be alone. More reliance on clinical controls/more of a residential feel/more of a therapeutic focus.

Ward/service area type: Areas where patients have high supervision and are not typically left alone for long periods.

Examples (not limited to those detailed):

- Activity room
- Interview room
- Clinic room

Mitigating controls

Environmental

- Staff are familiar with the environment that they are working in and have enough awareness of risks relevant to this specific area (for example, ligature points).
- Options for managing ligature points:
 - Remove all identified ligature points.
 - Where removal is not possible, individualised/system/process controls must be applied to minimise risks in areas with known ligature points.
 - Consider use of potential technological solutions to aid risk management.
 - Patient access is restricted when staff are not present.

Individualised

- Individualised risk assessment and management, knowledge of individual patient risks and corresponding levels of therapeutic engagement and observation levels to ensure patient's whereabouts is known.

- Activities individually risk assessed before patients access area and undertake any activity.
- Appropriate staffing levels/staffing skill mix in accordance with patient acuity/risk management.

System/process

- Staff have undertaken awareness training and are competent in ligature management, therapeutic observation, and engagement.
 - Robust MDT meetings where individual risks are considered in the context of the specific environments patient can access. Assessments, management plans and therapeutic observation levels are made amongst the MDT members, rather than by one individual.
 - Local induction procedure for temporary staff (for example students and agency staff) regarding the individual ward/ unit area (for example, challenges to clear line of sight when undertaking therapeutic engagement and observations and known ligature point/ risk areas).
 - Shift handover systems that include clinical assessment of acuity, safety, and risk of each patient and corresponding management plans being discussed at every handover. A summary of any incidents occurring since admission should be highlighted at each handover.
 - Ensure at least one member of staff is always present in the room when it is accessible by patients
 - Management of and access to ligature material; protocols to manage items brought on to the ward by patients, carers/families and/or staff and correct disposal of personal protective equipment (PPE).
 - Search procedure available to support the reduction of ligature material entering the ward environment.
-

Tier 2

High privacy/greater opportunity to be alone. Less reliance on clinical controls/more of an institutionalised feel/more of a safety focus

Ward/service area type: Areas patients may spend time with minimal supervision.

These will typically be freely accessed or open communal areas.

Examples (not limited to those detailed):

- Lounges
- Day Rooms
- Dining Rooms

Mitigating controls

Environmental

- Staff are familiar with the environment that they are working in and have enough awareness of risks relevant to this specific area (for example, ligature points).

- Options for managing ligature points:
 - Remove all identified ligature points.
 - Where removal is not possible individualised/system/process controls must be applied to minimise risks in areas with known ligature points.
 - Consider use of potential technological solutions to aid risk management.
 - Consider any adaptations to/in the room or equipment needed in response to patients' individual needs and/or the Equality Act 2010, that may introduce ligature risks.
 - Environmental design that is conducive to clear lines of sight with minimal opportunity for blind spots and controls to mitigate blind spots (for example, safety mirrors, technological interventions).

Individualised

- Individualised risk assessment and management, knowledge of individual patient risks and corresponding levels of therapeutic engagement and observation levels to ensure patients whereabouts is known.
- Appropriate staffing levels/staffing skill mix in accordance with patient acuity/risk management.
- Staff awareness of limitations to clear lines of sight and these are considered when assessing individual risk and management plans and inform levels of therapeutic engagement and observations.
- The private nature of the environment is considered, and risk assessed to inform the individual level of therapeutic engagement and observations (for example, higher observation level may be needed in areas with higher levels of privacy).

System/process

- Staff have undertaken awareness training and are competent in ligature management, therapeutic observation, and engagement.

- Local induction procedure for temporary staff, (for example, students and agency staff) regarding the individual ward/ unit area (for example, challenges to clear line of sight when undertaking therapeutic engagement and observations and known ligature point/ risk areas).
 - Robust escalation plans, should observation of a patient not be possible at an assessed level, with staff awareness of these procedures (for example, raising alarm, location of ligature removal equipment, emergency response protocol).
 - Shift handover systems that include clinical assessment of acuity, safety, and risk of each patient and corresponding management plans being discussed at every handover. A summary of any incidents occurring since admission should be highlighted at each handover.
 - Management of and access to ligature material; protocols to manage items brought on to the ward by patients, carers/families and/or staff and correct disposal of personal protective equipment (PPE).
 - Search procedure available to support reduction of ligature material entering the ward environment.
 - Staff are knowledgeable about available adaptations/equipment that could maximise lines of sight.
-

Tier 3

High privacy/ greater opportunity to be alone. Less reliance on clinical controls/more of an institutionalised feel/more of a safety focus.

Ward/service area type: Areas patients may spend a lot of time alone with minimal or no supervision.

Examples (not limited to those detailed):

- Bedroom
- Bathrooms
- En-Suites
- Toilets

Mitigating controls

Environmental

- Staff are familiar with the environment that they are working in and have enough awareness of risks relevant to this specific area (for example, ligature points).
- To balance patient safety and dignity, removal or environmental mitigations and controls should be in place to allow privacy when using these areas – for example collapsible curtain/shower rails, anti/reduced ligature showerheads and doors.
- Consider any adaptations to/in the room or equipment needed in response to patients' individual needs and/or the Equality Act 2010, that may introduce ligature risks.
- Staff awareness of lines of sight, and where they need to be to maximise lines of sight.
- Technology to monitor private areas (for example, contact free patient management platform). However, use of vision based technology should take into account a patient's need for privacy, and only used with the patient's consent or in their best interests as agreed as part of a recognised process.-
- Consideration of use of differing environments to manage immediate risk – for example de-escalation suite, seclusion room, PICU transfer if appropriate.

Individualised

- Individualised risk assessment and management, knowledge of individual patient risks and corresponding levels of therapeutic engagement and observation levels.
- Appropriate staffing levels/staffing skill mix in accordance with patient acuity/risk management.

System/process

- Staff have undertaken awareness training and are competent in ligature management, therapeutic observation, and engagement .
- Robust escalation plans, should observation of a patient not be possible at an assessed level, with staff awareness of these procedures (for example, raising alarm, location of ligature removal equipment, emergency response protocol).
- Consideration of room location when bed planning (for example, rooms that are easily visible/ have clear line of sight/ near team office).
- Management of and access to ligature material; protocols to manage items brought on to the ward by patients, carers/families and/or staff and correct disposal of personal protective equipment (PPE).
- Search procedure available to support reduction of ligature material entering the ward environment.
- Staff are knowledgeable about available adaptations/equipment that could maximise lines of sight.