CareQuality Commission

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.

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