Somerset Partnership NHS
NHS Foundation Trust

Ligature Point Management Policy

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CONTENTS

1. INTRODUCTION

1.1 Patient safety is the highest priority for the Trust and its staff. Providing a clear approach to manage ligature risk, in line with best practice and legislative guidance, enables patients and the Trust's commissioners to have confidence in Trust services. The Trust is committed to identifying, removing or managing potential ligature points and other risks for suicide and self-harm within the inpatient environment.

1.2 Hanging is a significant method of suicide for mental health patients, whether as an inpatient or in the community. Hanging may involve suspension from a high ligature point but many deaths also occur through asphyxiation without suspension using a ligature point below head height.

1.3 A significant proportion of suicides are believed to occur through impulsive acts using the first means to hand and without time for reflection. Because of this, the *National Suicide Prevention Strategy for England (DoH) 2002)* states **likely** ligature points in mental health inpatient environments should be removed or covered.

1.4 Where it is not possible to remove ligature points the Trust will adopt other risk controls including changes to buildings, fittings, operational management and clinical management of the patient.

1.5 Death by hanging from non-collapsible rails in an inpatient setting is a NPSA "never event". Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative resources have been implemented.

1.6 Due to human ingenuity and/or a lack of a technical solution, it is not possible for all potential ligature points to be eliminated and am assessment has to be made about the likelihood of something being used as a ligature point. Equally, there may be some potential ligature points that need to remain, as removing them will create a greater risk to the patient, i.e. grab rails in older persons' wards / disability accessible rooms. Operational management systems need to be in place for these areas/equipment/ patients at risk. It is also impossible to eliminate all potential sources of ligatures, since articles of clothing as well as material from everyday items such as bedding can be used. The Trust must also need to balance the need to maintain patients' privacy and dignity.

1.7 This policy has been developed to help staff to address ligature risk in a balanced, objective and systematic way using a tool developed by Greater Manchester West Mental Health NHS Foundation Trust. It is intended to support Trust staff and to give an assurance of consistency in the implementation of Trust processes.

1.8 This policy should be seen as an integral part of other measures to reduce the risk of suicide. Clinical risk assessment, observation and engagement form part of the overall strategy for managing ligature risk and patient safety.

2. PURPOSE AND SCOPE

2.1 This policy intends to address the environmental and clinical risks which could assist an inpatient attempting suicide using a ligature. This policy does not cover other risk factors in suicide prevention. These are included within clinical risk assessments and policies associated with patient safety.

2.2 This policy includes guidance and an audit tool, for assessing potential ligature points and ligature risks and recording the assessment findings. Where ligature points are identified action must be taken. Actions can include management/operational/clinical solutions or physical solutions.

2.3 The policy aims to ensure an appropriate level of operational management of ligature risk is maintained for the safety of inpatients and prevention of suicide. That appropriate technical advice is sought and action taken regarding the specification of anti-ligature fixtures and fittings within the inpatient environment.

2.4 The Trust aims to provide safe and therapeutic environments for its mental health inpatients which are as free as possible of ligatures and ligature points. It will seek to eradicate as far as is reasonably practicable all potential ligatures and ligature points and, where this is not practicable, to manage the risks by monitoring them.

2.5 This document and the guidance contained within it apply to all Trust staff working in mental health inpatient wards whether Temporary, Locum, Bank, and Agency.

2.6 The following areas are required to conduct annual (as a minimum) environmental ligature risk assessments:

- all mental health inpatient wards (Rowan, Rydon, Willow, Ash, Wessex, St Andrews and Holford) with the exception of older people's wards;
- facilities accessible to mental health inpatients (i.e. therapies areas and day patients) in the above facilities.

2.7 The following areas are not currently required to conduct environmental ligature risk assessments:

- all non-inpatient clinical areas. However, staff still need to be aware of ligature risks when seeing patients in clinical settings (surgeries, etc.) if clinical condition indicates immediate increased risk;
- all non-patient areas;
- exterior areas;
- all non-mental-health facilities.

2.8 Environmental ligature risk assessments must be reviewed annually or where there has been significant change (i.e. change of use, modification of the building or after a serious incident involving suicide or attempted suicide using a ligature).

3. DUTIES AND RESPONSIBLITIES

3.1 The **Chief Executive** is responsible for ensuring governance arrangements are in place to effectively manage ligature risks and provide the resources necessary.

3.2 The **Chief Operating Officer** must ensure:

- implementation of policy;
- appropriate assessment and management of risks;
- effective delegation of responsibilities*;*
- effective support for managers' decisions and recommendations to enable the provision of appropriate services;
- staff are adequately skilled and experienced to safely undertake their work;
- appropriate reporting procedures are in place;
- provide resources to enable appropriate action to be taken in light of priorities identified in ligature audit assessments.

3.3 The **Head of Corporate Business** will:

- conduct ligature point audits at least annually or sooner if any structural or decorative changes or improvements are made to the environment, or if there are any significant/serious incidents. These audits will be forwarded to the ward manager for approval and completion of an action plan;
- ensure ward managers are aware of the details of the ligature point audits and understand their part in ensuring any control measures are implemented correctly;
- inform relevant Head of Division about all significant risks identified;
- review the assessments annually or whenever circumstances change, acting upon the outcomes of those reviews as appropriate;
- ensure clinical staff are aware of the policy guidance relating to ligature risk;
- monitor the results of ligature risk audits and ensure these are shared within the relevant forums and action plans are developed and implemented.

3.4 The **Head of Division** with responsibility for inpatient mental health services will:

- satisfy themselves annual ligature audits are undertaken or sooner if any structural or decorative changes or improvements are made to the environment;
- ensure they are aware of all risks identified and the risks and the control measures have been communicated to all staff;
- inform the Chief Operating Officer of all significant risks identified;

- ensure action plans are agreed and executed following ligature audits and the process of risk assessment is ongoing;
- allocate the resources and time required to implement the action plans resulting from the ligature audits;
- organise any ligature risk reduction training to manage and undertake risk assessment effectively;
- ensure any local procedures produced supports this policy are regularly reviewed;
- ensure appropriate records are kept of site audits and risk assessment activity is undertaken regularly and thoroughly.

3.5 **Ward Managers** will:

- following completion of ligature audits, ensure risk assessments and local action plans are developed in their wards and assessments and actions taken are appropriately recorded;
- ensure their staff are aware of the details of the risk assessment and understand their part in ensuring any control measures are implemented correctly;
- complete risk assessment(s) on significant ligature risks identified;
- inform their Head of Division of all significant risks identified;
- review the assessments annually or whenever circumstances change, acting upon the outcomes of those reviews as appropriate;
- undertake training to manage and undertake risk assessment effectively;
- ensure their staff have the skills to enable them to identify and assess those risks associated with ligatures and anchor points.

3.6 The **Head of Estates and Facilities** will:

- Ensure the Estates team engage contractors and maintenance providers with previous experience of working on mental health wards in support of the management of ligature risks
- Engage project managers and design teams with previous experience in mental health ward design to provide a resource for those planning inpatient environments
- Provide estates support and membership to a Trustwide Environmental Risks Group

3.7 All **Members of Staff** members have a duty to safeguard their own health, safety and welfare and that of patients and colleagues. The Health and Safety at Work Act 1974 states the following duties:

- every employee has a duty of care for the health and safety of people at work and of other persons who may be affected by work activities;
- employees must take care of themselves and others at work and co-operate with the implementation of health and safety systems.

Staff have a duty to follow all safe systems of work, procedures, and clinical management plans in place to control the risks of suicide. Furthermore, staff must report any hazard that could increase risk of suicide using a Datix Incident Report Form. This information should be reported to the nurse in charge/manager immediately and, where appropriate, staff should take immediate compensating action; such hazards may include for example broken collapsible curtain track, improperly fixed collapsible rail, unlocked door to a secure non-patient area, which contains ligature points etc.

All staff (including bank and agency staff) on every shift should be familiar with the location of the unit's ligature cutter and how to access it.

3.8 **Project Managers for refurbishment/new build project work** must ensure new builds and refurbishments and other projects include instructions and formal sign-off from the Clinical ligature point lead in regards to potential ligature points. As part of this process consideration will be given to the elimination of ligature points by formulation of a project group including Clinical ligature point lead, Patient safety advisors, Health and Safety and Security staff to develop and agree the project specification and selection of anti-ligature products sourcing (where reasonably practicable to do so) appropriate fixtures and fittings suitable for the project. Such building specification will need to carefully balance the needs of providing a safe environment with a therapeutic environment. Consideration will be based on the needs of the patients who will be using the building and reference to relevant DoH guidance, safety alerts, Healthcare Technical Memorandums (HTMs) and Health Building Notes (HBNs). Where possible ligature risks will be engineered out to prevent suicide in all project work undertaken.

4. EXPLANATIONS OF TERMS USED

4.1 **Ligature** could be defined as any piece of clothing, cordage or any item that can be tied or fastened around the neck, which could be used when tied to an object as a tie or noose to self-harm by strangulation or hanging.

Examples include:

- plastic bags;
- belts;
- shoe laces;
- electrical cable flex;
- ties;
- rubber strips (from door seals, double glazed windows, etc);
- torn strips of clothing or bedding;
- phone charger leads.

4.2 **Ligature Point** is a fixture, fitting or construction element within an internal or external environment that can be accessed by a patient.

This can be used to secure a ligature to, where the whole, or significant part of the patient's weight can be suspended.

Anchor points can include;

- the gaps between a window or door and its frame;
- window, cupboard or door handles;
- coat and towel hooks;
- window curtain, bed curtain and shower rails;
- shower heads and shower controls;
- sink taps, plug and waste;
- window, door or cupboard edges and frames;
- door hinges, pivots and self-closers;
- ventilation grills ceiling vents and ducts.

4.3 **Anti-ligature fittings**

An anti-ligature fitting is any fitting designed in such a way as to prevent a ligature being attached to it. There is no British Safety Institute or international standard for these fittings and no fitting or product can be considered as ligature proof.

An anti-ligature fitting should:

- cause the ligature to slip off;
- the fitting should break away from its mount (at 20 Kg or less) when placed under pressure of weight.

5. POLICY STATEMENT

5.1 The policy of the Trust is that all areas listed under the Scope (section 2) of this policy are required to conduct annual assessments to identify ligature points.

5.2 The policy of the Trust is to remove all ligature points considered to pose a significant risk to patients so far as is reasonably practicable. Where this is not possible, safety is to be maintained through robust operational controls which mitigate the risk, such as through nursing observation and clinical risk assessment documented in individual patient care plans.

5.3 Environmental difficulties in observing patients, where identified, are communicated to staff and remedial action is taken as far as possible as part of this risk assessment.

5.4 Each ward shall have arrangements with their maintenance provider in place to instruct the removal of likely ligature points identified during on site clinical inspections. The ward staff are to sign-off satisfactory completion of the ligature point removal.

5.5 Each ward should have a ligature cutter available at all times.

5.6 In the cases of patients at high risk of suicide, staff should refer to the relevant Trust clinical policies for advice on operational management.

5.7 The policy also requires a daily safety walk is carried out in each inpatient ward to ensure risks are managed as far as is reasonably practicable. The

purpose of these inspections is to check for any new ligature points, risks, or loss of safety controls. This duty is not to repeat the whole risk assessment but to identify any damage, tampering with fittings or changes that could lead to increased risk of suicide. Such checks should be noted within the area's log or security log and any issues acted upon without delay. Such incidents should be reported on Datix.

5.8 All risk assessments produced as a result of the ligature audits must be reviewed at least annually or when a change occurs to the environment, the service provided or as the needs of individual patients dictate.

5.9 The Trust will periodically issue guidance and good practice advice to managers by the Ligature Point Management Group as part of its continual review and assessment of ligature risks

6. APPROACH TO RISK ASSESSMENT AND RISK MANAGEMENT

Risk Assessment Methodology

6.1 The Trust uses an environmental ligature risk assessment based around the Manchester Audit tool. Guidance for assessing environmental ligatures is given in Appendix A of this policy.

6.2 The Head of Corporate Business will visit the designated clinical area with a member of the Estates Team and ward staff to check all parts for what they consider to be likely ligature points. The Head of Corporate Business will then list all identified likely ligature points on the audit form. This will be forwarded to the ward manager for approval. This is the preferred method of recording an assessment a word version of the above can be found in Appendix C of this policy.

6.3 The Trust has a clinical risk assessment policy which should be used to assess individual patient risks.

Risk Management

6.4 Once the ligature risk rating is determined, any existing controls should be considered and these recorded on the assessment form. These compensating actions may be sufficient to reduce the risk of the ligature to an acceptable level – this is called the residual risk.

6.5 Managers should consider the strategies in the table on the following page for controlling ligature points. It is important to consider elimination is the best risk management solution but may be technically impossible or lead to a poor therapeutic environment.

6.6 The risk assessment is a tool to assist in the identification, evaluation, and appropriate control of ligature risks. It is essential where risks have been identified control strategies and actions are instigated and these are reviewed to ensure the controls remain appropriate.

6.7 It may be possible action is taken within the team (i.e. simply by removing a particular item that could be used as a ligature or changes to operational procedure) although it is highly likely many ligature points will require some significant expenditure to control. In these cases, immediate escalation to the next level in line with the Risk Management Policy is required.

6.8 During this time, it is important to ensure other appropriate actions are taken to reduce the on-going risk to the lowest level possible with consideration to closing the particular areas only if the risk remains unacceptable.

6.9 The audit tool at Appendix A is used to identify each ligature point and is not a risk assessment and therefore a risk assessment must be completed for all significant risks identified.

6.10 The Head of Corporate Business must visit all areas of the ward, excluding the garden, courtyard and adjacent public or private areas to the ward which patients do not have access to.

6.11 Where ligature points have been identified and recorded on the audit tool, ward managers must formulate a risk management plan for significant risks (or a group of risks that are the same in each room, for example) that have been identified to ensure suitable and immediate controls measures are put in place to safeguard patients.

6.12 Ward managers must escalate the identified risks to their line manager or in their absence to the Head of Division and communicate risk and immediate control measures to all staff.

6.13 The ligature point audit tool and any subsequent risk assessment must take into account the level of possible clinical risk presented by the patients on the ward.

6.14 The ligature point audit tool should classify any fixed or portable ligature risks as low, medium or high and having considered this in context of the level of patients' risk, identify clearly any actions to be taken to eliminate, reduce, or manage the risks by the ward or home.

6.15 **The outcome of ALL risk assessment and control measures identified MUST be shared with all staff working in the area assessed as many of the identified risks will involve interaction and monitoring of patients by staff.**

6.16 **Risk Reduction Strategies**

Remedial Action	Description Definition
Eliminate	The risk is deemed to be of such a nature that to leave it would put the patients at risk. The ligature point is removed and the surface finishes made good, as it is either no longer needed or that there is no suitable alternative.
Eliminate or Substitute	The risk is deemed to be of such a nature that to leave it would put the patients at risk. The ligature point is removed and replaced with anti-ligature equipment or materials.
Substitute and Renew	The risk is deemed to be of such a nature that to leave it would put the patients at risk. The ligature point is engineered out and alternative innovative equipment or materials are installed.
Protect	Provide materials that hide or encapsulate the potential ligature point.
Operational management	The ligature is of a nature that the manager believes it is unnecessary to remove **OR** There is no technical solution to the problem i.e. doors **OR** The need to keep the risk because of potential injury is greater than the potential of an attempted suicide, i.e. grab rails within an older patient's toilet, collapsible curtain tracking falling down when pulled on an organic older adults ward.
Clinical Management	The patient is managed in accordance with assessment need and risk assessment documented in their care plan.

7. OLDER PEOPLE

7.1 Older people admitted to Pyrland and Magnolia Wards may present with risks including self-harm / suicide, e.g. by ligature, in addition to high risk of falls and other risks. The need to provide a safer environment for these patients must be balanced with the need to meet their other care needs, such as mobility, visual impairment, limited dexterity and orientation to a familiar environment.

7.2 The ward environment must be balanced between the need to reduce ligature points without compromising other aspects of patient safety, most notably the risk of falls. The approach to managing these risks will be through the use of detailed clinical risk assessment and the use of the Therapeutic Observation Policy. Where appropriate, the patient may be

transferred to a Trust Adult Mental Health acute ward with appropriate support until they are assessed to be no longer at risk of self-harm.

7.3 All older patients receive a detailed risk assessment which is regularly reviewed by the clinical team. If a risk of suicide of self-harm is indicated, ward staff will determine the appropriate level of therapeutic observation to ensure the patient's safety including consideration of additional staffing to support the patient in these wards.

8. DEVELOPMENT PROJECTS, NEW BUILD OR REFURBISHMENTS

8.1 At an early stage of project planning it is important for consultation to include relevant Trust advisors to reduce ligature points.

8.2 Late assessments will inevitably lead to additional problems and costs for rectification.

8.3 Consideration should be given to such items and areas as building layout, building fabric, choice of furnishings, fixtures and fittings, equipment, hardware and ironmongery.

8.4 With refurbishment projects, the opportunity should be taken to carry out a ligature point survey to ensure new risks are not introduced by those planned changes and identified risks can be reduced or eliminated as part of the project.

9. DESIGN CONSIDERATIONS

9.1 Spaces where patients may not be continually supervised by staff (for example in bedrooms and toilets) should be designed, constructed and furnished to make the use of ligature points as difficult as possible.

9.2 Wherever possible/achievable all fixtures and fittings should be anti-ligature in acute inpatient ward environments.

9.3 All fixtures and fittings such as window and door furniture, door closers and hinges, taps, showerheads and coat hooks should be anti-ligature, robust and able to withstand sustained attack. In general, all fixtures and fittings should be specified, manufactured, fitted and maintained to help prevent the possibility of accidents, misuse or use as weapons or to aid self-harm. Local risk assessment is necessary, with fitting according to manufacturers' instructions. Projections, level surfaces that could form hook points, and horizontal rails or similar are also to be avoided.

10. TRAINING REQUIREMENTS

10.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix.

10.2 All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

11. EQUALITY IMPACT ASSESSMENT

11.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

12. MONITORING COMPLIANCE AND EFFECTIVENESS

12.1 The Clinical Governance Group which will receive quarterly reports of ligature and ligature point incidents.

12.2 The Health, Safety and Security Management Group will receive an annual report on Trust anti-ligature audits, or more frequently if required.

12.3 The maintenance of local risk registers.

12.4 Managers to report risks using Datix forms, ensuring a systematic approach to enable learning from adverse incidents.

12.5 Monitoring of NPSA (2008 Guidance – Appendix B) Seven Steps to Patient Safety in Mental Health.

13. COUNTER FRAUD

13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

14. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

14.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 17:	Good governance

14.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18:	Notification of other incidents

14.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

15. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

15.1 References

Key Documents and NICE guidance

- Greater Manchester West Mental Health NHS Foundation Trust (2004) Prevent Suicide by Hanging and Asphyxiation Ligature Point Audit Tool
- National Patient Safety Agency; Seven Steps to Patient Safety in Mental Health (2008)
- National Suicide Prevention Strategy for England (2002) Department of Health
- National Suicide Prevention Strategy for England: Annual Report on Progress (2004) National Institute for Mental Health England Available at: www.csip.org.uk/silo/files/ligature-audir-tool2-pdf.pdf
- Preventing Suicide – A Toolkit for Mental Health Services (2003 National Patient Safety Executive
- Health Building Note 03-01: Adult acute mental health units (Dept. of Health, March 2013) at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03-01_Final.pdf

15.2 Other Trust policies

- Health and Safety Policy;
- Risk Management Policy and Procedure;
- Clinical Assessment and Management of Risk of Harm to Self and Others Policy;
- Observation while Maintaining Safety and Patient Engagement Policy;
- Search of Patients, Persons and Property Policy;
- RCPA Policy.

16. APPENDICES

Appendix A	Undertaking And Environmental Ligature Point Assessment
Appendix B	Ligature And Ligature Point Definitions
Appendix C	Ligature Points Assessment Sheet
Appendix D	Ligature Audit Action Plan Report
Appendix E	Guidance On The Use And Storage Of Ligature Cutters

APPENDIX A

Undertaking an Environmental Ligature Point Risk assessment

Managing risk is neither, a discrete activity or precise science. It is also unlikely risk can be entirely removed. The most effective approach entails a whole system approach and this audit aims to capture the salient points and therefore provide ward managers with a toolkit which makes ward environments as safe as possible.

Risk is dynamic, environments change, patients and staff change and the way in which the ward is used changes every day.

The audit focuses upon five dimensions;

1. Room Designation Rating (Score from 1 to 3)
2. Patient Profile Rating (Score from 1 to 3)
3. Ligature Point Rating (Score from 1 to 3)
4. Type of Ligature Point
5. Compensating Factors (Score from 1 to 3).

Who does the Inspection?

The entire internal ward area will be audited by the Head of Corporate Business, the ward manager and a senior member of ward staff. It is the ward manager's responsibility to action all identified uncontrolled risk and where this is not immediately possible to ensure the area is made as safe as is reasonably practicable and report this to their service manager.

The ward manager will ensure all areas under their control are audited and a final report is forwarded to their respective line manager and for any necessary further action.

How long will the Inspection take?

The size of the ward and the type of service it provides is an important factor in deciding the overall level of risk. Experience suggests it will take a minimum of four hours to complete a comprehensive audit of one ward.

Areas which should be inspected?

All internal areas should be audited. External areas may contain numerous potential ligature points which may not be possible to eliminate. Individual risk assessments of patients and their ability to access these areas must be made and reviewed regularly.

It is acknowledged that very few areas can be completely safe but all can be made safer through collaboration with other agencies and departments, e.g. other parts of the service; other services; Estates and Facilities and the Risk and Safety Team.

HOW TO CARRY OUT THE MANCHESTER LIGATURE POINTS AUDIT

ROOM DESIGNATION RATING

Each room in the clinical area will have its own priority. This is rated according to the amount of time most patients will spend in the room without direct supervision from staff or those with unobserved opportunity e.g. toilets. For example: most patients will spend periods of time unsupervised in their bedroom or in the shower. This rating is an assessment of the **opportunity** a patient could have to use a ligature point. Auditing teams are expected to score the room designation according to usual staff supervision practices in the clinical area being audited. The ratings are to be in three groups as follows:

Room Designation Rating: 3	**Room Designation Rating: 2**	**Room Designation Rating: 1**
Most patients spend periods of time, in private, without direct supervision of staff: All bedrooms Toilet areas Shower / Bathroom areas Single Sex sitting rooms Some Smoking rooms Other isolated areas of the ward	Most patients spend long periods of time with minimum direct supervision of staff and are usually in company of peers: Day rooms Dining rooms Unlocked therapy rooms Unlocked offices Unlocked Store rooms Unlocked Utility rooms Unlocked Kitchens Some Smoking rooms	Areas where there is traffic from staff and patients moving through or rooms are inaccessible: General circulation spaces Corridors Locked rooms

Where risk(s) have been identified these should be recorded on the audit form.

Once a risk has been identified, the local management team must take appropriate and timely action to manage any uncontrolled risks and make sure all staff are aware of it.

Where management or removal of a risk is not immediately possible, a more detailed review is required and must be raised with the service manager and a report submitted to the respective Head of Division. Support may be also sought from a member of the Estates or Risk and Safety Team.

PATIENT PROFILE RATING

While mental health patients are at greater risk of suicide than the general population, some patient groups are more vulnerable and susceptible to suicide risk than others.

Clinical areas cater for different functional groups of patients who can, therefore, be profiled into groups who could have a significant, moderate or low **potential** to use ligature points.

Where a clinical area cannot be defined in terms of patient group, then the rating must be based on the most vulnerable patient within the group.

It is not possible to individualise a room to a patient due to movement of patients within services. The following table suggests a risk rating with associated scale. Please note that the ratings, once again, are in three groups (1, 2, and 3):

High Risk Patient Group: 3	Medium Risk Patient Group: 2	Low Risk Patient Group: 1
Patients with acute severe mental illness	Patients with chronic or enduring mental health problems	Patients in self-care groups
Patients who are unpredictable	Patients who are susceptible to periodic relapses or sub-acute episodes	Patients in rehabilitation
Patients who are depressed	Patients who are not symptom free (e.g. delusions/hallucinations)	Patients who have never been assessed as being at risk of suicide
Patient/s who are, or have been, of high risk of suicide or severe self-harm	Patients who have been assessed as NOT being an immediate risk of suicide	
Patients in initial recovery stage following suicide risk or on 1 to 1 observations		
Young people		
Patients with challenging behaviour		
Patients with chaotic behaviour		
Patients with concurrent substance misuse issues		
Patients with concurrent severe social need e.g. (marital / family breakup, financial concerns etc.		

Where risk(s) have been identified these should be recorded on the audit form.

LIGATURE POINT RATING

This rating scale identifies a potential ligature point in relation to its position in the room. As you stand in a room, you will be able to visualize the room as comprising of three levels of potential risks, 1, 2 and 3 (see table below):

ROOM HEIGHT

TOP AREA OF ROOM	**LOW RISK: 1** 4 metres & above
	HIGH RISK: 3 Between 1700mm & 4metres
MIDDLE AREA OF ROOM	**MEDIUM RISK: 2** Between 700 & 1700mm
LOWEST AREA OF ROOM	**LOW RISK: 1** Up to 700mm

Any ligature point identified in the area between 1.7m & 4.0 metres of the room must be scored at 3**,** given that it is the most obvious area in which a patient could hang himself or herself.

However above 4.0 metres access to the very top of the room is greatly restricted unless ladders are available and is to be scored as level 1.

Anything in the middle section of the room (0.7m – 1.7m) is rated at 2 and anything in the bottom area (below 0.7m) of the room at 1.

Where risk(s) have been identified these should be recorded on the audit form.

TYPES OF LIGATURE POINT

The following table is intended to assist auditing teams in the identification of **likely** ligature points. It must be noted that these lists are NOT EXHAUSTIVE

Bedrooms	**Bathrooms/ Toilets/ Showers**	**Lounges/ Quiet/Therapy Rooms**	**Corridors**
Windows – Frame, Handle, Hinges, Restrictors	Windows – Frame, Handle, Hinges, Restrictors	Windows – Frame, Handle, Hinges, Restrictors	Windows – Frame, Handle, Hinges, Restrictors
Doors – Frame, Architrave, Handle, Hinges, Door Closer, coat hooks	Doors – Frame, Architrave, Handle, Hinges, Door Closer, coat hooks	Doors – Frame, Architrave, Handle, Hinges, Door Closer, coat hooks	Doors – Frame, Architrave, Handle, Hinges, Door Closer, coat hooks
Rails / track – Curtains, Shower, Wardrobe, Blinds, Towel, Grab rails	Rails / track – Curtains, Shower, Wardrobe, Blinds, Towel, Grab rails	Rails / track – Curtains, Wardrobe, Blinds, Grab rails	Rails / track – Curtains, , Blinds, Grab rails
Pipe work – Sink and Shower Hot and Cold water, Toilet, Heating and radiators, Ducting	Pipe work – Sink and Shower Hot and Cold water, Toilet, Heating and radiators, Ducting	Pipe work – Sink Hot and Cold water, Heating and radiators, Ducting	Pipe work, Heating and radiators, Ducting
Ceilings – False ceiling panels, air vents and diffusers, light fittings, alarm	Ceilings – False ceiling panels, air vents and diffusers, light fittings, alarm	Ceilings – False ceiling panels, air vents and diffusers, light fittings, alarm	Ceilings – False ceiling panels, air vents and diffusers, light fittings, alarm

receivers, Hatches, smoke detectors	receivers, Hatches, smoke detectors	receivers, Hatches, smoke detectors	receivers, Hatches, smoke detectors
Walls – wall lights, pictures, mirrors, light switches, plug sockets, vents, and Extractor fans.	Walls – wall lights, pictures, mirrors, light switches, plug sockets, vents, and Extractor fans.	Walls – wall lights, pictures, mirrors, light switches, plug sockets, vents, and Extractor fans.	Walls – wall lights, pictures, mirrors, light switches, plug sockets, vents, and Extractor fans.
Sinks – pipe work, taps, soap dishes / dispensers, paper towel holders, sink plugs, waste pipes	Sinks – pipe work, taps, soap dishes / dispensers, paper towel holders, sink plugs, waste pipes	Sinks – pipe work, taps, soap dishes / dispensers, paper towel holders, sink plugs, waste pipes	
Beds – Can they be stood up on end?, Headboard and footboard, Controls, cables and actuators	Wardrobes / Cupboards – Doors, Handles, Hinges, rails, coat hooks, shelves.	Wardrobes / Cupboards – Doors, Handles, Hinges, rails, coat hooks, shelves.	
Wardrobes – Doors, Handles, Hinges, rails, coat hooks, shelves.	Showers – Shower head, controls, pipe work, towel hooks / rails, extractor fans		
Showers – Shower head, controls, pipe work, towel hooks / rails, extractor fans			

COMPENSATING FACTORS

Compensating Factors - positive aspects of a situation that offsets equally negative aspects, and vice versa.

Compensating Factors are things which would reduce the risk.

For example, the use of continuous observation at the time of the audit will not count as a compensating factor because this is a temporary clinical management strategy and not a permanent feature.

However, if use of a ligature anchor point would require a degree of ingenuity, this makes it less likely that it would be used impulsively, so the score would be reduced.

The following table of examples is NOT EXHAUSTIVE and local variations may also apply:

High Risk Remains: 3	**Medium Risk remains: 2**	**Medium Risk remains: 2**	**Medium – Low Risk: 1**
Limited observation through poor design	Good observation through good design	Limited observation through poor design	Good observation through good design
Limited Staff	Limited Staff	Good staffing Levels/skill mix	Good staffing levels/skill mix

CALCULATING THE RISK

In order to determine the level of risk a prioritisation score is given to each location.

How to score the risk:

Multiply the Room Designation Score x Patient Population Profile x Ligature Point Rating x Compensation factor, e.g.:

Bedroom (room designation), acute inpatient (patient population profile), weight-bearing coat hooks at head height (ligature point), and no permanent staff supervision (no compensatory factor):

3 x 3 x 3x 3 = 81.

The maximum score for any ligature point is 81. *Exposed pipes* at just above floor level (below 700 mm) rather than coat hooks in such a room would mean a score of:

2 x 3 x 1 x 3 = 27.

ACTION FOR WARD MANAGER FOLLOWING THE AUDIT

This audit is about reducing the ‘obvious’, ‘attractive’ or ‘opportunistic’ ligature points and ligature items that might enable or provide a patients in distress an opportunity to act upon their thoughts and feelings.

It is recognised most wards have already done a lot of work around these issues and it is important ward management and staff monitor the environment to ensure any measures in place are still effective.

It is important all risks that cannot be controlled effectively are recorded and brought to the immediate attention of senior manager.

These risks will have to be controlled through therapeutic engagement and observation of patients until such point funding can be identified to reduce or eliminate them.

The ward manager and service manager should consider seeking support from the Estates Team and / or the Risk and Safety Team for any risks considered to be not adequately controlled.

Where a ligature point can be removed easily by maintenance staff, the ward manager should contact the Estates help-desk to have this done, stating it is a safety priority.

Where reduction or removal of a ligature point requires significant investment by the Trust, the ward manager is required to report this to the service manager and a risk assessment should be raised and placed on the local risk register.

APPENDIX B

LIGATURES AND LIGATURE POINTS

Ligature

A ligature can be defined as anything a person can use to hang or strangle themselves with.

It can be made from anything that can be used to form a noose which may be used for self-strangulation and not necessarily obviously able to support body weight.

Examples:

Clothing accessories - Belts, braces, laces, stockings, tights, bras.

Plastic bags – carrier bags, rubbish bags, clinical waste bags.

Cords – Lighting pull cords, curtain pull cords, cord from curtain header tape, draw cord on bags, venetian blind pull cords or chains.

Clothing – shirts, blouses, t-shirts, ties, trousers (all which can also be torn up into strips or made wet).

Chains, ropes, hoses, string.

Curtains – shower curtains, window curtains, cubicle curtains.

Bedding (also when torn into strips).

Electrical leads, flex, telephone flex, mobile phone charger leads, head phone leads.

Rubber strips – from fire doors, double glazing, dust strips on cubicle curtain tracking.

This list is not exhaustive.

Ligature point

A ligature point is a solid point which would support body weight using anything from the list above which can be formed into a noose or a knot and can be attached to it.

It is often commonly thought that there is a requirement that a ligature point requires height, but the actual height needed could be as small as a few inches with the patient being able to slump sideways from an almost seated or even prone position.

Examples:

Doors – trapping a ligature between door and frame, particularly at the top; or from the top edge of an open door (this has been used with wardrobe doors); door self-closing mechanism.

Door hinges – either from the hinges themselves from the part of the hinge that is sticking out from the door; or by trapping a ligature in the door above the hinge; or tying a ligature around the hinge.

Handles – bedroom door handles, en-suite door handles, wardrobe door handles; chest of drawers and cabinets in service users rooms; toilets, shower rooms and bathrooms door handles.

Ceiling fittings – lights, air vents and diffusers, smoke detectors, extractor grills.

Curtain tracks – shower curtains, bed cubical tracking, window curtains.

Windows – trapping a ligature between window and frames; window handles; window opening restrictors, window locks.

Pipes – radiator pipes, hot and cold water pipes, tumble drier ducting.

Wall fittings – fire alarm bells, soap dispensers, paper towel dispensers, shelves, fire alarm call points, coat hooks, pictures and paintings, mirrors, cabinets, fire door electric or magnetic 'hold-back'/'hold-open' devices, alarm panels, key cabinets, wall mounted TV's, wall lights, patients' alarm/call points, disability rails/grab bars, stair rails.

Beds - bed head / headboard, beds upended or propped up on their end / against the wall, profiling beds from frame or actuating mechanism.

Cupboards - shelving, coat hooks, wire coat hangers, clothes racks, cupboard doors and handles.

Building structure – false ceilings, loft hatch, maintenance access hatch / panel.

Outside space - trees, fencing, gazebos', covered walkways, guttering, and rain-water down pipes.

Suggested vulnerable areas within inpatient wards

High Risk:

Places where patients are alone and away from staff and other patients e.g. bedrooms, en-suites, bathrooms, shower rooms and toilets. Other high risk areas are those which are out of direct sight of staff or other patients e.g. stairwells, lifts.

Medium Risk:

Areas where patients may be unsupervised for periods of time but are within the general ward or department environment. Contact with other patients or staff may be occasional, dependant on number of patients on ward and staff duties.

Examples may include gardens, designated smoking areas, activity/therapy rooms, lounges, kitchens, etc.

Low Risk:

Common areas where patients are routinely supervised and/or in the company of other patients e.g. dining rooms, main corridors, reception to the ward, etc.

Again it is important to note whilst categorising areas according to their level of risk nothing is entirely predictable and opportunistic risks arise within any environment.

Removing ligatures points is only ever part of the means by which the risk is managed and a whole systems approach must also consider the level of engagement and knowledge of individual patients' illness and risk they present. Managers should also consider the following:

- The use of the environment for the risk patients present;
- Any management issues such as staffing levels and staff skills.

APPENDIX C

LIGATURE POINTS ASSESSMENT SHEET

Ward	
Names of Assessor(s)	
Date	

Room Number	Room Type and Rating	Patient Population Profile and Rating	Ligature Point and Rating	Compensatory Factor and Rating	Total

APPENDIX D

Somerset Partnership NHS
NHS Foundation Trust

LIGATURE AUDIT ACTION PLAN REPORT

Division ……

Name of Inpatient Ward……

Audit completed by ……

Date ……

Please record below specific service / patients issues identified through the ligature audit action plan that are not felt to be adequately controlled

ENVIRONMENTAL ISSUES:

Reasons why it is felt they are not controlled:

MANAGEMENT ISSUES:

Reasons why it is felt they are not controlled:

Please send copies to Head of Division, Risk and Safety Team and Estates Team

APPENDIX E

Guidelines for the Storage and use of Ligature Cutters

Introduction

These guidelines should be read in conjunction with other Trust policies and guidelines relating to medical emergencies, moving and handling, infection prevention and control, prevention and management of aggression and incident reporting.

Equipment Specification and Maintenance

The ligatures cutters issued by the Trust are purpose specific items that must **not** be used for any other purpose than dealing with this type of emergency situation.

Ligature cutters offer improved safety and effectiveness for cutting a ligature from a person when compared to some traditional methods e.g. scissors.

Ligature cutters are specially designed items that offer an effective and safe method of cutting a ligature that is tied around a person's body part, whether the ligature is tied solely to the person or attaches the person to any aspect of the environment e.g. a door handle.

The ligature cutter issued within the Trust has a "hooked" metal piece that folds into a plastic covered handle. When the metal hook is unfolded it "locks" into the open position for use. The metal part is designed so that the outer edges are smooth and blunt and only the inner edge of the hook is sharp. The design of the metal hook allows for the speedy and relatively safe insertion under the ligature, whilst also minimising the risk of secondary injury to the person or staff e.g. lacerations.

The effectiveness of the ligature cutter is largely dependent upon the sharpness of the blade. Therefore, ligature cutters must only be used to cut ligatures that require quick removal to reduce risk. If a ligature cutter is used for any other purpose, or to cut anything other than a ligature, this will negatively impact upon the sharpness of the blade and ultimately, might render the ligature cutter less effective in an emergency situation.

The sharpness of the ligature cutter is so crucial that they are considered to be single-use items within the Trust i.e. whenever a ligature cutter has been used to cut a ligature it must be immediately replaced with an unused or re-sharpened one.

Importantly, staff should be aware a ligature cutter is likely to be most effective when used to cut softer materials that are not too thick e.g. shoe laces, string, linen, or thin electrical cable such as the wire used for headphones and mobile phone chargers.

Availability and Storage

The Trust acknowledges incidents involving the typing of ligatures might sometimes occur despite preventative strategies and measures. Consequently, all mental health inpatient wards and other identified high-risk areas will be issued with ligature cutters.

Locally, ligature cutters must be securely stored in areas which are only accessible to members of staff. However, it is important all members of staff have quick and easy access to the ligature cutters and therefore, appropriate storage places might

include clinical rooms or offices. A minimum stock of 3 ligature cutters should be maintained at all times.

Local managers are responsible for ensuring all staff working in their area(s) are aware of the availability and access to ligature cutters. This will need to be part of the local induction procedure for each area and documented.

If there is a shortage or need for replacements out of hours and there are no stocks locally then other mental health wards should be contacted if required.

Training

In all areas where ligature cutters are available, staff will receive information/training regarding the use of the ligature cutter at a variety of events across the Trust, e.g. local induction.

Instruction and information will include demonstration and practice of how to open, lock open, use, unlock, and fold away the ligature cutter.

After staff have received information/training relating to ligature cutters in clinical practice, they must familiarise themselves with their own local arrangements regarding access, storage and replacement. This is an on-going personal responsibility throughout their employment within the Trust and is particularly important where staff have to work for periods in unfamiliar areas e.g. booked out to another ward, working bank or overtime shifts.

The Use of Ligature Cutters in Practice

Whilst this guidance cannot replace the need for appropriate staff training relating to ligature cutters, it is important staff remember the fundamental points for their effective use:

- To optimise the safe and effective use of the ligature cutter, its rounded and blunt end should be initially placed flat against the person's body so that it can slide under the ligature
- Once it has been located between the person's body and the ligature, the ligature cutter should be turned so that the hooked blade faces the ligature i.e. away from the person
- At this point staff should pull aware from the person's body , using a sawing/rocking motion using the full length of the blade, so that the ligature cutter cuts through the ligature material
- Staff should always keep the cut ligature for later inspection.

Situations involving ligatures will generally fall into two main categories:

(a) "suspended strangulation" – where a person has tied a ligature around their neck and attached this to a fixed point so that their body weight is supported by the ligature and its fixing;

(b) "ligature unsuspended" – where a ligature is tied around part of the body to restrict breathing or blood-flow. Outline advice for each of the above is provided below.

Suspended Strangulation (hanging):

In the event of suspended strangulation, it is important to elevate the person and to support their body weight wherever possible, at the earliest opportunity. If staff make attempts to do this it is important that they should try to adopt and maintain the principles of manual handling to reduce the risk of injury to them during this high-risk manual handling activity.

As soon as the body weight is supported, or if this is not possible for any reason, the ligature should be cut at a central point between the person's neck and the suspension point so that there is a minimal interference with any potential investigation scene. The person should then be lowered to the floor.

If the ligature remains in place around the person's neck (or other body part) it should be removed using a ligature cutter. Staff should make every effort to cut the ligature at a point that is distant from any knot that may be present because the ligature and any knot can provide significant forensic evidence to any police investigation.

In situations where the person resists the staff actions to remove the ligature, it might be appropriate for staff to restrict the person's ability to struggle, especially where the struggling behaviour increases the risk(s) presented by the ligature, or by the use of the ligature cutter by staff. In such situations it is expected that staff will employ appropriate holding skills that are sensitive to the needs of the person and the safe removal of the ligature.

Ligature (unsuspended):

The ligature should be removed as described. If the person resists, then staff should act in accordance with the advice provided.

Instructions for After Use

Every incident involving the use of a ligature cutter should be recorded on the Trust Datix that provides details of the event; the use of the ligature cutter including the number, the outcomes and any future learning points e.g. problems or ideas.

Clearly, the nature of the incident and outcome(s) should prompt staff to comply with other Trust polices and guidelines as appropriate.

The ligature and any knot are important items for any police investigation and they should be 'interfered with' as little as possible and be preserved by leaving them at the scene wherever possible. Staff should avoid removing any remnants of a ligature still fixed to an environmental suspension point, and only tidy up or dispose of any items at the scene after advice and permission has been given by the police.

All ligature cutters in clinical areas must be replaced after use with a new or re-sharpened one. Staff must make immediate arrangements for a replacement to be available and for the used ligature cutter to be securely returned to for exchange.

In the unlikely event that the ligature cutters become contaminated with bodily fluids they should disinfected using blood spillage chemicals prior to replacement.