Estates and Facilities Alert

Reference:	Issued:	Valid to:
EFA/2018/005	**19 Sept 2018**	**19 Dec 2021**

Assessment of ligature points

Summary

Following the death of a patient using a ligature attached to low-level taps in a bathroom, a subsequent Coroner's Regulation 28 report highlighted that there was confusion over how ligature points should be assessed, and their removal prioritised. This Alert is not new guidance: it aims to clarify existing guidance and emphasises the importance of considering multiple factors in assessing the risk posed by ligature points. There have been misinterpretations and/or misunderstandings of the existing guidance and a lack of awareness of alternative equipment (eg tap designs that do not create a ligature point). The Care Quality Commission (CQC) has also revised its inspectors' guide for the same reason.

Action

- This alert should be brought to the attention of all appropriate managers, staff, specialist advisors and persons undertaking ligature point risk assessments.
- Review and revise current ligature risk assessment policies and associated ligature risk assessment forms/toolkits. This is to ensure adherence to the advice in this alert, including the importance of assessing multiple factors and not using height as the sole determining factor in identifying a ligature points risk.
- Ensure all staff are adequately trained and briefed on any new policy and toolkits.
- Review current risk assessments. Undertake multidisciplinary *in situ* risk assessments to identify ligature points, no matter what their height, in areas where patients are admitted, assessed or receive treatment. The risk assessment should take account of multiple environmental, clinical, and operational health and safety factors, including but not limited to:
    - patient population risks
    - type of healthcare facility
    - equipment and therapeutic environment needs of the room/space
    - operation and services undertaken in the room/space
    - staff resource and ability to observe a patient in the room/space.

Consult relevant current guidance and statistics for design and operational considerations to assist with the risk assessment and subsequent action plan processes regarding ligature points. This particularly relates to the provision of fixtures and fittings in rooms/spaces where service users may not be observable by staff (for example, in single bedrooms, toilets and en suite facilities). NB pipework and electrical conduit areas should be concealed. Surface-

mounted services are not recommended. Heating panels should be underfloor, ceiling-mounted or wall-mounted. Pipework, vents and the like should be boxed or set into the wall.

- Develop and implement necessary action plans from the revised risk assessments. Ensure that staff are aware of the identified ligature points and any risk management plans. Where possible, identified ligature points should be removed, and where agreed, any identified mitigation requirements should be in place.

- All remaining ligature risks and their developed risk management action plans should be submitted to executive management for their information and approval.

- Progress on health and safety action plans should be submitted to executive management for their information and action if required.

Action by

- Estates/facilities
- Clinical leaders – eg nurse directors, medical directors
- Health and safety
- Risk management
- Persons undertaking ligature point risk assessments

Deadlines for action

Actions underway: 26 September 2018
Actions complete: 19 March 2019

Problem/background

This alert is in response to the death of a patient using a ligature attached to low-level taps in a bathroom.

The inquest heard that there are ongoing challenges across England to eliminate ligature points in inpatient and other psychiatric facilities. To manage these challenges NHS organisations have ligature risk management policies that allow them to assess the risk, mitigate the risk and prioritise removal of the risk once a ligature point has been identified in any facility.

In this instance the organisation used a ligature risk assessment classification that suggested low-level ligatures (less than one metre) were a low priority for removal. Consequently, the organisation concerned had not considered that all ligature points in higher risk, unobserved private single spaces, regardless of height, are a priority.

The National Confidential Inquiry into Suicide and Homicide (NCISH, 2017) states that between 2005 and 2015 there were approximately 20 to 30 inpatient deaths per year in mental health units in England from hanging or strangulation. Most of these deaths involved either low ligature points or strangulation without any ligature point. Most occurred in a single bedroom (68%) or a toilet/bathroom (23%). Where a ligature point was used, the most common ligature points were doors (46%) or windows (16%).

The 2018 CQC brief guide states the risk posed by a ligature point is greater if:

- it is in a room in which patients spend time in private without direct supervision by staff (eg bedroom, toilet, bathroom)
- it is in a ward/area used by high-risk patients (eg acute mental illness; high risk of suicide; challenging or chaotic behaviour; co-morbid substance misuse)
- the ligature point is between 0.7 metres and 4 metres from the ground
- nurses cannot easily observe all ward areas because of poor design or because too few nurses are on duty.

The coroner's principal concern was that the local approach to risk assessment had not considered low-level ligature points a risk, and local systems' intention to prioritise the most urgent ligature point removal had become misinterpreted as meaning other known ligature points were acceptable.

All providers of mental health services should already have robust public and patient safety policies, including ligature risk assessment policies. These will need to be reviewed in the light of the coroner's concerns and the advice and actions given in this Alert. The principles of ligature point management should consider multiple environmental, clinical and operational health and safety factors such as height, access, room usage, patient population risks including infection control, dementia and self-harm, plus staff resource and the ability to adequately observe patients. This will include ligature point removal, or adequate controls with a record of the agreed mitigations put in place.

Distribution

Estates managers, risk, managers, health and safety

References

Health Building Note 03-01: Adult acute mental health units (2013)
https://www.gov.uk/government/publications/best-practice-design-and-planning-adult-acute-mental-health-units

Health Building Note 03-02: Facilities for child and adolescent mental health services (2017)
www.gov.uk/government/publications/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02

Suicide prevention: resources and guidance – Public Health England (2017)
https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives (2017)
https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

Brief guide for inspection teams: Ligature points (2018) – Care Quality Commission
www.cqc.org.uk/sites/default/files/20180404_9001397_briefguide-ligature_points_v1.pdf

Annual report (2017): The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness – University of Manchester https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-homicide-annual-report-2017/

Current guidance from the College Centre for Quality Improvement (CCQI), NAPICU (National Association of Psychiatric Intensive Care Units) and DiHMN (Design in Mental Health Network), eg:

- napicu.org.uk/uploads/2017/05/Design-Guidance-for-Psychiatric-Intensive-Care-Units-2017.pdf
- www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/picus/ourstandards.aspx
- www.rcpsych.ac.uk/pdf/RCPsych_Core_Standards_In.pdf
- DiMHN 'testing and standards' being developed for mental health components with the Building Research Establishment and suppliers

Health and Safety Executive risk management guidance:
http://www.hse.gov.uk/risk/index.htm

Enquiries

This alert has been compiled under a partnership arrangement by the organisations below, and it has been distributed across the UK. Enquiries should be directed to the appropriate regional office quoting the alert reference number.

England

Enquires should quote reference number EFA/2018/005 and be addressed to:
nhsi.mb-defectsandfailures@nhs.net

Reporting adverse incidents in England
Defects or failures should be reported on this system: http://efm.hscic.gov.uk/Login.asp

The web-based D&F reporting system is managed by NHS Digital on behalf of NHS Improvement. For further information on this system, including log-in details, please contact the EFM information helpdesk: 0300 303 5678.

Northern Ireland

Enquiries and adverse incident reports in Northern Ireland should be addressed to:

Northern Ireland Adverse Incident Centre, CMO Group,
Department of Health, Social Services and Public Safety
Tel: 028 9052 3868 Email: niaic@health-ni.gov.uk
http://www.health-ni.gov.uk/niaic

Reporting adverse incidents in Northern Ireland
Please report directly to NIAIC using the forms on our website.

Scotland

Enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre (IRIC)
Health Facilities Scotland, NHS National Services Scotland

Tel: 0131 275 7575
E-mail: nss.iric@nhs.net

Reporting adverse incidents in Scotland

Use our online report form or download the PDF form
Independent facilities that only provide private care should report to the Care Inspectorate.

Wales

Enquiries and adverse incident reports in Wales should be addressed to:

Simon Russell, Principal Engineer, NHS Wales Shared Services Partnership – Specialist Estates Services, 4th Floor, Companies House, Crown Way, Cardiff CF14 3UB

Tel: 029 2090 4100
E-mail: Simon.Russell@Wales.nhs.uk