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HSE Mental Health Services: Guideline on the Implementation and use of the National Ligature Risk-Reduction Audit Tool for Approved Centres

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Short summary:
This guideline document has been developed by the HSE Mental Health Services and is based on the work of the steering committee for ligature risk reduction in mental health services (2023) and this current guideline development group (2024). This work has conducted a comparative review of policies and guidance in mental health services both nationally and internationally. Implementation of these guidelines will require a local addendum. The risk of suicide in mental health services is recognised and the HSE Connecting for Life Strategy outlines the explicit action to implement an approach to improve environmental safety within HSE Mental Health Services. The risk from ligatures and anchor points are well known and are required to be managed. The risk of hanging or self-asphyxiation remains significant within mental health services and it is imperative we reduce these risks where known and where possible.

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Description:

It is now recognised that in isolation, all anchor points are considered as 'high risk' irrespective of their (low or high) height. The availability of items that can be used as ligatures should be considered by management & clinical teams respective to the patient and the setting with local policies developed to identify prohibitive/restricted items for the respective approved centre.

The guideline document is intended to support regional health area teams to ensure services offer the best and safest environment for all service users. It recognises that to create this safe environment, this care is best delivered in an integrated manner between clinicians, health & safety/quality and patient safety advisors, Capital & Estates and maintenance. It is considered that an environmental audit of ligature risks and a management plan to address these risks when delivered in conjunction with clinical risk assessment and integrated care plans for suicidal/deliberate self-harm & observation will provide the best possible outcomes.

The guideline acknowledges the HSE cannot implement a zero-risk environment without impinging on the individual's human rights, the creation of a therapeutic ambience or the delivery of care in a hospital setting. **The guideline is restricted to Approved Centres**.

Each centre should convene a committee to oversee the risk of ligatures from anchor points and to co-ordinate a clear process of communication between senior clinicians, managers, health & safety/quality and patient safety and maintenance management.

The guideline is presented as best practice which will assist staff in approved centres to meet the requirements related to ligature reduction of the Mental Health Act (2001) Approved Centre Regulations (2006) – Regulations 22 (Premises), 32 (Risk Management Procedures) and Judgement Support Framework (2024).

Introduction

The Health Service Executive (HSE) Mental Health Services aim to ensure the best and safest possible care for everyone who uses those services. In this context, Mental Health Services adhere to a range of regulations overseen by the Mental Health Commission, including regulations governing environmental safety of premises.

Mental Health Services is the lead agency for the implementation of a range of actions in 'Connecting for Life: Ireland's Strategy to Reduce Suicide' (HSE, 2015). This guideline document supersedes the ligature guidance review notice issued to mental health Heads of Service on 1 July 2023.
This guideline is based on best practice and will therefore assist approved centres to be compliant with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulations 22 (Premises) and 32 (Risk Management Procedures) requirements related to ligature reduction. This guideline can be used as a template to develop a localised policy by substituting policy for guideline where appropriate.

This guideline sets out the requirements for services to develop a Ligature Risk-Reduction Policy and implement a Ligature Risk Reduction audit that enables a plan to be put in place to remove potential anchor points or reduce to the lowest level practicable.

The development of a local addendum Ligature Risk-Reduction Policy and the implementation of regular ligature risk-reduction audits are essential for enhancing patient safety in approved centres. This guideline provides a structured approach to identifying, prioritising, and mitigating ligature risks from anchor points, ensuring compliance with regulatory requirements while maintaining a therapeutic and respectful environment for patients.

Contents

1.0 Planning

A Ligature Risk Reduction Addendum Policy (localised policy) and the use of the enclosed Audit Tool will assist in reducing risk but it may not be possible to remove all risks. This guideline should not be viewed as a substitute for a comprehensive risk assessment policy and should be read in conjunction with the HSE Enterprise Risk Management Policy and Procedures (HSE, 2023) Enterprise Risk Management Policy and Procedures. The localised policy and audit tool should be used in association with a clinical risk assessment and risk management plan for suicidal ideation and an observational policy along with local guidance on restrictive/prohibitive items to get the best possible outcome. Although it is extremely challenging to know exactly what method might be employed by someone who is intent on self-harm or suicidal ideation, the service should take all reasonable and practical steps to discover a person's intention and take the necessary measures to anticipate and prevent it.

1.1 Purpose

The purpose of the guideline is to:

- Support staff in approved centres to develop a ligature risk-reduction policy using this audit tool in line with best practice.
- Support staff in providing a safe and therapeutic environment for service users, which is as free as possible of ligature anchor points.
- Provide a procedural framework to enable staff to effectively identify, assess, document, reduce and manage environmental ligature anchor points.
- Outline the responsibility and arrangements whereby staff undertake to control the presence of ligature anchor points in the service.
- Reduce the risk of suicide/serious harm and self-harm by hanging and self-asphyxiation caused by the presence of ligature anchor points.

1.2. Scope

The guidelines apply to staff working in HSE approved centres, i.e. multidisciplinary team members. It also applies to Capital & Estates and Local Maintenance departments in

supporting the service in approved centres. Each member of the multidisciplinary team has a responsibility for identifying, documenting, managing, and communicating risks within the context of their work.
The development of an addendum ligature risk-reduction policy and audit tool using this guideline will enable staff to identify ligature anchor points that could be used in their mental health approved centres by any service user within that service.

The guideline is designed to ensure that correct procedures are used where risks are identified associated with ligature anchor points. Risk management is a core management process and a line-management responsibility requiring active involvement and oversight from managers to ensure adherence to risk reduction policies and procedures.

The guideline must be read in conjunction with the additional, relevant policy documents as listed under the supporting policies in section 1.7.

1.3. Objectives

- To support staff by creating awareness of ligature risks from anchor points amongst all staff working in approved centres.
- To enhance the safety of all service users within approved centres by removing, minimising or restricting access to ligature anchor points, as far as is practically possible.
- To provide a process that supports staff in the management of ligature anchor points.
- To provide an audit tool that will help staff to identify ligature anchor points within mental health services approved centres.
- To support staff to develop an addendum policy and audit tool that will identify, assess, document and manage, where possible, ligature anchor points within mental health approved centres to assist with the reduction of death/serious harm by hanging/self-asphyxiation within approved centres.

1.4. Outcome(s)

HSE approved centres will provide a safe and therapeutic environment for inpatients and service users, which is as free as possible of ligature anchor points by reducing access to means of self -harm. The approved centres will actively seek to eradicate as far as is reasonably practicable all potential ligature anchor points and, where this is not possible, to control the risks by monitoring them.

A localised Ligature Risk-Reduction Policy should be supported by other policies and practices, especially risk assessment, observation and service user engagement for each approved centre. It is impossible to make a building ligature free; therefore, knowing who is at risk and keeping that person under observation can help minimise the risk. Risk-assessment policies and processes for the management of operational and strategic risk, as well as individual safety- management plans, should be co-produced with service users, where appropriate.

It is not possible for all potential ligature anchor points to be eliminated, and a judgement must be made about the likelihood of something being used as a ligature anchor point. Any such anchor points must be documented and made known to all staff.

Some potential anchor points may not be able to be designed out and need to remain, as removing them will create a greater risk to the service user, e.g. grab rails in psychiatry of later life services or in disability-access rooms and toilets.

With regard to ligature resistant equipment, where equipment is installed incorrectly or is tampered with, this can reduce its effectiveness regardless of its design. It should be noted that a product that is considered ligature resistant in one location should never be the sole basis for selecting the same product in another location. The product must be viewed with all external or contributing factors included e.g. installation method, position in room and position in relation to other fixtures, material in which the product is fixed or installed into, the patient type and local observation policy.

Providing support for staff affected by suicide or attempted suicide incidents:

Staff who are on duty are among those most impacted by suicide or attempted suicide and should be offered access to the appropriate support.

Line managers can provide direction to their staff on how to access information and support services in the aftermath of such events. This includes Critical Incident Stress Management (CISM), HSE Employee Assistance Programme (EAP) – Staff Counselling and the “ASSIST ME” Model of Staff Support.

These services and resources are available at-

https://healthservice.hse.ie/staff/benefits-and-services/critical-incident-stress-management-cism/
https://healthservice.hse.ie/staff/benefits-and-services/employee-assistance-programme-staff-counselling/

https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/assist-me-a-model-of-staff-support-following-patient-safety-incidents-in-healthcare-january-2021-.pdf

1.5. Disclosure of Interests

No conflicts of interest were declared by the group.

1.6. Rationale/alignment with HSE national priorities

The Health Service Executive (HSE) Mental Health Services are designed to ensure the best and safest possible care for everyone who uses those services. In this context, Mental Health Services adhere to a range of regulations overseen by the Mental Health Commission, including regulations governing environmental safety of premises.

Furthermore, Mental Health Services is the lead agency for the implementation of a range of actions in 'Connecting for Life: Ireland's Strategy to Reduce Suicide' (HSE, 2015).

One of the actions in 'Connecting for Life' related to Mental Health Services outlines the requirement to "implement a strategy to improve environmental safety within the HSE mental health services (e.g. ligature audits)" (Action 6.2.2). The lead agency for implementation of this action is HSE Mental Health Services, with local Maintenance teams and HSE Capital & Estates identified as key partners. To address this action, a review was undertaken of approaches to ligature audit across all Community Healthcare Organisations (CHOs), which highlights the use / adaptation of six different audit tools across the country (HSE, 2015).

The Mental Health Commission Judgement Support Framework (JSF) 2024, Mental Health Act 2001, (Approved Centre) Regulation 2006, Regulation 22 (Premises) requires that the *"registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors".* It also states that approved centres should have processes and procedures in place to identify hazards and ligature points and indicates the requirement to complete a ligature audit, with the aim to minimise ligature risks to the lowest practicable level. The JSF, Regulation 32 (Risk Management Procedures) requires that

structural risks, including ligature points, are removed or effectively mitigated.

Staff within an approved centre and throughout all mental health services should remain alert to ligatures and ligature anchor points. Due to human ingenuity and/or a lack of a technical solution, it is impossible to eliminate all potential ligatures and ligature anchor points without setting aside a person's human rights. It is therefore necessary for structured judgement based on documented risk assessment to identify the likelihood of an item being utilised as a ligature point, and the opportunity for a service user to utilise the potential ligature point.

1.7. Supporting Evidence

A ligature risk-reduction policy must be read in conjunction with the additional, relevant local policy documents, including, but not limited to:

- HSE Enterprise Risk Management Policy and Procedures (HSE, 2023)
- HSE Incident Management Framework and Guidance (HSE, 2020)
- Admission policy
- Risk Management Policy & Approved Centre Risk Register
- Observational policy
- Premises policy
- Health and Safety Policy
- Visitor policy
- Search of resident's policy – person and belongings/prohibited items, ligature risks

The Guideline has been informed by:

- Mental Health Act 2001, (Approved Centres) Regulations 2006
- Judgement Support Framework: Working Together for Quality, Mental Health Services (Mental Health Commission,2024)
- The Cymru NHS Wales Health & Safety Committee Pwyllgor Iechyd A Diogelwch; Assessment and Management of Environmental Ligature Risks Procedure (2022)
- Preventing Suicide by Hanging and Asphyxiation: Ligature Audit Tool (Greater Manchester West NHS Foundation Trust, 2009)
- Care Quality Commission CQC Brief Guide: Ligature Anchor points, ligatures and other means of self-harm using fixtures and furniture (2022)

- Connecting for Life (HSE, 2015)
- National Incident Management System Patient Suicide Data (DOH 2019)
- Sharing the Vision: A Mental Health Policy for Everyone, gov.ie (DOH, 2020)
- Best Practice Guidance for Mental Health Services, HSE (HSE, 2017)
- Writing a Person-centred Individual Care Plan Guidance Document, HSE (HSE 2020)

2.0. Methodology

Existing ligature policies and procedures available were reviewed. The original guidance on the development of a Ligature Risk-Reduction Policy and Ligature Risk Audit software tool (version 0) was amended from a similar policy and tool in the HSE and was piloted in ten mental health approved centres.

Following on from the findings from the pilot project and guidance from Quality and Patient Safety, the policy and tool were amended and developed using the HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (2016).

Following concerns raised about the rating for heights of ligature points, a further review was carried out in 2023.

2.1. List of key questions this National Guideline will answer

- How do clinical staff working within mental health services reduce service users' risk of suicide and self-harm by hanging within the mental health approved centres?
- How does one raise awareness amongst staff regarding the risks of ligature anchor points?
- What process can be used to identify ligature anchors and risk rate them in terms of potential level of harm?
- What processes can be employed to develop remedial actions to remove ligature anchor points or minimise the risk associated with anchor points?
- What processes/mechanisms can be established to provide assurances to senior management, the Mental Health Commission, service users, families and carers/supporters regarding the adequacy of the environment in the approved centre?

- How to demonstrate compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 22 (Premises) pertaining to identifying hazards and ligature anchor points in the premises?
- How to demonstrate compliance with Mental Health Act 2001, (Approved Centres) Regulations 2006, Regulation 32 (Risk Management Procedures) requiring that structural risks, including ligature points, are removed or effectively mitigated?

2.2 Describe and document the evidence search

2.2.1. General outline

The original literature search strategy involved an electronic database search using CINAHL and psychINFO. The keywords used to guide the search included: 'mental health and mental illness', 'ligatures', 'ligature anchor points', 'approved centre' and 'acute psychiatry'. The search was limited to full text and English language articles that were peer reviewed. Articles were restricted to those published in the past ten years, to ensure recent and up-to-date articles were reviewed. A search of NHS Trust policies, the Mental Health Commission website and Healthcare Improvement Scotland was also completed along with reviewing policies from United States, Canada and Australia.

2.2.2. Supporting Evidence

- Hanging is a method of completed suicide in mental health services. Hanging may involve suspending the body from a high ligature anchor point, with or without the feet touching the ground, but many deaths also occur through asphyxiation without suspension of the body or using a ligature anchor point below head height. A significant proportion of suicides are believed to occur through impulsive acts, using what may be seen as reasonably obvious ligature points. Therefore, an obvious ligature anchor point would present a significant risk.

- Connecting for Life (CFL), Ireland's National Strategy to Reduce Suicide 2015-2020, outlines their objective to reduce or restrict access to means of suicide behaviour. The strategy also recommends that the HSE implements a strategy to improve environmental safety within the HSE mental health services, e.g. ligature audits.

- Ligature anchor points in approved centres should be, where possible, removed or covered. **It is not possible to remove or cover all potential ligature anchor points;**

therefore, judgement based on documented risk assessment is required regarding the likelihood of something being used as a ligature anchor point and the agreed management of the risk. Equally, some ligature anchor points must remain in place or be modified, as removing them would create a greater risk to the patient group, for example, handrails in elderly centres/disabled access facilities.

- Under the Mental Health Act 2001, Approved Centre Regulations, 2006, all mental health approved centres are required to complete an annual ligature environmental audit. In undertaking such work, due regard will be given to priority areas (and prevailing circumstances) which present the highest ligature risks, including fixed equipment (for example, cubicle curtain tracking), other equipment and pipe-work in ceiling voids and all potential risks in unsupervised areas and areas where supervision may be limited.

- Current literature would advise that all ligatures points regardless of height are treated with the same importance.

2.3. Describe the method of screening and evidence appraisal

All evidence was screened and appraised by each member of the group being assigned specific tasks to summarise and present to the group meetings. Decisions were based on consensus within the group. Based on the research and outcomes presented, the group decided to adopt an amended version of the previously outlined audit tool.

2.4. Attach any copyright or permissions sought

No Copyright or permissions are required in relation to this document.

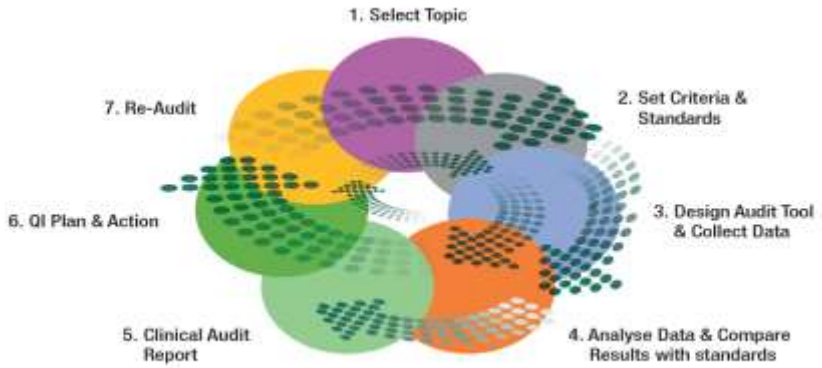
3.0 Procedure

3.1 Implementation of the recommended ligature risk audit process within this guideline

3.1.1 Conduct a yearly ligature anchor point audit

- The Registered Proprietor, Head of Service for mental health and the area mental health management team, should ensure that an annual audit is conducted to identify all ligature anchor points.
- A ligature risk reduction audit should also be carried out if there has been a suicide or near miss. Also, if there are any alterations to the building, or if the building has been damaged or repaired as these might cause unforeseen structural changes
- The excel Ligature Risk Audit Tool amended in line with this guideline can be used for auditing process. The audit can be done by directly inputting the data into the excel document or printing off a hard copy and inserting the data at a later stage.
- Anchor points identified are documented and the risk of the anchors points actively managed through the risk assessment process until they are closed off.
- A ligature risk audit should be completed on building plans, if possible, and prior to signing off on any revised or new modifications to any room or space within the approved centre.
- New kinds of ligatures and ligature points are always being found, so approved centre staff need to be constantly vigilant to potential risk. This includes staff teams being briefed and appraised of any new safety alerts, ensuring distribution and communication to the entire team.
- Learning will be shared with other sites (where applicable) to promote quality and safety for all patients from incidents and near misses. This can be done locally via the QPS Committee and nationally via the HSE National Patient Safety Alert (NPSA) committee who oversee the process for developing and disseminating HSE national patient safety alerts and patient safety supplements.

3.2. Ligature risk reduction audit process



An audit is a systematic review and evaluation of current practice and agreed standards

with a view to improving clinical care for service users (hse.ie-clinical-audit). The HSE have developed a seven-stage approach to clinical audits, which can also be applied to carrying out a ligature risk-reduction audit. (HSE National Centre for Clinical Audit: Clinical Audit – A Practical Guide 2023)

Figure 1: Seven stage approach to clinical audit

3.3 Planning the audit

- A number of multidisciplinary staff from each clinical area will be identified by service managers to be briefed on the ligature risk-reduction policy, audit process and tool.
- A number of staff members must complete the audit, of which at least one should be part of the multidisciplinary team from that clinical area. Getting a member of staff from outside the area or service can help to reduce the effects of over-familiarity with the environment. One member of the team must have experience in conducting ligature anchor point audits and managing ligature anchor points. It is also recommended that representation from local Maintenance* be involved due to their technical knowledge on removing or replacing any ligature anchor points identified. Quality and patient safety advisors and health and safety officers can also be part of the audit process, where available. This team will be referred to as the ligature risk audit team.

* Maintenance are managed through Capital & Estates in only a few areas. When developing your local policy please note local arrangements and contact the relevant maintenance manager for assistance with the audit.

3.3.1 Ligature risk-reduction audit teams should:

- Adopt a common and systematic approach to the task.
- Have appropriate training in the application of the audit tool being used. (Available on HSELAND)
- Be provided with details of the layout of each area being audited, including all areas that can be accessed by service users, noting which of those areas has limited or no supervision, or which are locked and therefore inaccessible at times.
- Check all rooms in a similar and structured manner, working each time from an identified point in the room and moving left-right and up-down from that point.
- Adopt a systematic approach to the identification of observation points into and within a room, noting all ligature anchor points.

- Record the details on the audit data sheets or directly on the excel audit tool when a ligature anchor point has been identified. All sections should be completed; including the section headed “recommended/remedial action”.
- Acknowledge that the evaluation of some risks will require specialist knowledge and advice from the services facilities management or a specialist contractor. An initial assessment of the risk should be made on the audit data sheet.
- Take into account the level of possible clinical risk presented by the service users of that centre and note this in the audit tool and in any subsequent risk assessment. Some centres, e.g., forensic services, may have higher risk areas than other centres. The floor plan risk map may be used as a supportive document to the ligature anchor point tool (Appendix II).
- Consider previous quality improvement plans where initial ligature risk reduction audit has taken place.

3.3.2 Set Criteria and Standards

The four criteria recommended in this policy and captured within the associated ligature risk-reduction audit software tool are **room designation, patient profile, ligature anchor point rating and compensatory factors.** These four criteria can be found in the methodology section of the Ligature Risk-Reduction Audit Tool. The risk rating for each criterion will be either 1, 2, or 3, as explained below, **except for ligature anchor point rating which will always be given a rating of 3**. The audit tool has a formula that will give a total risk-rating score. A risk rating will automatically appear, indicating high, medium or low risk.

3.4 Room designation

Each room is audited, and risk rated separately. The rating considers the amount of time most service users will spend in a room without direct supervision**.** For example, most service users will spend periods of time unsupervised in a bedroom or in the shower/bathroom. Please see description of the room designation and the associated risk-rating score below. It include all areas of the building not just areas the service user normally has access to. The higher the risk of a service user spending unsupervised time in a room, the higher the risk rating is for that room regardless of how many ligature anchor points.

ROOM DESIGNATION

Zone designation rating 3 – High isolation	Zone designation rating 2 – Medium isolation	Zone designation rating 1 – Low isolation
Most service users spend periods of time in private without direct supervision, e.g. • All bedrooms • Toilet areas • Shower/bathroom areas • Other isolated areas of the ward	Most service users spend long periods of time with minimum direct supervision of staff and are usually in company of peers, e.g. •TV lounges •Day rooms •Open dining rooms •Activity/recreation rooms •Unlocked therapy rooms •Unlocked offices •Unlocked kitchens •Enclosed garden/courtyard area	Areas where there is traffic from staff and service users moving through and isolation is unlikely, e.g. •General circulation spaces •Corridors •Locked rooms

Fig. 2.0 Room designation risk rating

It is important to note that whilst categorising areas according to their level of risk, nothing is entirely predictable and opportunistic risks arise within any environment. Despite checks and monitoring, 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.

Outside Areas: When considering outside areas, the fundamental decision that needs to be made prior to any risk assessment is how often service users are being supervised within the area. Consideration needs to be made on the design of any outside space, along with fixtures and fittings. Consider concealed areas, blind spots or poorly lit areas. Specifically focusing on any parts of the outside space that can be used as ligature anchor points, and or climbed, in order to access any roof space or outside perimeters of the area. Whenever possible, furniture needs to be positioned accordingly e.g. away from any form of climb situation (close to walls or fences) and screwed down in order to prevent the above.

3.5 Patient profile rating

Clinical areas cater for different functional groups of service users. These groups can be profiled as presenting a significant, medium or a low potential to use ligature anchor points. Please see Fig 3. for patient profile descriptions and risk-rating score. The higher the risk of the service user the higher the risk rating applied. Service users identified as high risk should be placed in high observation areas.

High-risk patient group Risk rating 3	**Medium-risk patient group Risk rating 2**	**Low-risk patient group Risk rating 1**
Patient/service user with acute severe mental illness Patient/service user who are unpredictable Patient/service user in initial recovery stage following suicide risk or on 1 to 1 observations. Patient/service user who are, or have been, of high risk of suicide or severe self-harm. Patient/service user who are depressed. Young people. Patient/service user with challenging behaviour. Patient/service user with chaotic behaviour. Patient/service user with concurrent substance misuse issues. Patient/service user with concurrent severe social need e.g. (marital / family breakup, financial concerns etc. Male aged between 35 – 55	Patient/service user in rehabilitation Patient/service user with chronic or enduring mental health problems Patient/service user who are susceptible to periodic relapses or sub-acute episodes. Patient/service User who continue to be distressed by delusions / hearing voices Patient/service user who have been assessed as NOT being an immediate risk of suicide	Patient/service user in self-care groups Patient/service user who have been assessed and identified as not being at risk of suicide Patient/service user who has a cognitive impairment, an example of this could include a patient/service user with a moderate learning disability who displays behaviours that challenge

Fig 3.0 Patient profile risk rating-In general, all acute psychiatric units should be rated with a high risk rating of 3

3.6 Ligature anchor point rating

This rating requires the audit team to identify any potential ligature anchor point in relation to

its position in the room. Any ligature point must be recorded and **regardless of the height of the anchor point, it should be rated as high risk (3)**

LIGATURE POINT RATING	
Height	**Risk**
Any ligature point should be recorded and Any ligature point must be rated as high risk (3) regardless of its height	High Risk: 3

3.7 List of Potential Anchor Points

Bicycle Blinds (Door) Blinds (Window) Book Shelves Brackets (Windows) Cable (Fan) Cable (TV) Cable (Water Dispenser) CCTV Camera Chair Cupboards Dispensers (paper towel) Dispensers (soap) Dispensers (toilet roll) Door Door closure Door frame	Door handle Door hinges Electric boxes/ sockets/ switches Exposed pipes (Wall) Exposed pipes (Waste) Exposed pipes(Ceiling) Extractor fan Fire Alarms Fire Extinguisher Handles (Bath) Handrails (Bath) Handrails (Shower) Handrails (Toilet) Hook on door Hook on wall Lights (Bed) Lights (Ceiling) Lights (Emergency)	Lights (Wall) Pergolas Picture Hooks Pocket masks Radiators Rails (Bed screen) Rails (Blind) Rails (Curtain) Rails (Shower) Sanitary ware (Hand basin) Sanitary ware (Toilet cistern) Sanitary ware (Toilet handle) Sanitary ware (Toilet seat) Shelving Shower cubicle door	Shower fitting Shower handle Shower head Shrubs/trees Soap shelf Suspended ceiling Table Taps (Bath) Taps (Hand basin) TV bracket on wall Wardrobes (Coat hooks) Wardrobes (Doors) Wardrobes (Handles) Wardrobes (locks) Wardrobes (rails) Window handles Window Hinges Other

Fig. 4.0: List of potential ligature anchor points – The list above is not an exhaustive list.

Some potential ligature point risks are less identifiable than others e.g. ligature points hidden behind a suspended ceiling. It is important to consider degrees of ingenuity required to assess and use the ligature anchor point identified, i.e. the ability of the service user to be cleverly inventive or resourceful and if a ligature point is capable of holding someone suspended. Levels of ingenuity may be arbitrary and if you are in doubt over any potential ligature point, seek a second opinion and go with the higher risk rating.

Consideration needs to be given to dynamic ligature anchor points, which may be brought into the approved centre.

3.8 Compensatory Factors

- Compensatory factors are design elements and situations relating to the level of observation around the service user and ligature anchor points.
- A compensatory factor must be common practice, or permanent if it relates to the design of the room. For example, a service user on continuous observations whilst in their bedroom at the time of the audit will not count as a compensatory factor because this is a temporary clinical management strategy and not permanent or consistent.
- In order to qualify as a compensatory factor, the item must either be a design element (e.g. one that allows for good observation or anti-ligature product that has been installed correctly) or be part of an established procedure (e.g. general observation practices of staff, service user engagement and co-produced safety plans).
- Compensatory factors are rated as low, medium or high-risk by the level of observation by design and the availability and skill mix of staff to observe service user.

High risk: 3	Medium risk: 2	Medium risk: 2	Medium to low risk: 1
Limited observation by nature of the design	Good observation by nature of the design	Limited observation by nature of the design	Good observation by nature of the design
And limited staff (staffing levels significantly below normal rostering levels for the approved centre	But compromised with limited staffing levels	But with agreed staff levels/skill mix	With agreed staff levels/skill mix
Little ingenuity	Little ingenuity required	Little Ingenuity required	Some Ingenuity Required

Fig 5.0 Compensatory factors risk rating

Observation is an important element of ligature risk reduction, and observation policies based on risk assessment should be followed. If CCTV is being used for observation then there should also be a policy in place to support this. For this policy, **'good observation by nature of the design'** means that the design of the area being audited allows staff to easily observe service users at all times, i.e. the location of the service user is easily determined. '**Limited observation by nature of the design'** means that the design of the centre does not enable staff to observe service users at all times and therefore the location of the service user is not easily determined in the area being audited, which creates a potential risk of harm.

The potential ingenuity of the service user should be considered here also taking account of the patient profile and risk assessment. 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.

3.9 Analyse Data

3.9.1 Scoring ligature risk findings

The ligature risk-reduction audit team will have completed their work, using a Ligature Risk-Reduction Audit Tool. All identified ligature anchor point will have been assigned a risk rating, which can then be ranked using the degree of risk posed by each ligature point identified.

The excel tool included with this guideline also carries additional information in relation to a

recommended course of action. The following examples are given to illustrate how the audit findings should be scored.

3.9.2 Calculating the risk rating

The Ligature Risk-Reduction Audit Tool multiplies "Room designation rating" x "Patient profile rating" x "Compensatory factors rating" x "Ligature anchor point rating to get the final aggregate score. This is automatically calculated by the software tool, using the formula, which has been inserted and protected. The scores are risk rated as follows and colour coded automatically by a formula on the audit tool for easy identification of the risk ratings.

- **Low = 1-23**
- **Medium = 24-53**
- **High = 54-81**

Some ligature anchor points can be managed through risk assessment and observational policies where removal is not possible, environmental/individualised/system/process controls must be applied to minimise risks in areas with known ligature points.

Examples that should be considered within each approved centre to mitigate the risk of the Ligature anchor point risk rating and outlined as potential controls in respective ligature risk assessments are as follows:

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).
- Patient access is restricted to specific rooms when staff are not present.
- To balance patient safety and dignity, removal or environmental mitigations and controls should be in place to allow privacy when using high-risk areas – for example collapsible curtain/shower rails, anti/reduced ligature showerheads and doors.
- 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).
- Consideration of use of differing environments to manage immediate risk – for example de-escalation suite, higher observation area transfer if appropriate.

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.
- 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 experienced in ligature management, therapeutic observation, and engagement.
- Robust Multi-Disciplinary Team 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.
- Consideration of room location when bed planning (for example, rooms that are easily visible/ have clear line of sight/ near team office).
- 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 specific rooms e.g. dining

rooms 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. A search procedure available to support the reduction of ligature material entering the ward environment along with a process where regular environmental checks are carried out on the unit.
- 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).

3.10 Quality Improvement Plan and Action

The Ligature Risk-Reduction Audit Tool will identify potential risks as low, medium or high. These risks need to be prioritised and addressed in a quality improvement plan (QIP). All risks will be actioned and have a named person responsible for actions.

The primary aim is to eliminate all high-risk ligature anchor points that are scored at 81 using the tool. The secondary aim will be to eliminate or reduce the significant risk from all anchor points scoring less than 81. The exception to this being in services where the physical needs of the patient/service user group may outweigh the need to remove a possible anchor point or to fit an anti-ligature alternative. The final rating advises on the likely severity of risk; however, the pure numerical score alone does not itself dictate specific actions or timetable for remediation.

Consideration should be given to the profile of the approved centre. Some long-term facilities are people's homes, removing all ligature anchor points could leave the area very stark, and non-therapeutic which may not be necessary based on suicide and self-harm risk assessment of the services users with chronic or enduring mental health needs living there.

The audit team will develop a Quality Improvement Plan (QIP) for the key areas that require improvement (as determined by the team). The QIP document informs everyone in the service as to the direction, timeline, activities and outcomes expected in addressing the quality deficit.

The steps involved in developing a QIP action plan include:

- Identifying areas for improvement in response to the audit
- Devising responsive action plans (using the SMART methodology)
- Appointing a person to manage and monitor progress and follow-up on issues
- Setting a review date for evaluation/completion of the plan
- Escalating outstanding QIPs to senior management teams, detailing their level of completion.

3.11 Communicating audit results and QIP

- Some elements of the audit findings and QIP will need to be addressed by senior managers and staff working in the approved centre. It is acknowledged that a range of environmental improvement works will be identified that require capital investment.

- The benefit of using the audit tool is that it is objective and set within a common framework. The process described in this guideline also means that risks will have been prioritised for each location. Using the findings of the audit, the risk should be added to the risk register and actioned through the current mechanism. The quality and patient safety committees (or equivalent) will be required to advise the area mental health management team on the most significant risks and the plan to manage and mitigate them accordingly, using the risk management process in place.

3.12 Sustaining improvements

The ligature risk-reduction audit team's findings will be subject to monitoring by the senior managers in the approved centre (and periodically the area mental health management team) to ensure progress is being made on those items for which capital funding has been approved and that local managers are taking appropriate action to manage the risks, where indicated. Risks are managed in line with the HSE risk-management process (HSE Enterprise Risk Management Policy and Procedures 2023).

3.13 Training

All staff will have an awareness and understanding of the Ligature Risk Reduction Guideline. All staff who are identified as members of the ligature risk-reduction audit team will be provided with training on ligature anchor points and auditing for ligature risks.
All new audit team members will be accompanied by someone with experience of conducting ligature audits. Training on the updated guideline and the use of the audit tool are available on HSEland.

3.14 Specific roles and responsibilities

3.14.1 Area mental health management team and registered proprietor

- The area mental health management team, including the registered proprietor, is responsible for the implementation of the ligature risk-reduction policy within the approved centre.
- The area mental health management team, including the registered proprietor, is responsible for identifying the lead person(s) responsible for the ligature risk-reduction policy in the approved centre.
- The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of Service Users and the safety and well-being of service users, staff and visitors.
- The registered proprietor should ensure that a ligature risk reduction policy is in place and updated as required.
- The registered proprietor should ensure that the ligature risk-reduction audit is conducted at a minimum on an annual basis.
- The area mental health management team is responsible for seeking the resources required to enable appropriate action to be taken in light of the risk-management priorities identified in the ligature risk-reduction audit.
- The area mental health management team is responsible for nominating relevant persons to review the ligature risk-reduction policy, as and when required.

3.14.2 Ligature risk-reduction audit team

- The ligature risk audit team is responsible for carrying out the ligature risk audit within the approved centre.
- The ligature risk-reduction audit team is responsible for ensuring that there are effective

processes in place for the identification and prioritisation of ligature risks.

- The risk-reduction audit team will ensure that remedial works will be prioritised and escalate any risks that cannot be managed locally to the responsible quality and risk committee/QPS meetings. Audit findings and Quality improvement Plans are discussed at these meetings.
- The risk-reduction audit team is responsible for updating the progress on the audit tool quarterly
- The risk-reduction audit team is responsible for reviewing incidents regarding ligatures and ensuring corrective actions are put in place
- The risk-reduction audit team is responsible for recommending managed solutions to the Quality and Patient Safety Committee. If a solution cannot be found or if the service is unable to implement or carry out a proposed action then the risk-reduction audit team should ensure it is recorded on the risk register.
- The risk-reduction audit team will also take guidance from HSE Capital & Estates on their area of expertise.

3.14.3 Quality and Patient Safety (QPS) Committee

- The risk reduction audit team will report their findings and recommendations to the Quality and Patient Safety Committee. The Quality and Patient Safety Committee are responsible for the cascading of the relevant findings of the audit team to staff within the Approved centre.
- The Quality and Patient Safety Committee will review the arrangements in place and support services with the identification, recording, investigating and learning from serious incidents or adverse events involving patients, in line with the HSE Incident Management Framework 2020 and the Mental Health Act 2001 (Approved Centres), Regulation 32.

3.14.4 Staff within the approved centre

- All clinical staff working within the approved centre are responsible for providing evidence that they have read and understood this guideline and that they can articulate the processes relating to ligature risk reduction.
- All relevant staff should have a working knowledge of the content of the localised addendum ligature risk-reduction policy and ensure that they are aware of their roles and responsibilities.
- Staff should be constantly vigilant in relation to identifying and reporting ligature risks and should take appropriate steps, in line with local services policy.
- All staff are responsible for reporting incidents or near misses involving ligatures or anchor

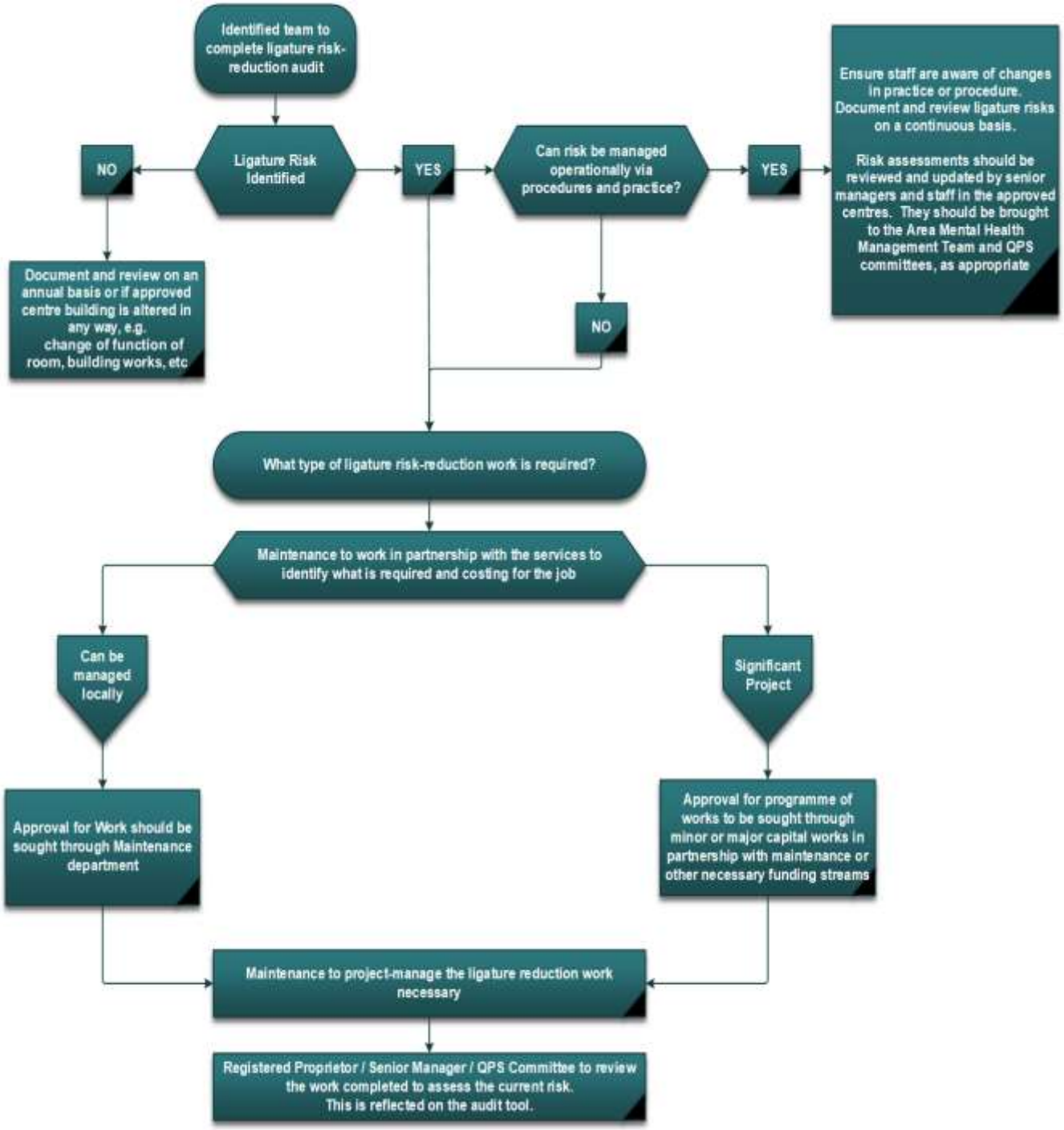
points on the National Incident Management System (NIMS) via the national incident reporting forms (NIRF).All relevant staff should complete education/training required by nominated staff under the remit of and approved by the area mental health team, e.g. training on the Ligature Risk-Reduction Policy and Audit Tool.

- Staff education and awareness on use and maintenance of ligature cutters.
- Every staff member has a responsibility to identify and manage risk within the context of his or her work.
- All staff should monitor ligature anchor point risk continuously, taking into account service user profiles, ligature anchor points, staffing and risk assessments.
- All staff members have a duty to safeguard their own health, safety and welfare and that of colleagues and service users.
- The CNM or nurse in charge is responsible for recording weekly checks to ensure that ligature cutters are located in designated locations.

3.14.5 Maintenance representative or Capital & Estates representative (based on your area)

- You will need to make contact with your local maintenance manager to support the undertaking of your local audit. In a few locations, capital & estates may also be involved.
- The local maintenance representative will support the undertaking of an annual ligature risk-reduction audit within mental health approved centres and the implementation of the quality improvement plan resulting from the audit.
- Service representatives will work with Capital & Estates and Maintenance teams to ensure that agreed anti-ligature service improvements, designs and installations are incorporated into any capital or minor works undertaken in mental health services.

3.14.6 Algorithm: Process map for identification, documentation and management/control of ligature anchor point identified risks



4.0 Consultation

4.1 Stakeholder involvement

The risk audit tool and associated procedures were presented to a number of forums as part of a consultation exercise, including:

- Executive Clinical Director Group
- Area Directors of Nursing Group
- Registered Proprietors Nominee Group
- Heads of Service Mental Health Group
- Service User/Family Member/Supporters Group
- Head of Service QSSI Group

Views were sought and feedback incorporated into the guideline document.

5.0 National implementation plan

5.1 Resource implications

- Each mental health service should identify resources to implement a local ligature risk-reduction policy and audit process.
- Major and minor capital resources should also be identified to address ligature anchor point risks.
- Service managers with support from local Maintenance teams should prioritise resources to address ligature anchor points.
-
- Clerical administration resources should be made available by each service.
- Staff training in ligature anchor awareness, auditing and suicide awareness should be provided.
- Staff education and awareness on use and maintenance of ligature cutters should be provided.
- Procedure for identifying and managing risks of ligature and ligature anchors should be accessible.
- Auditors to undertake ligature audit on an annual basis.

5.2 Describe the structure and governance of your national implementation team.

The National Mental Health office has lead responsibility for national implementation of this guideline. The office will be available to communicate, disseminate and provide guidance, education materials and support to enable local teams to implement the local policy and audit tool.

5.3 Tools and resources to support local implementation of your National PPPG

A sample implementation plan template is available in Appendix 4 of the National Template, available on the home page of the HSE National Central Repository]

5.4 Expected date of full implementation of your National PPPG

16 December 2024

6.0 Governance and approval

- The registered proprietor and senior management team in the approved centre are responsible for implementing the local ligature risk-reduction policy within their area, including the identification of responsible persons(s) to conduct the ligature anchor point audit.
- A ligature risk-reduction policy should be adopted by local mental health services and by those who provide the governance to ratify policies, procedures and guidelines.

7.0 Communication and dissemination plan

- This guideline will be made available to all HSE mental health staff members for onward dissemination and implementation within approved centres.
- Senior management are required to make this guideline available to all employees. Electronic and other communication means can be used to maximise distribution.
- Managers must create an awareness of this guideline throughout their services and ensure that employees under their supervision have read and understood the policy. A signature sheet is provided for this purpose (Appendix II).
- Communication and consultation with staff and service users in relation to the ligature

risk guideline and audit tool should occur throughout the process only on the HSE National Central Repository, which is the single trusted source for accessing, storage, and document control for National 3PGs. No duplicate copies of the National 3PG should be accessible in any secondary electronic locations, only the link to the document on the Repository should be used on other locations.

8.0 Sustainability

8.1 Monitoring

- Area mental health management teams should satisfy themselves that ligature risk-reduction audits are undertaken annually or more often if required. They are responsible for ensuring that control measures have been implemented and communicated appropriately.
- Area mental health management teams are responsible for developing and reviewing the mental health service risk register, including risk identification, risk assessment and risk treatment. Ligature risk-reduction quality-improvement plans should be reviewed on a quarterly basis to monitor progress.

- There must be ongoing daily monitoring by all staff, taking into account service user profiles, ligature anchor points, staffing and risk assessments.

8.2 Audit

- Annual ligature risk-reduction audits must be carried out by appropriately trained staff to ensure that they have identified all ligature anchor points. A ligature risk-reduction audit should also take place if there are any structural or decorative improvements to the environment or following an event where a service user has used a ligature point for the purpose of suicide or where there has been a near miss reported.

8.3 Evaluation

- Review and audit is in line with all legislative and best-practice requirements. Any changes to the Mental Health Act 2001, (Approved Centres) Regulations will be reflected in this guideline.

8.4 National Guideline Implementation Checklist/ National Guidance Compliance Audit tool

- This guideline recommends that each approved centre conduct an annual ligature anchor point audit. All risks identified must be documented and actively managed through the risk register process until they are closed off. This will ensure compliance with Mental Health Act 2001, Approved Centre Regulations, 2006, Regulation 22 and Regulation 32. (Appendix VI)

9.0 Review / update

9.1 Next review date

- This guideline will be updated by the national steering committee on 01 December 2027.
- Area mental health management teams are responsible for nominating relevant persons to review the addendum localised ligature risk-reduction policies as and when required to ensure they continue to guide practice.
- A ligature risk-reduction policy should be revised at least every three years in line with the Mental Health Act 2001 (Approved Centres) Regulations, 2006 and the Mental Health Commission Judgement Framework Version 6 (2024).

10.0 References

- Care Quality Commission (2015) Brief Guide for Inspection Teams, Ligature points
- Care Quality Commission CQC Brief Guide: Ligature Anchor points, ligatures ad other means of self-harm using fixtures and furniture (2022)
- Care Quality Commission (2023) Reducing Harm from Ligatures in Mental Health Wards and Wards for People with a Learning Disability
- Department of Health (2007) Sharing the Vision: A Mental Health Policy for Everyone Government Publications: Dublin
- Greater Manchester West NHS Foundation Trust (2009) Preventing Suicide by Hanging and Asphyxiation: Ligature Audit Tool
- NHS Greater Glasgow and Clyde (2022) Suicide Reduction and Management of Ligature Risks
- East London NHS Foundation Trust (2022) Ligature Risk Reduction Policy and Procedure
- Bendigo Health (2021) Mental Health Services Inpatient Units Ligature Risk Audit Protocol

- VHA National Center for Patient Safety; The Mental Health Environment of Care Checklist (MHEOCC) (2022)
- HSE (2023) National Centre for Clinical Audit: Clinical Audit – A Practical Guide
- HSE (2015) Approaches to ligature audit across all Community Healthcare Organisations Mental Health: Internal Review
- HSE (2015) Connecting For Life Ireland's National Strategy to Reduce Suicide 2015-2020, HSE: Dublin
- HSE (2023) How to Develop HSE National Policies, Procedures, Protocols and Non-Clinical Guidelines: A Practical Guide
- HSE (2017) Best Practice Guidance for Mental Health Services Mental Health Services: Dublin
- HSE (2023) HSE Enterprise Risk Management Policy and Procedures
- HSE (2005) Health and Safety Policy https://healthservice.hse.ie/staff/health-and-safety/health-and-safety-legislation/
- HSE (2020) Incident Management Framework and Guidance
- HSE (2023) HSE National Patient Safety Alerts Committee: Standard Operating Procedure for identifying, developing and disseminating National Patient Safety Alerts and Patient Safety Supplements
- HSE (2024) Recording Open Disclosure on NIMS and reporting Notifiable Incidents to the Relevant Regulator
- Leicestershire Partnership (NHS,2019) Management of Ligatures Policy
- Mental Health Commission (2024) Judgement Support Framework: Working Together for Quality- Version 6, Mental Health Commission: Dublin
- Mental Health Commission (2023) Mental Health Commission Annual Report 2022, including Report of the Inspector of Mental Health Services
- Mental Health Commission (2023) The National Quality Framework: Driving Excellence in Mental Health Services
- Mental Health Commission (2024) Regulatory Guidance for Approved Centres: Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023)
- Mental Health Commission (2024) Guidance on Quality and Safety Notifications
- Mental Health Justice Health and Alcohol & Drug Services (2019) Canberra Hospital and Health Services Operational Procedure, Ligature Risk Management for Mental Health, Justice Health and Alcohol & Drug Services Inpatient Mental Health Units ACT Health: Canbarra
- Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.
- Queensland Health (2012) Guideline for Managing Ligature Risks in Public Health

Services
- Sussex partnership (2013) Ligature &Anchor Point Risk Reduction Policy
- The Law Society of South Australia (2018) Queensland Coroner calls for guidelines to reduce residential suicide risk in mental health units – review of the inquest into the deaths of Steven Hitchins and Shawn Gudge, Iredale & Liu, Australian Health Law Bulletin: May 2018.
- The Cymru NHS Wales Health & Safety Committee Pwyllgor Iechyd A Diogelwch; Assessment and Management of Environmental Ligature Risks Procedure (2022)
- West London Mental Health Trust (2015) Policy L7:Ligature Risk Reduction Policy and Procedure
- Worchester Mental Health Partnership (2007) Policy for assessing, addressing and managing ligature risks in in-patient areas, 24 hour (off-site) nursed units and other clinical/ treatment areas

11 Glossary of Terms

Anti-ligature fitting: An anti-ligature fitting is any fitting that is designed in such a way as to prevent a ligature being attached to it. An anti-ligature fitting should:

- Cause the ligature to slip off, or
- Break away from its mount at 20kg or less, when placed under pressure of weight.

Anti-ligature curtains and curtain rails should break away at 40kg or less, in accordance with the manufacturer's instructions.

Approved centre: A '**centre**' is defined in the Mental Health Act 2001 as "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" and an '**approved centre'** is a centre that is registered by the Mental Health Commission.

Area Mental Health Management Team consists of senior representatives of the clinical professions, an experienced business manager and a service user representative and provides leadership, direction and support to local services.

Example of membership

- Executive Clinical Director
- Heads of Discipline (Speech and Language Therapy, Psychology, Social Work)
- Area Director of Nursing
- Area Lead for Mental Health Engagement
- Business Manager

HSE: Health Service Executive.

Incident:

An event or circumstance, which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events, which result in harm; near misses, which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be clinical or non-clinical and include incidents associated with harm to:

- patients, service users, staff and visitors
- the attainment of HSE objectives
- ICT systems
- data security e.g. data protection breaches
- the environment

(Incident Management Framework 2020).

Ligature: A ligature can be defined as anything a person can use to hang or strangle themselves. It can be made from anything that can be used to form a noose that may be used for self-strangulation and not necessarily obviously able to support body weight, including items such as:

- Plastic bags (including bin liners for sanitary bins), baby wipes and Personal Protective Equipment
- Belts, braces and handbag straps
- Boot and shoe laces
- Electrical cable flex and leads, including computer cables and mobile chargers, headphone leads
- Ties, scarves and headbands including Sarabands
- Underwear, including bra straps
- Rubber strips from door seals, double-glazed windows, dust strips on cubicle curtain tracking.
- Torn strips of clothing, piping/seams on clothing, towels or bedding
- 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).
- Chains, ropes, hoses, string.
- Curtains – shower curtains, window curtains, cubicle curtains.

- Bedding
- Rubber strips – from fire doors, double glazing
- ***This list is not exhaustive***

Ligature anchor point: An anchor point is a solid point that would support body weight and can be used to attach a ligature for the purpose of hanging or strangulation. It is commonly thought that there is a requirement that an anchor point requires height, but the actual height needed could be as small as a few inches with the patient/service user being able to slump sideways from an almost seated or even prone position. This could include:

- Shower heads, shower controls and shower rails
- Coat and towel hooks
- Gaps between a window, or door and its frame
- Sink taps, sink plugs, waste and water pipes
- Window door or cupboard edges and frames
- Window curtain, bed curtain and shower rails
- Ventilation grilles, ceiling vents and ducts.
- Furniture, for example, chair/table legs, metal bed frames, arms, etc.
- ***This is not an exhaustive list and other potential ligature points should be considered.***

Ligature Cutter e.g. Hoffman's or Barringtons: 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.

MDT: Multidisciplinary Team

NPSA: National Patient Safety Alert

National Incident Management System (NIMS):

The National Incident Management System, hosted by the State Claims Agency, is a highly secure web-based database, which facilitates direct reporting of adverse events by State authorities and healthcare enterprises; it is the single designated system for reporting of all incidents in the public healthcare system i.e. for HSE and HSE funded services.

National Incident Reporting Form (NIRF):
The National Incident Report Form was developed by the State Claims Agency in conjunction with all stakeholders including the HSE and voluntary hospitals. Use of a NIRF assures the accuracy of data and clarity of information being reported. There are four forms in total: Person, Property, Crash/Collision and Dangerous Occurrences/Reportable Circumstance i.e. Dangerous Occurrences/ Reportable Circumstances.

Near Miss:
Near Miss An incident that was prevented from occurring due to timely intervention or chance and which there are reasonable grounds for believing could have resulted, if it had not been so prevented, in unintended or unanticipated injury or harm to a service user during the provision of a health service to that service user. (National Standards for the Conduct of Reviews of Patient Safety Incidents and cited in Incident Management Framework 2020).

Patient Safety:
The term used nationally and internationally to describe the freedom from unnecessary harm or potential harm associated with healthcare services and the reduction of risk of unnecessary harm to an acceptable minimum (World Health Organisation, 2009). Where the term patient is used to describe ‘patient safety incident’, ‘quality and patient safety committees’ or ‘patient safety data’, it is intended to encompass all definitions of people who use health (including mental health) care services e.g. service users in both acute and community health care settings (Incident Management Framework 2020).

Patient safety incident:
A patient safety incident, in relation to the provision of a health service to a patient by a health services provider, means “an incident which occurs during the course of the provision of a health service” which: (a) has caused an unintended or unanticipated injury, or harm, to the Patient (b) did not result in actual injury or harm to the patient but was one which the health services provider has reasonable grounds to believe placed the patient at risk of unintended or unanticipated injury or harm or (c) unanticipated or unintended injury or harm to the patient was prevented, either by “timely intervention or by chance”, but the incident was one which the health services provider has reasonable grounds for believing could have resulted in injury or harm, if not prevented. (Civil Liability Amendment Act 2017)

Quality and Risk committee/Quality and Patients Safety (QPS) committee A sub-group of the area mental health management team.

Reporting Notifiable Incidents to the Mental Health Commission under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023

The 2023 Act provides a legislative framework for a number of important patient safety issues, including the mandatory open disclosure of a list of specified serious patient safety incidents that must be disclosed to the patient and/or their family and the notification of the same to the reportable bodies defined in the 2023 Act - the Health Information and Quality Authority, the Chief Inspector of Social Services and the Mental Health Commission.

Under the 2023 Act, approved centres will be required to notify certain incidents to the MHC through the new functionality of the National Incident Management System (NIMS). One of these notifiable incident types relevant to this guideline is 1.12: *"An unintended death where the cause is believed to be the suicide of a patient while being cared for in or at a place or premises in which a health services provider provides a health service whether or not the death was anticipated or arose from, or was wholly or partially attributable to, the illness or underlying condition of the patient".*

The MHC has updated its guidance on quality and safety notifications at Guidance on Quality and Safety Notifications
The MHC have also developed regulatory guidance to support service providers to comply with the requirement of the 2023 Act at Regulatory Guidance for Approved Centres on the Patient Safety Act 2023
The HSE have information about the Patient Safety (Notifiable Incidents) Act 2023 at: Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 - Corporate (hse.ie)
The HSE also have resources for HSE staff and HSE organisations at Resources for staff and organisations - Corporate (hse.ie)

12 Appendices

Appendix I: Floor plan risk map

Appendix II: Signature sheet

Appendix III: Membership of the PPPG Development Group

Appendix IV: Explanatory Guideline for the Ligature Risk-Reduction Audit Tool

Appendix V: National Guideline Implementation Checklist

Appendix I

Floor plan risk map

Floor plan risk maps (FPRMs) are used to map and identify ligature risk areas. They can be used in conjunction with the ligature risk-reduction strategy to raise staff awareness about areas within the approved centre identified or zoned as high, medium or low risk. They are colour coded to ensure quick reference and identification of higher risk areas of the centre: Red (high risk), amber (medium risk) and green (low risk).

For the purposes of this policy, areas should be risk assessed using a 24-hour approach. A common area in the green (low risk) zone during the day may become high risk due to lack of persons present during the night or evening. Please see risk zones below and a table outlining examples on page 23.

FPRMs are stored safely and not on display. FPRMs are used to assist the clinical handover process by specifically indicating the location of persons in need of higher levels of vigilance. FPRMs can also be included in the orientation of new staff to mental health approved centres.

Red zone **High risk**

Places where people receiving treatment and care are alone and away from direct observation and other persons for extended periods. This includes all bedrooms, shower/toilet ensuites, toilets located in common areas, and areas within the floorplan of the unit. These areas are to be zoned high risk and colour-coded red.

Amber zone **Medium risk**

Areas where people receiving treatment and care may be unsupervised for periods but are within the centre or department environment. Contact with other persons or staff may be occasional, dependent on the number of people in the centre and staff duties. Examples include therapy areas, activity rooms, lounges, kitchens, quiet areas, spiritual rooms and gardens. If some of these areas have limited observation at night and are not locked they may become high- risk zones.

Green zone **Low risk**

Common areas where people receiving treatment and care are regularly supervised and/or are regularly in the company of other persons, e.g. dining rooms, main corridors, reception areas, etc.

If common areas have limited observation at night and are not locked, they may become high-risk zones.

ROOM DESIGNATION

Zone designation rating 3 – High isolation	Zone designation rating 2 – Medium isolation	Zone designation rating 1 – Low isolation
Most service users spend periods of time in private without direct supervision, e.g. • All bedrooms • Toilet areas • Shower/bathroom areas • Other isolated areas of the ward	Most service users spend long periods of time with minimum direct supervision of staff and are usually in company of peers, e.g. •TV lounges •Day rooms •Open dining rooms •Activity/recreation rooms •Unlocked therapy rooms •Unlocked offices •Unlocked kitchens •Enclosed garden/courtyard area	Areas where there is traffic from staff and service users moving through and isolation is unlikely, e.g. •General circulation spaces •Corridors •Locked rooms

Note: **While areas can be categorised and zoned according to the level of risk, unpredictable and opportunistic risks will arise within any environment and vigilance is required, particularly at night, even in areas zoned and assessed as low risk. Anchor points can be introduced to an environment between audit cycles and therefore it is important that staff recognise the risk associated with this and have a plan to manage them.**

Appendix II

Signature sheet

I have read, understand and agree to adhere to this policy, procedure, protocol or guideline:

Print name	Signature	Area of work	Date

Appendix III

Membership of the PPPG Development Group

Please list all members of the development group (and title) involved in the development of the document.

Tony McCusker (Chairperson) General Manager, HSE Mental Health Operations	**Leo Kinsella** Head of Service Mental Health Services Mental Health Office CHO1
Paul Braham Senior Operations Manager/NFMHS Programme Director HSE Mental Health Operations & Performance	**Eugene Meehan** Area Director of Nursing Louth/Meath Mental Health Services
Aisling Duffy Senior Project Manager HSE Mental Health Operations	**David Timmons** Area Director of Nursing National Forensic Mental Health Services
Georgina Morrow Quality & Patient Safety Manager Community Operations - Mental Health	**Fiona Garvey** Quality & Patient Safety Manager, QPS Office, Access and Integration
Dr Amir Niazi National Clinical Advisor and Group Lead - Mental Health HSE National Mental Health	**Deirdre Groarke** Estates Manager Health, Safety & Infrastructural Risk HSE Capital & Estates
Feargus Callagy Peer Support Worker Mayo Mental Health Service	**Jenny O Brien** Business Manager Office of the National Clinical Advisor and Group Lead for Mental Health HSE National Mental Health

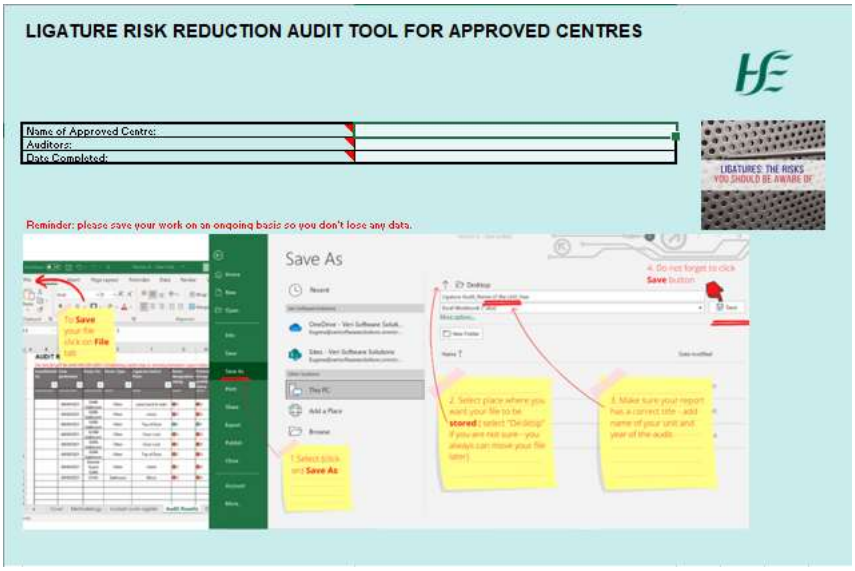
Appendix IV

Explanatory Guideline for the Ligature Risk-Reduction Audit Tool

To support staff to implement a Ligature Risk-Reduction Policy within an approved centre, a ligature risk-reduction audit software tool has been developed.

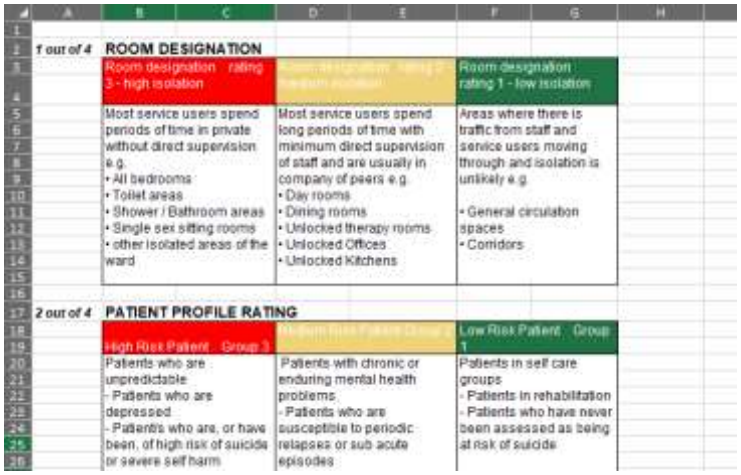
TOP TIP
Failure to "enable editing" and "content" will prevent the excel ligature risk reduction audit tool from performing all functionalities.

THERE ARE FIVE TABS IN THE AUDIT TOOL TAB 1: COVER SHEET



- NAME OF APPROVED CENTRE
- AUDITORS
- DATE OF COMPLETION OF AUDIT

TAB 2: METHODOLOGY



1 out of 4	ROOM DESIGNATION			
	Room designation rating 3 - high isolation	[illegible]	Room designation rating 1 - low isolation	
	Most service users spend periods of time in private without direct supervision e.g. • All bedrooms • Toilet areas • Shower / Bathroom areas • Single sex sitting rooms • other isolated areas of the ward	Most service users spend long periods of time with minimum direct supervision of staff and are usually in company of peers e.g. • Day rooms • Dining rooms • Unlocked therapy rooms • Unlocked Offices • Unlocked Kitchens	Areas where there is traffic from staff and service users moving through and isolation is unlikely e.g. • General circulation spaces • Corridors	
2 out of 4	PATIENT PROFILE RATING			
	High Risk Patient - Group 3	[illegible]	Low Risk Patient - Group 1	
	Patients who are unpredictable - Patients who are depressed - Patient's who are, or have been, of high risk of suicide or severe self harm	Patients with chronic or enduring mental health problems - Patients who are susceptible to periodic relapses or sub acute episodes	Patients in self care groups - Patients in rehabilitation - Patients who have never been assessed as being at risk of suicide	

This page provides the risk criteria information as defined in the in the guideline document:

ROOM DESIGNATION

PATIENT PROFILE RATING

LIGATURE POINT RATING

COMPENSATORY FACTORS

This supports the auditors in determining the relevant score for each criterion and provides examples. It also provides the formula for calculating the risk rating.

TAB 3: AUDIT RESULTS

This is where we insert our findings and the actions to address any ligature anchor points identified. There are a number of columns to be completed as below.

Insert name of the area or ward being audited

Insert the date of the entry, i.e. date of the audit

Insert the room number

Insert the room type

Insert the name of the ligature point, e.g. door handle, sanitary ware, curtain rails etc.

For the following 4 columns: room designation, patient group, ligature point rating and compensatory factors, please see description of this methodology and risk rating tables that will assist you to determine what risk rating to apply in these columns in Appendix One of the explanatory guide. Insert number 1, 2, or 3 in each column based upon the criteria outlined with the exception of height of ligature anchor point, which will always receive a rating of 3. The audit tool has a formula, which will multiply the ratings of these four categories together to give a total risk rating score for the ligature anchor. The colour of the total score will indicate the risk rating, red for high, amber for moderate or green for low risk.

CALCULATING THE RISK RATING

The software tool will multiply **Room Designation Score x Patient Population Profile x Ligature Point Rating x Compensation Factor** to give the final risk rating score of the

Ligature Anchor Point. This is automatically calculated by the tool, using the formula, which has been inserted and protected. The scores are risk rated as follows and colour coded automatically by a formula on the audit tool for easy identification of the risk ratings.

- **Low = 1-23**
- **Medium = 24-53**
- **High = 54-81**

Based on the risk rating an action plan is created to minimise or reduce each ligature anchor point if appropriate. Some ligature anchor points can be managed through risk assessment and observational policies. Consideration should be given to the use of the approved centre. Some long term facilities are people's homes, removing all ligature anchor points could leave the area very stark and non-therapeutic which may not be necessary based on suicide and self-harm risk assessment of the services users with chronic or enduring mental health needs living there.

1. Insert an **action plan** to address the ligature anchor point. It is important to use a suite of standardised terminology and be completely consistent with naming the ligature anchors. This will support filtering and generating accurate reports.

2. Insert name of **lead person responsible** for the action

3. Insert **date** by which action is due to be completed

The results of the audit are discussed with the team and communicated to all who are named as responsible for actions. It should also be communicated to the QPS committee and relevant managers.

Staff members link directly with maintenance to agree the work schedule and to update the tool on a monthly basis as remedial works are completed.

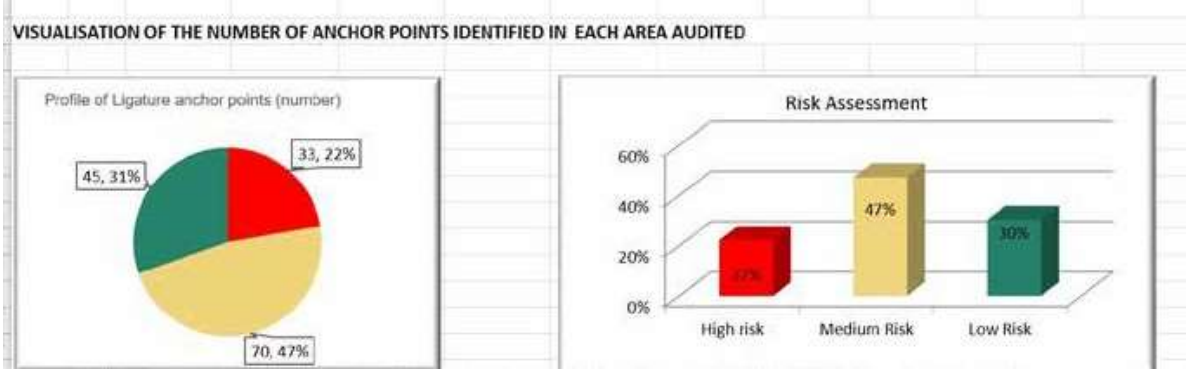
To support work being communicated to responsible persons/teams, the audit results worksheet can be filtered. For example:

1. Select column - 'Lead person'
2. Click on small box with triangle
3. A drop-down list of names will appear
4. Click on 'Select all' (ticks will disappear)
5. Select appropriate person from the drop-down list
6. Click 'OK'
7. All actions relating to this person will filter
8. Select 'File' & 'Save as' and it will save all actions relating to the lead person. This list can be emailed to them to action
9. To revert back to original list showing the entire action plan, click on small box with triangle and select 'All' and click 'OK'
10. On completion of any actions, update the spreadsheet on a regular basis as follows: Insert date of completion in column I and it will automatically turn green. This can also be filtered to generate a report on completed actions, if required.

Tab 4: ANALYSIS OF AUDIT FINDINGS

The analysis / number of ligature points identified in each area audited table will be self-generated from Tab 4.

The table will automatically calculate horizontally the total number of ligatures in each risk category and will generate a total figure and percentage of total. The table will also automatically calculate vertically the total number of ligatures for each area audited and



the total number for the approved centre. Visual charts will be automatically generated.

TAB 5: MONITORING RESULTS

This Tab will identify changes in relation to ligature removed and ligature anchor point remaining in each area. It will auto generate once ligature anchor point action plans are marked complete on the audit results tab. This can be printed off each quarter or saved to keep a record of progress.

Appendix V

National Guideline Implementation Checklist

Each statement in this Implementation Checklist has been taken from the accompanying Guideline on the Development and Implementation of Ligature Risk-Reduction and Audit Tool.

It is intended that this tool will provide each approved centre with a baseline through which they can assess to what degree they comply with the statements in their own area of practice and identify areas which require improvements. In the event of non-compliance, action plans should be developed and reviewed regularly as part of local quality improvement process. Completed tools should be kept locally for good practice assurance.

Users of this guideline compliance audit tool are free to add in additional statements, as they deem appropriate and adopt this tool for use in their own setting. This compliance audit tool is to be used to retrospectively audit practices.

Methodology

Population: A sample of target users e.g. members of Ligature risk-reduction team, Area mental health management team, QPS committee and Staff within the Approved Centre.
Sampling: A total of 10% or 10 target users, whichever is greater, should be selected.
Frequency: To be determined locally at least annually.
Method: Record **Y** for **Yes**, if the criteria are met. Record **N** for **No**, if criteria are not met or **N/A** for **Not applicable**.
Compliance requirement: 100%

Is standard/criteria being met for the following statements:	**Yes**	**No**	**N/A**	**Evidence** (Date of Policy/ Audit / Training / QIP Review etc)
Statement 1 *Has your service developed a Ligature Risk-Reduction Policy/Guideline?*				
Statement 2 *Is a ligature risk reduction audit conducted in approved centre at least annually?*				
Statement 3 *Is the HSE Mental Health Services Excel Ligature Risk-reduction Audit Tool used for this audit?*				
Statement 4 *Have all members of Ligature risk-reduction audit team received training on ligature anchor points and auditing for ligature risks?*				
Statement 5				

Are potential ligature anchor point identified during this audit documented and addressed via Quality Improvement Plan (QIP) / Risk Register process?				
Statement 6 *Are quarterly updates recorded on progress of ligature risk-reduction audit tool findings?*				
Statement 7 *Has the QPS committee cascaded relevant findings of the ligature risk-reduction audit to staff in the approved centre?*				
Statement 8 *Has there been an incident or near miss involving a ligature or anchor point since last audit*? If yes, did this trigger an immediate re-audit?				
Date of Audit: **Audited by (name/title):** **Compliance Rate %:**				
Calculation of Compliance Rate %: The score, expressed as a percentage, is calculated by dividing the number of "yes" and "no" answers. "Not applicable" answers are excluded from the calculation of the percentage score. **Example:** If there are 6 "yes" and 2 "no" answers, the score is calculated as follows: 6 (yes answers) divided by 8 (total of yes and no answers) multiplied by 100 = 75%				