Reviewing ligature points in communal areas and developing area-specific ligature risk-assessment folders

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<table>
<thead>
<tr>
<th>Trust name</th>
<th>Oxleas NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Provider type</td>
<td>Mental health</td>
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<tr>
<td>Site (if applicable)</td>
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<tr>
<td>Core service</td>
<td>Acute inpatient mental health wards</td>
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<tr>
<td>CQC rating (safe)</td>
<td>Good</td>
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<td>CQC rating (Overall)</td>
<td>Good</td>
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The challenge

Oxleas NHS Foundation Trust provides a wide range of health and social care services in south east London, specialising in community health, mental health and learning disability services. It employs around 3,500 people including many skilled health and social care professionals and has over 125 sites across the London boroughs of Bexley, Bromley and Greenwich, and into Kent.

Services include physical health services to adults and children in the community in Bexley and Greenwich. These range from health visitors working with the very young to district nurses and therapists meeting the physical health needs of older people. The trust has also been the main provider of specialist mental healthcare in Bexley, Bromley and Greenwich for over 10 years and provides specialist forensic mental healthcare across south east London and in Kent prisons.

As for any mental health organisation, environmental risk assessments and the identification and mitigation of potential objects which may act as ligature points in the event of a suicide attempt are an important element in the trust’s overall safety strategy. Whilst these had always been completed in inpatient areas, in line with national guidance, this was not the case for communal areas, such as kitchen and lounge.

This was highlighted during a Care Quality Commission (CQC) inspection in March 2016, with inspectors referring to good practice elsewhere suggesting that communal areas also had to be risk assessed for ligature points. The trust was requested to address this issue as a matter of urgency.
The solution

The trust immediately acted on the recommendation to review all communal areas in inpatient, day treatment and crises services.

However, as for many other trusts, it was not possible to remove every potential hazardous ligature point: there were some that could either not be practically removed, or such removal would be so costly that the trust could not afford it.

Therefore, the trust decided to mitigate ligature risks by equipping staff in all clinical areas with the awareness of these, as well as the knowledge how to minimise the risk of any such ligature point being misused for suicidal purposes.

The trust also took other mitigating actions including banning plastic bags and procuring special lockable bins, so that bags cannot be easily accessed. These were disseminated across all inpatient areas. Moreover, they banned the introduction of plastic bags to the forensic unit for both staff and service users.

Staff in the estates department worked closely with their clinical colleagues to devise an audit form and thoroughly screened all concerned areas.

To maximise the thoroughness of this review, the trust invited clinicians to inspect areas they don’t normally work in, to maximise their ability to identify ligature risk and overcome the risk of becoming de-sensitised through working in that environment.

They then produced a folder for each clinical area, including photographic evidence of potential ligature points and a written description of the mitigating action that each member of staff should take.

Newly enrolled staff are asked to review the folder and provide written evidence to show they have done so.

Enablers and challenges

Some clinical managers in clinical areas reported ‘risks identified’, without clearly stating what the mitigating action would be, which left clinical staff ill-equipped to mitigate risk.

The wide geographic area and number of sites of the trust posed a challenge for the estates team, who had to ensure that all areas were reviewed and appropriately risk assessed.
Impact

Before the CQC inspection in March 2016, the trust had already completed thorough ligature risk assessment for all patient rooms and this process was simply extended to communal areas. As there had not been any suicide attempts in these areas in the past, the impact of the intervention could not be measured, but the team was commended for their work during a follow up inspection in May 2017, during which the trust was rated ‘good’ in safety.

Next steps and sustainability

The trust continues to review its ligature risks and regularly update the registers.

Want to know more?

Have a look at the trust team produced for one of its clinical areas:

- ligature risk assessment folder

For more information, contact:

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To see the other case studies in this series: visit the NHS Improvement website at: Improving quality and safety in healthcare.