Humber Teaching
NHS Foundation Trust

Clinical Environmental Risk Assessment and Management Policy incorporating the Ligature Anchor Point Tool (OP-002)

Version Number:	1.6
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Name of approving body:	Quality and Patient Safety Group (QPaS)
Date full policy approved:	27 June 2024
Date Ratified at Trust Board:	N/a
Next Full Review date:	June 2027

Date approved by Lead Director:	
Date EMT as approving body notified for information:	

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

This policy incorporates the annual ligature anchor point assessment tool, which has been rewritten using the resources provided by the National Mental Health and Learning Disabilities Nurse Directors Forum, supported by the CQC Reducing harm from ligatures in mental health wards and wards for people with a learning disability - Care Quality Commission (cqc.org.uk). This policy should be read in conjunction with this guidance.

Providing care and treatment in a safe and therapeutic environment by knowledgeable and skilled staff is core to the recovery of individuals and to the prevention of death and other harm by suicide. The guidance incorporates the assessment of the built environment along with mitigating factors that include therapeutic engagement, staffing and staff training, technology, and procurement.

This policy has been written with reference to the Trust's Clinical Risk policy, the Supportive Engagement policy and guidelines, and PSIRF policies.

Human Rights Act 1998
No procedure considering the clinical environment and the manner in which we care for patients would be complete without reminding Trust employees of the Human Rights Act.

Specific relevance is given to Article 3 for the purposes of this policy.

Protection from torture and mistreatment

- Torture
- Inhuman or degrading treatment or punishment

Public authorities must not inflict such treatment and must protect from this treatment when it comes from someone else.

What is torture?

Torture occurs when someone acting in an official capacity deliberately causes serious pain or suffering (physical and mental) to another person. This might be to punish someone or to intimidate or obtain information from them.

What is inhumane treatment?

- Serious physical assaults
- Psychological interrogation
- Inhumane detention conditions or restraints
- Failing to give medical treatment or taking it away
- Threatening to torture someone

Treatment is likely to be degrading if it arouses feelings of anguish, fear and inferiority capable of humiliating the victim.

What will determine the matter is the effect of the treatment, not the motive for administering it. In many circumstances, the treatment may have a much more severe effect on children than on adults

2. SCOPE

This policy applies to all inpatient and crisis facilities in mental health and learning disability services.

All inpatient mental health, learning disability and crisis facilities (where patients who are deemed as acutely unwell and may be left without direct supervision) must undertake an annual audit that

assists with consideration of the clinical environment and impact upon patient safety. This assessment tool will allow clinical staff to highlight areas of concern and good practice arising in the clinical environment and provide guidance on escalation routes to deal with matters accordingly.

3. POLICY STATEMENT

This policy is written for inpatient mental health, learning disability and crisis services to assess the clinical environment in respect of risks and restrictions to the patient group. It is a mandatory requirement to assess the mental health and learning disabilities inpatient environment annually.

Humber Teaching NHS Foundation Trust has adopted this nationally approved tool to help staff address the risks within the clinical environment in a balanced, objective and systematic way. This assessment forms just one part of the Trust's approach to assessing, managing and mitigating clinical risk.

4. DUTIES AND RESPONSIBILITIES

Staff group	Duties
Director of nursing	The Director of Nursing has overall responsibility for ensuring that the Trust has in place clear processes for managing risks associated with the environment and ligature anchor points. That appropriate arrangements are in place to enable safe and effective care and that employees are fully aware of their statutory, organisational and professional responsibilities and that these are fulfilled.
Estates department	The estates department is responsible for ensuring attendance at the Clinical Environment Risk Group and providing specialist advice and support on estates solutions and actions in respect of risks identified within the clinical environments. The estates department will assist the matrons and service managers with the development of business cases as appropriate to offer solutions to risks identified.
Divisional general managers and clinical leads	Responsible for the development and implementation of a comprehensive procedure for auditing and managing the risks within the clinical environment (Risk Assessment for Clinical Environments: RACE). One of the General Managers/Clinical Leads will chair the Trust clinical environment risk group for mental health (CERG) through which all risk audits of the clinical environment will be scrutinised and quality checked prior to identification of actions by the care groups.
Service managers, matrons	• Ensure that the procedure is implemented within their area of responsibility. • Ensure that matrons work with ward managers to complete the audit. • Understand the nature of risks identified within each area and formulate possible solutions and action plans to reduce risks to patient safety wherever possible • Attend the clinical environment risk group for mental health.
Ward managers	• Ensure that they undertake the ligature risk assessment process at least once per year and when any changes to the environment or working practices occur that affect the content of the current assessment.

Staff group	Duties
	• Ensure that this assessment is carried out with the matron or appropriate other. • Ensure that outcomes of the assessment are shared with all staff in the clinical team to ensure they are aware of the risks within the environment and their role and that all staff are aware of this procedure, understand it and adhere to it. • Ensure a skilled and competent workforce through staff appraisal, clinical supervision and personal development planning.
Registered practitioners	• Read the risk assessments for their clinical place of work • Ensure that the required actions in relation to the clinical practice to mitigate risks to patient safety are maintained at all times. • Where practice cannot be maintained that this is escalated to the ward manager or equivalent with immediate effect. • Ensure that unexpected changes to the environment or management of the environment are considered in respect of the current risk assessment, referring to the ward manager or, out of hours, discussing any concerns with the on call manager.
Non-registered clinical staff	Read the risk assessment relevant to their clinical area of work and have an awareness of the local procedures for managing risks relating to ligatures and ligature points. Non-registered clinical staff will ensure they follow the local working instructions and clinical practice standards in place to ensure patient safety. Where they are unable to do so they should report this to their line manager.
All staff	The Trust expects all staff to contribute to its determination to provide safe care and, in doing so, to uphold the statutory duty of candour and to meet the responsibilities articulated in their professional standards and in NHS and Trust values. All staff should ensure that they are familiar with the requirements of the legal duty of candour, as set out in the Trust's duty of candour procedure

5. PROCEDURES

Description of Process for Risk Assessment for Clinical Environments (RACE)
The Trust has agreed that the RACE will be completed in a twelve-monthly cycle by Quarter 3 (September to December) each year. This allows for appropriate forward planning in relation to the financial plans of the Trust and prioritising environmental works and costings for the capital bids processes.

Risk assessment of the clinical environment, including the ligature point assessment (see appendices)
The matron or equivalent must ensure that the ligature assessment is completed at least twelve-monthly, following guidance in the appendices. This should be updated whenever structural or decorative changes to the environment have been undertaken since the last assessment.

- The assessment team must consist of a minimum of three people, of which two should be familiar with conducting assessments of the clinical environment, particularly in relation to identifying ligature anchor points. One person should be external to the area to enable "fresh eyes" on the environment. If possible, a person with lived experience or a patient safety partner should be part of the assessing team.
- The assessment team should have familiarised themselves with the assessment tool, including the tiers and mitigating factors, prior to commencing the assessment on the unit.

- A thorough assessment of the ward environment can be a time-consuming process
- If during the assessment an immediate risk becomes apparent and the assessment team feel this is unmanaged and presents a significant risk to patients requiring immediate action, a member of the team must contact the appropriate Divisional general manager or clinical lead for advice and support. If possible, discussions should also take place with the chair of CERG. An agreed plan should be documented to maintain patient safety for the identified risk.
- Visual checks of all identified anti-ligature fixtures/fittings must be undertaken as part of the annual review. Checks should include areas where ligature points may be less obvious or easy to reach and where wear and tear may have altered the effectiveness of fixtures/fittings. Where possible a physical test/inspection should be undertaken. Where any fixture/fittings are not deemed to be safe this must be escalated as per policy through the estates department for action and a risk management plan put in place until the works are completed.
- All areas of the ward including outdoor areas accessed by patients should be audited. Where more than one ward utilises a shared space, discussion and documentation between unit managers should take place as to which team audit the shared space. The matron is responsible for ensuring the overall environment has been appropriately audited. The assessments will be captured electronically held centrally and administered by CERG, with local copies in the clinical area.
- All **identified** ligature anchor points should be acted on appropriately, i.e. remove immediately where possible; restrict access; or control by local procedure including clinical management.
- Any works to remove/reduce an identified ligature risk must be visually inspected by the Manager or Lead for the ward or their nominated deputy as well as by a representative from the estates department, before it is deemed acceptable.
- Where ligature anchor points have been identified and recorded on the assessment tool the actions to ensure that suitable and immediate controls measures are put in place to safeguard patients will be completed. Once reviewed by CERG a decision will be made about which risks should be put forward to the care groups for recording on the risk register.
- The ward managers must ensure that the staff team are aware of identified risks and controls put in place to manage the risk. A clear communication plan including use of the environmental induction booklet or equivalent is essential.
- The RACE and any subsequent risk assessment must take into account the level of possible clinical risk presented by the patients on the ward/unit.

The assessment team must identify potential ligature anchor points in relation not just to their height in the room, but to the length of time which a patient may be able to be left unsupervised there. The assessment team should use their professional judgement to rate the risk level of the ligature point, using the Tiers and mitigating controls, as described in appendix 2.

Staff only areas
Areas of wards/units where patients are not permitted at all (for instance offices) do not need to be included in the ligature assessment.

RACE Clinical Environmental Assessment (Appendix 1)
This assessment must be conducted through two group meeting opportunities.

Patients and their carers should be invited to consider the assessment questions and asked to contribute their perspectives on the clinical environment. This can be facilitated in an existing unit meeting.

Staff from all disciplines and sectors should be invited to contribute their perspectives to the assessment questions and think about the safety and use of the clinical environment from their perspective.

These views should be pulled together and summarised in the assessment to be submitted to CERG alongside the ligature anchor point assessment.

Communicating the assessment outcome to the clinical team
The outcome of the assessment and control measures identified **must** be shared with all staff working in the area assessed, as management of the identified risks will involve therapeutic engagement and staff skills and presence. The recording tool (appendix 3) must be completed by the ward manager and matron (or equivalent). Immediate risks must be acted upon without delay to maintain safety. Each risk area must have details of the action taken to remediate the ligature point documented within the ligature risk assessment.

On completion, the assessment will have identified the following which must be actioned by the ward manager within 24 hours:

1. Actions for immediate escalation due to significant risk – datix report
2. Actions for logging with estates and interim mitigation plans
3. Actions for risks to be managed through clinical practice
4. Risks requiring business case development, including applications for funding to CERG

A local induction booklet of the clinical environment will be held on each unit for all staff to read and practice in line with the required standards. The induction booklet must be made available to all new starters, bank and agency staff who will work on the ward including domestic staff and porters. This must include the up to date ligature recording tool which includes management of the ligature points identified.

Ward managers should carry out a risk assessment on new equipment/items purchased or introduced into their care environment and must have in place safe systems of work to manage all equipment. The risk presented by these items must be considered in the context of the patient risk assessment and added to the RACE. Consideration can be given to the removal of these items to a secure environment if they present an unacceptable risk.

Role of the Clinical Environment Risk Group
The RACE will be taken to the clinical environment risk group for consistency, assurance and discussion on an annual basis for all service areas.

The clinical environmental risk group will:

- Sign off actions for clinically managed risks on the unit (challenge and confirm)
- Confirm actions logged for intervention through estates have been acted upon
- Support applications for business cases. Where appropriate, collate themes of work/risks to support the development of larger Trust-wide business cases
- Identify risks that require escalation for entry onto the risk register
- Report to QPaS via an annual report to provide updates and assurance.
- Estates will be represented within the group to inform decision making and solution options as necessary

6. EQUALITY AND DIVERSITY

An equality and diversity impact assessment has been carried out on this document using the Trust-approved EIA tool at the latest policy review.

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8. IMPLEMENTATION

Implementation of the policy began in December 2016 led by the assistant director of nursing for patient safety and safeguarding. Teams can request support to complete the tool through the clinical environment risk group.

9. MONITORING AND AUDIT

This will be through annual audit which will be carried out as per procedure with regards to ligature and RACE assessments.

10. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Procedure for the Removal of Ligatures and Safe Use of Ligature Cutters

Supportive Engagement Policy

Induction Policy

Appendix 1: Risk Assessment of Clinical Environments

Ward:
Date of Assessment: Auditors:

General Access

1. Exit from the ward

	Yes	No
Does the ward provide care to informal patients?		
Does the ward lock its front doors?		

Please provide a narrative on how the rights of informal patients are managed to ensure they can leave the ward when they wish, commenting on factors that may prevent this.

What environmental solutions do the clinical team/patient group believe would solve any issues highlighted above.

2. Access to personal space

	Yes	No
Can patients access their own bedrooms without restriction?		
Can patients lock their own bedroom to feel safe?		
Can staff override this function if a patient is felt to be at risk?		

Please provide a narrative on how patients access their bedrooms.

What solutions do the clinical team/patient group believe would solve this issue.

3. Access to shared social spaces and multi-use rooms

Can patients access without restrictions :	Yes	No
Garden/outdoor space during the day		
Lounge areas		

Quiet space		
Single gender space if a mixed gender ward		
Drinks		
Toilets		
Bathrooms/showers		

Please provide a narrative on how patients accessibility and restrictions for the areas above

What solutions do the clinical team/patient group believe would solve any issues.

4. Access to therapeutic space

Can patients access (restrictions may be in place due to safety reasons) :	Yes	No
Children's visiting space/family space		
Dining area space		
Space for activities		
Private rooms for 1:1 sessions		
Laundry facilities		

Are there any risk or restriction issues the clinical team or patients wish to raise?

5. Staff Access/Rapid Response

In the event of an emergency situation requiring a rapid response, are staff able to access all rooms in the unit easily?

	Yes	No
Are Anti-barricade fitments secured to all room doors where patients could be unescorted?		
Is the fitment easy to operate?		
Do all staff (including bank and agency) have access to keys/swipes required to provide a rapid response to emergency situations? Are they instructed how to operate the anti-barricade fitments		
Do bedroom doors have vision panels fitted for use in emergency situations?		
Can staff view shared social spaces with ease or are there voids and spaces that present observation challenges (within rooms)		

Are there any risk issues the clinical team wish to raise with regards to access & rapid response?

6. Lines of Sight

	Yes	No
Is the ward set on one floor?		
Does the ward change its monitoring of the environment and access to rooms from busier daytimes (and enhanced staffing levels) to night time?		
Are there any mirrors, CCTV or adjustments made to assist with lines of sight if required?		
If the ward has an outside area/garden, are lines of sight clear from the exit doors of the building for the entire outside area?		

Are there any risk issues the clinical team/patients wish to raise with regards to lines of sight or how these issues are mitigated/managed?

7. Seclusion Rooms

	Yes	No
Can patients communicate with staff if locked in the seclusion room?		
Is there a bed, pillow, mattress and blanket in the room, clean for use?		
Does the room have natural lighting?		
Does the door from seclusion open outwards?		
Can the heating/air con be controlled externally?		
Does the room have any blind spots?		
Can the patient see a clock from seclusion?		
Can the patient access the toilet and washing facilities as they request?		

Are there any risk issues the clinical team/patients wish to raise with regards to lines of sight?

Appendix 2: Tiers and Mitigating Controls

This guidance on levels or 'tiers' of risk and factors for mitigating controls for ligature point risks should be used in conjunction with the ligature point risk recording template (copied at appendix 3).

TIER 1

Low privacy/less opportunity to be alone. More reliance on clinical controls/more of a residential feel/more of a therapeutic focus.

Ward/service area type: Areas where patients have high supervision and are not typically left alone for long periods.

Examples (not limited to those detailed):

- Activity room
- Interview room
- Clinic room

Mitigating controls

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).
- Options for managing ligature points:
    - Remove all identified ligature points.
    - Where removal is not possible, individualised/system/process controls must be applied to minimise risks in areas with known ligature points.
    - Consider use of potential technological solutions to aid risk management.
    - Patient access is restricted when staff are not present.

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.

System/process

- Staff have undertaken awareness training and are competent in ligature management, therapeutic observation, and engagement.

- Robust MDT 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.
- 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 the room 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 and correct disposal of personal protective equipment (PPE).
- Search procedure available to support the reduction of ligature material entering the ward environment

TIER 2

High privacy/greater opportunity to be alone. Less reliance on clinical controls/more of an institutionalised feel/more of a safety focus

Ward/service area type: Areas patients may spend time with minimal supervision. These will typically be freely accessed or open communal areas.

Examples (not limited to those detailed):

- Lounges
- Day Rooms
- Dining Rooms

Mitigating controls

<u>Environmental</u>

- 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).
- Options for managing ligature points:
    - Remove all identified ligature points.
    - Where removal is not possible individualised/system/process controls must be applied to minimise risks in areas with known ligature points.
    - Consider use of potential technological solutions to aid risk management.

- Consider any adaptions to/in the room or equipment needed in response to patients' individual needs and/or the Equality Act 2010, that may introduce ligature risks.
- 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, technological interventions).

Individualised

- Individualised risk assessment and management, knowledge of individual patient risks and corresponding levels of therapeutic engagement and observation levels to ensure patients whereabouts is known.
- Appropriate staffing levels/staffing skill mix in accordance with patient acuity/risk management.
- Staff awareness of limitations to clear lines of sight and these are considered when assessing individual risk and management plans and inform levels of therapeutic engagement and observations.
- 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 competent in ligature management, therapeutic observation, and engagement.
- 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).
- 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).
- 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.
- Management of and access to ligature material; protocols to manage items brought on to the ward by patients, carers/families and/or staff and correct disposal of personal protective equipment (PPE).
- Search procedure available to support reduction of ligature material entering the ward environment.
- Staff are knowledgeable about available adaptations/equipment that could maximise lines of sight.

TIER 3

High privacy/ greater opportunity to be alone. Less reliance on clinical controls/more of an institutionalised feel/more of a safety focus.

Ward/service area type: Areas patients may spend a lot of time alone with minimal or no supervision.

Examples (not limited to those detailed):

- Bedroom
- Bathrooms
- En-Suites
- Toilets

Mitigating controls

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).
- To balance patient safety and dignity, removal or environmental mitigations and controls should be in place to allow privacy when using these areas – for example collapsible curtain/shower rails, anti/reduced ligature showerheads and doors.
- Consider any adaptions to/in the room or equipment needed in response to patients' individual needs and/or the Equality Act 2010, that may introduce ligature risks.
- Staff awareness of lines of sight, and where they need to be to maximise lines of sight.
- Technology to monitor private areas (for example, contact free patient management platform). However, use of vision based technology should take into account a patient's need for privacy, and only used with the patient's consent or in their best interests as agreed as part of a recognised process.
- Consideration of use of differing environments to manage immediate risk – for example de-escalation suite, seclusion room, PICU transfer if appropriate.

Individualised

- Individualised risk assessment and management, knowledge of individual patient risks and corresponding levels of therapeutic engagement and observation levels.
- Appropriate staffing levels/staffing skill mix in accordance with patient acuity/risk management.

System/process

- Staff have undertaken awareness training and are competent in ligature management, therapeutic observation, and engagement .

- 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).
- Consideration of room location when bed planning (for example, rooms that are easily visible/ have clear line of sight/ near team office).
- Management of and access to ligature material; protocols to manage items brought on to the ward by patients, carers/families and/or staff and correct disposal of personal protective equipment (PPE).
- Search procedure available to support reduction of ligature material entering the ward environment.
- Staff are knowledgeable about available adaptations/equipment that could maximise lines of sight.

Appendix 3: Ligature Anchor point recording template

Read the guidance for this template.
The recording template should be used in conjunction with the supporting 'Tier tables and mitigating controls' guidance.
Guidance for staff to minimise harm from ligatures within: **Ward/ service:** **Date of issue:** **Completed by:**
This guide has been produced following an intensive assessment of potential ligature point risks and review of local ward level information. The guide is designed to describe the potential known ligature point risks to inform those working on the ward about potential risks, controls, and mitigations and how to respond to a ligature event.
The guide contains only known information specific to Xxxx Ward and is not limited to ligature risks that may emerge that have not previously been identified.
Continued vigilance should be maintained to identify potential risks to patient and staff safety across all areas of the ward/ service.
Specific identified risks and controls to minimise harm
Consider the environment and mitigating controls/ actions to minimise harm e.g. areas with line-of-sight challenges, areas that should be locked/ only accessible by staff, potential to tailgate restricted areas, local arrangements such as use of baths.

Availability of items that may be used as a ligature and controls
Consider bedding, towels, clothes, charging cables, electrical equipment, PPE and disposal arrangements, items that can be adapted/tied together to form a ligature, search procedures following admission/leave from ward.
How to respond to a ligature event:
Outline of local protocol or where to find it. Inc how to raise alarm e.g. bell/ personal alarm systems. How to record incident on incident reporting systems
Location/type of ligature cutters (include pictures if helpful):
Enter local information.
Location of resus equipment:
Enter local information.
Incidents debrief/ support/ learning arrangements staff and patients:
Enter local information.
How to report a potential ligature risk e.g. damaged room/ area, new risk identified following a ligature event
Enter local information.

Appendix 4: Document Control Sheet

Document Type and Title:	Policy – Risk Assessment for Clinical Environments Policy (RACE) incorporating the Ligature Anchor Point Tool (OP-002)		
Document Purpose:	This policy applies to all inpatient and crisis facilities in mental health and learning disability services. Inpatient mental health, learning disability and crisis facilities (where patients who are deemed as acutely unwell and may be left without direct supervision) must undertake an annual assessment that assists with consideration of the clinical environment and impact upon patient safety. This assessment tool will allow clinical staff to highlight areas of concern and good practice arising in the clinical environment and provide guidance on escalation routes to deal with matters accordingly.		
Consultation/ Peer Review	Date	Group / Individual	
list in right hand columns consultation groups and dates	-	Clinical Environmental Risk Group (CERG)	
	-	QPaS	
Approving Body:	QPaS	Date of Approval:	27 June 2024
NB All new policies and policies subject to significant amendments require approval at EMT and Board ratification.		*(see document change history below for minor amendments and dates)*	
Ratified at:	Trust Board	Date of Ratification:	Sept 2016
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to EMT as the approving body that this has been delivered)*		Financial Resource Impact:	
Equality Impact Assessment undertaken?	Yes [√]	No [ ]	N/A [ ]
	If N/A, state rationale:		
Publication and Dissemination	Intranet [√]	Internet [ ]	Staff Email [√]
Master version held by:	Policy Management Team [√]	Author to send final document to HNF-TR.PolicyManagement@nhs.net	
Implementation:	*Describe implementation plans below - to be delivered by the author:* Implementation of the policy began in December 2016 led by the assistant director of nursing for patient safety and safeguarding. teams can request support to complete the tool through CERG.		
Monitoring and Compliance:			

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.0	*New policy*	*Sept 16*	*New policy approved.*
1.3	*Review*	*Sept 18*	*Minor amendments.*
1.5	*Full review*	*May 21*	*Minor amendments.*
1.6	*Full review*	*May 24*	*Reviewed and amended to incorporate new national guidance. Approved at Quality and Patient Safety Group (QPaS) on 27 June 2024.*

Appendix 5: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or process or service name: Risk Assessment for Clinical Environments Policy (RACE) incorporating the Ligature Anchor Point Tool (OP-002)
2. EIA reviewer: Nigel Hewitson, Modern Matron
3. Is this a policy, strategy, procedure, process, tender, service or other? Policy

Main Aims of the Document, Process or Service
Outlines rationale, 'Ligature Anchor point tool' to be used and frequency of assessment of clinical environments.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	Frequency of and assessment tool used will be the same for all age groups
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Low**	Frequency of, and assessment tool used will be consistent regardless of disability of patients involved. Focus is on minimising and mitigating environmental risk
Sex	Men/male Women/female	**Low**	Frequency of, and assessment tool used will be consistent regardless of gender of patients involved. Focus is on minimising and mitigating environmental risk
Marriage/Civil Partnership		**Low**	Frequency of, and assessment tool used will be consistent regardless of marital status of patients involved. Focus is on minimising and mitigating environmental risk
Pregnancy/Maternity		**Low**	Frequency of, and assessment tool used will be used and applied consistently across inpatient areas Focus is on minimising and mitigating environmental risk
Race	Colour Nationality Ethnic/national origins		Frequency of, and assessment tool used will be consistent regardless of Race of patients involved. Focus is on minimising and mitigating environmental risk

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Religion or belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	Frequency of, and assessment tool used will be consistent regardless of religion or belief of patients involved. Focus is on minimising and mitigating environmental risk. Those undertaking assessments will be sensitive to religious requirements.
Sexual orientation	Lesbian Gay men Bisexual	**Low**	Frequency of, and assessment tool used will be consistent regardless of sexual orientation of patients involved. Focus is on minimising and mitigating environmental risk.
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	Frequency of, and assessment tool used will be consistent regardless of Gender patient identifies with. Focus is on minimising and mitigating environmental risk. Those undertaking assessments will be sensitive to Gender requirements

Summary

Please describe the main points/actions arising from your assessment that supports your decision above This assessment tool should be used across all areas as indicated in order to continue to monitor environmental risks and mitigate against them in relation to ligature risk.	
EIA Reviewer: Helen Courtney	
Date completed: May 2024	Signature: HM Courtney