Estates and Facilities Alert

Reference:	Issued:	Review Date:
EFA/2019/003	**11 March 2019**	**11 March 2021**

‘Anti-ligature’ type curtain rail systems: Risks from incorrect installation or modification

Summary

‘Anti-ligature’ type curtain rail systems can be used as a point of ligature when installed incorrectly or not assessed as part of overall environmental health and safety risks. Recommendations are given on selection, installation, periodic inspections and user checks in mental health inpatient facilities or wherever ligature reduction is risk assessed as required.

Action

1. Suitable checks on ‘anti-ligature’ type curtain rail systems should be integral to the organisations overall patient and environmental health and safety risk management.

2. The organisation should ensure their ‘anti ligature’ type curtain rail system specifications installation and locations, is regularly assessed for alignment with legislation and current published guidance (see References section).

3. Carry out a collaborative multi-disciplinary risk assessment in-situ at department level to check all ‘anti ligature’ type curtain rails are installed and maintained in line with manufacturer’s instructions and the actions below.

    - Identify the type of curtain rail system installed and check that the relevant vertical load testing record is appropriate to patient risk and up to date

    - Additional collapse testing should be carried out at varying angles from the vertical plane to ensure the collapse weight continues to meet specification. Where rails fail to collapse with these tests refer to manufacturer’s instructions for required actions. - Please note that if rails are installed in a recess, this may require their reinstallation outside the recess

    - Assess magnet holders, magnets and discs for signs of wear or corrosion and replace if necessary as friction will increase the load they can bear. Where magnets have multiple fitting options, to vary, break weight for different patient groups (e.g. fitted with plastic coating facing outwards for low body weight patients) and also check they have not unintentionally been reversed during maintenance or repairs

    - Assess curtains and associated fabrics to identify if they could be made into ligatures or used to prevent collapse of the rail and replace, if required

    - Assess the adjacent environment and fittings for risk of curtain rail being readily used / combined to create an alternative ligature, e.g. across doors, shelves, furniture

    - The above assessments should be carried out following initial installation (pre-handover), after any change/ modifications (to either physical environment, legislation or patient risk group e.g. eating disorders), plus periodically. The appropriate period to

be agreed by multi-disciplinary assessment and scheduled in advance as part of organisations overall patient and environmental risk management

- If the above assessments fail for whatever reasons, consideration should be given to whether curtain rail removal is proportionate and other key health performance needs, e.g. therapeutic, privacy, dignity, infection control, human rights. If compromises are necessary, these and their mitigations should be recorded by the multi-disciplinary group and decisions on whether the room can be still used and for what purposes agreed along with time period(s) for appropriate rectification and remediation
- If there are no product instructions, or manufacturer cannot be identified / engaged, for above 'anti-ligature' type curtain rail system assessments, the multi disciplinary group should agree the appropriate checks to be adopted and any additional risks to be managed; or alternatively whether rail removal/ replacement is proportionate. If the latter, the above bullet point on assessment following an assessment failure should be used.

4. Ensure department staff are aware of the weight requirements for the collapsing of 'anti-ligature' type curtain rails installed within their unit. Staff should confirm the risk assessments above are undertaken and update care plans as required for any change, e.g. for very low body weight users.

5. Ensure that the above action points on 'anti-ligature' type curtain rail systems are incorporated into service area risk assessments, routine maintenance upgrades and physical modifications, as well as the commissioning of new installations. Evidence of appropriate updated checks should be provided pre-handover.

Action by

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

Deadlines for action

Actions underway: 18 March 2019
Actions complete: 11 September 2019

Problem / background

Seven separate incidents have been reported in the last 12 months involving attempted self-harm or suicide in a mental health ward where an anti-ligature curtain rail system failed to operate as expected.

Anti ligature curtain rail systems can fail to operate as expected if they are not installed according to the manufacturer's instructions.

For example, where rails are installed in a recess this may influence the direction of pull of the ligature preventing rail collapse.

In one reported incident, estates managers were able to identify that there was an excessive load required to activate the safety collapse of the rail, when angular force (30-45 degrees from vertical) was applied. Usual testing methods would not have revealed this.

Another incident involved thin lightweight shower curtains wound into a ligature, thicker products may help mitigate this.

In the remaining incidents, it appears likely the failure of the rail to collapse relates to one or more of the issues in the action checks above.

Manufacturer contacts

Not applicable, all systems should be looked at.

Distribution

Estates/ Facilities Managers, Risk Managers, Health & Safety, Clinical Directors

References

The previous alerts on ligatures are attached.

EFA/2010/009: Flush fitting anti-ligature curtain rails: ensuring correct installation

EFA/2010/003: Cubicle Curtain Tracks; Anti-ligature curtain rails (including shower curtains), risks from incorrect installation or modification.

The Never Events policy and framework sets out the NHS's policy on Never Events. It explains what they are and how staff providing, and commissioning NHS-funded services should identify, investigate and manage the response to them.
https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Never Events list 2018
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Northern Ireland Never Events List
https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-36-18.pdf

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

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

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

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

Brief guide for inspection teams: Ligature points (2018) – Care Quality Commission: NB The CQC inspectors' guides isn't original guidance, it is a summary of guidance produced by others.
www.cqc.org.uk/sites/default/files/20180404_9001397_briefguide-ligature_points_v1.pdf

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

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

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

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

Enquiries

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

England

Enquires should quote reference number **EFA/2019/003** and be addressed to:-
nhsi.mb-defectsandfailures@nhs.net

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

The web-based D&F reporting system is managed by the NHS Digital on behalf of NHS Improvement. For further information on this system, including obtaining login details, please contact the efm-information Helpdesk. Tel 0300 303 5678.

Northern Ireland

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

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

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

Scotland

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

Incident Reporting and Investigation Centre (IRIC)
Health Facilities Scotland, NHS National Services Scotland
Tel: 0131 275 7575 E-mail: nss.iric@nhs.net

Reporting adverse incidents in Scotland
Please report to IRIC here: http://www.hfs.scot.nhs.uk/services/incident-reporting-and-investigation-centre-iric/how-to-report-an-adverse-incident/

Independent facilities which only provide private care should report to the Care Inspectorate.

Wales

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

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

Tel: 029 2090 4118
E-mail: efa.ses@wales.nhs.uk