

August 2025

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# Ligature Point Audit Tool

Supporting guidance document

OFFICIAL



This publication discusses sensitive issues of mental distress, self-harm and suicide which may be distressing to some readers. Please take care when considering the publication and seek support if needed.

Reach out to Lifeline (13 11 14), Beyond Blue (1300 224 636), 13YARN (13 92 76) or Rainbow Door (1800 729 367) for support.

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# Contents

<b>Executive summary</b>	<b>4</b>
<b>Acknowledgments</b>	<b>5</b>
<b>Introduction</b>	<b>7</b>
<b>LPAT Part 1: Pre-assessment desktop review</b>	<b>11</b>
<b>LPAT Part 2: Ligature point identification walkaround</b>	<b>13</b>
<b>LPAT Part 3: Post-assessment action plan</b>	<b>16</b>
<b>Appendix A: NSQHS Standards<sup>1</sup></b>	<b>18</b>
<b>Appendix B: Care Quality Commission UK – tiers and mitigating controls<sup>2</sup></b>	<b>20</b>
<b>Appendix C: ISO – Hierarchy of controls<sup>3</sup></b>	<b>24</b>
<b>Appendix D: External stakeholder consultations</b>	<b>25</b>
<b>References</b>	<b>26</b>

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## Executive summary

Following the publication of Safer Care Victoria's (SCV) clinical guidance document, [Improving Safety for Consumers at Risk of Harm of Ligation](#)<sup>5</sup> (2024), an expert working group was commissioned to develop a Victorian statewide Ligation Point Audit Tool (LPAT), accompanied by this supporting LPAT guidance document. The expert working group comprised of senior mental health nursing leaders, lived experience colleagues, and executive leaders working in the public mental health and wellbeing sector across Victoria and interstate. The development process was led by colleagues within the Chief Mental Health Nurse team, under my governance and oversight, and in close consultation with key external stakeholders.

I would like to acknowledge that the foundations of this work were originally developed in the United Kingdom by the Care Quality Commission and have been thoughtfully adapted for use within Victorian mental health and wellbeing settings. I extend my sincere thanks to the participating health services and colleagues from supporting health organisations for their time, dedication, and commitment throughout the piloting and adaptation of the LPAT.

All levels of health services play a vital role in clinical and organisational governance, as well as ensuring consumer safety. This includes [governance](#) at the board, executive, divisional, and clinical workplace levels. I sincerely thank you for your continued commitment to strengthening Victoria's mental health and wellbeing system, and for your ongoing efforts to provide safe, high-quality mental health care for our community.



**Anna Love**

Chief Mental Health Nurse

Executive Director, Clinical and Professional Leadership Unit

Safer Care Victoria

# Acknowledgments

SCV would like to sincerely thank the following individuals for their time, commitment, and expertise in the development and adaptation of the **Ligature Point Audit Tool (LPAT)** and the accompanying **LPAT supporting guidance document** for use in the Victorian context.

SCV also gratefully acknowledges the support of the Victorian Government Library Service for their valuable assistance in conducting literature searches and sourcing key materials to help inform this work.

**Table 1: Project governance and expert working group membership**

Name	Role	Organisation
<b>Project Governance</b>		
<b>Anna Love</b>	Executive Sponsor Chief Mental Health Nurse and Executive Director, Clinical and Professional Leadership Unit	Safer Care Victoria
<b>A/Professor Janine Davies</b>	Clinical Lead Senior Mental Health Nurse Advisor Clinical and Professional Leadership Unit	Safer Care Victoria
<b>Sonalee Ghosal</b>	Project Management Lead Senior Project Officer Clinical and Professional Leadership Unit	Safer Care Victoria
<b>Expert Working Group</b>		
<b>A/Professor Janine Davies</b>	Chair	Safer Care Victoria
<b>Adele Northwood</b>	Safety Quality and Accreditation Manager	Northern Territory Health
<b>Anna Sowden</b>	Lived Experience Discipline Lead	Barwon Health
<b>Belinda Scott</b>	Executive Director, Mental Health	Northern Health
<b>Donna Hansen-Vella</b>	Director of Nursing, Mental Health	Barwon Health
<b>Harry Singh</b>	Senior Psychiatric Nurse	Eastern Health
<b>Kristy-Lee Allan</b>	Senior Psychiatric Nurse	Monash Health
<b>Thomas Wilson</b>	Senior Psychiatric Nurse	St. Vincents Health

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## Glossary of terms

**Ligature:** “is anything, like a cord or other material, that could be used for the purpose of hanging or strangulation” (Care Quality Commission, 2023, p.5).

**Ligature anchor point:** “is anything that could be used to attach a ligature” (Care Quality Commission, 2023, p 5).

**Controls:** for the purpose of this document the use of the word ‘controls’ is aligned to the ISO controls put in place to mitigate risks (See Appendix C: ISO Hierarchy of Controls)

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# Introduction

The Ligature Point Audit Tool (LPAT) and this supporting guidance document have been developed by an expert working group comprised of sector representatives and led by SCV under the governance of the Chief Mental Health Nurse team. The purpose of this document is to provide clear guidance to support the effective use of the LPAT in mental health and wellbeing settings.

The LPAT and supporting guidance forms part two in a series of work commissioned by the Chief Mental Health Nurse team to improve consumer safety. SCV acknowledges that the foundations of this work were developed by the Care Quality Commission in the United Kingdom, who published a Ligature Point Recording Template and guidance for use within mental health inpatient settings in August 2021. In 2025, the Care Quality Commission audit template was piloted in mental health settings across Victoria and additionally in the Northern Territory using Plan Do Study Act (PDSA) cycle principles and subsequently adapted for use in Victorian mental health and wellbeing settings.

The LPAT is designed to support services to implement a standardised approach in identifying and managing ligature risks, with the overarching goal of improving safety for consumers at risk of harm of ligature. Specifically, the tool supports:

- conducting audits of ligature point risks within specific wards, units, or other clinical settings
- identifying existing controls and mitigators
- documenting audit team recommendations and escalation pathways
- recording and tracking the post-assessment action plan.

The LPAT comprises of three parts:

- part 1: pre-assessment review
- part 2: ligature point identification walkaround
- part 3: post-assessment action plan.

SCV's [Improving safety for consumers at risk of harm of ligature](https://www.safercare.vic.gov.au/resources/clinical-guidance/mental-health/ligature)<sup>5</sup> (2024)

<<https://www.safercare.vic.gov.au/resources/clinical-guidance/mental-health/ligature>> clinical guidance document outlines four fundamental principles that underpin organisational and clinical governance.

## Key principles to be considered for each organisation

- **Principle 1:** organisational and clinical governance.
- **Principle 2:** engagement, therapeutic relationship and trauma-informed care.
- **Principle 3:** clinical responses to ligature incidents.
- **Principle 4:** consumer, workforce, and visitor impact and follow-up support.

The guidance emphasises the importance of continuous improvement, building workforce skills and capabilities, and fostering a supportive environment through targeted training, policies, and procedures. These efforts aim to

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promote alignment across services and support a 'just culture' within Victoria's public Mental Health and Wellbeing services.

## Dignity and autonomy, human rights and therapeutic engagement

Balancing risks identified through the LPAT, together with the principles of the *Mental Health and Wellbeing Act 2022* and *Occupational Health and Safety Act 2004* is a complex and nuanced task. Organisational decisions must prioritise rights, dignity and autonomy while balancing risk of harm to support both therapeutic engagement and environments.

Dignity and autonomy principle emphasises the promotion and protection for a person to exercise their rights and choices. However, minimising risk from ligature points as far as reasonably practicable is an important safety measure for mental health and wellbeing services, when caring for people who may be more vulnerable to suicide and/or self-harm.

## In-scope

The LPAT scope includes:

- mental health and wellbeing inpatient settings
- mental health and alcohol and other drug hubs
- mental health and wellbeing non-acute settings (including rehabilitation and extended care settings)
- mental health and wellbeing residential settings
- mental health and wellbeing community settings
- Psychiatric Assessment and Planning Units (PAPU)
- forensic settings.

## Out of scope

The identified areas out of scope for this tool are:

- general medical and surgical inpatient settings
- consultation liaison service settings
- emergency department settings\*
- alcohol and other drugs settings (bed based and community).

\* Mental health and alcohol and other drug hubs excepted.



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## The National Safety and Quality Health Service (NSQHS) Standards and LPAT supporting guidance document

The Australian Commission on Safety and Quality in Health Care provides guidance through the NSQHS Standards<sup>1</sup>. Of relevance to the LPAT are Standards 1, Clinical Governance and Standards 5, Comprehensive Care:

- Standard 1: Clinical Governance outlines the responsibility of health service leadership to the community. It emphasises continuous improvement in the safety and quality of care, ensuring services are patient\* centred, safe, and effective (Appendix A).
- Standard 5: Comprehensive Care focuses on delivering coordinated and holistic care that meets the individual needs of patients (Appendix A).

\*Where references are made to the NSQHS Standards and the term 'patient' is used, this guidance should be understood as referring to consumers.

## The underpinning principles of the LPAT

Health services who operate within the in scope settings are recommended to implement the LPAT annually, at a minimum. Additionally, a repeat LPAT should be considered following capital and infrastructure works.

Undertaking the LPAT involves a multidisciplinary team, ensuring a range of expertise across:

- clinical workforce
- lived experience workforce
- workplace management within the setting being audited
- engineering
- services capital and maintenance team
- occupational health and safety
- executive leadership.

Each audit team member plays a crucial role in ensuring a safe environment. Continuing this collaborative approach helps ensure safety for all involved.

Monitoring the LPAT action plan, specifically risk mitigation items, is the responsibility of the relevant committee, as determined by the executive or governance committee of the health service.

The LPAT is designed to complement and not replace existing health service processes, policy, procedures and protocols. These include:

- individual consumer risk assessments
- shift-to-shift environmental audits
- restrictions on items that may pose a ligature risk
- heightened staff awareness
- equipment audits and maintenance.

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Testing of anti-ligature infrastructure should be part of a health organisations regular schedule and carried out in accordance with its policy. The LPAT should be conducted in addition to these existing processes.

Organisations can also decide to invite external stakeholders on a case-by-case basis.

## LPAT audit team

Each health service is responsible for establishing an LPAT audit team, which should include the following members:

- mental health executive (essential)
- workplace health and safety, inclusive of local health and safety representatives (essential)
- engineering (essential)
- capital works and maintenance representative (essential)
- program or nurse unit manager of audit site (essential)
- quality and safety partner/manager (essential)
- mental health lived experience lead\* (essential, however this colleague may choose to opt out of the physical walkaround audit process)
- representative from a partner organisation, if the service being delivered is in a partnership model (recommended)
- staff member from the audit site (recommended)
- health services may, at times, consider inviting external stakeholders to participate in the audit process where appropriate.


\*The mental health lived experience lead is considered an essential participant; however, this colleague may choose to opt out of the physical walkaround component while remaining actively involved in other aspects of the audit process. This decision must be self-directed and respected.

The health service must identify an LPAT lead who will delegate roles, responsibilities and oversee the development of the action plan following completion of the LPAT.

Each member of the audit team should be provided a copy of the following:

- LPAT Excel file
- This LPAT supporting guidance document
- SCV's [Improving safety for consumers at risk of harm of ligature<sup>5</sup>](#) (2024) clinical guidance document
- Any other applicable health service policy and procedures.

The audit should be recorded in real time. It is essential that all members of the LPAT team are actively involved from commencement to conclusion. Every team member should be given equal opportunity to contribute and have their perspectives heard.

 Tip: To enable full functionality of the LPAT Excel file, it is recommended to save the LPAT as 'macros-enabled' file type onto a user's computer.

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# LPAT Part 1: Pre-assessment desktop review

The Part 1: Pre-assessment component of the tool is structured into five sections. The aim is to provide an overview of relevant data about the clinical setting prior to commencement of Part 2: Ligature point identification walkaround.

Part 1: Pre-assessment includes:

- reviewing local ligature incident data since the most recent audit
- reviewing the health service documented responses to ligature incidents
- analysing workforce induction and training requirements specific to ligature risks
- reviewing ligature incident equipment compliance and related information
- reviewing existing practice of identification of environmental hazards.

## Audit team responsibilities

It is the audit lead's responsibility to ensure Part 1: Pre-assessment section is completed by the following colleagues:

- manager (nurse unit manager or a delegate).
- workplace health and safety representative.
- quality and safety representative.

This completed section should be distributed to remaining team members prior to undertaking Part 2: Ligature point identification walkaround. Each team member must review the Pre-assessment information and seek clarification if required, prior to commencing Part 2.

Minimising the risk of harm from ligatures within mental health and wellbeing settings extends beyond the identification of ligature points. It is also recognised that each clinical area is different, therefore it is important for the audit team to understand the clinical setting, consumer profile which includes needs and supports and the model of care prior to commencing an audit.

When completing the LPAT, consider the below relevant information.

- List any outstanding maintenance requests which might impact audit results.
- List any capital or equipment upgrades since the last audit.
- List any future capital upgrades.
- External influences such as legislative changes, reforms, updated guidelines and standards.
- Economic changes since the last audit.

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## Section considerations

### For section 2a in the LPAT:

A brief overview of the clinical setting could include:

- consumer cohort
- average length of stay
- proportion of people under compulsory care
- information on restricted items (if applicable)
- number of beds, and whether the area includes intensive care areas
- environmental considerations, age of building, information regarding refurbishment (dates if known)
- staffing profiles and other workforce variables (acting roles, vacancy rates)
- model of care
- visiting hours and consumer leave arrangements.

### For sections 2b and 2c in the LPAT:

Analysis of information related to previous ligature incidents can consider the following:

- review of data from any ligature incidents (including incident severity rating) since the last audit was completed
- identification of any themes and/or trends, and actions being taken to address any risks identified

### For sections 2d and 2e in the LPAT:

- It is recommended that the most recent LPAT action plan is attached to the pre-assessment section. This should include a review of open and closed actions, and all risks endorsed as accepted at executive level.

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## LPAT Part 2: Ligature point identification walkaround

Part 2 of the audit is structured into three sections and involves physical inspection of the area. The aim is to identify and record any potential ligature point risks, and record the controls and actions required for each risk.

### LPAT audit lead responsibilities

The LPAT audit lead is responsible for the following:

- ensuring that each audit team member has reviewed Part 1: Pre-assessment information
- providing the audit team with a floor plan
- confirming that all audit team members are familiar with the LPAT tool, including the categorisation of mitigating controls
- assessing the risk of proceeding with the audit if essential team members are not available; in such cases, the mental health executive should decide whether to proceed or re-schedule the ligature point identification walkaround
- reinforce that all audit team members share responsibility for identifying ligature point risks
- updating the audit team on any immediate clinical risks within the audit area
- providing audit team members with personal protective equipment, including duress alarms or other workplace safety equipment, prior to entering the area
- ensuring consumers who are receiving care have been informed that the physical walkaround audit process is being completed within the clinical area. Following completion of the audit, consumers are communicated with the relevant information through existing mechanisms.

### Audit team member responsibilities

Key considerations for the wider audit team members during Part 2: Ligature point identification walkaround are below.

- Gather the audit team at the starting point for the audit.
- Appoint a scribe to document findings in real time, acknowledging that the audit represents a snapshot in time.
- Follow a structured and systematic approach when inspecting each area. Ideally, this should mirror the method used in previous audits. This can also be done by identifying a consistent starting point in a room.
- Conduct visual inspections thoroughly, scanning each space from left to right and top to bottom.
- Capture photos where required and insert them into relevant sections of the LPAT documentation.
- Inspect fittings and fixtures carefully, as products may shrink over time, and ligature accessible gaps can appear. Ensure checks are also conducted behind doors, window coverings, and furniture.
- Equipment used in vocational activities for example, cooking, art therapy or gym equipment should also be considered as part of the audit.

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- Check for missing or inappropriate components, such as screws, covers or shrouds. Ensure that anti-tamper fixings are used where required.
  - Be aware that height above floor level is no longer considered a determining factor when assessing what is a potential ligature risk.
  - Engage with staff working in the audit area by asking the questions provided in Section 7 of the LPAT. Based on their responses, the audit team should determine whether any follow up actions are necessary.

## Section considerations

### For section 8d in the LPAT:

Assess and allocate the tier based on the United Kingdom Care Quality Commission.

- **Tier 1** - areas where consumers have high supervision and are not left alone for long periods.
- **Tier 2** - areas where consumers have minimal supervision; typically, open areas with free access.
- **Tier 3** - areas where consumers may spend a lot of time alone with minimal or no supervision.

For further information about Care Quality Commission tiers or risk, please refer to Appendix B.

### For section 8e and 8f in the LPAT:

When assessing and documenting a ligature point risk, consider the following.

- Provide a clear and detailed description of the item and its location, ensuring that someone who is not part of the audit team can easily identify it. *Example:* "Approximately 2 meters from the floor, a potential anchor point in the form of a round metal clock is located on the lounge room wall".
- Take photographs of the identified ligature point. These may be included in staff briefings, induction, and health service training packages. Ensure that the storage of photographs complies with local health service policies and procedures.

### For section 8h and 8i in the LPAT:

- Review and document existing controls. For example, 'A substitution control has been implemented with the clock. It has been installed using non-weight bearing hooks that will release the clock in the event any weight above 3 kilograms is attempted to be anchored from it'.
- If a ligature point is identified and can be rectified immediately, the audit team should isolate the area, record the issue, and arrange for rectification. Where no existing controls are in place, the team should also consider whether the risk can be eliminated during the audit itself.
- If immediate elimination during the audit is not possible:
  - escalate the issue through appropriate organisational or clinical governance processes to ensure timely action and resolution
  - nominate two members of the audit team to undertake re-inspection in an agreed timeframe.

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The LPAT includes categorisation of controls to mitigate ligature point risks using the below indicators:

1. The Care Quality Commission 'Tiers and Mitigating Controls'<sup>2</sup> includes:

- environmental
- individualised
- system/process

For further information about Care Quality Commission tiers and mitigating controls, please refer to Appendix B<sup>2</sup>.

2. The ISO 45001 Hierarchy of Control<sup>3</sup> includes:

- elimination
- substitution
- engineering Controls
- administrative Controls
- personal protective equipment (please note, within this context personal protective equipment is not applicable).

For further information about ISO hierarchy of control, please refer to Appendix C<sup>3</sup>.

**For sections 8j, 8k, and 8m in the LPAT:**

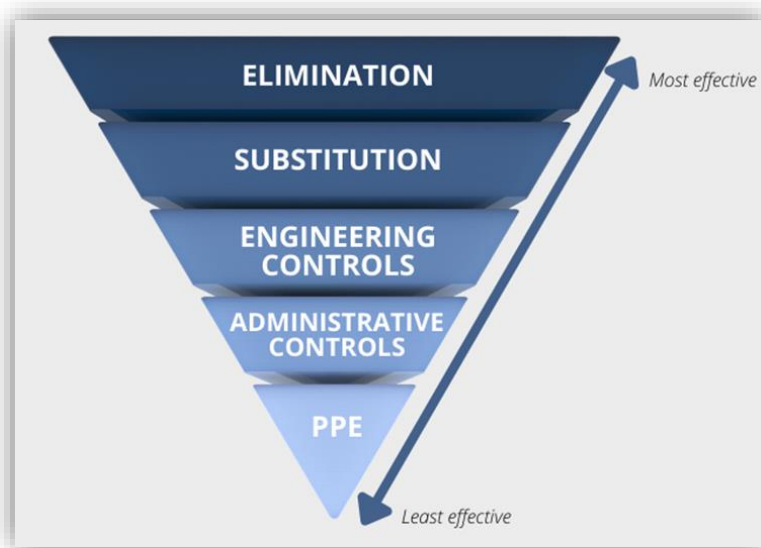
- For ligature points that do not require immediate remedial action, clearly note the audit team's recommendations and any actions required.
- If the identified risk is not new, ensure that any outstanding actions from earlier audits are noted in the current audit to maintain continuity.

## LPAT Part 3: Post-assessment action plan

Part 3 of the LPAT tool aims to provide an overview of identified risks, controls and mitigators for the audit. It assists health services to communicate and follow up on the action plan to ensure that all levels of a health service have a role in clinical, organisational governance and consumer safety.

### Key responsibilities and recommendations

- Monitoring of risk mitigation actions is the responsibility of the relevant committee, as determined by the governance of the health service.
- Results of the LPAT should be discussed at business or local unit meetings. This ensures that staff are aware of the identified ligature points in their working environment, as well as the available mitigations and controls (see Figure 1 or Appendix C<sup>3</sup>).
- The LPAT action plan should consider controls that are reasonably practicable, balancing risk mitigation with the promotion of dignity and autonomy.
- Robust clinical and operational governance systems at an organisational level ensure the boards of health services have an oversight of clinical care, risks and adverse events through monitoring systems.
- Health service boards are responsible for ensuring systems of care in place are effective in preventing harm<sup>1</sup>.



Please note, within this context PPE is not applicable.

**Figure 1: Hierarchy of controls (See Appendix C3) / Occupational Health and Safety Act 2004.**



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## Sharing LPAT results

It is recommended complete LPAT results are shared with staff working in clinical settings. The findings of the audit should also inform:

- updates to policies and procedures
- orientation of new staff
- updates to educational training material.

## Raising awareness

Consider displaying the LPAT results in non-consumer areas to support workforce awareness. A hard copy or digital link to LPAT results should be readily available to all staff for review. This information may also be displayed on the occupational health and safety<sup>4</sup> noticeboard, in line with current workplace practices. Ensure the displayed version is updated after each LPAT audit has been completed.

## Governance and accountability

Each health service, along with their mental health executive, is responsible for ensuring a safe environment is maintained. The information from the LPAT action plan outlines identified risks, existing controls and further actions required. Where risks are not able to be mitigated, they should be escalated to the clinical and organisational governance reporting systems in a timely manner. This allows for a decision on whether to accept the identified risks or take further actions.

## Audit completion and follow-up

The audit is considered complete once the audit has been undertaken and the corresponding report has been submitted to the executive governance committees within the organisation and reported up to boards of health services. It is the responsibility of each health service to monitor the LPAT action plan as part of internal risk management processes.

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# Appendix A: NSQHS Standards<sup>1</sup>

**Standard 1, Clinical Governance** specifically 1.10, 1.20, 1.29 and 1.30.

**1.10 for risk management:** The health service:

- a. identifies and documents organisational risks
- b. uses clinical and other data collections to support risk assessments
- c. acts to reduce risks
- d. regularly reviews and acts to improve the effectiveness of the risk management system
- e. reports on risks to the workforce and consumers
- f. plans for, and manages, internal and external emergencies and disasters.

**1.20 for workforce training:** The health service organisation uses its training systems to:

- a. assess the competency and training needs of its workforce
- b. implement a mandatory training program to meet its requirements arising from these standards
- c. provide access to training to meet its safety and quality training needs
- d. monitor the workforce's participation in training.

**1.29 safe environment:** The health service maximises safety and quality of care:

- a. through the design of the environment
- b. by maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose.

**1.30 risk of harm:** The health service:

- a. identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce
- b. provides access to a calm and quiet environment when it is clinically required.

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**Standard 5, Comprehensive Care** specifically 5.31 and 5.32.

**5.31: Assessing risk of self-harm and suicide** states:

The health service has systems to support collaboration with patients, carers and families to:

- a. identify when a patient is at risk of self-harm
- b. identify when a patient is at risk of suicide
- c. safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed.

**5.32 Predicting, preventing and managing self-harm and suicide** states:

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts.

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# Appendix B: Care Quality Commission UK – tiers and mitigating controls<sup>2</sup>

## 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.

### 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.

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### 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.
- 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

#### 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.
  - Consider any adaptations 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.
- 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

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## 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 adaptations 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 the purpose of this document, this sentence has been truncated and removed from the original reference in order to align within the Victorian context.*

### 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.
- 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.

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## Appendix C: ISO – Hierarchy of controls<sup>3</sup>

A risk mitigation action plan should consider the hierarchy of controls, within the context of balancing risk mitigation and dignity, when developing the plan.

1. **Elimination:** the most effective control measure. It involves completely removing the hazard from the workplace.
2. **Substitution:** replacing a hazardous process, or equipment with a less hazardous alternative.
3. **Engineering controls** implementing physical changes to the workplace or equipment to isolate or reduce exposure to the hazard.
4. **Administrative controls:** implementing procedures, policies, or training to limit exposure to the hazard.
5. **Personal protective equipment:** please note, PPE in this context is not applicable.



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## Appendix D: External stakeholder consultations

SCV would also like to thank the following stakeholders for their valuable contributions and partnerships during the consultation process.

External Stakeholder Organisations	Relevant Branch / Division / Team / Unit
Australian Nursing and Midwifery Federation (ANMF)	Mental Health Nursing Division, Victorian Branch
Coroners Court of Victoria	Coroners Prevention Unit, Mental Health Team
Department of Health	Aboriginal Health and Wellbeing Division
Department of Health	Office of the Chief Psychiatrist
Department of Health	Victorian Health Building Authority
Health and Community Services Union (HACSU)	Mental Health Policy
Independent Mental Health Advocacy (IMHA)	
Mental Health and Wellbeing Commission	Consumer Care Team
Victorian Institute of Forensic Mental Health	Forensicare
WorkSafe	Healthcare Prevention, Strategy and Planning Team

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