CASE STUDY

From Audit to Action: Transforming Ligature Risk Management in an Acute Mental Health Setting

A Mid-West Ireland Approved Centre | University Hospital Limerick Mental Health Service

Nearly 25 Years Senior Nursing Experience	4 Approved Centres in the CHO	National Guidelines Published Dec 2024

Background & Context

The service at the centre of this case study operates an Acute Mental Health inpatient unit in the Mid-West of Ireland, co-located with University Hospital Limerick (UHL). Regulated by the Mental Health Commission (MHC) as an Approved Centre under the Mental Health Act, the unit operates within a Community Healthcare Organisation (CHO) that includes four approved centres across the region.

Despite the unit's long-standing experience in risk management, the ligature and environmental safety audit represented a significant milestone — introducing new frameworks, new language, and — crucially — new stakeholders into a process that had previously rested almost entirely with nursing leadership.

The Challenge

Prior to the audit, the senior nursing lead described conducting ligature risk audits largely alone — communicating issues for modification but without the broader awareness or involvement of other departments. Key disciplines such as Estates, Maintenance, Facilities, Risk, and Health & Safety were not part of the process.

> *"Prior to this audit I operated as though I was the owner of the risks identified in the ligature risk audit. The global awareness at all levels of the management structure simply was not there."*

The Audit Process

The ligature and environmental safety audit was conducted with a thoroughness that went well beyond a standard checklist. Reviewers We

The concept of 'collective capabilities' was introduced during this process — emphasising that safe environments are only achievable when all relevant disciplines take shared ownership of risk identification and mitigation. A concise post-audit report and Quality Improvement Plan (QIP) provided a clear framework for delegating actions to the departments best placed to deliver them.

> *"The attention to detail beyond the obvious was eye-opening. The audit created a far greater awareness of how fixtures and fittings — not just obvious suspension anchors — can contribute to risk."*

Impact & Outcomes

The audit catalysed change at every level of the organisation — from frontline staff awareness through to capital investment planning and national policy alignment.

Leadership & Governance

Following the audit, senior meetings were held between the Maintenance Manager, General Manager, and the Registered Proprietor — the person legally responsible for the Approved Centre under MHC regulations. For the first time, these stakeholders convened specifically around ligature risk, moving responsibility beyond the nursing team.

At national level, a new guideline on the Implementation and Use of the National Ligature Risk-Reduction Audit Tool for Approved Centres was published in December 2024, formally requiring services to establish multi-disciplinary Ligature Reduction Groups. This validated the approach already taken locally and created a framework for replication.

Capital Investment & Environmental Improvements

Conversations regarding investment in ligature-reducing products are now held at the highest level within the service. Tangible improvements delivered to date include:

- Replacement of en-suite and bathroom doors with alarmed anti-barricade doors
- Installation of ligature-reduced windows in the High Observation Unit (with full replacement planned for 2026–27)

- Introduction of reduced-ligature beds, replacing older hospital-style beds with obvious anchor potential
- Anti-ligature consumable dispensers installed in toilet facilities
- Anti-ligature waste bins standardised across all four approved centres in the CHO
- Items previously attached with screws replaced with double-sided tape or secured alternatives
- Sustainability funding secured through joint works with UHL to replace windows service-wide

Planned Preventative Maintenance

Including Maintenance in the audit feedback process and delegating QIP ownership to relevant departments transformed the relationship between clinical and estates teams. Maintenance staff developed a greater awareness of the need for consistent attention to the unit's infrastructure — particularly doors, windows, and fixtures — and their response to staff-reported risks became more proactive and timely.

Multi-Disciplinary Collaboration

This year will see the first ligature audit conducted with representatives from Risk, Health & Safety, Maintenance, and the clinical unit present simultaneously. Capital project submissions are now made through Minor Capital Meetings attended by representatives from all four approved centres in the CHO, enabling coordinated investment decisions across the region.

Staff Training & Awareness

Ligature reduction is now a standing item on management meetings, with Clinical Nurse Managers actively briefed on risks associated with infrastructure elements such as doors, hinges, and windows. Staff have received training on the operation of the new alarmed anti-barricade doors and windows. Awareness of collective capabilities is routinely referenced at Senior Nurse Advisory Group meetings, Approved Centre Oversight Committee meetings, and Joint Mental Health Service & UHL oversight meetings.

> *"Without question, the biggest take-away has been the visibility of the requirement for other disciplines' involvement — and the shift that has created at every level of the management structure."*

Key Outcomes at a Glance

Governance	Multi-disciplinary Ligature Reduction Group established; risk escalated to Registered Proprietor level
Environment	Alarmed doors, anti-ligature windows, beds, bins, and dispensers introduced across the unit
Investment	Capital funding secured via CHO Minor Capital Meetings and UHL sustainability programme
Policy	Local approach aligned with and validated by new MHC National Ligature Risk-Reduction Guidelines (Dec 2024)
Maintenance	Proactive maintenance culture developed; QIP actions delegated to accountable departments
Consistency	Standardised products (e.g. anti-ligature bins) adopted across all 4 approved centres in the CHO

Lessons for Other Services

The following recommendations are offered by the service for other inpatient mental health settings considering a similar audit approach:

- Ensure all levels of the management structure — including Estates, Maintenance, Risk, and Health & Safety — are briefed on the audit's purpose before it begins, and understand their expected role in responding to its findings.
- Include the right stakeholders from the outset. Collective responsibility is the foundation of sustained improvement; those with the power to effect change must be present in the room.
- Use the QIP to delegate clearly. Assigning each action to the person or department best placed to address it creates accountability and increases the pace of change.
- Develop a tested product inventory. A formulary of tried-and-tested anti-ligature products — reviewed and approved at service level — prevents wasted expenditure and builds confidence among those with spending authority.
- Engage with sector forums. Events such as Design in Mental Health (UK) provide access to the latest product developments and environmental design thinking. A similar forum within Ireland is overdue.
- Anticipate national alignment. New MHC requirements for ligature-reduced environments in all approved centres — both new builds and existing facilities — mean that investment in this area is not optional; services that act proactively will be better positioned.

This case study is based on qualitative interview responses from a senior nursing leader with 25 years' experience in acute mental health inpatient care. All views are those of the participant.