NHS National Services Scotland

NHS SCOTLAND

Self Harm Reduction Report

Data Analysis, Assessment Tools and Environment

Prepared by Health Facilities Scotland & NHS Boards

Issued December 2020

Introduction

NHS Boards and Health Facilities Scotland co- created a Short Life Working Group (SLWG) with the aim to reduce self harm in mental healthcare settings.

Recommendations include improvements to:

a) NHS self-harm data gathering & dissemination

b) self-harm assessment process consistency and quality, including multi-faceted approach to facility environment audit e.g. Manchester ligature audit tool, plus a new therapeutic environment quality audit tool

c) MH Repeatable room* and ensuite. Communication of built examples between NHS Boards/ Trusts sharing success and challenges, without awaiting further or serious incident.

The key recommendations of the SLWG are accompanied with the appendices that capture the research and information gathered for this report.
Thinking within the mental health sector is a continually evolving in response to experience and incidents, and the SLWG believe this report should be a live document that can be updated and developed for an agreed period of time after it is issued.

*Self harm environment performance using NHS England (P22) Repeatable Room for Mental Health (MH) functional bedroom as basis

The SLWG

Active members have offered advice, knowledge and their experiences throughout the SLWG which has helped to formulate the recommendations of this report.

SLWG included representatives from:

- NHS Ayrshire & Arran
- NHS Fife
- NHS Grampian
- NHS Greater Glasgow & Clyde (chair)
- NHS Highland
- NHS Lothian
- NHS NSS Health Facilities Scotland
- NHS Tayside

Inputs were also invited from Mental Health Welfare Commission (MHWC), Healthcare Improvement Scotland (HIS) & Health & Safety Executive (HSE)

Figure 2.1 image below showing a version of bedroom layout

A: NHS self-harm statistics gathering & dissemination

The SLWG recommends agreed NHS glossary of terms and terminology in incident reporting process, to reduce confusion and aid future reviews of self-harm trends. Through the data analysis NHS Scotland's ultimate ambition is for zero suicides

B: Self-harm assessment process

The SLWG recommends a holistic risk assessment and management process be carried out, by suitably qualified professionals, which will include multiple facets. Facets of equal importance include, an assessment of the environment, a clinical assessment of the patient and the operational management of the area. The Facility Environment assessment will also be multi-facet e.g. ligature audit scoring, therapeutic quality audit scoring; then combined into an overall risk and mitigation assessment register.

C: Mental Health Repeatable Room Bedroom and Ensuite Layouts with Performance Specification/ Finishes

The SLWG looked at various options for the bedroom suite design and support two options for the MH bedroom and a single option for the ensuite. The two options for the bedrooms are differentiated by bed position. One layout with single sided bed access and another option with two sided access. The ensuite layout is the same for both options.

The bedroom and ensuite discussion allowed the SLWG to agree on a layout for both spaces. This in turn opened up the discussion for specification and finishes. This report provides a performance specification for finishes which can be adopted by the boards. It is important that a performance specification is recommended and not a specific product to allow the individual boards to determine the project specific product.

Long Term Strategy – Live tools going forward

Over the past twelve months the SLWG has discussed the fluidity of the mental health and healthcare sector. Most notably how Covid-19 has made the sector adapt too many new processes and ways of working. It is the opinion of the SLWG that the group continues to meet once this report has been issued to ensure current thinking is discussed and the information in this report can adapt and evolve as new data and experiences are brought forward

Figure 3.1 a version of the work area in bedroom

Figure 3.2 Stratheden IPCU NHS Fife

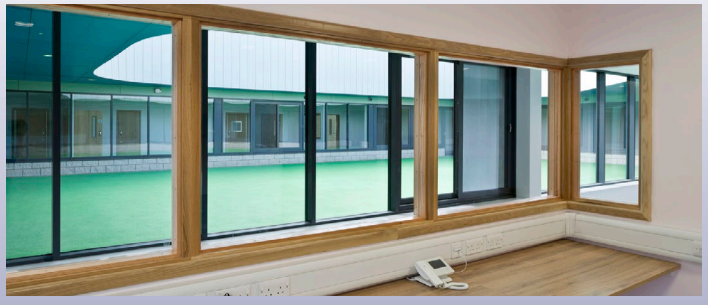


Figure 3.3 Internal image of Stratheden IPCU

Figure 3.4 Internal layout of an en-suite

NHS Self Harm statistics gathering & dissemination

BACKGROUND TO DATA ANALYSIS

NHS Scotland's ultimate ambition is that there should be zero suicides in healthcare premises. In 2018 Scottish Government reported that suicides in Scotland fell by 20% between 2002-2006 and 2013-2017. In 2018 it set out a plan designed to continue the work from the 2013-2016 suicide prevention strategy and the strong downward trend in suicide rates in Scotland. It includes a 2022 target to cut Scottish suicide rate by a further 20% and included the quote, "Every death by suicide is a tragedy and is preventable" (ref: Every Life Matters).

The Information Services Division (ISD) Scottish Suicide Information Database report (2018) states 5,286 people died from suicide in Scotland (data analysed between 2011 and 2017). 'Hanging, strangulation & suffocation' was the most common method of suicide among males, females under 25 and both genders combined. 'Poisoning' (including drug overdose) was the most common method among females of other ages, and the second most common cause of death overall. The vast majority of these suicides occur out with NHS facilities (e.g. at home) although ISD states many outwith had contact with NHS in 12 months leading up to the suicide (e.g. prescription services). This ISD data does not provide any statistics on completed suicides in specific NHS facility types (e.g. Mental Health ward, clinics, A&E) and evidence is not avaliable on whether suicide completions or self-harm is increasing / decreasing within NHS facilities (ref: ScotSID).

Healthcare Improvement Scotland (HIS) was the central depository for NHS suicide reviews and data until June 2017. HIS provided some useful themes in their briefing papers and also analysed some key themes over a certain period. HIS now has a members only 'Community of Practice' area to support clinical staff undertaking reviews. HIS continues to gather Serious Adverse Event Review (SAER) data from NHS Boards. Latest anonymised data from 2020 shows that suicide is the 3rd top SAER reporting item to HIS from NHS Boards.

This Short Life Working Group (SLWG) was convened as a priority by the NHS Scotland Scottish Property Advisory Group (SPAG), following concerns over an inconsistent approach to risk management of self-harm and suicide in NHS Scotland. The SLWG terms of reference are, "To enable better and more consistent approach to patient suicide and self-harm management within specific NHS facilities, by sharing best practice, plus identifying any gaps in current guidance, tools and support, then making recommendations to address these."

The Incident Reporting and Investigation Centre (IRIC) is a specialist safety and risk management unit within Health Facilities Scotland dealing with medical devices, estates & facilities, and social care equipment. Patient safety is at the heart of IRIC which supports both NHS boards and Local Authorities.

IRIC was asked to collate national self-harm statistics over 5 years (from near miss through to completed suicide) in order to inform SLWG decision making and priorities and make recommendations to improve the ongoing management of suicide and self-harm in NHS Scotland. IRIC sought to identify where on the NHS Scotland estate the self-harm incidents were occurring (down to ward / room level of detail), the mode of self-harm (e.g. use of ligature, laceration etc) and what part of the NHS estate was being used to self-harm (e.g. fixture and fittings, linen supplies etc.)

DATA ANALYSIS

Caveats on data:

- Not all NHS Boards supplied data
- Some NHS Boards had difficulties filtering and extracting the required information from their local risk management systems
- Data that was collected was not supplied in a consistent form across NHS Boards (e.g. similar events were captured using different coding descriptors and terminology from board to board)
- Use of free texts fields as opposed to drop down lists in incident reports used by health boards captured a lot of key information but the format made it difficult to analyse
- Key findings have been extrapolated from recorded data / data supplied that could be analysed

What data did IRIC request from NHS Boards?

- All self-harm incidents recorded between 2014 and 2019 (from near miss to completed suicide)
- Where the self-harm occurred (from facility types / services down to ward / room level if possible)
- Mode of self-harm (e.g. hanging, use of ligature / ligature point, laceration, etc.)
- What items, equipment or fixtures and fittings were used to self-harm (e.g. door handle as ligature point, etc.)

KEY POINTS EXTRACTED FROM THE DATA

Where the self-harm occurred

Key finding 1 - Over 80% of self-harm incidents recorded on NHS Board risk management systems occur in Mental Health Services (MHS) accommodation. One NHS Board reported 94% of its recorded self-harm incidents involving ligatures as occurring in MHS

Key finding 2 - Within MHS, the majority (over 50%) of self-harm incidents occur in "private" areas such as bedroom / bathroom / toilet (where recorded).

Key finding 3 - Other areas within MHS where self-harm incidents are recorded include: dayroom, corridor, side room, clinical room, dining room, consulting room, kitchen, waiting room, reception but for a large proportion of the incidents this level of detail is not recorded.

Key finding 4 – Although the majority of self-harm incidents occur in MHS settings a significant number of incidents take place in other parts of NHS Estate (e.g. Accident & Emergency units, medical and surgical wards). One NHS Board reported 16% of its recorded self-harm incidents occurred in acute settings with the highest rate in A&E over 5-year period

Key finding 5 - The majority (~97%) of completed suicides take place out with the NHS estate (e.g. patient's home). There is no data to confirm if these patients had been in contact with health services prior to committing suicide but the fact that the deaths are recorded on NHS Board risk management systems suggest they may have been.

Key finding 6 – The completed suicide rate on the NHS estate is low at about 3% although anything above zero is not acceptable. This reason for this may be due to the fact systems are in place to manage self-harm / suicide risks on the NHS Estate (particularly in MHS).

Key finding 7 – NHS Boards do have procedures in place to record self-harm incidents on local risk management systems. One NHS Board recorded over 8000 self-harm incidents across its entire estate over the 5-year period. Not all of these self-harm incidents involve use of estate fixture and fittings or NHS supplied equipment. However, of those that do (e.g. door handle, shower curtain rail, bathroom taps, radiator, etc. used as a ligature point) very few are reported onward to IRIC (national system).

Mode of self-harm

Key finding 8 – Due to variations in terminology across NHS Boards this was difficult to analyse. Laceration, use of ligature, asphyxiation / choking / suffocation, hanging and striking of body / limb / head as most common mode of self-harm in MHS. Hanging would typically use a ligature point such as doors / beds / bathroom taps. These hanging incidents should be reported to IRIC

Key finding 9 - In non-MHS, acute settings use of ligature was more common alongside laceration and overdose.

Key finding 10 - Other modes of self-harm recorded include: ingesting object / fluid, burn, poisoning, jump from height, drowning, self-immolation

What item / device was used to self-harm (if any)

Key finding 11 - Ligature - large number of clothing related ligatures recorded (belt, scarf. dressing gown cord, shoe lace, clothing – majority of recorded incidents involved the application of the ligature directly to the neck and did not involve a ligature point fixture or fitting (e.g. a patient tightening a belt directly round their own neck)

Key finding 12 - Laceration – razor blades, knifes, glass – majority of incidents recorded involve items procured and carried into the ward by patients themselves.

RECOMMENDATIONS FROM DATA ANALYSIS

- This data confirmed the initial focus of the SLWG's work should be on design of inpatient MHS bedrooms with en-suite shower rooms.

- The vast majority of self-harm incidents recorded on NHS Board risk management systems DO NOT come within IRIC's remit.

- IRIC should promote adverse incident reporting of self-harm incidents (including suicides) that come under its remit where the NHS estate is involved (e.g. room fixtures and fittings used as ligature points)

- IRIC should refine its recording categories for self-harm and suicide incidents on its national database (e.g. currently record "death / fatality" but not the term, "suicide" AND to expand on self-harm Equipment Categories)
- IRIC to work with a sub-group of SPAG with representation from mental health services where self-harm incident reports, investigation outcomes, safety concerns and any learning can be shared and discussed nationally and best practice shared.

- Standardise the way self-harm and suicide data is captured in local risk management systems across all NHS Boards:

1. Define what needs to be recorded and record it using harmonised terms and definitions
2. Note that the Datix Scottish User Group and Healthcare Improvement Scotland are already considering harmonised terms and definitions as part of their work capturing SAER data). This will improve the quality of data gathered locally and make national data analysis possible thus supporting consistent investigations / trend analysis / self-harm decision-making & management across Scotland
3. Add a reminder or trigger for staff on local risk management system for a secondary report to be made to IRIC after recording on local system (e.g. self-harm incident, attempted suicide and door handle used as point of ligature used in incident – IRIC needs to know about this)
4. Ultimately promote "Once for Scotland" reporting – one report to a local risk management system will be enough. Note that IRIC is developing a Batch Reporting system which will allow data to be extracted from local systems and imported directly into the IRIC national system with no need for a secondary report.

- NHS Boards should continue to act on safety advice published by IRIC (EFAs, SANS, IMs, MDAs and MHRA NatPSAs) – see table below for suggested relevant list

- Other areas out with Mental Health Services (MHS) are flagged for further work / investigation in reducing self-harm and suicide (e.g. A&E and other acute services).

RELEVANT SAFETY WARNINGS LIST DISTRIBUTED BY IRIC (1998 – 2020)

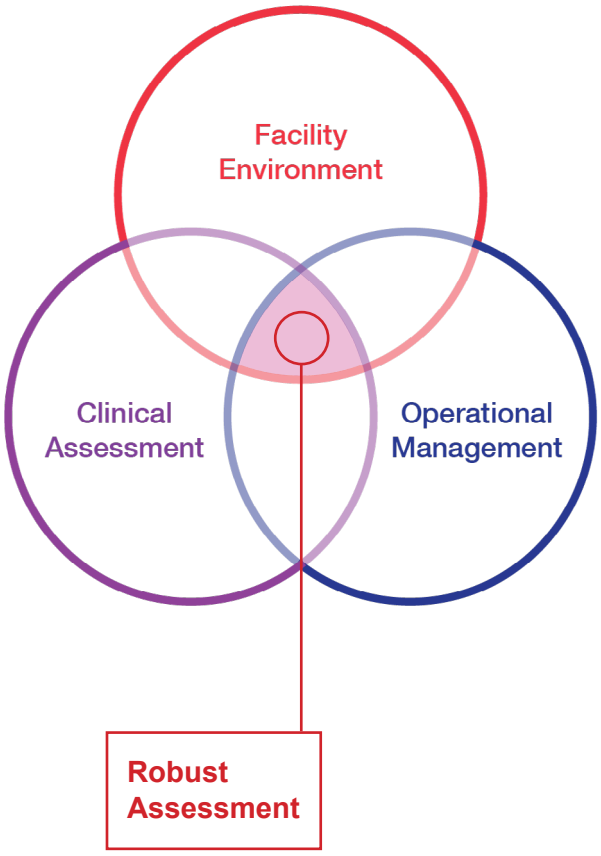
Any of the safety warnings listed below can be accessed: https://www.nss.nhs.scot/health-facilities/incidents-and-alerts/view-safety-alerts/

Year	Reference	Subject
2020	SAN(SC)20/02	Ligature and ligature point risk assessment tools and policies
2019	SAN(SC)19/03	Risk of death and severe harm from ingesting superabsorbent polymer gel granules
2019	EFA/2019/005	Issues with doorstops / door buffers
2019	EFA/2019/003	"Anti-ligature" type curtain rail systems: Risks from incorrect installation or modification
2019	EFA/2019/002	Ingestion of Cleaning Chemicals
2018	EFA/2018/005	Assessment of ligature points
2017	SAN(SC)17/03	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules
2017	EFA/2017/002	Anti-Barricade Devices: risk of ineffectivity in certain circumstances
2015	EFA/2015/003	Flush fitting Vandal and Tamper Proof light fittings in Mental Heath Environment and high risk areas
2015	EFA/2015/001	Window blinds with looped cords or chains
2014	EFA/2014/003	Window restrictors of cable and socket design
2013	EFA/2013/002	Window restrictors
2012	EFA/2012/001	Integral side-stay mechanism window restrictors fitted with plastic spacers and used in many window applications
2010	EFA/2010/011	Self-harm associated with wardrobes
2010	EFA/2010/009	Flush fitting anti-ligature curtain rails: ensuring correct installation
2010	EFA/2010/007	Window blinds with looped cords or chains. All types
2010	EFA/2010/006	Self harm associated with profiling beds
2010	EFA/2010/003	Anti-ligature curtain rails (including shower curtains)
2010	EFA/2010/002	Access hatches
2008	SAN(SC)08/21	Duvet covers and other soft furnishings: possible use of detachable ribbons, tapes or cords as a ligature
2008	SAN(SC)08/19	Toilet roll holders/dispensers: risk of ligature source
2008	SAN(SC)08/02	Rubber / PVC weatherproof seal on window and door openings: risk of use as a ligature
2007	SAN(SC)07/48	Cubicle curtain track rails (anti-ligature): obstructions preventing safe collapse
2006	HAZ(SC)06/24	Doors or other fixtures: use as improvised points of ligature
2006	HAZ(SC)06/18	Showerheads: risk of use as a point of ligature
2005	SAN(SC)05/34	Alcohol-based handrubs: risk of ingestion
2005	SAN(SC)05/23	Infrared personal attack alarm systems: risk of interference by high frequency lamps
2004	SAN(SC)04/50	Window curtain tracking systems: possible ligature points
2004	HAZ(SC)04/15	Cubicle curtain tracking dustcover strips: potential ligature
2004	HAZ(SC)04/02	Window security in the NHS Scotland Estate
2002	SAN(SC)02/23	Change of use of buildings to accommodate mental illness patients: risk of injury/suicide
2001	SAN(SC)01/21	Suicide risk from points of ligature related to suspended ceilings
1998	SAN(SC)98/49	Suicide risk from point of ligature on curtain tracks and similar equipment
1998	SAN(SC)98/47	Over-riding of window opening restrictors: risk of patients falling

Figure 15. 2 Storage and work space combined

Self-harm Assessment Process

Throughout the discussions with the SLWG a series of standard and bespoke assessment tools were put forward by the boards. It is important to understand that the types of risk assessment sit within three key areas all of equal importance that will produce a robust analysis. These areas of assessment are: facility environment, clinical assessment and operational management.



Clinical Assessment

This ensures that patients receive a thorough assessment of their mental health state upon contact or admission and at designated intervals thereafter. The clinical assessment is patient focused. Within the bounds of patient confidentiality this may include relevant information from friends, relatives, carers and other key people to assist in forming the assessment. All patients should be screened for suicide ideation upon admission using a brief, standardised questionnaire. Examples of such assessments are the Storm assessment that is used within Mental Health Services or the Greater Glasgow & Clyde Mental Health Triage and Risk Assessment that is used within Emergency Departments. The preferred method of clinical assessment should be undertaken on a board by board basis.

Facility Environment

Risk assessing the environment identifying all likely fixed ligature points, assessing the level of risk and implementing a management plan. This will include a number of assessments which will include ligature audit scoring and therapeutic quality audit scoring. These assessments will feed into an overall risk and mitigation assessment register. The preferred method of ligature assessment has been agreed by the boards to be the Manchester tool

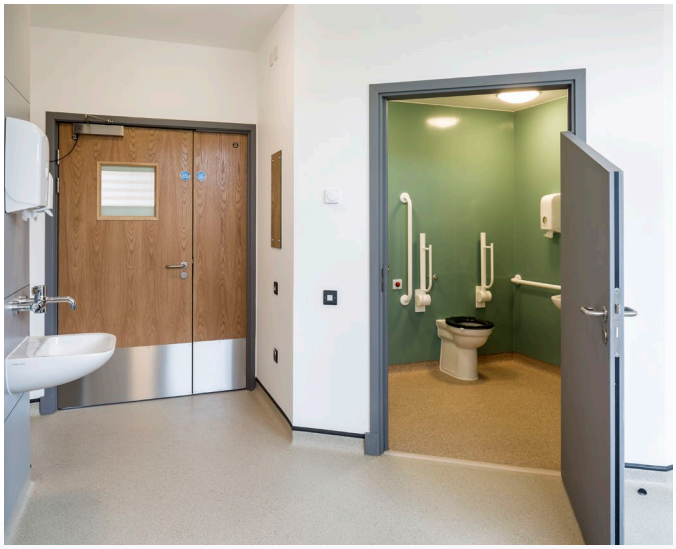


Figure 8.1 Orchard View NHSGGC

Operational Management

The management of suicidal patients throughout their stay in hospital inclusive of multi disciplinary review and where necessary increased levels of observations. The ward/ department operational management must ensure a safe and therapeutic environment by utilising safety measures such as one to one monitoring with continuous visual observation, removal of non fixed sharp objects from the room/area, or removal of equipment that can be used as a weapon, this can include an assessment of patient's own property and if necessary agreed removal. Observations and active engagement will optimise patient visibility and safe staffing levels will be essential in achieving this and good teamwork and communication with all members of the multi-disciplinary team. These may form part of procedures already in place within the environment.

Self-harm Assessment Process

The over arching framework for assessment is taken from the HIS Learning From Adverse Events Through Reporting and Review* which sets out the 5 X 5 tool framework

The table below demonstrates the 5x5 matrix and how the impact/consequences are analysed. As part of the self harm assessment process this framework feeds into the assessments that are undertaken

Likelihood	Impact/Consequences				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High
Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Figure 9.1 5 x 5 framework tool

Within the over arching 5 X 5 framework as illustrated in the diagram on the next page the SLWG also identify the need for a ligature assessment tool and an appropriate Therapeutic Benefits Tool.

It is the view of the SLWG that the self harm assessment process should encompass all three elements to allow for an integrated comprehensive analysis.

Figure 9.3 Stratheden IPCU NHS Fife

Figure 9.2 Orchard View NHSGGC

**https://www.health.org.uk/publication/framework-measuring-and-monitoring-safety
*https://www.healthcareimprovementscotland.org/our-5Fwork/governance-5Fand-5Fassurance/learning-5Ffrom-5Fadverse-5Fevents/national-5Fframework.Fig.

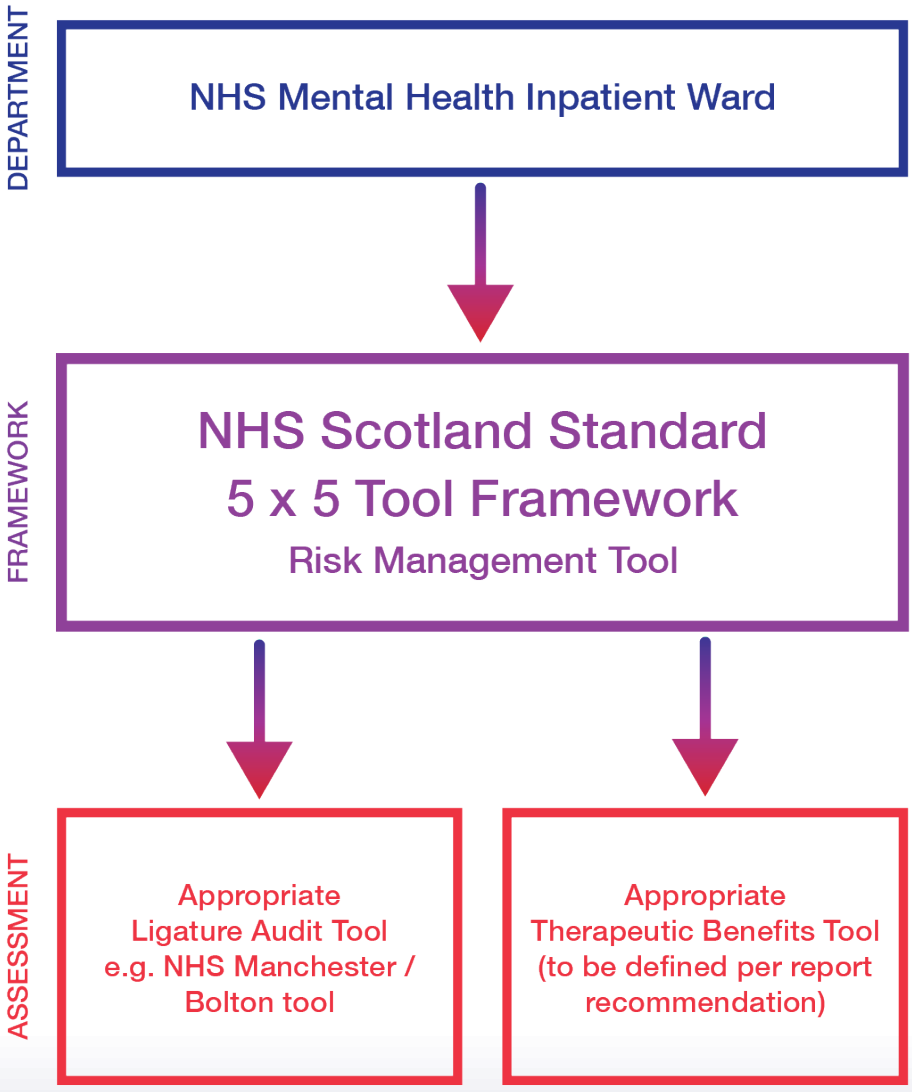
Self-harm Assessment Process

The 5x5 framework is at the centre of the process and will be an integral part of both the ligature and therapuetic assessment.

The anti-ligature assessment tool has been agreed by the SLWG as the manchester/bolton audit tool. This follows a number of discussions and variations of the manchester tool that were presented and analysed.

An outcome of the work undertaken by the SLWG, is the need for a therapuetic benefits tool to be developed or recommended.

*Figure 10.1 **Self harm assessment process***



Key Recommendations:

Follow current guidance:

1. CQC "Brief guide for Inspection teams – Ligature points"
2. Health Building Note 03-01: Adult acute mental health units
3. HBN 03-03 Patient safety and the prevention of self-harm in healthcare environments (in Draft)
4. Design in Mental Health 140 Network (DiMHN) and British Research Establishment (BRE) document "Informed Choices 141 Testing Guidance for Products in Mental Health Facilities" (2020)

Figure 11.1

Figure 11.2 Fraser Ward NHS Grampian

A) Improve data collection and dissemination

- This guidance sits on a closed member's website and is not publicly available.
- Agree a platform for the risk assessment to be formatted on that is suitable for sharing and has the capacity for regular reviews and update as and when required
- Have a glossary of terms and terminology to reduce confusion.
- Take into account information disseminated through Safety Device Alerts
- There is a process in place that ensures that the documentation that is produced undergoes regular review to ensure it remains up to date and relevant.

B) Consistent risk management

1. **A consistent overarching assessment tool e.g. 5x5 matrix**
- Carry out a risk assessment to identify the control measures and final risk rating of the identified ligature points
2. **A consistent safety audit tool e.g. manchester/bolton tool**
- Use an agreed audit tool to identify and risk rate the risk from each ligature point within a mental health ward to the patient group e.g. Manchester tool.
3. **A balanced therapuetic benefit tool - to be developed**
- A tool to be in place for demonstrating the effect of the therapeutic environment
- Should take account of the positive effect that the environment has upon the mental health of a patient.

C) Consistent application of good practice

- Should be a tool in place for the management of mental health in hospital facilities outside mental health wards. Highlighting the risks of ligation from fixed ligature points and the plans to meet them e.g. NHS Highland's Management of Suicide & Ligatures Local Procedure.
- A level of risk assessment and management to be carried out which will include, in equal importance, an assessment of the environment, a clinical assessment of the patient and the operational management of the area
- Use a consistent approach to the assessment of ligature points in NHS Scotland healthcare premises.
- Should have a clinical assessment tool for hospital facilities outside the mental health wards e.g. NHS GGC Emergency Departments Mental Health Triage and Risk Assessment. Staff in these areas must have access to a mental health awareness course to inform them of practical examples of caring for suicidal patients.

Mental Health Single Bedroom
In board ensuite

The Mental Health Single Bedroom has been developed in one key arrangement – that of an inboard en-suite shower room

Within this Repeatable Room, there are 2 variations:

Adult Single Bedroom nested, with Inboard En-Suite with one sided bed access.

Additional design options are included on page 16

Figure 12.1 One sided bed access

Adult Single Bedroom nested, with Inboard En-Suite, with two sided bed access.

Additional design options are included on page 16

Figure 12.2 Two sided bed access

Room Description

The Mental Health Bedroom has been designed to an area of 12.5m². The room has been designed and configured in order to comply with the guidance prescribed in HBN 03-01. The layout and zoning can offer a number of design options which this report will describe and highlight.

Key features

- 5 zones
- Entry threshold zone with wall mounted 'hall stand'
- Observation from obscurable door vision panel
- Choice of bed position against one wall and peninsular, to suit local service preferences
- Flexible furniture configurations
- Notice/art board
- Excellent day-light penetration
- Natural ventilation
- Choice of soft and hard floor coverings within the bedroom
- Opportunity for personalisation
- Window seat option

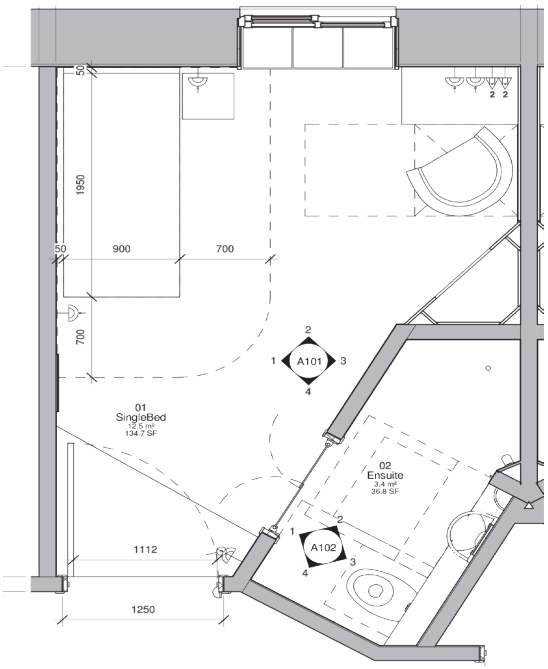


Figure 13.1 Plan Drawing of bedroom/en suite layout

Figure 13.2 Bedroom layout showing all zones

5 Zones in bedroom

1. Entry/threshold
2. Sleep/Rest
3. Work/Play
4. Storage
5. En-suite

Design Options

Window area

1. Window continues to floor to allow space for loose seat
2. Window at 450mm above floor level with deep cill to allow for soft furnishing/fixed seat
3. Bay window design to offer slightly larger area for loose seat

Work/Play Zone - Flexible furniture configurations

1. Single table and chair facing window
2. Single table and chair facing artwork wall
3. Integrated fixed furniture design incorporating both workspace and storage unit. Fitted against artwork wall

The zoning definitions in the room can be project specific. As an example zone 1 may be a harder vinyl finish and that could transition to a softer floor finish to zones 2, 3 and 4. Zone 5 might be a more wet durable solution. Similarly a lowered bulkhead ceiling at entry/threshold may define that zone. The solution of zoning and finishing should be worked through with the project team

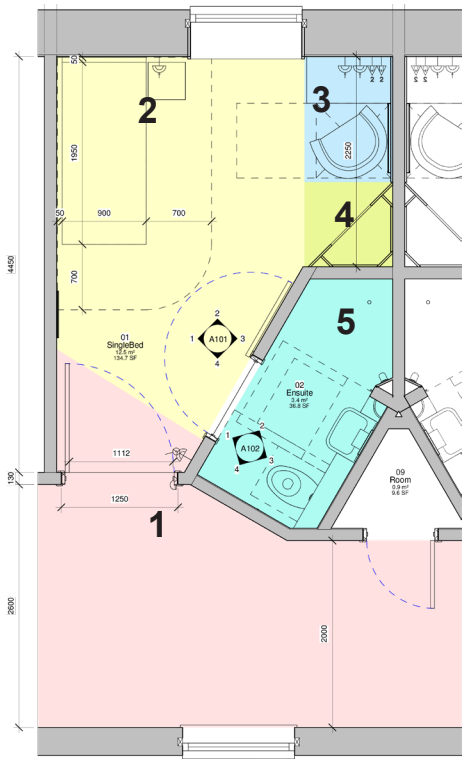


*Figure 14.1 **5 zones coloured***

*Figure 14.2 **Bedroom layout showing all zones***

Clinical benefits

- Clear zones within the room supporting the Recovery model of care
- Creation of a safe therapeutic environment including carpet, enhancing the service user's sense of value, and future-proofed for changing needs and acuity levels
- Generous shower space and en-suite designed with the service user in mind
- Built-in storage based on need, including a bedside table, secure safe and cupboard sized appropriately
- Entrance zone reflected in the different flooring and hall stand furniture
- Good sight-lines both into the room and to the outside, with good daylight providing a brighter, therapeutic environment
- Space for smart TV, artwork wall and additional artwork area or full length mirror and personalisation of the space
- Choice of bed positions and furniture configurations to suit local need
- Window seat option to further enhance the supportive environment

*Figure 15.1 **One sided bed access and window seat***

*Figure 15.2 **Work and storage zone example***

Design Options Bedroom

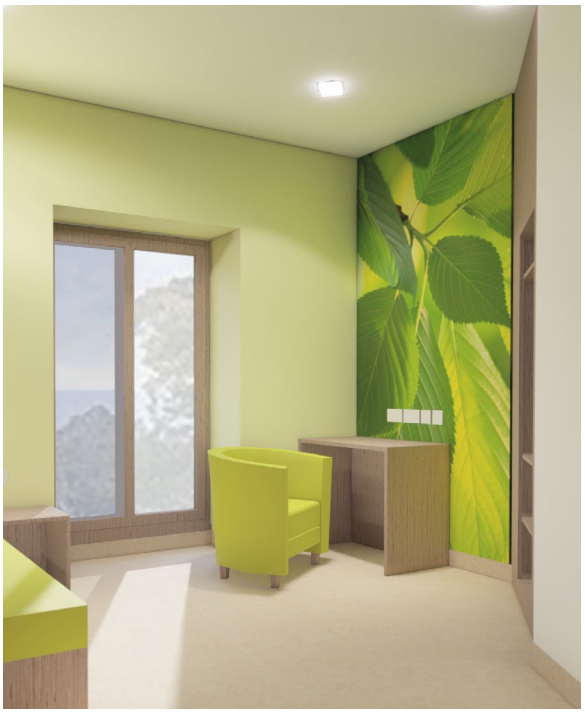


Figure 16.1 Furniture facing artwork wall

Figure 16.2 Storage and work space combined

Figure 16 3 Window full height with space for loose seat

Figure 16.4 Cushioned seating on window cill

Ensuite description

The ensuite has been designed to an area of 3.4m². The room has been designed and configured in order to comply with the guidance prescribed in HBN 03-01. The layout maximises the area for the shower and the location of the sanitaryware allows all services to be delivered and accessed from the services cupboard which is access from the main corridor.

Key Features:

- Hotel-quality feel
- Full width semi-vanity shelf
- Mirror
- Storage pockets for toiletries
- Anti-ligature towel hook
- Wet room
- Generous shower area
- Concealed services, accessed via shared service duct in corridor

Figure 17.1 ***Ensuite arrangement from above***

Note: *Ensuite design using NHS England (P22) Repeatable Room for Mental Health (MH) functional bedroom as basis.*

Room layout to comply with BS8300 for accessibility.

Ensuite door

The SLWG have concluded that there are a number of en suite door solutions that can be integrated as part of a project solution. The outcome of this is the development of the below table that sets out each en-suite door type and the positive and negative impact of choosing one.

Ensuite Doorway Options in MHU bedroom

Type	Positives ('+'s)	. Negatives ('-'s)
A Saloon-type Door	Ligature risks in unsupervised areas (ensuite) are reduced due to ability to observe	Door does not feel 'normal', and greatly reduces patient privacy/ comfort
	Ligature risks from door are eliminated due to magnetic load release pivots for leafs.	Door leaf can be removed easily, adding burden on staff to reattach
	Magnets are at the top, instead of side-hung, the door is held at the pivot points, whilst allowing the door to rotate open/ closed	Door provides no sound privacy
	Detached leaf designed not to be weaponised	
	Detached leaf may show a potential disturbance, as leaf can only be reattached by staff	
	Leaf designed so that magnets cannot be removed/ swallowed.	
	Leaf can be printed with artwork	
B Lock-open Door	In lock-open, ligature risks in unsupervised areas (ensuite) are reduced by ability to observe	Staff burden to assess risk, resulting in lock-open rarely/ never reduced to 'normal'
	Potential to reward good behav-iour, giving high level of privacy/ normal, when door not lock-open	Door does not feel 'normal', and lock-open greatly reduces patient privacy/ comfort
	Ligature risks from door are reduced, when door is lock-open	Ligature risks still exist when door is lock-open and unlocked.
C Curtain	Ligature risks in unsupervised areas (ensuite) are reduced due to ability to observe	Curtain does not feel 'normal', and greatly reduces patient privacy/ comfort
	Ligature risks from door are eliminated due to magnetic load release pivots for curtain/ pole	Curtain provides no sound privacy
	Curtain (& pole) can be easily removed by staff, following a rapid local risk assessment	Curtain can be removed easily, adding burden on staff to reattach/ reasess regularly
	Curtain can be printed with artwork	Detatched curtain & pole could be weaponised
D Standard Door (leaf with or without a sloping top)	If sloping top, ligature risks in unsupervised areas (ensuite) are slightly reduced by ability to hear (/ limited, if any observation).	Staff burden to carry out more regular checks, and explicitly disturb privacy by lock overide.
	Door feels close to 'normal', with good privacy and comfort.	Ligature risks exist with or without sloping top.
	Staff can overide lock & open outwards, if incident suspected	Staff burden to assess risk, often resulting in 'lock-closed'. Consequential Human Rights, Equality & staff burden of impaired access to toiletting.

A) Saloon type door

B) Lock-open door

C) Curtain solution

Performance Specification

Bedroom Door: anti-barricade, reduced ligature ironmongery. Prefer wood-effect, single door; sized for bariatric bed e.g. 1080, W1150mm. Vision panel H800 to ~1800mm FFL, W~300mm; patient privacy control with soft-closer & staff override; (≥95% bedroom fully visible). Fire & smoke door ≥30min, swing-free arm closer(s).

Flooring: use to define privacy zones

Bedroom: prefer infection control compliant carpet or wood effect vinyl.
Ensuite: non-slip waterproof sheet, ≥1:40 fall to drain, & wetroom transition strip;
Entry lobby: prefer a continuation of corridor sheet covering. Prefer no or welded joints, with visual contrast (≥30LRV) cove or skirting edges, & ≤30LRV where thresholds

Sockets: prefer ≥3 twin power, incl. at desk, at bed and at mirror/ entry lobby. Option: wifi, screen, data, USB

Solid ceiling: H ≥2.7m; prefer ≥3m, sloping or stepped, entry lobby & ensuite H ≥2.4m. If any ≤2.7, prefer reduced ligature fittings eg. detector. Option: acoustic panel(s)

Art & acoustics: need ≥1 panel(s), (≥1.5 sqm) for both; prefer nature.

Robust walls: prefer block or 2-layer plasterboard. Option:

Lighting: prefer ≥3 lighting options, incl. general (≥150 lux to FFL), task light (300 lux to desk) & mood/ feature. Reduced ligature.

Ensuite: ≥95% room fully visible; reduced ligature fixtures & fittings. Prefer no-touch controls; service access from corridor duct, to allow room Isolation. Prefer no IPS or service hatches. If required, must be secured with special key. Visual contrast (≥30LRV) for user controls, wc seat & floor edges. No sockets. Light at mirror, plus ≥150 lux to FFL. Option: fixing to add a detachable shower hose. Option: fixings to add mobility rail aids in selected rooms.

Furniture: reduced ligature, self-harm & barricade. Prefer wood-effect; ≥2 variant layouts for bed.

Mirror: H 500 to ~2000mm FFL, W≥ 300mm;

Soft furnishing: HAI team agreed, washable; in colours/ pattern to suit interior design /art, eg. cushions, curtains, bedding, rug.

Window: need view of nature plus local control of ventilation & light. Reduced ligature, self-harm & falls risks. Option: anti-contraband. Prefer H ≤450mm FFL to ceiling; with opening(s) H ≥1500mm. with seat built-in or in bay window

Figure 15. 2 Storage and work space combined

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