Shearwater Ward

Ligature Assessment Tool

RESPONDING TO LIGATURES

- Avoid pulling alarms unless deemed absolutely necessary by the responder
- Avoid all restraint and be as hands off as possible with the patient
- Only have the required amount of staff, many responders are not necessary and can be unhelpful and chaotic
- We try to never use enhanced observations on Shearwater unless it is unavoidable
- Encourage the patient to untie their own ligatures if this is possible
- If the ligature requires cutting off seek consent from patient if there is no risk of fatality and the patient is able to verbally respond
- If consent is refused take time to assess and observe and respond accordingly
- Maintain a calm presence on the ward, the aim of this is to not alert other patients the incident
- Discretion with regards to carrying ligature cutters to the location, as to not create chaos on the ward
- Do not remove risk items or lock bedrooms or physically move patients away from that space
- Offer support after the incident, if this is rejected, ensure the patient knows how to access the support and allow the patient space to regulate themselves

POSITIVE WORDS

'Research has also shown that clinicians compassionate views of their clients is predictive of positive client outcomes' (Bateman & Krawitz 2013 p45).

Patient Feedback

"The ward staff were both helpful to our granddaughter but also to ourselves explaining things that previously we had not fully understood" Patients' family in relation to staff explanation of approach with personality disorder.

"The nursing staff at Shearwater are totally professional in expertise, caring and respectful allowing dignity for both patients and visitors and offering help and advice" Patients' family after brief admission on Shearwater for a patient with Emotionally Unstable Personality Disorder.

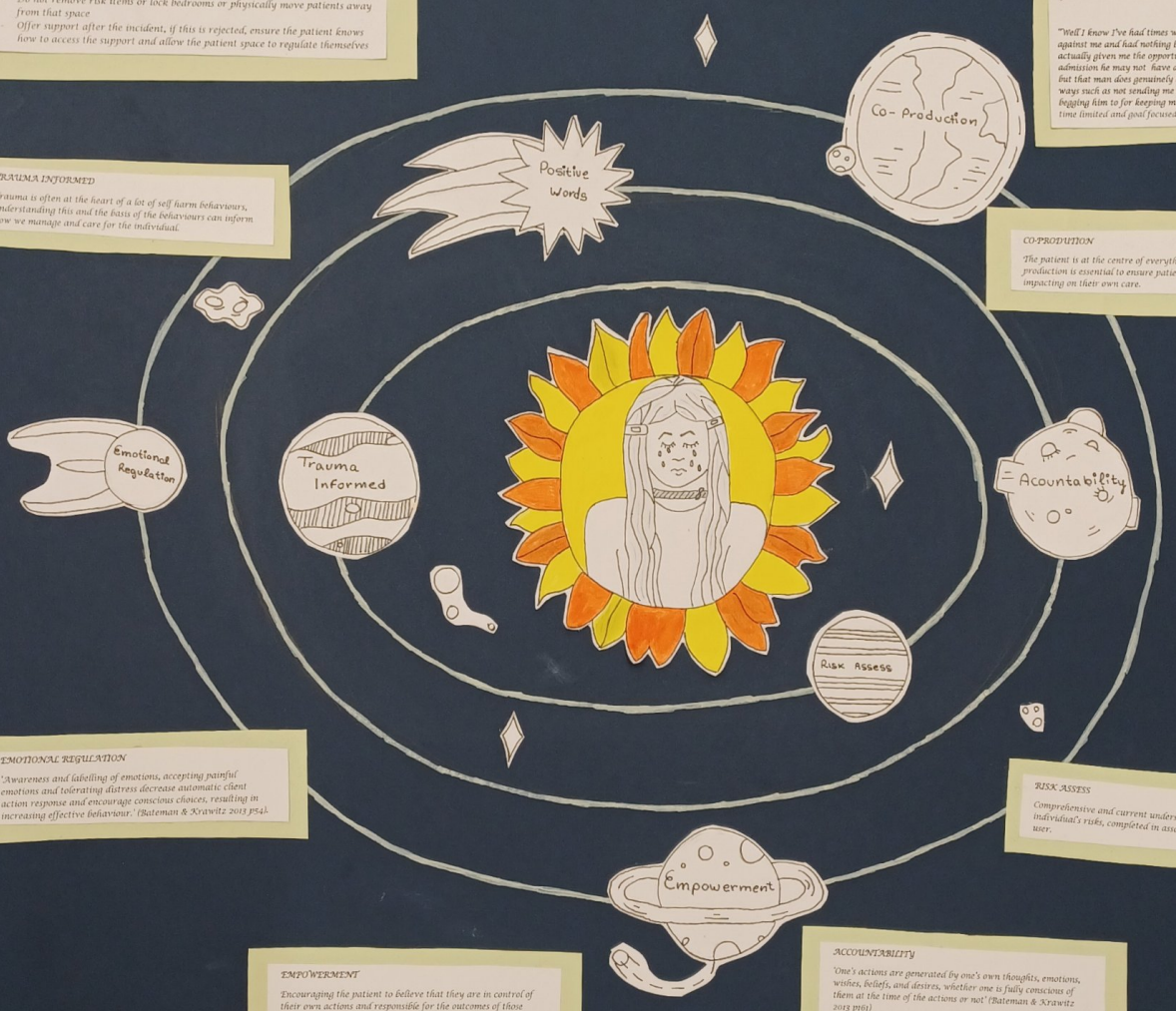
"I well and truly hit the lowest of the lows before and during the start of this admission and I never thought I'd come back from it, I had never felt so desperate or unwell in all my life it was 100% rock bottom for me. The thing is I know that with a diagnosis of EUPD and still very much finding my eating disorder difficult that there are going to be struggles still for me to face yet and I'd be silly to say that I'm "recovered" and never going to have a crisis of any kind again but one thing I've learned from this admission is that to have the support around me that I've had here and after I leave here I am very very lucky and it's not going to be there and available forever so I wouldn't be so gutted if I look back in the future with regret that I had all this support to give me the help and skills I needed but only half heartily used it" - Patient with Emotionally Unstable Personality Disorder after admission on Shearwater.

"St Mary's have made a big impact on how I see things and even though I still have the odd moment this has been the biggest eye opening admission and the one that has helped me see where I want me life to go now rather than keeping myself stuck in the past and I have to say a massive thank you to the staff" Patient with Emotionally Unstable Personality Disorder after admission on Shearwater.

"Well I know I've had times where I've felt he's completely against me and had nothing but bad intent for me but he has actually given me the opportunity to grow during this admission he may not have always been my favourite person but that man does genuinely care and he's shown that in many ways such as not sending me to a long term hospital despite me begging him to for keeping me here" Patient feedback about a time limited and goal focused admission speaking about the Dr.

TRAUMA INFORMED

Trauma is often at the heart of a lot of self harm behaviours, understanding this and the basis of the behaviours can inform how we manage and care for the individual.



CO-PRODUTION

The patient is at the centre of everything we do and co-production is essential to ensure patients feel they are impacting on their own care.

EMOTIONAL REGULATION

'Awareness and labelling of emotions, accepting painful emotions and tolerating distress decrease automatic client action response and encourage conscious choices, resulting in increasing effective behaviour.' (Bateman & Krawitz 2013 p54).

RISK ASSESS

Comprehensive and current understanding of what drives an individual's risks, completed in association with the service user.

EMPOWERMENT

Encouraging the patient to believe that they are in control of their own actions and responsible for the outcomes of those choices.

ACCOUNTABILITY

'One's actions are generated by one's own thoughts, emotions, wishes, beliefs, and desires, whether one is fully conscious of them at the time of the actions or not' (Bateman & Krawitz 2013 p161)

A Case Study

Sarah was admitted to an acute psychiatric ward on 11th November 2021. She remained on the acute ward until being transferred to Shearwater Female Psychiatric Intensive Care Unit (PICU) on 17th May 2022. In the preceding month (16th April - 17th May 2022) Sarah had tied 75 ligatures, engaged in another 5 incidents of self-injury, there had also been 5 incidents of physical aggression with 3 seclusions in that period. During this period the notes refer to a number of restrictive interventions utilised to manage the risk to both self and others. This included the use of a sterile room, rip proof clothing, no leave, a forced depot, bedroom door locked during the day time, one set of clothes per day, no electronic devices after 19.00 and only having access to bedding at night. There were also discussions around the label of anti-social personality disorder and psychopathy and the need for locked rehab or a forensic referral.

Following transfer to Shearwater PICU, during the initial few days Sarah met the members of her Multi-Disciplinary Team (MDT) and a comprehensive nursing care plan was co-produced with Sarah. A psychological formulation was also co-produced with Sarah, including the use of personality screening assessment. This was completed in order to identify relevant personality traits and to consider how this relates to risk, in order to provide staff with a more in-depth understanding of her presentation and difficulties. An OT treatment plan was also co-produced and a sensory ladder developed to support Sarah and staff in the use of strategies/interventions that may be helpful in reducing levels of distress and dysregulation. The main focus of 1:1 nursing key work sessions and psychological intervention was centred around empowering Sarah to take ownership over her own safety, in a supportive and recovery-focussed manner. This included supporting Sarah to identify and develop specific coping strategies, Sarah's input in to helpful and unhelpful interventions was incorporated into her care plan; reflecting the importance of collaborative work within an inpatient setting. Crisis Wheels were completed after some of the ligatures tied, in order to better understand the psychological drivers for this and learn lessons for the future, both from a patient and staff perspective in terms of managing risk. Sarah's room was never locked, she had no additional restrictions to items in her room. She had all of her clothing and had bedsheets in her bedroom. She was given access to her laptop and phone including charging wires and headphones. Rip proof clothing was never used. The Ward Psychologist also met with Sarah's family to promote their involvement and to provide psychoeducation in relation to the model of care being used. Leave was granted after 10 days of PICU admission. This was the first time she had used leave since the beginning of the admission in November 2021. She used leave successfully for the rest of the admission without any AWOL attempt.

During the PICU admission Sarah tied 46 ligatures and had 1 other incident of self-harm. There was no restraints or seclusions in this period. Aside from a standard contraband list, Sarah did not have any additional restrictions in regards to having access to her items. Her diagnosis was confirmed and a community based psychological intervention was arranged. Sarah left the PICU on 18th June 2022, transferring to an acute ward and spent a further 6 weeks in hospital before being discharged to supported accommodation. She gave the below feedback via email on her discharge.

"Hello Adam. After an 8mth admission I was finally discharged on 2nd August. I am determined to make this work and I would like to thank the whole team on Shearwater for their amazing help because I wouldn't of got this far if it wasn't for everyone on Shearwater. You got me into a much better place mentally that I hadn't been in for months and months prior. Thank you!"

OVERVIEW OF THE PROJECT

- We are interested in developing a ligature assessment tool, which will support and guide staff within PICUs and other inpatient settings to manage patients that tie ligatures as a way of coping with their mental state and/or emotional fluctuations
- we have anecdotally demonstrated good results when managing ligatures by creating space time and support to allow patients to utilise their existing skills, as well as having the opportunity to develop new coping and self-regulation skills within a safe and supportive environment
- We aim to encourage patients to take increased responsibility for managing their own emotions and to work with staff positively to promote a sense of autonomy
- We are using trauma informed principles and working in a patient centred way to encourage patient to self-regulate and seek help where necessary.
- allow for the development of skills to cope with 'ligature tying urges' within the community upon discharge.
- We are keen to develop a grading system for ligatures in order to provide a guidance for staff in terms of how they should approach and manage a ligature incidents.
- The intention to grade the ligature would allow staff to feel empowered in a more intricate understanding of the risk of the ligature and would be useful to communicate risk to the wider MDT.

We are NHS