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Making 1-1 Support Person Centred and an Effective Therapeutic Intervention

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ABSTRACT

The use of 1-1 support in care homes within the healthcare system in England and Wales is a recognised protective safeguard. However, it is not without its controversies and conflicts as it can prove to be both a highly restrictive and expensive intervention. This paper will examine the use of 1-1 support within care homes for people who present with behaviours that challenge. It will record the findings from a review of 1-1 support for 23 service users over a 30-month period. It will also make a number of recommendations to make 1-1 support an effective, therapeutic, person centred and a correctly targeted resource.

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Introduction

In 1999 the now defunct Department of Health Standing Nursing and Midwifery Advisory Committee recommended four levels of observation in England and Wales [1].

Level 1, otherwise known as General Observations is the minimum acceptable level for all patients where the location of the patient is known at all times. Where a patient's location is checked at least once every 15-30 minutes is known as Intermittent Observations (Level 2).
Level 3 is otherwise known as Within Eyesight. Here the patient should be kept within eyesight at all times night and day. The highest level (Level 4) Within Arm's Length or Special Observations where the patient should be kept in very close proximity at all times, day and night.

Unfortunately, whilst these four degrees of observation appear to be standardised throughout mental health settings in England and Wales, there is some evidence of significant inconsistency surrounding issues such as terminology and its application within different clinical/care settings.

A scoping review by Wood et al 2018 identified several terms in place to describe the process, including '1 to 1 nurse specials', '1 to 1 care' 'nurse specials' or 'special observation' or 'direct nurse observation' and even the term 'sitters' – though this latter term tends to be used more often in the USA and Canada [2].

Within care home and residential care settings the term '1-1' appears to be the agreed and accepted term for enhanced or special observations in the UK. However, based upon this group of authors' experiences, this term seems to straddle both levels 3 and 4 observations.

This paper is based upon findings over a thirty-month period between October 2019 and April 2022 when a programme of reviewing 1-1 support was commissioned by a then CCG now ICB (CCG will be used throughout) in the North West of England. Twenty-four different service users were assessed over this period of time and each were then followed up on average every four to six weeks for further reviews. In a bid to dispel ambiguity for the benefit of the reader, the term '1-1 support' will be the term used to describe this intervention. One to one support is a combination of levels 3 and 4 of the definitions described above. For the sake of consistency, we will refer to the people involved in the 1-1 support as service users.

How and why 1-1 care is Commissioned, Implemented and Evaluated Within Care Homes

A survey of NHS Trusts published in 2000 by Bower. et al, recorded that Special Observations are primarily initiated to reduce the risk of self harm and suicide and to prevent aggressive behaviour or absconding [3]. Whilst there are clear parallels within care homes throughout the UK, with violence towards others, self-injury and absconsion, we also found that sexualised behaviour – whether sexual assault or dis-inhibited conduct to be an issue.

One to one support can also be used when a client is at risk of physical exhaustion due to extreme and prolonged overactivity. Then, 1-1 support can protect, prevent harm and restore therapeutic equilibrium to the environment. In many authorities, it was standard practice for the care home staff to inform commissioners either from the CCG or Local Authority that there was a requirement for 1-1 support and often without question the provision was put in place. According to Fazel et al, the reason for requiring or initiating special observations is '…largely based on an assessment of risk and the need for that risk to be minimised [4].' Fazel added, 'however, risk assessment can often be a vague and imprecise practice.'

How 1-1 Support has Historically been used, Mis-used and even Abused

Within our clinical roles we observed that sometimes 1-1 support was not being utilised in accordance with the requested need/s of the care provider or the service user. There was both anecdotal and evidence-based concerns that the 1-1 support staff were not always being allocated to the person originally identified as needing the support. They were often simply a 'free' pair of hands to buttress the established number of staffs.

Disputes could arise when commissioners sought to review the 1-1 support and seek further evidence to maintain or even reduce the number of hours funded. Claims that commissioners were not aware of the situation with a client, not understanding the issues or it would be 'too risky' to change the 1-1 support would be cited.

Another 'practice' was to employ 1-1 support as an active restraining 'tool' – at one extreme by telling a client to 'stay there' in a chair when they tried to stand up. Or, of even greater concern, by physically stopping them and controlling their movements – in other words using restrictive physical interventions. One home, which had been receiving funding to prevent a client from escaping and putting himself in danger continued to be supported even though on later discovery that he had both legs amputated almost a year earlier!
These are isolated incidents however.

The Human Right Element

It is an immutable fact that 1-1 support- irrespective of whether it is used within hospital or a care home environment - is a restrictive intervention and as such should only ever be medically indicated and in the best interest of the service user [5,6]. With this in mind, care providers also need to be cognisant of the fact that restricting a person's freedom without medical necessity may well be a breach of the person's human rights. Constant 1-1 support may impact on a service user's right to privacy (Article 8), their right to freedom, (Article 5) and also Article 3 which is about protecting a service user from inhuman or degrading treatment [7].

Making a Start

As part of the pilot study, our role was to review a selection of four 1-1 supported service users in 4 different care homes. This then spread to over 9 care homes and a total of 24 service users. One of our first lessons was to establish ourselves as being independent from both the Homes we were visiting and the commissioners. This issue came into focus during our very first care home visit, when we were asked if we were there for the CCG. The nature of the project could mean that we would be making recommendations that either the Home or the CCG would not necessarily agree with. We advised that our evidence-based findings would only be clinical recommendations and ultimately the decision rested with the commissioners.

It was also vital that we were clear in understanding and establishing the reasons for 1-1 support being agreed as our decisions were clinically based and not fiscal.

There was a need to establish a baseline and possible trigger factor(s) for the behaviour, times of the day when the behaviours happened or peaked and what interventions were being employed to address the need prior to 1-1 support being implemented. A 1-1 support application form was designed to be completed by Homes seeking 1-1 support.

The form sought crucial information, but there was also a perception that it was bureaucratic and time consuming. However, it was pointed out that in an emergency the form could be completed at the earliest opportunity after 1-1 support was in place. An additional aim of the form was to promote and develop reflective practice around 1-1 support, its value and impact on the home population. One major role of the form was to identify the exact reasons for the 1-1 support request.

Once 1-1 support was agreed and implemented our next stage was to monitor how it was used.

Service user Group
Figure 1

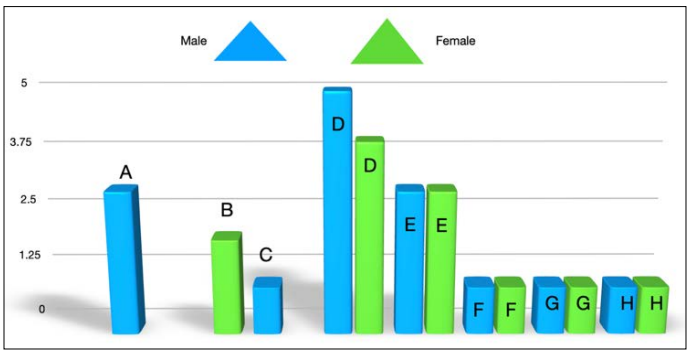
Male	Female	Other
14	10	0

Age range 38-92 years
Average -age 71 years

Reasons for 1-1 support request
Figure 2

Reason for	Male	Female	Total
A- Absconding risk	3	0	3
B- Self-injurious	0	2	2
C- Sexually dis-inhibited	1	0	1
D- Violence towards others	4	3	7
E- Falls risk	3	2	5
F- Verbal abuse	1	1	2
G- Agitation	1	1	2
H- Wandering into other's areas	1	1	2

Gender Breakdown Figure 3



Functional Assessment Gathering the Data
One of the most consistent problems encountered, was a lack of evidence upon which to base the 1-1 support need. Care plan,

daily notes, risk assessments and incident forms were the main source of information. We wanted to know more about the service user, how they behaved also why and when they behaved in a certain way. Floyd wrote, '…behavioural observation involves the systematic observation of specific domains of behaviour in order to accomplish this the behaviour must be coded or broken down into recordable units, and the criteria for the assignment of labels or for making evaluations must be objectified [8].'

A 'Data Gathering Form' (DGF) was drafted. Its aim was to gather a functional 'picture' of a client's behaviour as observed by the 1-1 support staff. The reason for introducing the DGF was an attempt to clarify the service user's behaviour within the context of their overall activity over a 24-hour period. We wanted to have a picture of the service user and their behaviours as well as an understanding of the carer's behaviours during the 1-1 support periods.

After several drafts were tested, we were able to develop a form that required the observer to record the person's behaviour every 10 minutes, using a letter for each activity.

Figure 4: Data Gathering Form – key to activities

Date_____ Name of Patient/client being observed –

Behaviours being observed: Name of Observer_____

A=Sleeping
B= Eating
C= Sitting quietly
D= standing up
E= Trying to get out of bed
F= Agitation (unsettled)
G= Trying to stand up. Unsteady on feet/ at risk of falling.
H = Wandering/pacing environment
I = Verbal abuse.
J = Physical violence towards others
K= Deliberate Self injurious behaviours.*
L = Behaviours that require physical interventions- Breaking away.
M= Behaviours that require physical restraint.
N= Sexually dis -inhibited behaviours
O = other behaviours which challenge others** **Please specify what the behaviour is**

A full copy of the form will be found in the appendix to this paper.

The key seemed to be self-explanatory. If Mr X was eating then the letter B would be inserted. If they were eating and shouting at staff then the letters B&I would be used. There would be a space every 10 minutes.

We asked the homes to keep the forms going for the duration of the 1-1 support for between ten, fourteen and occasionally thirty days. The aim of the DGFs was to enable care staff and us to recognise trends such as trigger factors – for example: times of day, visitors, certain staff and interactions with other service users.

The data gathered was then represented as matrix and a number of charts.
Below are examples of the data representation:

Figure 5: Collated data

Date January 2022	Behav. A	Behav. B	Behav. C.	Behav. D.	Behav. E.	Behav. F.	Behav. G.	Behav. H.	Behav. I.	Behav. J.	Behaves. K.	Behav. L.	Behav e. M
1st													
2nd													
3rd													
4th	9	7	17	77	0	50	0	0	13	0	0	0	0
5th	13	13	12	74	0	48	0	0	12	9	0	0	0
6th	40	0	25	63	7	41	1	0	29	0	0	0	0
6th	12	5	24	78	8	43	0	0	13	1	0	0	0
8th	10	10	38	54	5	41	0	0	14	2	0	0	0
9th	7	2	47	78	2	11	0	0	15	6	0	0	0
10th	9	0	39	73	7	30	0	0	10	10	0	0	0
11th	1	3	69	55	0	9	0	0	0	0	0	0	0
12th	13	9	22	59	0	52	0	0	9	2	0	0	0
13th	6	0	32	46	0	34	0	0	6	0	0	0	0
14th	13	12	23	69	5	0	6	0	23	0	0	0	0
15th	10	10	32	66	1	25	0	0	10	1	0	0	0
16th	28	12	49	51	1	24	0	1	11	2	0	0	0
17th	7	0	6	34	4	9	0	0	7	0	0	0	0
18th	7	4	3	39	2	15	0	0	5	0	0	0	0
19th	11	8	25	65	3	47	0	0	23	2	0	0	0
20th	No DATA	XXXXXX X	xx	xx	xx	xx	xx	xx	xx	NO DATA	0	0	0
21st	11	0	23	74	0	45	0	0	18	0	0	0	0
22nd	0	9	16	62	0	44	9	0	7	0	0	0	0
23rd	0	9	15	37	0	29	0	0	0	10	0	0	0
24th	10	4	14	58	0	43	0	0	16	3	0	8	12
25th	19	13	5	71	1	41	13	0	26	0	0	3	0
26th	12	11	33	106	0	26	0	0	23	0	0	0	0
27th	11	4	22	85	0	25	0	0	25	0	0	0	0
28th	13	4	29	88	0	28	0	0	30	0	0	0	0
29th	15	12	24	58	0	26	0	0	11	0	0	0	0
30th	0	4	0	20	0	19	0	0	17	0	0	0	0
Average Score													
	11	6	25	63	2	31	1	0	14	2	0	0	0

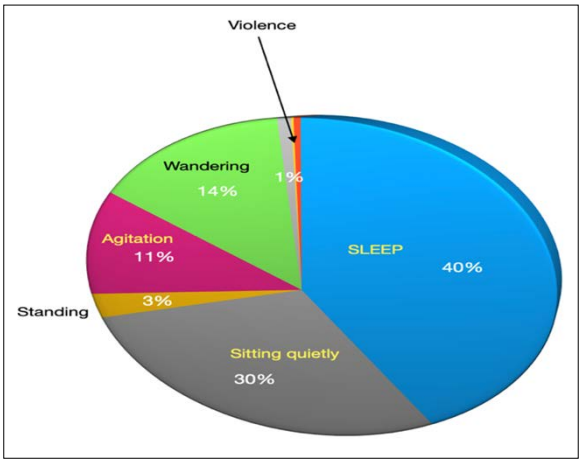


Figure 6: Pie chart illustrating different behaviours as percentages

Endeavouring to build positive relationships with the various care providers we visited each home, spending time talking with the carers and addressing any issues with the DGFs. We would also observe the service user receiving the 1-1 support and the person providing the 1-1 support.

This also gave us an opportunity to assess the environment and the general milieu of the home.

Assessing 1-1 Support Needs

The data obtained from the 1-1 support observations was analysed and a descriptive narrative was added with findings and recommendations. For example, Mr A had been described as very aggressive towards staff at his care home. We also asked staff to be more specific, was he hitting out at people, threatening violence towards others or was he verbally abusive? We spent a morning with the staff helping them to frame and record Mr A's behaviour over day (and night).

Based upon the varied reasons for care providers requesting 1-1 support, it was important to establish a baseline of what those employees who were being tasked with implementing the intervention what they were told or perceived their role to be.

Findings

One to one support can offer an important dimension to care provision in certain situations. However, this project has also presented a significant learning challenge to the authors as we sought to understand how it was used and how its use has evolved significantly in less than three years. Reasons for applying for 1-1 support were often unclear, with the erroneous belief that – for example - being agitated was a defined justification for 1-1 support without explaining just how the agitation was impacting on the service user and the rest of the population.

Or the incorrect assumption a person at risk needs 24-hour 1-1 support for risk of falling when there is clear evidence that a single member of staff would be unable to catch a person as they fall.

Too often agency employees with only a rudimentary knowledge of the service user in their care were expected to spend inordinate periods alone with the person. This resulted in less contact time for the service user with the main carers which basically became a worrying outsourcing of care. As part of the process we developed an audit of baseline knowledge for 1-1 support carers – mainly agency staff (N=14). (a copy of this is contained in the appendix)

Only 8 out 14 actually knew why they were providing 1-1 support, with 10/14 (71%) being clear what they were expected to do if the service user expressed the defined behaviour. Three of the carers questioned had been told to push the service user back into a chair if they kept trying to stand up. Most worryingly only about three quarters of care providers had a DoLS in place to justify 1-1 support. The data gathering forms were often unsigned and also being completed hours after incidents occurred. Too often the 1-1 support provider would not be engaging with the service user. However, we did witness some exceptionally good examples by some Homes when the 1-1 support provider would be fully active in stimulating the service user physically and cognitively with therapeutic activities. Another finding was that 1-1 support should not extend beyond twenty hours per day. There is sufficient reason to expect core provision – in the absence of any 1-1 support to provide at least 4 hours of care per day, including: washing, dressing, feeding and continence care. Too often 1-1 support was felt to be the only intervention when there was evidence that the care providers had not eliminated fundamental issues such a mental health review, involvement of falls teams and Behavioural Support Services and even a review of a person's medication to eliminate pain as a cause of agitation and distress.

Recommendations

- To ensure that 1-1 support is a truly effective intervention within care home settings, it must target at those service users whose behaviours indicate its use. This starts by clearly defining and framing the actual behaviours that challenge using the 1-1 application form.
- Reduce the use of 1-1 support for falls risk by ensuring that multifactorial risk assessments are completed and of Falls Team input is evidenced.
- Implement a policy of 20 hours maximum for 1-1 support unless exceptional evidence-based risk factors are indicated.
- All 1-1 applications must also prompt a Deprivation of Liberty Safeguard (DoLS) application or amendment to an existing safeguard and this needs to be evidenced as part of the application process.
- To develop a graduated approach to 1-1 support by involving other professionals such as Falls teams, Positive Behavioural Support and GPs to eliminate factors that may be addressed without relying upon 1-1 support.
- There is a vital need for care home staff (and even some senior professionals) to undergo training in why and how to provide 1-1 support safely and appropriately.

Such training should include:

1. The impact of 1-1 support and extensive segregation on the service user.
2. Why it is an intrusive and restrictive imposition
3. Why DoLS must be automatically triggered by 1-1 support
4. Understand what a restrictive physical intervention is
5. Recognise the service user's Human Rights including articles 3, 5 and 8
6. How to frame the actual behaviours that have triggered the 1-1 support request
7. How, recognising 1-1 support as a restrictive (physical) intervention to ensure it also embraces the national policy of restraint reduction

- To have an agreed consistent approach within the new Integrated Care Boards that works to an agreed protocol before agreeing to 1-1 support
- To introduce digital data gathering technology to ensure accurate, contemporaneous recording with faster analysis and reports.
- To develop a template policy for care homes for the use of 1-1 support as enhanced observation.
- To develop a template policy for care homes for the use of restrictive (& physical) interventions.

Impact from a Service Perspective

One to one is never the least restrictive, however it tends to be the go-to for care homes to manage those with behaviours that challenge and falls as this seems to place an extra burden on the potentially depleted staffing levels. However, it is also a deprivation of liberty and one that should not be put in place lightly. Hospitals are very different environments and the majority of requests come following a discharge where one to one has been in place on the ward. 'Initially to settle' is the reasoning behind this, but then removal of the same, from a commissioning perspective becomes hard as it's felt to be, from the providers, finance lead. Yes, there are financial implications, however, quality of care within the persons home is of paramount importance and depriving a person of their liberty is not appropriate. Yes, there have been savings by reviewing in an appropriate and timely manner and a safe, planned reduction or removal of one to one care.

Having an independent agency look at these cases has had a major impact for these service users. Staff have been supported to appropriately plan and implement care and have followed guidance on training making this a better outcome for all who need the service not just that individual. The team have found this service extremely beneficial and know those being reviewed are being looked at holistically with safety being the main priority. Recommendations have been thoroughly explained and reasoned and services users have been able to live a less restricted life due to the support offered.

A full copy of the form will be found in the appendix to this paper.

Glossary of Terms

Restrictive Interventions are:

'planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and

- end or reduce significantly the danger to the person or others; and
- contain or limit the person's freedom' [9].

Behaviours that Challenge are:

"Culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to, ordinary community facilities" [10].

Appendix

Date_____ Name of Patient/client being observed –

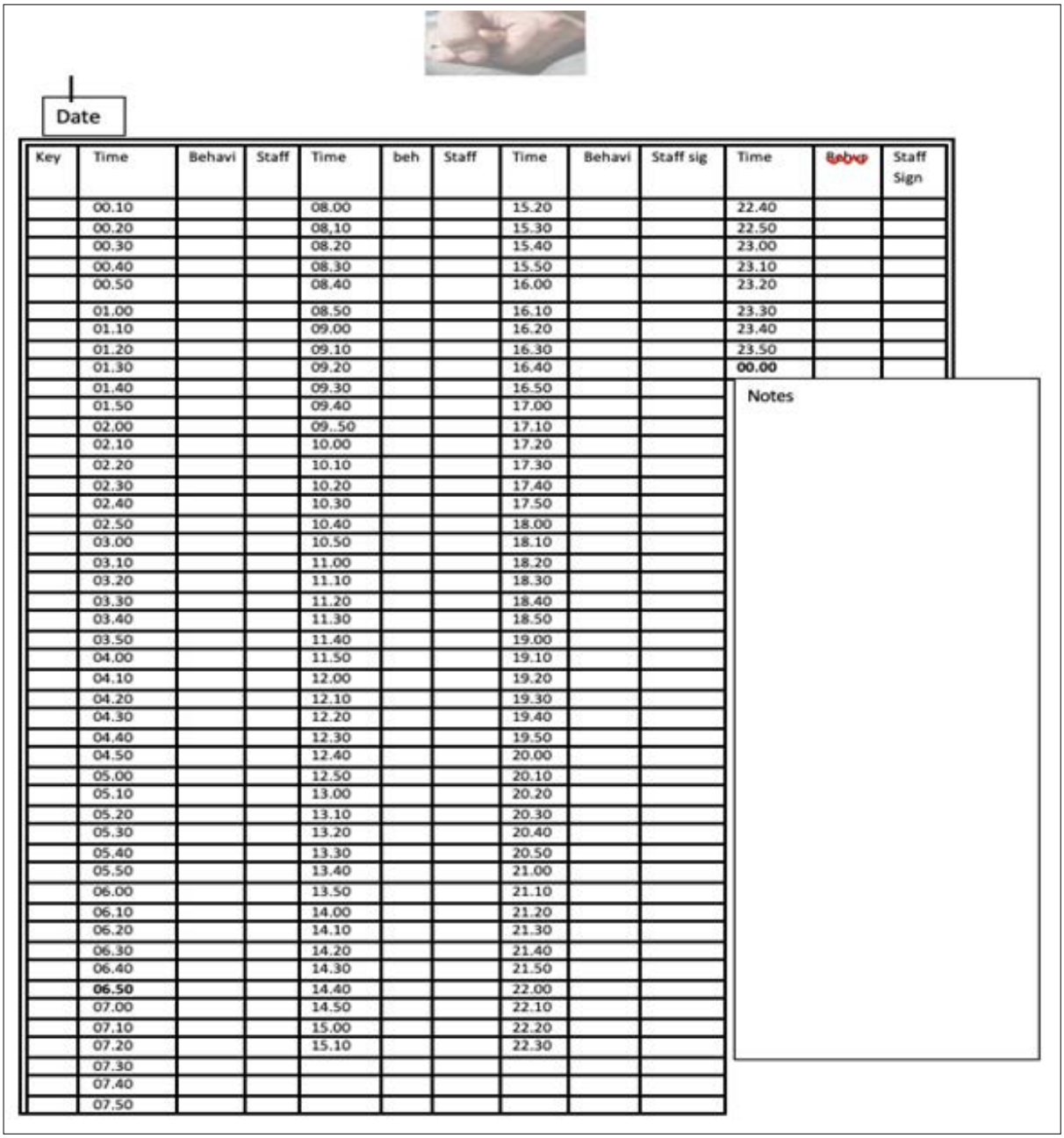
Behaviours being observed: Name of Observer_____

A=Sleeping
B= Eating
C= Sitting quietly
D= standing up
E= Trying to get out of bed
F= Agitation (unsettled)
G= Trying to stand up. Unsteady on feet/ at risk of falling.
H = Wandering/pacing environment
I = Verbal abuse.
J = Physical violence towards others
K= Deliberate Self injurious behaviours.*
L = Behaviours that require physical interventions- Breaking away.
M= Behaviours that require physical restraint.
N= Sexually dis -inhibited behaviours
O = other behaviours which challenge others** **Please specify what the behaviour is**

Please note – as an observer you only need to write the LETTER pertaining to the activity. EG. If the PERSON is asleep then you just write 'A' Or if he/she is agitated, then you input 'F' etc. Occasionally a person may be exhibiting two or even more behaviours simultaneously. A person may be agitated, verbally abusing staff whilst standing up. In which case you may have to record this as, 'F, G, I'. However most of the time you will only need to input one letter which makes it easy and faster to complete. * K= self injurious behaviours. Please note this is regarding people who deliberately self injure or harm themselves, not to be used if a person, for example accidentally falls over, unless they have done this to deliberately hurt themselves.
*Please ensure you record the date and your signature/initials***

Please complete one sheet for each 24 hour period. So, for example if the 1-1 commences at 23.45 on 11/01/21 then please commence a new sheet for the 12/06/21. This reduces confusion when we analyse the data.

Please ensure that the data is inputted regularly and in a timely manner to ensure its accuracy.



Date

Key	Time	Behavi	Staff	Time	beh	Staff	Time	Behavi	Staff sig	Time	Behvp	Staff Sign
	00.10			08.00			15.20			22.40		
	00.20			08,10			15.30			22.50		
	00.30			08.20			15.40			23.00		
	00.40			08.30			15.50			23.10		
	00.50			08.40			16.00			23.20		
	01.00			08.50			16.10			23.30		
	01.10			09.00			16.20			23.40		
	01.20			09.10			16.30			23.50		
	01.30			09.20			16.40			00.00		
	01.40			09.30			16.50					
	01.50			09.40			17.00					
	02.00			09..50			17.10					
	02.10			10.00			17.20					
	02.20			10.10			17.30					
	02.30			10.20			17.40					
	02.40			10.30			17.50					
	02.50			10.40			18.00					
	03.00			10.50			18.10					
	03.10			11.00			18.20					
	03.20			11.10			18.30					
	03.30			11.20			18.40					
	03.40			11.30			18.50					
	03.50			11.40			19.00					
	04.00			11.50			19.10					
	04.10			12.00			19.20					
	04.20			12.10			19.30					
	04.30			12.20			19.40					
	04.40			12.30			19.50					
	04.50			12.40			20.00					
	05.00			12.50			20.10					
	05.10			13.00			20.20					
	05.20			13.10			20.30					
	05.30			13.20			20.40					
	05.40			13.30			20.50					
	05.50			13.40			21.00					
	06.00			13.50			21.10					
	06.10			14.00			21.20					
	06.20			14.10			21.30					
	06.30			14.20			21.40					
	06.40			14.30			21.50					
	06.50			14.40			22.00					
	07.00			14.50			22.10					
	07.10			15.00			22.20					
	07.20			15.10			22.30					
	07.30											
	07.40											
	07.50											

Notes

Baseline knowledge questionnaire on the use of 1-1 Support within care homes or care support staff and agency personnel

1. Do you know why this person is receiving 1-1 support?
2. If you are not sure why they are receiving 1-1 support can you access information to establish this fact?
3. If the person tries to leave the room or the building what are you supposed to do?
4. If the person becomes violent towards you or other service users, what are you supposed to do?
5. If a person is at risk of falling and they are unsteady on their feet, what are you supposed to do?
6. When you are sat with the person, have you been given any plan to use to engage with the person?
7. Do you try to read to them or play games with the person?
8. How many hours per day will you spend carrying out the 1-1 support with the person?
9. Have you undergone the same type of training in the use of restrictive physical interventions as the permanent staff working at the Home?
10. Have you ever received training in 1-1 support or close observation?
11. Do you know what a DoLS is and what it is used for?
12. If you had concerns about how the 1-1 was impacting on the person would you feel able to express your concerns to senior staff within the Home?

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