Norfolk Safeguarding Adults Board

1:1 Protocol

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1. Rationale

Sharing and embedding learning from Safeguarding Adult Reviews (SARs) and other reviews is an integral part of NSAB's role in promoting safer direct practice across our multi-agency partnership.

Specific learning was identified in a rapid review held in 2020, linked to one-to-one care provided to adults at risk. This led to a Safeguarding Adult Review Group (SARG) recommendation that a multi-agency one to one (1:1) protocol be developed, to better support the positive outcomes intended by the provision of such support, by improving understanding and use of this intensive method of care delivery.

1:1 care may be arranged in social and health care settings (including acute hospitals) as well as in people's own homes. Information from this review and other safeguarding enquiries suggests that the way one to one is commissioned and delivered can vary greatly, indicating that with more consistency in use, a range of potential safeguarding adults issues and associated harm may be prevented.

The objectives of using this protocol are to:

- Reduce risks around restriction, deprivation, and restraint (principles of the Mental Capacity Act, human rights)
- Reduce negative impact on the individual (MSP; avoiding one size fits all approach, promoting personalised and directed planning in relation to 1:1 care delivery)
- Reduce risk of neglect & acts of omission (improving monitoring and review to ensure 1:1 follows planning, recognising where it can be a trigger to harm itself)

This protocol is designed for use not just by providers of services, but for health and social care staff when considering / arranging 1:1 care for adults with care and support needs / adults at risk.

This is specifically looking at circumstances where care staff are allocated to one person in a home or 24 care service for a particular purpose, but the principles apply to those receiving regular observations also.

2. 1:1 care as a safeguarding measure

The most common reasons for considering regular or continuous observation of an individual in relation to safeguarding adult concerns are:

- Walking with purpose and / or agitation (including high risk of leaving home or care setting)
- Physical and verbal aggression – towards other adults and risk, and staff too - very difficult to manage
- Unpredictable behaviours, including falls, self-harm
- Preventing incidents with others through distraction / diversion / restraint
- Safety of the person and those they encounter (including staff)

Close monitoring and support aim to minimise risk of harm to the person / others however, such close observation is a restriction on the person's freedom and can lead to escalation of the behaviour in some circumstances; it also requires increased staffing and funding which may not be sustainable in the longer term.

1:1 care is often viewed as an effective safeguarding measure, a 'quick win', but the actual objective and outcomes must be carefully considered before, during and after implementation.

As a safeguarding measure we must consider the experience of the people who have 1:1 care, thinking about what they may experience or feel, in line with the principles of Making Safeguarding Personal enshrined in the Care Act 2014. Where the person has cognitive impairment, intervention must follow legislation and guidance under the Mental Capacity Act. The person / family / representatives (as appropriate or possible) should be fully involved in the decision and any reviews.

3. Deprivation of liberty

1:1 care is not in itself a deprivation of liberty but is seen as a restriction. Short term use of 1:1 care to ensure the safety of individuals is unlikely to require authorisation, but to continue to use it may well.

Q. Does the way the person's care is organised severely restrict what they can do in other ways? Is the person free to leave the setting?

This may include preventing the person from entering or leaving an area or setting, limiting private contact with friends and relatives, restricting activities where risk to self or others is higher.

Mental Capacity Act including DoLS | Local Government Association (the page at this link will be updated as the LPS come into force)

4. What other options have been considered?

Consider the root cause of the behaviour you are looking to protect the person or

others from when agreeing appropriate strategies.

ABC (Antecedent – Behaviour – Consequence) charts, or dementia mapping for older people can be valuable tools to support mapping, analysis and understanding; they can be used in relation to specific incidents or patterns over a period of time. These may identify specific triggers for the person which may prompt more focused care planning or external referral for additional support.

Positive Behavioural Support (PBS) is increasingly used as well as trauma informed approaches – understanding the behaviour as a form of communication or need that cannot be expressed in other ways. Understanding what the person with an impairment may be experiencing differently – e.g. perception / auditory or visual hallucinations. Where PBS plans are in place, ensure they are understood and being followed.

Use and review of **medication** – are there interactions happening if a person is on a lot of different meds, are the dosages right (e.g. too much medication for high blood pressure can cause more falls)? Is the person refusing medication on a regular basis, is PRN being offered appropriately? Are staff confident in managing more complex regimes and PRN doses of medication such as sedatives?

Use of medication very clearly has limitations, especially when considering sedation – it is not only potentially restrictive, but also we must consider impact on mobility and cognition in itself.

Assistive technology – are there sensors, monitors or other technology options which could help to support the need?

Suitability of environment / setting – is the person living in the right place, with the right support for them? Anecdotally there can be a drive towards admission to hospital under the Mental Health Act where there are complex behavioural needs; but this is likely only to help where there is a therapeutic need. Moving the person may simply move the unmet need if the underlying cause is not identified.

5. Sustainability

Issues to consider where there is no clear end point of the 1:1 provision:

- Cost – to the provider, to the commissioner, to families
- Resourcing – difficult to find care; 1:1 staff may need additional support / training depending on the need
- If 1:1 is only being provided for some of the time, consider what will happen for the rest of the time and how the risks will be managed.

- Intensive – particularly without planning what the carer will actually be doing, can end up either ‘boring’ or overwhelming
- Deprivation
- Impact of ceasing on the individual – if funding stops, does the need stop?

6. Practical steps

1:1 can increase agitation and distress so may in fact be counterproductive
Questions to consider when commissioning or delivering 1:1 care:

a) **rationale**:
   - Have all other options (less restrictive) been considered?
   - What risks are you looking to mitigate?
   - Is there a clear rationale for deploying 1:1 care?

b) **objective**:
   - Are you clear what you expect the 1:1 care to achieve? This includes having a clear expectation from the commissioner of the service (e.g. health or social care)
   - Does it really meet the assessed need? (e.g. if 1:1 is in place for 4 hours, what happens for the rest of the time?)
   - What precise support are you offering the person through the 1:1 (e.g. engage in meaningful activity or just observing – if the latter, from what distance / frequency?)
   - Is there an end date or review date, with a plan for how to manage those?

c) **risk**:
   - is harm more likely, distressing the person rather than calming them, or because staff will need to physically intervene?
   - Is there any increased risk to staff if they are having to physically intervene more frequently?
   - Are you, and the staff who will be providing the care, clear about how they will intervene if required? Have they received additional training in terms of physical restraint? Are they clear where and when it may or may not be used?

d) **communication**:
   - is the rationale, objective and risk clearly documented for the service and for the person/people delivering the care?

- Have you communicated the rationale, objective and risk clearly to the provider/care giver?

e) **delivery of care:**
- Is the staff member fully aware of the reason they are providing the care, i.e. the risks they are mitigating?
- Purposeful / meaningful for both the individual and the care staff – what does the person *enjoy* doing? Are there a range of identified activities so care staff can quickly adapt according to the situation? For example, the person may like to listen to a podcast, watch a television programme, walk in the garden. How can the delivery of 1:1 care positively enhance the person's life?
- Accountability – documentation reflects the care offered and accepted, any incidents including ABC or similar
- Opportunities for reflection and support for staff to adapt the interventions where required / as things change
- Changeover and staff breaks are included in planning, to avoid gaps in delivery and potential neglect
- Make sure staff are aware they must try to avoid any situation which puts their own safety at risk, and that they know what to do if they are concerned

f) **review**:
- Those commissioning the service must include this, e.g. adult social care, Continuing Health Care
- Is the service expected being provided? Review should be against the agreed care plan
- Is there evidence to show that 1:1 care is actually happening, what takes place during that time?
- Does the provider need additional support to achieve this? Are there useful templates or guidance that may help to generate proportionate evidence?

1:1 support as a safeguarding measure is rarely a sustainable long-term solution and is different to providing similar levels of care to those who require it to meet other identified care and support needs.

It tends to reduce immediate risks to the person or those around them but is unlikely to remove risk altogether, and the restrictive and intensive nature of the support must be balanced with the best interests of the person.

7. Example protocol (24 hour care setting)

Green - Routine oversight

Routine checks through 24hr period to monitor well-being, safety and meet unplanned needs as required. Recorded in daily records. Checks through the night are completed according to individual preference and need.
It is likely that all adults in 24 hr care settings would meet these criteria.

Amber - Intermittent supervision / monitoring (where possible 'In line of sight')

Staff are allocated to monitor a person's whereabouts at regular intervals following a specific plan of care detailing the reason(s) for support, frequency of supervision and risk factors. Care plan should also include detail of personalised interventions and interactions to minimise these risks, which must be recorded to evidence actual support given during the relevant period.
An appropriate review period should be set to evaluate the effectiveness and impact of the care plan, with contingency in the event of a change of need for oversight.

Red - Continuous 1:1 supervision

A member or members of staff are allocated to support one adult directly for a specified period of time. They are not expected to provide care to any other person during that time, with appropriate contingency for breaks and handovers agreed.

Best practice would be that staff undertaking observations are rotated every 2 hrs to other activities to avoid burn out / complacency / tired. They must have access to and follow a specific plan of care detailing the reason(s) for support and risk factors. Care plan should also include detail of personalised interventions, activities and interactions to minimise these risks, which must be recorded to evidence actual support given during the relevant period.

Records should be completed at least hourly depending on the overall length of the continuous supervision period. This will also support identification of any particular patterns or triggers to observed behaviour and potentially prompt a change to the required level of support on review.
The member of staff must be able to see the person at all times and possibly be close enough to intervene if there is an incident, whilst respecting privacy and dignity where possible.

The member of staff will provide positive interaction in conjunction with therapeutic interventions and activities.

DoLS / LPS will need to be considered at this level.