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One-to-One Support Requests for People Living in Care Homes: Why, When, and for Whom?

RESEARCH

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ABSTRACT

Context: Care home managers (CHMs) may request additional funding to enable them to provide one-to-one care and support in order adequately to meet an individual's needs or to keep them, or others, safe. This can present a significant cost for local authorities (LAs) as well as concern about the impact of such surveillance on individuals.

Objectives: This study sought to better understand the reasons for one-to-one support requests from CHMs for residents aged 65 and over, and the experiences of LA staff who deal with such requests.

Methods: CHMs and LA staff were invited to participate in an interview about their experiences of one-to-one support requests. The qualitative data were analysed using template analysis.

Findings: We recruited 22 CHMs and eight LA staff across three LA areas. Seventeen homes supported older people, 5 supported people with learning disabilities, and 4 supported people with mental health issues, autism and/or learning disabilities. Interviews focused only on residents aged 65 and older. Requests for one-to-one care varied from time-limited to longer-term requests. Some requests were limited to a certain number of hours, whilst others sought additional resources for 24-hour care. There was evidence of differing attitudes between CHMs and LA staff as to the appropriateness of requests for one-to-one support.

Key reasons for requesting one-to-one support included resident safety, self-harming behaviour and physical and cognitive health needs. It was also requested to support people to settle into a care home, to manage behaviour that challenges, and enable people to go outside of the home. Some respondents saw one-to-one support as a restrictive practice in some circumstances, considering it only appropriate when all other options were exhausted.

People living in care homes often have complex needs requiring time-limited support for them to settle in a home. For CHMs, safety is the overarching reason for requests for one-to-one support.

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Limitations: The self-selection of CHMs into the study may have resulted in a systematic bias in their reasons for participating.

Implications: Staffing levels impact on the ability of care homes to provide support for the specific needs of individual residents. Further research to understand the impact of receiving one-to-one support from the perspective of residents would be beneficial.

BACKGROUND

Many countries provide residential care for those unable to age in place in their own homes, though access to care, particularly state care, can vary considerably (Chee *et al*., 2025; Ghailani *et al*., 2026) and there is considerable pressure to manage increasing demand (Førland, 2024). In England, the Care Act 2014 places a range of general duties on local authorities (LAs) in respect to people living in their area, including duties to promote individual wellbeing, to provide information and advice, promote diversity and quality in the provision of services, and to assess need. A request for an assessment may be made by the individual themselves, or third parties, and having received a request, LAs are required to have an appropriately trained assessor carry out an assessment of an individual's existing needs for care and support.

If, following an assessment of a person's needs, it is decided that a care home is the best option, the LA will work with the person (and their family) to find a suitable home and develop a support plan. Some individuals may be eligible to receive financial support towards their care from the LA, for example, if an individual has savings of less than £23,250, including all their assets, e.g., their home (calculations vary with circumstances). This 'upper threshold' for savings is set nationally and has not changed since 2010/11 (The King's Fund, 2026). It applies to everyone, including those who may not have capacity to make decisions about their care and support. In these circumstances, the LA must comply with the Mental Capacity Act 2005, which requires that any decision or intervention made on their behalf must be the least restrictive of their individual rights and freedoms.

INCREASING LEVELS OF NEED FOR SUPPORT

The European Commission estimates that the number of people in need of long-term care is set to increase from 30.8 million in 2019 to 38.1 million in 2050 (Ghailani *et al*., 2026). It is difficult to access contemporary data on the profiles of older people receiving residential care; however, the available evidence suggests increasing levels of care needs (see, for example, Gibson, 2020; Grosshauser *et al*., 2022; White, Sun and Coe, 2024). In the United Kingdom, the Department of Health and Social Care (DHSC) issued a statistical bulletin in 2025 that reported occupancy rates based on management information submitted by around 92% of older adult care home providers in England. These providers were then caring for some 327,758 residents aged 65 and over (DHSC, 2025a). Using data from the 2021 Census, the Office for National Statistics (ONS) reported that there were 278,946 people aged 65 and over living in a care home in England and Wales, accounting for just over 82% of all care home residents, of whom 56.4% were 85 years and over (ONS, 2023b). Almost 53% of those in this age range resided in care homes without nursing. In 2022–2023, 48.9% of residents over 65 were self-funding their stay, with the remainder funded either by LAs or the NHS (ONS, 2023a). Analysis of care home residents in two population-based studies, the Cognitive Function and Ageing Studies in England and Wales and the English Longitudinal Study of Ageing, found that between 1992 and 2016, the prevalence of severe disability and of complex multimorbidity among residents increased substantially, as did the prevalence of cognitive problems (Barker *et al*., 2021).

THE COST OF CARE

Different LAs may adopt different models, but payment for care generally involves a weekly agreed rate, in return for which care home providers agree to meet the person's needs for care and support as outlined in their support plan. Some commissioning models provide scope for additional resources where complex or intensive needs mean that a person requires enhanced support (CQC, 2026).

In some circumstances, a care home manager (CHM) may request additional funding to enable them to provide one-to-one care and support in order adequately to meet an individual's needs or to keep them, or others, safe. Such a request may be made on assessing a potential resident's care needs following a request for a care home place (for example, as part of a planned discharge from hospital), or because of changes in circumstances (for example, a deterioration in health or an increase in behaviours that challenge).

Brennan *et al*. (2023) identified the following reasons for one-to-one support requests in England and Wales: violence towards others, falls, absconding risk, self-injurious behaviour, sexual disinhibition, and verbal abuse and agitation. Pinpointing the ways in which these rather general categories justified the request for one-to-one support proved elusive, and this, together with the restrictions of liberty entailed by one-to-one

surveillance, led the authors to suggest other steps that care home staff could, and should consider first, such as involving a falls team or seeking advice from mental health services.

One-to-one support of this kind is sometimes referred to as 'specialing', or as 'direct observation' or 'special observation' (Wood *et al*., 2018). Funding for such support may be requested for a specified number of hours per day, or for 24-hour care, depending on a person's assessed needs. Such additional funding, on top of the weekly agreed cost, can present a significant cost for LAs which have limited resources, and – when procuring services – are expected not only to meet agreed quality standards, but to do so in ways that provide effective value for money to the public purse (DHSC, 2025b).

THE PRESENT STUDY

The present study formed part of a four-year project designed to build capacity in the use of research by decision-makers in adult social care – the Connecting Evidence with Decision Making [ConnectED] project. ConnectED was a partnership between two universities, three LAs and a charity providing advice and support to older people. The project was designed to bring together the worlds of research and practice by establishing 'Research Practice Partnerships', each comprising an academic researcher (Researcher in Residence), a social care practitioner (Evidence Champion) and Experts by Experience. One of the aims of the project was to establish a pipeline of research relevant to practitioners, via a small number of exploratory studies on topics that partners regarded as priorities.

From the outset, therefore, agency staff at all levels were canvassed for their views as to what they regarded as priorities for research, as were members of the project's Service User and Carer Advisory Group (SUCAG). The research team first eliminated those topics where there was already an evidence base and the resulting longlist of topics was organised thematically, commented on by members of the SUCAG and presented to the project's Programme Board, comprising agency directors and commissioners and co-chaired by a Director of Adult Social Care and the Chair of the SUCAG.

The Board was advised that the topics listed would require further specification to shape answerable questions. One of the topics was '*Attitudes to risk and the mitigation of risk within care settings. Relates to increased cost via 1-1 care requests etc*'. This was selected by the Programme Board as one of their study priorities, and an advisory group was established to refine it and oversee its delivery. The advisory group comprised members from each agency plus members of the SUCAG. Following three meetings, it was agreed that the focus should be on older people. The rationale was that agencies would benefit from a better understanding of how one-to-one care is used in care homes, how it affects residents (both positively and negatively) and whether one-to-one care is the best way to meet their needs. This was felt to be an appropriately broad scope for what would be an exploratory study.

Advisory group members were particularly interested to understand the reasons for requests for one-to-one support for older people, not primarily from the perspective of costs (although this was a factor) but because they were concerned that such support should only be provided when the benefits outweighed the potential negative impacts of the associated surveillance. In an ethnographic study of the care of people living with dementia in nine hospital wards, Northcott *et al*. (2026) found that 'Patients who were considered at risk of "absconding" were often given one-to-one care … whose primary purpose was not to provide care as such, but rather to supervise patients to prevent them from leaving the bedside, or from disrupting other aspects of the workflow of the ward.' This was particularly the case in busy medical wards, though better practices were observed in mental health wards (see also Spencer *et al*., 2025).

The legal status of continuous one-to-one observation is not settled by simply describing it as care. In Section 6(4) of the Mental Capacity Act (2005), restraint is said to include restricting a person's liberty of movement, whether or not they resist. Set against the 'acid test' in Cheshire West, under which continuous supervision and control is considered one of the three limbs of a deprivation of liberty (Harding, 2021), requests for one-to-one support in care homes raise safeguarding questions that the commissioning route through which they are made does not automatically pose.

This study aimed to understand reasons for one-to-one support requests from managers of care homes for residents over 65, and to investigate the experience and views of LA staff of requests for one-to-one support. The Advisory Group and members of SUCAG oversaw the delivery of the study and commented on the analyses and final report. Meetings took place online at each key stage and when challenges were encountered.

METHODS

STUDY DESIGN

This exploratory, qualitative study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury and Craig, 2007). See Supplementary File 1 for the COREQ checklist. We used semi-structured interviews developed by the research team, with advice from members of the advisory group. The study was approved by the Research Ethics Committee of School for Policy Studies, University of Bristol (Reference number SPSREC/REF. 19369) on 28 June 2024.

SAMPLING AND RECRUITMENT

Sampling was purposive. CHMs were invited to participate in the study if they were currently supporting, or had recently supported, a resident with one-to-one care.

All potential participants were approached by email, which included information about the study. CHMs were first contacted by a staff member of one of the participating LAs. Following limited responses, a further invitation was emailed to all care homes in the relevant Integrated Care Board area via a regional CHMs group.

LA team managers were asked to send an email with information about the study to those staff with relevant experience of requests for one-to-one support.

Potential participants were asked to contact the research team if they were interested in taking part and those who did were sent an acknowledgement and potential dates for interviews via email.

SAMPLE SIZE

Given the exploratory nature of the study, and based on the experience of the advisory group, we drew on the concept of information power to identify an adequate sample size. We estimated that this would be around 30 participants, because the study aim was narrowly focused on specific experiences of 1-1 care requests (Malterud, Siersma and Guassora, 2016).

DATA COLLECTION

Interviews were undertaken by six women, including three members of the ConnectED team experienced in conducting research interviews, two post-doctoral researchers (LD, KG) and an experienced social worker (KH). The interviewer recorded participants' consent prior to the interview. All participants chose to be interviewed via Microsoft Teams, all but three with video. The transcription feature of TEAMS was used to provide an initial transcription of each interview, which was then checked for accuracy (using the audio recording) and amended where necessary. Transcripts were not shared with participants.

Details of the interview schedules can be found in Supplementary File 2. Interviews ranged from 19 to 51 minutes, with an average of 30 minutes.

DATA ANALYSIS

Template analysis (King, 2012) was used for data analysis. All transcripts were independently coded by LD, KH and CC. *A priori* topics, such as '*reasons for 1-1 support requests*' were used as higher-order codes, and lower-order codes, e.g. different types of reasons, were developed inductively from the data. Some higher-order codes were also developed inductively. A subset of transcripts was also coded by two carers (JB, EB) from the SUCAG. The higher-order codes were developed into the themes which best answered the research questions. Themes in the final template were discussed and agreed by the whole research team.

FINDINGS

PARTICIPANTS

Thirty people were interviewed, comprising 22 CHMs and eight LA staff. Fifteen CHMs self identified as female. Eight were from LA(A) and seven from LA(B) and LA(C), respectively. Four people each managed two homes (see Table 1).

Details of the LA staff we interviewed are summarised in Table 2. The participants were evenly spread between the three LA areas: a county with a large urban population, and two rural counties. No systematic differences were found between the responses from the CHMs or staff in the three different areas.

Interviews focused solely on 1-1 requests in respect to people aged 65 and over.

REASONS FOR REQUESTS FOR ADDITIONAL SUPPORT

A range of one-to-one support was requested, from 24-hour support arising from concerns about a resident's safety to a few hours a week to enable people to go outside the home. It was also used for limited periods to manage short-term health concerns or to help settle people into the home, and longer-term to manage behaviour that challenges.

Duty of care – keeping residents safe

CHMs talked about being responsible for the safety of their residents. One-to-one support was requested to enable people to go out who had Deprivation of Liberty Safeguards (DoLS) in place and had poor road safety or were at risk of getting lost. One-to-one support was also requested where a specific risk was identified, for example, a resident with involuntary movements who spent most of their time in the garden smoking and was at risk of burning themselves. The one-to-one support provided companionship and physical assistance to prevent burns, during the day, to enable the person to continue with their preferred activity.

Twenty-four hour one-to-one observation was sought to minimise risk and understand how to support residents who were harming themselves and at risk of suicide. CHMs recognised that this was a restriction for the resident but referred to their duty of care:

> *'[We] have a duty of care to keep people safe. If you've got somebody on 24 hours a day to stop them self-harming, then yes, that is a massive restriction. How else can you manage that restriction? Because ultimately, if that person injures themselves in your care, you will be accountable and you will be asked what you did to mitigate the risk.' (CHM18)*

One respondent documented the success of one-to-one support in reducing suicide attempts:

PARTICIPANT (LA)	MANAGER OF		PRIMARILY SUPPORTING			SELF-IDENTIFIED[2]	
	RESIDENTIAL HOME	NURSING HOME	OLDER PEOPLE[1]	ADULTS WITH LEARNING DISABILITIES	ADULTS WITH MENTAL HEALTH, AUTISM AND/OR LEARNING DISABILITIES	GENDER	ETHNICITY
CHM01(A)		1	Y			M	White Other
CHM02(A)	1		Y			F	White British
CHM03(B)	1			Y		F	White British
CHM04(B)		1	Y			M	African
CHM05(A)		1	Y			M	British Indian
CHM06(A)		1	Y			M	Asian Indian
CHM07(A)		1	Y	Y		F	White British
CHM08(A)	1		Y			F	White British
CHM09(A)		1	Y			F	White British
CHM10(C)		1	Y			F	Asian Indian
CHM11(B)	2			Y	Y	M	White British
CHM12(A)		1	Y			F	Asian Indian
CHM13(C)	1		Y			F	White British
CHM14(C)		1	Y			M	White Irish
CHM15(C)		1		Y		F	White British
CHM16(B)	1				Y	F	White British
CHM17(C)		1	Y			F	White British
CHM18(C)		2	Y			F	White British
CHM19(B)		1	Y		Y	F	Black African
CHM20(B)	1	1	Y			M	British Indian
CHM21(B)	1			Y		F	White British
CHM22(C)	2				Y	F	White British

Table 1 Profile of Care Home Managers.

[1]Including people with dementia; [2]Non-mandatory question posed in interview.

PARTICIPANT (AREA)	ROLE	SELF-IDENTIFIED GENDER	SELF-IDENTIFIED ETHNICITY
LA1(A)	Team manager	F	White Other
LA2(B)	Team Manager	F	White British
LA3(B)	Deputy Manager	F	White British
LA4(A)	Senior Practitioner	F	White British
LA5(A)	Senior Practitioner	M	British Asian
LA6(B)	Senior Practitioner	M	White British
LA7(C)	Social Worker	M	White British
LA8(C)	Social Worker	F	White British

Table 2 Profile of Local Authority Participants.

> *'it's been it's been really good since we implemented 1–1. There's been no attempt. So before that there were two attempts. After that, none.... It did help a lot ... the 1-1 is no longer in place, what we do now is just have half-an-hour checks' (CHM01).*

In contrast, one manager of a home for people with learning disabilities felt one-to-one care should support positive risk taking:

> *'We need to encourage people to take risks ... we can only help people take positive risks if there's somebody there to help them take that risk as safely as possible' (CHM16)*

Falls

Supporting residents who experienced falls was the most cited reason for requesting one-to-one support. Falls were linked both to physical factors, such as reduced mobility

and impaired gait, and to cognitive difficulties, particularly among people with dementia who might attempt to stand without remembering that they were unable to walk. Falls occurred at different times of the day, with risk being higher in the evening when fewer staff are available:

> *'Because of the delirium. He's having a lot of falls in the evening, but it's because he's up and about and there's less staff here' (CHM02)*

Care homes used bed rails, low-profile beds, crash mats and occupancy sensors to minimise risk and alert staff to people getting out of bed, but these methods were not suitable for all residents, for example, if the risk of climbing over bed rails was identified. LA staff and CHMs sought assessments from specialist falls teams, care home liaison teams and rehabilitation specialists who may provide medication or recommend one-to-one support to prevent falls through continuous observation. Respondents acknowledged that falls could not be eliminated, but one-to-one support was considered as a positive action to prevent injury and admission to hospital:

> *'I would love to have everybody who's on a high-falls on a one-to-one. That's my ideal world. … because how many times have we had to send in to hospitals, they've got a fractured hip. They take up the bed in hospital. It takes time for them to come out to us … I'd love to see the comparison between the money of that and the money of having them on one-to-one whilst they're up walking around during the day' (CHM07)*

Short-term one-to-one support was used to establish a routine to reduce falls, and longer-term support was requested to provide verbal prompts to residents to reduce falls. Reducing one-to-one support for people with unpredictable needs led to a very poor outcome for one resident.

> *'[he] was on 24 hours of one-to-one because he was at such high risk of falls… because it was unpredictable, more so at night than during the day, they requested that we remove the one-to-one during the day. — three weeks after the one-to-one was removed this gentleman had a fall, fractured his hip and subsequently died … he used to walk with a frame … he would sometimes try and walk too fast or turn too quickly so he would get his feet all tangled up. And actually when we had to review the CCTV for when he did fall. That's exactly what did happen.' (CHM18)*

Short-term and long-term health

One-to-one support to manage short-term health concerns was usually provided from within existing staffing levels.

> *'So, if a resident is poorly … and we know that it's a reversible course, a UTI, for example, or a chest infection … we would facilitate the one-to-one to keep them safe, but it wouldn't be a sustainable thing for us to do long-term.' (CHM08)*

One-to-one support was sought for people considered at greatest risk, due to complex or unstable health conditions. This included people with breathing difficulties, diabetes or epilepsy requiring timely administration of a health device (e.g., buccal midazolam) to stop a seizure.

> *With diabetes … they've got to be really unstable to have to have that one-to-one so that their blood glucose can go either way very quickly (CHM07)*

For some residents, one-to-one supervision was recommended by speech and language therapists during all instances of eating and drinking to reduce the risk of choking.

Settling in

One-to-one support was requested by some homes on a time-limited basis to support residents to settle into a new environment and a new routine, and might be reduced after a few days, a few weeks or longer.

> *they've come in and the placement has completely thrown them unsettled them. You know, they want to get home. They want to get out, why are they here? So they become aggressive and agitated. And you just need someone to watch them until that passes'. (CHM02)*

In one instance, the request was made to support an informal carer who was having to spend a lot of time with their cared for person.

> *'It was a very significant carer breakdown … somebody having to spend a lot of time in the care home, because the person wasn't settling at all. … we were able to sort out one-to-one so that it would give that carer a break as well… that's an unusual circumstance. (LA2)*

For care homes supporting people with complex learning disabilities or mental health issues, requests for one-to-one support were usually for longer periods, typically six months: two months to help someone settle in, and a further four months to understand their behaviours and build a person-centred support plan. The additional time provided evidence of how much support the person needed, and whether or not the one-to-one support was required in the longer term.

> *'with his schizophrenia, his autism, his learning disability as well he can suddenly be really wanting*

to go out. So, we plan the one-to-one around that, but then as soon as he steps foot out, his anxiety sort of kicks in and he wants to change … we'll use this one-to-one … to build the support plan so we can then reduce the one-to-one, reduce the restrictions on the individual'. (CHM11)

LA staff expressed concern about dependency on one-to-one support. Some felt that care homes might seek to extend temporary one-to-one support arrangements indefinitely, making them a permanent feature of care provision. The staff member suggested that as the home had never tried to support the resident without one-to-one support, the evidence of that need was lacking.

Going outside

CHMs identified a need for older people to continue with activities outside of the home. Some homes accompanied groups of residents to places within walking distance, some used community transport or had their own vehicles. Opportunities for residents were limited by the size of vehicles, particularly if people needed wheelchair accessible transport. Some homes had activities coordinators to take people out:

'But you know she can't always do it because there's thirty people here … she's got to spread herself'. (CHM02)

However, CHMs made few requests for one-to-one support in order to help older people to participate in activities, as they saw limited appetite amongst residents for participating in activities outside the home. Requests for one-to-one support were sometimes made (and agreed) in order to help staff address particular mental health concerns. For example, one-to-one support was requested to enable staff to manage the challenging behaviour of one resident:

'he wanted to go out all the time, and when he didn't, his voices got very loud and he would then get very verbally aggressive'. (CHM22)

Providing one-to-one was described as making 'a phenomenal difference' to some residents:

'She was really low in mood. She was talking about not wanting to live anymore. She was only in her 60s. And she had two hours every single day. And the staff took her to Tesco's so she was able to go and do a bit of shopping for herself. And it's worked out so well … it's about enabling that person to have a reason to get up out of bed every day. (CHM18)

A few hours a week of one-to-one support enabled people to participate in '*external activities that are more suited to their age*' *(LA3):*

'She's really young … 66 … She settled in really well now we've got to know her. So for her, it was a great benefit. And it worked because she likes going to the cinema and stuff like that. You know, she still likes doing all those things that she used to do'. (CHM13)

MANAGING BEHAVIOURS THAT CHALLENGE: PREDICTABLE UNPREDICTABILITY

CHMs gave descriptions of residents with complex needs that were difficult to meet within existing staffing ratios, particularly residents living with dementia. LA staff also recalled receiving requests for one-to-one support when the '*shared support*' (regular staff ratios) (LA1) was insufficient to manage the distress of a person and their risk to others. Some residents became agitated, particularly in the evening when fewer staff were available.

'the person with dementia … the night and days change so they are more alert during night-time … we cannot engage them 12 hours throughout the night because there are other persons to care for. (CHM07)

Other examples of behaviours that challenged included issues of dignity, sexual disinhibition, aggression, and threatening or hitting other residents or staff that may lead to safeguarding investigations. Residents may go into other people's rooms and move things around, turn taps on, try on clothes, break or take items – resulting in concern and complaints from family members. Some residents had behaviours that were a risk to their health, such as removing urostomy bags or using the same brush to clean the toilet and their teeth: *'he's someone who is just not safe to be left alone at any given time' (CHM19).*

One LA staff member considered that the needs and behaviours of people with dementia were to be expected by the care home and supported within existing staffing levels:

'… people have dementia you would expect that kind of behaviour. Obviously, they didn't understand … maybe thought that food was their food or whatever … maybe they think about their staff, they find it difficult and of course they want to retain their staff. So they want to make their jobs easier in that sense. (LA8)

Behaviour was attributed to the person's condition, and this could change over time, with residents needing a timely response to give them reassurance:

'One minute he is looking for the car. You reassure "here are the keys OK" [he had previously owned a car and the home had had some keys made for him]. The next minute he's about to miss his flight because they are travelling…you just follow what

his mind is saying …. The next thing you might play draughts, after 15 minutes he wants to leave it. He wants to go somewhere, after 10 minutes, he's calling for his son. … If he's just talking about his family, we do have video call, then the sons will speak to him. … throughout the 24 hours, something new comes up. … At one point he wanted to go out for fresh air because you know, in the nursing home, it's closed. So I said to one carer, OK, go with him'. (CHM19)

One CHM reported that the provision of one-to-one support had reduced the use of anti-anxiety medication administered on an as-needed basis (known as PRN, *pro re nata*) among a high proportion of residents. The support also improved the health of some residents:

'He constantly called out when no one was with him, this distressed the family to the point where they stopped visiting. He needed companionship. With the provision of one-to-one support his behaviour has drastically changed and he's now a totally different man…his health has improved. He's eating and drinking well'. (CHM05)

ATTITUDES TOWARDS ONE-TO-ONE SUPPORT: 'FOR THE GREATER GOOD'

All CHMs were aware of DoLS. There were mixed responses to a question about one-to-one being a restrictive practice, and LA staff said they needed to remind care homes of the restriction of one-to-one support. Some CHMs were clear that it was restrictive practice and sought to request this only on rare occasions, to regularly review whether it remained '*absolutely necessary*' and actively work to reduce it. Using one-to-one support to prevent someone self-harming, for example, was considered restrictive, yet taking someone outside of the home was not. Some did not see it as restrictive in any negative sense or viewed it as part of the home's duty of care to keep people safe:

'I have noticed a difference with people having one-to-ones. The benefit is palpable for those residents and the other residents as well. From whichever angle you come at it, it is a positive I haven't identified any negatives with it at all.' (CHM07)

'It's definitely invading their privacy, however, for the greater good to prevent them from falling constantly and obviously dying, at some point the one-to-one becomes important.' (CHM04).

Care homes sought to balance invasion of privacy and the wellbeing of the resident. They advised the person providing one-to-one support to give the person space, not to restrict them and to do activities *with* the person. CHMs often spoke about the home as a whole and how individual residents affected it. One-to-one was described as calming for the home by taking the pressure off staff:

'We are a nursing home all of the residents are happy here. So, if that person comes without enough support, that will disturb that equilibrium'(CHM06).

LA staff also felt that care homes are concerned about '*the wider collective of other residents in the care home'(LA01)*, whilst their focus was solely the wellbeing of individuals and meeting their needs.

CONTEXTUAL REASONS

The care home setting, staffing levels and changing practice were contextual reasons for requesting one-to-one support. Some care homes were old houses or listed buildings which prevented the installation of lifts. Some homes were widely spread or had a lot of floors that limited the ability for staff to reach people in need in a timely way.

'So we have a sensor mat system, which is one of the best inventions. But the problem is by the time we run from the 4th floor … to downstairs the person will be fallen.' (CHM10)

Increasing levels of need and the availability of moving to a care home from hospital were cited as some of the reasons for one-to-one support requests:

'I do think people are staying at home longer and … by the time they do need a care environment they're needing a lot more care than they probably would have … two years before … quite a lot of [social workers] do say 'this person's going to need one-to-one' (CMH 13).

In the past, people who needed some attention from the Mental health unit, used to be sectioned … this discharge model came in, we have beds in care [homes]. When people are needing to go to mental health, it's not happening because they are in a 'safe' environment, 24 hour care placement. They know that if this is not working, we will put some one-to-one in place. (LA7)

'He was discharged from a hospital setting and I think not very ready to be leaving a hospital setting. And almost instantly we had to put emergency one-to-one in place for him because he was very aggressive. … But I think it was probably the social workers knew that they'd placed him wrongly.' (CHM22)

When care homes felt that they were unable to meet increased needs of a resident, they requested one-to-one support whilst an alternative placement was found.

One-to-one support was agreed as the least restrictive option to prevent one person having multiple moves between care homes:

> *' ... not sleeping and calling out at night a lot and they just didn't have the staffing levels to be able to meet her need each time .... It felt to be the least restrictive thing in her best interests ... The risk of her having to move multiple times, the impact on people living with dementia, that's absolutely something we were trying to avoid.' (LA2)*

Low staff ratios in care homes made it difficult to move away from an institutional feel and engage residents in *'things they want to do' (CHM2)*, as residents have *'different likes, dislikes, preferences and wishes'(CHM15)*. Some care homes were able to increase staffing ratios to provide more individualised support, on a flexible basis but could not sustain the additional cost in the longer term. One CHM suggested that variable funding for a care home placement would be more flexible than the current set weekly cost to accommodate changing needs of residents.

EXHAUSTING ALL OPTIONS

CHMs said that they completed risk assessments and created action plans to mitigate risk, trying all options before requesting one-to-one support as a *'last resort... where everything else fails*' (CHM05). They sought support from family members, specialist dementia teams, mental health teams, care home liaison teams and a doctor for older people. The complexity of needs, and the different professionals involved in decision-making, was also apparent in a conversation with a LA staff member who was working with a person constantly trying to leave the home:

> *'I went to many meetings. I spoke to the Care Home liaison team .... They were titrating her medication for a long time, it was very unpredictable in nature, her agitation and her behaviours. And so we couldn't even explore kind of continuing healthcare ... because I was thinking that her needs were beyond social care at that point, especially given that we were requesting this additional one-to-one, but they viewed that it was a therapeutic input and that actually it could just be used to distract her and to involve her in activities that were more person-centred for her. So it was agreed on a 12 week basis'. (LA6)*

Some LA staff considered that one-to-one support was requested to enable the additional member of staff to react quickly to a person and work proactively with them, and suggested that better training may support the care home staff to work with people differently:

> *'It's just having the right training and expertise to manage that risk in a different way other than just always thinking of getting more staff' (LA8)*

However, all care homes provided training on topics such as mental capacity, mental health and dementia, as a means of increasing staff skills, and training in positive behaviour support and conflict management was cited by three CHMs as training that enabled them to support residents in different ways and reduce the need for one-to-one support.

RELATIONSHIPS WITH THE LA

Asking for one-to-one support was described as a challenging, lengthy process, involving *'a fight*' (CHM07) and a process that '*feels like you are begging*' (CHM02). The process was described as unclear, with respondents highlighting apparent inconsistencies in decision-making by LAs, suggesting a need for clearer criteria. The difficulties were a deterrent to care homes applying for one-to-one support. Managers described having to evidence requests with, for example, records of behaviour and numbers of falls as well as demonstrating that every other step had been taken to mitigate the risk. This was difficult and time-consuming, and some managers said that if requests for one-to-one support were not granted, they might give notice to end the placement if the situation felt unsafe.

Cognisant of the pressures on LA staff, CHMs felt that decisions were driven by financial concerns rather than the wellbeing of residents. Alternative options sometimes suggested by LA staff, such as sleeping in a wet pad, were considered unacceptable by CHMs, one of whom used the Human Rights Act 1998 to argue the case for waking night support – subsequently funded.

LA reviews of people receiving one-to-one care were anxiety-provoking for CHMs:

> *'it's around somebody with one-to-one, that's what they're coming for, as opposed to actually reviewing the client and what's going well' (CHM03)*

Some CHMs felt that good communication and positive relationships with the LA eased the process of obtaining funding for one-to-one support, and some considered it straightforward if the person was at high risk, or if funding prevented a move to another care home. The timely agreement and allocation of funding for one-to-one support was a key concern for CHMs. They said that requests were not prioritised *'because [the person concerned is] in 24-hour care and there's someone looking after them*' (CHM16).

THE OPINION OF CHMS

Some CHMs who were registered nurses contrasted their experience of working in health care with the apparent lack of trust afforded their opinion by the LA:

> *'I kept saying to them, I'm an NHS background I'm pro social care. I'm not going to take money off you that isn't required. And the minute he stops needing one-to-one I will inform you and we'll stop it, but they can't take that. They have to have all the justification … but it wasn't just how is he doing in or popping in to see him. It was, provide the paperwork for every day and then…Perhaps a bit more trust between organisations…it was frustrating that they wouldn't listen.' (CHM09)*
>
> *'I found that even when I switched to social care, even some of my colleagues in healthcare looked down on social care … People would generally look at a hospital manager and think, well, that must be a very experienced professional person and I don't think people view nursing home managers the same.' (CHM14)*

DISCUSSION

This study builds on previous research by Brennan *et al*. (2023) on the reasons given for 24 requests for one-to-one support in one Integrated Care Board in the North West of England, and how such support was, in fact, used. In that study, violence towards others and falls were the two most cited reasons, and all were broadly focused on the safety of the individual or other residents, e.g., risk of absconding, verbal abuse (see also Evans *et al*., 2018; Johansson *et al*., 2009).

In this study too, the main reasons related to safety, particularly falls, supporting health needs, and reducing risk of injury to the person or to other residents. This is unsurprising, as the question of whether the care home is safe, alongside whether it is effective, caring, responsive and well led are the key questions that the regulator of care homes in England, the Care Quality Commission (CQC), focuses on during its inspection and grading of care homes (CQC, 2025). Whilst little detail was forthcoming from managers as to how residents were supported by an additional carer in the home, they spoke of the positive difference to residents in decreasing incidents of falls and reducing suicide attempts. They were also mindful of the impact of that support – and its absence – on care home residents as a whole.

Whilst continuous observation of people at risk of suicide is common practice in mental health units, there is a paucity of research to support its use (Manna, 2010). As in the present study, Manna found that continuous observation was accepted to maintain the safety of the person, with staff reporting that it was a nursing strategy to reduce risk of harm. Similarly, in hospital settings, there is no robust evidence that 'sitters' (one-to-one surveillance) reduce falls (Greeley *et al*., 2020). Brennan *et al*. (2023) suggest other steps that care home staff could, and should consider first, such as involving a falls team, and CHMs in this study did this. The input of falls services to care homes may provide the comprehensive falls assessments recommended in the NICE guideline on falls (NICE, 2025). The guideline also recommends a review of medication and participation in structured programmes that look at balance, strength and coordination, and encouraging people to be active to reduce the risk of falls, but these were not mentioned by our participants. The implementation of guidelines requires time, skills and organisational support, together with adequate resources, including staffing (Bauer *et al*., 2024). For CHMs in this study, these may have been in short supply, given that many of the residents experiencing falls live with dementia. The NICE guideline has recommended further research on supporting people with dementia who have falls, as no strong evidence was found to warrant a recommendation.

Providing support for people to settle into the home was identified as a short-term measure to understand the person and how best to work with them. Moving into a care home is challenging for people with dementia and impacts on experiences of depression, which improves as people settle into the home (Sury, Burns and Brodaty, 2013). LA staff were concerned that one-to-one support provided at the beginning of the placement is difficult to remove later, as the care home normalises the additional support for a person. Timely, holistic reviews of the person, considering safety, have been used to support reduction of one-to-one support requested for settling people into the home (Brennan *et al*., 2023).

People with mental health concerns or dementia were identified as needing individual support when they become distressed, to calm them and prevent risk of harm to others. Both CHMs and LA staff spoke of residents' needs changing as their dementia progressed – a journey of predictable unpredictability. Existing staffing levels in care homes do not enable residents to have individual support either to enable residents to visit places of their choice, or to support people who are active in the evening when fewer staff are present. Care home residents in other studies have attributed a meaningful life in the care home to the opportunity to go out and to participate in activities they enjoy, increasing their autonomy and quality of life (Bradshaw, Playford and Riazi, 2012). Participating in meaningful activity and maintaining and developing personal identity are quality standards for the improvement of care of older people in care homes (NICE, 2013). As the needs of people moving into care homes have increased in recent

years, predetermined staffing levels are insufficient to both reduce the risk to the person and to support people as individuals. Understaffing has been recognised as a barrier to the autonomy of care home residents and the quality of their care (Gilbert *et al*., 2021; van Loon *et al*., 2021).

One-to-one support was requested not only for 24 hours a day but for different lengths of time during the day or week and for both long-term and short-term reasons, suggesting a need for flexibility in funding for care home placement. Guidance from the Association of Directors of Adult Social Services supports this, promoting person-centred, flexible commissioning (ADASS, 2025). Despite this, CHMs in this study felt that the weekly set fee for each resident did not enable them to be flexible with their support. LA social care expenditure has continued to reduce in the United Kingdom and spending cuts have a negative effect on health-related quality of life (Stokes *et al*., 2022). CHMs were clear that LA funding did not currently cover the cost of support.

Clarity around eligibility criteria for one-to-one support would be helpful. CHMs said they only requested one-to-one support as a last resort. Some had experienced an inconsistent response to requests from LAs that might be attributable to changes in the availability of funds as LA budgets are tightened at various times. Others expressed frustration that LA staff did not recognise their expertise as professionals able to determine a need for one-to-one support (see also Orellana, Manthorpe and Moriarty, 2017). Marshall *et al*. (2023) describe CHMs as being on the periphery of care support without genuine partnership-working with health and social care organisations, particularly in times of change.

LIMITATIONS

Due to the recruitment processes adopted, the CHMs we interviewed self-selected to be in the study. This may mean that there was a systematic bias in their reasons for participating, or for seeking one-to-one support. Whilst we asked for examples of cases in which one-to-one support requests were made, it was not within the scope of the research to triangulate these responses by other forms of data collection such as observations in care homes or interviews with residents, family members, or case-holding social workers or those making decisions about individual cases.

CONCLUSIONS

People living in care homes often have complex needs requiring support for them to settle in the home and to manage individual needs and behaviours related to living with long-term health concerns. Safety is the overarching reason for requests for one-to-one support due to falls, risk of suicide and perceived risks outside of the home. Whilst some CHMs recognised the restriction that one-to-one care imposes on residents, concerns about safety were paramount. Further research to understand the impact of receiving one-to-one support from the perspective of residents would be beneficial.

Care homes found it difficult to provide individual support to meet the specific needs of individuals due to current staffing levels. Despite this, care homes provided training for staff and sought the advice of specialist services before requesting one-to-one support as a last resort.

IMPLICATIONS FOR POLICY, PRACTICE AND FUTURE RESEARCH

Policies that enable flexible support to enable older care home residents to participate in activities they value, both in and out of the home, would improve their quality of life.

NICE guidance suggests that structured strength and balance programmes should be prioritised over one-to-one support to reduce the risk of falls in their residents, and is something that would merit future investigation.

Further research seeking the views of people who receive one-to-one support and their families would provide a broader perspective of this topic.

DATA ACCESSIBILITY STATEMENT

Participants agreed that anonymised transcripts of their interviews could be stored for up to 20 years on a password-protected file on the University of Bristol servers. Anyone wishing to conduct secondary analyses of these data should contact the data custodian, Dr Christie Cabral, with the appropriate ethical approvals that ensure confidentiality and usage is in line with uses to which participants have consented.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Supplementary File 1.** COREQ Checklist. DOI: https://doi.org/10.31389/jltc.636.s1
- **Supplementary File 2.** Interview schedules/topic guides. DOI: https://doi.org/10.31389/jltc.636.s2

ETHICS AND CONSENT

The research plan, data collection and storage procedures were approved by the Ethics Committee of the School of Policy Studies at the University of Bristol on 28 June 2024 (Reference number: SPSREC/REF 19369).

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

GM and CC designed the study. LD, KG and KH conducted the interviews. LD and KH conducted the analyses, with advice from CC, EB and JB. KG oversaw the ethics submission. All authors contributed to drafting the paper.

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