Durham Safeguarding Adults Partnership

Practitioner Newsflash – Professional Curiosity

What and why

Professional curiosity is about having the capacity, communication and understanding to find out what is really happening with an individual, their environment, and their day-to-day life. The adults who are most at risk are often the least able to tell someone about abuse and neglect. But someone's behaviour, presentation, or their aside comments may speak volumes.

- Safeguarding Adult Reviews (SARs) take place where an adult has died or been seriously harmed through abuse, neglect, or self-neglect, in order to learn how organisations can work better together. Some recent SARs have found that there was a lack of professional curiosity.

Key Messages

In many SARs there were tensions over balancing respect for an adult's autonomy and concern over risk; suspending critical judgement over values and living conditions; the challenge of working with people with mental health issues and who misuse drugs or alcohol; and judgements about substance misuse.

Safeguarding adults always must put the adult at the centre of the process as supported by the Empowerment principle and Making Safeguarding Personal. But this does not mean always accepting an adult's words at face value, or always viewing their refusal of care services, or lack of engagement as capacitated decisions.

Act on capacity - consider mental capacity early and make a formal capacity assessment when it is required, especially the higher the risk of harm. Seek advice for more complex challenging situations, for multiple and accumulative risk, and if family refuse or reduce care and support. Know that if there is severe self-neglect or long-term alcohol dependency, there is likely to be a deterioration in the person's functioning. At some point the adult may no longer have executive capacity, or ability to sequence decisions to minimise risk over their living arrangements or care. Consider when and how to intervene. Use Best Interests processes.

Practice Points

- SARs have found that if there had been a proactive discussion, within teams, or between different organisations, harm may have been reduced or a death may have been prevented. This links to the need to have 'professional curiosity' and to beware of the tendency of services to work in 'parallel lines' or silo working.
- In a busy round of client appointments, pausing, reflecting, putting into words, and proactively telling someone about something that doesn't feel quite right can be difficult. If the atmosphere is 'off' something is probably wrong.
- The 'little things' that can begin as complaints by families about poor care can if continued slide into abuse and neglect: being dressed in someone else's clothes; going to few activities; the wrong food being given...
- What is the day-to-day life like for someone who is self-isolating with their family, or whose links with community have been reduced – what are the risks? What is their living environment like? Ask what would it feel like to be in your shoes?
- If someone repeatedly makes harmful decisions, or neglects themselves, consider The Mental Capacity Act what good looks like: capacity assessment
- Begin with negotiation, persuasion, and building trust. Is there someone who already has a relationship with the person who can be involved?

'I' questions:

- What am I concerned about?
- Am I going to walk away and worry about this?
- Do I need to tell someone?

Professional Curiosity

- Being inquisitive, not taking things at face value are assets in safeguarding.
- Harm, abuse, and neglect can and do happen anywhere, and can be caused by well-meaning people as well as being a deliberate abuse of power.
- Consider the Protection Principle: "Support and representation for those in greatest need". Assume if an adult has care and support needs, there is likely to be abuse or neglect unless it is prevented.
- Keep an open mind; ask why especially where there are missed appointments, changes in behaviour, or behaviours that other people view as "difficult". Consider why behaviours that challenge are being expressed.
- Beware 'Professional optimism', wishful thinking. Are you being told what you want to believe? 'Next of kin' do not have a right to refuse care. Are family members colluding in concealing abuse?
- Beware assuming "that's just how they are" – watch out for changing risk or decline. Some SARs have found serious harm did not 'come out of the blue'.
- Is the adult at risk of delirium? Are they suddenly confused, and agitated or have they become withdrawn and lethargic?
- Don't assume someone else is aware of or dealing with any abuse or neglect.
- If you feel a risk is not recognised or being managed and no one is hearing you, use the new procedure Managing Professional Differences 2023.
- Have an inquisitive approach to risk assessment and in considering previous history. Review risk assessments with fresh eyes. Ensure chronologies for individuals are kept; read them to spot change or patterns. Delve into detail.
- Be aware the most obvious problem may not be the only one.
- If strangers have appeared – find out where they are from and why? Consider Home invasion (also known as Cuckooing).
- Consider history taking to include the whole family when appropriate.
- When it is safe to, ask direct questions: "'Do you feel safe?" "I've noticed you have this injury. Is there anything going on for you which may have caused this?" "Do you feel frightened of anyone?" "Who makes decisions about what you can and cannot do?"
- Keep safeguarding on your radar; be vigilant, be persistent.
- If you feel something is not right, ask yourself "what else can I find out?"

Closed cultures

- The CQC has published guidance to enable staff to recognise a closed culture and to flag the warning signs that there is the risk of a closed culture developing.
- It highlights the need for professional curiosity, and being better at understanding, hearing from and 'seeing' adults who are placed in care settings or who are isolated.
- CQC How CQC identifies and responds to closed cultures

Warning signs include:

- staff not seeing people as equals;
- people who are visited less often, or are a long way from their communities, or are unable to speak up for themselves;
- weak relationships between families and staff.

Also see the ADASS checklist for practitioners and senior managers: Safeguarding people in closed environments (derbyshiresab.org.uk)

Triangulate

That is, check what you have been told. Is it reliable? Do you really know or is it an assumption that needs checking? Does it make sense with other information? Does it match your observations? For example:

- If an adult with needs for care and support is going home from hospital and assures staff that they have contacted the care firm or that their daughter says she will look after them…Ask did that happen? Will it happen? When and how? Can you confirm it?
- Do not make assumptions about who is next of kin, even when 'relatives' live-in – check your facts. [Learning from SARs, 2021]

ABC
Assume nothing
Believe no one
Check everything

What does good look like?

- 94-year-old 'Ada' lived with dementia, disabilities, her son, and daughter in law. On a home visit, the district nurse saw make-up caked on her face and washed it off to reveal cuts, bruising and injuries (which later were found to be broken bones). She made a safeguarding referral. East Sussex SAR, February 2020
- Staff in some agencies proactively sought out Mr B outside the supermarket and other known local spots when he was not at home. Leeds SAR, Mr B, 2020
- Social worker on a home visit to a young person with learning disabilities wearing a face mask found the mask hid injuries, after assault by family member.

An opportunity missed

- Beware disguised compliance. Despite Ada's son being unable to explain the cuts, bruising and injuries, the district nurse accepted it when the son said he would take Ada to A&E and did not call herself. He didn't take her. East Sussex SAR, February 2020
- Over years staff lacked confidence to challenge Ada's assertive family who provided care; they felt inhibited when in the family home. East Sussex SAR 2020
- Extensive bruising was not recorded on a body chart; increased bruising over time was missed. Staff only recorded skin damage when it was known to be abuse.
- The podiatry clinic cancelled the case after the first appointment was missed (It was unclear what info was passed onto the podiatry clinic). Mr B who had memory issues, cognitive impairment, and was known by other services to severely self-neglect, died of sepsis with gangrene in both feet six weeks later. Sixteen days before he died, a community mental health practitioner saw Mr B's feet in a poor state but did nothing; Mr B said they were not painful. Leeds SAR, Mr B, 2020

What if your client does not keep appointments or refuses services?

NHS Safeguarding: 'Was Not Brought' Rapid Read

- The change in language from Did Not Attend to Was Not Brought recognises that people who rely on others to bring them, such as people with learning disability or memory issues, or children, are not choosing to not keep their appointment.
- Using your Was Not Brought policy, be especially proactive following up missed appointments. Protect human rights.
- When someone is reluctant to engage or a pattern of refusal of services emerges, or living conditions are a risk, consider passing on your concerns using tools: the Clutter Rating Tool, mental capacity assessments, Best Interests decision making, and safeguarding. Explore and assess non-engagement as a risk factor.

To report abuse, neglect, or self-neglect

Call Social Care Direct (or the Emergency Duty Team if an emergency and outside office hours). Call 03000 26 79 79

Support to decide how to raise my concern

- Use your organisation's policy and procedures and talk to your safeguarding adults lead person or your line manager.
- If you are the safeguarding lead or a manager, you can contact Social Care Direct during office hours for advice. Give details of your use of the Risk Threshold Tool and Risk Factors Record Sheet, which are on: Policies, procedures and forms - Durham Safeguarding Adults (safeguardingdurhamadults.info)
- Escalate risk which increases in intensity or seriousness, share concerns and information - Working Collaboratively and Information Sharing toolkit. If you disagree with another practitioner or service, use the 4-step procedure in Managing Professional Differences
- Coming soon: DSAP Working with Adults Reluctant to Engage Toolkit and Pathway with a formal process to convene a multi-agency meeting.

Legislative links

- Care Act 2014
- Care and support statutory guidance - GOV.UK (www.gov.uk);
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)
- The Serious Crime Act 2015 – Section 76 offence of controlling or coercive behaviour
- Statutory guidance framework: controlling or coercive behaviour

Further resources

- Hampshire SAB LSAB-7-Minute-Briefing-Tyrone-Goodyear.pdf
- Delirium | Alzheimer's Society (alzheimers.org.uk)
- Sudden confusion (delirium) - NHS (www.nhs.uk)
- SCIE - Building Rapport using technology in Social Work
- The Importance of Professional Curiosity in Safeguarding Adults
- How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK