

Type of Abuse	Non-Reportable	Requires Consideration	Reportable
MALADMINISTRATION OF MEDICATION Mismanagement/ misadministration/ misuse of drugs Please refer to local organisational guidance	Low Risk No Impact Lower-level concerns where the threshold for further enquiries under safeguarding are unlikely to be met. However, a record should be kept of what happened and what action was taken. Where there are a number of low-level concerns consideration should be given as to whether the threshold is met for a safeguarding enquiry due to increased risk	Medium Risk Some harm or risk of harm Incidents at this level should be recorded and considered for escalation, including consultation with Adult Social Care where appropriate. Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.	High Risk Significant harm or risk of harm Incidents at this level should be formally raised as a safeguarding concern with the local authority Adult Social Care department. Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.
	Examples: - Isolated incidents where the person is accidentally given the wrong medication, given too much or too little medication or given it at the wrong time but no harm occurs - Isolated incident causing no harm that is not reported by staff members - Isolated prescribing or dispensing error by GP, pharmacist or other medical professional resulting in no harm	Examples: - Recurring missed medication or administration errors in relation to one service user that caused no harm - Recurring prescribing or dispensing errors that affect more than one individual but cause no harm - Over reliance on sedative medication to manage behaviour - Covert medication without correctly recorded authorisation with no harm caused - Repeated medication errors for the same individual or across multiple individuals indicating potential systemic failure	Examples: - Recurrent missed medication or administration errors that affect one or more adults and/or result in harm - Deliberate maladministration of medicines (e.g. sedation) - Covert administration without proper medical supervision or outside the Mental Capacity Act, with a detrimental impact - Pattern of recurring administration errors or an incident of deliberate maladministration that results in ill- health or death. - Fabricated illness/ induced illness - Deliberate falsification of records or coercive/intimidating behaviour to prevent reporting
Actions/Outcomes to consider at every stage	- Review of relevant policies and procedures - Internal relevant training provided - Review of existing care plans or	- DATIX, serious Incident or alternative review or investigative process - Discussion with the GP/Pharmacy - Share information with the ICB Quality Team	RAISE SAFEGUARDING CONCERN Where there is an indication of a criminal offence, the police should be considered and contacted in line with local procedures.

	creation of new care plans/risk assessments • Complaints or disciplinary processes	and/or the CQC • Consider Provider Concerns process as lined in the Safeguarding Policies and Procedures	
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