

COVERT ADMINISTRATION OF MEDICINES

Pages 1 and 2 to be completed at time of first covert administration assessment and all subsequent reviews

To be completed by medication administrator:

Patient Name	
NHS Number	
Date of Birth	
Location/Address	
Date	

1	When was the patient last encouraged to take their medication? (provide date)	
2	What problems were encountered?	
3	Has the person expressed views that are relevant to the present treatment? If so, what were those views?	

To be completed by prescriber:

<p>Covert treatment may only be considered for a person who lacks capacity. Outline the assessment of mental capacity (see appendix for guidance)</p> <p>Parties involved in assessment (name and signature):</p> <p>Care Manager: Pharmacist: Patient rep: Other:</p> <p>Assessed by: Signature: Date of assessment: Next review Date:</p>	<p>Assessment:</p>
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Medication Review including requirement and method for covert administration

To be completed by prescriber and pharmacist in conjunction with care staff and any other interested parties (e.g. relative)

	Benefit of drug outweighs potential risks (see appendix) – give reason	Any view expressed by patient? (All means of expression should be explored)	Alternative methods considered (e.g. Liquid)	Action taken (e.g. Medication stopped, formulation change)	Covert administration required?	Method of covert administration
Medication 1:						
Medication 2:						
Medication 3:						
Medication 4:						
Medication 5:						

For patients with more than 5 medicines to be given covertly, please copy this page as necessary

APPENDIX

Background

- Covert administration of medicines is the term used when medicines are administered in a disguised form without the knowledge of consent of the person receiving them (for example, medicines added to food and drink).
- Covert medication must NEVER be given to someone who is capable of giving informed consent to medical treatment.
- Administration of medication against a person's wish may be unlawful.
- Covert administration is only likely to be necessary or appropriate where a service user actively refuses their medication but is judged not to have the capacity to understand the consequences of their refusal and the medication is deemed essential to the patient's health and wellbeing.
- The proposal to administer covertly should be discussed with the resident's GP and with a relative, carer/ patient advocate and pharmacist.

Procedure

Necessity

- Will the patient consent to the medication being given in another form?
- Is the treatment so essential it needs to be given by deception?
- Practitioners should base their clinical decisions on clinical guidelines where available, e.g. National Institute of Health and Social Care Excellence (NICE) Clinical Guidance 42, which relates to dementia or best clinical practice.

Capacity

- Does the person have the capacity to decide about medical treatment?
- The person must have been assessed in accordance with the Mental Capacity Act 2005 (MCA). This process should be timely and documented.

Benefit

- Is the treatment of benefit to the person?
- Treatment must be for the benefit of the individual and not to benefit others.
- Is there an evidence based indication for the medication?
- Are any potential risks of any possible adverse effects that might be caused by administering the medicine covertly, outweighed by the benefit obtained, e.g. change in absorption or risk of person tasting medicine and then refusing all food and drink.

Least Restriction of freedom

- Is the covert method the best way to achieve administration of medication?
- Any covert administration must not compromise the individual's freedom.
- Is the chosen method for covert administration the best way of providing the medicine to the person and also causes the person the least distress?

Take the person's past and present wishes into account

- Has an advance statement been made?
- It is important to take into account anything the person may have said to family and friends or involve an independent advocacy

Consult others

- Has there been full discussion within a multidisciplinary team (e.g. GP, consultant, pharmacist, care manager, family/advocate) with expert pharmacy guidance?
- Consideration must also be made of ethical, cultural or religious beliefs.

Encourage the person to use existing skills

- Have all means of expression been explored?
- The person should have every opportunity to understand the need for medical treatment and communicate decisions.

The prescriber will ensure:

1. The above points are considered and documented in the patient's medical records
2. The proposed treatment and possible methods of administration are discussed with a pharmacist who will need to consider the pharmaceutical stability of the medication
3. The decision is communicated in writing to the person administering, who will document the use of covert administration into the care plan.
4. Reviews are regularly undertaken. The treatment plan should be reviewed within a week of initiation of the covert medicine and if the requirement of covert medication persists, full reviews should be done at less frequent intervals depending on individual circumstances. The review should be led by the original decision maker where possible.
5. Necessary instruction is added to the prescription

Those who administer the medication will need to consider the following:

1. Does documentation exist allowing the medication to be given covertly, before administration takes place.
2. What instructions are written on the MAR sheet?
3. What training have staff had regarding the covert administration of medicines?
4. How are medicines crushed such as with tablet crushers, metal spoons, pestle and mortar?
5. Any medical, cultural or religious dietary requirements should be complied with (e.g. gluten-free for patients with coeliac disease, avoidance of animal gelatine for vegetarian, Jewish or Muslim patients)?
6. Which foods to use to hide medicines in and where are these medicines stored (e.g. jam, yoghurt, juice)?
7. Does the care plan carry an assessment of the resident's capacity and identifies who carried out the assessment and when?
8. Does the care plan reflect the person's assessed needs and any agreements to administer medicines in food or drink are clearly documented?
9. Are there agreed review dates and do reviews take place?

Assessing Capacity

1. Who should assess capacity?

The Act does not specify who should assess capacity. However, anyone who wishes to carry out an action in connection with the care or treatment of an individual, or who wishes to make a decision on their behalf, must be reasonably satisfied that they lack the requisite capacity. This will require taking appropriate steps to assess their capacity to make the decision. Where consent to medical treatment is required, the health professional proposing the treatment needs to decide whether the patient has the capacity to consent. The reasons why capacity is in doubt should be recorded in the medical records, as should details of the assessment process and its findings. The more serious the decision, the more formal the assessment of capacity is likely to be, and, where appropriate, it might be advisable to refer to a psychiatrist or psychologist for a second opinion.

2. How do you assess capacity?

The Act makes use of a 'functional' test of capacity, adapted from the common law, which focuses on the decision-making process itself. First it must be established that the person being assessed has 'an impairment of, or a disturbance in the functioning of, the mind or brain' which may affect their ability to make the decision in question. Under the Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she is unable:

- To understand the information relevant to the decision
- To retain the information relevant to the decision
- To use or weigh the information; or
- To communicate the decision (by any means)

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed.

In assessing capacity, consideration should be given, where appropriate, to the views of those close to the individual. Family members and close friends may be able to provide valuable background information, although their views about what they might want for the individual must not be allowed to influence the assessment. An assessment that a person lacks capacity to make a decision must not be discriminatory. It must not be based on a person's age, appearance, assumptions about their condition or any aspect of their behaviour.

3. Uncertainties about capacity

Difficult judgements will still need to be made, particularly where there is fluctuating capacity or where some capacity is demonstrable but its extent is uncertain. The Act requires that any decision that a person lacks capacity must be based on a 'reasonable belief' backed by objective reasons. Where there are disputes about whether a person lacks capacity that cannot be resolved using more informal methods, the Court of Protection can be asked for a judgement.

Assessing Best Interests

1. What does the Act mean by best interests?

All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. This is a statutory restatement of the previous common law position. The Act provides a checklist of common factors that must be taken into account when making a best interests judgement. A best interests judgement is not an attempt to determine what the person would have wanted, although this must be taken into account. It is as objective a test as possible of what would be in the person's actual best interests, taking into consideration all relevant factors.

2. What should be taken into account when assessing best interests?

Lacking capacity to make a decision should not exclude an individual from participating in the decision-making process as far as is possible. The decision-maker must also take into account the likelihood that the person will regain capacity. A decision should be delayed if it can reasonably be left until he or she regains the capacity to make it. Other relevant factors are likely to include:

- The person's past and present wishes and feelings, including any relevant written statement made when she or he had capacity – this would include general statements of wishes.
- His or her beliefs or values where they would have an impact on the decision.
- Other factors the person would have considered if able to do so- such as the effect of the decision on other people.

A crucial part of any best interests judgement will involve a discussion with those close to the individual, including family, friends or carers, where it is practical or appropriate to do so, bearing in mind the duty of confidentiality. It should also include anyone previously nominated by the person as someone to be consulted, anyone appointed to act under a Lasting Power of Attorney or any deputy appointed to make decisions by the Court of Protection.

3. Are there any exceptions to the best interests principle?

The best interests principle will not apply where someone has previously made an advance decision to refuse medical treatment while they had capacity. Where the advance decision is valid and applicable, it should be respected, even if others think that the decision is not in his or her best interests.

References

Mental Capacity Act Toolkit, British Medical Association, Card 4, Mental Capacity and Card 5, Best Interests.

College Statement on Covert Administration of Medicines, Royal College of Psychiatrists 2012. Northampton Healthcare NHS Foundation trust. Covert administration of medicine, Policy and Guidance June 2017.

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Flowchart for the use of covert medication

