Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Covert Administration of Medication (Adult)

Best practice guidance

June 2022

Author:	Harprit Bhogal - Care Home Pharmacist Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB)
Responsibility:	All General Practitioners and Non-Medical Prescribers who may need to consider covert administration for patients in their care. All care providers administering medication. All other relevant members of the multidisciplinary team who may be involved in the process.
Effective Date:	June 2022
Review Date:	June 2024
Reviewing/Endorsing committees	BLMK ICB Prescribing Committee
Version Number	V7
Related Documents:	Mental Capacity Act Policy Deprivation of Liberty Safeguards Policy – to be replaced with Liberty Protection Safeguards – date to be confirmed

DEVELOPMENT PROCESS

Names of those involved in guidance development

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Key stakeholders included in the consultation for the development of the guidance:

- LMC to provide input into the implications for GPs in following the processes within this document
- GP and Nurse leads for safeguarding within the ICB who will assist in the implementation of the guidance within practice
- Mental Capacity Leads within Borough Councils who will assist in the use of the guidance when needed within the local councils.
- BLMK ICB Mental Capacity Act and Liberty Protection Safeguards Lead who will assist in the implementation of the guidance within the ICB and member practices.
- Adult Safeguarding leads within the ICB Quality and Safety directorates who will assist in the implementation of the guidance within the social care settings.

Names of those consulted regarding the guidance approval

Date	Name	Designation	Email
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Committee where guidance was discussed/approved/ratified

Committee/Group	**Date**	**Status**
Prescribing committee	10/3/2020	Approved
Prescribing committee	30/6/2022	Approved

Equality Impact Analysis/Statement

Equality Impact Assessment

This best practice guidance, properly followed would have no adverse impact on individuals from any of the nine protected characteristics in the Equality Act namely age, disability gender, sexual orientation gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief.

The guidance proscribes the process to be followed across BLMK Health Care Partnership (HCP) to meet the legislative requirements and ensures that the use of covert medicines for the treatment of either a physical or mental illness is only used in prescribed circumstances. All decisions will be taken in accordance with the law and will be based on the capacity of the individual not their disability, diagnosis, age etc. The policy also highlights the need to ensure that appropriate dietary requirements are met which may be used to contain covert medication for religious and/or medical reasons.

The guidance is comprehensively based on current statutory requirements and NHS and other specialist policies and practices, which are, where appropriate, subject to equality impact assessments in their own right.

Considering all these factors a separate equality impact assessment for this policy is not required.

Equality Impact Assessment/Statement above reviewed by Equality and Diversity Team March 2020

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1. Introduction

This guidance supports best practice for the administration of medicines to patients who are unable to give informed consent to treatment and refuse to take medication when offered to them and for whom medicines are administered in drinks and foods **unknowingly**. The intention is to ensure that individuals refusing treatment as a result of their illness will have access to effective medical treatment when it is considered to be clinically in their best interest and proportionate to their level of risk.

1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) strives to ensure the safety of its population and to promote a safe environment in which to deliver care. An important part of care is the prescribing and administration of medicines, which must be undertaken lawfully at all times.

1.2 This guidance provides support for staff regarding the covert administration of medicines including explanation of when this can be done within the law and practical implementation.

1.3 The Nursing and Midwifery Council (NMC) recognises that there may be exceptional circumstances in which covert administration may be considered necessary to prevent a person from missing out on essential treatment. However, it should be acknowledged that an unsubstantiated instruction to covertly administer is against professional practice and potentially unlawful.

1.4 The British Medical Association (BMA) provides resources to support doctors to help in good decision-making when providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf. The Mental Capacity Act 2005 sets out a number of basic principles that must govern all decisions made and actions taken under its powers. These are rooted in best practice and the common law and are designed to be fully compliant with the relevant sections of the Human Rights Act.[1]

2. Definitions

2.1 Covert administration is the administration of any medical treatment in a disguised form. This usually involves hiding oral medicines (tablets, capsules or liquids) by administering in food or drink. But it can also apply to medicines by other forms of medicines administration, such as patches, injections, or medicines given by a feeding tube, if the person lacks capacity to consent and they don't know they are taking that medicine.[2] As a result the person is unknowingly taking medication which they have previously refused when offered. **It is not acceptable to simply tell a person you are putting their medication into food or drink when capacity to understand has not been assessed.**

2.2 Overt administration is the practice of putting medication into food and drink to make it more palatable often at the request of the patient. This could still be regarded as deceitful and open to abuse unless clear documentation supports the practice in the individual care plan. Overt administration is a co-operative process that is transparent and open to scrutiny and audit, and by definition requires a patient's capacity to understand what is being done.[3]
It is therefore NOT covert administration if a patient has swallowing difficulties and has consented to medication being mixed in food and drink to aid administration and is fully aware that this is being done.

[1] http://bma.org.uk/practical-support-at-work/ethics/mental-capacity
[2] Covert administration of medicines in adults: legal issues, Specialist Pharmacy Service
[3] Best practice guidance in covert administration of medication, PrescQIPP Bulletin 101, 2015

3. Objectives

3.1 The ICB recognises the key importance of respecting the autonomy of individuals who refuse treatment. However, there are times when very severely incapacitated patients can neither consent nor refuse treatment.[4]

3.2 The practice of offering medication in food or drink is only allowable in particular circumstances and could be open to abuse. The aim of this document is to provide guidance as to when this practice is lawful, and to ensure that if it happens due process has been followed and that the practice is transparent and open to public scrutiny and audit.

3.3 The guidance has been developed to provide clear processes to support decisions to follow a covert administration pathway thereby supporting consistent and safe practice.

3.4 Care homes should have medication policies in place to include covert administration. This guidance is not intended to replace a care home's covert administration policy. However, it is expected that any care home's covert administration policy will be aligned with this guidance document.

4. Scope

4.1 The document provides guidance on covert administration of medication for:

- General Practitioners and Non-Medical Prescribers who may need to consider covert administration for patients under their care.
- Nurses or paid carers who may be instructed to administer medication covertly. Whilst the ICB guidance provides the principles which are expected for its population, additionally, a nurse would be expected to work within NMC guidance and a paid carer to follow the policy of their organisation.
- Other members of the multidisciplinary team (e.g., pharmacists) who may be involved in the care pathway.

The scope of this guidance does not cover the administration of medication in an emergency situation.

This guidance only applies to individuals aged 18 and over. For individuals under the age of 18, please discuss with your local Safeguarding Children team.

5. Responsibilities

All individuals involved in Covert administration of medication should understand the aims, intent and implications of such treatment, and should be fully aware of their responsibilities arising from this practice.

5.1 General Practitioners and Non-Medical Prescribers

- Both the prescriber and the responsible individual within the care home setting should ensure that medication has been reviewed, mental capacity to consent or refuse treatment has been assessed, best interest decision process followed, and all documentation has been completed.

[4] Psychiatric bulletin (2004) 28:385-386

- Crushing medications and mixing them with food/liquids often renders each medication unlicensed. The prescriber must therefore authorise such practice in writing prior to administering medication in this way – refer to section 12 for further information.

5.2 **All care providers administering medication.**

- All care home providers must have procedures in place for arranging covert administration of medicines and ensure these are followed appropriately.
- The person administering the medication needs to be able to do this safely and should receive the appropriate level of training and supervision to do so.
- Care providers should ensure a review takes place at pre-agreed regular intervals or if there is a change in medication, or the physical or mental state of the individual.

5.3 **Members of the multidisciplinary team who may be involved in the process**

- Best interest decisions involving medication should be made by the prescribing practitioner in conjunction with a multi-disciplinary team including the care home staff and family or advocate.
- Participants in the best interest meeting must agree and record a management plan if a decision is taken to covertly administer medicine to an adult care home resident.

5.4 **Pharmacists**

- A pharmacist may be responsible for conducting a Structured Medication Review (SMR) prior to a decision to administer medication covertly to ensure that the medicines prescribed for the individual are essential for their current medical conditions;
- A pharmacist's advice should be sought before medication is administered covertly, in order to check the suitability of the medication to be administered in this way;
- The pharmacist should take reasonable steps to ensure any advice regarding administering medication covertly, including the crushing of tablets or emptying of capsule contents, will not cause harm to the patient or staff administering the medicine;
- The pharmacist should refer to the standard texts, the SPC for the medicine concerned, and to any appropriate reference sources to advise on suitability.

6. General Principles of Covert Administration

6.1 Any healthcare professional involved in the covert administration of medication should be aware of the treatment aims and the legal and ethical implications of covert administration.

6.2 Where covert administration is considered to be the most appropriate option, the following principles should be seen as good practice:

- **Last resort-** covert administration is the least restrictive when all other options have been tried.
- **Medication specific-** the need must be identified for each medication prescribed by conducting a clinical structured medication review.
- **Time limited-** it should be used for as short a time as possible
- **Regularly reviewed-** the continued need for covert administration must be regularly reviewed within specified time scales as should the person's capacity to consent.
- **Transparent-** the decision-making process must be easy to follow and clearly documented.
- **Inclusive-** the decision-making process must involve discussion and consultation with appropriate advocates for the patient. It must not be a decision taken alone.
- **Best interest decision-** all decisions must be in the person's best interest with due consideration to the holistic impact on the person's health and well-being.

7. Process

Below is a summary of the 'Seven Steps' process and the key legal issues when considering covert administration:

Step 1: Structured Medication Review (SMR) – see section 8

It is recommended that a SMR is conducted by a prescriber or pharmacist to explore and try and resolve reasons for refusals of medicines. This is also an opportunity to consider whether deprescribing is appropriate for the individual where risk/benefit assessment of need is considered and see if stopping the medicine (temporarily or permanently) is an option.
If issues are resolved whilst conducting a SMR, covert administration may not be necessary, and you may not need to proceed to the next step.

Step 2: Assess capacity – see section 9

Covert administration should only take place when a person does not have the capacity to consent to treatment in line with the Mental Capacity Act 2005 and does not understand the consequences of the refusal of their medication.

Step 3: Best interests decision – see section 10

Any decision to administer medicines covertly needs to be formally agreed as being in the individual's best interests. A best interests meeting should take place to discuss and record the decision.

Step 4: Management plan – see section 11

A management plan should be agreed and documented at or shortly after the best interests meeting.

Step 5: Obtain prescriber authorisation – see section 12

A prescriber must authorise covert administration of medicines as this usually involves altering medication and therefore may be an unlicensed (off label) activity.

Step 6: Record keeping and documentation – see section 13

Good record keeping throughout the process is essential as inspecting bodies (e.g., CQC) will challenge covert administration, so it is important to make sure there are proper records to support the process.

Step 7: Regular reviews – see section 14

The continued regular review of the covert administration plan is essential. Reviews must be initiated by the care home and conducted by a prescribing clinician or could be delegated to practice pharmacist or care home pharmacist.

See Appendix 2 for 'Covert Administration Flow chart' including the above steps

8. Structured Medication Review[5,6]

8.1 A Structured Medicine Review (SMR) is an evidence-based, comprehensive review of a person's medication, taking into consideration all aspects of their health. In a structured medication review, clinicians and patients work as equal partners to understand the balance between the benefits and risks of and alternatives of taking medicines.

8.2 The purpose of an SMR is to optimise the use of medicines for the patient, identifying any medicines which could be stopped or need a dosage change, or new medicines that are needed.

8.3 A SMR can identify problematic polypharmacy where, for an individual taking multiple medicines, the potential for harm outweighs any benefits from the medicines and/or they do not fully understand the implications of the medication regime they are taking. This includes:

- medicines that are no longer clinically indicated or appropriate or optimised for that person
- combination of multiple medicines has the potential to, or is actually causing harm to the person
- practicalities of using the medicines become unmanageable or are causing harm or distress.

8.4 Prior to consideration of covert administration, a SMR should be carried out by a prescriber or pharmacist. The SMR may reveal reasons for refusal of medicines which could be easily resolved. For example, if the patient is struggling to swallow the medicine due to the medication size or unpalatable taste, it may be possible to switch to a different formulation of the medicine (e.g., liquid, dispersible tablets, patch etc.), or to a different medicine that the patient may find more acceptable.

8.5 The SMR also identifies whether deprescribing is appropriate for the individual and stopping the medicine, either temporarily or permanently, may be an option.

8.6 If issues can be resolved during a SMR, covert administration may not be necessary, and you may not need to proceed to the next step.

9. Assessing Mental Capacity (see Appendix 3)

9.1 A Mental Capacity Act (MCA) assessment is usually completed by an appropriately trained senior carer or nurse involved in the daily administration of medication to the patient. However, if the outcome of the assessment is not entirely clear or further support is required, then an appropriately trained healthcare professional (registered practitioner) such as a GP, Pharmacist or Specialist nurse should be involved.[7] The assessment can be carried out jointly with care home staff and the involvement of family, close friends or carers can be beneficial, especially if there is any doubt about a decision. A multidisciplinary team meeting at the care home can be arranged as good practice. **A prescriber must take overall responsibility for the MCA assessment**, so it could be 'dual' signed as partnership working. The law requires a prescriber to be responsible for determining whether medication should be administered covertly.

9.2 A MCA assessment can be completed using the form (see appendix 3). This form can also be accessed on SystmOne via the 'CCG Preferred Choice' link on the Ardens 'Covert Medication Administration' template. This allows completion of the assessment in the patients notes and can be saved in the journal.

[5] Structured medication reviews and medicines optimisation, NHS England
[6] Quality Statement 6: Structured medication review, Medicines Optimisation Quality Standard, March 2016
[7] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

9.3 Decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the 5 key principles set out below:

The five key statutory principles in assessing capacity are:

1. A person must be assumed to have capacity to make a decision unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. For example, advocates or communication support may be necessary.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

9.4 For the purposes of assessing capacity to understand medication, you must answer two questions:

Stage 1 – is the person unable to make a particular decision (the functional test)?

Stage 2 – Is the inability to make a decision caused by an impairment of, or disturbance in the functioning of, a person's mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol (the diagnostic test).[8]

Consideration should be given to the patient's individual needs and whether reasonable adjustments need to be made e.g., need for an interpreter, easy to read leaflet, support with sign language etc. A patient will be considered to lack mental capacity in law to consent if he or she is unable to:

- **Understand** in simple language what the treatment is, its purpose and why it is being prescribed
- **Retain** the information for long enough to make an effective decision
- **Use or weigh up** the information in considering the decision, understand its principle benefits, risks and alternatives and understand in broad terms what will be the consequences of not receiving the proposed treatment
- **Communicate** their decision in any form

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.

See Appendix 7 for sample of completed MCA assessment

9.5 An Advance Decision to Refuse Treatment (ADRT) in anticipation of future incapacity must be adhered to if valid and complete. Crucially the patient must have made clear which treatments they are refusing (a general desire not to be treated is insufficient) and in what specific circumstances they refuse them. The advance decision must apply to the proposed current treatment and in the current circumstances.

[8] Assessing capacity, Mental Capacity Act (MCA), Social Care Institute for Excellence (SCIE), Sept 2017

Please note – a person's Lasting Power of Attorney (LPA) could override an ADRT if the LPA is registered after the ADRT was drawn up and it is stipulated in the LPA documentation.[9]

9.6 A patient may be mentally incapacitated for various reasons. These may be temporary reasons, such as the effect of sedative medicines, or longer term reasons such as mental illness, coma or unconsciousness. It is important to remember that capacity may fluctuate, sometimes over short periods of time and should therefore be regularly assessed by the clinical team treating the patient. There may be a need to consider delaying the decision to administer medication covertly if there is a significant chance that capacity will be regained and delaying the decision will not have life threatening risks.

9.7 Where adult patients are capable of giving or withholding informed consent to treatment, no medication should be given without their agreement. For that agreement to be effective, the patient must have been given adequate information about the nature, purpose, associated risks and alternatives to the proposed medication. An adult with mental capacity has the right to refuse treatment, even if refusal will adversely affect his or her health or shorten his or her life. It may be considered necessary to seek the advice of Court of Protection if the clinician is unsure of the ethics of such decisions. Therefore, registrants must respect a competent adult's refusal as much as they would his or her consent. Failure to do so will be unlawful and may be a breach of their human rights. The exception to this principle concerns compulsory treatment authorised under the relevant mental health legislation.

9.8 When an emergency arises in a clinical setting and it is not possible to determine the patient's wishes, they can be treated without their consent provided the treatment is immediately necessary to save their life or prevent a serious deterioration of their condition. The treatment provided must be the least restrictive option available. Any medical intervention must be considered in the patient's best interest and should be clearly recorded noting who took the decision, why the decision was taken and what treatment was given and when.

9.9 Due consideration must be given to the Human Rights Act 1998. The following relevant sections of the Act have been highlighted by Royal College of psychiatry regarding covert administration[10].

Article 2: ***'Everyone's right to life shall be protected by law'***
Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article might be used to justify such a practice. Clearly no treatment can be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatment may, sometimes, shorten life as a secondary result of their administration). Administration of treatments whose purpose is to shorten life is illegal.

Article 3: ***'No one shall be subject to torture or inhuman or degrading treatment or punishment'***
In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than the covert administration of medication.

Article 5: ***'Everyone has the right to liberty and security of person'***
To justify the invasion of privacy which covert medication entails, it must be clear that this invasion is justified by the need for effective treatment.

Article 6: ***'Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law'***

[9] Mental Capacity Act Policy (2016) Bedfordshire CCG
[10] http://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf

It is essential that, if medication is administered covertly this is done following discussion and with clear clinical records, so that a fair and public hearing may be obtained when required.

Article 8: ***'Everyone has the right to respect for his family life, his home and his correspondence'***
See comments to Article 5 above.

10. Best Interest decision (see Appendix 4)

10.1 'Best interests' is a method for making decisions which aims to be objective. It requires decision makers (e.g., responsible clinician) to think what the 'best course of action' is for the person. It should not be the personal views of the decision-makers.[11]

10.2 When a patient is considered as lacking mental capacity to make a decision about their treatment options, the responsible clinician must make a decision following the best interests process in section 4 of the Mental Capacity Act 2005. This process is summarised below and each element must be followed when making a decision for someone else.

Summary of best Interests checklist

- Consider all the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision - **and**
- Consider a delay until the person regains capacity - **and**
- Involve the person as much as possible - **and**
- Not to be motivated to bring about death - **and**
- Consider the individual's own past and present wishes and feelings - **and**
- Consider any advance statements made - **and**
- Consider the beliefs and values of the individual - **and**
- Take into account comments of family and informal carers (trying to glean what the person would have wanted if they were able to make this decision for themselves) - **and**
- Take into account views of any Independent Mental Capacity Advocate (IMCA) or other key people involved - **and**
- Show evidence and document it is the least restrictive alternative or intervention.

10.3 When covert administration is being considered, holding a 'best interests' meeting is recommended by NICE. This may be beneficial to explore the best interests process. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. If the situation is urgent, it is acceptable for a less formal discussion to occur, however a formal meeting should be arranged as soon as possible. This meeting can take place remotely.

10.4 A best interests meeting should be attended by care home staff, a prescriber, any relevant health professionals (which may include a pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend, an Independent Mental Capacity Advocate (IMCA) or a Representative appointed by court order depending on the resident's previously stated wishes and individual circumstances). However, nobody can

[11] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

consent for someone else; but the views of family/carers may be beneficial in determining a patient's wishes and feelings and what is in their best interests. If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.[12] Please note: If a pharmacist cannot be present, their advice should be sought before the decision to proceed is made in order to check the suitability of the medication to be administered in this way (See appendix 5)

10.5 A Best Interest decision can be completed using the form in appendix 4. This form can also be accessed on SystmOne via the 'CCG Preferred Choice' link on the Ardens 'Covert Medication Administration' template.

11. Management Plan

11.1 A management plan should be agreed after a best interests decision has been made, and this would usually include:

- The need to include acute treatments for emergencies (e.g., Antibiotics to treat infections or medication such as Lorazepam to manage challenging behaviours).
- A medication review by a pharmacist to advise the care home how the medication can be covertly administered safely. See appendix 5 for 'Instructions for carers from pharmacist'. This form can also be accessed on SystmOne via the 'CCG Preferred Choice' link on the Ardens 'Covert Medication Administration' template.
- Clear documentation of the decision of the best interests meeting (see appendix 4).
- A plan to review the need for continued covert administration of medicines on a regular basis. This should be done at least 6 monthly, but sooner if required. This should include details of what to do if the patient regains capacity.

12. Obtain prescriber authorisation

12.1 Covert administration usually involves altering medicines, for example crushing tablets or opening up capsules, and/or adding medicines to food or drink. Altering medicines is usually an **unlicensed** (off-label) activity. It is important to get authorisation, preferably in writing, from a relevant prescriber to do this.

12.2 Prescribing medicines for off-label use affects, and probably increases, the prescriber's professional and legal responsibility (liability). Any changes to medicines or how they are given comes with risks.

12.3 Covert administration should only be carried out if the prescriber can justify, and is confident in, the use of the medicine in this manner. At present only an **independent prescriber** can authorise off-label use of medicines. Although other healthcare staff or professionals may be able to offer advice, they cannot authorise the action.

12.4 Giving a medicine in an off-label way without a prescriber's authorisation could result in a finding of professional misconduct.[13]

[12] NICE Quality Standard (QS85) Medicines Management in Care Homes, March 2015
[13] Covert administration of medicines in adults: legal issues, 19 January 2022, Specialist Pharmacy Services

13. Record Keeping and documentation (See Appendices 3 & 4)

13.1 Good record keeping is essential for ensuring safety and quality of care. Covert administration of medication will be challenged by regulating bodies such as CQC unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the persons care and clear documentation is essential.

It is not appropriate to act on an "ad hoc" verbal direction or a written instruction to covertly administer as this would not constitute appropriate documentation and could subject the nurse administering the medicine covertly to a Fitness to Practice concern.[14]

MCA assessment and Best Interests documentation:

13.2 **The prescriber has overall responsibility for ensuring the completion of both the mental capacity assessment for understanding of medication issues and the best interest decision record to support covert administration.** As per section 8.1 the MCA assessment can be delegated to an appropriately trained senior carer or nurse involved in the daily administration of medication to the patient. However, the prescriber must be reassured that the person delegated to conduct the assessment is appropriately trained and has access to all the relevant information required for the assessment.

13.3 The assessment can be done using the forms as per appendix 3 & 4. These can be accessed via the 'CCG Preferred Choice' link on the Ardens 'Covert Medication Administration' template.

13.4 The completed documentation must be saved or scanned in the patient's clinical notes at the surgery and copies must be kept by the provider (e.g., care home) for inclusion in the care plan for that individual. This documentation authorises covert administration and the use of the medication in an unlicensed fashion as appropriate. It is good practice for all documentation to be in place with the provider (e.g., care home) and at the surgery within 48 hours of the assessment being conducted.

Please note: there is a 'read code' on SystmOne (Xacu1 – Best Interest Decision to allow covert administration of medicines under Mental Capacity Act) which can be used to document discussions in the patients notes.

MAR chart documentation:

13.5 The patient should still be encouraged to take their medication in the normal way and if administration is successful this should be documented on the MAR chart as usual. However, if medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet each time. This may be done using an appropriate code. The recording of covert administration on MAR charts is especially important for when reviews are conducted.

13.6 Where covert administration has been unsuccessful (i.e., refusal of the food or drink containing medication), this must be documented using an appropriate code or documenting on the reverse of the MAR chart and/or in the care plan. It should also be noted if it is partially consumed as the dose is then uncertain. A refusal code (e.g., 'R') must not be used as this is not a refusal of medication being administered in the normal way.

13.7 It is useful for kitchen staff in care homes to be aware of a person who is being given medication covertly as dietary changes may be needed.

[14] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

14. Regular reviews (see Appendix 6)

14.1 The need for continued covert administration should be reviewed within time scales which reflect the physical state of each individual. This should be agreed at the time of agreeing the implementing of covert administration. It is particularly important at End of Life that relatives or advocates are made fully aware of the decisions that are made around medication, particularly if medication is stopped so that they are reassured.[15]

14.2 A review of the care plan relating to medication should be done **monthly by the care home** to check if covert administration is still required and this should be documented in the care plan.

14.3 A review of a covert administration plan could take place at a multidisciplinary team (MDT) meeting or any issues with the plan could be discussed at a 'weekly check-in' with the aligned GP surgery if needed.

14.4 The care home must ensure that a full review of the covert administration of medication plan is conducted every 3 to 6 months, with the maximum interval between reviews not exceeding 6 months. The prescribing clinician is responsible for reviewing the covert plan but this could also be delegated to a practice pharmacist or care home pharmacist. The review process must also include a review of capacity and best interest decision.

14.5 In some case's a review may be required earlier than anticipated and reasons for this must be documented. For example, where behaviour modifying medication is being administered, the best interest review process must be more frequent and well documented.

14.6 Fluctuating capacity requires more frequent monitoring in order to ensure that human rights are respected.

14.7 The only justifiable reason for not conducting a review would be if the reviews were causing distress to that individual. This would need to be evidenced in the surgery records and in the care plan but should still be revisited regularly to check if a review could be done.

14.8 The review can be documented using the form as per appendix 6. The form can be accessed via the 'CCG Preferred Choice' link on the Ardens 'Covert Medication Administration' template. All completed review documentation must be saved or scanned in the patient's clinical notes at the surgery and copies must be shared with the provider.

14.9 Any significant changes to medication made as a result of the review should prompt a review of any DoLS in situ. It is the care home manager's responsibility to request a review by the local authority.

14.10 The removal of a covert administration care plan must only be made if everyone involved in best interest discussions is in agreement that covert administration is no longer required. This must be documented in the patient's notes and care plan. It would be prudent to monitor the plan for at least a month before stopping altogether. The provider may also need to notify the "Responsible body" if the covert administration care plan has been removed.

15. Changes to medication

15.1 Any new medication added to the regime (including new medicine or changes made by a hospital or specialist clinic) must be treated as a new situation and the need for covert administration identified, and the legal process must be followed.

[15] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

15.2 A best interests discussion must be held when new medicines are prescribed or doses changed and this must be documented.

16. Transfer of care

16.1 It is essential that, should the person receiving their medication covertly, be transferred to another care facility or to Domiciliary Care, that the correct and relevant documentation (e.g., MCA assessment and best interests discussion) accompanies them including a verbal handover to the person or persons who will be responsible for their care. On arrival at a new care venue, any covert administration of medication should be reviewed, and the necessary assessments, plans and documentation completed. Any existing Deprivation of Liberty authorisation is not transferable and will require re-application by the new care provider.[16]

17. Deprivation of Liberty Safeguards (DoLS)

Please note DoLS will be replaced by the Liberty Protection Safeguards (LPS) via The Mental Capacity (Amendment) Act 2019.

17.1 Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

17.2 DoLS are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restriction to be used – but only if they are necessary and proportionate and in the person's best interests. DoLS are used when any restrictions or restraints mean that a person is being deprived of their liberty.[17] Restrictions and restraint must be proportionate to the harm the care giver is aiming to prevent, and can include the use of some medication, for example, to calm a person or modify behaviour.

17.3 DoLS has to be a consideration if medication is administered covertly as it is an impingement of the person's basic rights and freedoms. The need for DoLS would be considered within the context of each individual case and together with any other criteria which contributes to the potential to deprive a person of their liberty. Covert administration of medications alone may not constitute a deprivation of liberty but may add to a package of care that amounts to a deprivation of their liberty. This is more likely if the medication alters mental state, mood or behaviour, and if it restricts a patient's freedom.[18]

17.4 Patients with existing DoLS must have covert medications declared and listed, and any change of medication or treatment should trigger a review. It is the care home manager's responsibility to ensure that a request for a DoLS review is sent to the local authority as another restriction is being placed on that individual.

Please note: Users of this guidance should be aware that this section on DoLS will not be valid following implementation of the LPS. This section may be updated sooner than the intended guidance review date to reflect the change in policies.

In the interim, please refer to the BLMK Health and Care Partnership 'Holding Statement for The Mental Capacity Act and Deprivation of Liberty Safeguards Policies' below:

[16] Covert Medicines Guidance May 2018, NHS Buckinghamshire CCG
[17] Deprivation of Liberty Safeguards Policy (2017) Bedfordshire CCG
[18] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

18. Practical points for Best Interests Decisions

The following points should be taken into account when covert administration is being considered and form part of a best interest decision to administer covertly.

18.1 The best interest decision should include a risk/benefit assessment which should be made by the prescribing clinician, and in discussion with relatives/advocates.

18.2 The option of stopping the medication should be considered **as the least restrictive option**, particularly where there are risks of food or drink being refused. This decision must be documented in patient's clinical notes and care plan with reasons for the decision.

18.3 Patterns of behaviour need to be monitored. A person may refuse their medication at certain times of day. Can the timing of administration be altered? Is there a formulation which can be given less frequently?

18.4 Dementia commonly presents challenges to carers administering medication. Dementia training is essential to develop persuasive techniques and document personalised preferences such as particular carers, environment, ways of giving etc.

18.5 If a person is not eating or drinking very well covert administration could be harmful as taste may be affected causing refusal of meals and drinks. It is important not to compromise the patient's nutrition. A dietician should be consulted if there are concerns.

18.6 The prescriber should consider an alternative route of administration of that medication (e.g., topical) or an alternative medication (e.g., available in different forms which are more palatable, or which can be given less frequently).

18.7 The properties of the medication (e.g., its bioavailability) should not be significantly affected by administering it covertly (where this information exists). Modified release (e.g., MR / SR / CR / XL) and enteric coated (E/C) preparations are generally not suitable for covert administration – always seek advice from a pharmacist before doing so.

18.8 If a licensed liquid preparation of the prescribed medication is available, this should preferably be used to mix with drink / food if appropriate. This is in preference to crushing or dissolving tablets or capsules, which is unlicensed use unless specified in the Summary of Product Characteristics (SPC). There may be occasions where it is still preferable to crush or dissolve tablets e.g., taste of liquid is unpalatable, these decisions would need to be made on an individual basis.

18.9 The pharmacist should refer to the standard texts, the SPC for the medicine(s) concerned, and specifically to appropriate reference sources to advise on suitability.

18.10 The prescriber, pharmacist and administering professional/carer should take reasonable steps to ensure administering medication covertly (including the crushing of tablets or emptying of capsule contents) is safe and will not cause harm to the patient or the person administering the medication. For example, ensure staff have appropriate equipment to be able to crush tablets safely, such as a tablet crusher or mortar & pestle. Taking into account the need for appropriate infection control and hygiene measures when using equipment. It is good practice for each resident to have their own individual tablet crusher to prevent cross contamination.

19. Practical points for administering covertly

19.1 Before administering medication covertly the patient should be encouraged to take it in the normal way e.g., by providing information and explanation by different team members if needed.

19.2 Care home staff should be aware of personal preferences for administration through the care plan. Refusal after appropriate steps have been taken, as detailed in the care plan, can then proceed to covert.

19.3 In general the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible (rather than the whole portion). If possible, try and add the medicine to the first mouthful of food so that the full dose is received. Not all drinks are suitable e.g., tea or milk interacts with some medication.

19.4 The medication must be administered immediately after mixing it with food or drink. It must not be left for the person to manage themselves. If the person is able to feed themselves, care staff must observe to ensure that it is consumed.

19.5 Consider the taste and other possible effects of the medicine, particularly if tablets are crushed or contents removed from capsules. For example, crushed Sertraline tablets have a bitter taste and may also have a slight anaesthetic (numbing) effect on the tongue. This means you will need to consider the best way to hide the taste, such as using strongly- flavoured drinks such as blackcurrant juice, or foods such as yoghurt or jam. Check individual likes and dislikes with family or carers to decide what might be suitable. Because of the possible numbing effect (with Sertraline), care should be taken with giving hot food or drinks with, or immediately after giving crushed Sertraline tablets.[19]

19.6 Different medicines should not be mixed together in food or drink as this cannot be quantified and also could be unsuitable to be mixed together. There may be some cases where mixing different medicines together may need to be carried out in the best interest of the person. If this is the case, it should be agreed by a multidisciplinary team and clearly documented in the care plan.

[19] Covert administration of medicines in adults: pharmaceutical issues, 14 January 2020, Specialist Pharmacy Service

20. Legislation and Guidance

20.1 This guidance should be read in conjunction with:

- Mental Capacity Act Policy 2016 for Bedfordshire CCG
- Deprivation of Liberty Safeguards Policy 2017 for Bedfordshire CCG – *to be replaced with Liberty Protection Safeguards Policy – date yet to be confirmed*
- Mental Capacity Act 2005 Code of Practice.
- Mental Capacity (Amendment) Act 2019
- NMC (2015) The Code – Professional standards of practice and behaviour for nurses and midwives
- NICE Guidance - Management of medicines in Care Homes good practice guidance March 2014
- NICE Quality standard (QS85) Medicines management in care homes, March 2015, Quality statement 6: Covert medicines administration
- Care Quality Commission – Covert administration of medicines, 27 January 2020
- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission "Essential standards of quality and safety" March 2010 Outcome 9 Management of Medicines.
- Human Rights Act 1998
- BMA Mental Capacity Toolkit
- Bournemouth University – Mental Capacity Toolkit
- Specialist Pharmacy Service – Covert administration of medicines in adults: legal issues, 19 January 2022
- Specialist Pharmacy Service – Covert administration of medicines in adults: pharmaceutical issues, 14 January 2022
- PrescQIPP C.I.C. Bulletin 269: Care homes – Covert administration
- NICE and SCIE – Giving medicines covertly: A quick guide for care home managers and home care managers providing medicines support
- **Case Law examples:**
  - 39 Essex Chambers | AG v BMBC & Anor | 39 Essex Chambers | Barristers' Chambers
  - 39 Essex Chambers | BHCC v KD | 39 Essex Chambers | Barristers' Chambers
  - Covert Medication: Medication Covert and to Manage Behaviour: AG V BMBC & SNH [2016] EWCOP37

Useful contacts:

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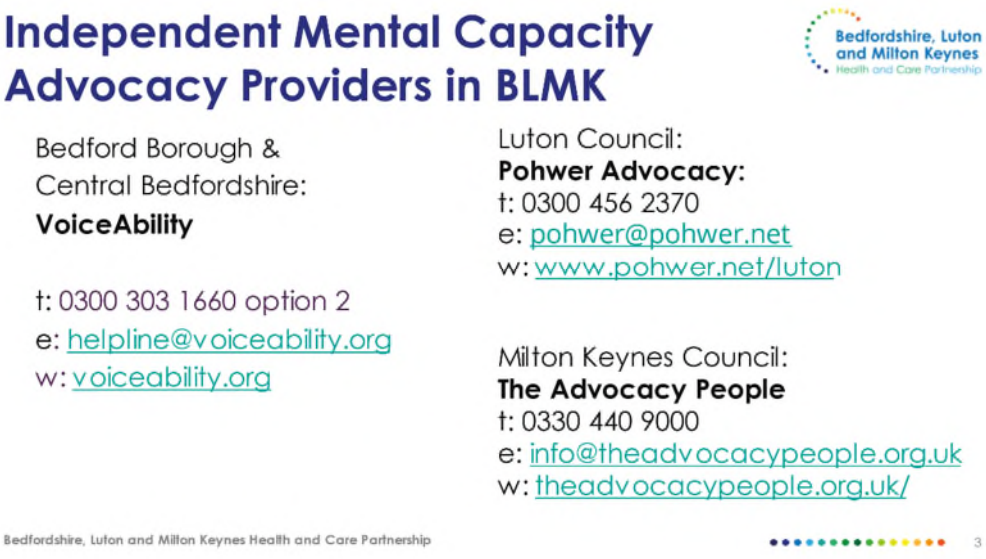
- Kaylie McNaughton – **Luton team**
  Care Home Pharmacist – Luton
  Email: kaylie.mcnaughton@nhs.net
  Mobile: 07809 148291

- Office of the Public Guardian (OPG)
  OPG can be contacted to find out if someone has an LPA or Deputy acting for them
  You need to complete form 'OPG 100' to search the register. This is a free service.
  Send your completed form to: Office of the Public Guardian
  customerservices@publicguardian.gsi.gov.uk
  Fax: 0870 729 5780



Appendix 1 – Best Practice Checklist

Checklist of practical steps when considering covert administration[20]

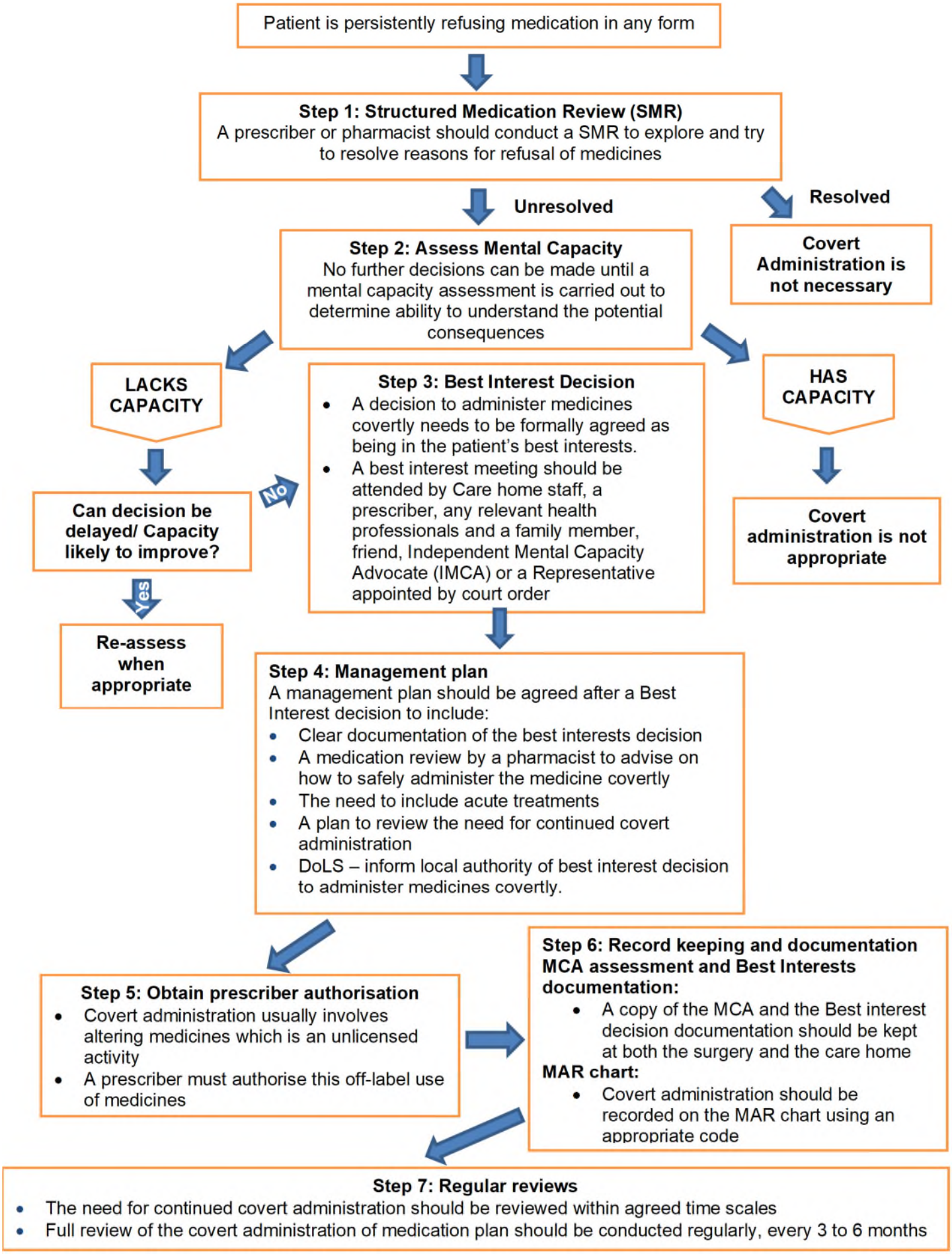
- ✓ Is the patient consistently refusing medication?
- ✓ Establish reasons why the patient is refusing medication – e.g., medication unpalatable, adverse effects, swallowing difficulties, administration timing etc
- ✓ Consider alternative methods of administration, for example a change in formulation such as a liquid or dispersible tablet
- ✓ Conduct Structured Medication Review (SMR) and decide what is essential
- ✓ If patient is refusing medication for a mental health disorder, the relevant mental health team needs to be consulted
- ✓ If there is no reason to doubt a patient's mental capacity, then medication cannot be administered covertly
- ✓ If there is a reason to doubt the patient's mental capacity, then firstly support the patient into making his/her own decision
- ✓ Assess the patient's mental capacity if such support has not helped
- ✓ If patient lacks capacity to decide about his/her treatment, establish whether there is an Advance Decision, Lasting Power of Attorney for health & welfare, Court appointed deputy or Independent Mental Capacity Advocate (IMCA)
- ✓ A Best Interests meeting with the relevant people should be organised
- ✓ If a decision is made to administer medication in a covert manner, such essential medication needs to be specified and a care plan agreed with a review date
- ✓ A pharmacist should be involved to advise on the forms of administration and what food or drink the medication can be disguised in.
- ✓ Once a covert administration plan is implemented, the care provider should coordinate the review with the relevant people and inform the DoLS team

Covert administration is only likely to be necessary or appropriate where[21]:

- ✓ A person actively refuses their medication **AND**
- ✓ That person does not have the capacity to understand the consequences of their refusal (as determined by the Mental Capacity Act 2005) **AND**
- ✓ The medicine is deemed essential to the persons health and wellbeing

[20] Guidelines in Practice, February 2019, Volume 22, Issue 2: 19-24
[21] Care Quality Commission: Covert administration of medicines, 23 October 2020

Appendix 2 - Covert Administration Flow Chart



Appendix 3: MCA 01 Mental Capacity Assessment Form for LESS complex decisions (November 2015)

1	**Name of Relevant Person**	**Address of Relevant Person**						
2	**Preferred Name of Relevant Person**							
3	**Date of Birth**							
4	**NHS Number**							
5	**I am starting this assessment on (insert date and time) ……** **Although I presume capacity, I doubt the person is able to make this particular decision at this time.**							
6	**What is the decision that needs to be made?**							
7	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**					Yes		No
7a	**Details of Impairment:** (For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, a dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)							
8	**Can the decision be delayed because the person is likely to regain capacity in the near future? Give Reasons below:**	Yes		Not likely		Not appropriate to delay		
9	**Assessment (Please provide evidence for points 9a to 9d):**							
a. Person has ability to <u>understand</u> information related to the decision to be made? If answer is 'No' please provide evidence						Yes		No
Details:								
b. Person has ability to <u>retain</u> information long enough for the decision to be made? If answer is 'No' please provide evidence						Yes		No
Details:								
c. Person has the ability to <u>use or weigh up</u> the information in considering the decision? If answer is 'No' please provide evidence						Yes		No
Details:								
d. Person has ability to <u>communicate</u> their decision by any means? If answer is 'No' please provide evidence						Yes		No
Details: (State what steps have been taken to achieve communication)								
If you have answered YES to all of the questions 9a – 9d above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. If you have answered **NO** to one or more of those question's then on the balance of probability the person is not likely to have capacity for this decision and you will be required to proceed.								

Details of any Advance Decisions to Refuse Treatment (ADRT): (Does any ADRT relate to this particular decision. Reference and attach any relevant documents)

Conclusion:

10	**Person HAS the capacity to make this informed decision at this time?**	Yes		No	

Document and detail your evidence and give reasons for your conclusion:

11	**What is the persons Preferences/Wishes?** NB. If person has the capacity for this decision, you must respect their preferences and wishes, document these here and sign and date below the completion of this capacity decision. If they DO NOT have capacity for this decision, you must still respect the rights, will and preferences of the individual and give weight to their views when making a decision in their best interests.

Signed:		**Date of Completion:**	

If person is found to lack the capacity to make this decision for themselves please continue

12	**Are there any known relatives or friends to consult with?** If they have Lasting Power of Attorney that covers this decision, i.e., Person Welfare to cover Health decisions) they may be able to make this decision in the best interests of the person, photocopy LPA docs and keep on person's file.	Yes		No	

Names of relatives/friends you have consulted	Contact/Email/ Telephone

13	Where there are NO relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) **MUST be instructed** (by the decision maker, i.e. person completing this form) if the decision is about **Serious Medical Treatment, a permanent accommodation move** or you have identified that you are likely to be depriving the relevant person of their liberty; **Deprivation of Liberty Safeguards** (DoLS). Call the local IMCA for further advice and to make a referral

Name of IMCA allocated	**Referral sent (date)**	**Tel/Email of IMCA**

14	**Detail any disputes or disagreements and who is disputing:** (Include details of what steps were taken to resolve the disputes) Attach other sheets if required.
15	**State final decision made in the person's best interests:** (please refer to Section 4 of the MCA or Chapter 5 of the MCA Code of Practice)

Declarations:

I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.

I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death.

I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter. I reasonably believe that the person does lack capacity (because of the impairment or disturbance in the functioning of their mind or brain), in relation to this matter and that it will be in the person's best interests for the decision to be made or act to be done.

I confirm that where the decision or act is intended to restrain, I believe that the restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.

Name of Assessor/Decision maker/person completing this form:	
Role/Job Title of the above:	
Signature:	
Date of completion:	
Date when decision will be reviewed:	

Appendix 4 – Best interest decision record form

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient			
Date of birth		Location	

-What treatment is being considered for covert administration? *(Consider inclusion of acute treatments for emergencies e.g., Antibiotics, Lorazepam)* **It has been confirmed that no advanced decisions are in place concerning this treatment.**		
-Why is this treatment necessary? -How will the person benefit? -Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g., NICE.		
-What alternatives did the team consider which were not successful? Examples - other ways to manage the person, other ways to administer treatment, different formulations such as liquids or dispersible tablets -Why were they not appropriate?	State the options tried:	
Treatment may only be considered for a person who lacks capacity. -When was Mental Capacity Assessment (MCA) for this issue completed?	Date:	
	Assessed by:	Name: Signature:
-Who was involved in the decision? N.B. A pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable (see Appendix 5) **If there is any person with Lasting Power of Attorney to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable.**	Name of health care professionals involved:	
	Name of relatives, advocates or other carers involved:	
-When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review - at least every three months)	Date of first planned review	

Important – please note that covert administration usually involves altering medicines and this may be <u>unlicensed</u> (off-label) activity. By signing this form the prescriber is also authorising unlicensed (off-label) use of medication. At present this can only be done by an independent prescriber.

Prescriber name:	
Signature:	
Date:	

Appendix 5 - Instructions for carers from pharmacist

This information should be included in the patient's care plan and with the medicines administration record (MAR) sheet.

- Instructions for administration must specify clearly how each medicine is to be administered.
- If possible, the prescriber should include additional instructions on directions on the prescription for community pharmacists to add to dispensing label
- Include any cautions such as temperature/types of food to avoid.

Practical points for care staff:

- ✓ *Before administering medication covertly the patient should be encouraged to take it in the normal way*
- ✓ *Care home staff should be aware of personal preferences for administration through the care plan*
- ✓ *In general, the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible*
- ✓ *Try and add the medicine to the first mouthful of food so that the full dose is received*
- ✓ *The medication must be administered immediately after mixing it with food or drink.*
- ✓ *Consider the taste and other possible effects of the medicine, particularly if tablets are crushed or contents removed from capsules*
- ✓ *Different medicines should not be mixed together in food or drink as this cannot be quantified and also could be unsuitable to be mixed together*
- ✓ *Covert administration must be recorded on the MAR chart (e.g. sign and use a specific code if necessary)*

Name of patient			
Date of birth		Location	

Medication:	Advice from pharmacist:	Resource(s) used:	Date:	Pharmacist signature:

Report to GP at next contact if:

- Covert administration results in a refusal to eat or drink
- It appears that the full dose of medication has not been taken (make a note on MAR chart)
- There appears to be a deterioration in the patient's health and well being.

Appendix 6 – Review form for Covert administration

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient		Date of birth	
Date review performed			

Is the medication still necessary? If so, explain why	
Is covert administration still necessary? If so, explain why	
Who was consulted as part of the review?	
Is legal documentation still in place and valid? (MCA assessment and evidence of Best interests discussion)	
Date of next review:	

Name of prescriber or pharmacist:	
Job role/title:	
Signature:	
Date:	

Appendix 7 – Samples of completed documentation

MCA 01 Mental Capacity Assessment Form for LESS complex decisions (November 2015)

1	**Name of Relevant Person** *Mr J Bloggs*	**Address of Relevant Person** *Rainbow Care Home, Anytown*					
2	**Preferred Name of Relevant Person**	*'Joe'*					
3	**Date of Birth**	*1/1/43*					
4	**NHS Number**	*1234567890*					
5	**I am starting this assessment on (insert date and time) …….***13/2/2020 at 2pm* **…….** **Although I presume capacity, I doubt the person is able to make this particular decision at this time.**						
6	**What is the decision that needs to be made?** *Whether the patient has capacity to consent or refuse treatment and whether receiving treatment covertly is necessary and in their best interest*						
7	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**	Yes	√	No			
7a	**Details of Impairment:** (For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, a dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition) *Has Alzheimer's Dementia*						
8	**Can the decision be delayed because the person is likely to regain capacity in the near future? Give Reasons below:**	Yes		Not likely	√	Not appropriate to delay	√
Patient is unlikely to regain capacity in the near future as Alzheimer's dementia is advancing and it is not appropriate to delay treatment with medication, as it is essential to prevent seizures.							
9	**Assessment (Please provide evidence for points 9a to 9d):**						
a. Person has ability to <u>understand</u> information related to the decision to be made? If answer is 'No' please provide evidence		Yes		No	√		
Details: *I asked Joe if he knew what his medication was for but due to his confusion (as a result of Alzheimer's disease) he was unable to answer the question and just replied 'I will have a cup of tea with sugar'. When asked how many tablets he was taking, he again replied 'just a cup of tea with sugar'. I then asked if the medication caused any side effects and he just pointed at another resident in the care home and said 'he's not very nice that man'*							
b. Person has ability to <u>retain</u> information long enough for the decision to be made? If answer is 'No' please provide evidence		Yes		No	√		
Details: *When I asked Joe if he knew who I was and the purpose of my visit, he just answered 'I'll have to be at work soon so you'll have to go'. He could not recall who I was or the purpose of my visit, even though I had introduced myself and explained my role a few minutes ago. Joe forgets the name of his main carer even if reminded frequently and sometimes refers to him as his dad. Joe was not orientated to time or place during assessment, which is usual for him according to main carer.*							
c. Person has the ability to <u>use or weigh up</u> the information in considering the decision? If answer is 'No' please provide evidence		Yes		No	√		
Details: *Joe was unable to comprehend very basic questions such as 'how are you?' To this he replied 'Is she bringing my clothes in today'. Joe was unable to demonstrate that he understands the consequences of the decision to be made. Subsequently I have concluded he would not have the ability to use or weigh up information related to his medication.*							
d. Person has ability to <u>communicate</u> their decision by any means? If answer is 'No' please provide evidence		Yes		No	√		
Details: (State what steps have been taken to achieve communication)							

Although Joe can speak English he is unable to communicate any decisions as he does not understand what decision is being made, cannot retain information for decision to be made and cannot weigh up the information provided, due to advanced Alzheimer's disease. Joe did not respond appropriately to any of the questions during the assessment, Alternative methods of communication (such as sign language) are not helpful in this case, due to level of confusion.

If you have answered YES to all of the questions 9a – 9d above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. If you have answered **NO** to one or more of those questions then on the balance of probability the person is not likely to have capacity for this decision and you will be required to proceed.

Details of any Advance Decisions to Refuse Treatment (ADRT): (Does any ADRT relate to this particular decision. Reference and attach any relevant documents)
No ADRT in place

Conclusion:

10	**Person HAS the capacity to make this informed decision at this time?**	Yes		No	√

Document and detail your evidence and give reasons for your conclusion:
It is evident following the assessment that Joe does not have the capacity to understand why it is important that he takes his medication. He was unable to answer very basic questions and has very poor short term memory.

11	**What is the persons Preferences/Wishes?** *N/A* NB. If person has the capacity for this decision you must respect their preferences and wishes, document these here and sign and date below the completion of this capacity decision. If they DO NOT have capacity for this decision you must still respect the rights, will and preferences of the individual and give weight to their views when making a decision in their best interests.		
Signed:	*Dr Who*	**Date of Completion:**	*13/2/20*

If person is found to lack the capacity to make this decision for themselves please continue

12	**Are there any known relatives or friends to consult with?** If they have Lasting Power of Attorney that covers this decision, i.e., Person Welfare to cover Health decisions) they may be able to make this decision in the best interests of the person, photocopy LPA docs and keep on person's file.	Yes	√	No	

Names of relatives/friends you have consulted *Daughter – Mrs Smith*	Contact/Email/ Telephone *Tel: 01234 456789*

13	Where there are NO relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) **MUST be instructed** (by the decision maker, i.e., person completing this form) if the decision is about **Serious Medical Treatment, a permanent accommodation move** or you have identified that you are likely to be depriving the relevant person of their liberty; **Deprivation of Liberty Safeguards** (DoLS). Call the local IMCA for further advice and to make a referral

Name of IMCA allocated	**Referral sent (date)**	**Tel/Email of IMCA**
N/A	N/A	N/A

14	**Detail any disputes or disagreements and who is disputing:** *No disputes* (Include details of what steps were taken to resolve the disputes) Attach other sheets if required.
15	**State final decision made in the person's best interests:** (please refer to Section 4 of the MCA or Chapter 5 of the MCA Code of Practice) *Agreed to administer essential medication in a covert manner*

Declarations:
I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.
I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death.
I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter. I reasonably believe that the person does lack capacity (because of the impairment or disturbance in the functioning of their mind or brain), in relation to this matter and that it will be in the person's best interests' for the decision to be made or act to be done.
I confirm that where the decision or act is intended to restrain, I believe that the restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.

Name of Assessor/Decision maker/person completing this form:	Dr Who
Role/Job Title of the above:	GP
Signature:	*Dr Who*
Date of completion:	13.2.20
Date when decision will be reviewed:	13.5.20

Sample – Best interest decision record form

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient	*Mr Joe Bloggs*		
Date of birth	*1/1/43*	Location	*Rainbow Care Home*

-What treatment is being considered for covert administration? *(Consider inclusion of acute treatments for emergencies e.g., Antibiotics, Lorazepam)* **It has been confirmed that no advanced decisions are in place concerning this treatment.**	- *Sodium Valproate 100mg crushable tablets* - *Antibiotics for acute treatment of infections* *There is no advanced decision in place*	
-Why is this treatment necessary? -How will the person benefit? -Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g., NICE.	- *To control seizures* - *To treat acute infections when necessary* *Treatment is essential for the health and wellbeing of the patient and should not be stopped*	
-What alternatives did the team consider which were not successful? Examples - other ways to manage the person, other ways to administer treatment, different formulations such as liquids or dispersible tablets -Why were they not appropriate?	State the options tried: *Staff tried various persuasive techniques, change of administration time, different staff members administering medication, also tried switching from tablets to liquids.* *Joe continued to refuse or spat out his medication routinely for more than a week*	
Treatment may only be considered for a person who lacks capacity. -When was Mental Capacity Assessment (MCA) for this issue completed?	Date:	*13/2/2020*
	Assessed by:	Name: Dr Who Signature: *Dr Who*
-Who was involved in the decision? N.B. A pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable (see Appendix 5) **If there is any person with Lasting Power of Attorney to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable.**	Name of health care professionals involved:	*Dr Who – GP* *Mrs White – Care Home Manager* *Mrs Brown – Senior Carer* *Ms Jones – Pharmacist*
	Name of relatives, advocates or other carers involved:	*Mrs Smith – Daughter*
-When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review - at least every three months)	Date of first planned review	*3 months – 13/5/2020*

Important – please note that covert administration usually involves altering medicines and this may be <u>unlicensed</u> (off-label) activity. By signing this form the prescriber is also authorising unlicensed (off-label) use of medication. At present this can only be done by an independent prescriber

Prescriber name:	*Dr Who*
Signature:	*Dr Who*
Date:	*13/2/2020*

Sample - Instructions for carers from pharmacist

This information should be included in the patient's care plan and with the medicines administration record (MAR) sheet.

- Instructions for administration must specify clearly how each medicine is to be administered.
- If possible, the prescriber should include additional instructions on directions on the prescription for community pharmacists to add to dispensing label
- Include any cautions such as temperature/types of food to avoid.

Practical points for care staff:

- ✓ *Before administering medication covertly the patient should be encouraged to take it in the normal way*
- ✓ *Care home staff should be aware of personal preferences for administration through the care plan*
- ✓ *In general, the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible*
- ✓ *Try and add the medicine to the first mouthful of food so that the full dose is received*
- ✓ *The medication must be administered immediately after mixing it with food or drink.*
- ✓ *Consider the taste and other possible effects of the medicine, particularly if tablets are crushed or contents removed from capsules*
- ✓ *Different medicines should not be mixed together in food or drink as this cannot be quantified and also could be unsuitable to be mixed together*
- ✓ *Covert administration must be recorded on the MAR chart (e.g. sign and use a specific code if necessary)*

Name of patient	*Mr Joe Bloggs*		
Date of birth	*1/1/43*	Location	*Rainbow Care Home*

Medication:	Advice from pharmacist:	Resource(s) used:	Date:	Pharmacist signature:
Sodium Valproate 100mg crushable tablets	*Tablet to be crushed (using tablet crusher or between two spoons), then dose to be added to small amount of soft food, e.g., yoghurt or jam. The tablets have a bitter taste. Please witness all the dose has been consumed by the service user*	*The NEWT Guidelines*	*13/2/2020*	Ms Jones

Report to GP at next contact if:

- Covert administration results in a refusal to eat or drink
- It appears that the full dose of medication has not been taken (make a note on MAR chart)
- There appears to be a deterioration in the patient's health and well being.

Sample – Review form for Covert administration

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient	*Mr Joe Bloggs*	Date of birth	*1/1/43*
Date review performed	*13/5/2020*		

Is the medication still necessary? If so, explain why	*Yes* - *To control seizures*
Is covert administration still necessary? If so, explain why	*Yes* *If offered medication in non-covert manner, Joe continues to spit out medication*
Who was consulted as part of the review?	*Mrs White – Care Home Manager* *Dr Who – GP* *Ms Jones – Pharmacist* *Mrs Smith – Daughter*
Is legal documentation still place and valid? (MCA assessment and evidence of Best interests discussion)	*Yes*
Date of next review:	*6 months - 13/11/2020*

Name of prescriber or pharmacist:	*Ms Jones*
Job role/title	*Pharmacist*
Signature:	*Ms Jones*
Date:	*13/5/2020*