Appendix 3 – Best interests decision record for covert administration

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

<table>
<tr><td>Name of patient</td><td colspan="3"></td></tr>
<tr><td>Date of birth</td><td></td><td>Location</td><td></td></tr>
</table>

<table>
<tr><td>-What treatment is being considered for covert administration? (Consider inclusion of acute treatments for emergencies e.g., Antibiotics, Lorazepam)</td><td colspan="2"></td></tr>
<tr><td>Are there any advanced decisions in place for this person concerning this treatment?</td><td colspan="2"></td></tr>
<tr><td>-Why is this treatment necessary?
-How will the person benefit?
-Could this treatment be stopped?
Where appropriate, refer to clinical guidelines, e.g., NICE.</td><td colspan="2"></td></tr>
<tr><td>-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?</td><td colspan="2">State the options tried:</td></tr>
<tr><td rowspan="2">Treatment may only be considered for a person who lacks capacity.
-When was Mental Capacity Assessment (MCA) for this issue completed?</td><td>Date:</td><td></td></tr>
<tr><td>Assessed by:</td><td>Name:
Role:
Contact details:</td></tr>
<tr><td rowspan="2">-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 4)
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.</td><td>Name of health care professionals involved with role and contact details:</td><td></td></tr>
<tr><td>Name of relatives, advocates or carers involved and contact details:</td><td></td></tr>
<tr><td>-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)</td><td>Date of first planned review</td><td></td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td>Prescriber name:</td><td colspan="2"></td></tr>
<tr><td>Signature:</td><td colspan="2"></td></tr>
<tr><td>Date:</td><td colspan="2"></td></tr>
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