Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Covert Administration of Medication (Adult)

Good Practice Guidance for care homes

Version 7.1

October 2024

For local adaptation to fit within individual Care Home medication policies

Document produced by: Care Home Medicines Optimisation Team,

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

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Version Control

Version	Date	Reviewer (s)	Revision Description
Version 1-4	Before 2017	Bedfordshire CCG (BCCG) Care Home Medicines Optimisation team	Archived
Version 5	12/2017	Bedfordshire CCG (BCCG) Care Home Medicines Optimisation team	- Improved format of content throughout document - Updated legislation and guidance - Added 'Summary of best interests checklist'. - Added 'General principles of correct administration'. - Useful contacts updated
Version 6	04/2020	Bedfordshire CCG, Luton CCG & Milton Keynes CCG Care Home Medicines Optimisation teams	- Organisation changed from BCCG to BLMK CCG in whole document - Section 6.1 -additional legislation and guidance added - Section 7.2 – new information added re: Ardens templates access on SystmOne - Section 8.4 – information added on consideration of acute treatment in plan e.g., antibiotics - Section 10 – new section on Liberty Protections Safeguards (LPS) added - Section 15 – new section on 'changes to medication' added - Appendix 1 -replaced flowchart with best practice checklist - Appendix 2 – added the need to provide evidence for section 9 of MCA assessment - Appendix 4 – updated format for 'Instructions for carers from pharmacist' - Appendix 5 – Review form added - Appendix 6 – samples of completed documents added
Version 7	06/2022	Bedfordshire, Luton & Milton Keynes ICB Care Home Medicines Optimisation team	-Section 2 – clearer definition of covert administration -Section 5 – Responsibilities updated -Section 7 – New stepwise (7-steps) process added -Section 8 – New section on Structured Medication Review (SMR) -Section 9 – clearer guidance on who can support with MCA assessment -Section 12 – New section on 'Obtaining Prescriber Authorisation' - Section 13 – updated record keeping and documentation section -Section 14 – added 'onus' on care home to ensure reviews done -Section 16 – New section on 'Transfer of Care' -Section 17 – LPS section removed and BLMK HCP Holding statement added -Section 18&19 – Practical points separated into two sections

			-Section 20 – updated reference links - Useful contacts updated - Updated IMCA details for each locality - Appendix 2 – New ‘Covert Administration Flowchart’ explaining stepwise process - Appendix 5 – updated to include practical points for care staff
Version 7.1	10/2024	Bedfordshire, Luton & Milton Keynes ICB Care Home Medicines Optimisation team	- Extension of guidance review date from 2 years to 3 years - Version control information added - Section 9 Assessing Mental Capacity – process has been elaborated with new sub-headings. MCA assessment questions moved under Stage 1. - Section 10 Best Interests Decision – process expanded with new sub-headings. Information on ADRT and LPA have been moved to this section. - Section 11 Management plan – additional advice included on checking interactions, practical advice for safe covert administration. Information on DoLS moved to this section. - Removal of information on LPS and BLMK HCP MCA& DoLS Holding statement - Section 13 Record Keeping and documentation - includes new information on care plan documentation. - Section 14 Regular reviews – includes additional information to support care homes with monthly reviews. Statement added to explain if there are no clinical changes then to document that all aspects remain the same on the review documentation. - Section 15 Legislation and Guidance – updated with new references including BLMK ICB MCA Policy and new case law - Useful contacts updated and new IMCA information added - Removal of previous ‘Best Practice Checklist’ - Appendix 2 – updated version of MCA assessment form in order of 2-stage process in line with case law. Best interests statement removed on form in line with ‘seven steps’ process. - Appendix 5 – Review form – additional questions added

The following individuals were consulted for comments on this guidance review.

Designation
BLMK ICB Mental Capacity Act Lead
BLMK ICB - Designated Nurse Adult Safeguarding
BLMK Local Authority MCA/DoLS Leads
Beds & Herts LMC Liaison Manager

Committee where guidance was discussed/approved/ratified.

Committee/Group	Date	Status
BCCG Prescribing Committee	Before 2017	Approved
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Bedfordshire CCG Prescribing Committee	10/3/2020	Approved
BLMK CCG Prescribing Committee	30/6/2022	Approved
BLMK ICB Prescribing Committee	17/10/2024	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

CONTENTS

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 lack of capacity will have access to effective medical treatment when it is considered to be clinically in their best interests.

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)[1] 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 1998.[2]

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.[3] As a result the person is unknowingly taking medication which they have previously refused when offered.

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.[4]
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. **This guidance ONLY applies to covert administration**, for further information on overt administration please refer to the quick reference guide on the care home page via the BLMK ICB Medicines website.

[1] Ethics (bma.org.uk)
[2] Human Rights Act 1998 (legislation.gov.uk)
[3] Covert administration of medicines in adults: legal issues, Specialist Pharmacy Service
[4] Best practice guidance in covert administration of medication, PrescQIPP Bulletin 101, 2015

3. Objectives

The ICB recognises the importance of respecting the autonomy of individuals who refuse treatment. However, there are times when a person does not have the capacity to consent or refuse treatment or to understand the consequences of refusing to take medicines.[5]

3.1 The practice of covert administration 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.

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

3.3 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] Covert administration of medicines in care homes - The Pharmaceutical Journal (pharmaceutical-journal.com)

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 (GP) 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 interests decision process followed, and all documentation has been completed.
- Crushing medications and mixing them with food/liquids often renders each medication unlicensed. The prescriber must therefore authorise such practice in writing prior to the administration of 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 interests 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 interests 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 Summary of Product Characteristics (SPC) for the medicine concerned, and to any appropriate reference sources to advise on suitability, for example NEWT guidelines.

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 Covert administration should only take place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines.

6.3 Covert administration is only likely to be necessary or appropriate where[6]:

- a person actively refuses their medicine **and**
- that person is assessed not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005 **and**
- the medicine is deemed essential to the person's health and wellbeing.

6.3 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. The medicine must be deemed essential to the person's health and wellbeing.
- **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 person. It must not be a decision taken alone.
- **Best interests decision -** all decisions must be in the person's best interests with due consideration to the holistic impact on the person's health and well-being.

[6] Covert administration of medicines - Care Quality Commission (cqc.org.uk)

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 to resolve reasons for refusals of medicines. During the review, clinicians should consider whether deprescribing is appropriate for the individual as a first line approach.
If issues are resolved whilst conducting a SMR, covert administration may not be necessary, and there may be no 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 a suitably trained pharmacist.

See Appendix 1 for 'Covert Administration Flow chart' including the above steps

8. Step 1: Structured Medication Review[7,8]

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 a 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 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.

8.7 If issues can be resolved during a SMR, covert administration may not be necessary, and there may be no need to proceed to the next step.

9. Step 2: Assessing Mental Capacity (see Appendix 2)

9.1 What is the Mental Capacity Act?

The Mental Capacity Act (MCA) applies to everyone who works in health and social care and is involved in the care, treatment or support of people aged 16 and over who live in England and Wales and who are unable to make all or some decisions for themselves. The inability to make a decision could be caused by a psychiatric illness (e.g., dementia), a learning disability, mental health problems, a brain injury, or a stroke.

The MCA is designed specifically to empower and protect an individual who may be unable to make decisions for themselves.

[7] Structured medication reviews and medicines optimisation, NHS England
[8] Quality Statement 6: Structured medication review, Medicines Optimisation Quality Standard, March 2016

9.2 What is Mental Capacity?

Having mental capacity means that a person is able to make their own decisions.

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 presumption of capacity - a person must be assumed to have capacity to make a decision unless it is established that they lack capacity.
2. Supporting individuals to make their own decisions - a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. For example, advocates or communication support may be necessary.
3. Unwise decisions – a person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. Best Interests - 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 their best interests.
5. Least restrictive - 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.

9.3 When should capacity be assessed?

An assessment of capacity may be needed where a person is unable to make a particular decision at a particular time because their mind or brain is affected by an illness or disability. Lack of capacity may not be a permanent condition.

An assessment of capacity should be time and decision specific, which means it must be about a particular decision that has to be made at a particular time and is not about a range of decisions. For example, if covert administration is being considered, the decision being assessed is whether the person has capacity to consent or refuse treatment with their medication.

A person cannot be assessed as lacking capacity based upon age, appearance, condition, or behaviour alone.

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.

9.4 Who should assess capacity?

- Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity – the two-stage process should be followed.
- The MCA is designed to empower those in health and social care to do capacity assessments themselves, rather than rely on expert testing by psychiatrists or psychologists – it is essential that anyone completing a MCA should have undertaken appropriate training to do so.
- In a care home setting, 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 or Specialist should be involved.[9]

- 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. If necessary, an assessment could be 'dual' signed as partnership working.

The law requires a prescriber to be responsible for determining whether medication should be administered covertly. Medical treatment is the responsibility of the prescriber. **The prescriber must ensure an assessment has been carried out by a competent person.[10]**

If the MCA assessment has been delegated to a senior carer or nurse, then 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.

The prescriber may still do their own MCA assessment if they are not satisfied by an assessment done by care home staff.

9.5 Assessing Capacity

To decide whether the person has capacity to make a particular decision, the following two questions must be answered:

Stage 1 - Is the person unable to make the particular decision after all appropriate help and support to make the decision has been given to them? (this is termed the functional test)

On the balance of probability, the person will be unable to make their own decision if they cannot do one or more of the following four things:

- **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 – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

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 is called the "Causative Nexus"). 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 (this is termed diagnostic test). Where there is a diagnosis relating to Stage 2, this should be documented. It is also good practice to record details and/or symptoms of the impairment or disturbance, for example, short-term memory loss, inability to process information, or takes time to process new information.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity for that decision at that time? There should be clear records of the assessment process and its findings to demonstrate how a conclusion was reached as to whether capacity is either present or lacking for the particular decision.

[9] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020
[10] GP mythbuster 96: Covert administration of medicines - Care Quality Commission (cqc.org.uk)

9.6 Outcome of assessment

The person will be deemed to lack capacity if they are unable to make a particular decision after all appropriate help and support to make the decision has been given to them and because of their impairment or disturbance in their mind or brain they cannot make that decision.[11]

- If the person is deemed to **lack** mental capacity, proceed to the best interests decision (Step 3)

- If the person is deemed to **have** mental capacity, the clinician should be mindful of the following:

  - 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. If the clinician is unsure about the ethics of the decision, they may wish to contact the BLMK ICB MCA lead in the first instance for advice. Any further advice may be obtained from their registered body.

  - A competent adult's refusal must be respected as much as their 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.

  - 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 interests and should be clearly recorded noting who took the decision, why the decision was taken and what treatment was given and when.

9.7 Mental Capacity Assessment Documentation

A MCA assessment should be completed and documented using a suitable MCA form – BLMK ICB recommends the 'MCA 01 Mental Capacity Assessment Form for LESS Complex Decisions (2024) V2 (see appendix 2).

This form can be accessed by GP staff on SystmOne via the 'Communications ( )' tab, under the 'Other' section. This allows completion of the assessment in the patients notes and can be saved in the journal.

See Appendix 6 for sample of completed MCA assessment

[11] BLMK ICB Mental Capacity Act Policy July 2024

10. Step 3: Best Interests decision (see Appendix 3)

10.1 What is 'Best Interests'

- If a person has been assessed as lacking capacity for the specific decision, then the decision made for, or on behalf of, that person, must be made in his or her best interests.[12]

- 'Best interests' is a method for making decisions which aims to be objective. It requires decision makers to think what the 'best course of action' is for the person. It should not be the personal views of the decision-makers,[13] and should reflect what the person would have wanted if they had capacity to make the decision themselves.

- The best interests decision should include a risk/benefit assessment which should be made by the prescribing clinician, and in discussion with relatives/advocates. Whilst nobody can consent for someone else (except a Registered LPA for Personal Welfare), the views of relatives/advocates may be beneficial in determining a person's wishes and feelings and what is in their best interests.

- When covert administration is being considered, holding a 'best interests' meeting is recommended by NICE. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. The 'best interests' meeting can take place remotely but there must be clear records of who was involved and what was agreed.[14]

10.2 Who should be involved in a Best Interests Decision for Covert Administration

A best interests meeting should be attended by:

- Care home staff,
- The healthcare professional prescribing the medicines,
- Any relevant healthcare professionals (which may include a pharmacist)
- 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.
- A LPA (If the resident has a Registered LPA for Personal Welfare appointed under the Mental Capacity Act for health and welfare decisions)[15]

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 4)

10.3 Advance Decision to Refuse Treatment (ADRT)

- A person may have expressed verbally or documented an advance decision to refuse specific treatments, which may relate to medical decisions and treatment. These may also be logged with the person's GP. ADRTs are legally binding if made in accordance with the Mental Capacity Act.[16]

[12] BLMK ICB Mental Capacity Act Policy July 2024
[13] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020
[14] GP mythbuster 96: Covert administration of medicines - Care Quality Commission (cqc.org.uk)
[15] NICE Quality Standard (QS85) Medicines Management in Care Homes, March 2015
[16] BLMK ICB Mental Capacity Act Policy July 2024

- 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.

10.4 Lasting Powers of Attorney (LPA)

- This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future.

- If the person lacking capacity has created a Personal Welfare LPA, the Registered Attorney is the decision-maker on all matters relating to the person's care and treatment.

- In order to act as the persons Registered LPA, they must provide an authorised copy of the LPA documentation to the professionals working with the person to allow the LPA to make those decisions. This must be checked to be clear about what decisions the Registered LPA is allowed to make. Unless the documentation specifies limits, the LPA has the authority to make personal welfare decisions and consent to or refuse treatment on that persons behalf.

- If the Registered LPA does not produce the documentation, or allow access to it, then professionals can assume it does not exist, and the best interests pathway should be followed.

- The LPA must make these decisions in the best interests of the person lacking capacity and if there is a dispute that cannot be resolved, for example, between the LPA and a doctor, it may have to be referred to the Court of Protection.[17]

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.[18]

10.5 Best Interests decision process for Covert Administration

When covert administration is being considered for a person lacking mental capacity, the best interests process in section 4 of the Mental Capacity Act 2005 should be followed.

This process is summarised below, and each element must be followed when making a decision for someone else.

1. Consider all the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision - **and**
2. Consider a delay until the person regains capacity - **and**
3. Involve the person as much as possible - **and**
4. Not to be motivated to bring about the person's death - **and**
5. Consider the individual's own past and present wishes and feelings - **and**
6. Consider any advance statements or ADRT's made - **and**

[17] Making decisions: a guide for people who work in health and social care - GOV.UK (www.gov.uk)
[18] BLMK ICB Mental Capacity Act Policy July 2024

7. Consider the beliefs and values of the individual - **and**
8. 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**
9. Take into account views of any Independent Mental Capacity Advocate (IMCA) or other key people involved (e.g., Registered LPA) - **and**
10. Show evidence and document it is the least restrictive alternative or intervention.
11. Ensure other options have been explored, for example, have patterns of behaviour been 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?
12. Check if care staff have undertaken dementia training and engaged techniques to encourage medication to be taken in the normal way.
13. Make sure there is an identified need for covert administration for each individual medicine prescribed.
14. Consider including acute treatments for emergencies in the process (e.g., Antibiotics to treat infections or medication such as Lorazepam to manage distressing behaviours).
15. Be mindful that 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 person's nutrition. A dietician should be consulted if there are concerns.

10.6 Outcome of Best Interests Meeting

All decisions must be formally agreed to be in the person's best interests and must be a multi-disciplinary team decision. It is essential to always remember the potentially abusive nature of this process and for this reason assurance is needed that there is really no other option.

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.

10.7 Best Interests Decision Documentation

A Best Interests decision should be completed and documented using a suitable form – BLMK ICB recommends the use of the 'Best interests decision record form' found in appendix 3. This form can be accessed via the 'Communications ( )' tab, under the 'Other' section.

11. Step 4: Management Plan

A management plan should be put into place after a best interests decision has been made to administer medication covertly. The management plan should be added to the person's care plan to ensure that all carers involved in administration of medication are aware of the correct process for that individual.

The management plan should include the following:

11.1 Outcome of the Best Interests decision

There should be clear, accessible documentation of the decision of the best interests meeting to indicate the outcome of the decision is to administer medication covertly. (see appendix 3).

11.2 Medication review by a pharmacist

The purpose of this review is to check the medication can be covertly administered safely. The review will need to consider pharmaceutical issues as well as patient preferences and should include the following:

- Advice sourced from standard texts, the SPC for the medicine(s) concerned, and appropriate reference sources to advise on suitability for covert administration.

- A check to ensure that the properties of the medication (e.g., its bioavailability) would 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.

- Rationale for product choice - 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.

- Consideration as to whether 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) is preferable.

- Advice on 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.

- Instructions for administration which must specify clearly how each medicine is to be administered. Particular attention should be given where medication can interact with food or drink, for example, tea, milk, grapefruit juice and cranberry juice can have interactions with some medication. In addition, any cautions around temperature should be included and highlighted.

- Consideration of 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. 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] Covert administration of medicines in adults: pharmaceutical issues, 14 January 2020, Specialist Pharmacy Service

- Advice on the best way to hide the taste, such as using strongly flavoured drinks such as blackcurrant juice, or foods such as yoghurt or jam. Individual likes and dislikes should be checked with family or carers to decide what might be suitable.

- Written documentation of advice - the pharmacist should provide, in writing, clear instructions for carers on how the medication should be administered. The template form in Appendix 4 could be used and this form can be accessed via the 'Communications ()' tab, under the 'Other' section. This allows completion of the assessment in the patients notes and can be saved in the journal.

11.3 Practical Advice for safe covert administration within the care home

The management plan should include information and advice on how to safely undertake covert administration of medication. The following points should be considered:

- Care homes should have a robust process to ensure it is clear that a person has a management plan for covert administration in place and to advise staff to refer to the best interests decision documentation. This could be highlighted on the person's profile sheet alongside their MAR chart, or on the equivalent summary page on eMAR systems.

- Care home staff should be aware of personal preferences for administration through the care plan.

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

- 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.

- Refusal after appropriate steps have been taken, as detailed in the care plan, can then proceed to covert administration.

- Staff should have appropriate equipment to be able to crush tablets safely, such as a tablet crusher or mortar & pestle. Staff should undertake 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.

- In general, the medication which is to be administered covertly should be mixed with the smallest volume of food or drink possible (rather than the whole portion). If possible, staff should add the medicine to the first mouthful of food so that the full dose is received.

- Not all drinks are suitable - tea, milk, grapefruit juice, cranberry juice are drinks that can interact with some medication – the 'Instructions for carers from pharmacist' form should be followed to ensure the medication is mixed with suitable food or drink.

- 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.

- 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 were mixing different medicines together may need to be carried out in the best interests

of the person. If this is the case, it should be agreed by a multidisciplinary team and clearly documented in the care plan.

- 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.

- Care home staff should ensure administration is recorded in the correct manner – see Step 6 – Record Keeping and Documentation.

11.4 Review plan

The management plan should include details of the 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. See Step 7 for further information on reviews.

11.5 Deprivation of Liberty Safeguards (DoLS)

- Deprivation of Liberty Safeguards (DoLS) has to be a consideration if medication is administered covertly and this should be included in the Management Plan.

- 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.

- Deprivation of Liberty Safeguards 2009 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 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.[20] 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.

- 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.[21]

- Patients with existing DoLS must have a covert administration plan declared and listed as administration of medication covertly is an impingement of the person's basic rights and freedoms. In addition, 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.

11.6 Changes to medication

- The care home should have robust processes to ensure that 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. The legal process must be followed including conducting a new MCA assessment.

[20] BLMK ICB Deprivation of Liberty Safeguards Policy (2024)
[21] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

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

- Any new medication added to the plan must be reviewed by a pharmacist so they can advise the care home how the medication can be covertly administered safely.

12. Step 5: 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.[22]

12.5 There should be clear documentation to indicate the prescriber has authorised unlicensed use of medication. The 'Best interests decision record form' in Appendix 3 can be used as a record – by signing the form, the prescriber is also authorising the unlicensed use of medication.

13. Step 6: Record Keeping and documentation

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.[23]

13.1 MCA assessment and Best Interests documentation (See Appendix 2 & 3)

- **The prescriber has overall responsibility for ensuring the completion of both the mental capacity assessment and the best interests decision record to support covert administration.** As per section 9.4 the MCA assessment can be delegated to an appropriately trained senior carer or nurse involved in the daily administration of medication to the patient.

[22] Covert administration of medicines in adults: legal issues, 19 January 2022, Specialist Pharmacy Services
[23] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

- The MCA assessment and Best Interests decision can be recorded using the forms as per appendix 2 & 3. This form can be accessed via the 'Communications (➡)' tab, under the 'Other' section.
- The completed documentation must be saved or scanned in the patient's clinical notes at the surgery.
- Copies of the forms 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 manner as appropriate.

- It is good practice for all documentation to be in place with the provider and at the surgery within 48 hours of the assessment being conducted.

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

13.2 Care Plan documentation:

Care homes must include the following in a covert medicine management care plan:

- Outcome of MCA assessment which indicates the person has:
  - Lack of understanding about what the medicine is for
  - Lack of understanding of the consequences of refusing to take a medicine
- Outcome of Best interests decision
- Any relevant ethical, religious, or personal beliefs about treatment
- Actions taken to give medicines in the normal manner
- Advice from pharmacist on how each medicine will be administered covertly, for example crushed or mixed with certain food or drinks
- Whether the medicine is unpalatable
- Adverse effects (actual or perceived)
- Swallowing difficulties
- What to do if the person refuses food or drink

13.3 MAR chart documentation:

- 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 chart or electronic MAR (eMAR) system 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.

- Where covert administration has been unsuccessful (i.e., refusal of the food or drink containing medication), this must be documented using an appropriate code on the MAR chart or on eMAR, if possible. Staff may also document 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.

13.4 Transfer of care documentation

- It is essential that, should the person receiving their medication covertly be transferred to another care facility or to Domiciliary Care, 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.[24]

14. Step 7: Regular reviews (see Appendix 5)

14.1 The need for continued covert administration should be reviewed within time scales based on the person's individual circumstances. This should be agreed at the time of implementation of covert administration.

14.2 A review of the care plan relating to covert administration of medication should be done **monthly by the care home** to check if covert administration is still required. This review should include an audit of the MAR chart or eMAR to check frequency of covert administration; feedback from staff; discussions around whether any suspected change in capacity and any issues around refusing food or drink containing the covert medication. The review should be documented in the care plan. Any ongoing or new issues with the plan could be discussed at a 'weekly check-in' with the aligned GP surgery if needed.

14.3 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 suitably trained pharmacist. The review process must also include a review of capacity and best interests decision. If there have been any changes (e.g., in medical condition, medication changes etc) then the MCA assessment and best interests processes should be repeated. However, if there are no changes, then this should be documented, specifying that all aspects remain the same. A full review of a covert administration plan could take place at a multidisciplinary meeting (MDT).

14.4 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 interests review process must be more frequent and well documented.

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

14.6 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.

14.7 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.

14.8 The removal of a covert administration care plan must only be made if everyone involved in best interests 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. 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.[25] The provider may

[24] Deprivation of Liberty Safeguards (DoLS) - Care Quality Commission (cqc.org.uk)
[25] Covert administration of medication, PrescQIPP C.I.C. Bulletin 269, October 2020

also need to notify the "Responsible Supervisory Body" or DoLS team if the covert administration care plan has been removed.

14.9 The review can be documented using the form as per appendix 5. This form can be accessed via the 'Communications ( )' tab, under the 'Other' section. The 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.

15. Legislation and Guidance

This guidance should be read in conjunction with:

- BLMK ICB Mental Capacity Act Policy 2024
- BLMK ICB Deprivation of Liberty Safeguards Policy 2024
- 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
- GP mythbuster 96: Covert administration of medicines - Care Quality Commission (cqc.org.uk)
- 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
- Mental Capacity Act toolkit (bma.org.uk)
- 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
- Assessing capacity - SCIE
- NICE and SCIE – Giving medicines covertly: A quick guide for care home managers and home care managers providing medicines support
- Capacity for care providers – Mental Capacity Law and Policy
- **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
  - A, Re (Covert Medication: Residence) [2024] EWCOP 19 (20 March 2024) (bailii.org)
  - AG, Re [2016] EWCOP 37 (6 July 2016) (bailii.org)

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  Mobile: 07557 084916

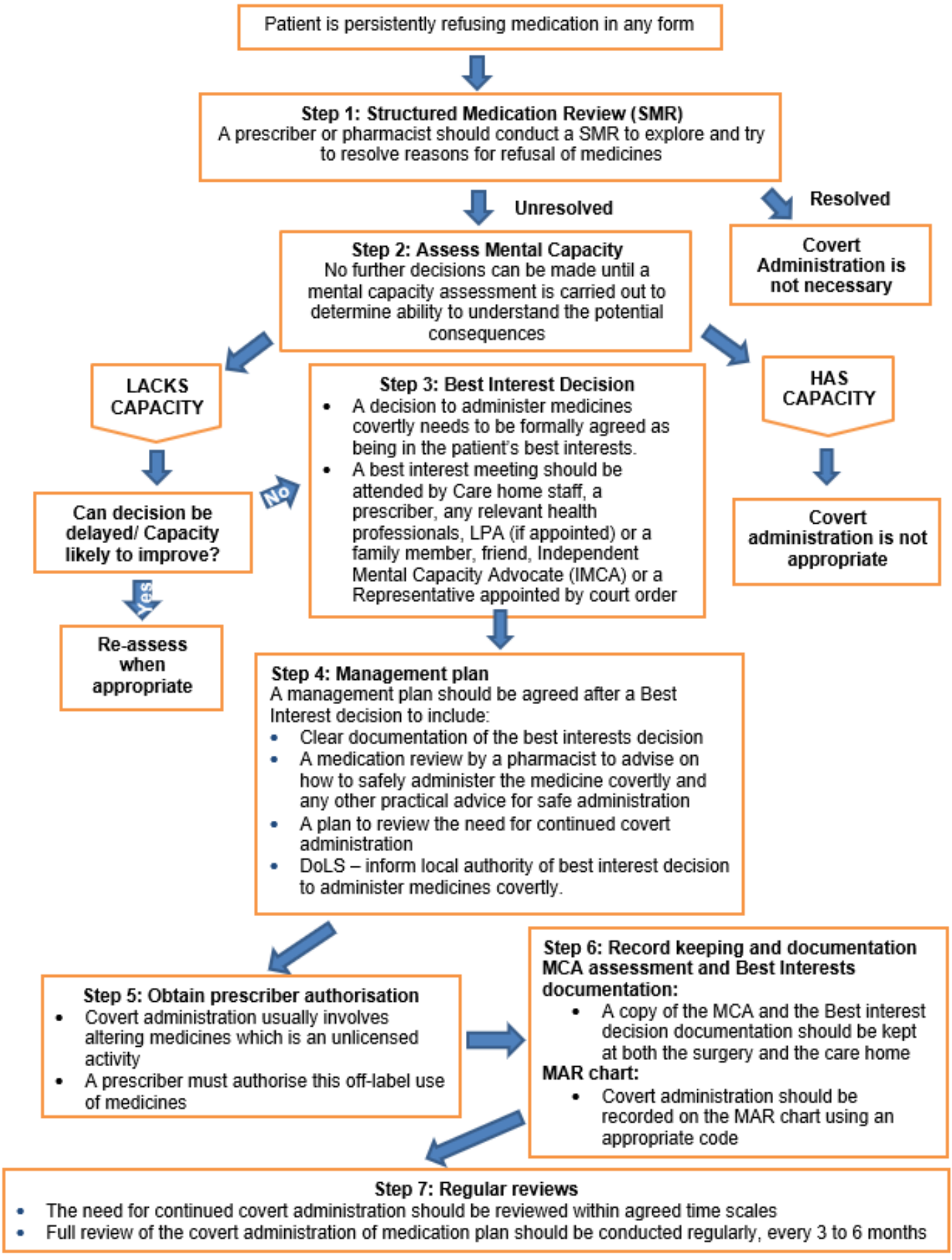
- Office of the Public Guardian (OPG)
  OPG can be contacted to find out if someone has an LPA or Deputy acting for them.
  You need to complete form 'OPG 100' to search the register. This is a free service.
  Send your completed form to: Office of the Public Guardian
  customerservices@publicguardian.gsi.gov.uk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

Independent Mental Capacity Advocacy Providers in BEDFORDSHIRE LUTON AND MILTON

Bedford Borough & Central Bedfordshire	Luton	Milton Keynes
VoiceAbility t: 0300 303 1660 option 2 e: helpline@voiceability.org w: voiceability.org	*Community Connex* t: 0208 869 8484 e: hello@communityconnex.co.uk w: https://communityconnex.co.uk	*The Advocacy People* t: 0330 440 9000 e: info@theadvocacypeople.org.uk w: theadvocacypeople.org.uk/

KEYNES:

Appendix 1 - Covert Administration Flow Chart



Appendix 2: MCA 01 Mental Capacity Assessment Form for LESS Complex Decisions (2024) V2

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	**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		
8	**Assessment:**							
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)								
9	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**	Yes		No				
9a	**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)							
If you have answered YES to all of the questions 8a – 8d 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)								

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 person's 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.					
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.

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 a best interests meeting will be convened to discuss administering essential medication in a covert manner.

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 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.

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)*		
Are there any advanced decisions in place for this person 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: Role: Contact details:
-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.**	Name of health care professionals involved with role and contact details:	
	Name of relatives, advocates or carers involved and contact details:	
-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 4 – Covert instructions for carers from pharmacist

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

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*
- ✓ *Pay particular attention to the pharmacist's advice with regards to specific instructions for how each medicine should be given, including cautions such as temperature/types of food to avoid.*
- ✓ *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 or an appropriate healthcare professional 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 5 – 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	
Have there been any changes since last review? (e.g., changes in medical condition, new medication etc). If no, please state 'all aspects remain the same' For any changes was the legal process repeated with new MCA assessment and Best Interests discussion? If no, then to be conducted	
Where there have been no changes since the last review, is legal documentation still in place and valid? (MCA assessment and evidence of Best interests discussion)	
Are the covert administration instructions (from pharmacist) up to date?	
Who was consulted as part of the review? Include roles and contact details	
Date of next review:	

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

Appendix 6 – Samples of completed documentation

MCA 01 Mental Capacity Assessment Form for LESS complex decisions (2024) V2

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 with medication and whether receiving treatment covertly with medication is necessary and in their best interests*						
7	**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.							
8	**Assessment (Please provide evidence for points 8a to 8d):**						
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.*							
9	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**	Yes	√	No			

9a	**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*				

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.

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: 07777 123456*

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.

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 a best interests meeting will be convened to discuss administering essential medication in a covert manner.

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 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.

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)*	- *Sodium Valproate 100mg crushable tablets* - *Antibiotics for acute treatment of infections*	
Are there any advance decisions in place for this person concerning this treatment?	*There are no advance decisions in place for 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.	- *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* Role: *GP at surgery* Contact details: *tel.01234 567890*
-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.**	Name of health care professionals involved with role and contact details:	*Dr Who – GP (tel.01234 567890)* *Mrs White – Care Home Manager (tel: 09876 543210)* *Mrs Brown – Senior Carer at the home* *Ms Jones – Pharmacist (tel: 01234 098765)*
	Name of relatives, advocates or carers involved and contact details:	*Mrs Smith – Daughter* *(tel: 07777 123456)*
-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 – Covert instructions for carers from pharmacist

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

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*
- ✓ *Pay particular attention to the pharmacist's advice with regards to specific instructions for how each medicine should be given, including cautions such as temperature/types of food to avoid.*
- ✓ *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 or an appropriate healthcare professional 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 – covert administration is required on some days* *Administration depends on Joe's mood on the day, some days he will accept his medication when offered in the normal way (non-covert manner), but on other days he will refuse or push your hand away. In this instance staff may have to resort to administering his medication covertly.*
Have there been any changes since last review? (e.g., changes in medical condition, new medication etc). If no, please state 'all aspects remain the same' For any changes, was legal process repeated with new MCA assessment and Best Interests discussion? If no, then to be conducted	*No changes to medical condition or medication, all aspects remain the same since covert administration plan was implemented on 13/2/2020* *N/A*
Where there have been no changes, is legal documentation still place and valid? (MCA assessment and evidence of Best interests discussion)	*Yes* *MCA assessment conducted 13/2/2020* *Best Interests discussion held on same day 13/2/2020 and decision documented*
Are the covert administration instructions (from pharmacist) up to date?	*Yes – no changes*
Who was consulted as part of the review? Include roles and contact details	*Mrs White – Care Home Manager (tel: 09876 543210)* *Dr Who – GP (tel.01234 567890)* *Ms Jones – Pharmacist (tel: 01234 098765)* *Mrs Smith – Daughter (tel: 07777 123456)*
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*