Kent and Medway CCG

Covert Administration

Best Practice Guidance

Approved by KMMOC and Clinical Cabinet
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Contents

Background

Section 44 of The Mental Capacity Act 2005 made it a criminal offence to wilfully neglect care. So, for patients/residents lacking capacity to accept or refuse medication, covert medication must be considered.

Covert administration can only occur in exceptional circumstances where the resident has been assessed under the Mental Capacity Act 2005 and there has been careful assessment of patient's needs through a best interests meeting.

The refusal of medicine by a resident who has capacity must be respected. If a resident is refusing their medicines they should be asked why they have decided to do this to establish if there are issues that can be addressed.

Covert administration of medicines is a complex issue and involves the administration of a medicine disguised in food or drink to a resident who resists it when given it openly, where a best interest meeting has been held with the appropriate people and it is agreed to be in the best interest of the resident to do so.

This practice applies exclusively to those people who lack the capacity to consent to treatment under the Mental Capacity Act 2005.

Consent and Capacity

A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life.

Care staff must respect a competent adult's refusal as much as they would his or her consent. Failure to do so may amount not only to criminal battery or civil trespass, but also to a breach of Article 8 of the European Convention on Human Rights, the right to respect for private and family life.

The exception to this principle concerns treatment authorised under the relevant mental health legislation (Mental Capacity Act 2005).

The Mental Capacity Act 2005 defines mental incapacity and how it should be assessed. The Act states that there must be a presumption of capacity even when a person makes an unwise decision, unless it has been established that the person lacks capacity to make a particular decision, and the treatment options must be the least restrictive possible on the person's rights and freedom.

Deprivation of Liberty Safeguards (DoLS) may be authorised to reasonably restrict a person's liberty in their best interests if they are under continuous supervision and control and lack mental capacity to decide on their care, accommodation, and treatment. Deprivation of

Liberty Safeguards are statutory checks that aim to ensure that any care which restricts a person's liberty is both appropriate and in their best interests.
If a patient has been deemed to not have capacity, decisions can be made on their behalf in their best interest and covert administration of agreed medications may be judged as being in their best interest. If a resident is judged to have capacity, covert medication **cannot** be used.

Policy

Detail of the process and procedure must be managed and documented within each care home's policies and procedures. Content of the process must include an initial assessment to verify a resident's capacity. The resident must have an assessment to confirm whether they can accept or refuse medication, by care home staff.

The following stages need to be considered:

1) Representation

Who should decide the resident's use of medication? Is there an Advance care plan covering medication in place?

Nursing home staff should take the opportunity to discuss the issue of covert administration with residents in the early stages of dementia, or when they have 'capacity', so that patients themselves can be involved in decisions in advance about any covert administration that may become necessary. Discussions ideally should involve family members if possible and all decisions made should be documented in patients' medical records and in care plans at the home. End of Life Practitioners (Care Home Team) should help with advanced care planning needs.

The resident may have appointed Lasting Powers of Attorney (LPA) registered through the Office of the Public Guardian to act on their behalf if they are no longer able to make decisions

2) Collaboration

In a care home, covert medication should only be given to adult patients who have been assessed as lacking capacity, and a best interest meeting conducted with the conclusion the medication should be administered in the best interest of the resident. The purpose of the best interest meeting is to discuss the treatments options for the resident in light of their capacity and whether it is in the patient's best interests to have his/her medications administered covertly.

A management plan should be agreed as part of the best interest meeting including the joint decision making and rationale for decisions made on behalf of the residents well-being and care will be documented within the management plan. Please follow guidance on conducting a best interest meeting, this can be found on the
Medway council website.
https://www.medway.gov.uk/downloads/file/1063/mca_best_interest_meetings
Kent county council website

https://www.kent.gov.uk/social-care-and-health/information-for-professionals/mental-capacity-act/mca-forms-and-policies

At a Best Practice Meeting the following representatives should be present:

- care home staff
- relevant health professionals (including the prescriber and pharmacist)
- a person who can communicate the views and interests of the resident (e.g. a family member, friend, or independent Mental Capacity Advocate (IMCA), depending on the resident's previously stated wishes and individual circumstances)
- an Lasting power of attorney (LPA) for health and welfare, if the patient has appointed one.

If a patient made an advance decision (while they had had mental capacity to do so) to refuse a particular medical treatment, then that has to be followed, but refusal of life-sustaining treatment has to be in writing. In some circumstances, if it is not possible or practicable to have a face-to- face meeting, then a decision regarding covert medication can be made as long as a discussion has taken place with all the relevant people. All discussions must be documented including who was involved in making the decision and what was agreed.

3) Alternatives

The decision to **administer medication covertly must not be considered routine**; the resident's nominated doctor or a pharmacist must be contacted to discuss alternative formulations to jointly explore alternatives to covert medication.

Some examples that may be considered are alternative formulations if there are swallowing difficulties or changing the time of day medication can be given if patient is drowsy.

Crushing medicines and mixing medicines with food or drink (to make it more palatable or easier to swallow) for administration when the person has consented /has capacity does not constitute covert administration.

If administering medicines with food or drink expert advice must be sought from the pharmacist. These options should be discussed with the doctor or the pharmacist, and there may also be a need to discuss the necessity of the medication.

4) Evidence

Care Plans should show assessment of capacity and assessment of need and who was involved in the assessment process. Records of details also to be included in any medicines

profiles.

Evidence of DoLS, if in place, should also be kept.

Written agreement of the decision to administer medication covertly, the action taken and the names of all parties concerned should be obtained and documented in the resident's care plan and medicines profile. This decision should be reviewed regularly, the timescale of the review should be based on the individuals circumstances. Mental capacity assessments should also be reviewed and recorded regularly to continue to support any decisions made. An example of such a document is included at the end of this guidance (Covert Medication Form Page 6).

The decision should also be documented on the resident's MAR chart. If not involved in the decision, the community pharmacy should be informed of the agreed administration information so that MAR charts can be updated accordingly. So that all staff administering the resident's medicines are aware of the reasons and method for covert administration for each medicine concerned.

5) Administration

The method of giving the medication covertly is checked with a pharmacist who is in the best position to advise and to ensure the medication remains efficacious and it's pharmaceutical integrity and stability are not affected so that the patient still benefits from the medication once crushed and mixed with food.

MARs: The Medicine Administration Record Sheet (MARs) sheet will be used to document the medication given covertly. Any instructions and information related to the administration of covert medication must be documented on the MARs Sheet.

6) Regular reviews

Review for the need of covert administration by the care home Manager or registered responsible person, with a nurse or clinician, must be on a planned and regular basis, and recorded. Each subsequent new medication added to the regime should trigger a review. The decision to administer each additional new medicine covertly or any change in the administration regime must be communicated to the supervisory body or relevant person's representative, and the DoLS reviewed.

7) Supervision

Care home staff administering medication covertly should have on-going training/clinical supervision.

The ultimate decision to administer medicines covertly must be one that has been informed and agreed by the multidisciplinary team caring for the resident.

Support Contacts

- The Care Quality Commission Tel: 03000 616161
- The Nursing and Midwifery Council: 0207 333 9333
- Integrated care team at Kent and Medway CCG - kmccg.medicinesoptimisation@nhs.net

Further Information

- Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety.
- Further information on the handling of medicines in Social Care' can also be found on the Royal Pharmaceutical Society website: www.rpharms.com
- Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents
- Royal College of Psychiatrists statement on the use of covert administration. http://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf
- NICE QS85 (derived from the NICE SC110 guidance)
- NICE Guideline 108 on Decision-making and mental capacity

Acknowledgements

NHS Medway CCG

https://www.nationalcareforum.org.uk/wp-content/uploads/2019/11/Homely-Remedies-guide.pdf

Covert Medication Form

Name of Resident		Date of birth	

Care home		Date	
Completed by		Position	

Capacity assessment completed	**YES/NO** if no this **must** be completed prior to covert administration being considered
Name and signature of staff member completed mental capacity assessment	
Date mental capacity assessment completed	
Does patient have insight in to their condition? Do they have capacity to make a decision regarding medication?	
What other treatment has been considered? Why were these rejected? (e.g. alternative methods of administration or other ways to manage the person / behaviour)	
If known, what are the past views of the patient regarding treatment?	

List of medication being considered for covert administration	Why is the treatment essential and in the best interest of the patient

The decision to administer medicines covertly has been discussed and agreed by

	Name and signature	Date
Named nurse		
GP		
Next of Kin/Advocate		
Other specify role		
Review date		

Covert Medication Administration Details Form

To be completed by a pharmacist

Name of Resident		Date of birth	
Care home		Date	
Name of pharmacist		Organisation	

Name of current medication, form, strength, dose and frequency	Details of any changes (e.g. preparation, new frequency/dose if appropriate)	Administration details (e.g. crush and mix with water/food etc)

Covert Administration Review Form

This form is to be used to evidence a review for the continued need of covert administration.
If significant changes to medications have been made since initial meeting, the covert medication plan should be fully updated.

Name of Resident		Date of birth	
Care Home		Date of review	
Reason for review	Change to treatment / Review date / Change in circumstances		
Is covert administration still required	YES/NO		
Give reason for decision			
Are all the relevant legal documentation still in place and up to date (DoLS/mental capacity assessment)			
Are all medications still necessary	YES/NO		
If no give details			
Name and role of persons involved in review			
Name and position of person leading review		Date	
Signature			
Name and position of 2nd person completing review		Date	
Signature			
Date of next review			