NHS
Herts Valleys
Clinical Commissioning Group

COVERT ADMINSTRATION OF MEDICATION POLICY FOR CARE HOMES IN WEST HERFORDSHIRE

Document Control Summary

Title	Covert administration of medication policy for care homes.
Purpose of document	To provide guidance for care home staff regarding the covert administration of medication to adults and older people in care homes.
Status	Final
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1. Introduction

1.1 Herts Valleys Clinical Commissioning Group strives to ensure safe practice for administration of medication within care homes. An important part of care is the prescription and administration of medicines, which must be undertaken lawfully at all times.

1.2 National Institute for Health and Clinical Excellence (NICE) defines covert administration as when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.[1]

1.3 The Nursing and Midwifery Council (NMC) recognizes that there may be exceptional circumstances in which covert administration may be considered to prevent a resident from missing out on essential treatment.[2,3,4]

1.4 This policy provides guidance for staff regarding the covert administration of medicines and explains when this can be done within the law.

2. Aim of Policy

2.1 The practice of offering medication in food or drink is only allowable in particular circumstances and could be open to abuse. The aim of this policy is to provide guidance as to when this practice is lawful, and to ensure that if it happens in a care home, it has been properly considered, thorough consultations have been made and that the practice is transparent and open to public scrutiny and audit.

2.2 The covert use of medication should only be used in exceptional circumstances and must be necessary and in accordance with the Mental Capacity Act 2005(MCA). The Mental Capacity Act sets out the need for a multidisciplinary approach in decision making [5] .

3. Scope of policy

3.1 This policy applies to all adults who are residents within care homes in West Hertfordshire. It does not apply to children and adolescents.

3.2 In general terms, if a resident has the capacity to refuse medical treatment then this decision must be respected, and covert administration of medication would be unlawful.

3.3 It is necessary to distinguish between the concealing of medication in food or drink, and a co-operative process where consenting patients who find taking medication difficult have the medication delivered in food or drink for ease of ingestion/swallowing, in which case it is not necessary to consider that the medication has been given covertly.

3.4 The Mental Health Act provides for the administration of psychiatric treatment to patients who refuse such treatment, and in some situations it may be clinically appropriate to administer other oral medications by covert means.

3.5 However patients being treated under the Mental Health Act may not be treated for physical illness if they refuse treatment and have the mental capacity to do so; unless the physical illness arises as a result of the resident's mental state.

3.6 Adults who lack the mental capacity to consent to or refuse treatment may need to be treated under the framework of the Mental Capacity Act 2005.

4. Assessment of Residents Refusing Treatment

4.1 If a resident is actively refusing treatment, attempts must be made to alleviate any contributory factors. The prescribing GP/clinician should, if possible, discuss the reasons for refusal with the resident, explaining why the treatment has been prescribed.

4.2 If the refusal persists, the prescribing GP/clinician with the care home staff should conduct and document a formal assessment of capacity, using the framework of the Mental Capacity Act 2005, unless the refusal concerns treatment of a mental illness, in which case consideration needs to be given to using the Mental Health Act, if the resident meets the criteria for detention under the Act.

4.3 If it is established that the resident lacks capacity to make the relevant decision, then a best interests decision must be made to decide how to proceed, using the guidance contained in the Mental Capacity Act 2005 Code of Practice, taking into account the following factors.

a) A review as to whether it is essential to continue with treatment, and a judgment about the relative importance of the treatment to the residents quality of life and general health, bearing in mind the need to identify the least restrictive option that will meet the person's needs.

b) The resident's views and stated reasons for refusal and any advance decision to refuse treatment made by the resident when they had capacity to do so.

c) The wishes of the nearest relative/carer or an advocate for the resident should be sought, and in particular any attorney appointed for health and welfare issues under a Lasting Power of Attorney must be consulted, along with any deputy appointed by the Court of Protection.

d) The views of the multidisciplinary team [MDT] should be sought where applicable (this may include a pharmacist or other healthcare professional who provide care to the resident)

4.4 If it is decided that it is necessary to provide the treatment in the best interests of the person, and that in order to do so it may be necessary to administer medication by covert means, the care home staff should facilitate the completion of a Covert Medication Risk assessment and ensure that all team discussions and consultations with others are fully documented in the resident's notes, including a detailed care plan.

4.5 Relevant professionals who have made recommendations as part of the MDT must sign and date the risk assessment.

4.6 It is important to make the pharmacist who supplies the patients' medicines aware of the outcome of the risk assessment even if they are not required to input into the process.

5. **Mental Capacity**

5.1 Residents who have the mental capacity to make choices about their treatment must be given the opportunity to do so and their wishes should be respected and documented. Residents with a cognitive impairment may retain the capacity to make particular health care decisions.

5.2 The assessment of capacity is always time specific for any decision that needs to be taken. Mental capacity should be assessed in accordance with the principles and guidance of the Mental Capacity Act 2005 and code of practice, which requires a two stage test, first to establish that there is an impairment or disturbance of the mind, and then to establish whether that disturbance renders the person unable to make the decision in question.

5.3 If a person is judged to lack mental capacity to make a particular decision then a best interests decision needs to be made, in accordance with the Mental Capacity Act 2005 code of practice, which allows for proportionate interventions where authority to treat may be given under section 5 of the Act.

5.4 Covert administration of medications to a patient 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[6,7]

5.5 The Mental Capacity Act 2005 includes Deprivation of Liberty Safeguards (DoLS). DoLS are a set of checks that apply to patients in a hospital or care home, who lack capacity to make decisions about their care and treatment. They aim to make sure that when care restricts a person's liberty, with the aim of preventing harm or providing treatment, it is both appropriate and in their best interests. The use of covert medication within a care plan must be clearly identified within the DoLS assessment and authorisation. It is the responsibility of care home staff to ensure a DoLS application has been made and once in place that the conditions are followed. The process includes at least two assessments, one by a best interest's assessor and one by a mental health assessor, appointed by the local authority [6,7].

6. Covert Administration of Medication – General Principles

6.1 Once all necessary assessments and procedures have been completed, covert medication may be given for specified medicines for a clearly defined period using the following principles of good practice:

- **Last resort:** The decision to administer medicines covertly must not be routine practice and must be a contingency/emergency measure when all other options have been tried.

- **Medication specific**: each medicine must be considered individually for covert administration. Risk assessment (Appendix1) carried out should identify and list each individual medication for covert administration and its method of administration i.e. in food or drink. It may not be necessary to administer in this way on every occasion unless this is specifically noted in the risk assessment.

- **Clearly Documented:** the clinicians involved (e.g. doctors, nurses and pharmacist) should clearly label and annotate prescriptions, MARs and individual medication boxes with clear instructions on how each medication should be administered.

- **Method of Administration**: This must be agreed with the prescriber and recorded in the risk assessment which must be kept with the medication prescription chart. It is not good practice to crush tablets or open capsules unless it has been agreed by the prescriber[8] that it is safe to do so as this may alter the properties of the medication and renders it unlicensed. Also some foods or drinks may affect how medication is absorbed.

  It is important to ensure that giving medication in food does not compromise the resident's nutrition or affect the properties of the medications.

  When necessary the medication should be mixed with a small amount of food or liquid (first spoonful or mouthful) rather than in a whole drink or portion of food. Care staff must ensure that the entire dose is administered. The solution should always be "freshly" prepared and not made up too long previously.

- **Supervision:** Residents receiving medication administered in food or drink must be supervised until the medication has been consumed by the carer/nurse responsible for dispensing the medication.

- **Time limited:** it should be used for as a short time as possible

- **Regularly reviewed**: It is recommended that once covert administration is deemed necessary for a particular resident, and an initial risk assessment including covert medication plan and the person's capacity to consent (Appendix1) has been carried out by a multidisciplinary team that includes GP, named care home personnel and residents relative (may include a community pharmacist if required). At this assessment a decision for date of next review by the team should be documented. In the interim, a monthly follow up assessment for the need for covert administration should be done and documented by the named nurse/care staff. An earlier date of review could be prompted if conditions have changed. Below are examples of suggested intervals of review

  - **MONTHLY** [6,7] if new resident and /or situation not clear or care home new to conducting risk assessments.
  - **3 MONTHS, 6 MONTHS, 1 YEAR** at discretion of clinician if resident stable.
  - **Other date (specified)** if resident situation not stable and depending on change of situation as agreed by the multidisciplinary team during

assessment e.g. changes in medication, discharge from hospital, SALT assessments.

Care homes must be able to identify all patients on covert administration and that they have received regular reviews which should be documented in writing on the care plan.

- **Transparent;** the decision making process should be easy to follow and clearly documented.

- **Inclusive;** the decision process should involve discussion and consultation with the team of people responsible for caring for the person and the persons relatives where appropriate.

- **Best interests**; all decisions should be in the persons best interests, having undertaken a holistic assessment of the impact of covert medication on the person.

It should be remembered that covert medication is entirely different to medication given under restraint. Covert medication is given without the persons consent or knowledge, whereas medication given under restraint is given with the resident's full knowledge but not consent. This would need to be formally authorized under the Mental Health Act and is not covered by this policy.

7. Professional Conduct

7.1 All practitioners must reflect on the treatment aims of disguising medication and be absolutely confident that they are acting in the best interests of the resident in line with the Mental Capacity Act. The treatment must be considered necessary in order to save life, prevent deterioration in health, or ensure an improvement in the resident's physical or mental health status.

7.2 Disguising medication in order to save life, prevent deterioration, or ensure an improvement in the person's health, cannot be taken in isolation from the recognition of the rights of the person not to give consent. It may, in such circumstances, be necessary to administer medicines covertly in line with the NMC or other local guidance. However, it may be that in some very exceptional cases the only correct course of action may be to seek the permission of the Court to do so.

8. Education and Training

8.1 All staff should be aware of this guidance and must be fully aware of the aims, intent and implications of such treatment. They should be appropriately trained in covert medication administration. If an employee is involved in covert administration, they carry professional responsibility for their actions; it is the responsibility of the manager in charge to ensure that staffs are fully aware of their responsibilities arising from this practice.

9. References

1. National Institute for Health and Clinical Excellence (NICE) 2015 – QS85- Medicines management in care homes https://www.nice.org.uk/guidance/qs85/resources/medicines-management-in-care-homes-pdf-2098910254021

2. Nursing and Midwifery Council (2007) Advice; covert administration of medicines: disguising medicine in food and drink http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/

3. NMC (2009) Record Keeping; guidance for nurses and midwives http://www.nmc-uk.org/Documents/Guidance/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf

4. NMC (2010) Standards for medicines managementhttp://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf

5. Mental Capacity Act 2005
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga 20050009 en.pdf

6. England and Wales Court of Protection Decisions (July 2016)
http://www.bailii.org/ew/cases/EWCOP/2016/37.html

7. Kelly-Fatemi,B (2016). Covert Administration of medicines in care homes. The Pharmaceutical Journal https://www.pharmaceutical-journal.com/learning/learning-article/covert-administration-of-medicines-in-care-homes/20201536.article

8. Guidance on crushing tablets or opening capsules in a care home setting. January 2017, Pharmacy and Medicines optimisation team, HVCCG. http://hertsvalleysccg.nhs.uk/publications/pharmacy-and-medicines-optimisation/care-homes/care-home-staff/5493-policy-on-crushing-tablets-or-capsules-in-a-care-home-setting-1/file

Appendix 1

Covert Medication Risk Assessment

Risk assessment to be completed and held with the resident's medication chart and a copy in their care plan.

Residents Name:	**Date of Birth:**
Named Carer/Nurse:	**Date:**

Members of the Multidisciplinary Team/relatives/carers involved in decision making:

Summary of problems encountered with administration of medication:

What other alternatives have been considered? (i.e. alternative medication options/methods of administration or other ways to manage behaviour)

Has a capacity and Best interests assessment been completed: Yes/No
Date completed:

Has a DOLs notification/application been completed: Yes/No
Date completed:

Original Medication	Change to Medication	Formulation	Administration information and advice	Date

The decision to administer medication covertly has been discussed and agreed with:

GP **Date: .....**

Signature:

Named Carer/Nurse **Date: .....**

Signature:

Next of Kin/Advocate .....Date: .....

Signature:

If needed, appropriate method of administration has been advised by:
(Signature of a pharmacist is only required if they have inputted into this assessment)

Pharmacist **Date: .....**

Signature:

Date of next review

□ 1 Month..... **□ 3 months……**

□ 6 months ..... **□ 1 year……**

□ Other (specify date) .....

Appendix 2

Flowchart for the use of covert medication