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Medicines Optimisation

Covert Administration of Medication

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Document Summary

Directorate:	Medicines Optimisation (MO)
Document Purpose:	A guide to good practice to what should be considered and documented prior to any covert administration and explains the requirement for planned review of any covert administration arrangements
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Description	
Action Required:	To note for compliance with the procedure
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Document Status

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Covert Administration of Medication

1. Purpose of the report

1.1. Background

The practice of offering medication covertly, for example, in food or drink is only allowable in particular circumstances and could be open to abuse (1). This document provides good practice guidance as to when this practice may be lawful and explains what should be considered and documented prior to any covert administration and explains the requirement for planned review of any covert administration arrangements.

This guidance is appropriate for all adults who are in receipt of direct or commissioned NHS or social care services. This guidance does not apply to children under the age of 18.

Appendix Three gives an example of a covert medication care pathway covering the essential elements in this guidance document and Appendix Four gives an example of a pathway to support the review of established covert administration arrangements.

1.2. Objectives and scope of the report

The objective of this document is to inform Care Homes of best practice and to ensure safe management of medicines.

1.3. Target Audience

The target audience for this document is Care Home staff.

2. Introduction

'Covert administration' is the term used 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, 2).

- It is important to respect the autonomy of competent adult service users who refuse treatment. An important part of treatment is the prescribing and administration of medication, which must be undertaken lawfully at all times (3).
- In social care the covert administration of medication is sometimes necessary and justified, but should never be used for competent adult service users who are capable of deciding about their own medical treatment. The lawful exception to this is treatment for a patient's mental disorder under the terms of the Mental Health Act 1983 (MHA), which provides safeguards to patients treated for a mental disorder. The Royal Pharmaceutical Society (RPS) of Great Britain site reference documents in their guidance "Handling of Medicines in Social Care (2007) (1).''

3. Consent and Capacity

This guidance does not apply to the co-operative process where consenting patients find taking medication difficult and have their medication delivered in food or drink to ease ingestion.

- If a patient has the capacity to refuse the administration of medicines then this decision must be respected and covert administration of medication would be unlawful. The only exception is for a person detained under the MHA (5).
- The MHA provides for the administration of psychiatric treatment to patients who refuse such treatment and in some situations it may be clinically appropriate to administer oral medication by covert means (5)
- If a person does not have the capacity to give informed consent to the administration or to the refusal of the administration, a best interest decision needs to be made and documented for the administration process. Administering medication in the absence of informed consent may be regarded as deception.
- Where a person lacks capacity, the use of covert administration is governed by the principles and procedures of the Mental Capacity Act (MCA), including consideration of whether the covert administration of medication also represents a deprivation of liberty (DoLs). A DoLs referral is most likely to be needed when the medication is intended to control or modify behaviour(6).

The use of covert administration must not be considered routine and should only be used if it is in the best interests of the person.

4. Procedural Guidance Points

These points should be considered before administering a medicine covertly. The type of review undertaken should be determined by the medical practitioner dependant on individual patient circumstances.

4.1. Necessity

- Is the treatment so essential it needs to be given by deception?
- Practitioners should base their clinical decisions on clinical guidelines where available, e.g. National Institute for Health and Care Excellence (NICE) Clinical Guidance 42, which relates to dementia or best clinical practice.

4.2. Capacity

- Does the person have the capacity to decide about medical treatment?
- The person must have been assessed in accordance with the MCA 2005. This process should be timely and documented.

4.3. Benefit

- Is the treatment of benefit to the person?
- Treatment must be for the benefit of the individual and not to benefit others.
- Is there an evidence based indication for the medication?
- Are any potential risks of any possible adverse effects that might be caused by administering the medicine covertly, outweighed by the benefit obtained, e.g. change in absorption or risk of person tasting medicine and then refusing all food and drink.

4.4. Least Restriction of Freedom

- Is the covert method the best way to achieve administration of medication?
- Any covert administration must not compromise the individual's freedom.
- Is the chosen method for covert administration the best way of providing the medicine to the person and also causes the person the least distress?
- Is the person already subject to a DoLs/Is a referral to DoLs necessary?

4.5. Take the person's past and present wishes into account

- Has an advance statement been made?
- It is important to take into account anything the person may have said to family and friends or involve independent advocacy.

4.6. Consult others

- Has there been full discussion within a multidisciplinary team with expert pharmacy guidance?

This is essential and in addition there must be some consultation out with the clinical team. Consideration must also be made of ethical, cultural or religious beliefs. Consider if Covert could be a DoLS e.g. psychotropic medication.

4.7. Encourage the person to use existing skills

- Have all means of expression been explored?
- The person should have every opportunity to understand the need for medical treatment and communicate decisions.

4.8. Responsible Commissioner Responsibilities

When commissioning care for a person from a social care organisation the commissioner should confirm that the organisation has a clear policy and procedure for the administration of covert medication. It is not sufficient for the organisation to state that they will not administer medication covertly as there are occasions when covert administration may be necessary and justified to ensure a person can receive essential treatment

Where the commissioner has a responsibility for assessing and monitoring the provision of a person's care they should check that the policy is being followed in practice by the staff at the organisation.

4.9. GP/Prescriber Responsibilities

In respect of covert administration it is usually the prescriber's responsibility to assess for themselves if the person lacks capacity to determine if they will take their medication or not. Concerns of representatives, formal carers and other health and social care professionals should be considered, but prescribers should not condone covert administration solely at the request of others. Prescribers should keep the person's capacity under review.

Prescribers should document in the person's record any assessment of capacity, including who was involved and the outcome.

Prescribers should be aware that manipulating dosage forms to facilitate covert administration or putting medicines in food or drink often means that the medication is being used outside of the product licence. This has medico-legal consequences for the prescriber who takes a greater degree of responsibility for the medication. Prescribers should seek the advice of a pharmacist to assist in assessing the

appropriate means of administering the medication where the method will be off licence.

The prescriber should ensure that their support of covert administration and the method used is provided to the social care organisation in writing. Prescribers should consider if the administration of the medicine could be a deprivation of liberty. (e.g. sedatives, psychotropic medicines)

Only medicines which are essential for the person to prevent serious consequences or deterioration of their condition should be administered covertly. Prescribers should take the opportunity to review the person's medication and consider discontinuing any medication which does not fit into these criteria**.**

Prescribers should review the administration of covert medication at any point in the change in therapy (e.g. new medicine)

4.10. Social Care Organisations Responsibilities

Social care organisations should ensure that they have a robust policy in place for covert administration of medicines and that it is applied in practice to ensure that covert administration is only used when absolutely necessary.

Appropriate documentation should be made of all assessments of capacity and best interests decisions made in respect of covert administration in order to demonstrate that all necessary steps have been taken to ensure that covert administration is used appropriately.

All health and social care staff involved with the treatment or care of a person.

All health and social care staff must be aware of the principles and procedures of the MCA. A DOLS should be made if necessary

All health and social care staff have a responsibility for ensuring that vulnerable adults are safeguarded from harm and should be aware of how to report concerns about a person's care.

5. Practicalities of administering medicines covertly for nursing and care staff (7)

In all cases, care or nursing staff can only administer medication covertly if authorised by the prescribing practitioner.

If the resident lacks capacity there should be a best interest meeting, which should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and

interests of the resident (this could be a family member, friend, or independent mental capacity advocate (IMCA) depending on the resident's previous stated wishes and individual circumstances (8)).

No medicine should be crushed or opened without the prescriber's written instruction to do so. This is because, if crushing a tablet or opening a capsule is not within the product license, the manufacturer will not accept responsibility for any harm as a result of this 'off-license' practice. Any person giving crushed tablets or opened capsules to a patient without directions from the prescriber and without making the appropriate checks could be held liable for any harm caused.

NICE guidance (8) states that if the decision of the best interests is for medicines to be administered covertly, a management plan should be agreed. This would usually include:

- Medication review by the GP
- Medication review by the pharmacist (to advise how the medication can be administered safely)
- Clear documentation of the best interest meeting
- A plan to review the need for continued covert administration of medicines on a regular basis

5.1. Can the medicine be safely disguised?

- Advice from a pharmacist should be sought to identify the most appropriate method of covert administration for the particular medicine involved.

This is because some medicines can be safely crushed etc. before administration; however, for others such processing could render the medicine dangerous to the patient.

5.2. Who is administering the treatment?

- Care and nursing staff need to understand how to give the medication safely and have documented pharmacy advice on administrating covertly. Informal carers giving treatment at home should be given support and education.

5.3. Procedure for covert administration?

- Offer medicine in the normal way. Only if medication is refused should the covert pathway be followed.
- According to care plan, prepare the first medication that is required to be administered covertly.
- Watch the service user to ensure full dose is taken.
- Continue process until all medicines have been administered. Medication must be administered one medicine at a time

5.4. How is covert medication recorded?

- Care plans and the MAR chart should clearly record when and how a medicine is to be administered covertly.
- Medicines should be offered openly in the first instance, if refused the MAR should be annotated with the correct code for refusal. When the medication is given covertly, the MAR should be annotated with the right code. Record on the back of the MAR, the time, reason and how the medicine was administered covertly.

5.5. When should the need for covert medication be reviewed?

- It is important to review whether the treatment continues to be necessary and if so, if the covert administration is still necessary. An early review once the initial decision has been made is recommended, then further reviews to be agreed depending on individual circumstances.

5.6. What happens if additional treatment is needed?

- This should be considered as a completely new situation and all the above issues should be reconsidered.

Appendix One: Abbreviations

Abbreviation	Definitions
MHA	Mental Health Act
RPS	Royal Pharmaceutical Society
DoLs	Deprivation of Liberty
NICE	National Institute for Health and Care Excellence
IMCA	Independent Mental Capacity Advocate
MCA	Mental Capacity Act

Appendix Two: References

1. The handling Of Medicines in social care (2007). Royal Pharmaceutical Society of Great Britain.

2. Covert Administration of Medicines, The Pharmaceutical Journal, volume 270,No7230, Jan 2003.

3. Royal College of Psychiatrists. Statement on Covert Administration of Medicines 2004.

4. Position Statement: Covert Administration of Medicines – disguising medicines in food and drink, Nursing and Midwifery Council 2006

5. DOH(1999) Mental Health Act 1983 Code of Practid

6. Deprivation of Liberty Safeguards (DoLS)

7. Mental Health Briefing: The Covert Administration of Medicine, Number 101 Covert Medications. Mental Welfare Commission for Scotland. November 2006

8. NICE (March 2014). Managing medicines in care homes – full guideline (14/03/2014).

Further Reading

1. Code of professional Conduct, Nursing and Midwifery Council 2002

2. British Medical Council, Consent: patients and doctors making decisions together 2008.

3. A Pill in a Sandwich: Covert Medication in Food and Drink. Treloar JR. Soc Med 2000;93:408-411

4. Care Quality Commission: Essential standards of quality and safety (guidance about compliance). What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008; Outcome 9, (December 2009).

5. Prof Nick Barber et al. Care Homes Use of Medicines Study (CHUMS). Patient Safety Research Portfolio (PSRP), School of Pharmacy, University of London. Policy Paper, University of Leeds, University of Surrey (January 2010).

Appendix Three: Covert Medication Care Documentation form

Good Practice Guidance for Care homes			
Covert Medication Care Documentation form			
Name of Client:		**Date of Birth:**	
Address:		**Date:**	
Completed by:		**Position:**	
Assessing Capacity: Does the person have impairment, or a disturbance in the functioning of their mind or brain? Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?		Yes/No(if yes a best interests decision must be documented) Yes/No (if yes a best interests decision must be documented)	
Functional tests of capacity To be able to make a decision a person must be able to: • understand the information relevant to the decision, • retain that information, • use or weigh that information as part of the process of making the decision, or • Communicate the decision.		Describe how assessed	
What medication is being considered for covert administration?			
Why is this medication necessary or what benefit is there for the patient? Where appropriate refer to clinical guidelines, e.g. NICE. Is it the least restrictive option?			
What alternatives have been considered? (e.g. alternative methods of administration or other ways to manage the person/behaviour)			
What is the person's past or present views of the proposed treatment, if known?			
Is there a person nominated with the power to consent (e.g. welfare attorney/welfare guardian)? If yes have they been consulted with regard to covert administration?		Yes/No (if yes a best interests decision must be documented) Yes/No (if yes a best interests decision must be documented)	
Is the person subject to a DoLs? If yes the safeguard needs updating? Does the prescription be considered a DoL?			
Who was involved in the decision to administer medicine covertly? Please name prescriber e.g. GP, Acute Trust or Mental Health Doctor Please name relatives or other carers involved:		**Names of people involved:**	

Has anyone apposed the decision to administer covertly?	**Yes/No. If Yes give details of who and why?**

Good Practice Guidance for Care homes

Covert Medication Care Documentation form continued

A Pharmacist must be involved to give advice if administration involves crushing tablets, opening capsules or combining medicines in any way with food or drink.	**Name of Pharmacist**: **Name of Pharmacy/organisation**: **Date**:
Describe the method for administrating in food agreed with pharmacist e.g. If tablet administration is refused, the tablet can be administered covertly by crushing tablets and mixing with one teaspoon of yogurt.	
When will a review of the covert administration arrangements be made?(specify timeframe and circumstances) e.g. monthly or when a new medicine is started)	**Date of planned review:**

Appendix Four: Covert Medication Review form

Good Practice Guidance for Care homes					
Covert Medication Review form					
Name of Client:		**Date of Birth:**			
Address:			**Date:**		
Completed by:		**Position:**			
Is treatment still necessary? **If so, explain why?**					
Is covert administration still necessary? If so, explain why.					
Who was consulted as part of the review?					
Is any appropriate legal documentation still in place and valid?					
Date of next review					
Signed:			**Date:**		
Countersigned:			**Date:**		
Name:			**Position:**		