COVERT ADMINISTRATION
OF MEDICINES IN CARE HOMES POLICY
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1. **INTRODUCTION**

1.1. Covert medication may be appropriate for those individuals who have been assessed as lacking mental capacity, in exceptional circumstances, to prevent a person from missing out on essential treatment.

2. **SCOPE OF POLICY**

2.1. This policy provides guidance to care home staff regarding the covert administration of medications and explains when this can be done, within the law.

3. **DEFINITION OF COVERT ADMINISTRATION OF MEDICATION**

3.1. Covert administration of medication occurs when medications are administered in a disguise format without the knowledge or consent of the person receiving them, for example in food or in a drink. Covert administration of medication can only be necessary and justified in exceptional circumstances, when certain legal requirements have been satisfied. **Medicines should never be administered covertly to patients who have capacity to make their own decisions.**

3.2. For patients with swallowing difficulty, medication can sometimes be administered with soft food or in a drink. Administering medication in this way **would not be considered as covert if the patient is fully aware and has consented to having their medication administered in this way.** Patients must be advised that their medication has been mixed with food every time it is administered in this way. Advice on mixing medication with food/liquids should always be sought from a pharmacist. Where medication is mixed with food, care staff must ensure that the entire dose is administered. (It should be noted that crushing medication renders each medication unlicensed. Contact Medicines Management Team (email Prescribing Partnership: capccg.prescribingpartnership@nhs.net) or local community pharmacist if advice is required).

4. **PURPOSE**

4.1. This policy is intended for use by registered practitioners or carers working within Cambridgeshire and Peterborough CCG, who may be planning the use of covert medication or who may be administering medications covertly as part of a treatment plan, within the care home setting. It is important that the guidance within this policy is followed every time covert medication is used or whenever it is being considered.

4.2. All care home providers must have procedures for arranging for covert administration of medicines. This policy will provide guidance around the decision making process and the documentation required to administer medicines covertly.

5. **EXCEPTIONS TO GUIDANCE**

5.1. **Extreme Situations:** When an emergency arises in a clinical setting, and it is not possible to determine a patient’s wishes, they can be treated without their consent provided the treatment is immediately necessary to save their life or to 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 patients best interests and should be clearly recorded noting, who took the decision, why the decision was taken, and what treatment was given.

6. **EDUCATION AND TRAINING**

6.1. All staff involved in the administration of medicines should be aware of this guidance and appropriately trained.
7. MONITORING AND REVIEW

7.1. The policy will be reviewed every two years by the Cambridgeshire and Peterborough CCG Medicines Management Team, or earlier in the event of changes to legislation or good practice.

7.2. The MMT will include assurance in regard to the use of covert medications during the care home review process and support care homes, where required, using the guidance within this policy. If covert medication is being administered without the appropriate measures taken, or supportive documentation, then this will be discussed with safeguarding colleagues.

8. IMPLEMENTATION AND DISSEMINATION

8.1. Prescribers and care providers need to be aware of the requirements when carers/nurses are requested to administer medication covertly. Both the prescriber and responsible individual within the care setting should ensure that mental capacity has been assessed, medication reviewed, best interest decision process followed, and that all documentation has been completed. Documentation must be maintained, kept up to date and reviewed regularly.

8.2. As part of any decision to administer medication covertly there should be a discussion between the prescriber and those administering the medication as to whether there is a need to also consider Deprivation of Liberty. In situations where the person resides in Care/Nursing Home or Hospital the responsibility for making the application for DoLS sits with the Care Provider (the Managing Authority). In community based setting (person’s own home, supported living, extra care, etc), the responsibility for making a DoLS application to the Court of Protection sits with either the body commissioning the care (local authority or CCG), or for self-funders the Local Authority (the social care team that is most appropriate to that persons’ needs).

9. REFERENCES


10. Covert Medication Administration Policy for Care Homes

General principles of covert administration

Human rights law is the first principle that determines the decision to proceed. The right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal might lead to a detrimental outcome. Covert medication cannot be given to someone who is capable of deciding about medical treatment. So the first step in the process is ascertaining the capacity of a person to make a decision about their medical treatment.

Where covert administration is being considered as 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.
- **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 patient. It must not be a decision taken alone.
- **Best interest** - all decisions must be in the person’s best interest with due consideration to the holistic impact on the person's health and well-being.

**Suggested care pathway with supporting flowchart** (Appendix 1)

**Step 1: Assessing mental capacity (MCA assessments)**

Before covert administration is considered as an option, decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the five key principles set out below. It is important to remember that an assessment is task specific and consequently must be carried out for each individual issue which compromises a person’s quality of life.

**The five key statutory principles in assessing capacity are:**

1. A person must be assumed to have capacity to make a decision unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. For example, advocates or communication support may be necessary.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision. Everyone has the right to make what would appear to be an unwise decision. This does not mean that the person does not have capacity.
4. 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 his or her best interests.
5. 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.
Process of assessment
For the purposes of assessing capacity to understand medication there will be a need to first establish that a person is unable to make a decision because of an impairment of, or disturbance in, the functions of the mind or brain. **This clinical diagnosis provides the justification for proceeding.**

The second stage of assessment can only proceed if the answer to the first stage is “yes” i.e. the person has a clinical diagnosis that justifies the process to proceed. Consideration should be given to the patient’s country of origin and their understanding of English.

A patient will be considered to lack mental capacity in law, to make a decision or consent, if he or she is unable to:

- Understand in simple language what the treatment is, its purpose and why it is being prescribed,
- Understand its principle benefits, risks and alternatives,
- Understand in broad terms what the consequences will be of not receiving the proposed treatment,
- Retain the information for long enough to make an effective decision, and communicate their decision in any form.

**Where an individual cannot demonstrate an understanding of one or more parts of this test, then they do not have the relevant capacity at this time.**

An advance decision to refuse particular treatment in anticipation of future incapacity must be adhered to if valid and complete. 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. It is important that clinicians are made aware of advanced decisions and that carers are aware within care plans.

Who can carry out a mental capacity assessment?
In the context of care the practical assessment of capacity for a specific decision may be made by the carer. Some care providers have developed their own Mental Capacity Act (MCA) paperwork but it is essential that it fulfils all legal aspects and that the assessor has undertaken specific training to appreciate the principles of the assessment process.

The person who can assess an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times. **However, the prescribing GP must be involved in assessing mental capacity when covert administration of medication is being considered.**

Difficult situations may arise where a person may have fluctuating capacity or limited capacity and occasionally a person may refuse to participate in an assessment. In such situations a healthcare professional must always be involved and Court of Protection decisions may be necessary.

MCA assessments benefit from involvement of family, close friends or carers especially where there is any doubt about a decision.
Step 2
The individual must have been **assessed to lack capacity** to understand the consequences of refusing their medication. Next steps cannot be taken unless this has been determined.

**Best interest decision**

‘Best interests’ is a method for making decisions which aims to be objective. It requires the 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. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them.

The Mental Capacity Act 2005 provides a checklist which must be followed when making a decision for someone.

**Summary of Best Interest checklist**

- Consider all the relevant circumstances ensuring that age, appearance, behaviour, etc. are not influencing the decision **and**
- consider a delay until the person regains capacity **and**
- involve the person as much as possible **and**
- not to be motivated to bring about death **and**
- consider the individual’s own past and present wishes, and feelings **and**
- consider any advance statements made **and**
- consider the beliefs and values of the individual **and**
- take into account views of family and informal carers **and**
- take into account views of Independent Mental Capacity Advocate (IMCA) or other key people **and**
- show it is the least restrictive alternative or intervention.

A person 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 person. 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.

**Who should be involved in making a best interest decision for medication issues?**

Best interest decisions involving medication should be made by the prescribing practitioner in conjunction with a multi-disciplinary team of healthcare professionals. If a pharmacist cannot be present their advice should be sought before the decision to proceed to covert administration is made, in order to check the suitability of the medication to be administered in this way.

The person’s family/friends/carers/advocates must be involved in, and informed of, the decision to administer medication covertly (note: nobody can consent for someone else; but the views of family/carers may be beneficial in determining a person’s wishes and feelings and what is in their best interests). In cases where there is no-one to consult with there is a need to refer to the advocacy service.
Factors to consider before deciding to covertly administer

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.

The best interest decision includes a risk benefit assessment which should be made by the prescribing clinician, and in discussion with relatives/advocates. 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. Clinicians are frequently concerned of medico-legal challenges in stopping medication but supporting documentation provides evidence.

Patterns of behaviour need to be 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?

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.

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. The prescriber should consider an alternative route of administration of that medication (e.g. topical, parenteral) or an alternative medication (e.g. available in different forms which are more palatable).

Step 3: Suitability of medication

If the best interest decision is to administer covertly, the suitability of the medication must then be considered.

The properties of the medication, e.g. its bioavailability, should 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 as they cannot be crushed – always seek advice from a pharmacist before doing so.

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).

The prescriber, pharmacist and administering professional/carer should take reasonable steps to ensure administering medication covertly, including the crushing of tablets or emptying of capsule contents, will not cause harm to the patient. The pharmacist should refer to the standard texts, the SPC for the medicine(s) concerned, and specifically to appropriate reference sources to advise on suitability.

If further advice is required on the suitability of medications to be administered covertly contact Prescribing Partnership: capccg.prescribingpartnership@nhs.net.

Step 4: Record keeping

Covert administration of medication will be challenged by inspecting bodies 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 and this could be liable to legal challenge.
The prescriber must have documentation of both mental capacity assessment for the understanding of medication issues and the best interest decision pathway to support covert administration. Copies of this documentation should be in the person’s clinical records in their GP surgery and a copy needs to be shared with the relevant person/care team. (Appendix 2)

Carers should produce a personalised instruction for each medicine to be given covertly, in line with the advice of the pharmacist. This should be added to the care plan to ensure that all carers are aware of the correct process. (Appendix 3)

It is also useful for kitchen staff to be aware of a person who is being given medication covertly as dietary changes may be needed.

Each time medication is administered covertly, in accordance with the care plan, it should be clearly documented on the MAR sheet.

Where administration is unsuccessful this must be documented, and any consequences reported to the prescriber and the GP/specialist in time scales as agreed at the commencement of the treatment and within the best interest decision.

**Step 5: Practical points in administering medications covertly**

In the context of care it is important to remember that dignity and respect must be maintained in a potentially abusive situation.

Carers must be supported by healthcare professionals to be able to deliver care appropriately with due regard to their accountability.

Consistency in practice is only possible if carers are given clear guidance that they can follow.

Carers who are trained to administer medication should consider the following points when covert administration has been deemed necessary.

- A person should be offered their medication overtly each time, especially where fluctuating capacity is evident.
- The carer should be aware of personal preferences for administration through the care plan. Refusal after appropriate steps have been taken can then proceed to covert.
- In general, the medication(s) which are to be administered covertly should be mixed with smallest volume of food or drink possible (rather than the whole portion). This increases the likelihood that the prescribed dose is actually taken. Not all drinks are suitable, e.g. tea or milk interacts with some medication and this should be documented clearly.
- The medication must be administered immediately after mixing it with the food or drink. Do not leave it for the person to manage themselves. If the person is able to feed themselves, observe to ensure that it is all consumed.
- Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet.
- Refusal of the food or drink containing medication must be recorded on MAR sheet as refusal. It should also be noted if it is partially consumed as the dose is then uncertain.
- Good record keeping is evidence to enable the prescriber to review the continued need for covert administration.
• Carers/ nurses must ensure that the food or drink containing the medication is not consumed by other residents.

**Step 6: Review of continued need**

(Appendix 4)

The need for continued covert administration should be reviewed within time scales which reflect the physical state of each individual. This should be agreed at the time of agreeing the implementing of covert administration within the best interest decision. It is important at end of life that relatives or advocates are made fully aware of the decisions that are made around medication so that they are reassured.

Referring back to the general principles, the least restrictive approach should be the first option that ultimately requires a review of risk/benefit in stopping the medication, especially if evidence of non-compliance demonstrates no apparent harm.
Appendix 2: Covert Administration Medication Record Form

**Name of service user:**

**Date of birth:**

<table>
<thead>
<tr>
<th>List medications being considered for covert administration?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Why are these treatments necessary?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What alternatives have the multidisciplinary team considered? (e.g. other ways to manage the condition or administer treatment)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Why were these alternatives rejected?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>An assessment by medical practitioner has been performed to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Confirm service user lacks capacity to consent.</td>
</tr>
<tr>
<td>- Confirm the continued need for the above treatment following a medication review</td>
</tr>
<tr>
<td>- Confirm that covert administration is essential</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment completed and appropriate document stored in service users notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature ..................................</td>
</tr>
<tr>
<td>Name ......................................</td>
</tr>
<tr>
<td>Designation ..............................</td>
</tr>
<tr>
<td>Date ......................................</td>
</tr>
</tbody>
</table>

Has the person expressed views in the past that are relevant to the present treatment? Yes/No

If yes, what were those views?

<table>
<thead>
<tr>
<th>Name all involved in the decision to administer medication covertly (e.g. health care professionals, carers, family etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>..................................</td>
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<td>..................................</td>
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<td>..................................</td>
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<td>..................................</td>
</tr>
</tbody>
</table>

Continued overleaf
Name the pharmacist consulted and record advice on separate form (Appendix 3)

<table>
<thead>
<tr>
<th>Pharmacist name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there a person with power to consent on behalf of the service user e.g. welfare guardian?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment may only be administered covertly with that person’s consent unless this is impractical</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Has this person given consent? (If No please state reason)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Do any of those involved disagree with the proposed use of covert medication?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>If yes, they must be informed of their right to challenge treatment</td>
<td>Date informed:</td>
</tr>
<tr>
<td>Which members of staff will be administering the medication?</td>
<td>Names:</td>
</tr>
<tr>
<td>These members of staff must receive appropriate guidance on administration of this medication</td>
<td></td>
</tr>
<tr>
<td>How will this be recorded on the MAR chart? (e.g. Detailed in prescription directions)</td>
<td></td>
</tr>
<tr>
<td>When will the need for covert administration be reviewed?</td>
<td>Date for first planned review</td>
</tr>
</tbody>
</table>

Care Home Manager signature:

Name:

Date:

To be stored in service user’s notes
Appendix 3: Covert Administration Medication Guidance From Community Pharmacist

<table>
<thead>
<tr>
<th>Medication</th>
<th>Formulation</th>
<th>Advice from pharmacist</th>
<th>Date</th>
<th>Pharmacist signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>example</td>
<td>liquid</td>
<td>add to small amount of blackcurrant juice just prior to administration. Witness all juice has been consumed by service user</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To be stored in service users notes. A copy should be kept with the current MAR chart

If further advice is required on the suitability of medications to be administered covertly contact Prescribing Partnership: capccg.prescribingpartnership@nhs.net
Appendix 4:

Administration of Covert Medication Review Form

Name of service user

Date of birth

Date review performed

<table>
<thead>
<tr>
<th>Are the medications still necessary?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If so, explain why</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is covert administration still necessary?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If so explain why</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who was consulted as part of the review?</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Is legal documentation still in place and valid?</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Date of next review</th>
<th></th>
</tr>
</thead>
</table>

Signed:..................................................

Name of prescriber:..................................

Date:..................................................

To be stored in service users notes