

COVERT ADMINISTRATION OF MEDICATION GUIDELINE FOR CARE HOMES

DOCUMENT CONTROL SHEET

Document Owner: Director of Quality & Nursing
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Version: 1.1
Directorate: Nursing & Quality
Approved By: Quality Committee Meeting
Date of Approval: 13th December 2018
Date of Review: July 2018
Effective Date: 13th December 2018

Change History:

Version	Date	Reviewer(s)	Revision Description
v1.0	July 2018	Louise Kelleher	Vanguard Logo removed from footer. ENHCCG logo updated Minor changes to text Update of references following withdrawal of NMC standards for Medicine Management Jan 19 Removal of need for pharmacist to attend meeting but must be consulted for advice Addition of information on review periods

Implementation Plan:

Development and Consultation	Head of Quality Improvement HVCCG Quality manager ENHCCG Senior Pharmaceutical Adviser, Pharmacy and Medicines Optimisation Team HVCCG Senior Pharmaceutical Adviser ENHCCG Specialist Pharmaceutical Advisers- Care Homes Head of Adult Safeguarding LMC LPC
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Dissemination	To care homes in E&NHCCG and GP practices
Training	None required
Monitoring	None required
Review	This guideline will be reviewed every 2 years by the management team along with the adult safeguarding lead or earlier if changes to legislation or good practice.
References	<p>RPS (2007) The Handling of Medicines in Social Care https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/handling-medicines-social-care-guidance.pdf?ver=2016-11-17-142751-643</p> <p>NMC (2009) Record Keeping; guidance for nurses and midwives http://www.nmc-uk.org/Documents/Guidance/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf</p> <p>NMC (2010) Standards for medicines management http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf</p> <p>Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contentsNICE</p> <p>Managing medications in care homes good practice guidance https://www.nice.org.uk/guidance/sc1</p> <p>England and Wales Court of Protection Decisions (July 2016) http://www.bailii.org/ew/cases/EWCOP/2016/37.html</p> <p>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</p> <p>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</p>

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Covert administration of medication guideline for care homes

1. Introduction

- 1.1 East & North Herts Clinical Commissioning Group strives to ensure the safe practice for administration of medication within the care homes in ENHerts CCG. An important part of care is the prescription and administration of medicines, which must be undertaken lawfully at all times.
- 1.2 The Nursing and Midwifery Council (NMC) recognises that there may be exceptional circumstances in which covert administration may be considered to prevent a resident from missing out on essential treatment.
- 1.3 This guideline provides guidance for staff regarding the covert administration of medicines and explains when this can be done within the law.
- 1.4 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)

2. Aim of Guideline

- 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 guideline 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

3. Scope of Guideline

- 3.1 This guideline applies to all adults who are residents within care homes in ENHerts CCG. It does not apply to children and adolescents.
- 3.2 In general terms, if a resident has the mental 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 oral medication 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] 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, then the advice of the community pharmacist should be sought to establish whether it is practical to do so, and if so for advice about method of administration.
- 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 nevertheless 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
- 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 appropriate, in their best interests and within the framework of the law. 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. 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
 - **Time limited;** it should be used for as a short time as possible

- **Medication specific;** each medicine must be considered individually for covert administration. The method of administration must be agreed with the pharmacist and 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 a pharmacist advises 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 may not be necessary to administer in this way on every occasion unless this is specifically noted in the risk assessment.
 - 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 e.g. open capsule and sprinkle contents on food, crush and add to food.
 - 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 must be mixed with a small amount of food or liquid rather than in a whole drink or portion of food. Care staff must ensure that the entire dose is administered and where practical given within the first mouthful. The solution should always be "freshly" prepared and not made up too long previously.
 - 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.
- **Regularly reviewed;** the necessity of covert medication plan should be regularly reviewed as should the person's capacity to consent. The date of next review should be documented on the initial risk assessment. Suggested review intervals are:
 - Monthly – if a new resident/ situation not clear or care home new to conduct in risk assessments.
 - 3 months, 6 months, 1 year at discretion of clinician if resident stable.
 - Other specified date if resident not stable, and depending on change of situation as agreed by MDT during initial risk assessment e.g. changes in medication, discharge from hospital, SALT assessment.
 - 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 person's relatives where appropriate.

The resident's best interests must always be the first consideration, 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 person's consent or knowledge.

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.
- 7.3 It should be remembered that covert medication is entirely different to medication given under restraint. Covert medication is given without the person's consent or knowledge, whereas the latter is given with their full knowledge but not consent. This would need to be formally authorised under the Mental Health Act.

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 authorised employee is involved in covert administration, it is the responsibility of the manager in charge to ensure that staff is fully aware of their own responsibilities arising from this practice.
- 8.2 The Nursing and Midwifery Council (NMC) states that all Registered nurses and midwives involved in administering medicines covertly must act within the principles of the 2008 NMC Code.

Monitoring and review

This guideline will be reviewed every 2 years by the management team along with the adult safeguarding lead or earlier if changes to legislation or good practice.

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 medication options have been considered e.g. 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 from pharmacist	Date

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

Name of GP: Date:

Signature:

Named Carer/Nurse: Date:

Signature:

Name of Pharmacist: Date:

Signature:

Discussed with Next of Kin/Advocate

Name of Next of Kin/Advocate

Date:

Signature of next of kin where possible:

Review date:

Regular Review is Recommended – Record Renew Date in Care Plan

Flowchart for the use of covert medication

