NHS
Shropshire
Clinical Commissioning Group

NHS
Telford and Wrekin
Clinical Commissioning Group

COVERT ADMINISTRATION OF MEDICINES POLICY

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Appendices

1. INTRODUCTION

1.1 This policy relates to the covert administration of medicines to individuals who are unable to give informed consent to treatment and refuse to take medication when they are offered openly

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

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

2. SCOPE OF POLICY

2.1 This policy provides guidance to all health and social care workers involved in the care of adults.

3. DEFINITION OF COVERT ADMINISTRATION OF MEDICATION

3.1 Covert administration of medication occurs 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. 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 Covert medication can refer to medication given to treat either mental or physical health problems. Covert medication should not be confused with enforced medication, where it is given with the person's full knowledge, but not their consent.

3.3 For patients with swallowing difficulty, some medication can be administered with soft food. 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. Following agreement with the prescriber, a note should be made in the patient's care plan/medical notes outlining how medication is to be administered. It may not be necessary to administer in this way on every occasion unless this is specifically noted in the patient's care plan. Administration in this way must be continuously reviewed and it **should not** be regarded as routine practice. Advice on mixing medication with food should always be sought from a pharmacist. Where medication is mixed with food care staff must ensure the entire dose is administered e.g. by mixing in a small quantity of food before offering further nutrition. Altering the formulation in any way renders a medicine unlicensed e.g. crushing tablets or opening capsule contents and mixing with food. The effects of the medicine may be less well understood. Responsibility for unlicensed use lies with the prescriber therefore medicines should not be given in this way unless expressly authorised by the prescriber. Contact medicines management team or local community pharmacist if advice is required.

3.4 **The NMC position statement on covert administration of medicines 2001 states that:**
"Disguising medication in the absence of informed consent may be regarded as deception. However a clear distinction should always be made between those patients or clients who have capacity to refuse medication and whose refusal should be respected and those who lack capacity. Among those who lack capacity, a further distinction should be made between those for whom no disguising is necessary because they are unaware they are receiving medication, and others who would be aware if they were not deceived into thinking otherwise."

When assessing patients for the suitability of covert administration these distinctions must be carefully considered.

The Royal College of Psychiatrists has also issued a statement on the covert administration of medicine which states:

- *The importance of respecting the autonomy of individuals who refuse treatment*
- *That there may be times when severely incapacitated individuals can neither consent nor refuse treatment*
- *Treatment should be made available to severely incapacitated individuals judged according to their best interests and administered in the least restrictive manner*
- *In exceptional circumstances it may be necessary to administer medication in foodstuffs without the individual's awareness that it is being done*

4. PURPOSE

4.1 This policy is intended for use by all provider organisations within Shropshire CCG or Telford & Wrekin CCG who may be planning the use of covert medication, or who may be administering it as part of an agreed treatment plan. 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 required to administer medicines covertly.

5. LINKS TO OTHER POLICIES

5.1 This policy should be read in conjunction with:

- Mental Capacity Act 2005 (Making decisions)
- NMC (2010) Standards for medicines management
- NMC (2015) The Code; standards of conduct, performance and ethics for nurses and midwives
- NICE Managing medicines in care homes good practice guidance

6. MEDICATION NON-ADHERENCE

6.1 Many people do not wish to take medication and often fail to follow the treatment regime recommended by health professionals. Data available from the World Health Organisation shows that in the developed world only 50% of people take their medication as prescribed.

6.2 Non-adherence with medication can be due to a variety of reasons including;

- Inadequate information about why a drug is being prescribed/administered
- Because the person feels the symptoms of their illness are mild and do not require treatment
- Because the treatment is preventative and the person does not feel it is essential
- Because the medication has unpleasant side-effects
- The reputation of certain drugs
- Concerns about long-term dependence/addiction
- Beliefs about the value or efficacy of medication
- Beliefs about medicines in general
- Relationship with the person prescribing or administering the medication

- Not remembering how to take the medication

6.3 The reluctance of a person to take prescribed medication should not be automatically seen as part of a mental illness, or a sign of a lack of mental capacity. Healthcare professionals need to understand and support people who do not wish to take their medication, rather than imposing their own values, or blaming the person for not following advice.

7. OPTIMISING MEDICATION CONCORDANCE

7.1 Adherence with medication can often be improved by considering why the person does not wish to take the medication, and taking simple steps to support them:

- Involve the person as much as possible in the process of prescribing and consult them about their views
- Find out why the person does not wish to take their medication and offer information/advice/support where needed
- Offer choice where possible in order to give the person a heightened sense of control
- Regularly discuss medication with the person, including any side-effects that they might be experiencing
- Provide information about medication and address any concerns that the person may have
- Offer alternative formulations if available, where the person finds swallowing tablets or capsules difficult (**advice about crushing medicines should always be sought from a pharmacist/local medicines management team**)
- Build trust with the person and listen to their concerns

8. LEGAL, ETHICAL AND CONSENT CONSIDERATIONS

8.1 Covert medication is a complex issue which involves the fundamental principles of patient/client autonomy and consent to treatment, which are set in common law and statute and underpinned by the Human Rights Act 1998. All staff should be aware of the patient's rights and of their professional duties around treatment and medication.

8.2 Any adult who has mental capacity to make treatment decisions has the right to give or refuse consent to treatment or nursing intervention even if it adversely affects their health. (The only exception to this rule is where the treatment is for a mental disorder and the person is detained under the Mental Health Act (1983)). The ethical principle underpinning this free choice is respect for autonomy and the health care professional's duty to respect the decision of the patient is enshrined within 'The Code' (NMC 2008) and the Mental Capacity Act 2005. It is important to be clear that a person is entitled to make a decision, which may be perceived by others as unwise, as long as they have the capacity to do so. To administer medication covertly to a competent adult could therefore be seen as unlawful (an assault) and unethical (overriding autonomy). However, if the person lacks capacity as defined within the Mental Capacity Act (2005) or is detained under the Mental Health Act (1983), then in certain circumstances covert medication could be justified and might be seen as both legal and ethical. Covert practice cannot be justified as part of a research project.

In law, no adult can consent for giving or withholding medical treatment on behalf of another fully competent adult with intact mental capacity. In addition, no adult can give consent for giving or withholding medical treatment on behalf of an adult who **does not** have capacity for that decision **unless either** they have been authorised to do so under a Lasting Power of Attorney **or** they have been approved by the Court of Protection to act as a deputy. Therefore spouses, partners, close relatives, professional carers or independent

mental capacity advocates **cannot** legally give or withhold consent to medical treatment on behalf of such an adult without this authority.

Covert administration of medicines should only be undertaken when the person concerned lacks capacity to make a treatment decision and will not comply with the treatment regime. Both the Capacity Assessment and Best Interest Decision should be fully recorded and included in the persons care record and where the person is in receipt of care in a residential care setting a consideration for a Derivation of Liberty Safeguard (DOLs) referral will be required.

9. GENERAL PRINCIPLES OF COVERT MEDICATION

9.1 Where covert medication is used the following principles should be seen as good practice:

- **Last resort**; covert medication should only be used when all other options have been tried
- **Medication specific**; each medicine must be considered individually for covert administration
- **Time limited**; it should be used for as short a time as possible
- **Regularly reviewed**; the necessity of a covert medication plan should be regularly reviewed as should the person's capacity to consent
- **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.
- **Best interests**; all decisions should be made in the person's 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 medication 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.

10 PROTOCOL FOR USE OF COVERT MEDICATION (See Appendix 2)

10.1 The use of covert medication should be a last resort and not be a routine or unplanned contingency measure should the person not agree to take their medication. However there are certain circumstances in which covert medication could be both legally and ethically justified, providing certain requirements have been met. The following protocol incorporates these requirements and should be followed by all healthcare providers before covert medication is commenced.

10.2 **Establish that the person lacks the mental capacity to decide whether to take the medicine or not.** The principles of the Mental Capacity Act (2005) should be followed. The two stage capacity assessment should take place directly with the person where a conversation should be had about their medication. It should be determined that the person:

Stage 1 Has an impairment or disturbance in the functioning of their mind or brain (whether permanent or temporary)
AND
Stage 2 The impairment or disturbance means they are unable to make the specific decision at the time it needs to be made.

Provided you have demonstrated both of the above you must then consider if they are able to:

- Understand information relevant to the decision (e.g. the risks from not taking it)
- Retain this information (if only briefly)
- Weigh up the information/risks involved
- Communicate their decision (whether by talking, using sign language or any other means)

10.3 As detailed in the MCA (2005) all reasonable efforts must be made to help the person understand. It should be recognised that many people's capacity fluctuates during the day and so an optimal time of day should be chosen. In some cases several attempts may be required. A record should be made of the discussion that has taken place, including methods used to help overcome any communication issues such as use of an interpreter and of the information and options discussed.

10.4 If the person satisfies the requirements of all four points above then they should be assumed to possess the mental capacity to make the decision themselves, even if their decision appears unwise. In these circumstances the decision must be respected, and covert medication cannot be given. It is important that this process is followed as presumptions about a person's mental capacity cannot be based solely on a person's diagnosis (MCA 2005). If you reasonably believe that the person fails to pass any of the four tests they are deemed to lack the mental capacity to make the specific decision about their medication.

Where doubt exists over whether the person has capacity to consent or where capacity fluctuates, then the principles of the MCA (2005) should be followed and medication should not be given covertly until a capacity assessment has taken place and the best interest decision process has been followed.

10.5 **Establish the reason why the person does not wish to take the medication**. Consideration should be given as to whether this reflects a long held belief about medication, whether an advance decision to refuse treatment (ADRT) exists, whether it amounts to a religious or cultural belief, or a decision that may be perceived as 'eccentric/unwise' by another person. All are valid reasons for declining medication and must be respected. The person's reasons should be recorded in their clinical notes/care plan and medication should not be given covertly. If an ADRT exists, the person's wishes stated within it must be respected as they are usually legally binding, although this may be overruled if a person is detained under the Mental Health Act (1983).

10.6 **Establish that the medication is essential for the person's health and well-being or for the safety of others**. However if the person is subject to Deprivation of Liberty Safeguards (DoLS) the safety of others is **not** an authorised consideration. There should be a clear expectation that the person (or the safety of others unless under DoLS) will benefit; significant harm to their physical or mental wellbeing should be avoided. Where more than one medicine is prescribed, each medicine should be given separate consideration as to whether it is regarded as essential. This must be documented in the person's clinical records. The medication that the person is declining must be deemed to be essential for the person's health and wellbeing, or for the safety of themselves, and this must be documented in the person's clinical records.

10.7 **Ensure that alternatives have been explored**. Consider offering alternative preparations if these are available. Medication adherence is improved when the person has been involved in the decision making process and has been enabled to have some control over what is prescribed.

10.8 **Discussion about best interests**. Having established that the person lacks capacity to make the decision about their medication, a decision about whether covert medication is in the person's best interests should be discussed in an open and inclusive way, ensuring that holistic factors are considered. All staff involved in the decision making process should be aware that covert medication is not always appropriate or in line with what the individual would have wanted. What is suitable for one person may not be for another.

The least restrictive care option that would achieve the desired benefit and be in the person's best interests and diversity should always be sought. Consider whether other forms of administration would result in the need for restraint or force and whether covert medication would cause least distress or be less likely to require restraint.

The decision to give medication covertly should therefore only be made following a detailed examination of the individual's circumstances and should consider the likelihood and potential severity of any medication adverse effects and the possible impact on any co-morbid physical conditions. Any Advance Statement must be taken into consideration; likewise any statement in a registered Lasting Power of Attorney (Health & Welfare).
Consideration should also be given to factors such as the ability to detect adverse effects e.g. whether the person is able to report adverse effects that may not be obvious to another person or whether the person will allow any blood testing that may be advisable to monitor treatment or rule out adverse treatment effects.

Unlicensed medicines or medicines used for an unlicensed indication should not be administered covertly unless there are exceptional circumstances, the carers or relatives have been fully informed of the unlicensed nature and are in agreement and the multi-professional team consider this to be in the person's best interest.

A covert medication plan must be developed detailing which medication(s) can be administrated covertly, the reasons for covert administration and an appropriate review date and the name and position of the decision maker. Appendix 1 contains a 'best interest' decision making tool which may help to inform the discussion.

10.9 The views of people involved in the person's care should be sought, as it is important that the decision to administer covert medication is not an isolated one. The person's GP or medical prescriber, other members of the multi-disciplinary team, the person's family (unless it is clear that the person would not wish for them to be involved), people closest to them, and (if applicable) care home manager or advocate, should all be invited to express a view. It is crucial that a decision is reached which is based on what the person would have wanted, not necessarily what is best for their physical or mental health. Where consensus cannot be reached, you should consider appointing an IMCA (Independent Mental Capacity Advocate) or consider a second opinion.

10.10 **Involvement of the pharmacist**. Advice must be sought from the pharmacist when mixing any medication with food or drink. This is to ensure that the medicines the person takes are safe to be given in this way and recommendations can be made about use of alternative formulations or medicines as necessary. Any changes to the person's regular medication after a plan for covert medication is put in place, would require a further best interest decision and again should be discussed with a pharmacist. If the person is living in the community then the dispensing (community) pharmacist should be contacted for advice. If the community pharmacy is unable to offer advice, care providers should contact local medicines management teams for advice and support.

Practical issues around administering medicines covertly.
Wherever possible, a suitable licensed liquid or soluble formulation should be used. There is a risk of altered bioavailability if tablets are crushed or capsules opened, particularly for modified release, gastro-resistant or enteric coated preparations.

Consider implication of switching to liquid medicines in the context of whether the person may have a choke risk and the potential impact of any thickeners that may be added to the medicines to minimise choke risk.

Consider whether medicines that require swallowing with a full glass of water are suitable where a person has swallowing difficulties. Any medical, cultural or religious dietary requirements should be complied with e.g. gluten free diets, avoidance of animal gelatin for vegans and vegetarians, special requirements for some faith groups i.e Jewish, Muslim followers.

Food or drink at a high temperature should generally be avoided or allowed to cool down somewhat before using as a vehicle for covert administration. Any food or drink that has medication added to it should not be left unattended and should be taken directly to the person for consumption. Mixing of medicines that are not specifically designed to be mixed together should be avoided as this may lead to inactivation of one or more components, a chemical reaction or even the formation of a toxic product. Mixing two (or more) medicines for administration where one is not a vehicle for dissolving, dispersing, diluting or mixing the other, results in a new unlicensed product. Mixing of medicines immediately prior to administration should therefore be avoided unless benefits to the person are thought to outweigh the risks.

10.11 **Documentation**. In order to be transparent and to provide a clear audit trail any person receiving covert medication should have a care plan which contains information about who the decision maker is, why the person is not compliant with their medication, the reason it is necessary for the medication to be administered covertly, ways in which adherence could be improved and how often this will be reviewed. The decision to use covert administration should be recorded in the person's notes/care plan.

Transfer between care settings
If a person is being transferred to another care setting, arrangements should be made to clearly communicate the covert medication plan to the family/care home manager/care provider, however it will be the responsibility of the new provider to complete a capacity assessment and follow the best interest process to agree a new covert medication plan, it is not appropriate to rely on the decisions made by the previous care setting.

10.12 **Review**. On-going attempts to encourage adherence are essential. As far as possible, a reason for refusal must be sought and documented within an appropriate care plan. Once taken, the decision to administer covert medication **must** be reviewed in respect of each patient on a regular basis. It should be understood by the team that covert medication is not a long-term solution. Patients' needs may change over time and this should be recognised and continuously reviewed.

The covert medication care plan must be reviewed at least every 6 months or following any changes to the person's treatment/medical condition or where the person regains capacity to consent. Regularly attempt to offer medicines openly; it should not be assumed that covert administration will be necessary as a long term solution. If a person who previously lacked capacity for treatment subsequently regains capacity, the person should be offered medication openly and if they refuse, the medicine should not be given covertly. Certain medicines may have side-effects (e.g. sedation or affecting mobility) which may amount to deprivation of a person's liberty. It is the responsibility of any care worker to be vigilant in identifying such persons affected and taking the necessary action to secure the least restrictive options in the person's best interests.

11. EXCEPTIONS TO GUIDANCE FOR OBTAINING A PERSON'S CONSENT

11.1 **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 patient's best interests and should be clearly recorded. noting who took the decision, why the decision was taken and what treatment was given.

11.2 **Patients Detained Under Mental Health Act (1983)**
For patients detained under the Mental Health Act, the principles of 'consent' continue to apply to any medication for conditions not related to the mental disorder for which they had been detained. The assessment of their capacity to consent or refuse such medication therefore remains important. However, in relation to medication for the mental disorder for which the patient has been detained, medication can be given against a patient's wishes for up to 3 months after which treatment may only be continued if sanctioned by a Second Opinion Approved Doctor (SOAD).

12. EDUCATION AND TRAINING

12.1 All staff involved in the administration of medicines should be aware of this guidance and appropriately trained and competent.

13. MONITORING AND REVIEW

13.1 The policy will be reviewed every 2 years by the Medicines Management Team/Adult Safeguarding Lead or earlier in the event of changes to legislation or good practice.

13.2 The Medicines Management Team along with the Safeguarding Lead will investigate and monitor compliance to this policy

14. IMPLEMENTATION AND DISSEMINATION

14.1 Clinical service leads for each care provider will be responsible for ensuring all care staff are aware of and understand the requirements of this policy

15. CONSULTATION

15.1 This policy has been developed in consultation with the following individuals:

- Ceri Wright - Care Homes Lead Medicines Management, Team Shropshire CCG
- Kathy George – Named Nurse Adult Safeguarding, Telford and Wrekin CCG
- Amy Potts – Care Homes Medicines Management Technician, Telford and Wrekin CCG
- Hitesh Patel – Senior Pharmaceutical Adviser NHS Telford and Wrekin CCG

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NICE Managing medicines in care homes good practice guidance
https://www.nice.org.uk/guidance/sc1

GMC: Consent. Patients and doctors making decisions together.
http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

Appendix 1:

Balance sheet

This balance sheet can be used as a tool to assist decision making when covert medication is being considered, especially where there may be a lack of consensus within the team. It must be ensured that all alternative options have been exhausted before the decision to covertly administer medication is considered.

Questions for consideration by the team:

- How urgent is the medical need and is the medication necessary?
- Will the medication cause side effects that are unacceptable to the person?
- What are the chances of the medication successfully treating the condition?
- What were the person's prior beliefs about medication?
- Will it affect the therapeutic outcome?
- Is the condition likely to improve without medication?
- Have alternatives been tried or considered?
- Is capacity likely to return?

Pros of giving medication covertly	**Cons of giving medication covertly**

Appendix 2

Flowchart for the use of covert medication