NHS
Bedfordshire
Clinical Commissioning Group

Covert Administration of Medication (Adult)

Best practice guidance

December 2017

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Responsibility:	All General Practitioners who may need to consider covert administration for patients in their care. All care providers administering medication. All other relevant members of the multidisciplinary team who may be involved in the process.
Effective Date:	December 2017
Review Date:	December 2019
Reviewing/Endorsing committees	Patient Safety and Quality Committee
Version Number	V5
Related Documents:	Mental Capacity Act Policy Deprivation of Liberty Safeguards Policy

DEVELOPMENT PROCESS

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Equality Impact Assessment prepared and held by

Date	Name	Designation	Email

Committee where guidance was discussed/approved/ratified

Committee/Group	Date	Status
Prescribing committee	5/12/17	Approved

Equality Impact Analysis/Statement

Equality Impact Assessment

This best practice guidance, properly followed would have no adverse impact on individuals from any of the nine protected characteristics in the Equality Act namely age, disability gender, sexual orientation gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief.

The guidance proscribes the process to be followed by CCG employees to meet the legislative requirements and ensures that the use of covert medicines for the treatment of either a physical or mental illness is only used in prescribed circumstances. All decisions will be taken in accordance with the law and will be based on the capacity of the individual not their disability, diagnosis, age etc. The policy also highlights the need to ensure that appropriate dietary requirements are met which may be used to contain covert medication for religious and/or medical reasons.

The guidance is comprehensively based on current statutory requirements and NHS and other specialist policies and practices, which are, where appropriate, subject to equality impact assessments in their own right.

Considering all these factors a separate equality impact assessment for this policy is not required.

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APPENDICES

1. Introduction

This guidance supports best practice for the administration of medicines to patients who are unable to give informed consent to treatment and refuse to take medication when offered to them and for whom medicines are administered in drinks and foods **unknowingly**. The intention is to ensure that individuals refusing treatment as a result of their illness will have access to effective medical treatment when it is considered to be clinically in their best interest and proportionate to their level of risk.

1.1 Bedfordshire Clinical Commissioning Group (BCCG) strives to ensure the safety of its population and to promote a safe environment in which to deliver care. An important part of care is the prescription and administration of medicines, which must be undertaken lawfully at all times.

1.2 This guidance provides support for staff regarding the covert administration of medicines and explains when this can be done within the law and how it can be implemented.

1.3 The Nursing and Midwifery Council (NMC) recognises that there may be exceptional circumstances in which covert administration may be considered necessary to prevent a person from missing out on essential treatment. However it should be acknowledged that an unsubstantiated instruction to covertly administer is against professional practice and potentially unlawful.

1.4 The British Medical Association (BMA) provides resources to support doctors to help in good decision-making when providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf. The Mental Capacity Act 2005 sets out a number of basic principles that must govern all decisions made and actions taken under its powers. These are rooted in best practice and the common law and are designed to be fully compliant with the relevant sections of the Human Rights Act.[1]

2. Definitions

2.1 Covert administration is the administration of any medical treatment in a disguised form. This usually involves disguising by administering in food or drink. As a result the person is unknowingly taking medication which they have previously refused when offered. **It is not acceptable to simply tell a person you are putting their medication into food or drink when capacity to understand has not been assessed.**

2.2 Overt administration is the practice of putting medication into food and drink to make it more palatable often at the request of the patient. This could still be regarded as deceitful and open to abuse unless clear documentation supports the practice in the individual care plan. Overt administration is a co-operative process that is transparent and open to scrutiny and audit, and by definition requires capacity to understand what is being done.[2]
It is therefore NOT covert administration if a patient has swallowing difficulties and has consented to medication being mixed in food and drink to aid administration and is fully aware that this is being done.

[1] http://bma.org.uk/practical-support-at-work/ethics/mental-capacity
[2] Best practice guidance in covert administration of medication, PrescQIPP Bulletin 101, 2015

3. Objectives

3.1 BCCG recognises the key importance of respecting the autonomy of individuals who refuse treatment. However, there are times when very severely incapacitated patients can neither consent nor refuse treatment.[3]

3.2 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 document is to provide guidance as to when this practice is lawful, and to ensure that if it happens due process has been followed and that the practice is transparent and open to public scrutiny and audit.

3.3 The guidance has been developed to provide member practices with clear processes to support decisions to follow a covert administration pathway thereby supporting consistent and safe practice.

4. Scope

4.1 The document provides guidance on covert administration of regular medication for:

- BCCG General Practitioners and Non-Medical Prescribers who may need to consider covert administration for patients under their care.
- Nurses or paid carers who may be instructed to administer medication covertly. Whilst the BCCG guidance provides the principles which are expected for its population, additionally, a nurse would be expected to work within NMC guidance and a paid carer to follow the policy of their organisation.
- Other members of the multidisciplinary team (e.g. pharmacists) who may be involved in the care pathway.

The scope of this guidance does not cover the administration of medication in an emergency situation.

5. Responsibilities

5.1 In the development of the guidance key stakeholders have been included in the consultation. These include:

- LMC to provide input into the implications for GPs in following the processes within this document
- GP lead for safeguarding within BCCG who will assist in the implementation of the guidance within practice
- Mental Capacity Leads within Borough Councils who will assist in the use of the guidance when needed within the local councils.
- CCG Mental Capacity Act and Deprivation of Liberty Safeguards Lead/Manager who will assist in the implementation of the guidance within the CCG and member practices.
- Adult Safeguarding lead within BCCG Quality and Safety directorate who will assist in the implementation of the guidance within the social care settings.

[3] Psychiatric bulletin (2004) 28:385-386

6. Legislation and Guidance

6.1 This guidance should be read in conjunction with:

- Mental Capacity Act Policy 2016 for Bedfordshire CCG
- Deprivation of Liberty Safeguards Policy 2017 for Bedfordshire CCG
- Mental Capacity Act 2005 Code of Practice.
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf
- NMC (2010) Standards for medicines management
  http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-for-medicines-management.pdf
- NMC (2015) The Code – Professional standards of practice and behaviour for nurses and midwives
  https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
- NICE Guidance - Management of medicines in Care Homes good practice guidance March 2014
  http://www.nice.org.uk/guidance/SC1
- NICE Quality standard (QS85) Medicines management in care homes, March 2015
  https://www.nice.org.uk/guidance/qs85
- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission "Essential standards of quality and safety" March 2010 Outcome 9 Management of Medicines.
  http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf
- Human Rights Act 1998
- Joint Medicines Policy for domiciliary care agencies Bedfordshire CCG and Bedford Borough Council
- BMA Mental Capacity Toolkit
  https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit
- PrescQIPP Bulletin 101 – Best practice guidance in covert administration of medication, September 2015
  https://www.prescqipp.info/care-homes-covert-admin/send/216-care-homes-covert-administration/2147-b101-covert-administration

7. Assessing Mental Capacity (see Appendix 2)

7.1 A Mental Capacity Act (MCA) assessment is the responsibility of the prescriber, usually a GP. The prescriber is responsible for leading and undertaking the assessment, this is not the care home's or home manager's responsibility. The assessment can be carried out jointly with care home staff and the involvement of family, close friends or carers can be beneficial, especially if there is any doubt about a decision. A multidisciplinary team meeting at the care home can be arranged as good practice.

7.2 An MCA assessment form can be found on System One or see appendix 2 for a word version.

7.3 Decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the 5 key principles set out below:

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 lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him 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 makes an unwise decision.
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.

7.4 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[4]. 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 consent if he or she is unable to:

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

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed.

7.5 An Advance Decision to Refuse Treatment (ADRT) in anticipation of future incapacity must be adhered to if valid and complete. Crucially 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.
Please note – a person's Lasting Power of Attorney (LPA) could override an ADRT if the LPA is registered after the ADRT was drawn up and it is stipulated in the LPA documentation.[5]

7.6 A patient/client 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 patient/client. 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.

7.7 Where adult patients/clients are capable of giving or withholding informed consent to treatment, no medication should be given without their agreement. For that agreement to be effective, the patient/client must have been given adequate information about the nature, purpose, associated risks and alternatives to the proposed medication. An adult with mental

[4] Mental Capacity Act 2005
[5] Mental Capacity Act Policy (2016) Bedfordshire CCG

capacity has the right to refuse treatment, even if refusal will adversely affect his or her health or shorten his or her life. It may be considered necessary to seek the advice of Court of Protection if the clinician is unsure of the ethics of such decisions. Therefore, registrants must respect a competent adult's refusal as much as they would his or her consent. Failure to do so will be unlawful and may be a breach of their human rights. The exception to this principle concerns compulsory treatment authorised under the relevant mental health legislation.

7.8 When an emergency arises in a clinical setting and it is not possible to determine the patient's wishes, they can be treated without their consent provided the treatment is immediately necessary to save their life or prevent a serious deterioration of their condition. The treatment provided must be the least restrictive option available. Any medical intervention must be considered to be in the patients best interest and should be clearly recorded noting who took the decision, why the decision was taken and what treatment was given and when.

7.9 Due consideration must be given to the Human Rights Act 1998 and the following relevant sections of the Act have been highlighted by Royal College of psychiatry regarding covert administration[6].

Article 2: ***'Everyone's right to life shall be protected by law'***
Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article might be used to justify such a practice. Clearly no treatment can be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatment may, sometimes, shorten life as a secondary result of their administration). Administration of treatments whose purpose is to shorten life is illegal.

Article 3: ***'No one shall be subject to torture or inhuman or degrading treatment or punishment'***
In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than the covert administration of medication.

Article 5: ***'Everyone has the right to liberty and security of person'***
To justify the invasion of privacy which covert medication entails, it must be clear that this invasion is justified by the need for effective treatment.

Article 6: ***'Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law'***
It is essential that, if medication is administered covertly this is done following discussion and with clear clinical records, so that a fair and public hearing may be obtained when required.

Article 8: ***'Everyone has the right to respect for his family life, his home and his correspondence'***
See comments to Article 5 above.

[6] http://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf

8. Best Interest decision

8.1 When a patient/client is considered as lacking mental capacity to make a decision about their treatment options, the responsible clinician must make a decision following the best interest's process in section 4 of the Mental Capacity Act 2005. This process is summarised below and each element must be followed when making a decision for someone else.

Summary of best Interests checklist[7]

- 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 comments of family and informal carers (trying to glean what the person would have wanted if they were able to make this decision for themselves - **and**
- Take into account views of any Independent Mental Capacity Advocate (IMCA) or other key people involved - **and**
- Show evidence and document it is the least restrictive alternative or intervention.

8.2 When covert administration is being considered, a 'best interests' meeting may be beneficial to explore the best interests process. This is recommended by NICE, although this is not a legal requirement. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.

8.3 A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and a pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or an Independent Mental Capacity Advocate (IMCA) depending on the resident's previously stated wishes and individual circumstances). However, nobody can consent for someone else; but the views of family/carers may be beneficial in determining a patient's/resident's wishes and feelings and what is in their best interests. If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.[8] Please note: If a pharmacist cannot be present, their advice should be sought before the decision to proceed is made in order to check the suitability of the medication to be administered in this way. (See appendix 3 for documentation).

8.4 A management plan should be agreed after a best interests meeting, and this would usually include:

[7] Best practice guidance in covert administration of medication, PrescQIPP Bulletin 101, 2015
[8] NICE Quality Standard (QS85) Medicines Management in Care Homes, March 2015

- A clinical medication review by a prescriber or pharmacist
- A medication review by a pharmacist to advise the care home how the medication can be covertly administered safely.
- Clear documentation of the decision of the best interests meeting (see appendix 3).
- A plan to review the need for continued covert administration of medicines on a regular basis.

9. Deprivation of Liberty Safeguards (DoLS)

9.1 Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

9.2 DoLS are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restriction to be used – but only if they are proportionate and in the person's best interests. DoLS are used when any restrictions or restraints mean that a person is being deprived of their liberty.[9]

9.3 A DoLS authorisation does not necessarily need to be in place if covert administration is being considered. Covert administration alone would not constitute a deprivation of liberty. However, DoLS has to be a consideration if covert administration of medication is given as it is an impingement of the person's basic rights and freedoms.

9.4 A DoLS that is already in situ must be reviewed when medication is being administered covertly. It is the care home manager's responsibility to ensure that a request for a DoLS review is sent to the local authority as another restriction is being placed on that individual.

Please refer to the BCCG Deprivation of Liberty Safeguards Policy for further information.

10. General Principles of Covert Administration

10.1 Any healthcare professional involved in the covert administration of medication should be aware of the treatment aims and the legal and ethical implications of covert administration.

10.2 Where covert administration is considered to be 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 by conducting a clinical medication review.
- **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 decision-** 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.

[9] Deprivation of Liberty Safeguards Policy (2017) Bedfordshire CCG

11. Practical Implementation **(See appendix 2 Covert medication care pathway)**

All of the points below should be used as evidence of best interest decision to administer covertly and should form part of the documentation to support it.

11.1 Before administering medication covertly the patient should again be encouraged to take it in the normal way e.g. by giving regular information and explanation by different team members.

11.2 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.

11.3 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?

11.4 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.

11.5 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. It is important not to compromise the patient's nutrition. A dietician should be consulted if there are concerns.

11.6 The prescriber should consider an alternative route of administration of that medication (e.g. topical) or an alternative medication (e.g. available in different forms which are more palatable or which have to be given less frequently).

11.7 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 – always seek advice from a pharmacist before doing so.

11.8 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).

11.9 The pharmacist should refer to the standard texts, the SPC for the medicine(s) concerned, and specifically to appropriate reference sources[10] to advise on suitability.

11.10 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) is safe and will not cause harm to the patient.

11.11 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

[10] "Handbook of Drug Administration via Enteral Feeding Tubes" Rebecca White and Vicky Bradnam, Pharmaceutical Press

the likelihood that the prescribed dose is actually taken. Not all drinks are suitable e.g. tea or milk interacts with some medication.

11.12 The medication must be administered immediately after mixing it with the food or drink.

12. Record Keeping

(See appendices 2&3)

12.1 The prescribing clinician must have completed both the mental capacity assessment for understanding of medication issues (appendix 2) and the covert medication pathway which includes the best interest decision (appendix 3) to support covert administration.

12.2 The completed documentation must be scanned in the patients/residents clinical notes at the surgery and copies must be shared with the provider (e.g. care home) for inclusion in the care plan for that individual. The covert medication pathway authorises covert administration and the use of the medication in an unlicensed fashion as appropriate.

Please note: it is important that the provider (e.g. care home) receives copies of completed documentation as this may be required if a DoLS assessment needs to be undertaken.

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

12.4 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.

13. Review of continued need

13.1 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.

13.2 A review of the care plan relating to medication should be done monthly by the care home to check if covert administration is still required and this should be documented in the care plan.

13.3 The prescribing clinician is responsible for reviewing the covert administration of medication every 3 to 6 months, with the maximum interval between reviews not exceeding 6 months. The review process must also include a review of capacity and best interest decision. All completed review documentation must be scanned in the patients/residents clinical notes at the surgery and copies must be shared with the provider (e.g. care home).

13.4 Fluctuating capacity requires more frequent monitoring in order to ensure that human rights are respected. In some cases a review may be required earlier than anticipated and reasons for this must be documented.

13.5 The only justifiable reason for not conducting a review would be if the reviews were causing distress to that individual. This would need to be evidenced in the surgery records and in the care plan, but should still be revisited regularly to check if a review could be done.

13.4 Any significant changes to medication made as a result of the review should prompt a review of any DoLS in situ. It is the care home manager’s responsibility to request a DoLS review by the local authority.

Useful contacts:

- Karen McCulloch
  Mental Capacity Act & Deprivation of Liberty Safeguards Lead for BCCG & Luton
  Email: Karen.mcculloch1@nhs.net
  Tel: 01525 624321 or 01582 531853 or mobile: 07769 137149

- Harprit Bhogal
  Care Home Pharmacist BCCG – Bedford Locality
  Email: harprit.bhogal1@nhs.net
  Mobile: 07733 013073

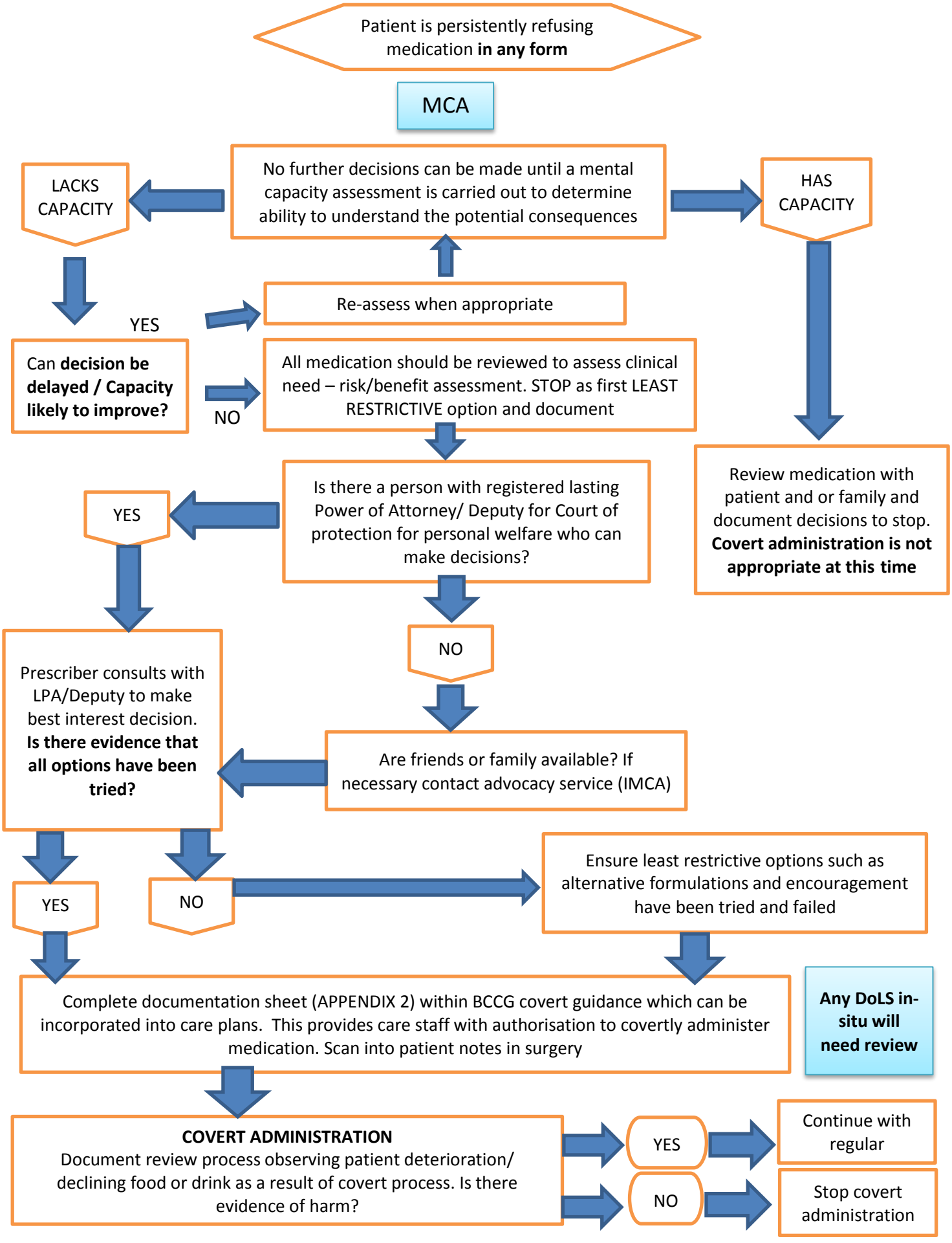
- Independent Mental Capacity Advocate (IMCA)
  IMCA provision for Bedfordshire and Luton is POhWER
  Email: pohwer@pohwer.net or imca@pohwer.net and http://www.pohwer.net/
  Tel: 0300 456 2370

- Office of the Public Guardian (OPG)
  OPG can be contacted to find out if someone has an LPA or Deputy acting for them
  You need to complete form 'OPG 100' to search the register. This is a free service.
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/286541/OPG 100_Apply_to_search_PG_registers.pdf
  Send your completed form to: Office of the Public Guardian
  customerservices@publicguardian.gsi.gov.uk
  Fax: 0870 729 5780

Appendix 1- Covert medication flow chart

NHS Bedfordshire Clinical Commissioning Group

This flow chart must be used in conjunction with the full BCCG Covert administration guidance



APPENDIX 2: MCA 01 Mental Capacity Assessment Form for LESS complex decisions (November 2015)

Every adult should be assumed to have the capacity to make a decision unless it is proven that they lack capacity for that decision.
An assumption about a person's capacity cannot be made on the basis of a person's age, appearance, diagnosis or aspect of their behaviour.

1	**Name of Relevant Person**	**Address of Relevant Person**						
2	**Preferred Name of Relevant Person**							
3	**Date of Birth**							
4	**NHS Number**							
5	**I am starting this assessment on (insert date and time) …… Although I presume capacity, I doubt the person is able to make this particular decision at this time.**							
6	**What is the decision that needs to be made?**							
7	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**					Yes		No
7a	**Details of Impairment:** (For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, a dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)							
8	**Can the decision be delayed because the person is likely to regain capacity in the near future? Give Reasons below:**	Yes		Not likely		Not appropriate to delay		
9	**Assessment:**							
a. Person has ability to <u>understand</u> information related to the decision to be made?						Yes		No
Details:								
b. Person has ability to <u>retain</u> information long enough for the decision to be made?						Yes		No
Details:								
c. Person has the ability to <u>use or weigh up</u> the information in considering the decision?						Yes		No
Details:								
d. Person has ability to <u>communicate</u> their decision by any means?						Yes		No
Details: (State what steps have been taken to achieve communication)								
If you have answered YES to all of the questions 9a – 9d above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. If you have answered **NO** to one or more of those questions then on the balance of probability the person is not likely to have capacity for this decision and you will be required to proceed.								

Details of any Advance Decisions to Refuse Treatment (ADRT): (Does any ADRT relate to this particular decision. Reference and attach any relevant documents)					
Conclusion:					
10	**Person HAS the capacity to make this informed decision at this time?**	Yes		No	
Document and detail your evidence and give reasons for your conclusion:					
11	**What is the persons Preferences/Wishes?** NB. If person has the capacity for this decision you must respect their preferences and wishes, document these here and sign and date below the completion of this capacity decision. If they DO NOT have capacity for this decision you must still respect the rights, will and preferences of the individual and give weight to their views when making a decision in their best interests.				
Signed:		**Date of Completion:**			
If person is found to lack the capacity to make this decision for themselves please continue					
12	**Are there any known relatives or friends to consult with?** If they have Lasting Power of Attorney that covers this decision, i.e. Person Welfare to cover Health decisions) they may be able to make this decision in the best interests of the person, photocopy LPA docs and keep on person's file.	Yes		No	
Names of relatives/friends you have consulted		Contact/Email/ Telephone			
13	Where there are NO relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) **MUST be instructed** (by the decision maker, i.e. person completing this form) if the decision is about **Serious Medical Treatment, a permanent accommodation move** or you have identified that you are likely to be depriving the relevant person of their liberty; **Deprivation of Liberty Safeguards** (DoLS). Call POhWER for further advice and to make a referral: 0300 456 2370 or email: IMCA@pohwer.net				
Name of IMCA allocated	**Referral sent (date)**	**Tel/Email of IMCA**			
14	**Detail any disputes or disagreements and who is disputing:** (Include details of what steps were taken to resolve the disputes) Attach other sheets if required.				
15	**State final decision made in the person's best interests:** (please refer to Section 4 of the MCA or Chapter 5 of the MCA Code of Practice)				

Declarations:

I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.
I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death.
I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter. I reasonably believe that the person does lack capacity (because of the impairment or disturbance in the functioning of their mind or brain), in relation to this matter and that it will be in the person's best interests' for the decision to be made or act to be done.
I confirm that where the decision or act is intended to restrain, I believe that the restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.

Name of Assessor/Decision maker/person completing this form:	
Role/Job Title of the above:	
Signature:	
Date of completion:	
Date when decision will be reviewed:	

Appendix 3 –Covert medication care pathway

Best interest decision and instructions for carers

NHS Bedfordshire Clinical Commissioning Group

Please provide a copy of this pathway to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of patient			
Date of birth		Location	

• What treatment is being considered for covert administration? It has been confirmed that no advanced decisions are in place concerning this treatment.		
	Confirmed by:	
	Signature:	
• Why is this treatment necessary? • How will the person benefit? • Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g. NICE.		
• What alternatives did the team consider which were not successful? E.g. Other ways to manage the person or other ways to administer treatment. • Why were they not appropriate?	State the options tried.	
Treatment may only be considered for a person who lacks capacity. • When was Mental Capacity Assessment (MCA) for this issue completed?	Date:	
	Assessed by:	
• Who was involved in the decision? N.B. A qualified pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable If there is any person with power to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable.	Name of practitioner staff involved:	
	Name of relatives, advocates or other carers involved:	
When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review - at least every three months)	Date of first planned review	

GP name:	
Signature:	
Date:	

NHS Bedfordshire Clinical Commissioning Group

Instructions for carers

This information should be included in the patient's care plan and with the medicines administration record (MAR) sheet.

Name of patient			
Date of birth		Location	

Name of medication to be administered:	
Instructions for administration Specify clearly how it is to be administered. Include instructions on directions for pharmacist to label if possible. Include any cautions such as temperature/types of food to avoid.	
Name of pharmacist/GP providing instruction for administering:	
Date of commencement:	
Date of review:	
Authorised by:	

Report to GP at next contact if:

- Covert administration results in a refusal to eat or drink
- It appears that the full dose of medication has not been taken (make a note on MAR chart)
- There appears to be a deterioration in the patients health and well being.