Covert Administration of Medicines Policy

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1. Executive Summary

1.1. People should not be given medications without their knowledge if they have the mental capacity to make decisions about their treatment and care.

1.2. NICE stated in its guidance on “Giving Medicines Covertly” that adults should not be given medicines covertly unless they have been assessed as lacking the mental capacity to make decisions about their health or medicines.

1.3. There might be situations where the patient decline their medicine and have the capacity to make these decisions, the care staff should record that the patient have declined and the reason why (if a reason is given) documented in the patient’s record.

1.4. The prescriber should be asked to review the person’s treatment or administration process for possible other ways to influence administration of medicines.

1.5. However, there might be situations where this happens regularly or may present a risk to the person’s health or risk to others if medications are not administered. It is during these exceptional circumstances that health care professionals try to consider other ways to get patient take their medications and covert administration is one of the options often considered for a short term.

1.6. Covert administration is when medicines are administered to a person in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.

2. Introduction

2.1. East London NHS Foundation Trust (ELFT) strives to ensure the safety of its service users and to promote a safe and therapeutic 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.

2.2. There may be exceptional circumstances in which covert administration may need to be considered to prevent a service user from missing out on essential treatment.

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

3. Purpose

3.1. The aim of this policy is to:

3.1.1. ensure that covert administration of medication is appropriately used only in exceptional circumstances;

3.1.2. provide guidance on the process for assessing, consulting, documenting, administering and monitoring of covert administration of medication, to ensure it is

carried out lawfully;

3.1.3. ensure that if covert administration happens within any service setting of the trust, that it has been properly considered and that the practice is transparent and open to public scrutiny and audit;

3.1.4. ensure that the trust has a framework for the use of covert administration which complies with legal requirements, and also provide governance structure to protect patients and staff;

3.1.5. enable the delivery of effective patient care in the service setting, without compromising patient safety, or open to abuse.

4. Definition for covert administration of medicines

4.1. The covert administration of medicine is the process by which medication is administered to a person in a disguise format without their consent and knowledge of that person receiving it. It may be mixed with food or drink to conceal administration. This can only occur when it is deemed justified and necessary and all legal requirements as laid out in this policy are fulfilled.

4.2. For patients with swallowing difficulty, sometimes the medication can be administered with soft food or in a drink and **this would not be considered as covert if the patient is fully aware, and has consented (and has mental capacity to give valid consent which has been recorded), to having their medication administered in this way**. The patient must be advised by the care staff that their medication has been mixed with food or liquid every time it is administered, and this should be clearly documented.

4.3. When medication is mixed with food/drink, staff must ensure that the entire dose is administered to the patient and that it is not left unattended, ensuring that no other service user have access to it. It is also important to note that crushing medications and mixing them with food/drinks often renders the medication unlicensed. Therefore, the prescriber/pharmacist must be consulted and authorise such practice prior to administering medication in this way.

4.4. Contact your local ELFT pharmacy team for written advice on crushing medications and/or mixing medications with food/drinks.

5. Duties and Responsibilities

5.1. Prescribing Health Care Practitioner:

5.1.1. responsible for undertaking mental capacity assessment when covert administration of medication is being considered and there are doubts to rebut

the presumption of capacity;

5.1.2. must record capacity assessment and any relevant best interest decision using the mental capacity form on electronic patient records;

5.1.3. must consider if the medication administered covertly would be a form of chemical restrain which could lead to the patient being deprived of their liberty (this consideration must be clearly recorded in the best interest decision documentation);

5.1.4. must complete the covert medicines care plan (Appendix 1);

5.1.5. must specify the medications that need to be given by covert administration;

5.1.6. authorise such practice in writing prior to medications being administered covertly;

5.1.7. must ensure regular reviews of covert care plan as agreed, **not later than 3 months;**

5.1.8. must ensure that carer/relative/significant other/person with power of attorney or deputy for health and welfare appointed by the Court of Protection are involved in meeting;

5.1.9. must review the covert medicines care plan whenever changes are made on the medications.

5.2. Service Pharmacist/Pharmacy Technicians, within their own scope of responsabilities, must:

5.2.1. provide advice on appropriate and safe way to administer medication covertly, which involves advice regarding formulation, dispersing or crushing of medication;

5.2.2. review medication and make appropriate recommendation on concealment of medication in food and drink, using the format in appendix 4;

5.2.3. provide written instructions on how medications can be mixed with foods/liquid drinks and the appropriate food/drinks that can be used;

5.2.4. must sign the covert medicines care plan form prior to administration of medications covertly;

5.2.5. in respect of the pharmacist and/or pharmacy technicians providing reconciliation service for the care home providers in the local area, in collaboration with the Integrated Care Boards. The staff must notify respective prescribers and follow specific internal protocols of the Integrated Care Boards' Medicine Optimisation Teams as per the local arrangements, when the use of the covert medication is identified during the reconciliation process, as long as those policies/protocol do not contradict the hereby policy.

5.3. Nurses administering medications must:

5.3.1. ensure medication is only administered covertly where there is a covert care plan in place, and using method advised by the pharmacist;

5.3.2. ensure any required signatures on the covert medicines care plan are in place;

5.3.3. try to offer the medication first openly and only administer them covertly when refused by the patient;

5.3.4. ensure that all food/drink in which the doses of the medication were mixed, are finished, by the patient the food is meant for;

5.3.5. notify the prescriber, pharmacist and the charge nurse of any difficulties observed giving the medications covertly so that review can be considered;

5.3.6. to ensure the covert medicines care plan in use is valid and has not expired.

6. Scope of the policy

6.1. This policy applies to:

6.1.1. adults and children who are admitted to inpatient settings managed by ELFT;

6.1.2. adult and children with regard to whom ELFT clinicians provide treatment of their healthcare needs in relation to which particular medicine has been prescribed.

6.2. This policy also applies to all ELFT registered clinicians and health care professionals administering/prescribing medication for patients residing in care homes, who may be considering use of covert medication administration as part of a treatment plan.

6.3. The policy provides guidance for professionals involved in prescribing and administering medicines who may need to consider covert administration for patients under their care.

7. Principles of administering medicines covertly

7.1. If a patient has the capacity to refuse medical treatment then this decision must be respected, and covert administration of medication would be unlawful, unless provided in line with the provisions of the Mental Health Act 1983 (MHA 1983), for patients subject to relevant provisions of the aforesaid act. The MHA 1983 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.

7.2. Clinicians need to be mindful that patients being treated under the MHA 1983, may not be treated for physical illness which are unrelated to the mental disorder for which they receive compulsory treatment, if they refuse treatment and have the mental capacity to do so or made an advanced decision to refuse this particular treatment.

7.3. Covert medication may only be given to a mentally incapable patient who is detained under provisions of MHA 1983, if they fall under Part 4 of the aforesaid Act, i.e. if sections

58(3) or 58(3)(b) or 63 of the aforesaid Act apply.

7.4. It is important to highlight that the s58 and s63 MHA 1983 do not apply to patients detained under s4, s5(2), s5(4), s17A, s35, s135, s136 MHA 1983.

7.5. Additionally, the s58 and s63 MHA 1983 would not be applicable in relation to the person detained under Part 3 of the MHA 1983, in a place of safety, pursuant to s37(4) and 45A(5) MHA 1983 and the proposed use of covert medicine, constitutes treatment for mental disorder.

7.6. Adults who lack the mental capacity to consent to or refuse treatment may need to be treated in their best interest, pursuant to provisions of the Mental Capacity Act 2005 (MCA 2005).

7.7. Note that the scope of this guidance does not cover the administration of medicines in an emergency situation.

7.8. Administration of the covert medication, pursuant to MCA 2005, must be done in line with ELFT Mental Capacity Act Policy.

7.9. Medicating a person without their consent constitutes the tort of battery or assault under the common law, and the courts have confirmed that it is also a serious infringement of a person's article 8 ECHR rights, and must be strictly justified, to be lawful. Further, it may also be a factor contributing to a deprivation of liberty under article 5 of the ECHR. All of this points to the need for strict justification and proper scrutiny.

7.10. In the situation when the person refuses to accept medication prescribed by the clinician orally, every effort should be made to explore reasons for this and work with the person to convince them to accept medication, before restoring to the covert use of medication.

7.11. If the clinician responsible for prescribing medication, following the period of refusal of the oral medication being administered, considers that there is a likelihood that the person might lacks mental capacity to consent to the medication being administered, the clinician must complete the mental capacity assessment and clearly document this using designated form on electronic patient record.

7.12. Whilst assessing the mental capacity of the patient, the clinician needs to consider factors which might impact on person's refusal to accept medication orally, such as:

7.12.1. long established reluctance to engage with medical treatment that precedes the loss of capacity,

7.12.2. disengagement from medical treatment because of personality and behavioural problems associated with dementia,

7.12.3. a reluctance to accept medication because of difficulty swallowing tablets, or

7.12.4. if the cognitive impairment is severe, refusal of medication because of an inability to recognise what is being offered, or what is expected, (among other reasons).

7.13. If the clinician assessing person's mental capacity will conclude that they lack mental capacity to accept the medication orally, the best interest decision needs to be made by the clinician who oversees the prescribing the treatment.

7.14. The clinician who completed the mental capacity assessment must explore if there is any donee with the LPA/deputy for health and welfare as they will be decision makers.

7.15. Any decision made by the donee or deputy regarding the covert use of medication must be clearly recorded on patient electronic record within the designated form for the best interest decisions.

7.16. If the prosed use of covert medication, is part of the decision to consent to the serious medical treatment, the clinician must involve the person's relatives/significant other who have been involved in their care, or in case the person is not befriended, make a referral to the local advocacy services for the Independent Mental Capacity Advocate to be appointed.

7.17. The best interest decision must consider if the medication is a sedative and is used a chemical restrain, as this could lead to the care plan amounting to person being deprived of their liberty.

7.18. In case when the donee or deputy will disagree with the recommendations of the clinician in relation to the covert use of medication, and the clinical team will consider this to be in the best interest of the patient, the clinician must seek advice from MCA Lead via e-mail: elft.mentalcapacity@nhs.net. Additionally, in case of any dispute/objection raised by the relatives/significant others of the person or their IMCA, or strong and clear objection expressed by the person themselves, the clinician must seek advice from ELFT's Mental Capacity Lead via e-mail: elft.mentalcapacity@nhs.net as the consideration would need to be given if any proceedings in respect of this decision ought to be brought before the Court of Protection.

7.19. It is especially important for the clinician to consider, as per the guidance formulated by the courts through their jurisprudence, including the following:

7.19.1. the nature of the proposed course of action (administration of covert medication),

7.19.2. the position of the family and their wish for this matter to be considered by the court,

7.19.3. the potential impact of this course of action on the relationship person might have with the clinical team involved in the covert medication decision;

7.19.4. person's relationship with the family due to their involvement with the clinical team responsible for that decision.

7.20. Additionally, the clinical team should consult ELFT's MCA Lead in cases where:

7.20.1. the decision is balanced, or

7.20.2. there is a difference of opinions among medical staff and/or pharmacists, or

7.20.3. there is a potential conflict of interest on the part of those involved in the decision-making.

7.21. As highlighted above, the use of covert medication within a care plan must be clearly identified of a person deprived of their liberty, which has been authorised under the DOLS framework. If a standard authorisation of DOLS is granted for a period longer than six months, there should be a clear provision for regular reviews of the use of covert medication, involving family/significant others and relevant healthcare professionals.

7.22. The Trust must notify the supervisory body of changes to the covert medication regime, including changes to the nature, strength or dosage of medications being administered covertly, which were part of the consideration under the DOLS assessment. In addition, changes should always trigger a review of the authorisation.

7.23. Additionally, if the person is deprived of their liberty in the community setting and the care plan envisages use of covert medication, this needs to be clearly outlined in the application to the Court of Protection.

7.24. When implementing the care plan involving use of covert medication, where the carers/family strongly objects to their use, the professionals need to consider if there is any risk of those people obstructing the care plan and potentially disclosing to the patient that they have been covertly medicated. In such cases, practitioners need to approach the ELFT MCA Lead via e-mail: elft.mentalcapacity@nhs.net for the case discussion to be arranged.

8. Covert administration of medication to children and young people

8.1. This chapter should be read in line with the Trust's:

8.1.1. Mental Capacity Act Policy;

8.1.2. Mental Health Act Supplementary Policy;

8.1.3. Consent to Treatment Policy

which contain details related assessment of mental capacity of young people age 16 and 17 and the Gillick competence of children under the age of 16 as well as elaborates on the use of covert medication for children and young people who are treated compulsorily under the provisions of Mental Health Act 1983.

8.2. The principle of administration of covert medication are very similar as those pertinent to adults, however the guiding principle is the welfare of the child, pursuant to s1 Children Act 1989.

8.3. In situation when the prescribing clinician considers use of the cover medication, when

the child/young person is not subject to compulsory treatment under provisions of MHA 1983, it needs to consider if the use of proposed medication, which were to be used covertly aims to sedate or control the person's behaviour otherwise, could lead to the care plan in its totality would amount to the child/young person being deprived of their liberty. In case of any doubt, the clinician must seek advice from ELFT Mental Capacity Lead to explore appropriate legal framework, which would need to be implemented: the email is elft.mentalcapacity@nhs.net

9. Assessment for service users refusing treatment

9.1. When patients with advanced dementia are reluctant to accept medication, all prescribed medication should be reviewed as part of end of life care planning to assess the appropriateness of the prescribed medication in this situation.

9.2. 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 ward pharmacist should be sought to establish whether it is practical to do so, and if so for advice about method of administration.

9.3. Staff should then complete a 'Covert Medicines MDT Care Plan' (Appendix 1) and ensure that all team discussions, and consultations of others are fully documented in the medical notes, including a detailed care plan.

10. Covert Administration of Medicines

10.1. Once all necessary assessments and procedures have been completed, covert medication may be given for a clearly defined period bearing in mind the following:

10.1.1. the decision to administer medicines covertly must not be routine practice and must be a contingency/emergency measure;

10.1.2. the service user's best interests must always be the first consideration;

10.1.3. the form in appendix 3 should be attached to the drug chart (where paper chart still in use) where nurses document if oral medication was accepted or refused. This need to be documented on electronic patient records also;

10.1.4. all conscionable efforts are to be made to encourage service users to take the medication prescribed for them without using covert administration;

10.1.5. if a service user continues to refuse the offered medication, this should be documented in their clinical notes, on appendix 3 form and the MDT team informed prior to covertly administering medications;

10.1.6. if a patient usually accepts oral but requires covert administration on some occasions, document the reason why they required covert administration on

electronic patient record, i.e. patient was more confused and unsettled today, etc.;

10.1.7. the method of administration must be agreed with the pharmacist and recorded in the care plan to be kept with the medication prescription chart or uploaded on electronic clinical record;

10.1.8. medicines can only be administered in food or drink when this manner of medicines administration has been prescribed by a doctor and endorsed by pharmacist in the 'additional instructions' part of the prescription chart;

10.1.9. the number of times/occasions medications are offered to service users before they are covertly administered should be agreed by the MDT on a case by case basis and stated on the "Covert Medicines MDT Care Plan" form;

10.1.10. it is important to ensure that giving medication in food does not compromise the service user's nutrition or affect the properties of the medicines;

10.1.11. administer medicines at the end or after a meal except where the properties of the medicines dictate otherwise;

10.1.12. when necessary the medicines must be mixed with a small amount of food or liquid rather that in a whole drink or portion of food;

10.1.13. generally medicines should be administered one at a time, unless the pharmacist has been consulted and given the go-ahead to administer medicines together.

10.1.14. service users receiving medicines administered in food or drink must be supervised until the medicine has been consumed.

11. Professional Conduct

11.1. All practitioners must reflect on the treatment aims of disguising medicine and be absolutely confident that they are acting in the best interests of the service user. The treatment must be considered necessary in order to save life, prevent deterioration in health, or ensure an improvement in the service user's physical or mental health status.

11.2. Registered nurses involved in covert administration of medicines must be fully aware of the aims, intent and implications of such treatment. If an authorised employee is involved in covert administration, it is the responsibility of the appointed practitioner in charge to ensure that they are fully aware of their own responsibilities arising from this practice.

11.3. The Royal College of Psychiatrists have issued a statement clarifying their position on the covert administration of medicines. The college statement recognises that, the key importance of respecting the autonomy of individual who refuse treatment. The statement went further to explain that there are times when very incapacited patients

can neither consent or refuse treatment. In these circumstances the college echoes the view of the law commission that treatment should be made available to severely incapacitated patients judged according to their best interest and the treatment admistered in the least restrictive fashion. The full detail of the college statement could be accessed via this link https://www.cambridge.org/core/journals/psychiatric-bulletin/article/college-statement-on-covert-administration-of-medicines/F0FAD544C59EF28D167D49A8F4BA921E

References:

- David Taylor, Carol Paton, Shitij Kapur (Authors); The Maudsley Prescribing Guidelines in Psychiatry (12th Edition), April 2015.
- Department of Health (2005): *Mental Capacity Act* London
- National Institute for Health and Care Excellence: *Giving Medicines Covertly* https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/giving-medicines-covertly
- 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
- Royal College of Psychiatrists: *College Statement on Covert Administration of Medicines*

  https://www.cambridge.org/core/journals/psychiatric-bulletin/article/college-statement-on-covert-administration-of-medicines/F0FAD544C59EF28D167D49A8F4BA921E

Appendix 1 Covert Medicines MDT Care Plan

Nursing Care Plan – to be completed and filed in patient's notes.

Patient's Name: …… RiO Number: ……..……

Date: ……

Summary of problems encountered:

What other medication options have been considered, e.g. different route?

In what way are the medicines (to be given covertly) essential and in the patient's best interests? Have the provisions of the Mental Health Act 1983 been considered? Please list the drugs to be given covertly.

Continued overleaf

What is the method agreed for administering each medicine? Please list.

How often should an attempt be made to administer medication openly (i.e. without using covert administration): _____ attempt(s) per medication round/day/week/month (circle as appropriate)

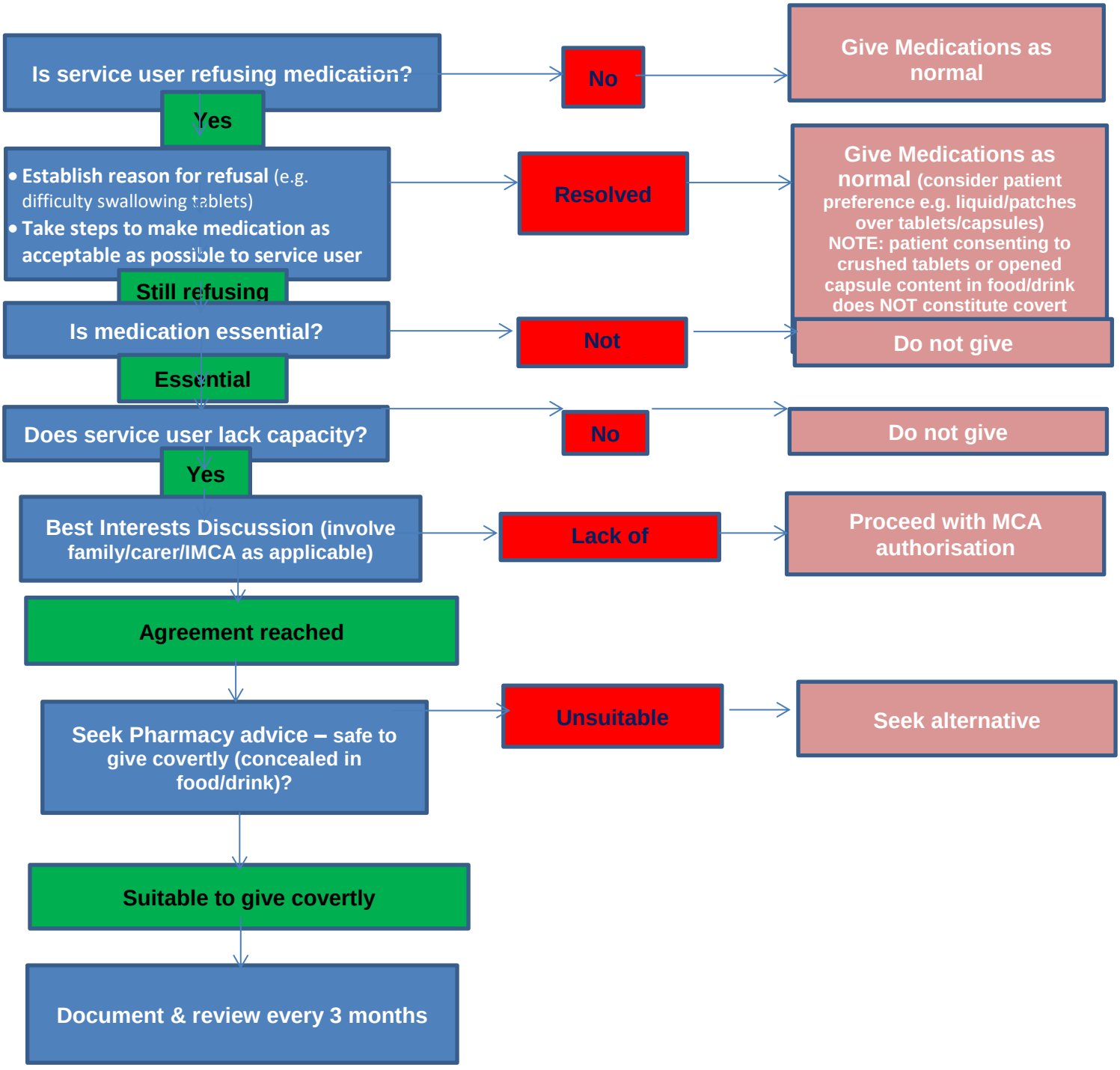
The decision to covertly administer medication has been discussed and agreed with:

Responsible Clinician	……	Date	…….
Signature	……		
Named Nurse	……	Date	…….
Signature	……		
Pharmacist	……	Date	…….
Signature	……		
Discussed with next of Kin/Advocate	…….	Date	……..
Signature	…….		
Ward / Unit	…….		
Review Date	…….		

(**3-monthly review date** unless otherwise stated in the care plan)

Were all parties in support of the decision? YES/NO If no, please list names and their objections / concerns

Appendix 2 Procedure for Covert Administration – Flowchart Summary



Appendix 3 Method of Medication Administration

Patients Name: ……DOB:……..

Date	Time	Covert	Oral medication (not concealed)	Signature

Appendix 4 Covert Administration Example

Patient's name	
NHS number	
Rio number	
Date of Birth	
Date Covert Administration completed	
Completed by **Pharmacist/Pharmacy Technician (Name/Role)**	

Current Medication	**Suggest formulations**	**Food / Drink Interactions**	**Other Considerations**
Regular medication			
Capsaicin cream	Continue with cream	N/A	N/A
Sodium valproate MR Granules	1st choice: liquid formulation preferred 2nd: for patients who are stabilised on MR formulations, the granules should be used. 3rd: crushable tablets	Food appears not to affect the bioavailability of valproate Moderate social drinking of alcohol does not appear to significantly affect serum levels of sodium valproate.	The granules should not be chewed or crushed, and therefore this method may not be appropriate for patients with limited understanding or impaired ability to follow instructions. Crushable tablets can be crushed and mixed with a small amount of soft food e.g. yoghurt or jam. The have an extremely bitter taste

		However, alcohol can worsen the adverse effects of some antiepileptics. Note that alcohol consumption can increase seizure risk in those with epilepsy.	Mentioned in MDT that Patient used to enjoy liquid formulation but then began spitting it out
Lamotrigine soluble tablets	1st: continue with dispersible tablets 2nd: oral solution or suspension if available	N/A	The MHRA has issued guidance recommending that (where possible) patients on lamotrigine (when used for seizures) are maintained on a specific manufacturer's product, due to variability in product characteristics which may lead to a loss of seizure control when switching between brands / manufacturers. When managing patients with enteral tubes or swallowing difficulties it may not be possible to maintain the patient on their previous preparation due to the need to change to an appropriate formulation. However all

			product switches should be carried out with care and close monitoring, and where possible patients should be maintained from then onwards on a single manufacturer's product.
Risperidone 500 microgram orodispersible tablets	1st: use liquid or orodispersible tablet	N/A	The liquid can be mixed with any non-alcoholic drink except tea
Rivastigmine patch	Continue Patch	Tobacco smoking increases the clearance of Rivastigmine	
PRNs			
Paracetamol 250mg/5ml oral suspension	1st: use soluble tablets or continue suspension 2nd: suppository	Severe liver damage, fatal in some instances, can occur in some alcoholics and persistent heavy drinkers who take only moderate doses of paracetamol. Occasional and moderate drinkers do not seem to be at risk.	Risk of hypernatremia when taken soluble tablets due to high sodium content