East London NHS
NHS Foundation Trust

Covert Administration of Medicines Policy

Version number :	5
Consultation Groups	Medicines Committee, Pharmacy Department, Mental Healthcare of Older People Directorate, Mental Health Law Department, Community Health Newham
Approved by (Sponsor Group)	Medicines Committee
Ratified by:	Medicines Committee
Date ratified:	9 January 2019
Name of originator/author:	Pharmacy Leads
Executive Director lead :	Medical Officer
Implementation Date :	January 2019
Last Review Date	September 2018
Next Review date:	September 2021

Services	Applicable
Trustwide	
Mental Health and LD	x
Community Health Services	

VERSION CONTROL SUMMARY		
Version	**Date**	**Comment/Changes**
1.0	September 2009	
2.0	April 2010	No changes
3.0	June 2012	Appendix 1 renamed
4.0	July 2015	Content 3.2 addition of definition of covert administration Content 3.4 strengthening of wording about practice that constitutes true covert administration Content 3.8 addition of statement qualifying scope of policy Content 4.2 mental capacity assessment in relation to cognitive impairment Content 5.1, 5.3, 5.4 (points C, D & E) (Assessment For Service Users refusing treatment) updated Content 6 (Covert Administration of Medicines) updated Content 7.3 Addition of statement referring to Royal College of Psychiatrists statement on covert administration. Content 7.4 contact details for Mental Law Department updated Appendix 1 – Amendment of statement regarding how often to attempt to administer medication openly. Review date changed to 3-monthly. Appendix 2 added – Flowchart Summary Appendix 4 added- Royal College of Psychiatrists' Statement on Covert Administration
5.0	October 2018	Content 5.8 Mental Health Act and DoLS Content 6.1 Use of the Method of Medication Administration form Appendix 3 Method of Medication Administration form

Covert Administration of Medicines Policy

Content		Page
1	Introduction	5
2	Aim of Policy	5
3	Scope of Policy	5
4	Mental Capacity	6
5	Assessment For Service Users Refusing Treatment	6
6	Covert Administration of Medicines	8
7	Professional Conduct	10
8	References	9
Appendices		
Appendix 1	Covert Medicines MDT Care Plan	11
Appendix 2	Procedure for Covert Administration – Flowchart Summary	13
Appendix 3	Method of Administration Form	14
Appendix 4	Royal College of Psychiatrists: College Statement on Covert Administration of Medicines	15

Covert Administration of Medicines Policy

1. Introduction

1.1 East London NHS Foundation Trust 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.

1.2 The Nursing and Midwifery Council (NMC) and Royal College of Psychiatrists (RCPsych) recognise that 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.

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. Aim of Policy

2.1 The practice of concealing medication in food or drink is only allowable in particular circumstances and could be open to abuse. The aim of this policy is to provide guidance as to when this practice is lawful, and to ensure that if it happens in an inpatient setting, it has been properly considered, thorough consultations have been made and that the practice is transparent and open to public scrutiny and audit

3. Scope of policy

3.1 This policy applies to all adults who are inpatients in the Trust. It does not apply to children and adolescents.

3.2 Covert administration occurs when medication has been deliberately disguised before administration with the intention of concealing the administration from the service user.

3.3 In general terms, if a patient has the capacity to refuse medical treatment then this decision must be respected, and covert administration of medication would be unlawful.

3.4 It is necessary to distinguish between the concealing of medication in food or drink, and a co-operative process in which consenting patients who find taking medication difficult have the medication delivered in food or drink for ease of ingestion. Making medication more palatable or acceptable to patients by administering it with food or drink does not constitute covert administration.

3.5 The Mental Health Act provides for the administration of psychiatric treatment to patients who refuse such treatment, and in some situations it may be

clinically appropriate to administer oral medication by covert means.

3.6 However patients being treated under the Mental Health Act may not be treated for physical illness if they refuse treatment and have the mental capacity to do so; unless the physical illness arises as a result of the patient's mental state

3.7 Adults who lack the mental capacity to consent to or refuse treatment may need to be treated under the framework of the Mental Capacity Act 2005.

3.8 This policy should be used in conjunction with all other relevant medicines-related policies (for example, the Medicines Policy and the Controlled Drugs Policy).

4. Mental Capacity

4.1 Service users who have the mental capacity to make choices about their treatment must be given the opportunity to do so and their wishes should be respected. Service users with cognitive impairment may nevertheless retain the capacity to make particular health care decisions.

4.2 Patients who lack capacity to consent to or refuse treatment as a result of cognitive impairment may decline to accept oral medication for a variety of reasons. This can range from a long established reluctance to engage with medical treatment that precedes the loss of capacity, to disengagement from medical treatment as a result of personality and behavioural problems associated with dementia, to a reluctance to accept medication because of difficulty swallowing tablets, or even, if the cognitive impairment is severe, refusal of medication as a result of an inability to recognise what is being offered, or what is expected.

4.3 The assessment of capacity is always specific to the decision that needs to be taken. Mental capacity should be assessed in accordance with the principles and guidance of the Mental Capacity Act 2005, which requires a two stage test, first to establish that there is an impairment or disturbance of the mind, and then to establish whether that disturbance renders the person unable to make the decision in question.

4.4 If a person is judged to lack mental capacity to make a particular decision then a 'best interests' decision needs to be made, again using the framework and guidance of the Mental Capacity Act 2005, which allows for proportionate interventions where authority to treat may be given under section 5 of the Act.

5. Assessment for Service Users Refusing Treatment

5.1 If a service user is actively refusing treatment, attempts must be made to alleviate any contributory factors. The multidisciplinary team (MDT) should try to understand the reasons for the refusal, and respond appropriately on an

individual best interest's basis. The prescribing clinician should, if possible, discuss the reasons for refusal with the service user, explaining why the treatment has been prescribed. The response may range from respecting the refusal, to the use of the covert medication policy, to changing the formulation and timing of medication, or openly administering medication in food or drink.

5.2 If the refusal persists, the prescribing clinician should conduct and document a formal assessment of capacity, using the framework of the Mental Capacity Act 2005, unless the refusal concerns treatment of a mental illness, in which case consideration needs to be given to using the Mental Health Act, if the service user meets the criteria for detention under the Act.

5.3 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.

5.4 If it is established that the service user lacks capacity to make the relevant decision, then a best interests decision must be made to decide how to proceed, using the guidance contained in the Mental Capacity Act 2005 Code of Practice, taking into account the following factors:

a) A review as to whether it is essential to continue with treatment, and a judgment about the relative importance of the treatment to the service user's quality of life and general health, bearing in mind the need to identify the least restrictive option that will meet the person's needs.

b) The service user's views and stated reasons for refusal and any advance decision to refuse treatment made by the service user when they had capacity to do so.

c) When appropriate, the views of the relative or carer (or independent mental capacity advocate (IMCA) for those service users requiring 'serious medical treatment' as defined by the Mental Capacity Act 2005).

d) The views of any attorney appointed for welfare issues under a Lasting Power of Attorney (LPA), along with any Deputy appointed by the Court of Protection. If the attorney appointed under LPA or Deputy appointed by the Court of Protection have powers in respect of the service user's health and welfare, then the decision whether or not to administer medication covertly will ultimately rest with them.

e) The views of the multidisciplinary team, taking the Mental Capacity Act (MCA) 2005 into consideration where consensus cannot be reached.

5.5 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.

5.6 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.

5.7 If a service user is being treated for mental disorder under the Mental Health Act, then Covert medication should not be given to a mentally capable detained patient without their consent. It may only be given to a mentally incapable patient who is detained under the Mental Health Act, if they fall under Part 4 of the Act i.e. if section's 58 or 63 apply (section 58 & Section 63 do **not** apply to the following – S4, S5 (2), S5 (4), S17A, 35,135,136, Part 3 patients detained in place of safety (S37 (4) & 45A (5)); conditionally discharged patients) and it is treatment for mental disorder. If a mentally incapable patient is not subject to Part 4 of the Mental Health Act, covert medication may be given under the Mental Capacity Act if it is deemed that it is in the best interests of the patient (see Section 4 above). If a mentally capable patient is not subject to Part 4 of the Mental Health Act, any refusal of consent for medication (in whatever form) must be respected and not overridden. If in doubt, please always seek advice first from your local mental health law department.

5.8 The Mental Capacity Act 2005 also includes the Deprivation of Liberty Safeguards (DoLS). The safeguards ensure that, when a person who lacks capacity to agree to their care and treatment is being deprived of their liberty (and they do not meet the criteria for detention under the Mental Health Act 1983), there is a legal process to independently assess whether a deprivation is occurring and, if so, for it to be legally authorised when it is both appropriate and in their best interests.
The Court of Protection has provided guidance to be followed when providing covert medication to patients subject to a DoLS authorisation (see AG v BMBC & Anor [2016] EWCOP 37):

- Best interest decision meetings must include the relevant person's representative (RPR) outlined in the DoLS authorisation. The RPR will usually be a relative or friend of the person who is being deprived of their liberty. If there is no appropriate friend or relative, the RPR will be someone appointed by the local authority, known in the process as the supervisory body (e.g. an IMCA);
- If there is no agreement about whether medicines should be given covertly, there should be an application made to the Court of Protection;
- The use of covert medication within a care plan must be clearly identified within the DoLS assessment and authorisation;
- 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 care plan involving family and healthcare professionals;
- 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. In addition, changes should always trigger a review of the authorisation.

6. Covert Administration of Medicines

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

- The decision to administer medicines covertly must not be routine practice and must be a contingency/emergency measure.
- The service user's best interests must always be the first consideration.
- The form in appendix 3 should be attached to the drug chart where nurses document if oral medication was accepted or refused
- All conscionable efforts are to be made to encourage service users to take the medication prescribed for them without using covert administration.
- 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.
- If a patient usually accepts oral but requires covert administration on occasion document the reason why they required covert administration on RIO. For example, patient was more confused and unsettled today
- The method of administration must be agreed with the pharmacist and recorded in the care plan to be kept with the medication prescription chart
- 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.
- 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.
- 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.
- Administer medicines at the end or after a meal except where the properties of the medicines dictate otherwise.
- 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.
- Generally medicines should be administered one at a time, unless the pharmacist has been consulted and given the go-ahead to administer medicines together.
- Service users receiving medicines administered in food or drink must be supervised until the medicine has been consumed.

6.2 Once a patient is transferred back to the community or to a care home local policies regarding covert administration should be followed.

7. Professional Conduct

7.1 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.

7.2 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.

7.3 The Royal College of Psychiatrists have issued a statement clarifying their position on the covert administration of medicines. This statement can be found in Appendix 4 of this document.

7.4 Disguising medicines in order to save life, prevent deterioration, or ensure an improvement in the person's health, cannot be taken in isolation from the recognition of the rights of the person not to give consent. It may, in such circumstances, be necessary to administer medicines covertly. However, in some very exceptional cases the only correct course of action is to seek the permission of the Court to do so. In such circumstances the Service Manager or the patient's consultant should obtain further advice from the Trust Mental Health Law department on 0207655 4046 or 4264.

8. References

- Department of Health (2005). *Mental Capacity Act*. London, HMSO.
- David Taylor, Carol Paton, Shitij Kapur (Authors); The Maudsley Prescribing Guidelines in Psychiatry (12th Edition), April 2015.
- Royal College of Psychiatrists: *College Statement on Covert Administration of Medicines*. Psychiatric Bulletin 2004, 28:385-386
- *Risk, rights, recovery: the Mental Health Act Commission twelfth biennial report 2005-2007*. Great Britain Mental Health Act Commission. Jan 2008. ISBN: 9780113228072.

East London NHS
NHS Foundation Trust

Appendix 1

Covert Medicines MDT Care Plan

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

Patient's Name: ……………………………………………… RiO No : ……………..……

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:

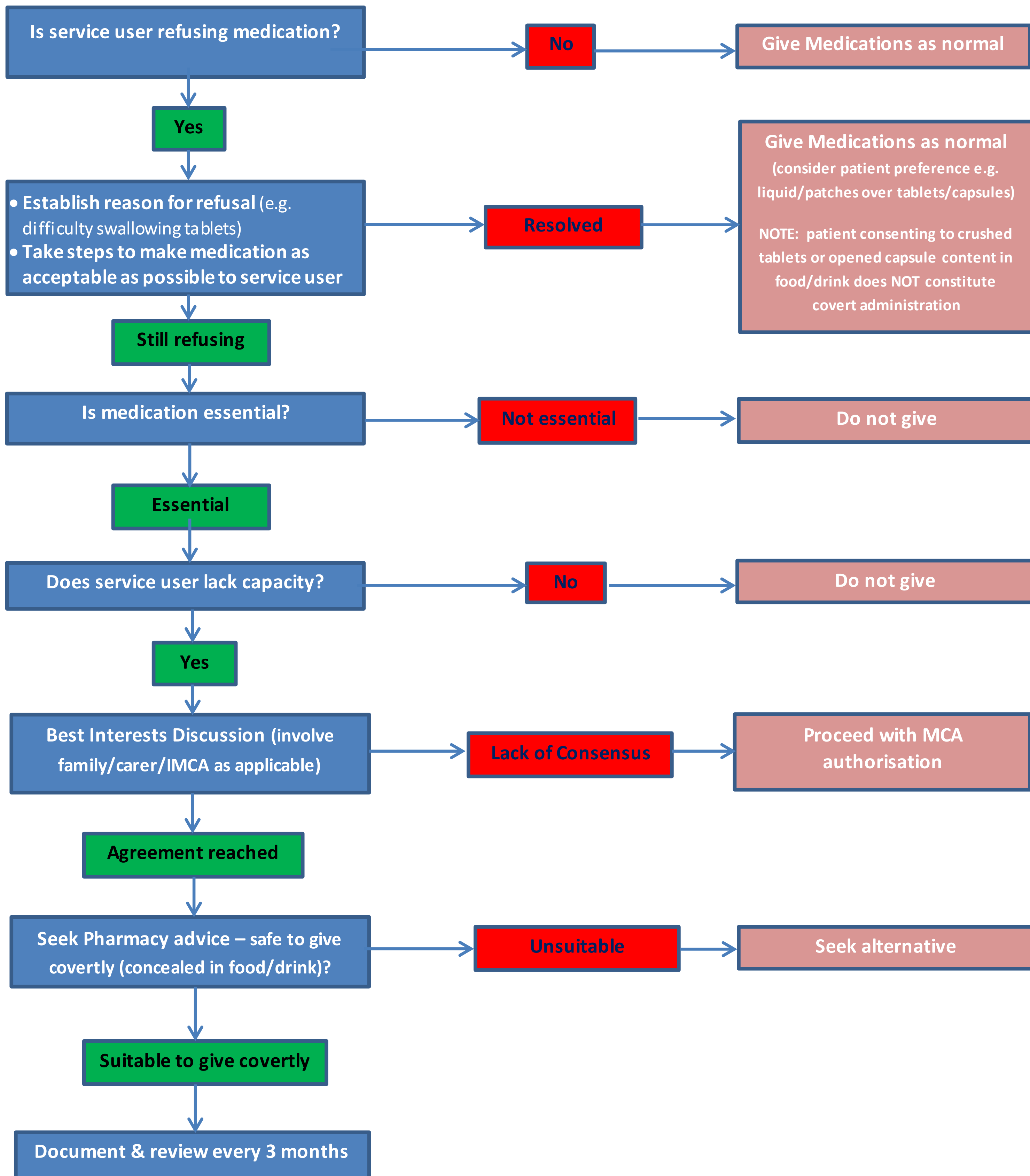
Responsible Clinician	………………………………………	Date	……….
Signature	………………………………………		
Named Nurse	………………………………………	Date	……….
Signature	………………………………………		
Pharmacist	………………………………………	Date	……….
Signature	………………………………………		
Discussed with next of Kin/Advocate	……………………………………….	Date	………..
Signature	……………………………………….		
Ward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

Date	Time	Covert	Oral	Signature

Appendix 4

Royal College of Psychiatrists: College Statement on Covert Administration of Medicines

Available in: Psychiatric Bulletin 2004, 28:385-386, or via web-link:
https://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf

The College 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. 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 interests and administered in the least restrictive fashion. In exceptional circumstances, this may require the administration of medicines within foodstuffs, when the patient is not aware that that is being done.

The College advocates the following:

1. Mental health law legislation such as the Draft Mental Capacity Bill in England and the Adults with Incapacity Act (Scotland) 2000 should be used in all circumstances where they apply.

2. All efforts must be made to give medication openly in its normal tablet or syrup form.

3. A record of the reasons for presuming mental incapacity (including at the time medication is administered) should be made in the clinical notes. Incapacity should be assessed as per the BMA guidelines (see endnote).

4. The patient should be unable to learn, even with support, and there should be a need for them to take medicine as well as a profoundly limited understanding of what is occurring. This will most often be due to severe dementia or profound learning disability.

5. Whenever such procedures are considered, there must be clear expectation that the patient will benefit from such measures, and that such measures will avoid significant harm to the patient or others.

6. Harm can include both mental and physical harm.

7. The proposed treatment plan and reasons for the plan should be discussed by the multidisciplinary team (or between consultant and nurse in charge of the ward in cases of urgency) and a record of the discussion made. In residential or nursing home settings, this might be between the senior nurse or manager on duty, and the consultant or general practitioner. Where patients are living at home with families or carers, we would encourage discussion between carers, the patient's GP and community health teams.

8. The proposed treatment plan should be discussed with a relative, carer or nominated representative unless it is clear that the patient would not have wished this.

9. The proposed treatment should be discussed with a pharmacist to ensure that medication may be mixed with food and will not be affected by procedures such as crushing. Any medical, cultural or religious dietary requirements should be complied with (e.g. gluten-free for patients with coeliac disease, avoidance of animal gelatin for vegetarian, Jewish or Muslim patients).

10. A record should be made of language or communication issues and the methods used to overcome these. For example, if an interpreter is used, note which language or dialect was used. This should also apply to discussions with the relatives.

11. The issue of covert medication should be included in the care plan and communicated in writing to the general practitioner. The issues may also require consideration when orodispersible medicines are used.

12. The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.

13. The College believes that this guidance applies to the administration of either physical or mental health medicines.

14. The covert administration of medication in patients with schizophrenia and other severe mental illnesses where patients can learn and understand that they will be required to take medication is unacceptable.

15. Because this practice should only occur in exceptional circumstances, responses must be subject to review.

16. Trusts and organisations should develop a policy on this issue.

17. The College does not believe that the practice could ever be justified as part of a research project. Exceptional circumstances do not include research. Covert administration of medication is therefore not justified for research purposes.

Commentaries

Assessment of capacity

There is a presumption that all patients have capacity unless demonstrated otherwise. Patients with capacity must be able to:

- Understand in simple language what the treatment is, its purpose and why it is being proposed.
- Understand its principal benefits, risks and alternatives.
- Understand in broad terms what will be the consequences of not receiving the proposed treatment.
- Retain the information long enough to make an effective decision.
- Make a free choice (i.e. free from pressure).

Endnote on Human Rights Act 1998

We are not aware of any test case under the Human Rights Act 1998 of the practice of administering medication covertly. The following articles of the Human Rights Act seem particularly relevant.

Article 2 ‘Everyone’s right to life shall be protected by law’

Article 3 ‘No one shall be subject to torture or inhuman or degrading treatment or punishment’

Article 5 ‘Everyone has the right to liberty and security of person’

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’

Article 8 ‘Everyone has the right to respect for his private and family life, his home, and his correspondence’.

Article 2 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 may be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatments may, sometimes, shorten life as a secondary result of their administration). Administration of treatments whose purpose is to shorten life is illegal.

Article 3 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 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 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 See comment to Article 5 above.

Related policies

- Covert Administration of Medication Nursing and Midwifery Council guidance is accessible on www.nmc-uk.org.uk
- Mental Welfare Commission for Scotland, rights, risks and limits to freedom, disguised medication: www.mwcscot.org.uk
- Ethical Conduct of Research on the Incapacitated, Medical Research Council: www.mrc.ac.uk
- British Medical Association and Law Society (1995). *Assessment of Mental Capacity, Guidance for Doctors and Lawyers*. London: BMA.

Related articles

- Treloar A, Philpot M, Beats B. (2001) Concealing medication in patients' food. *Lancet*, **357**, 62-64.
- Treloar A, Beck S, Paton C. (2001) Administering medications to patients with dementia and other organic cognitive syndromes. *Advances in Psychiatric Treatment*, **7**, 444-452.