Covert Administration - supporting information for LIMOS & Care Worker / Care Home Staff

Definition of covert administration

The use of person/patient and resident is interchanged throughout document. The administration of any drug or medical treatment to a resident without their knowledge, in a disguised or deceptive form, is known as covert administration.

All our residents have the right to refuse to take medicine if they wish to do so, and it is important that this is recognised. We must assume the resident has capacity to refuse unless formally documented otherwise. There may be occasions when residents lack capacity to take medicines or to understand the consequences of refusing to take medicines. In these circumstances it may be necessary for professionals involved in the resident's care to take a formal process to act in their best interest.

General Principles of covert administration

a) A last resort, implemented only when there is no appropriate alternative.
b) Specific to each medicine- the need must be identified for each medicine prescribed.
c) Time framed- it should only be used for as short a time as possible, and the need should be regularly reviewed (minimum of monthly review, timescales will depend on individual circumstances e.g. the expected duration of treatment)
d) Transparent processes are required.
e) Inclusive of family and friends where appropriate.
f) Any decision to administer medication covertly must follow the principle of the Mental Capacity and Decisions of Best Interest.
g) Any decisions to administer medication covertly to residents in residential/nursing/hospital settings must be accompanied by a deprivation of liberty safeguarding authorisation.
h) Any decisions to administer medication covertly in someone's own home must be accompanied by a referral to the responsible local authority as a possible safeguarding concern (as an un-authorised deprivation of liberty).

Considerations when administering medication covertly

a) Explore reasons why medication is refused – swallowing issues, the formulation, the time of day and tiredness or needs prompting with a spoon to mouth.
b) The clinical need must be identified for each medicine prescribed. Stop all non-essential medicines, as agreed by best interest meeting/decision.
c) What is the resident's relationship with food and drink, as it may not be appropriate to put medication in food, if they frequently refuse mouthfuls or due to mental health they are suspicious of food.
d) It should always be the last resort and attempts should always be made to give the medication in an overt way first. Document in the care plan all the options that have been considered and tried.
e) The assurance that the complete dose has been taken. Administration of medicines covertly should be quantifiable. Ideally mix each dose of medicine into one teaspoonful of cool soft food, to ensure the person administering can qualify and be assured that the whole dose was taken.

f) Only give one medicine at a time, avoid mixing multiple medicines together if possible, clarify this in the medicine care plan.

g) Prescriber/Pharmacist to ensure suitability and safety of medication form for any adaptation or addition to food and bioavailability; How they mix with food or drink, how palatable the medicine is once crushed. (e.g. sertraline is bitter in taste once crushed), interactions with food. (e.g. tetracyclines and milk), how can the medicines efficacy will be monitored (e.g. in the case of antihypertensive by monitoring blood pressure)

h) If using a tablet crusher, ensure one crusher per resident and wash after use in warm soapy water and ensure dried thoroughly before next used.

i) Ensure LIMOS 'How to alter medication for oral administration' protocol is in place – has been considered and actioned for all medication given 'off license' in this form. Specific instructions should be included on the medicines label and included within the medicines care plan / care notes of the resident and communicated with the community pharmacy.

j) Educate staff as to what the medication is for in the care plan and prioritise medication administration from most to least important, always administering the most important medicine first.

Resources to support decision-making

a) British National Formulary (BNF)

b) Electronic Medicines Compendium (eMC)- Summary of Product Characteristics (SPC)

c) Medicines Complete – Handbook of drug administration via enteral feeding tubes.

d) NEWT guidelines – for administration of medication to patients with enteral feeding tubes or swallowing difficulties.

e) Mental Capacity Act 2005 Code of Practice – Assessing Capacity and Decisions of Best Interest

Suggested Care Pathway

Step 1: Mental Capacity Assessment (MCA)

Covert administration is only applicable to someone who lacks the capacity to understand it is in their best interest to continue to take medication for health reasons. **If someone has capacity then they have the right to refuse**. If medication is being crushed and put in soft food or liquid form to ease the administration and the person has the capacity to understand this is happening, this is not covert administration.

The person assessing the mental capacity will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times. (MCA: section 4.38)

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 or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. E.g. advocates or communication support may be necessary.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision. Everyone has the right to make what would appear to be an unwise decision. This does not mean that the person does not have capacity.
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 right and freedom of action.

The process of assessment:

The legal test of capacity follows a two stage test, it is important to remember in any assessment of capacity that the onus is on the assessor to prove the person lacks capacity, not for the assessed person to prove they have it. Consideration must be given to the above principles in any assessment of capacity.

The two stage test:

Stage one: For the purposes of assessing capacity to understand medication there will be a need to first establish that the person is unable to make a decision because of an impairment of or disturbance in the functions of the mind or brain. This clinical diagnosis provides the justification for proceeding – note that it does not need to be a clinical diagnosis, you can proceed on balance of probability that there is a reasonable likelihood that the person does not have the capacity to understand their medication.

Stage two: Stage two of the test can only be undertaken if there is a positive assessment for stage one, that is, that the assessed person HAS an impairment of or disturbance in the functions of the mind or brain.

A patient will be considered to lack mental capacity in law to make a decision or consent if he or she is unable to complete the four assessment indicators of being able to:

- Weigh
- Retain– remember that with retain the legislation says that the person only has to hold the information for long enough to communicate a decision, communicate – any communication counts here, verbal or non-verbal.
- Understand
- Communicate the salient information in relation to the decision at hand

They must:

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

Where an individual cannot demonstrate an understanding of one or more parts of this test, then they do not have the relevant capacity at this time.

Advanced Decisions

An advance decision to refuse particular treatment in anticipation of future incapacity must be adhered to if valid and complete. The patient must have made clear which treatments they are refusing; a general desire not to be treated is insufficient. The advance decision must apply to the proposed current treatment and current circumstances.

Once the MCA is completed and the outcome is that the resident does not have the relevant capacity to make decisions about medicines, a best interest decision must be made.

Lasting Power of Attorney or Court Appointed Deputy for Health and Welfare

Documents granted by Court of Protection will appoint persons and outline varying scopes in relation to the residents'/patients' health and welfare on a case by case basis. This evidence should be provided, to be seen and documented as such in the individuals' care plan.

Step 2: Best Interest Meeting or Decision

All medicines must be reviewed clinically by the care home GP with input from the LIMOS pharmacist, where needed, to ensure any safe alteration of medicines. Any decisions to administer medication covertly must be made within a 'Best Interest Decision'

'Best interests' is a method for making decisions which aims to be objective. It requires the decision makers to think what the best course of action is for the person. It should not be the personal views of the decision-makers. Instead it considers the current and future interest of the person who lacks the capacity, weighs them up and decides which course of action is, on balance, the best course of action for them.

A best interest meeting will be held with the relevant healthcare professionals and resident's family members. If the resident has power of attorney for health and welfare, this person must be consulted about the treatment decisions. If the resident has no representatives, an independent mental capacity advocate (IMCA) will be invited or solicited.

The decision maker is the person who makes the decision to covertly medicate. They may be different to the person who has undertaken the assessment of capacity. The decisions makers role is to make sure that a decision of best interest is made, taking account of all the principles of the MCA act, but in particular, making sure that Section 5 of the act (Protection from liability) is covered and also making sure that where a decision to covertly medicate tips into restraint (Section 6) that additional safeguards are covered.

The Five statutory principles of the MCA act are:

1. A person must be assumed to have capacity unless it is established that they lack 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.
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 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.

See section 6.41 MCA Code of Practice: *'Section5(1) provides possible protection for actions carried out in connection with care or treatment. The action may be carried out on behalf of someone who is believed to lack capacity to give permission for the action, so long as it is in the person's best interest. Actions that might be covered by section 5 include giving medication.'*

The best interest principle underpins the MCA. It is set out in section 1(5)

See Principles of Best Interest – Chapter 5 of the MCA Code of Practice: *'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 best interests. The concept has been developed by the courts in cases relating to people who lack capacity to make specific decisions for themselves, mainly decisions concerned with provision of medical treatment or social care.'*

MCA assessments benefit from involvement of family, close friends or carers especially where there is any doubt about a decision. Difficult situations may arise where the person may have fluctuating capacity or limited capacity and occasionally a person may refuse to participate in an assessment. In such situations a healthcare professional must always be involved and Court of Protection decisions may be necessary.

Step 3: Suitability of the medication

To be assessed by GP/LIMOS, see considerations above.

Step 4: Record Keeping

Covert administration of medication will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made, lies with everyone involved in the persons care and clear documentation is essential.

It is not appropriate to act on an 'ad hoc' verbal direction or a written instruction to covertly administer and this could be liable to legal challenge.

The prescriber must have documentation of both MCA for the understanding of medication issues and the best interest pathway to support covert administration. Copies of this documentation should be in the person's clinical records in the GP records and relevant care home resident notes.

Where a provider is asked to submit a DOLS, record when this was done in care plan.

The management plan should specify timeframes for regular review (possibly weekly or monthly) and circumstances (such as change in medication), which will trigger a review. Assess whether the decision to covertly medicate and whether it remains the least restrictive option. These reviews should involve the relevant healthcare professionals, RPR (if appointed) and family members if appropriate. Kitchen staff may need to be informed as dietary needs may be changed to accommodate covert administration.

Each time a medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR chart. Note there may be times when a patient may take medication overtly sometimes but requires it covertly on other occasions, it would be useful to record entries on the MAR e.g. C=covert with signature underneath and just a signature when resident takes it overtly, so patterns of administration can be observed at review. Where administration is unsuccessful this must be documented and any consequences reported to the prescriber within the agreed timescales at the commencement of the treatment and within the best interest decision.

Deprivation of Liberty Safeguards (DOLs)

On 1st April 2009, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) come into force. The Safeguards are designed to strengthen the protection of very vulnerable people in hospitals and care homes, who have no capacity with regards to their care and treatment.

The MCA DOLS apply to people in hospitals, acute hospitals, independent hospitals and residential and nursing homes registered under the Care Standards Act 2000. And who met the following criteria;

- Aged 18 or over;
- Has a mental disorder such as dementia, brain injury or a learning disability;
- Lacks capacity to consent to arrangements made for their treatment and/or care;
- Is at risk of deprivation of liberty in order to protect them from harm;

In exceptional circumstances it may be that the Care Home or hospital finds it not possible to care for someone other than by imposing a regime which may amount to a deprivation of the person's liberty. The administration of medication covertly, as part of a wider care plan is likely to be considered a restriction on someone's liberty, and for this reason any decisions to covertly administered medication should be accompanied by a Deprivation of Liberty Safeguard Authorisation.

As the visiting Pharmacist you should seek to reassure yourself that the care home or hospital (known under the safeguards as the 'Managing Authority') has submitted a Deprivation of Liberty Safeguards application to the Local Authority (known under the Safeguards as the Supervisory Body). The Managing Authority would submit an application using Form 1: Request for a Standard Authorisation and Urgent Authorisation. If the Managing Authority has not completed and submitted the Form 1, then the pharmacist must seek to notify the Supervisory Body as soon as possible.

If the service user is currently under an existing Authorisation under the Deprivation of Liberty Safeguards, then the visiting pharmacist must ensure, by asking the managing authority, that the administration of covert medicines is covered as a restriction under that authorisation. If it is not covered then the Managing Authority must seek to request a review of the existing authorisation, by completing a Form 10: Request for a Review of a Standard Authorisation. The same would apply if changes were made to the medication being given covertly (ie: increases to dosages, changes to the type of medication given) If the Managing Authority does not complete and submit this form then the pharmacist must seek to notify the Supervisory Body as soon as possible.

The Deprivation of Liberty Safeguards, describe the legal process to be followed whereby any decision to make a deprivation of liberty can be made in a lawful and proper manner. It prevents arbitrary decisions, provides advocacy where needed and provides people with rights of appeal against unlawful detention. Further assessments will clarify whether or not an authorisation for deprivation of liberty can be granted, or not, and these will be carried out by the Supervisory Body. Where covert administration is brought to the attention or noticed by a LIMOS pharmacist, that pharmacist holds to make sure the application has been made by the Managing Authority, and where not made, notify the Supervisory Body.

See DOLs Team letter template.

The contact details are provided below for visiting pharmacists to use should they need to

Supervisory Body -DOLs Team	IMCA referral Service	University Hospital Lewisham
Community Services Directorate	Advocacy for All	Adults Safeguarding Service
2nd Floor Lawrence House	www@advocacyforall.org.uk	Phone: 0208 8365803
Catford, London SE6 4RU	Phone:08458320044	Mobile: 07990795002
dols@lewisham.gov.uk		LH.adultsafeguarding@nhs.net
Phone:02083146369	Referral form on LGT intranet	Contacts on LGT intranet

References:

1. Prescqipp Best practice guidance in covert administration of medication. Bulletin 101/September 2015
2. UKMI Q&A 365.3, August 2014. What legal and pharmaceutical issues should be considered when administering medicines covertly?
3. Mental Welfare Commission for Scotland. Good practice guide Covert Medication
4. Kelly-Fatemi B. The Pharmaceutical Journal, Vol 297,10/2016 : Covert administration of medicines in care homes.
5. Lewisham and Greenwich NHS Trust. Policy for best practice for assessing mental capacity and conduction Best Interest Meetings.
6. Adass. The Mental Capacity Act Deprivation of Liberty Safeguards. Guidance to the forms.
7. Safety Signals August 2016. Covert Medication and Deprivation of Liberty Safeguards (DOLS) LGT Intranet
8. Mental Capacity Act Code of Practice