Kirklees Safeguarding Adults Board

Partners in preventing abuse and neglect

Guidance on the Administration of Covert Medication and Deprivation of Liberty

West Yorkshire Police · West Yorkshire Fire & Rescue Service · Locala Community Partnerships · NHS · Kirklees Council

Introduction

This guidance relates to the covert administration of medicines to individuals who are unable to give informed consent to treatment, and refuse to take tablets/capsules or liquid preparations when they are offered openly.

The administration of covert medicines is a complex issue and involves the administration of a medicine in a disguised form to a resident without their knowledge or consent.

Individuals* who are competent to make their own decisions, are entitled to refuse treatment even when this decision may adversely affect their health. Care staff should not administer medicines to a resident without their knowledge if they have the capacity to make a decision.

The use of covert medication must always call for close scrutiny, especially in cases where the medication impacts on the person's behaviour/mental health or has a sedative effect.

In the 2016 Court of Protection judgement: AG v BMBC & Anor [2016] EWCOP 37; District Judge Bellamy noted that treatment without consent is also potentially a restriction contributing to the objective factors creating a Deprivation of Liberty (DOL) within the meaning of Article 5 of the Convention of Human Rights. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL.

The judge in the case identified that the administration of covert medication needs to be subject to proper reviews and safeguards and went on to identify guidance as to the procedural steps to be followed when covert medication is being considered for persons subject to Deprivation of Liberty Safeguards (DOLS) authorisations.

Every provider of care who carries out the administration of medication should have a clear written policy on the administration of covert medicines, so that staff can consistently follow best practice.

This guidance has been produced based on the judgement noted above; the National Institute for Clinical Excellence (NICE) guidance for the administration of covert medication and the Mental Capacity Act (2005). The document aims to support healthcare professionals and carers to manage difficulties and challenges in dealing with adult residents who are refusing medication when openly offered to them, and should be read in conjunction with the organisation’s policy on covert medication administration.

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Before considering covert medication - try to understand why the individual may be refusing

Before any actions can be taken it is important to understand why the individual is refusing to take a prescribed medication. For example:

- Finds the taste of the preparation unpalatable or has difficulty swallowing a large tablet or capsule;
- Perhaps does not understand what to do with the offered tablet or spoonful of liquid;
- Perhaps the person does not understand what the medication is for;
- Lacks the understanding of the consequences of refusing the medication.

Individuals may be refusing to comply, but their reasons may not be understood, so it is an important first step to try to understand the reason why and help support the person.

The covert administration of medicines is only likely to be appropriate or necessary in the case of residents who actively refuse medication and who are judged not to have the capacity to understand the consequences of their refusal, and then**:**

- **Only in exceptional** circumstances when deemed necessary and as part of an assessment of the person's needs.
- It should be **time limited and reviewed regularly**.
- **Only** in accordance with the Mental Capacity Act - this means **only** those people who have had an assessment of their mental capacity to consent or refuse a certain medication, it has been identified that they **lack capacity** to make a decision – **this means a capacity assessment must always be carried out.**
- Unless it's an emergency, covert medication should not be given until **after** a '**Best Interest'** meeting/discussion has been held with all relevant parties (described later).

Remember:

A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life.

If a person is lawfully detained under a section of the Mental Health Act some forms of forced or disguised medications are recognised by law. Staff should refer to the Mental Health Act and code of practice.

Failing to respect a competent adult's refusal to take a prescribed medication may breach a person's human rights and may amount to a criminal offence. (Box 1)

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What is Covert medication?

Covert medication is the practice of giving medication to someone in a disguised format (such as hiding medication in food or beverages). For example, tablets may be crushed or medication in liquid form may be used **without** the individual's knowledge or **consent.**

The individual has difficulty swallowing

If an individual has swallowing difficulty or dislikes the taste of a medication, and consents or requests their medications are crushed, in liquid form or mixed with drink or food, then this is **different and is not** covert administration.

Advanced decisions to refuse certain medications

Sometimes the individual may have decided they do not want a particular medication at an earlier stage, while they still had mental capacity to do so; this is called an Advanced Decision.

For Advanced Decisions refusing medications:

- The individual must have made clear which treatments they are refusing - a general desire not to be treated is insufficient - and in what specific circumstances they wish to refuse taking the medication.
- The decision must apply to the proposed current treatment and in the current circumstances. It is important that clinicians are made aware of advanced decisions and that carers are aware within care plans.

Where the individual's wishes are known, health care professionals should respect them, provided that the decision in the living will or advance care statement is clearly applicable to the present circumstances and there is no reason to believe that the individual has changed their mind.

If an emergency situation arises and it is not possible to determine the individual'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 in an emergency must be the least restrictive option available (what is **immediately necessary)** and clearly documented as to why the medication was given, when and who administered.

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A six step process is recommended when considering covert medication

There are many ethical, legal, pharmaceutical and individual issues that need to be considered before medicines are given covertly.

Only essential medication should be considered for administration covertly. All other medications can be postponed, but with clear documentation on the person's notes or records identifying the reasons the medication is not essential and who was involved in making this decision.

In an **emergency** situation the prescriber and the nurse can make a decision to administer a medication covertly (see section on Advanced Decisions). It is recommended that this be a joint decision where possible and documented in persons care file/records. A capacity assessment should be completed and signed by both parties making the decision, which should be reviewed at the earliest opportunity.

These guidelines propose a six step process that should be followed as best practice to support the decision to administer a medicine covertly. It provides a simplified approach whilst ensuring all legal requirements are satisfied:

1. The person's mental capacity to consent to or refuse the specific medication;
2. A best interest meeting;
3. The suitability of the medication to be administered covertly;
4. That accurate documents and records are kept, including detailed care plans;
5. How the covert medication should be administered without the resident knowing – detailed care plans;
6. Clear plans for reviewing the covert medication - detailed care plans.

Box 2

These steps are represented simply in the flow chart, see figure 3 - however more detailed guidance for each step is now provided.

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Step 1: Assessing the person's mental capacity

For the purposes of assessing capacity to consent to taking or refusing medication there is a process identified within the Mental Capacity Act 2005 (MCA) that must be followed.

Organisations such as care homes will likely have their own policies and procedures to be followed when undertaking MCA assessment (following the MCA code of conduct remembering the 5 statutory principles of the Act). However as a reminder please see the two stage assessment process noted in figure 1.

Where a person cannot demonstrate any understanding of one or more parts of the test, then **they do not have the relevant mental capacity, at this time.** A reasonably detailed account of the assessment must be clearly document within the individual's records.

Who should carry out the mental capacity assessment?

MCA Code of Practice states *"If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent. But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed."* Other practitioners and carers retain a responsibility to participate in discussions about this assessment.

Within a care home or hospital the practical assessment of capacity for a specific decision should be made by the nurse or senior carer who is directly concerned with the person at the time the decision is made. However, these assessments always benefit from the involvement of family, close friends and other carers, particularly if there is any doubt about the decision.

Registered Nurses

Where Registered Nurses are involved in the administration of medicines, guidance from the Nursing and Midwifery Council (NMC) makes it clear that nurses **are accountable** for the decision to administer medicines covertly, and that this is in the individual's best interests.

The nurse also needs to determine whether these decisions are supported by the rest of the multi-disciplinary team as above, as well as voicing their own opinion on this practice for a particular individual. It is proposed that nurses may not want to covertly administer medicines in isolation.

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Step 2: Best Interest decisions

'Best Interests' is a method for making decisions which aims to be objective and not based the views of those who are making the decision. It requires the decision makers to think what the 'best course of action' is for the individual and considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for the person.

The Mental Capacity Act 2005 provides a checklist which must be followed when making a decision for someone - figure 2 provides a summary of a Best Interests checklist. If an individual has been assessed to lack capacity to understand the consequences of refusing their medication, then (unless it is an emergency situation) a multi-disciplinary Best Interests meeting/discussion with relevant parties must be held.

Who should attend the Best Interest meeting/discussion?

Wherever possible, it is recommended that a formal Best Interests meeting is held. However if it is not possible the decision maker must hold Best Interests discussions with all relevant parties. Best interests meetings/discussions should be attended by/include:

- Relevant health professionals and including the prescriber and pharmacist (consider a written report that could be supplied to support the decisions) and staff delivering care to the person.
- A family member or friend of the person who will need to be able to communicate the views and interests of the individual. This will also be dependent on an individual's previously stated wishes or individual circumstances, for example the individual has previously given a trusted person a legitimate Lasting Power of Attorney for Health and Welfare to make decisions on their behalf.
- If appointed - an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting. Where a Deprivation of Liberty Safeguards (DoLS) authorisation is already in place, the person's Relevant Persons Representative (RPR)'

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Purpose of the Best Interest meeting

The Best Interest meeting/discussion is held to agree whether to administer specific medicines without the individual knowing (covertly), and is an opportunity to ensure families are aware of the decision. The meeting should consider each specific medication (decision specific) for the individual and include detailed assessment for each including:

- The past and present wishes of the individual in relation to the medication.
- Whether the medicication in question is essential for health of the person (including any potential impact of the medication not being taken – verbal or a written report from the prescriber/pharmacist): i.e. the risk/benefits of the medication (the prescribing medical practitioner should identify these).
- If stopping the medication is the least restrictive option.
- Or if the medication is for the protection of others (i.e. if they are at risk of assault by the individual).
- Assurance that no other option is available for the individual for example:

  - *alternative route of administration of that medication (e.g. topical, parenteral) or an alternative medication*
  - *Consider patterns of the person's behaviour - do they refuse medication at certain times of a day – could the medication be given at a different time of the day?*
  - *If a person is not eating or drinking very well, medication mixed in the food or drink could potentially be harmful as taste may be affected causing further refusal of meals and drinks.*

Box 3

What happens if the attendees at the Best Interest meeting cannot agree about giving a medication covertly?

If one or more attendees disagree (for whatever reason) with a decision at a Best Interest meeting that a specific medication should be given covertly, then an **immediate application** should be made to the Court of Protection for a formal decision.

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Step 3: Suitability of the medication

If the decision from the Best Interest meeting is that a certain medication needs to be administering covertly, the suitability of the medication must then be considered. A pharmacist should be asked to review the medication as not all medications are suitable for administering covertly (for example the medication may not be suitable for crushing or the absorption rate may be affected if given with food or drink). The pharmacist should:

- Assess that the properties of the medication are not going to be significantly affected by administering it covertly.
- The crushing of tablets or releasing contents of capsules do not automatically make the medication an unlicensed formulation (if a medication is being administered in an unlicensed manner, the prescriber, the pharmacist and the member of staff involved in administering the medicine will assume greater legal responsibility).
- What alternative medication more suitable to covert administration is available?
- Ensure that the supply is made in the best interest of the individual and should provide advice on the most appropriate way to administer the medication.

Step 4: Accurate Documents and Records

The administration of Covert medication can and is likely to be challenged by inspecting bodies unless appropriate records are in place to support the process, therefore clear documentation must be in place:

- It is not appropriate to act on an 'ad hoc' verbal direction or a written instruction to covertly administer without the Best Interest decision process, as this could be liable to legal challenge.
- The prescriber and care provider must have documentation of both mental capacity assessment for the understanding of medication issues and the Best Interest decision pathway to support covert administration. Copies of this documentation should be in the individual's clinical records in their GP surgery and a copy needs to be shared with the relevant care team.
- Details of the covert medication must be clearly included within the individual's Care Plan and then reviewed at appropriate, documented intervals (see below step 6). Carers should produce a personalised instruction for each medicine to be given covertly in line with the advice of the pharmacist. This should be added to the Care Plan to ensure that all care staff administering the medication are aware of the reasons for, and the method of, covert administration for each medication concerned.
- The care provider (Managing Authority – e.g. the care home or hospital) **must notify** the Supervisory Body (e.g. Local Authority) and **Relevant Persons Representative** of covert medication when applying for Deprivation of Liberty Safeguards (DoLS) authorisation, and any changes to the covert medication regime as this may trigger a new/review of a DoLS authorisation.

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Step 5: How the covert medication should be administered

Dignity and respect must be maintained at all times and the following points must be detailed within individual Care Plans that nurses and carers (who are trained to administer medication) must follow:

- In the first instance wherever possible, the individual should be offered their medication openly each time, especially where fluctuating capacity is evident.
- Details of the individual's personal preferences for administration of medications must be clearly documented within an individualised Care Plan (please see Box 3); and the decision to proceed to administer covertly after appropriate steps have been taken.
- In general, covert medications should be mixed with **smallest** volume of food or drink possible. This increases the likelihood that the prescribed dose is actually taken. Not all drinks are suitable, e.g. tea or milk may interact with some medication.
- The medication must be administered immediately after mixing it with the food or drink. It must not be left for the resident to manage themselves; if the person is able to feed themselves they should be observed to ensure complete consumption.
- Each time medication is administered covertly it should be clearly documented on the Medication Administration Record (MAR) sheet/prescription chart.
- Refusal of the food or drink containing medication must be recorded on MAR sheet/prescription as 'refused' and clearly documented in the evaluation section of the person's individual Care Plan. It should also be noted if the individual only consumes some of the food/drink as the dose is then uncertain.
- Good record keeping provides evidence to enable the prescriber to review the continued need for covert administration.
- It must be clearly documented and highlighted that the individual has their medications covertly administered when transferring between care settings, for example on admission to hospital.
- A plan for review should be included in the care plan

Step 6: Clear plans for reviewing covert medication

Once a Best Interest decision has been made to administer a medication covertly, then a clear plan of regular review is required to ensure that for the medication being administered the process of administration remains appropriate and current for the individual (for example, the individual may regain their capacity or to ensure the correct medication and dosage for least restriction possible).

National Institute of Clinical Excellence (NICE) guidance proposes and it is recommended that a covert medication plan is developed that is reviewed on a regular basis – this may be weekly initially to ensure the plan for administration remains appropriate. This may progress to monthly intervals over time if appropriate. The covert medication plan should form a key element of the individual's individualised Care Plan.

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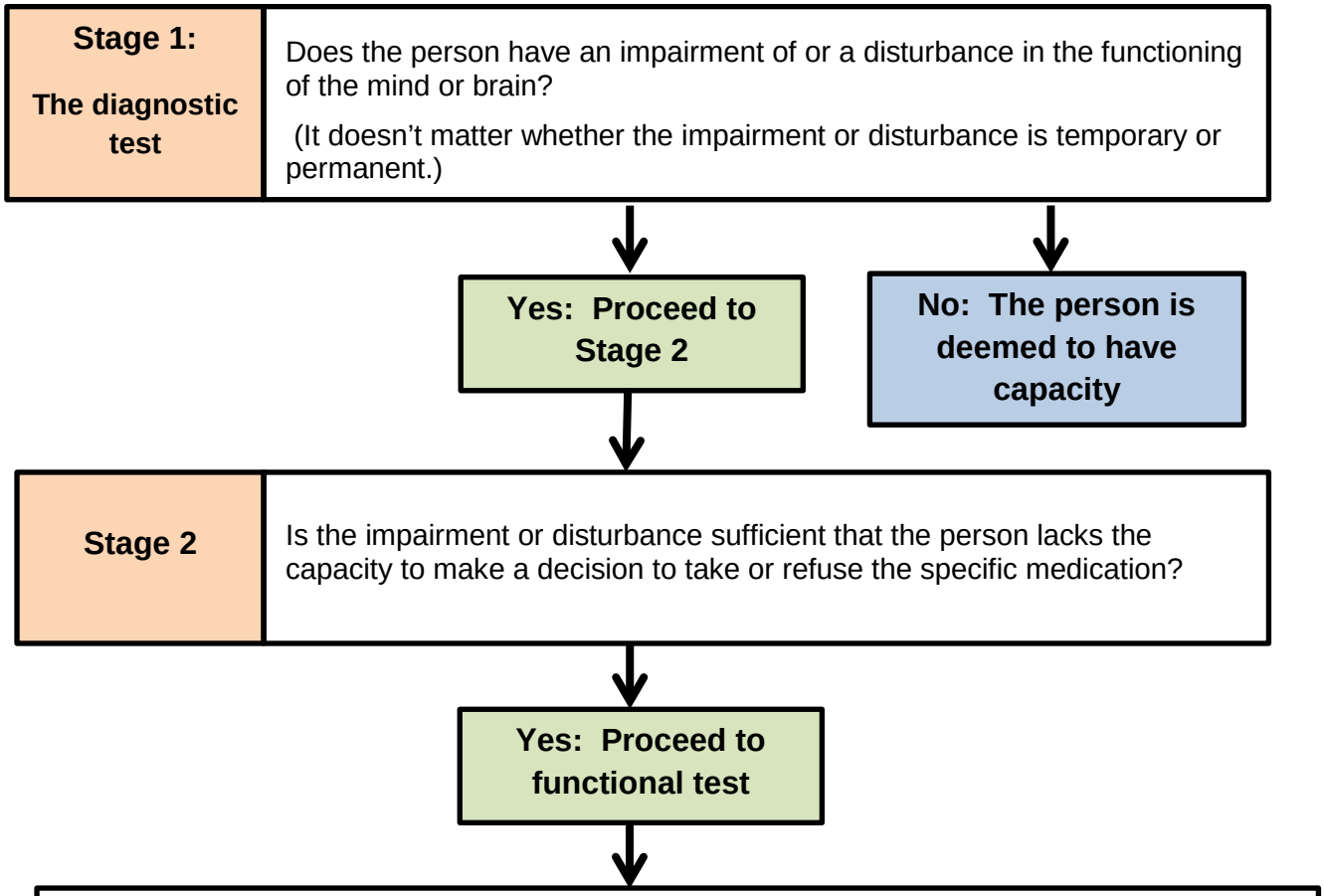
Figure 1: Two stage Mental Capacity assessment



The Mental Capacity Act 2005, says that an individual is unable to make their own decision if they cannot do one or more of the following four things:

- Understand information given to them about the medication (includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision).
- Retain that information long enough to be able to make the decision about whether to take or refuse the medication (retaining information for a short period only **does not** prevent them from being regarded as able to make the decision).
- Weigh up the information available to make the decision about taking or refusing the medication (can they consider pro's and con's, risks, consequences of actions).
- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

If the answer to ALL the above questions is YES, then the person has capacity to make the decision.

If the answer to ANY ONE of the above questions is NO, then the person lacks capacity and decisions will need to be made in their best interests through a Best Interests meeting.

Remember: An assessment of a individual's capacity must be based on their ability to make a **specific decision at the time it needs to be made**, and **not** their ability to make decisions in general.

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Figure 2: Summary Best Interests checklist

- 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**
- The decision should 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 views of family and informal carers - **and**
- Take into account views of Independent Mental Capacity Advocate (IMCA) or other key people - **and**
- Show it is the least restrictive alternative or intervention.

Using the Best Interest checklist:

- The decision maker is responsible for the decision.
- The decision maker must consult and involve others as much as possible.
- The decision maker does not have to follow the views of anyone else, but would need a good, reasoned argument for ignoring the views of others.
- Do not avoid discussion with people who may disagree with the decision maker. Involving people who might disagree with the decision in the process can often reassure them of how the decision is being made and can allow them to accept the final decision.
- There is no prescribed method of consultation. The decision maker could see family members together with the person being assessed if appropriate but this may not be helpful.
- There is no hierarchy of whose views within a family should carry more weight. The concept of 'next of kin' does not mean anything under Mental Capacity Act, 2005 (MCA).
- A Best Interest decision needs to consider a holistic assessment of the individual. For instance, what would be clinically indicated may not be in someone's best interests when their past views are considered or the possible effects of the treatment are considered. If a move from one care home to a different one is being considered it could be that someone's needs might be better met in a different setting, but consider as well the effects of the stress of a move or the distance from family contact.
- Under the Deprivation of Liberty Safeguards (DoLS) there is a specialist role for experienced staff who receive extra training of 'Best Interests Assessor'. This role only relates to decisions taken under DoLS and does not apply to Best Interests decisions made under MCA.

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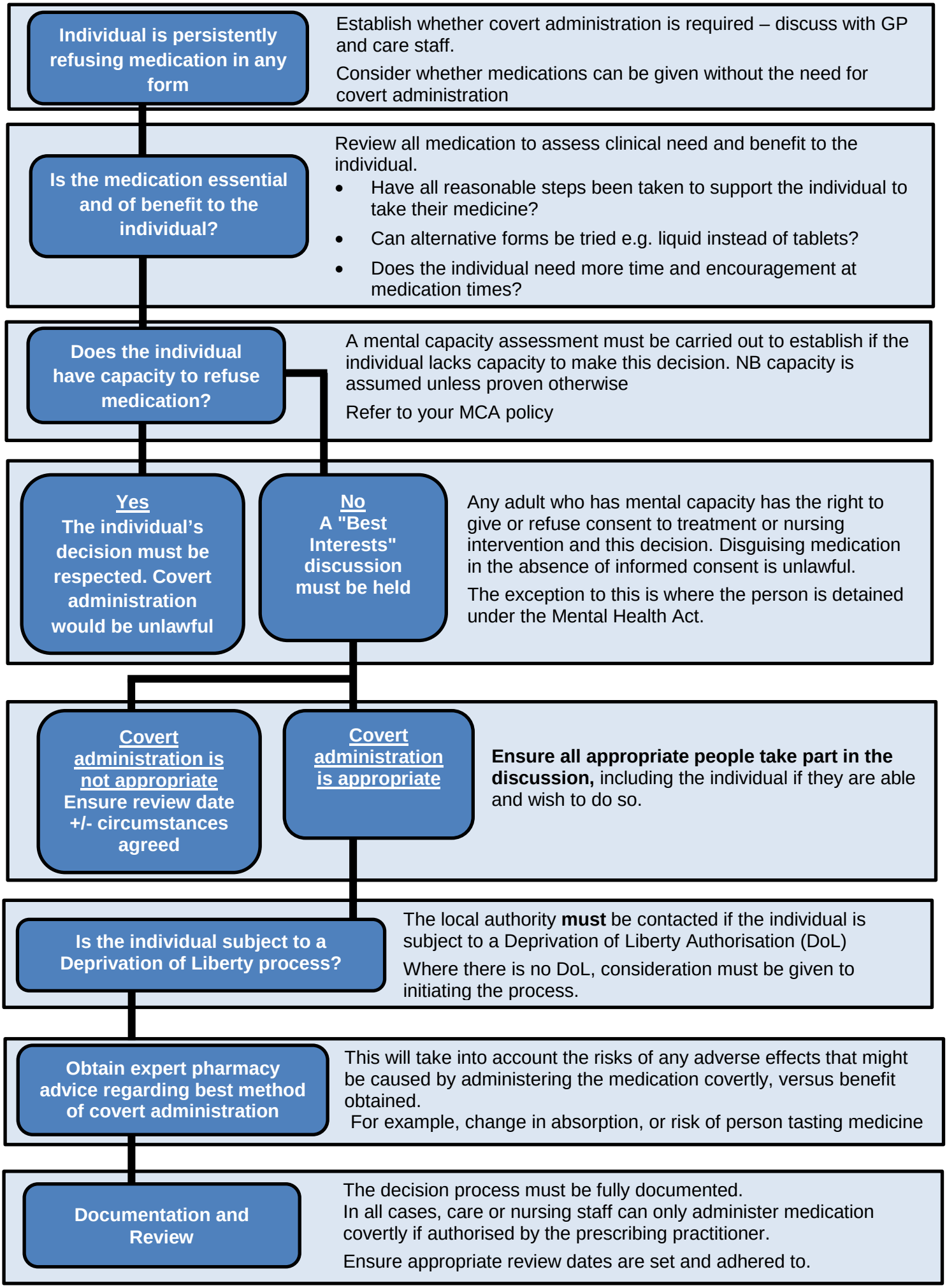
Figure 3: Flow chart for the administration of covert medication



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References and Resources

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