Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Covert Administration of Medicines Policy

Version: Version 7

Reference Number: CL37

Supersedes

Supersedes: Version 6

Description of amendment(s):

1. Various insertions and amendments to clarify the roles MHA and DoLS
2. Addition of a summary record sheet (Appendix 2)
3. Addition of a sample care plan (Appendix 1)
4. Appendix 1 (NMC statement on covert administration) moved to Appendix 3

Originator

Originated By: Lesley Smith

Designation: Chief Pharmacist

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by: Lesley Smith/ Robert Hallworth

ERA undertaken on: 14 November 2016

ERA approved by EIA Work group on: 14 December 2016

Where policy deemed relevant to equality-

EIA undertaken by:

EIA undertaken on:

EIA approved by EIA work group on:

Approval and Ratification

Referred for approval by: **Lesley Smith**

Date of Referral: 20 December 2016

Approved by: Drugs and Therapeutics Committee

Approval Date: 4 November 2016

Date Ratified by Executive Directors: 16th January 2017

Executive Director Lead: Medical Director

Circulation

Issue Date: 16th January 2017

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 4 November 2019

Responsibility of: Lesley Smith

Designation: Chief Pharmacist

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 16th January 2017

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COVERT ADMINISTRATION OF MEDICINES

1 INTRODUCTION

The Trust recognises that it is important to respect the autonomy of patients who receive treatment. However, there might be times when a patient lacks capacity either to consent to, or to refuse, treatment. In such circumstances, the treatment should be given to the patient if it is in accordance with the Mental Capacity Act 2005 (MCA), and if its use would be accepted as proper by a responsible body of relevant practitioners. In exceptional circumstances, this might require that medicines are administered covertly, for example within foodstuffs, and without the incapable patient's knowledge.

The effects of the use of covert administration of medication on the therapeutic alliance must be considered in detail, especially on patients who might regain capacity, or who might detect the use of covert administration.

Given the risk of the therapeutic alliance being severely compromised by the use of covert administration of medicines, it is often likely to be appropriate only for patients with severe dementia or a profound learning disability.

2 AIMS OF POLICY

To provide guidance to staff on:

(i) The circumstances in which this may be appropriate

(ii) The legal justification for the administration

(iii) The procedures which need to be followed within that administration

(iv) The procedures for the recording of the process

(v) Arrangements for an appeal

3 LEGAL JUSTIFICATION

3.1 If, while capable, a patient makes a valid and applicable advance decision in which s/he refuses specified medical treatment, that advance decision should be respected after the patient has become incapable unless it does not apply to the present circumstances or it was revoked by the patient while s/he was still capable.

Where it is available and appropriate, mental health legislation, such as the Mental Health Act 1983 (MHA 1983), should be considered. However, the

MHA will only have power to override an advance decision that refuses treatment for mental disorder under certain sections of the MHA.

The authority of advance decisions affects the MHA in a number of ways:

ECT:
A person can make an advance decision for ECT and it would have to be respected despite the person being detained under the MHA and lacking capacity to consent. However this can be overridden if the treatment is classed as emergency under section 62 of the MHA (immediately necessary to save the patient's life or treatment which (not being irreversible) is immediately necessary to prevent serious deterioration in the patient's condition. Further advice can be sought from your local Mental Health Law Office.

Community Treatment Orders (CTO) (S17a MHA)
A person can have an advance decision to refuse treatment and this will limit treatment powers of the CTO if the person lacks capacity. But if the treatment is classed as urgent, the powers of the CTO will override the powers of the advance decision.

Sections 4, 5(2), 5(4), 35, 135, 136, guardianship and conditional discharge are not covered by any compulsory treatment powers consequently, an advance decision to refuse treatment for mental disorder will have authority and the treatment cannot be overridden.

Sections 2, 3, 36, 37, 47, 48 – these sections will override an advance decision concerning treatment for mental disorder, however the Code of Practice to the MHA states that even where clinicians may lawfully treat a patient compulsorily under the Act, they should, where practicable, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the patient.

3.2 Where a patient is incapable of making a decision about his/her medical treatment, it may be that consent for that treatment can be given by an Attorney under a Lasting Power of Attorney for health and social care which the patient executed while capable, or by a Deputy appointed by the Court of Protection. An Attorney or Deputy will stand in the patient's shoes in this regard, and if s/he has the power to consent to medical treatment, s/he will also have the power to withhold such consent.

3.3 In the case of a patient aged 16 years or more who is capable of making decisions about his/her healthcare, treatment other than under MHA 1983 (as described above) may be given with his/her consent, but not without it. However if a young person refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection. This is the legal body that oversees the operation of the Mental

Capacity Act (2005). Further advice can be sought from your local Mental Health Law Office.

Where a patient is deemed incapable, such treatment must be given under MCA if it is confirmed that it is in the patient's best interests to do so and consistent with both MCA and its Code of Practice. Although the views of others will be relevant – and must be sought – when an incapable patient's best interests are to be determined unless it is clear that the patient would not have wished this, they need only be taken into account and will not be conclusive.

3.4 Although it may be lawful under MCA to give medical treatment in the best interests of an incapable patient, it will not be so where the effect of the treatment would be to deprive the patient of his/her liberty under Article 5 of the European Convention of Human Rights (ECHR).The Supreme Court in March 2014 in the case of Cheshire West clarified that there is a deprivation of liberty in circumstances where a person is under supervision or control and is not free to leave, and the person lacks capacity to consent to these arrangements.

3.5 Covert medication is also deemed an interference with an individual's right to a private life (Article 8), so unless the patient is subject to treatment under the Mental Health Act, it can occur lawfully (in the longer term, at least) only in accordance with an appropriately-conditioned Deprivation of Liberty Safeguard (DoLS) authorisation.

3.6 Further guidance on capacity and the law about consent to medical treatment may be found in the Trust policy entitled Consent to Examination or Treatment and Treatment of Patients subject to the Mental Health Act 1983, part 4 and Part 4A as well as your local Mental Health Law Office.

4 SCOPE OF THE POLICY

4.1 This policy applies to the administration of medicines for treatment of either physical or mental disorder to inpatients and community-based patients of the Trust.

4.2 Medicines should never be administered by covert means as part of a research project.

5 CHILDREN

5.1 This policy relates primarily to adults; but, except for the issue of consent, the principles it contains are the same for children.

5.2 It should not be assumed that a child is unable to give consent:-

5.2.1 Young people aged 16 and 17 are presumed to have the capacity to give consent for themselves.

5.2.2 Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). A child that has sufficient understanding may consent to treatment on his/her own behalf. Such children are commonly referred to as being 'Fraser competent'. In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent.

5.2.3 Where a competent child refuses it would be unwise to rely on the consent of a person with parental responsibility. The MHA Code of Practice suggest that detention under the MHA should be considered or an application to the court.

6 CAPACITY ASSESSMENT

6.1 The law presumes every adult to be capable unless demonstrated otherwise. Every patient should be assessed to see whether, in fact, s/he is capable to make an informed decision at the time the decision needs to be made. The assessment of a patient's capacity should be subject to continuous review.

6.2 The assessment of a patient's capacity should be recorded in his/her medical notes. Capacity should be assessed in accordance with MCA.

7 PREPARATION OF TREATMENT PLAN

7.1 To treat a patient lawfully using covert medication, other than in an emergency, that patient must be subject either to treatment under relevant provisions of the Mental Health Act, or to restriction under an appropriately-conditioned DoLS authorisation.

7.2 All reasonable efforts must be made to give the medication openly in its solid or liquid formulation

7.3 The team must consider the possible impact of the patient's discovering the attempts at covert medication, particularly with respect to subsequent refusal of diet and fluids, and impairment of the therapeutic relationship. These considerations might restrict the utility of covert medication to circumstances where the patient has on-going-impaired cognition, such that the covert administration is unlikely to be recognised both at the time of covert administration and subsequently.

7.4 The proposed treatment plan, including the provision for medication to be administered covertly, will be discussed by all relevant practitioners and with those whom MCA/DoLS requires to be consulted about the patient's best interests. If, according to MCA, the patient is 'un-befriended' and the treatment would be 'serious medical treatment', it will be necessary to involve an Independent Mental Capacity Advocate (IMCA) in discussions about his/her best interests. The extent of any discussions will depend upon individual circumstances and the time available, and in an emergency,

discussions may be more limited. Where a patient is living at home with family or carers there should be discussion between the carers, the patient's General Practitioner (GP) and the community mental health teams. Consideration must also be made of ethical, cultural or religious beliefs. A record will be made of any discussions that take place and this will be in the clinical notes, the best interest meeting documentation or the mental capacity assessment documentation, as appropriate. If the patient is detained under DoLS, or an application for a DoLS authorisation is being made, then the Best Interest Assessor/ Relevant Person's Representative must also be involved in these discussions and should form part of the conditions of an application for a DoLS authorisation. Further advice/guidance can be sought from your local Mental Health Law Office.

7.5 The use of covert administration should be included in the care plan. A sample care plan is shown in Appendix 1. The use of covert administration should be communicated in writing to the GP at the point of discharge

7.6 The care plan will be countersigned by the senior health professionals involved and this would usually involve a Consultant Psychiatrist (or GP, in intermediate care) and a Senior Registered Nurse. That written record will record the views of carers who have been consulted.

7.7 Before covert administration is commenced, the Covert Administration of Necessary Medication Summary Record forms (Appendix 2) must be completed. The list of medications considered 'necessary' for covert administration must be completed following a full medication review, which must include appropriate simplification of the regimen. This should involve a pharmacist and if appropriate clinicians from other specialities to inform use of medicines for physical health, for example.

7.8 The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication persists, full reviews at specified less frequent intervals should take place. These reviews should be at least every 3 months depending on the chronicity of the condition and must be recorded in the medical notes.

7.9 While covert medication is being used, the list of medications considered 'necessary' must be updated to reflect any change to treatment.

8 SUPPLY OF MEDICATION

8.1 Except in the case of emergency, the proposed treatment and possible methods of administration should be discussed with the Pharmacist to ensure that medication may be mixed with food or drink and will not be affected by crushing or dispersing in water. The Pharmacist will consider ethical, cultural or religious beliefs that could affect the choice of medicines. Ideally the advice and recommendations of the Pharmacist should be received in writing to be documented in the patient's medical notes.

8.2 The method of administration should be clearly recorded on the Inpatient Prescription.

9 RISK MANAGEMENT ISSUES

Any medicines-related incident which occurs as a result of the covert administration of medicines should be reported via the Trust's Incident Reporting Form and following the Trust's Incident Reporting, Management and Investigations Policy.

10 APPEAL

If a member of staff, a relative, carer, friend or representative of the patient, or an IMCA wishes to raise concerns about the use of covert means to administer medication, or about the process by which it was decided to use such means, they can be referred to the Medical Director or Chief Pharmacist.

11 ADVICE FOR NURSING STAFF

11.1 The Code of Professional Conduct of the Nursing and Midwifery Council (NMC) requires each registered nurse, midwife and health visitor to act at all times in such a manner as to justify public trust and confidence. Registered practitioners are personally accountable for their practice and, in the exercise of professional accountability, must work in an open and co-operative manner with patients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care.

11.2 As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication when in fact they are. Registered practitioners will need to be sure that what they are doing is lawful under MCA and they will be accountable for their own decisions and practice. It is therefore imperative that there is good record of discussions and decisions made by all relevant parties.

11.3 The NMC position statement on the covert administration of medicines. 'Disguising medicine in food and drink' is given in Appendix 3

12 RELATED POLICIES

This policy should be read in conjunction with

12.1 Medicines Policy (CL15).

12.2 Consent to Examination or Treatment Policy (CL2).

12.3 Treatment of patients subject to the Mental Health Act 1983, Part 4 and Part 4A (CL58)

12.4 Code of Practice: Mental Health Act 1983.

13 IMPLEMENTATION AND TRAINING

The Trust will ensure that the policy for the covert administration of medicines has been issued and implemented as follows:-

13.1 Issue and Implementation

A variety of dissemination methods are in place to make sure that all staff are aware of, have access to and comply with the covert administration of medicines policy:

Lists of all new policies are published in the Trust's Corporate Brief including a brief description and its intended audience

All policies are held on the Trust's intranet to which all staff have access. Staff should always consult the intranet for the latest version.

Where a hard copy is kept on a ward/clinical area, it is the responsibility of the Ward Manager/Team Leader to ensure that the current version is on file.

Following approval, the Chief Pharmacist is responsible for cascading details of the latest version of all policies to all healthcare professionals.

Ward and team managers are responsible for ensuring staff in their area of managerial control are fully aware of the content of the covert administration of medicines policy.

All healthcare staff are responsible for ensuring they understand the content of the covert administration of medicines policy and act accordingly.

13.2 Training

Training in medicines management and in relation to the covert administration of medicines policy, forms part of the Trust's mandatory and essential training programme for identified staff groups.

The format of the mandatory medicines management training is described as per the Trust Training Needs Analysis.

Checking and monitoring of non-completion of mandatory medicines management training is undertaken by the Organisational Development (OD) department.

Where pharmacy staff provide additional training on medicines on an ad hoc basis or at the request of managers within the Trust, attendance records will be completed and forwarded to the OD department for inclusion on the training database.

Pharmacy staff input on an on-going basis to the induction programme of junior medical staff.

Further training will be made available when necessary to support initiatives of the National Reporting and Learning System (NRLS) and / or NICE.

Medicines management training needs in relation to the covert administration policy should be identified through the Individual Performance and Development Review (IPDR) process and feed into the Trust Training Needs Analysis (TNA).

Training required for individual members of staff is identified through the Trust's IPDR process and arranged as appropriate. Any non-attendance is reported via e-mail from the OD department to the individual's authorising manager for action and future attendance to be arranged.

14 AUDIT AND MONITORING OF COMPLIANCE

14.1 Audit

Audit in relation to the covert administration policy will be carried out as part of the Trust's clinical audit programme and in accordance with the annual audit calendar.

14.2 Monitoring

Compliance with this policy will be monitored by means of an analysis of incidents and complaints, by the Managing Prescribing Risk group on a quarterly basis, where there has been a failure to follow procedure.

Quarterly medication error/incident reports (Safeguard) prepared and reviewed by Managing Prescribing Risk Sub Group. Analysis allows identification of trends and themes.

Action plans to manage improvement in compliance with be developed by the Managing Prescribing Risk group on a quarterly basis, where necessary.

Key findings of both audit and monitoring of compliance will be reported to the Drugs and Therapeutics Committee.

Training required for individual members of staff is identified through the Trust's IPDR process and arranged as appropriate. Any non-attendance is reported to the individual's Service Manager.

15 REVIEW

This policy will be reviewed every 3 years or sooner should the need arise.

16 REFERENCES

(1) British Medical Association. *Assessment of mental capacity: Guidance for doctors and lawyers. A report of the British Medical Association and the Law Society.* London: BMA, 1995: 56-66.

(2) British Medical Association**.** *Assessment of mental capacity: Guidance for doctors and lawyers. A report of the British Medical Association and the Law Society.* London: BMA, 2004: 95-106.

(3) Nursing & Midwifery Council. Covert administration of medicines. Standards for medicines management. September 2010

(4) Good Practice in prescribing and managing medicines and devices. General Medical Council. February 2013

Maybe also add reference to the Cheshire West case and AG (By her litigation friend the Official Solicitor) v (1) BMBC and (2) SNH 2016] EWCOP 37,

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Appendix 1

Sample Care Plan for disguising medication in food and/or drink

(Covert Medication)

Patient…….. ……. needs to receive the medicines identified as necessary, in order to maintain their health and well-being in a safe and appropriate manner.

Action Plan

- This patient will be given the opportunity to take the medication voluntarily
- If they refuse medicines identified as necessary, these will be administered in food or drink as described on the inpatient prescription
- If the disguised medicine is refused, it must be discarded and the refusal recorded on the prescription and in the nursing notes. If the food or drink is administered by another member of staff as a delegated duty, the registered nurse must supervise, and remains responsible for the administration of the medicine and the recording of it.
- If only part of the disguised medicine is taken, an estimate should be made of the likely amount taken. This should be recorded on the prescription and in the nursing notes.
- The prescriber must be informed of any on-going problems in administering the necessary medicines.

Signature…….

Date…….

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Appendix 2

Covert Administration of Necessary Medicines Summary Record

To be completed by a medical officer before start of covert administration.
A copy to be kept with the patient's inpatient prescription

Patient's Name

Date of Birth

NHS Number

Ward

Consultant

1. Appropriateness of Covert Administration of Medicines

		Date recorded in clinical notes	Medical Officer	
			Signature	Name
1.1	Patient lacks capacity to consent to/refuse treatment			
1.2	Likely impact of patient's recognition of covert administration considered			
1.3	Reasonable attempts to give medicines by overt means have proved impracticable or are considered inappropriate			
1.4	Medicines proposed for covert administration have been reviewed by appropriate prescribers/specialists and identified as being 'necessary'	Please complete table overleaf and amend inpatient prescription appropriately		

Covert Administration of Necessary Medicines
Summary Record

To be completed by a medical officer before start of covert administration.
A copy to be kept with the patient's inpatient prescription

Patient's Name Ward Date of Birth
Consultant NHS Number

2. Medicines reviewed and considered necessary for covert administration

If possible, a pharmacist should be consulted at this stage to determine the practicality of administration of the necessary medicines

Name and Route	Indication	Reviewed by	Medical Officer		
			Signature	Name	Date

Covert Administration of Necessary Medicines Summary Record

To be completed by a medical officer before start of covert administration. A copy to be kept with the patient's inpatient prescription

Patient's Name Ward Date of Birth Consultant NHS Number

Lawful Authority and other considerations

			Summary details	Date recorded in clinical notes (if appropriate)	Medical Officer	
					Signature	Name
3.1	Patient detained under	MHA				
		DoLS				
3.2	Treatment authority specifies, or is conditioned for, covert administration	Please specify treatment authority				
3.3	Consider relevant advance decision/LPA (if any)	Escalate to MHL Office if any objection to the medication and/or its being administered covertly				
3.4	Discussion of covert medication, involving carers, relatives, IMCA, BIAs and relevant professionals has taken place					
3.5	Covert medication has been agreed as being in the patient's best interests					
3.6	Method of covert administration is specified on the Inpatient Prescription following advice from a pharmacist	Give name of pharmacist consulted				

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Appendix 3

Covert administration of medicines

Information on the relevant resource and processes regarding the covert administration of medicines

This information relates to the administration of medicines in food or drink to people unable to give their consent to or refuse treatment. It should be read in conjunction with:

The Code : standards of conduct , performance and ethics for nurses and midwives [PDF]

- Standards for medicines management [PDF]
- Consent

Nurses and midwives involved in decisions relating to administration of medicines in this way must act within the principles of The Code, NMC 2015 and ascertain and record the support, or otherwise, of the rest of the multi-professional team, and where appropriate family members, carers and others. It is inadvisable for nurses and midwives to make a decision to administer medication in this way in isolation. They will need to refer to local and national policies and apply the requirements of the law, particularly in relation to capacity. Some forms of disguised medication are recognised in law, for example, if a person is lawfully detained under a section of the relevant mental health legislation.

As a general principle, by disguising medication in food or drink, the patient /client is being led to believe that they are not receiving medication, when in fact they are. The covert administration of medicines is only likely to be necessary or appropriate in the case of patients or clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal.

As well as the ethical and legal considerations the nurse or midwife needs to consider that administering medicines in this way may alter their therapeutic properties rendering them ineffective and not covered by their product licence. This is a matter to be discussed with the pharmacist as part of the decision making process.

Further information

- Mental Capacity Act 2005
- Mental Welfare Commission for Scotland - Covert Medication [PDF]