COVERT MEDICATION GUIDANCE, DECISION TOOL and RECORD:

to be used with the covert administration of medication flow chart.

Name Address CRN/Paris ID DOB

INITIAL DECISION / REVIEW (delete as appropriate)

DEFINITION OF COVERT MEDICATION

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.
(NICE, Medicines management in care homes, Quality standard [QS85])

NICE guidance states that the covert administration of medicines should only be used in exceptional circumstances.

NOTE: MEDICATION CANNOT BE GIVEN COVERTLY (I.E WITHOUT THE PERSON'S KNOWLEDGE) IF THEY HAVE CAPACITY TO CONSENT TO/REFUSE IT, UNLESS THEY ARE DETAINED UNDER MENTAL HEALTH ACT 1983

CHECKLIST OF THINGS TO TRY BEFORE CONSIDERING COVERT MEDICATION

*Mark the boxes to record that you have given consideration to **each** of the following:*

☐ If the person is refusing medication, try to find out the reasons for refusal and resolve the issues if possible.

If you cannot establish the reasons:

☐ Try to administer essential medicines a short time later when the person may be more compliant (or another nurse/carer could approach the person)

☐ Consider alternative drugs/formulations with reduced administration frequency

☐ Ask the Pharmacist if the medication is available in another form e.g. syrup may be more palatable and easily taken; some tablets can be crushed or are available in dispersible form

☐ If the person is still objecting to/refusing the medication: ask the Dr/GP/ Independent Prescriber to review and confirm that the medication(s) is essential

ESSENTIAL MEDICATION(S) *(list)*

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.....
.....

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

.....
.....
.....

MENTAL CAPACITY

*Mark the box to record YES **or** NO responses***.**

Is there reason to doubt the person's mental capacity to consent to/refuse the medication(s)?

☐ **YES – please state your reasons**

☐ **NO –** ***covert medication cannot be given, unless the person is detained under Mental Health Act 1983***

IS THE MEDICATION FOR MENTAL DISORDER?

In hospital

Is the patient objecting to being in hospital for the purpose of receiving treatment for **mental disorder** or is objecting to being treated for that disorder (i.e. refusing essential medication)?

If so, the patient must be assessed for detention under the Mental Health Act 1983

Not in hospital

If the person is refusing medication for treatment of a **mental disorder** (which may include dementia) consult with the mental health team involved. If no mental health team is currently involved consult with/refer to the appropriate team. This is because consideration must be given to whether the Mental Health Act rather than the Mental Capacity Act is more appropriate to the patient's circumstances. They would also be able to advise on the medication used for mental disorder in these circumstances.

If the person is detained under the Mental Health Act, the medication for mental disorder ONLY may be given. You do not need to complete the rest of this form.

If any other medication(s) are essential or the person does not warrant detention in hospital under Mental Health Act, continue with this assessment.

SUPPORT AND ENABLE THE PERSON TO MAKE THEIR OWN DECISION

Engage support to help the person understand why they need the medication - e.g.

- providing information about why they need it, etc, in small steps
- providing an easy read leaflet if available
- involving someone who has a really good relationship with the person in helping them to understand about the medication

Then if they don't respond to this support, assess their mental capacity to consent to or refuse the medication.

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

ASSESSMENT OF PERSON'S CAPACITY (IN ACCORDANCE WITH THE MENTAL CAPACITY ACT 2005)

The key information needed to make this decision includes:

- why the medication(s) has been prescribed
- any alternatives
- risks and benefits to the particular individual
- what may happen if the person continues to refuse the medication(s)

*Mark the boxes to record YES **or** NO responses and enter relevant information into each box.*

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

☐ **YES** – *record the nature of the impairment or disturbance*

☐ **NO** – *presume capacity and end assessment*

Does the person understand the nature and consequences of accepting or refusing the medication, or of not making a decision about it?

☐ **YES**

☐ **NO** – *provide examples/ evidence of this*

Is the person able to retain the information long enough to make the decision?

☐ **YES**

☐ **NO** – *provide examples/ evidence of this*

Is the person able to use or weigh the information as part of making the decision?

☐ **YES**

☐ **NO** – *provide examples/ evidence of this*

Is the person able to communicate their decision in some way? *NOTE: they will only fail this if they cannot communicate in any way at all.*

☐ **YES**

☐ **NO** – *provide examples/ evidence of this*

If you have answered 'YES' to all four, then this person has capacity to make this decision.

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

If the answer is 'NO' to ANY of the four questions, then this person lacks capacity to consent to or refuse their medication.

Outcome of assessment

I have assessed this person's capacity to decide whether to consent to or refuse this medication(s) and it is my belief, on the balance of probabilities and given the evidence above, that this person:

☐ has the mental capacity to consent to/refuse the medication (end assessment)
☐ lacks the mental capacity to consent to/refuse the medication

Name, role and signature of the person undertaking the capacity assessment:

Name Signature
Role Date

ADVANCE DECISION TO REFUSE TREATMENT

Mark the box to record appropriate response.

☐ There is a valid and applicable advance decision which refuses the medication. (*End assessment)*
☐ I am not aware of a valid and applicable advance decision which refuses the medication

PERSONAL WELFARE LASTING POWER OF ATTORNEY (LPA) / COURT APPOINTED DEPUTY

If there is an attorney or court appointed deputy, check if they have the power to decide whether the person should be given covert medication

*Mark **one of the** boxes to record appropriate response*

☐ I have not been made aware of an Attorney or Deputy who has authority to make this decision

☐ I have seen and read the LPA and I am satisfied that the Attorney can make this decision

☐ I have seen and read the Court Order and I am satisfied that the Deputy can make this decision

Name, role, signature of the person checking for an advance decision or attorney or court appointed deputy:

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Name	Signature
Role	Date

Llofnod yr Atwrnai / Dirprwy	**Signature of Attorney / Deputy**
Mae gennyf awdurdod i wneud y penderfyniad yma. Rwyf wedi ystyried y materion perthnasol ac rwyf yn cydsynio i roi meddyginaeth cudd.	I have authority to make this decision. I have considered the relevant issues and I consent to the administration of covert medication.

Llofnod yr Atwrnai/Dirprwy / Signature of Attorney/Deputy:……

Enw (LLYTHRENNAU BRAS) / Name (PRINT): .....

Dyddiad / Date: ……

<u>If there is a valid and applicable advance decision refusing the medication OR a decision of an attorney or deputy, you do not need to complete the rest of this form.</u>

INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

Where there is no one appropriate to consult with about the person's best interests, you **must** instruct an IMCA.

WORKING OUT WHAT IS IN THE PERSON'S BEST INTERESTS

The law requires you to do everything you reasonably can to work out what the person's best interests are.
Only proceed if the decision cannot be delayed and the person is unlikely to regain capacity in the short term.

*Mark the boxes to record that you have given consideration to **each** of the following or that none are available***:**

Have you considered:

- ☐ any verbal or written wishes and feelings that the person has previously expressed or is currently expressing about this issue?
- ☐ the beliefs and values that would be likely to influence the person's decision if they had capacity?
- ☐ any other factors that the person would have considered if they were able to do so?

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Record considerations:

☐ There are none available.

If an IMCA was instructed explain how you have taken into account the IMCA's report in deciding what is in the person's best interests?

BEST INTERESTS CONSULTATION

The following people, must be consulted, if practical and appropriate, for their views about the person's best interests:

- Anyone the person has previously named as someone they want to be consulted
- Anyone involved in caring for the person/ or who has an interest in their welfare (e.g. family members, friends, Attorney, Deputy, carers etc)
- **A Pharmacist must be consulted about the formulation of the medication**
- The prescriber (if not leading on the best interests decision-making)
- If the person is already subject to DoLS authorisation then their Relevant Persons Representative (RPR) must be consulted

Any information about the person's wishes, feelings, beliefs and values and other relevant factors must be taken into consideration.

Give names, professional roles (where appropriate) and relationship of people consulted and details of discussions held:

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Were there any disagreements encountered during the assessment of best interests? ☐ **YES** – *record what these are, how they are being taken into account and what steps you are taking to resolve them e.g. best interests meeting (NB: If the decision is disputed you must seek legal advice).* ☐ **NO**

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

BEST INTERESTS DECISION (*prescriber to complete*)

*You, as the prescriber, are responsible for the final decision. Record the decision that has been made in the person's best interests below by marking the boxes to record that you have reviewed and are satisfied with **each** of the following*:

I confirm that I am satisfied with

- ☐ the assessment of mental capacity to consent to/refuse the medication
- ☐ consideration for whether or not there is an advance decision / someone with legal authority to make this decision
- ☐ consultation with relevant people **(including a Pharmacist)** regarding what is in the person's best interests
- ☐ the decision that has been made about the person's best interests

☐ I confirm that, in my judgement as the prescriber, the covert administration of *(specify medicines*)

……

……

is in the best interests of this patient because ……

☐ Initial review date…….. ☐ Review frequency…….

Signed: Role:
Name: Date:

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If the person is **in either a hospital or care home,** the managing authority must apply for DoLS authorisation.

Where a person is subject to DoLS authorisation, if the covert medications are changed, contact the DoLS Team so that a DoLS review can be carried out.

If the person is in other accommodation, **e.g. their own home, supported living, etc –** then consult with their care co-ordinator to obtain court authorisation for the deprivation of liberty.

If a DoLs authorisation is given, the managing authority (hospital ward or care home) must let the prescriber have details of any conditions attached to the authorisation regarding covert medication – e.g. review period. The prescriber must co-operate with the managing authority regarding these conditions.

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

REVIEWS

Develop a plan of care. The care home/ hospital ward need to review the plan of care at least monthly, this will include how and when covert medication will be administered. If there is a need to change this documented plan of care consult with the prescriber, who will need to arrange a review.

If the person is in their own home, supported living, etc, the responsible person for reviewing the plan of care will be the prescriber.

The prescriber will set out the Best Interests review period (although be aware that any DoLS authorisation may stipulate more frequent reviews as a condition of the authorisation). The review must involve family, healthcare professionals, RPR if they are in place and an IMCA if there are no family/friends to consult with.

The review needs to consider all the issues set out within this form including

- Whether the person's capacity to consent to or refuse the medication has changed?
- Is the medication still essential?
- Are there any unforeseen consequences of the covert medication?
- Are there additional essential medications needed?
- Any other relevant information

If there is any reason to suggest that there have been changes to the above issues a full reassessment is required.

The DoLS team or care co-ordinator must be informed of any changes.

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Prescriber review

Mark the boxes

PRESCRIBER REVIEW DECISION FOR COVERT ADMINISTRATION

I confirm I am satisfied that:

☐ there is no reason to believe that there is a change in the person's mental capacity to consent to/refuse the medication

☐ there is no reason to believe that a LPA has been registered or a Deputy appointed with legal authority to make this decision

☐ the consultation with relevant people (family, friends, RPR or IMCA) regarding what is in the person's best interests has not revealed any new information

☐ there are no unforeseen consequences of the covert medication

☐ the decision about the person's best interests remains the same

☐ I confirm that, in my judgement as the prescriber, the covert administration of *(specify medication*)

……

……

is in the best interests of this patient because ……..

……

☐ Next planned review date……..

Signed: Role:
Name: Date:

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Prescriber review

PRESCRIBER REVIEW DECISION FOR COVERT ADMINISTRATION

I confirm I am satisfied that:

☐ there is no reason to believe there is a change in the person's mental capacity to consent to/refuse the medication
☐ there is no reason to believe that a LPA has been registered or a Deputy appointed with legal authority to make this decision
☐ the consultation with relevant people (family, friends, RPR, IMCA**)** regarding what is in the person's best interests has not revealed any new information
☐ there are no unforeseen consequences of the covert medication
☐ the decision about the person's best interests remains the same

☐ I confirm that, in my judgement as the prescriber, the covert administration of *(specify medicines*)

……..

……..

is in the best interests of this patient because ……..

……

☐ Next planned review date…….

Signed: Role:
Name: Date:

PRESCRIBER REVIEW DECISION FOR COVERT ADMINISTRATION

I confirm I am satisfied that:

☐ there is no reason to believe there is a change in the person's mental capacity to consent to/refuse the medication

☐ there is no reason to believe that a LPA has been registered or a Deputy appointed with legal authority to make this decision

☐ the consultation with relevant people (family, friends, RPR, IMCA) regarding what is in the person's best interests has not revealed any new information

☐ there are no unforeseen consequences of the covert medication

☐ the decision about the person's best interests remains the same

☐ I confirm that, in my judgement as the prescriber, the covert administration of *(specify medication*)

……..

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.

Prescriber review

.....

is in the best interests of this patient because ……..

……

☐ Next planned review date……..

Signed: Role:
Name: Date:

PRESCRIBER REVIEW DECISION FOR COVERT ADMINISTRATION

I confirm I am satisfied that:

☐ there is no reason to believe there is a change in the person's mental capacity to consent to/refuse the medication
☐ there is no reason to believe that a LPA has been registered or a Deputy appointed with legal authority to make this decision
☐ the consultation with relevant people (family, friends, RPR, IMCA) regarding what is in the person's best interests has not revealed any new information
☐ there are no unforeseen consequences of the covert medication
☐ the decision about the person's best interests remains the same

☐ I confirm that, in my judgement as the prescriber, the covert administration of *(specify medicines*)

……

.....

is in the best interests of this patient because ……..

……

☐ Next planned review date……..

Signed: Role:
Name: Date:

If the person is being moved to a new care setting, this information MUST be shared with that setting, to avoid confusion and possible discontinuation of the medication.