

## Best practice guidance in covert administration of medication

This guidance aims to support clinicians and carers who are trying to manage challenges in dealing with patients who are non-compliant with medication through direct refusal. **Covert administration** is the administration of any medical treatment in a disguised form. Everyone has the right of refusal and current practice is inconsistent in recognising this right. Taking the most appropriate actions for each individual based on their capacity to understand the consequences of their decision is key to personalised care.

There is a common misunderstanding around the practice of putting medication into food or drink to make it more palatable often at the request of the patient. This could still be regarded as deceitful and open to abuse unless clear documentation supports the practice in the individual care plan. This is **overt** administration and is a co-operative process that is transparent and open to scrutiny and audit, and by definition requires a capacity to understand what is being done.

There is also a need to consider that covert administration is always assumed to be disguising oral medication. Alternative routes of administration may be considered acceptable but the capacity to understand that a patch is delivering medication must be questioned and invasive routes such as suppositories may cause more distress. If a person has capacity, altering the route of administration cannot be done without consent or best interest decision. Decisions that are made must consider all options carefully for each individual.

In the context of care it is important to understand what might make a person refuse to take medication which is intended and prescribed to meet a clinical need, as this understanding might present a resolution which does not involve covert administration. For example:

- A person may be refusing to take treatment because they find it difficult to swallow a large tablet or the taste of the liquid is unpalatable to them.
- A person may not understand what to do when they are presented with a tablet or a spoonful of a liquid possibly due to advancing dementia.

These people are technically refusing to comply but their reasons can be easily rectified through discussion with the patient and prescriber, and appropriate support to manage the problem.

And finally there is a lack of understanding in the use of “when required” medication, where refusal is often recorded when the medication is offered but declined. Technically the person has refused but has made a decision which should be based on a judgement of “no requirement” as there is no medical need at that time. Unfortunately this process may be managed very badly unless the person is being told what it is they are being offered, what it is for and the consequences of not taking it and has the capacity to understand. There is a lot more support needed to clarify the management of “when required” medication, which is beyond the scope of this guidance.

## Purpose of the guidance

To make a decision to ignore a person's refusal to take their medication could be legally challenged if appropriate steps have not been taken to exhaust all available options. These guidelines detail the pathway that should be followed as best practice to support a decision to administer a medicine covertly, thereby demonstrating that there is no other option available.

There is also a need to support a simplified approach to the implementation of due process whilst ensuring that it satisfies legal requirements. It is therefore the intention of this guidance to provide simple tools to assist both healthcare professionals and carers supporting people in their care.

This guidance has been developed from reading existing good practice statements and the requirements of the law. Anyone considering covert medication should use this guidance to develop local policies and procedures. It considers:

- The need to consider covert medication.
- The legal framework for its use.
- Practical guidance in how to administer.
- A suggested care pathway for its use.
- Some case examples.

## Legislation

One of the reasons that unchallenged covert administration of medication continues within the care environment is a lack of understanding that it is potentially an unlawful act unless appropriate actions have been completed. There may also be a lack of support from healthcare professionals due to a perception that complex and time consuming processes are necessary. Awareness of legislation in this area of practice is essential, but complex decisions may require legal advice to protect the patient, carer and healthcare professional.

The British Medical Association (BMA) provides resources to support doctors to help in good decision-making when providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf.<sup>1</sup>

The Mental Capacity Act (MCA) 2005 (c. 9 Part 1 "The principles" Section 1) sets out a number of basic principles that must govern all decisions made and actions taken under its powers.<sup>2</sup> These are rooted in best practice and the common law and are designed to be fully compliant with the relevant sections of the Human Rights Act, 1998.<sup>3,4</sup> The MCA is accompanied by a statutory Code of Practice providing guidance on how it should be used.<sup>5</sup> Certain people have a legal duty to have regard to the guidance in the Code of Practice, including anyone acting in a professional capacity.

Due consideration must be given to the Human Rights Act 1998<sup>3</sup> and the following relevant sections of the Act have been highlighted by Royal College of Psychiatry regarding covert administration.<sup>6</sup>

### Article 2: 'Everyone's right to life shall be protected by law'

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 in the context of the wider issues considered.

### Article 3: 'No one shall be subject to torture or inhuman or degrading treatment or punishment'

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. This substantiates the need to consider the consequences of alternative routes of administration.

### Article 5: 'Everyone has the right to liberty and security of person'

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. This highlights the need for review of the clinical need to continue treatment by means of a risk/benefit discussion.

### 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'

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 audit trail may be obtained when required.

### Article 8: 'Everyone has the right to respect for his family life, his home and his correspondence'

See comments to Article 5 above.

The Nursing and Midwifery Council (NMC) recognises that covert administration of medication is a complex issue that has provoked widespread concern. Each professional is personally accountable for actions and omissions in practice, and decisions must always be justifiable. Consequently the NMC code of practice<sup>7</sup> and the NMC Standards for medicines management<sup>8</sup> provide advice for nurses in supporting non-compliant patients in their care. It is important that they are not asked to perform actions outside of their code of practice.

Section 1.15 of the March 2014 NICE social care (SC1) guidance on managing medicines in care homes, makes it very clear that "*Health and social care practitioners should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines*".<sup>9</sup> The full guidance also states that commissioners and providers of care should consider establishing a wider policy on the covert administration of medicines across health and social care organisations. This encourages integrated working and demonstrates the fact that carers need support from health professionals to deliver appropriate care. In developing such policies it is imperative to utilise the expertise of Mental Capacity Act leads within social care organisations to ensure that all legal requirements have been satisfied.

## General principles of covert administration<sup>10</sup>

Human rights law is the first principle that determines the decision to proceed. The right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal might lead to a detrimental outcome. **Covert medication cannot be given to someone who is capable of deciding about medical treatment.**

So the first step in the process is ascertaining the capacity of a person to make a decision about their medical treatment.

Where covert administration is being considered as the most appropriate option the following principles should be seen as good practice:

- **Last resort** - covert administration is the least restrictive when all other options have been tried.
- **Medication specific** - the need must be identified for each medication prescribed.
- **Time limited** - it should be used for as short a time as possible.
- **Regularly reviewed** - the continued need for covert administration must be regularly reviewed within specified time scales as should the person's capacity to consent.
- **Transparent** - the decision making process must be easy to follow and clearly documented.
- **Inclusive** - the decision making process must involve discussion and consultation with appropriate advocates for the patient. It must not be a decision taken alone.
- **Best interest** - all decisions must be in the person's best interest with due consideration to the holistic impact on the person's health and well-being.

## Suggested care pathway

The pathway is represented simply in a flow chart included in the toolkit. Below is a more detailed step by step explanation which provides the necessary background information.

### Step 1

#### Assessing mental capacity (MCA assessments)

Before covert administration is considered as an option, decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the five key principles set out below. It is important to remember that an assessment is task specific and consequently must be carried out for each individual issue which compromises a person's quality of life.

#### 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. For example, 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 rights and freedom of action.

#### Process of assessment

For the purposes of assessing capacity to understand medication there will be a need to first establish that a person is unable to make a decision because of an impairment of or disturbance in the functions of the mind or brain.<sup>2</sup> This clinical diagnosis provides the justification for proceeding.

The second stage of assessment can only proceed if the answer to the first stage is "yes".

Consideration should be given to the patient's country of origin and their understanding of English.

**A patient will be considered to lack mental capacity in law to make a decision or consent if he or she is unable to:**

- 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 the 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**

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) and in what specific circumstances they refuse them – the advance 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.

When an emergency arises in a clinical setting and it is not possible to determine the patient'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 must be the least restrictive option available. Any medical intervention must be considered to be in the patient's best interest and should be clearly recorded noting who took the decision, why the decision was taken and what treatment was given and when.<sup>1</sup>

### Who can carry out a mental capacity assessment?

In the context of care the practical assessment of capacity for a specific decision may be made by the carer. Some care providers have developed their own MCA paperwork but it is essential that it fulfils all legal aspects and that the assessor has undertaken specific training to appreciate the principles of the assessment process.

So the person who can assess an individual's capacity to make a decision 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).

Difficult situations may arise where a 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.<sup>1,11</sup>

MCA assessments benefit from involvement of family, close friends or carers especially where there is any doubt about a decision.

One of the reasons why MCA assessments are not carried out by healthcare professionals is due to the complexity of some of the paperwork. To support the assessment process a suggested MCA format has been produced from examples of forms used across many organisations. This has simplified the questions which are necessary to make the assessment legally valid. See attachment 2.

## Step 2

The individual has been assessed to lack capacity to understand the consequences of refusing their medication. Next steps cannot be taken unless this has been determined.

### 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 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 them.<sup>12</sup>

The Mental Capacity Act 2005 provides a checklist which must be followed when making a decision for someone.

### Summary of 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**
- 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.

A person may be mentally incapacitated for various reasons. These may be temporary reasons, such as the effect of sedative medicines, or longer term reasons such as mental illness, coma or unconsciousness. It is important to remember that capacity may fluctuate, sometimes over short periods of time and should therefore be regularly assessed by the clinical team treating the person. There may be a need to consider delaying the decision to administer medication covertly if there is a significant chance that capacity will be regained and delaying the decision will not have life threatening risks.

### Who should be involved in making a best interest decision for medication issues?

Best interest decisions involving medication should be made by the prescribing practitioner in conjunction with a multi-disciplinary team of healthcare professionals. If a pharmacist cannot be present their advice should be sought before the decision to proceed to covert administration is made, in order to check the suitability of the medication to be administered in this way.

The person's family/friends/carers/advocates must be involved in and informed of the decision to administer medication covertly (note however that nobody can consent for someone else; but the views of family/carers may be beneficial in determining a person's wishes and feelings and what is in their best interests). In cases where there is no-one to consult with there is a need to refer to the advocacy service.

### Factors to consider before deciding to covertly administer

It is essential to always remember the potentially abusive nature of this process and for this reason assurance is needed that there is really no other option.

- The best interest decision includes a risk benefit assessment which should be made by the prescribing clinician, and in discussion with relatives/advocates. The option of stopping the medication should be considered **as the least restrictive option**, particularly where there are risks of food or drink being refused. This decision must be documented in patient's clinical notes and care plan with reasons for the decision. Clinicians are frequently concerned of medico-legal challenges in stopping medication but supporting documentation provides evidence.<sup>13</sup>
- Patterns of behaviour need to be monitored. A person may refuse their medication at certain times of day. Can the timing of administration be altered? Is there a formulation which can be given less frequently?
- Dementia commonly presents challenges to carers administering medication. Dementia training is essential to develop persuasive techniques and document personalised preferences such as particular carers, environment, ways of giving etc.
- If a person is not eating or drinking very well covert administration could be harmful as taste may be affected causing refusal of meals and drinks.
- The prescriber should consider an alternative route of administration of that medication (e.g. topical, parenteral) or an alternative medication (e.g. available in different forms which are more palatable).

### Step 3

If the best interest decision is to administer covertly, the suitability of the medication must then be considered.

- The properties of the medication (e.g. its bioavailability) should not be significantly affected by administering it covertly (where this information exists). Modified release (e.g. MR/SR/CR/XL) and enteric coated (E/C) preparations are generally not suitable for covert administration as they cannot be crushed – always seek advice from a pharmacist before doing so.
- If a licensed liquid preparation of the prescribed medication is available, this should preferably be used to mix with drink/food if appropriate. This is in preference to crushing or dissolving tablets or capsules, which is unlicensed use unless specified in the Summary of Product Characteristics (SPC).
- The prescriber, pharmacist and administering professional/carer should take reasonable steps to ensure administering medication covertly (including the crushing of tablets or emptying of capsule contents) will not cause harm to the patient. The pharmacist should refer to the standard texts, the SPC for the medicine(s) concerned, and specifically to appropriate reference sources to advise on suitability.<sup>14</sup>

## 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 person's 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 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 person's clinical records in their GP surgery and a copy needs to be shared with the relevant person/care team.

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 carers are aware of the correct process.

It is also useful for kitchen staff to be aware of a person who is being given medication covertly as dietary changes may be needed.

Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet.

Where administration is unsuccessful this must be documented and any consequences reported to the prescriber and the GP/specialist in time scales as agreed at the commencement of the treatment and within the best interest decision.

Examples of documentation templates are included in the care homes webkit.

## Step 5

### Practical points in administering covertly

In the context of care it is important to remember that dignity and respect must be maintained in a potentially abusive situation.

Carers must be supported by healthcare professionals to be able to deliver care appropriately with due regard to their accountability.

Consistency in practice is only possible if carers are given clear guidance that they can follow. For this reason it is clear that provider organisations must develop process driven covert medication policies as detailed in NICE guidance SC1.<sup>9</sup>

Carers who are trained to administer medication should consider the following points when covert administration has been deemed necessary.

- A person should be offered their medication **overtly** each time, especially where fluctuating capacity is evident.
- The carer should be aware of personal preferences for administration through the care plan. Refusal after appropriate steps have been taken can then proceed to covert.
- In general the medication(s) which are to be administered covertly should be mixed with smallest volume of food or drink possible (rather than the whole portion). This increases the likelihood that the prescribed dose is actually taken. Not all drinks are suitable, e.g. tea or milk interacts with some medication and this should be documented clearly.
- The medication must be administered immediately after mixing it with the food or drink. Do not leave it for the person to manage themselves. If the person is able to feed themselves, observe to ensure that it is consumed.

- Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet.
- Refusal of the food or drink containing medication must be recorded on MAR sheet as refusal. It should also be noted if it is partially consumed as the dose is then uncertain.
- Good record keeping is evidence to enable the prescriber to review the continued need for covert administration.

## Step 6

### Review of continued need

The need for continued covert administration should be reviewed within time scales which reflect the physical state of each individual. This should be agreed at the time of agreeing the implementing of covert administration within the best interest decision. It is important at end of life that relatives or advocates are made fully aware of the decisions that are made around medication so that they are reassured.

Referring back to the general principles, the least restrictive approach should be the first option that ultimately requires a review of risk/benefit in stopping the medication, especially if evidence of non-compliance demonstrates no apparent harm.

## References

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## Further reading

UKMI Q&A 365.3, August 2014. What legal and pharmaceutical issues should be considered when administering medicines covertly?

UKMI Q&A 294.3, July 2013. What are the therapeutic options for patients unable to take solid oral dosage forms?

UKMI Q&A 339.2, December 2012. Crushing tablets or opening capsules in a care home setting.

## Additional PrescQIPP resources



Assessment tools, case studies, flowchart,

Available here: <http://www.prescqipp.info/carehomes>

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