Guidance regarding Covert Medication and Mental Capacity for Care Homes
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Introduction
from the Medical Director

I’m pleased to be able to offer a few words of introduction to this guidance for Care Homes.

While covert medication is sometimes necessary and justified, it must never be given to someone who is capable of deciding about medical treatment. As Doctors, Nurses, Social Workers and Pharmacists we are agreed that

• It is usually unlawful to administer medication without consent.

• Where the individual is incapable of consenting, it could still be regarded as an assault unless done appropriately and within the law.

• The rights of the individual must be protected.

• Those prescribing or administering covert medication require Protection from liability and allegations of harm.

This guidance has been produced to support practitioners, and others, when considering the use of covert medication. Please be aware, this document is offered as guidance and there are other documents and sources of information to go to for support with, what is, a complex area of practice.

We hope you find it useful.

Dr. George Kissen
Medical Director
NHS Trafford
Introduction
from the Designated Nurse for Vulnerable Adults

The carers and practitioners I meet on a daily basis are keen to make sure they get things right for vulnerable adults, particularly those vulnerable people who have fluctuating capacity or lack capacity to make decisions about their health care.

I know that this isn’t always easy. Working with dependent people and balancing the wishes of their relatives and friends, whilst having to operate within a complex legal framework can sometimes be difficult and at times seem overwhelming.

We have produced this guidance to support practitioners.

The use of covert medication is a serious step. But, under section 44 of the Mental Capacity Act 2005 it is a criminal offence to wilfully neglect care, so, for residents with fluctuating capacity or those who lack capacity to accept or refuse medication, covert medication is an option that should be carefully considered.

Please, remember, there is help and advice available if you need it, you’re not alone. A guide regarding from whom, and where, you may seek further support is included at the back of this document.

Please note this document is a guide and therefore not exhaustive, you may choose to seek support from other relevant and appropriate sources, including the Nursing & Midwifery Council or the Royal College of Nursing.
Guidance for the covert administration of medicines

Definition

Covert administration of medicines is when medication is given to a service user without their knowledge and/or consent in a drink or with food.

Adults who are able to consent

Giving medication to a person who has consented to having their medicine(s) administered in this way, e.g. due to an unpleasant taste or difficulties with swallowing does not constitute covert administration. Therefore, this guidance would not apply.

“A care worker (or registered nurse) should not mix medicine with food or drink if the intention is to deceive someone who does not want to take the medicine. This is called ‘covert’ administration. The exception to this is when a medical practitioner states that the person lacks ‘capacity to consent to treatment’ and the medicine is essential to their health and well being.

For more information refer to the Mental Capacity Act and Code of Practice.”

Source: Care Quality Commission Professional advice: The administration of medicines in care homes, 2010

It must be remembered that administration of medication against a person’s wish may be unlawful.

Care Homes and this document

This document is issued as GUIDANCE to care homes in Trafford.

Each care home is responsible for ensuring it has its own policies and procedures for covert administration of medication and for the administration of medicines more broadly.

This document is in no way intended to replace, supplement or augment the policies and procedures effective in each care home.

Each registered and non registered practitioner remains accountable for their actions under the law and, where relevant, their Code of Conduct or Standards of Practice.
Consideration of the “Why?” question

Care Home staff are asked to consider the reasons why a service user may not be taking their prescribed medication. Is it that:

- they do not understand what to do when presented with a pill or a spoonful of syrup?
- they find the medication unpalatable?
- they have difficulty swallowing the formulation?
- they lack understanding of what the medication is for?
- they do not understand in broad terms the consequences of refusal?
- there are ethical, cultural or religious beliefs?

Every attempt should be made to encourage the service user to take their medication by usual means. This may be achieved by giving regular information and clear explanation. The service user must have every opportunity to understand the need for medical treatment. Before covert administration is contemplated, alternative ways of administering the medication by usual means should be used.

Mental Capacity and covert medication

People with mental ill health, learning disabilities or those who are physically unwell do not necessarily lack capacity. However, people with a physical health difficulty, a mental illness or a learning disability may experience a temporary loss of capacity to make decisions about their care and treatment. If they have capacity to refuse this should be respected and discussed with the prescriber.

When determining if covert administration is appropriate consider:

- **Capacity to consent**: does the service user have the capacity to decide about medical treatment? The medical practitioner needs to confirm that the service user lacks ‘capacity to consent to treatment’. The service user may have a representative who has a Lasting Power of Attorney for Health & Well Being, or is Court Appointed Deputy who should be consulted.

- **IMCA**: The service user may have nobody to represent their interests or be consulted and therefore an Independent Mental Capacity Advocate must be appointed.

- **The Human Rights Act 1998**: covert administration will be considered unlawful if the patient has not been given the opportunity of consenting to or refusing such medication. Or in circumstances where the service user is unable to refuse or give consent, where the prescribed legal process to act in the persons best interests have not been followed.

The Mental Capacity Act 2005 has produced an assessment tool called the two stage functional test.

**The two-stage functional test**

In order to decide whether an individual has the capacity to make a particular decision you must answer two questions:
Stage 1. Is there an impairment of, or disturbance in the functioning of a person’s mind or brain? If the answer to this question is yes, progress to stage two:

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

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

- Understand information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision
- 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.

In the absence of capacity to consent consider:

- **Past and present wishes taken into consideration** – take into account why the service user is refusing medication. The refusal could be an indication that the service user no longer wishes treatment.

- **Benefit** - the best interests of the service user must be considered at all times. A medication review should be performed to ensure all prescribed medicines are required. The medication must be considered essential for the service user’s health and well-being. Is it so essential that it needs to be given by deception?

Alternative strategies for managing behavioural symptoms of dementia or confusion should always be considered. Medication should not be given solely for the benefit of others; however, although the benefit to the service user is paramount, occasionally it may be necessary e.g. if staff are in danger of assault by the service user.

**Personalise** – identify any specific care needs of the service user which may impact on treatment options e.g. food dislikes

- **Open discussion** – there is a multi-disciplinary approach involving, e.g. the doctor, nurse, care worker, pharmacist and friends/family of the service user or IMCA who discuss and agree the decision to covertly administer medication in the current circumstances.

- **Documentation** – it is essential to document the decision and action taken to covertly administer medication including the names of all parties involved. Please refer to appendix 1 – use a separate form for each medication (see appendix 1a for example). Ensure the decision and action is effectively communicated with all relevant staff.

- **Pharmacist advice** – ask the pharmacist to provide advice on the most appropriate way to administer the medication. **It is not good practice to crush tablets or open capsules unless a pharmacist informs you that it is safe to do so as this may alter the properties of the**
medication. Also some food or drinks may affect the medication and how it is absorbed. Please refer to appendix 2.

- **Responsibility** – If medication is altered in any way it will no longer be covered by the manufacturer’s product licence. In this scenario, the prescriber takes on greater responsibility so should be informed about any changes in presentation prior to administration. Care staff may only give licensed medicine in an unlicensed way if there is a written direction in the service users’ care plan.

- **Administering the medication** – care staff need to understand how to give the medication. There must be appropriate supervision, education and support provided to enable the safe administration of the medication as authorised by the named prescriber and pharmacist.

- **Additions of new medication** – any new medication added to the current regime is treated as a completely new situation and all the above issues should again be considered.

- **Review regularly** – a service user’s mental capacity can change so it is important to review if treatment and covert administration is still necessary. Set formal review meetings – the timescale will depend on circumstances. It is recommended that initially reviews should be frequent e.g. monthly. The timescale of review should also be dependent on the service user’s condition and what medication is being administered at that time e.g. if mental capacity is impaired for a short period of time due to acute infection.

- **Policy** – there should be a clear written local policy in the care home, taking into account this good practice guidance.

**What issues does covert administration raise?**

Failure to consult with the General Practitioner and Pharmacist before commencing the administration of covert medication regimens is likely to result in a referral to CQC and an adult safeguarding investigation.

**Deprivation of Liberty**

- All residents have the right to refuse to take their medication.

- To covertly administer medication may amount to a deprivation of their liberty, dependent on the medication being covertly administered

*For example: the administration of sedatives covertly may be considered to amount to a deprivation of liberty.*
Documentation

All information pertaining to the covert administration of medication including, Mental Capacity Assessments, Best Interest decisions and suitability of administering the medicine with food and drink must be documented in the service users care plan and contemporaneous care record.

Human Rights

The following articles of the Human Rights Act, 1998 are of particular relevance:

**Article 2: Everyone’s right to life shall be protected by law.**

_Covert medication and Article 2:_ Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article is used to justify such a practice. Clearly no treatment may be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatments may, sometimes, shorten life as a secondary result of their administration). **Administration of treatments whose purpose is to shorten life is illegal.**

**Article 3: No one shall be subject to torture or inhuman or degrading treatment or punishment.**

_Covert medication and Article 3:_ In an incapacitated adult, repeated restraint and injection of treatment (with attendant risk to life) may well be more degrading and inhuman than the covert administration of medication.

**Article 5 Everyone has the right to liberty and security of person**

_Covert medication and Article 5:_ 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.

**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.**

_Covert medication and Article 6:_ It is essential that, if medication is administered covertly, that this is done following discussion and with clear clinical records, so that a fair and public hearing may be obtained if and when required.

**Article 8: Everyone has the right to respect for his private and family life, his home and his correspondence.**

Article 8: See article 5 above.
References

Care Quality Commission, Essential Standards 2011

Care Quality Commission Professional advice: The administration of medicines in care homes, 2010

NMC Advice sheet: Covert administration of medicines – disguising in food or drink

Mental Capacity Act, 2005

Mental Health Act, 1983 (amended 2007)

Human Rights Act, 1998

Tweddle, F. Covert medication in older adults who lack decision-making capacity
British Journal of Nursing Vol. 18, Iss 15, 13 August 2009, pp 936 - 939
Case scenario 1

Mr. Smith has dementia and is receiving respite care in a care home. His dementia is severe, he cannot communicate verbally and he resists nursing care. He is a widower and his only close relative is his daughter. She would like to look after him at home, but the difficulty of caring for him would make this impossible. Mr. Smith has high blood pressure and heart trouble. He needs medication to keep his blood pressure stable. He is also on diuretics and tablets for angina. Without all of these, he is in danger of stroke, heart failure or a heart attack. He has become increasingly reluctant to take his medication. When he is given tablets, he spits them out. Trying medication in liquid form is no better. Without his medication, his health is in danger. His daughter is very concerned and wants him to get treatment, no matter what.

We decided that covert medication was an option. Before making the decision, we thought that it would be important to consider why he is refusing. Could he be making a decision not to accept his medication? Has he made any previous statement about not wanting to go on living if he is dependent and in a care home? His daughter and other relatives may have information on this. He may have the right to “give up”, although assessment for depression would be important. The team needs to consider the risks and benefits of any treatment he may need. For instance, preventing discomfort caused by breathlessness and angina is more important than treatment that, for example, might reduce the risk of stroke by a few percent.

An assessment of capacity by the General Practitioner is essential in this case. It is undertaken and the General Practitioner decides that he lacks capacity to decide whether to refuse his medication. A best interest decision is made in consultation with his daughter, the care home, the pharmacist and General Practitioner and it is decided to give his medication covertly. This is also written into his care plan.

Care staff begin to give Mr. Smith his medication covertly. He is taking it and his medical condition is stable. He is still quite resistant and aggressive. His daughter is still keen to try to care for him at home, but only if he is less disturbed. Medication might make this better. You already give him other medication covertly. The daughter asks if he can be given medication to take the edge off his aggression covertly.

We saw no fundamental difference between this decision and the decision to treat his physical condition. It must be considered anew with a full risk/benefit analysis. Is this of benefit to him? Would it improve his quality of life if his daughter cared for him? Might the effect of sedative medication detract from this benefit? Would the team be doing this for his benefit or his daughter’s?

His daughter is able to care for him at home. A long lost son appears on the scene. He is horrified that his sister is giving his father medication covertly. He demands that she stops doing this. The GP thought that it would be essential to arrange a meeting with the son to explain the decision and talk through his concerns. If he still disagrees with treatment, he should be informed of his option to apply to the Court of Protection to request an order to stop treatment.
Case scenario 2

Ms. Brown has a severe degree of learning disability. Her parents care for her in the family home. They are known to be very caring and have her best interests at heart.

She has epilepsy and can have outbursts of aggressive behaviour around the time of her seizures. She can communicate for most of the time but does not understand that she has epilepsy. She does not realise that her behaviour can become a problem at times. Her doctor prescribes anticonvulsant medication for her epilepsy. Usually, she takes this without any problem. Sometimes, when her behaviour becomes disturbed, she refuses her medication. Her parents ask the GP to prescribe it in liquid form so that they can give her the treatment covertly.

It is likely that treatment will be necessary.

The GP would need to consider Ms. Brown’s capacity and will need to undertake a Mental Capacity Assessment. To support the assessment process communication aids and education would be very helpful and involvement of the multidisciplinary team is essential. If this she is determined to lack mental capacity regarding this decision, then covert administration could be considered if it was considered to be in her best interests. Any decision to administer medication covertly would also need to be included on Ms. Brown’s care plan.

We are aware that these capacity assessments and best interest decisions are not always used when they should be. In this case, the GP decided to prescribe the medication and let the parents administer it covertly without any legal steps being taken. He also gave them some sedative medication in liquid form in case Ms Brown became very disturbed.

The family use sedative medication very rarely. Mrs Brown, the mother, takes seriously ill and is admitted to hospital. Caught between the needs of his wife and his daughter, Mr Brown asks for respite care for his daughter. She is admitted to a residential care to a short stay/respite facility with 24 hour professional staffing. The care home asked the GP to undertake an assessment of capacity with regard to the admission to respite care, as Ms. Brown was unable to make this decision herself. She was deemed to lack capacity by the GP and the best interest decision was made that she needed to go into respite care.

During the pre-admission assessment screening the care home staff are told about the arrangements for giving medication covertly. They are unhappy about doing this under the informal arrangement between the GP and the parents. Our advice would be to get the GP to complete an assessment of capacity and, if Ms. Brown is deemed to lack capacity, make a best interest decision, with the family and the care staff as soon as possible.

In the meantime, she may suffer if she does not get the treatment she needs. Continuing her anticonvulsant treatment could be justified in this way as an emergency. Giving sedative treatment is less likely to be justified.
All Care facilities need to have policies about covert medication.

We worried that some people might not get necessary treatment if the care facility has a blanket policy against such treatment.

**Case scenario 3**

Mr. Jones suffers from schizophrenia. Without medication, he becomes very paranoid. He sometimes agrees to take medication but often refuses because he does not like the side effects.

He lives at home with his mother who is very caring but also afraid of him when he is paranoid. She is very keen that he gets his medication. A year ago, he was being given medication by depot injection. He agreed with his doctor and his mother that he would come off the depot and take oral medication instead.

He is not being treated under any legislation.

A new community mental health nurse takes Mr. Jones on to her caseload. When she visits, Mr. Jones says that he has stopped his medication because he feels he can manage without it and he has put on a lot of weight, a known side effect. However, his mother takes her aside and quietly tells her that she has been giving Mr. Jones his medication crushed up in his food.

This is a very difficult situation.

Mr. Jones’ mother should not have been doing this and must be advised to stop by the community mental health nurse. If she refuses, the nurse would need to discuss with the Psychiatrist the possibility of stopping the prescription. The community mental health nurse had mixed feelings about telling Mr Jones about his covert treatment, as it would risk the relationship with his mother and possibly jeopardise the mother’s safety. Ideally, she needs the support to tell him herself. The community mental health nurse raised an adult safeguarding alert. In the midst of the community mental health nurse trying to sort the situation out, Mr Jones is admitted as an emergency to a general hospital. There is no connection between this and his mental illness.

He needs to stay in for at least a fortnight. His mother tells the general hospital staff to give him his antipsychotic covertly.

The general hospital nursing staff do not agree to this. The ward sister tells Mrs Jones that her son’s mental ill health does not mean he cannot make any decisions for himself, she has met him and talked to him about all of the medication he may need to take whilst in hospital and she has
no reason to doubt his presumed capacity to make decisions regarding taking medication. The ward sister agrees to a referral to the liaison psychiatric team, which is appropriate.

He was offered treatment for the management of his schizophrenia by the Psychiatric Liaison Team. This was declined, as, from his point of view, he has been free from treatment for months and is mentally well.

It was agreed by the multi-disciplinary team that the most appropriate action was for him to remain free from mental health drug treatment. The mental health service would monitor his mental health carefully whilst an in-patient and when he goes home and be ready to intervene if he shows signs of relapse.

Case scenario 4

Mr Black is in a care home.

He has a mild degree of dementia and loses things regularly. He believes that someone is coming into his room and stealing his possessions and frequently calls the police. The lost items always turn up and it is clear that he has mislaid them. He does not accept this and all efforts to help him have failed. He is on several medications for physical conditions. He has taken these for many years and is fully aware of what he is on and why.

He is seen by an old age psychiatrist. She thinks that antipsychotic medication might help but he adamantly refuses this. She considers using mental health legislation to give compulsory treatment in the form of a depot injection.

The care home staff are unhappy about the trauma that removal to hospital and forcible treatment will cause. They ask if they can give him covert medication.

The suggestion to use covert medication in this scenario seems disproportionate. If we remove the word “dementia” then the question of covert medication is unlikely to arise. The need for medication was also questioned and advised the Psychiatrist undertook a careful risk/benefit analysis.

In this situation, any treatment would need to be under the terms of mental health legislation. It is understandable that care home staff did not want to remove Mr. Black to hospital. However, covert treatment was not appropriate. He could not be treated by force in the care home, but he could be detained and treated under the Mental Health Act, 1983 (2007. If force was necessary, the team would need to consider whether admission to hospital for treatment would be of enough benefit to outweigh the distress and disorientation that it may cause.
Useful web enabled links

NMC: Covert administration of medicines: Disguising medicine in food and drink

CQC: Essential Standards

The Mental Capacity Act Code of Practice

The code: Standards of conduct, performance and ethics for nurses and midwives (2008)


Record Keeping: Guidance for nurses and midwives

GSCC: Code of Practice for Social Workers

HPC: Standards of conduct, performance and ethics

GMC Standards and Ethics for Doctors

Making decisions: A guide for staff in health and social care

Making Decisions: An easy read guide

Making decisions about your health, welfare and finances, who decides when you can’t?

Trafford Mental Capacity Act and Best Interest Decision Form

Trafford Adult Safeguarding Policy and Procedure
Local Contact Details

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Covert medication and Mental Capacity guide

Decision re covert medication

Have all reasonable steps been taken to support the person to make their own decision?

Yes

Identify the decision maker

Is there an Advanced Directive, Lasting Power of Attorney?

No

Best Interest Decision

Does the person have a representative able to speak on their behalf?

No

Consider requesting an IMCA

Yes

Involve key people including: Solicitor, Deputy, Family, Social Worker, Mental Health

Is this a complex, controversial or important decision?

No

Repeat previous steps

Yes

Decision made

In the case of covert medication the Decision Maker will almost always be the General Practitioner.

Lasting Powers of Attorney
The Mental Capacity Act allows a person to choose someone to act on their behalf if they lose capacity in the future.

Before is can be used a Lasting Power of Attorney for health and welfare will need to be registered with the Office of the Public Guardian.

The person in question will then need to be assessed as lacking capacity regarding a specific decision set out in the Lasting Power of Attorney before someone else can act on their behalf.

Independent Mental Capacity Advocates
Do you doubt the person’s capacity: to make the decision? or to consent to Serious Medical Treatment?

If there are no family or close friends willing and available to be consulted about the treatment?

You may need an IMCA!

Telephone: 0161 872 6825

Best Interest Checklist
Giving equal consideration and non discrimination
Considering all relevant circumstances
Regaining capacity
Permitting and encouraging participation
Special Considerations for life-sustaining treatment
The persons wishes, feelings, beliefs and values
The views of other people

For further information contact: Mr. Michel Le-Straad, Designated Nurse for Vulnerable Adults and Mental Capacity Act Lead for Trafford on 0161 873 6084