COVERT MEDICATION ADMINISTRATION IN RESIDENTIAL CARE AND SUPPORTED LIVING

GUIDANCE FOR HEALTH AND SOCIAL CARE PROFESSIONALS

October 2023 **Review Date May 2024**

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1. INTRODUCTION

These guidelines have been developed for health and social care professionals in residential care and supported living settings on the legal, safe and appropriate use of giving prescribed medication covertly. Any such decision or actions taken must be compliant with the Mental Capacity and Human Rights legal frameworks and the relevant regulatory guidance here (NICE: Giving Medicines Covertly).

People who have the mental capacity to make a decision about their treatment can refuse medical treatment, including the administration of prescribed medications, even if the refusal can cause harm or accelerate the person's death. Giving treatment without consent is a breach of Article 8 of the European Convention on Human Rights; the right to respect for private and family life. The exception is treatment for mental health disorder when a person is detained under the Mental Health Act (1983).

Covert medication involves disguising the administration of medication and may be used when:

- a person is actively refusing their prescribed medication;
- that person is assessed not to have the capacity to understand the consequences of their refusal under the Mental Capacity Act (MCA), 2005; and
- the medicine is deemed essential to the person's health and wellbeing.

When care home and supported living residents have been assessed under the MCA 2005 to lack the mental capacity to consent to take their prescribed medication or to understand the consequences and potential impact on their health of refusing their prescribed medication, all staff must follow a formal process to allow them to act in the best interests of the person.

Important Note: covert medication does not include:

- *People who are willing to have their medication disguised in food as they find taking medication difficult in the usual way.*
- *People who are unconscious and for this reason, unable to refuse treatment.*

2 THE PERSON IS CONSISTENTLY REFUSING THEIR MEDICATION

2.1 MEDICATION REVIEW

As a first step, a prescriber, for example GP, Nurse and other appropriately qualified health professionals who have completed an accredited prescribing course should be asked to conduct a medication review for the person. This should include considering the indications, treatment goals and ongoing need for all the prescribed medication.

In trying to establish the reason the person cannot or does not want to take their medication, the following may need further exploration to support the person in their decision making:

- Does the person understand what the medication is for and why they are being given it?
- Is the person experiencing swallowing difficulties and need a referral for a Speech and Language Therapy (SALT) assessment?
- Is the medication unpleasant to take, are there alternatives?
- Does the person understand what to do when being presented with the prescribed medication?

- Does the person understand the risks and consequences to their health of not taking the prescribed medication?
- Are there personal, ethical, cultural or religious beliefs affecting choices surrounding medications? (for example, some people may refuse capsules if they contain animal products)
- Does the person have a valid Advance Decision to Refuse Treatment in place?
- Whether the person is making an informed and capacious decision not to take their prescribed medication.

2.2 MENTAL CAPACITY

Every person from the age of 16 has a right to make their own decisions if they have the capacity to do so.

Principle 1 of the MCA delivers protection for people, who may have assumptions made about their ability to make a decision for themselves, on the basis of their age, behaviour, condition, or appearance.

If there is reasonable doubt that an impairment or disturbance in the functioning of the mind or brain is affecting the person's ability to make a particular decision, it is the health and social care professional's responsibility to undertake the capacity assessment to demonstrate the person's capacity or incapacity for the specific decision. The burden of proof lies with the assessor, not the person. The health and social care professional must be able to show that it is more likely than not, i.e., there is a balance of probability that the person lacks the capacity to make the specific decision.

The Mental Capacity Act (2005) defines what it means to lack capacity for a certain decision

> 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain' (s.2(1) MCA 2005).

For the purposes of assessing capacity to consent to taking or refusing prescribed medication there is a need to firstly establish that a person is unable to make a decision.

2.2.1 UNABLE TO MAKE A DECISION

Mental capacity should be assessed in accordance with the [1]principles of the Mental Capacity Act 2005 (MCA). Every adult and young person aged 16 years and over must be presumed to have the mental capacity to consent or refuse prescribed medication. Section 3(1) of the MCA 2005 states that a person is unable to make a decision if they cannot Understand, Retain, Use and Weigh, Communicate the decision (the functional assessment).

For a mental capacity assessment regarding consent to medication, the person will need to:

- Understand in simple language what the treatment is, its purpose and why it is being prescribed.
- Understand (use) and weigh up its main benefits, risks and alternatives.
- Understand (use) and weigh up in broad terms what will be the consequences of not receiving the proposed treatment.

[1] Mental Capacity Act 2005 (legislation.gov.uk)

- Retain the information for long enough to make the decision, and
- Communicate their decision in any form.

Where the person cannot demonstrate an understanding of one or more parts of the functional assessment, then they do not have the relevant mental capacity in the decision at that time.

2.2.2 IMPAIRMENT OF, OR A DISTURBANCE IN THE FUNCTIONING OF THE PERSON'S MIND OR BRAIN

What is the impairment of, or disturbance in the functioning of the mind or brain? The impairment can be diagnosed formally by a clinician, but it does not have to be. Equally, it does not have to be as specific as a mental disorder diagnosis, it can be based on what you can see of or observe about the person or gathering collateral history information from family, friends and other professionals known to them.

An impairment of the mind or brain does not have to be permanent to satisfy this aspect of the test; it can be temporary because of an acute infection or the effects of substances or alcohol, for example.

If the cause is a temporary one, consideration should be given as to whether the Best Interests decision can be delayed until the person regains capacity.

2.2.3 IS THERE A DIRECT LINK BETWEEN THE TWO?

This is where the health and social care professional must make a link between the person's inability to make the decision (stage one) and the mental impairment (stage two). The Court made clear in the [2]PC v York case that to be deemed as lacking capacity under the terms of the Mental Capacity Act (2005), the person must be unable to make the decision **because** of their mental impairment.

2.2.4 OUTCOME: THE PERSON LACKS CAPACITY TO CONSENT TO THEIR MEDICATION

Follow Section 4 of the Mental Capacity Act, Best Interest Checklist. See Heading 3 below.

2.2.5 OUTCOME: THE PERSON IS ASSESSED TO HAVE CAPACITY TO CONSENT TO THEIR MEDICATION

Where the person has the mental capacity, (they can understand, retain, use and weigh and communicate the relevant information), to give consent to treatment, no medication should be given without their agreement. A person with mental capacity has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life.

If a person with capacity declines to take their medication, they will need to be given information about the purpose of the medication, associated risks of not taking it and any alternatives to the prescribed medication. The person should also be advised that should they wish to do so, they can change their mind at a future point about not taking the prescribed medication.

Health and social care professionals must document their discussion with the person, the reason(s) they have declined and record the reason, if given, on the medicines administration record (MAR). The responsible health and social care professional should also refer to their medication policy for

[2] PC & NC v City of York Council | 39 Essex Chambers

guidance on when the prescriber needs to be informed the person has stopped taking their medication.

3 WHO IS RESPONSIBLE FOR CARRYING OUT THE CAPACITY ASSESSMENT?

The Mental Capacity Act does not specify who should assess capacity. The person who assesses mental capacity should be the person who is either:

a. Involved in supporting the person at the time that the decision needs to be made; or
b. The person with responsibility for making a decision if the person is unable to do so.

Important Note: The assessment will usually be undertaken by the prescriber. However, in some circumstances and, in consultation with the care home or supported living lead, the prescriber may agree that the best person to undertake the capacity assessment to consent to medication is a **suitably qualified person** in the care and support team. This will be because they may have the relationship with the person (in consideration of S2 of the MCA). ***The responsibility, however, remains with the decision maker (i.e., the prescriber) to satisfy themselves that there is reasonable belief that the person lacks capacity, and the assessment has been undertaken, evidenced and appropriately recorded in the patient's records in line with the MCA 2005.***

4 BEST INTERESTS DECISION MAKING

A best interests decision only applies once a person has received all support and assistance to make their own decision and, despite such support, they have been assessed to lack mental capacity in the decision. It is through this process of decision making that protection from liability (S5 MCA,2005), is provided and allows 'decision makers' to carry out actions or make decisions for another person where they cannot obtain valid consent.

Best interests are not defined in the MCA. This was a deliberate decision by those drafting the Act. It would be impossible to specify in advance what would be in every person's best interests and such decisions will be taken by a range of professionals, in a variety of settings and circumstances.

The process of making a best interests decision is commonly referred to as the best interests 'check list' within the code of practice (S4 MCA, 2005). This section of the Act contains a list of factors that must, if applicable, be considered when making a best interests decision. The checklist is not a hierarchy and no one principle is more important than the others. The basic legal principles are as follows:

- Consider all the relevant circumstances ensuring that factors such as age, appearance, behaviour are not leading the decision.
- Consider a delay until the person regains capacity.
- Involve the person as much as possible.
- Consider the individual's past and present wishes and feelings.
- Consider any advance statements made.
- Consider the beliefs and values of the individual.
- Consider the views of family and informal carers.
- Consider the views of the Independent Mental Capacity Advocate (IMCA) (where this applies).
- Evidence it is the least restrictive option after other options including different medicines and methods of administration have been tried.

The best interest decision making process will be **led by the prescriber** and will require consultation with the person and all the relevant people in their life including family, carers and healthcare professionals. People that will need to be involved in the best interest decision making process are: the prescriber - decision-maker (GP, nurses and other appropriately qualified health professionals), care home or supported living staff, pharmacist (such as community pharmacist, GP practice/PCN pharmacist or a member of the Medicines Optimisation in Care Homes (MOCH) team), family, Lasting Power of Attorney (LPOA) for Health and Welfare and others where relevant. This could include the community mental health team and any allied healthcare professionals.

The best interests decision making process will, where possible, follow best practice and be held in person but it can be done remotely. All parties will need a copy of the documented best interests decision.

In an emergency where there is doubt as to what is in a person's best interests and treatment is required urgently, the prescriber can take this decision in discussion with the care staff, pharmacist and family or advocate – unless there is a valid and applicable advance decision refusing such treatment (ADRT).

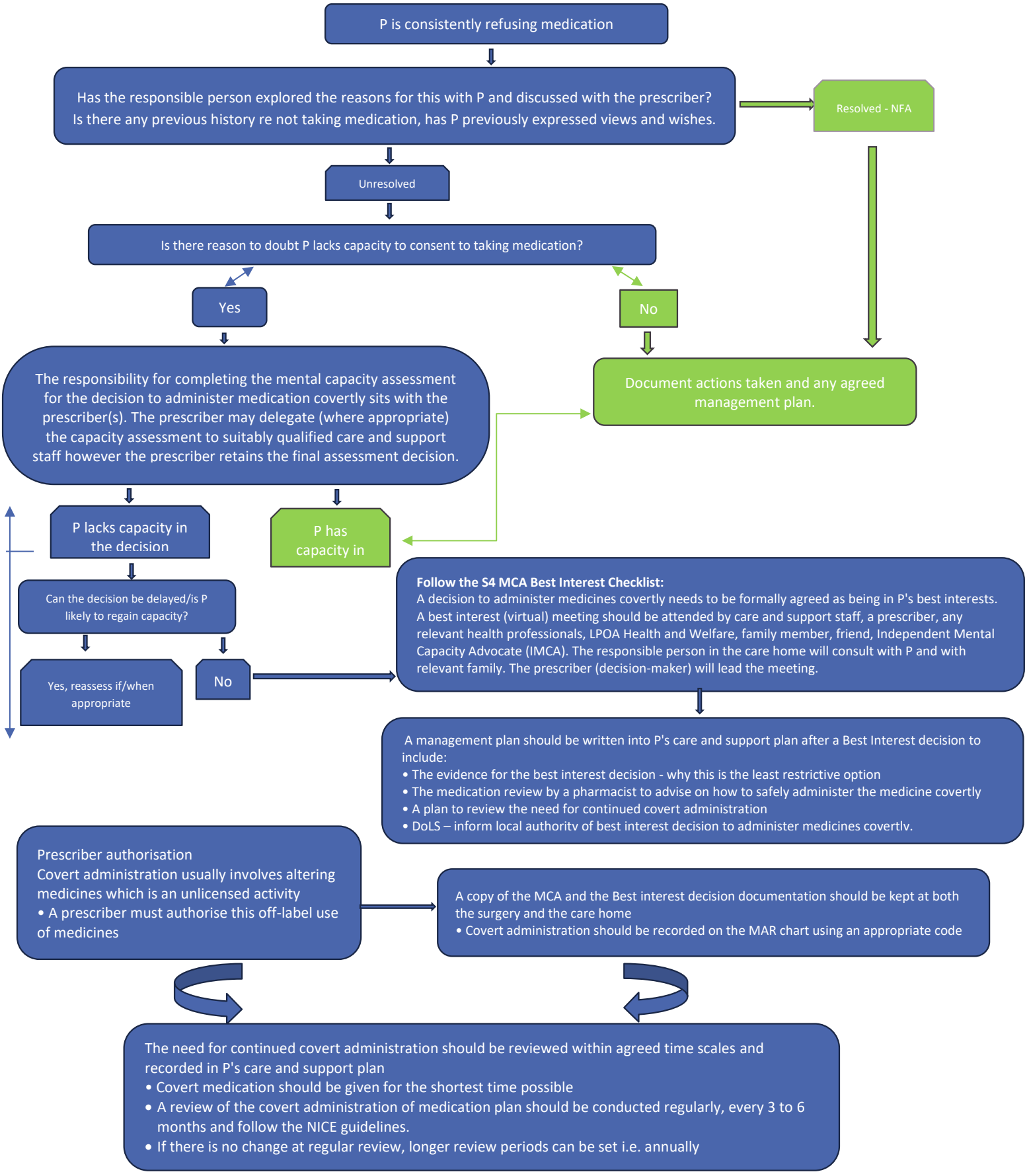
4.1 CHECKLIST FOR THE PRESCRIBER:

- The prescriber should review all prescribed medications to establish if covert administration is necessary and proportionate to protect the person from harm.
- Ensure other mechanisms for administering medication have been fully explored prior to deciding that covert medication is the least restrictive option.
- That full discussion within a multidisciplinary team (e.g., GP, consultant, pharmacist, care home/supported living manager, family/advocate) with expert pharmacy guidance has taken place.
- The proposed treatment and methods of administration are discussed with a pharmacist who will need to consider the pharmaceutical stability of the medication.
- The prescribed medication is individually listed and instructions how to administer are recorded in the decision documentation and communicated in writing to the responsible person in the care home.
- The use of covert administration will need to be recorded in the person's medical record held by the GP practice (see Appendix 2) and in their residential/supported living care plan.
- Covert medication is a restrictive practice and should be used for as short a time as possible. The treatment plan should be reviewed within a week of the start of the covert medicine and if the requirement of covert medication persists, full reviews should be done at regularly agreed intervals i.e., three monthly or six monthly depending on individual circumstances.
- The review should be led by the original decision maker where possible.
- Necessary instruction is added to the prescription, specifying the dosage for each prescribed medication and how to administer.

4.2 CHECKLIST FOR CARE AND SUPPORT STAFF

- There is a dated capacity assessment re consent to medication and best interest decision for the use of covert medication in the person's care plan that identifies the decision maker and when the best interests decision was made.
- Full instructions are written on the MAR sheet. Instructions to include whether it is feasible to attempt to administer medication overtly and only offer covert medication if overt medication is refused (preferred). If there is evidence that it would distress the person to be offered medication, then instructions for the administration of covert administration should be followed.
- Care home and supported living staff have had relevant training regarding the covert administration of medicines.
- They have clear instructions for how medicines are crushed such as with tablet crushers, metal spoons, pestle and mortar.
- Any medical, cultural or religious dietary requirements are complied with (e.g., gluten free for people with coeliac disease, avoidance of animal gelatine for vegetarians, avoidance of porcine gelatine for people from Jewish or Muslim communities).
- Which foods can be used to disguise medicines in and where are these medicines stored (e.g., jam, yoghurt, juice).
- The care plan reflects the person's assessed needs and any agreements to administer medicines covertly in food or drink are clearly documented
- There is evidence that the agreed reviews are taking place.

APPENDIX 1: ADMINISTRATION OF COVERT MEDICATION FLOWCHART



APPENDIX 2: COVERT MEDICATION RECORDING IN SYSTMONE FOR HEALTH PROFESSIONALS