Covert Administration of Medicines
Policy and Procedure

Policy Procedure Protocol Guideline
Y Y N N

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<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date of Review</th>
<th>Reviewer Name</th>
<th>Completed Action</th>
<th>Approved By</th>
<th>Date Approved</th>
<th>New Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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1. **Background**

1.1 The covert administration of medicines (i.e. getting the patient to take drugs without their knowledge e.g. when it has been mixed in food or drink) is only justifiable in exceptional circumstances, i.e. where there is no alternative and the patient may suffer significant mental or physical harm otherwise (Royal College of Psychiatrists 2004).

1.2 The Nursing and Midwifery Council (2006) recognises that the covert administration of medicines is a complex issue that has provoked widespread concern. It involves the fundamental principles of patient autonomy and consent to treatment, which are set out in common law and underpinned by the Human Rights Act 1998.

1.3 Medicines should only be administered covertly in exceptional circumstances because the NMC has advised that the practice may be regarded as a deception. Disguising medication simply for the convenience of the health care team is unacceptable.

1.4 Unwarranted administration of medication by such covert means could amount to a breach of the patient’s Human Rights (see 1 below) and constitute an assault. It should not be confused with the administration of medicines against someone’s will, which in itself may not be deceptive, but may be unlawful.

2. **Considerations**

2.1 In considering whether to administer medication covertly, an assessment of the patient’s mental capacity to decide whether to accept or refuse their prescribed medication is crucial. Covert administration is not lawful where a patient has mental capacity and is refusing medication. Where a clinical judgement has been made that a patient lacks mental capacity then there is a further need to distinguish between patients who lack the mental capacity to be even aware that they are receiving medication and those who would be aware were they not being deceived into thinking otherwise. Where a patient is unconscious and having medication by an obtrusive route e.g. PEG tube, and there is no intent to deceive the patient, administration is not considered to be covert.

2.2 Detailed guidance on the law on consent can be found by referring to the Cardiff and Vale NHS Trust Policy on Consent and on the Welsh Assembly Government website (Reference guide for Consent to Examination or Treatment). Where appropriate, reference should also be made to the Human Rights Act 1998, the NMC ‘A-Z Advice Sheet on Medicines Management’ (NMC, 2006) and the Royal College of Psychiatrists ‘Statement on Covert Administration of Medicines’ (RCPsych, 2004).

2.3 Since administering disguised medication in the absence of informed consent may be regarded as a deception and also may be unlawful, it should be regarded as a contingency measure for certain patients who lack mental capacity in certain exceptional circumstances which are patient specific. It should never be regarded as a routine measure.

2.4 An adult patient with mental capacity who makes an informed decision to refuse treatment must have this decision respected. However, in certain circumstances patients detained under certain sections of the Mental Health Act 1983 may be treated against their wishes, providing that the treatment is for mental disorder and is duly authorised.

2.5 Adults are always assumed to be mentally capable of making decisions unless demonstrated otherwise. Unwise decisions do not imply that the patient is mentally...
incapable, but may indicate a need for further information or explanation. For any lawful treatment to be given to a patient who is unable to consent,

- the patient must lack mental capacity to give or withhold consent to this treatment AND
- the treatment must be in the patient’s best interests (there must be a clear expectation that the patient will benefit from such measures) AND
- the treatment must be the least restrictive to prevent significant harm to the patient or others.

2.6 The determination of what is in the patient’s best interests/least restrictive in relation to any treatment is a professional judgement and any health professionals involved will be accountable for their decisions.

2.7 Consideration of a patient’s best interests should encompass medical, emotional and all other welfare issues. In considering a patient’s best interests the person making the decision must consider, so far as is reasonably ascertainable:

- the person’s past and present wishes and feelings
- the beliefs and values that would be likely to influence his/her decision if he/she had capacity
- and the other factors that he/she would be likely to consider if he/she were able to do so.

Additionally, the person making the decision must consider:

- anyone the person (lacking capacity) has previously named as someone they want to be consulted
- anyone named by the person (lacking capacity) as someone to be consulted on the matter in question or on matters of that kind
- the views of the main carer/nearest relative, unless it is clear that the patient would not have wanted this
- the views of any nominated representative for the patient, such as the donee of a Lasting Power of Attorney, an Independent Mental Capacity Advocate or a Court Appointed Deputy
- the views of anyone involved in providing care to the patient or interested in their welfare, including the multi-disciplinary team.

2.8 In order to determine whether a patient has mental capacity, a test of mental capacity must be carried out, in accordance with that set out in the Mental Capacity Act 2005. A patient will be considered to lack mental capacity in law to consent if he or she is unable to:

- understand in simple language what the treatment is, its purpose and why it is being proposed
- 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
- communicate their decision.

Decisions should be made free from pressure, i.e. the mentally capacitlated patient must make a free choice.
2.9 Mental capacity assessment should be single issue specific, i.e. a blanket assessment which covers a range of decisions cannot be applied. However, an assessment of ‘ongoing mental incapacity’ may cover inter-related or sequential decisions. It is important to note that a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

2.10 Mental capacity may be lacking on a temporary, fluctuating or ongoing basis. It is sometimes a difficult judgement to make and appropriate assistance should be sought from relevant specialists where necessary. However, as stated in the Trust’s ‘Guideline for the Assessment of Mental Capacity to Consent in Relation to Protection Of Vulnerable Adults Procedures’ (2006), the first assessment of mental capacity should always be by a senior clinician on the treating team, where possible taking into account the consensus view of the multi-disciplinary team.

2.11 Mental capacity assessments should be detailed and evidence-based. Decisions should be documented using the form provided as an attachment to this document (Appendix 1). Mental capacity assessment is based on a balance of probabilities assessment and the Mental Capacity Act 2005 protects clinicians from incurring legal liability if they can demonstrate that the care or treatment they provide is in the mentally incapacitated person’s best interests and follows the least restrictive legal principle.

2.12 Where there is doubt as to the patient’s mental capacity to consent, following first assessment, a second opinion assessment should be sought from a specialist in the field, such as a psychologist or psychiatrist. Legal advice should be sought if there is still doubt over the patient’s mental capacity to decide or a lack of consensus amongst the multi-disciplinary team over what treatment or care would be in his or her best interests. Any actions agreed and taken must be informed and defensible.

2.13 Sometimes a patient who lacks mental capacity may have expressed wishes or feelings about a particular type of medical treatment prior to becoming mentally incapacitated. These expressions of a patient’s wishes or feelings (often known as Living Wills) must be considered before a decision is made about whether that treatment should be provided in the patient’s best interests. The Mental Capacity Act 2005 places special emphasis on written statements, but it is important to note the distinction between a written statement expressing treatment preferences and a statement which constitutes an Advance Decision to refuse treatment, which has a different status in law. Doctors cannot ignore a written statement that is a valid and applicable Advance Decision to refuse treatment. An Advance Decision to refuse treatment must be followed if it meets the Act’s requirements and applies to the patient’s circumstances. In these cases the treatment must not be given.

2.14 As above, unless the patient has clearly indicated otherwise, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse, partner, family, friends, carer, advocate) in the decision-making process regarding best interests and least restrictive legal principles.

2.15 If a decision has been made that a patient lacks mental capacity, then an entirely separate decision needs to be made as to whether, in an exceptional case, it may be appropriate to administer medication covertly. This should not be considered as a routine measure. The best interests of the patient concerned are paramount. The practitioner will need to be certain that any decision is made following consultation and that he or she has the support of the rest of the multi-disciplinary team and those close to the patient. In reaching such a decision, the aims, intent and implications of the treatment should be
carefully considered. Any medicine to be administered covertly should be regarded as essential for the patient’s health and well being or for the safety of others.

2.16 A regular review of the covert administration of medication should be undertaken at intervals decided by the multi-disciplinary team in consultation with the main carer/nearest relative, or nominated representative, using the attached form (Appendix 2). The treatment plan should be subject to weekly review initially and if the requirement of covert medication administration persists, full reviews at less frequent intervals should take place (no longer than monthly). In any event, ongoing and regular attempts should be made to encourage the patient to take their medication overtly and these attempts should be recorded.

2.17 The overriding principle is that a decision to administer medicines covertly must only be made following extensive communication with all parties, including any donee of Lasting Power of Attorney, the patient’s main carer/nearest relative, an Independent Mental Capacity Advocate or Court Appointed Deputy (if there is no family), the Consultant or nominated deputy, the Named Nurse, the Pharmacist and other members of the multi-disciplinary team as appropriate. The decision should be jointly agreed and documented within the patient’s care plan (see procedure). Individual clinicians and practitioners must not make the decision to covertly administer medicines alone.

3. Advice to Pharmacists

3.1 Pharmacists asked to dispense products for covert administration must consider whether alternative licensed products are available, such as the same drug with a different formulation or a different drug for the same indication.

3.2 Pharmacists should be aware that if a formulation is crushed, dissolved or otherwise tampered with then the product will be rendered unlicensed.

3.3 Pharmacists must consider and advise on the potential for distortion in the bioavailability profile of the medicine and whether there is a need for reduction or increase in dose and how or whether this can be quantified.

3.4 Pharmacists must consider the risks and benefits for patients of administering in altered form against not administering.


4. Children

4.1 The Policy relates primarily to adults, but, except for the issue of consent, the principles it contains are the same for children.

4.2 It should not be assumed that a child is unable to give consent.

4.2.1 Children under the age of 16 are presumed to be incapable of consenting or refusing consent to medical treatment. Consent for such treatment may be given by anyone with parental responsibility for the child. However, a child that has sufficient understanding may consent to treatment on his/her own behalf. Such children are commonly referred to as being ‘Gillick competent’.
4.2.2 Children of 16 or 17 years of age are presumed to be capable of consenting to medical treatment on their own behalf.

4.2.3 Even if a child is considered capable of consenting to medical treatment on his/her own behalf, his/her refusal to do so may be over-ridden by anyone with parental responsibility for him/her, or by the Court.

5. **Involving the Court**

5.1 Where a patient lacks mental capacity and is thus unable to refuse or consent to treatment, covert administration of medication may be lawful provided that it would be in the view of a reasonable body of medical opinion necessary to use this means to save the patient’s life or prevent deterioration in his/her health and accords with the best interests of the patient.

5.2 If there is any doubt about the patient’s mental capacity then a second opinion should be sought, in the usual way.

5.3 If there remains doubt legal advice should be sought with a view to a possible application to the Court of Protection for a declaration as to whether or not the patient has mental capacity to make a decision with regard to consent to treatment and as to what treatment would be in his/her best interests.

6. **Procedure**

The following procedure should be applied when considering covert administration of medicines:

6.1 The patient refuses medication, on several occasions.

6.2 Continuing regular attempts are made to encourage the patient to take their medication overtly.

6.3 Failure to administer medications must be recorded on each occasion.

6.4 The implications of continued medication refusal and the alternatives available are discussed by the multi-disciplinary team, including the Consultant or nominated deputy, the Named Nurse and Pharmacist.

6.5 The implication of continued medication refusal and the alternatives available are discussed with any donee of Lasting Power of Attorney and/or the main carer/nearest relative, unless the patient has indicated that they do not wish their involvement in decision-making, or there are best interests arguments for them not to be informed.

6.6 The patient’s mental capacity to consent to or refuse treatment is formally assessed in accordance with the Trust’s Consent Policy.

6.7 If the patient is assessed to have mental capacity then his/her wishes must be respected. However, there should be a review as to whether the patient has been given adequate information as to the nature, purpose, associated risks and alternatives to the medication.
6.8 If the patient is assessed as lacking mental capacity to consent or withhold consent, then the attached form (Appendix 1) should be completed and retained in the patient’s notes.

6.9 Appropriate members of the multi-disciplinary team (which would include at least the Consultant or nominated deputy, the Named Nurse and the Pharmacist) should meet to discuss covert medication administration. The purpose of this meeting is to decide whether the circumstances are so exceptional that covert administration may be appropriate to prevent a patient being significantly harmed due to not receiving essential medication.

6.10 As part of this discussion:

- medication is reviewed to reduce to essential medicines only
- alternative routes or forms of medicine are considered with the Pharmacist
- the Pharmacist checks suitability of prescribed medicines for adding to food or fluids, to ensure that medication will not be altered or become unsafe
- the Pharmacist advises whether any change in dosage may be required and the risks and benefits of administration in an altered form
- consideration as to whether there is an Advance Decision which may apply to the circumstances is given.

6.11 Consultation with any donee of Lasting Power of Attorney and/or the main carer/nearest relative, or any delegated representative, takes place and their views are recorded.

6.12 Where the patient is detained under the Mental Health Act, the Responsible Medical Officer considers appropriate use of powers under the legislation to administer essential medication by the least restrictive means for the treatment of the mental disorder. This could be covertly or by IM or IV routes, with or without restraint as deemed appropriate.

(If the patient is mentally disordered and is refusing psychiatric medication, and he/she is not under a section of the Mental Health Act 1983 then consideration should be given to using Mental Health Act powers. If the patient is in a general hospital setting, referral to a Liaison or On Call Psychiatrist should be made at this point.)

6.13 The decision to covertly administer medicines is made and documented in the patient’s notes and Appendix 1 is completed and also filed there.

6.14 The method of administration is agreed with the Pharmacist.

6.15 The Consultant or nominated deputy reviews the patient’s medication prescription chart, clearly documenting which medicines are to be covertly administered, stating ‘Administer medicine covertly’ alongside each for administration via this route.

6.16 A review date to reassess both the patient’s mental capacity and the covert medication administration decision is set (see section 2.16 regarding frequency of review requirements). The review date is recorded on the form provided in Appendix 1.
6.17 Medicines are covertly administered in food or fluids as agreed following consultation and under close supervision (see below cautions).

6.18 Continuing and regular attempts are made to encourage the patient to take medication overtly and attempts and outcomes are recorded.

6.19 The Consultant is informed if covert medicine administration fails, e.g. by food or fluid refusal at the earliest opportunity. The registered nurse administering the medicine covertly records the outcome if the administration fails on the patient’s drug administration chart, using the standard refuse code printed on bottom of the prescription chart, i.e. 4. A further multi-disciplinary team meeting is reconvened, urgently if necessary.

7. Cautions

7.1 Alternative approaches should be tried where a patient initially refuses essential medication

- try to administer essential medicines a short time later when the patient may be more compliant (or another nurse could approach the patient)
- ask the Pharmacist if the drug/s is/are 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
- consider alternative drugs/formulations with reduced administration frequency

7.2 To facilitate safe and effective covert administration, consider

- stability of drug/s when added to food or fluid (Pharmacist advice must be sought)
- adjust the timing or site of delivery, e.g. the psychotic patient may become suspicious when being offered a drink when the drug trolley is in sight
- additional safeguards to avoid drug errors on other patients who lack mental capacity, e.g. another confused patient may take the patient’s drink containing the medication.

7.3 The covert administration must be supervised by the registered nurse administering the medication. If the patient is taking medication in food or drink then delegated supervision by a nursing assistant is acceptable, but must continue until all the medication has been taken. A note should be made in the patient record of successful (or otherwise) completion of the administration.

7.4 If covert medicines administration fails as a result of food or fluid refusal, consider

- leaving the patient without medication until such time as covert medication or medication administration by normal means becomes possible
- administration by another route if medicines are essential to life/comfort and are available in other forms.

7.5 If the covert administration of medication in the patient’s food or drink makes the patient resistant to eating or drinking, then consideration should be given to ceasing the practice immediately as the significance of harm caused by diminished hydration and/or nutrition may be greater than the harm caused by not receiving essential medication orally. In such circumstances non-oral routes of administration should be considered.
8. Responsibilities

This policy applies to all staff who may be involved with covert medicines prescribing and administration. It is the responsibility of every professional group to ensure that this procedure is followed.

9. Equality

This policy has had an equality impact assessment and has shown there will be no adverse effect or discrimination made on any particular or individual group.

10. Distribution

This procedure will be available via the Trust Intranet.

11. Audit

It will be necessary to ensure that relevant clinical staff are adhering to the requirements of this procedure. It is not envisaged that the procedure will require frequent audit. However, individual case review will be required.

12. Review

This procedure will be reviewed every 3 years, or more frequently if required, i.e. following further relevant primary legislation or national guidance.

13. References

Royal College of Psychiatrists (2004) Statement on Covert Administration of Medicines
RCPsych website www.rcpsych.ac.uk


Appendix 1 - Assessment Form for Covert Administration of Medicines
To be retained in the patient’s notes

Patient details

Name ........................................................................
Date of birth ..............................................................
NHS number ............................................................... Consultant ................................................................. (name)
................................................................................... (signed)
Date ...............................................................................

Other health professional consulted
.................................................................................. (name)
.................................................................................. (signed)

Job title/Grade ............................................................

Date of assessment .....................................................
Date of review .............................................................
(weekly initially, no longer than monthly if required as a longer term measure)

Details of procedure or course of treatment agreed

Assessment of the patient’s mental capacity

I confirm that the patient lacks mental capacity to give or withhold consent to this course of treatment because (tick):

☐ the patient is unable to understand in simple language what the treatment is, its purpose and why it is being proposed
☐ the patient is unable to understand its principle benefits, risks and alternatives
☐ the patient is unable to understand in broad terms what will be the consequences of not receiving the proposed treatment
☐ the patient is unable to retain the information for long enough to make an effective decision
☐ the patient is unable to communicate their decision.

Note further details (for example, how the above judgements were reached; which colleagues were consulted; what attempts were made to assist the patient make his/ her own decision and why these were not successful)
Assessment of the patient’s best interests

To the best of my knowledge, the patient has not refused this treatment in a valid Advance Decision. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the treatment to be in the patient’s best interests because:

Where mental incapacity is likely to be temporary, for example if the patient is unconscious, or where the patient has fluctuating capacity, the treatment cannot wait until the patient recovers capacity because:

Involvement of the patient’s family and others close to the patient
(to be signed by a person or persons close to the patient if they wish)

I/we have been involved in a discussion with relevant health professionals over the treatment of ..............................................(patient’s name). I/we understand that he/she is unable to give his/her own consent based on the criteria set out in this form. I/we also understand that treatment can lawfully be provided if it is in his/her best interests to receive it and that I/we am/are not at liberty to consent or withhold consent on behalf of the patient to receive the treatment.

Any other comments (including any concerns about the decision)

Name ...............................  Relationship to patient ..............................
Address (if not same as patient) .................................................................
.................................................................
Signature  ...................................... Date .................................

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the phone?) YES NO
Appendix 2 – Review Form for Covert Administration of Medicines
To be retained in the patient’s notes

Patient details

Name ..........................................................................

Date of birth ............................................................

NHS number ..............................................................

Consultant ................................................................. (name)

................................................................. (signed)

Date .................................................................

Other health professional consulted

................................................................. (name)

................................................................. (signed)

Job title/Grade ........................................................

Date of first assessment ..................................................

Date of next review .......................................................

(weekly initially, no longer than monthly if required as a longer term measure)

Details of procedure or course of treatment initially agreed

Comment on success or otherwise of covert medication administration over preceding period

Proposed changes to course of treatment agreed following further multi-disciplinary review, including Consultant or nominated deputy, Named Nurse and Pharmacist
Re-assessment of the patient’s mental capacity

I confirm that the patient continues to lack mental capacity to give or withhold consent to this course of treatment because (tick):

- [ ] the patient is unable to understand in simple language what the treatment is, its purpose and why it is being proposed
- [ ] the patient is unable to understand its principle benefits, risks and alternatives
- [ ] the patient is unable to understand in broad terms what will be the consequences of not receiving the proposed treatment
- [ ] the patient is unable to retain the information for long enough to make an effective decision
- [ ] the patient is unable to communicate their decision.

Note further details (for example, how the above judgements were reached; which colleagues were consulted; what attempts were made to assist the patient make his/ her own decision and why these were not successful)

Re-assessment of the patient’s best interests

To the best of my knowledge, the patient has not refused this treatment in a valid Advance Decision. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the treatment continues to be in the patient’s best interests because:

Involvement of the patient’s family and others close to the patient

(to be signed by a person or persons close to the patient if they wish)

I/we have been involved in a further discussion with relevant health professionals over the treatment of …………………………..(patient’s name). I/we understand that he/she is still unable to give his/her own consent based on the criteria set out in this form. I/we also understand that treatment can lawfully be provided if it is in his/her best interests to receive it and that I/we am/are not at liberty to consent or withhold consent on behalf of the patient to receive the treatment.

Any other comments (including any concerns about the decision)

Name ……………………… Relationship to patient ..............................

Address (if not same as patient) ……………………………………………

………………………………………………….
If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the phone?)

YES  NO

1 Human Rights implications, taken from Royal College of Psychiatrists Statement on Covert Administration of Medicines

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. Clearly no treatment can be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatment 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’

In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than to covert administration of medication.

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.

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 hearing 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.