NHS Lanarkshire

NHS Lanarkshire Covert Administration of Medication Guidance

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Change Form

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Sep19	New guidance and review of NHSL Covert Administration Pathway 2016 version	G. Laughlan L. Dewar L. Bradley A. Donaldson	1.0

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Introduction

The covert administration of medication is where the individual is being given medication in a disguised form, usually in food or drink. This can only happen when the individual is refusing to accept medication which is essential for physical or mental health and they do not have the capacity to understand the implications of their refusal. It does not refer to the situation where a patient knowingly accepts medication in food and drink to make it more palatable or easier to swallow. However, if medication is given in food and drink without informing the individual that they are receiving treatment, then it may be considered as being given covertly. The Mental Welfare Commission's 'Good Practice Guide for Covert Medication' must be followed when considering covert administration in an individual.
www.mwcscot.org.uk

Legislation

In Scotland, there are two legal frameworks available for giving medical treatment to individuals who lack decision-making capacity: The Adults with Incapacity (Scotland) Act 2000 [AWIA] and the Mental Health (Care and Treatment) (Scotland) Act 2003 [MHA]. Use of such legislation regarding treatment must be in concordance with the Human Rights Act 1998 and comply with the European Convention on Human Rights Act (1953).

Covert medication must never be given to someone who is capable of making decisions about their medical treatment i.e. adults who can make reasoned decisions about their welfare including the risks of refusing treatment.

Under Adults with Incapacity legislation, decision-making capacity is presumed, unless assessed to be lacking. Good practice would be to support individuals to promote decision-making capacity as far as possible to make decisions about their welfare. Decision-making capacity is not 'all or nothing' and assessment should be for individual decisions. For example, a patient with a moderate learning disability may be able to consent to analgesia for a headache, but could not provide fully informed consent to antihypertensives. It should also be considered that capacity may change or fluctuate over time. For example, due to delirium, dementia or other mental disorder, a patient who had decision-making capacity in the past could lack decision-making capacity for a period of time. The patient's decision-making capacity may require to be reassessed accordingly.

The MHA only covers treatment for mental disorder under Part 16 of the Act. During the patient's initial few weeks of treatment, this can be administered if the patient is incapable of giving or refusing consent. If the patient refuses to consent, then the Responsible Medical Officer (RMO) must give clear reasons for treatment in writing. After two months, a second opinion must be sought regarding ongoing treatment by a Designated Medical Practitioner (DMP) appointed by the Mental Welfare Commission.

In children, decision-making capacity develops according to age and stage of development. Any child capable of expressing a view about their treatment should have that taken into account. For children who have not yet gained decision-making capacity for medical treatment, the parents will usually be responsible for considering necessity, providing consent and administering medication.

In all situations which involve treatment, the individual's rights and opinions must be considered.

Assessing Capacity under Adults with Incapacity (Scotland) Act 2000 [AWIA]

Decision-making capacity will depend on the individual. Under AWIA legislation, incapacity is defined as being incapable of acting, or making decisions, communicating decisions, understanding decisions, or retaining the memory of decisions.

All of the above should be considered in assessing decision-making capacity. Under AWIA, incapacity must be because of a mental disorder or inability to communicate due to a physical disorder. Examples of mental disorder include severe and enduring mental illness, learning disability or dementia. Acute mental disorders such as delirium should also be considered. Inability to communicate due to a physical disorder may include expressive/ receptive dysphasia (problems with communication) or a sensory impairment such as deafness or blindness. An individual can only be deemed to lack decision-making capacity due to inability to communicate if this cannot be overcome by methods such as translation, the use of sign language/Makaton, braille or other communication aids.

The patient must be assessed principally by a medical practitioner who can assess the patient's decision-making capacity about the proposed necessary treatment including risks of refusal of treatment. For example, as an inpatient in hospital, this would be the patient's clinical team led by the inpatient consultant. Within the community, this may be the patient's general practitioner (GP) in consultation with members of the multiagency team involved in the patient's care. It may be that certain medications/ treatments may be outwith a practitioner's area of expertise to assess and advice from the appropriate specialty should be sought accordingly. After assessment of decision-making capacity has been completed and the treatment deemed necessary for the patient's health and wellbeing, then a Certificate of Incapacity (Section 47 AWIA Part V) can be issued. When the patient has a Welfare Guardian or Power of Attorney in place, they must be consulted (if practical and reasonable to do so) as part of the assessment process and their views considered and recorded within the patient's medical notes. Even if the Welfare Guardian or Power of Attorney have powers to make decisions about medical treatment and give consent, the certificate must still be completed. The AWIA allows treatment for both mental and physical disorders, but covert administration should only be considered for essential treatment that is necessary for the patient's health and wellbeing. It is good practice to include covert administration in the Section 47 treatment plan.

Anyone who has an interest in the individual's welfare should be consulted and their views recorded. Ideally, this should be facilitated through a multiagency meeting and a consensus agreed for treatment. If considered appropriate to the patient's needs, representation from advocacy should be considered. Should anyone disagree with the proposed treatment, their views should be recorded and they should be made aware of the procedure to appeal the decision to the Sheriff.

The AWIA excludes the use of force except in an emergency and the Mental Welfare Commission does not interpret covert medication as treatment by force. However, this has not been tested in court.

Responsible Person

The practitioner with primary responsibility for the individual's treatment has the ultimate responsibility to decide whether or not to authorise covert administration. This will usually be the patient's consultant/RMO in hospital or the patient's GP in the community. In supporting the individual practitioner to assess the patient's decision-making capacity, and which treatment is deemed necessary, the covert pathway should be completed with multiagency team involvement.

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Covert Medication Pathway

The NHSL Covert Medication Pathway Document has been developed so that the necessity for treatment and the decision-making capacity of the patient are both fully considered, whilst applying the appropriate legal principles and procedures.

The benefits of administering medication covertly to an individual should be balanced by the risks of doing so e.g.

- Patient stops eating and drinking because they are put off by the taste of the medication in the food or drink (unpalatable)
- Patient stops eating and drinking because they become suspicious or paranoid of their food or drink, which can lead to an increased loss of trust
- Fluctuating dosing – medication isn't always consistently consumed
- Harm to staff e.g. crushing tablets and exposure to active ingredients
- Inadvertent administration to wrong patient
- Off-label/ unlicensed use of medications

The completed pathway provides a record of how the decision for covert treatment was considered. Following completion of the initial record for covert administration, there should be regular review using the Covert Medication Pathway Review Document

Practitioners must familiarise themselves with the full good practice guidance for covert medication from the Mental Welfare Commission: www.mwcscot.org.uk

Medication Review

The least restrictive option should always be used. This means only medication that is considered essential should be given covertly. Medication reviews should be undertaken to ensure that non-essential medicines are not given covertly. This may involve consultation with other specialists and a medication review in line with the current NHS Scotland Polypharmacy Guidance www.polypharmacy.scot.nhs.uk/polypharmacy-guidance-medicines-review/. Patients can be offered less essential medicines non-covertly and should be offered medicines they consent to taking, in the normal manner.

Covert Administration Advice
Part A: Provision of Pharmaceutical Advice for Covert Medicines and Part B: Covert Administration Care Plan

A pharmacist must always be consulted on appropriateness and method of covert administration of medication. In hospital, advice should be sought from the clinical pharmacist working within the ward/ hospital. In community, advice should be accessed via the Locality Prescribing Support Team firstport2/staff-support/prescribing-support/prescribing-team-contacts

This advice should be given in a format that can be appended to the individual's covert medication pathway. A template for the provision of this advice can be found here;

Template for Provision of Pharmaceutical Advice for Covert Medication & Administration Care Plan

- Part A: Provision of Pharmaceutical Advice for Covert Medicines should be completed by the pharmacist.
- Part B: Covert Administration Care Plan should be completed by nursing staff or care provider.

The Covert Administration Care Plan should be used to provide a clear plan for those administering medication covertly and should be based on the pharmacist's advice and tailored to the individual patient, detailing the precise food or drink each medicine is to be mixed with, to optimise patient acceptance e.g. flavour of yoghurt etc. and provide a uniformity to the way the medicine is given. The care plan will also be subject to review every time a new medication or formulation is commenced.

Covert Medication Pathway Review

The individual's Covert Medication Pathway should be reviewed regularly to ensure it is still appropriate and in the best interests of the patient to continue to administer medicines covertly. The Mental Welfare Commission recommends that the initial review should be soon after covert administration is implemented to assess if it is having the intended benefits. The pathway includes a decision on the initial intended review date. This date should aim to give sufficient and appropriate time based on the individual patient's circumstances. The Covert Medication Pathway Review should be followed for initial and subsequent reviews. At the end of each review, the date for the next planned review should be decided and recorded.

If new medications are started, this should initiate a review.

Covert Medication Pathway Document

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