CHI no ....

First name .... DOB ..... /..... /.....

Last name .... Sex: ☐ M ☐ F

Address ....

....

or attach addressograph label here

Current location of patient:
(specify hospital and ward/care home/patient's home/other)

....

NHS Lanarkshire

Covert Medication Pathway

A copy of this record should be transferred when the individual moves between care settings

What treatment has been identified for covert medication? • Name specific medicines. • Each medicine should be reviewed - are all treatments necessary? • Some medicines may be able to be withheld for a short time. • Consultation with different specialists may be required to determine which medicines are essential to be given covertly.	
What ALTERNATIVES did the team consider? e.g. • Would the individual accept medicines at a different time of administration? • Would the individual accept medicines in a different form? • Are there alternative medicines/ therapies which could manage the symptoms? • Would the individual accept medicine from different staff members/family?	
Why were these ALTERNATIVES rejected by the team?	
What are the benefits of the treatment to the individual? e.g. the management of epilepsy/ mental illness. List these for each medicine. *Also consider the risks of covert administration, e.g. risk of food or drink refusal if medicine is detected.*	

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CHI no ....

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Covert Medication Pathway	
Has the individual's capacity been assessed? Treatment may only be considered for an individual who lacks capacity.	☐ Yes Name of medical practitioner who undertook assessment: Contact details:
Is additional advice from another specialist required to assess capacity about a specific treatment?	☐ Yes ☐ No If yes, appropriate advice should be sought
What legal steps have been followed?	☐ Mental Health (Care and Treatment) (Scotland) Act 2003 - Date of T3 Form: .... ☐ Adults with Incapacity (Scotland) Act 2000 - Date of S47 Certificate: ....
Does Welfare Guardianship or invocation of Power of Attorney need to be considered?	☐ Yes ☐ No
Confirm this is the least restrictive way to treat the individual? *The principles underpinning the Mental Health Act, Adults with Incapacity Act and Human Rights Act should be taken into consideration.*	☐ Yes **Give reasons:**
If known, what are the individual's present/past views of the proposed treatment?	
Does the individual have an advanced statement or living will which indicates they do not wish to be treated covertly?	☐ Yes ☐ No
If yes, confirm the team wish to pursue covert administration	☐ Yes ☐ Not applicable **Give reasons:**
If pursuing, has the Mental Welfare Commission been informed?	☐ Yes ☐ Not applicable

CHI no ....

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Covert Medication Pathway	
Who is involved in making the decision? e.g. Responsible Medical Officer, Family, GP, Named Person, Advocate, Welfare Guardian, Welfare Attorney. N.B. if there is any person with the power to consent (Welfare Attorney/Guardian) then the treatment may only be administered covertly with that person's consent unless this is impractical.	**Names of those consulted:** **Date of the decision:** ....
Does the patient require an advocate?	☐ Yes ☐ No
Do any of those involved disagree with the proposed use of covert medication?	☐ Yes ☐ No **Names and designation/relationship of those who disagree:**
They must be informed of their right to challenge the treatment and the procedure for doing so.	**Date informed of right to challenge:** ....
Have they been provided with appropriate information about the procedure for challenging treatment?	☐ Yes ☐ No
A pharmacist must provide pharmaceutical advice on the safe administration of medicine by covert means. The advice should be attached as it details how medicines might be best delivered covertly. This should form the basis of the patient specific Covert Administration Care Plan.	**Name of pharmacist:** **Employer:** **Contact details:**

CHI no ....

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Covert Medication Pathway

Are there any additional actions from the meeting that need to be completed?	☐ Yes ☐ No		
List any additional actions in the table	**Action**	**By Whom**	**Timescale**
Does there need to be a further meeting before the pathway can be completed?	☐ Yes ☐ No		
When do you plan to review? The Mental Welfare Commission recommends that initial review should be soon to assess if covert administration is having the intended benefits.	**Date of first planned review:**		

Completed by: (PRINT NAME)	**Designation:**
Signature:	**Date:** .... /............ /............ **Time:** .... : ....