Good Practice Guidance 8: COVERT Administration of medicines – (Disguising medicines in food or drink)

Adapted from previous NHS Berkshire East guidance, ‘Guidance on the use of Covert Medication’ (2010) and the CQC Pharmacy tip: Disguising medicines in food or drink (27 October 2008) which has now been withdrawn.

Advice for care home staff only

Key Points

- Every adult must be presumed to have the mental capacity to consent or refuse treatment.
- Care staff must obtain consent where possible to administer medication and explain any information beforehand if needed.
- No medication should be given without consent and consent may be verbal or non-verbal.
- A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life.
- The refusal of medicine by a resident who has capacity should be respected.
- If a resident is refusing their medicines they should be asked why they have decided to do this to establish if there are issues that can be addressed.
- Covert administration can only occur where the resident has been assessed under the Mental Capacity Act 2005 and there has been careful assessment of patient’s needs by a multi-disciplinary team.
- Residents may have indicated consent or refusal at an earlier stage, while still competent, in the form of a living will or advance care statement or plan.
- The decision to administer medication covertly must not be considered routine.
- Written agreement and reasons for the decision to administer covertly to a specific resident, the action taken and the names of all parties concerned (including the residents GP and relatives/advocate) should be obtained and documented in the resident's care plan.
- It is important that care staff have sought the professional guidance of a pharmacist who is in the best position to advise on whether a particular medicine can be mixed with food or drink and the advice is documented in the care plan.
- Care homes must have a clear policy and procedure on covert administration.
- Crushing medicines and mixing medicines with food or drink to make it more palatable or easier to swallow is different to covert administration and residents must always be
Background
Covert administration of medication is the practice of hiding medication in food or beverages so that it will be undetected by the person receiving the medication. For example, tablets may be crushed or medication in liquid form may be used. **This practice exclusively applies to individuals who are not capable of consenting to treatment (see section below regarding consent).** It is intended to ensure that individuals refusing treatment as a result of their illness will have access to effective medical treatment.

It is sometimes necessary and justified to administer medication covertly **but should never be exercised with people who are capable of deciding about their medical treatment.**

CONSENT - what does it mean?¹
Every adult must be presumed to have the mental capacity to consent or refuse treatment, including medication, unless he or she:

- is unable to take in and retain the information about it provided by the treating staff, particularly as to the likely consequences of refusal
- or is unable to understand that information
- or is unable to weigh up the information as part of the process of arriving at a decision.

The assessment of ‘capacity to give consent’ is primarily a matter for the treating clinicians, but other practitioners and carers retain a responsibility to participate in discussions about this assessment.

No medication should be given without consent and consent can be verbal or non-verbal e.g. resident opening mouth when told ‘it’s time to take medication’. Nobody, not even a spouse, can consent for someone else, although the views of family and close friends may be helpful in clarifying a resident’s wishes and establishing his or her best interests.

**A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life. Therefore, care staff must respect a competent adult’s refusal as much as they would his or her consent.** Failure to do so may amount not only to criminal battery or civil trespass, but also to a breach of their human rights. The exception to this principle concerns treatment authorised under the relevant mental health legislation (Mental Capacity Act 2005).

When a resident is considered incapable of providing consent, or where the wishes of the mentally incapacitated resident appear to be contrary to the best interests of that person, the registered responsible person should provide an objective assessment of the resident’s needs and proposed care or treatment. He or she should consult relevant people close to the
resident, such as relatives, carers and other members of the multi-disciplinary team including GP and pharmacist, and respect any previous instructions.

In some cases the resident may have indicated consent or refusal at an earlier stage, while still competent, in the form of a living will or advance care statement or plan. Where the resident’s wishes are known, registrants should respect them, provided that the decision in the living will or advance care statement is clearly applicable to the present circumstances and there is no reason to believe that the resident has changed their mind. **The ultimate decision to administer medicines covertly must be one that has been informed and agreed by the multidisciplinary team caring for the resident**.

A resident may be mentally incapacitated for various reasons. These may be temporary reasons, such as the effect of sedatory medicines, but more commonly, it is because of long term mental health illness such as dementia or Alzheimer’s disease. It is important to remember that capacity may fluctuate, sometimes over short periods of time, and therefore capacity to consent should be regularly reassessed by the clinical team treating the resident. **The Royal College of Psychiatrists advises** that the need for covert administration should be reviewed on a weekly basis initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.

**Nurses**
Where registered nurses are involved in the administration of medicines in a care home, guidance from the Nursing and Midwifery Council (NMC) makes it clear that nurses need to be clear that they are accountable for the decision to administer medicines covertly, and that this is in the patient’s best interests. The nurse also needs to determine whether these decisions are supported by the rest of the multi-disciplinary team as above, as well as voicing their own opinion on this practice for a particular resident. It is advised that nurses do not covertly administer medicines in isolation.

**Difficulty swallowing?**
Crushing medicines and mixing medicines with food or drink to make medication more palatable or easier to swallow is different to covert administration and patients must always be informed medication is being administered in food in such cases. When a resident has consented to this, it does not constitute covert administration. It is good practice for GPs to clarify this in dosage instructions e.g. ‘Take one tablet twice each day. Crush and mix with jam for ease of swallowing before administering’.

**Documentation**
Details of any assessments and those carrying out assessments of ‘capacity to give consent’ should be kept in the resident’s care plan.

Written agreement of the decision to administer medication covertly, the action taken and the names of all parties concerned should be obtained and documented in the resident’s care plan and medicines profile. An example of such a document is included at the end of this guidance (Appendix 1).

The decision should also be documented on the resident’s MAR chart so that all staff administering the resident’s medicines are aware of the reasons and method for covert administration for each medicine concerned.
Advanced care planning
If appropriate, it may be that GPs discuss the issue of covert administration with patients in the early stages of dementia or when they have ‘capacity’ so that they can make decisions in advance about covert administration for themselves. Such discussions ideally should involve any family members if possible and any decisions made should be documented in patient’s medical records and in care plans at the care home.

Policies and procedures
Care homes must have a clear policy on the covert administration of medicines and this must include guidance on the action to take if it is necessary. Guidance and support should be available from clinicians and the Medicines optimisation team for the appropriate use of covert medication. Care Home staff should also be able to access support from mental health staff where necessary. The Mental Capacity Act 2005 made it a criminal offence to wilfully neglect care, under section 44. So, for patients/residents lacking capacity to accept or refuse medication, covert medication must be considered.

Care homes may wish to seek legal advice on their policy for covert administration.

It is advised that the full NMC guidance is consulted for more in-depth detail of the legal issues surrounding covert administration of medicines, including topics such as previously made living wills/advance statements or covert administration in the paediatric population.

Detail of the process or procedure must be managed and documented within each care home’s policies and procedures. Content of the process should include an initial assessment to verify if the resident has capacity. The resident must have an assessment of whether they can accept or refuse medication, by care home staff, using the framework of the Mental Capacity Act 2005. If they have capacity, covert medication cannot be used. If they lack capacity, the following stages need to then be considered:

- **Representation:** Is their care, such as use of medication, decided by a Donee, Deputy or by Advance care plan?

- **Collaboration:** Joint decision making with all those involved in the patient’s care and wellbeing and evidencing rational practice. Contact AGE UK if needed 0845-0770755.

- **Alternatives:** Jointly explore alternatives to covert medication.

- **Necessity:** A doctor, nurse and pharmacist to discuss and consider the necessity of the medication.

- **Advocacy:** Any family or carer or advocate is also to be consulted.

- **Evidence:** Care Plans show assessment of capacity and assessment of need and who was involved in the assessment process. Records of details also to be included in any medicines profiles.

- **Administration:** The method of giving the medication covertly is checked with a pharmacist to ensure the medication remains efficacious and it’s pharmaceutical integrity and stability are not affected so that the patient still benefits from the medication once crushed and mixed with food.

- **MARs:** How the use of covert administration will be documented on the Medicine Administration Record Sheet (MARs).
Good Practice Guidance documents are believed to accurately reflect the literature at the time of writing.

- **Safety**: Systems are in place for safe, optimal practice with a clear audit trail of events.

- **Review**: Review for the need of covert administration by the care home Manager or registered responsible person, with a nurse or clinician, on a planned and regular basis.

- **Supervision**: Care home staff administering medication covertly should have on-going training/clinical supervision.

**Support contacts:**
- The Care Quality Commission Tel: 03000 616161
- The Nursing and Midwifery Council 0207 333 9333
- Care homes prescribing support pharmacist 07909 505658

**Thing to consider:**
- What instructions are written on MAR charts?
- What training have staff had regarding the covert administration of medicines?
- How are medicines crushed such as with tablet crushers, metal spoons, mortar and pestle?
- Any medical, cultural or religious dietary requirements should be complied with (e.g. gluten-free for patients with coeliac disease, avoidance of animal gelatine for vegetarian, Jewish or Muslim patients)?
- Which foods to use to hide medicines in and where are these foods stored? e.g. jam, yoghurt, juice?
- Does the care plan carry an assessment of the resident's capacity and identifies who carried out the assessment and when?
- Does the care plan reflect the person's assessed needs and any agreements to administer medicines in food or drink are clearly documented?
- There are agreed review dates and reviews take place

**Further information**
Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety.

Further information on the handling of medicines in Social Care’ can also be found on the Royal Pharmaceutical Society website: [www.rpharms.com](http://www.rpharms.com)

Mental Capacity Act 2005
Royal College of Psychiatrists statement on the use of covert administration.
http://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf

References

1 The Nursing and Midwifery Council, Covert administration of medicines: Disguising medicine in food and drink, Nov 2007 [http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/].