GREATER MANCHESTER
CLINICAL COMMISSIONING GROUPS

Guidance for the Covert Administration of Medicines in Care Home Settings

DOCUMENT CONTROL PAGE	
Title	Greater Manchester Guidance for the Covert Administration of Medicines in Care Home Settings
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Review	Annually following ratification and following the implementation of Liberty of Protection Standards 2020.

Contents

1 Introduction

1.1 Who is this document for?

1.1.1 This document provides guidance to health and social care professionals and care home staff working with care homes in Greater Manchester, who may be:

- Considering the use of covert administration for a resident.
- Already administering medicines covertly as part of an agreed treatment plan for a resident.

1.1.2 This guidance is not intended to replace a care home's covert administration policy. However, it is expected that any care home's covert administration policy will be aligned with this guidance document.

1.1.3 This guidance only applies to individuals aged 16 and over. For individuals under the age of 16, please discuss with your local Safeguarding Children team.

1.2 What is the aim of this guidance?

1.2.1 The aim of this guidance is to provide healthcare professionals and carers with recommendations and advice on the legal, safe and appropriate use of covert administration. This includes:

- Understanding why residents might refuse medicines
- Practical tips on how residents may be encouraged to choose to take their medicines
- How to assess if covert administration is needed
- What the legal steps are before covert administration can happen
- Provide good practice guidance on ensuring that covert medicines administration is safe and appropriate and that any risk to residents is reduced.

1.3 Definition

Covert administration of medicines is when medicines are given to a resident without their knowledge and/or consent, for example, in a drink or with food.[1]

2. Consideration of the "why?", "when?" and "who?" questions

2.1 Why?

2.1.1 All staff irrespective of their employers are asked to consider the reasons ***why*** a resident may not be taking their prescribed medicines. Is it that:

- They do not understand what to do when presented with a pill or a spoonful of syrup?
- They find the medicines unpleasant to taste?
- They have difficulty swallowing the formulation?
- They lack understanding of what the medicine is for?
- They have diurnal changes in mood and have a preferred time of day for taking their medicines?
- They do not understand in broad terms the consequences of refusal?
- There are ethical, cultural or religious beliefs?
- They are feeling unwell or in pain?
- Recent changes have unsettled them?
- Or are they making an informed decision not to take it?

2.1.2 It is important to look for patterns of refusal as this may help to determine reasons for refusal. Consideration should also be given to whether refusal is temporary as a result of acute illness, pain or recent changes in environment.

2.1.3 Every attempt should be made to encourage the resident to take their medicines by usual means. This may be achieved by providing regular information and clear explanations to the resident.

2.2 When?

2.2.1 Covert administration should be considered ***when*** ALL of the following apply***:***

- A resident actively refuses their medicine
- That resident is judged not to have the capacity to understand the consequences of their refusal. Mental capacity should be assessed formally as outlined in section 4.2.
- The medicine is deemed essential to the resident's health and wellbeing.

Covert administration should only be considered as a last resort

See Appendix A for extra information from the Care Quality Commission.

2.3 Who?

It is essential that consideration is also given to ***who*** makes the decision to administer medicines covertly to a resident:

- A 'best interest meeting' should be held to agree whether administering medicines covertly is in the resident's best interests. Ideally this should involve care home staff, the healthcare professional who is prescribing the medicines, a pharmacist, and family or advocate. See section 4.3 for full details.
- If the situation is urgent, it may be acceptable for a less formal discussion to occur; this should be between care home staff, the prescriber, and family (or advocate). A formal meeting should be arranged as soon as possible.

3. Factors to take into account BEFORE considering covert administration

3.1 Dementia training and awareness

3.1.1 Dementia often presents as a challenge to care home staff administering medicines. Training in the care of residents with dementia is essential to develop persuasive techniques. Resident preferences such as particular members of care home staff, environment, ways of giving etc. should be clearly documented in the care plan.

3.2 Resident choice

3.2.1 NICE guidance on medicines adherence (CG76) states that all healthcare professionals and care home staff involved in the resident's care should involve the resident in decisions about medicines to support adherence.[(2)] Healthcare professionals should establish the most effective way of communicating with each resident and if necessary, consider ways of making information accessible and understandable. For example; using pictures, symbols, large print, different languages, an interpreter or an advocate.[(2)]

3.2.2 Healthcare professionals should explore resident preferences, beliefs and understanding of their treatment. In order to help residents make informed decisions about their treatment based on consideration of the likely benefits and risks.

3.2.3 Healthcare professionals should accept that an individual with capacity has the right to decide not to take a medicine, even if the healthcare professional

does not agree with the decision. Informed dissent should be clearly recorded in the resident's clinical record.

3.3 Number of medicines prescribed/polypharmacy

3.3.1 Polypharmacy (the use of multiple medicines by a resident) should be taken into consideration. Generally speaking, the fewer medicines or different products a resident is prescribed, the easier the treatment regimen will be to adhere to. [3] Polypharmacy may be:

- 'Appropriate- where a resident has complex conditions or multiple conditions and best evidence supports the use of each medicine.
- 'Problematic'- where a resident is prescribed multiple medicines inappropriately e.g. where there is limited evidence for a medicine, or the medicine is not providing the resident with benefits, or the overall demands of taking all of the different medicines make it difficult for the resident to adhere to.

3.3.2 Before considering covert administration, a medicines review should be carried out by the prescriber or pharmacist to ensure that the medicines prescribed for the resident are for their current medical conditions and any medicines not considered to be essential are stopped. This may help avoid the need for covert administration if some medicines can be stopped.

3.3.3 If a resident is refusing medicines, then each of their medicines should be reviewed to make sure that there is a real need for them to continue. This is particularly important for those who are frail or have limited life expectancy. Consideration should be made not only to the number of medicines but also to the number of different ways that the medicines need to be taken (e.g. eye drops, inhalers, creams, tablets) as well as multiple doses of the same medicine.

3.3.4 Following exploration of the above points an individualised management plan should be agreed and shared (with the resident's permission if possible) with other people involved in their care.

3.4 Difficulty in swallowing medicines

3.4.1 Residents may experience difficulties in swallowing their oral medicines due to a number of reasons.

3.4.2 The following points should be considered.[4]

- Is there a suitable alternative formulation of the medicine available? E.g. soluble tablet, liquid etc?

- Can this tablet/capsule be swallowed whole with thickened fluid, yoghurt or other food? Check compatibility and drug-food interactions.
- Can the tablet be crushed or the capsule opened and administered with the resident's specified food and fluid consistency? For example - thickened fluid, yoghurt or other food.
- Does the person administering the medicine know how to prepare and administer it? E.g. does it require crushing/mixing before administration?

3.4.3 The crushing, dispersing of tablets or release of capsule contents automatically make the medicine an unlicensed formulation (with the exception of some medicines that have been licensed by the manufacturer to be administered in this manner). The use of a licensed preparation, administered in a licensed manner without altering the formulation is the recommended option.[5] *See Appendix A for extra, useful information regarding the legal and pharmaceutical issues to be considered when administering medicines covertly as well as considerations when crushing tablets or opening capsules in a care home setting.*

3.4.4 Advice on alternative medicines or routes of administration can be provided by a pharmacist.

3.4.5 Putting medicines in food or drink to make it more pleasant to taste with the consent of a resident who has capacity does not constitute covert administration of medicines. However, clear documentation should support this practice in the resident's care plan.

4 Covert medicines administration

Covert administration of medicines should be considered if all the aforementioned factors have been taken into account, suitable alterations have been made and the resident is still refusing to take medicines.

4.1 When considering covert administration it is recommended that the following steps (A-F) are followed:-

- **A**ssessment of the mental capacity of the resident
- **B**est interest decision
- **C**heck suitability of prescribed medicines for covert administration
- **D**ocumentation and records must be clear and appropriate
- **E**stablish method of covert administration of medicines
- **F**requency of review of covert medicines plan should be agreed

*Please see **Appendix B** for an example of a Covert Administration Checklist which can be used to ensure that all the above points are covered before covert administration of medicines is initiated.*

4.2 A – Assessment of mental capacity

4.2.1 Before covert administration can be considered, any decision and action carried out under the Mental Capacity Act (2005) must be tested against the following five key statutory (i.e. controlled by law) principles.[6]

- A person must be assumed to have capacity unless proven otherwise
- All practicable steps must be taken to enable a person to make their own decisions, for example: involvement of an advocate or communication support
- A person should not be deemed as incapable of making a decision simply because they make an unwise decision.
- An act done, or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity, must be in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

4.2.2 A person will be considered to lack mental capacity in law (MCA Code of Practice [2005])[6] if due to an impairment of, or disturbance in the function of their mind or brain they are unable to demonstrate one or more of the following:

- Understand information in simple language about the decision to be made (the Act calls this the relevant information).
- Retain that information long enough to be able to make the decision
- Use or weigh up that information as part of their decision making process or
- Communicate their decision (by talking, using sign language or any other means) what the treatment is, its purpose and why it is being prescribed.

Additional considerations may be an inability to:

- Understand the principal benefits, risks and alternatives to their health.
- Understand in broad terms what will be the consequences of not receiving the proposed treatment.

4.2.3 A loss of capacity may be temporary, fluctuating or permanent and it is important to note that capacity assessments are always decision and time specific. Consideration maybe needed to reassess the resident or delay the assessment if their capacity is fluctuating or temporary.

4.2.4 **Who should assess capacity?** The Mental Capacity Act does not specify exactly who should assess capacity to make a decision.[7] However the associated Code of Practice states that it should be the person who is directly concerned with the individual at the time the decision needs to be made.[6] Put more simply, it is the responsibility of the prescriber who is attending the person at the time the assessment is carried out to decide if the resident has capacity to consent to taking medicines. Good practice would be to include information from care home staff AND family or advocates as part of the decision making process. Care home staff also have a responsibility to make any attending prescriber aware of changes in the resident's condition which may affect/influence decision making.

4.2.5 If the outcome of the assessment is not entirely clear, the Local Authority Mental Capacity/Deprivation of Liberty Safeguards (DoLS) team must be contacted. In difficult circumstances where the assessment remains unclear or the resident has fluctuating or limited capacity, it may be necessary to refer to the Court of Protection.

4.2.6 The use of covert medication which is prescribed and administered in someone's best interests is now considered to be a deprivation of liberty and amounts to continuous supervision and control.[8] Care homes therefore have a duty to apply for a standard authorisation in respect of any of their residents who are covertly medicated due to them lacking mental capacity to consent to medication. See Appendix C (DoLS section).

4.2.7 An advance decision to refuse particular treatment (ADRT) in anticipation of future incapacity must be adhered to. It is therefore important that the clinicians and other health and social care professionals are made aware of advanced decisions and that information is clearly documented within the resident care plans. Where a valid and applicable ADRT is in place, it is a statutory requirement for it to be adhered to.[6]

4.3 B – 'Best interests' decision

4.3.1 Residents who have been assessed as lacking capacity should only be administered medicine covertly if a management plan has been agreed after a 'best interests' meeting.[9] This can take place virtually if appropriate.

4.3.2 'Best interests' is an objective method for making decisions. It should not be the personal views of the decision makers but should instead consider the current and future interests of the resident who lacks capacity and decide on the best course of action for them.[6]

In consideration of covert medicines, a 'best interests' decision should be undertaken in a transparent discussion between**:-**

- The GP or clinician responsible for the care of the resident
- The care home staff members administering the medicines
- Relative or close friends
- Any person nominated to have lasting power of attorney for health and welfare decisions or Court Appointed Deputies.
- In scenarios where there is no-one to consult with and there is a need to refer to the advocacy service, the following services are available for advice:- Age UK Advocacy Service. Visit www.ageuk.org.uk to find your local service.
- Local contacts are available via local council websites.
- Best interest decisions involving medicines should be made by the prescribing clinician, as they are the decision maker, with input from a multi-disciplinary team of health and social care professionals. If a pharmacist cannot be present during the meeting their advice should be sought before the decision to proceed with covert administration is made. This will ensure that the suitability of the medicine to be administered covertly is checked. (10)

4.3.3 The Mental Capacity Act (2005) provides a checklist that practitioners must follow when making a best interests decision for someone:- (7)

- Consider all the relevant circumstances, ensuring that the resident's age , appearance and behaviour are not influencing the decision;
- Consider delaying the decision if there is a possibility that the resident may regain capacity;
- Involve the resident in the decision as much as possible;
- Consider any advance statements made (e.g. advance decision to refuse treatment (ADRT);
- Consider the past and present beliefs and values of the resident, and the person's history of decision making;
- Take into account views of the family and informal carers, as well as independent mental capacity advocates (IMCAs) or other relevant people;
- Demonstrate that all options have been exhausted (e.g. administration of medicines at different times, using a different formulation or use of personalised preferences). The decision made should be the least restrictive alternative or intervention.

4.3.4 It should be noted that if the situation is urgent, NICE propose that it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate in order to make an urgent decision so that covert administration can take place. A formal meeting should be arranged as soon as possible afterwards.(9)

4.3.5 The option chosen should be the least restrictive and should always give consideration as to whether the medicine can be omitted or stopped without an adverse effect on the individual's welfare. Healthcare professionals should consider how long the resident has been non-compliant with their medicines, and what the consequences have been. This is especially important where intake of food or drink may be impaired due to the presence of covert medicines within it.

4.3.6 It is advised that prescribers take the opportunity to review the resident's medicines for clinical need.[10]

4.3.7 Any decision must be documented in the resident's clinical notes and care plan.

4.3.8 Each time a new medicine or change in dose is being considered, care home staff should advise prescribers of the current situation regarding covert administration. Another 'best interests' meeting must be held to ensure that treatment continues to be in the best interests of the resident. Please refer to section 4.3.4 if the change is urgent e.g. prescription of antibiotics out of hours.

4.4 C - Check suitability of medicines for covert administration

4.4.1 If the 'best interests' decision is to administer covertly, the suitability of the medicine must then be considered. Prescribers and pharmacy teams must take reasonable steps to ensure that administering medicines covertly will not cause harm to the individual.

4.4.2 If giving the medicine covertly will reduce its effect or increase the risk of side-effects, an alternative treatment option should be considered. A number of preparations are not suitable to be crushed or opened (e.g. enteric coated or modified release preparations). Advice should always be sought from pharmacy professionals such as CCG medicines management teams, community pharmacists or any other pharmacy team involved in the request for covert administration of medicines.

4.4.3 Additional consideration should be given to the safety of the member of staff administering the medicine when altering or coming into contact with the newly altered formulation. Ensure that if required, appropriate personal protective equipment is used.

4.4.4 Crushing tablets or releasing the contents of capsules can automatically make the medicine an unlicensed formulation, unless the marketing authorisation of

the medicine allows for such changes. Consequently, where licensed preparations such as liquid or oro-dispersible formulations are available, they should be used first line and administered in a licensed way if practical. Note that administration of medicines in food or liquid may be outside of the medicine's marketing authorisation.

4.4.5 The decision over the formulation chosen and the method of administration should be individualised, taking into account the eating and drinking habits of the resident in addition to the characteristics of the medicine.

4.4.6 Consideration must also be given to how pleasant the taste of the altered medicine is. Staff must be aware that this change may affect the resident's intake of food and fluids.[10]

4.5 D – Documentation and records must be clear

4.5.1 Covert administration of medicines will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made rests with everyone involved in the resident's care. Therefore, clear documentation is essential.[11]

4.5.2 It is not appropriate to act on any verbal direction or an 'ad-hoc' written instruction to covertly administer medicines as this could be liable to legal challenge.

4.5.3 Covert administration must comply with an individual organisation's policy and procedure.

4.5.4 The prescriber must have documentation of both the mental capacity assessment (for the understanding of medicine-related issues) and the 'best interests' decision (to support covert administration) in the resident's clinical records. The care home should keep a copy of these documents within the resident's care plan.

4.5.5 Prescribers should document the appropriate read code on the clinical records e.g. *Best interest decision to allow covert administration of medicines under Mental Capacity Act 2005.*

4.5.6 There should be clear written instructions for each medicine to be given covertly in line with the advice of the pharmacist. This should be added to the care plan to ensure that all care home staff administering the medicines are aware of the reasons for, and the method of covert administration for each medicine.

4.5.7 Good record keeping provides evidence to enable individuals involved in the decision to administer medicines covertly to review accurately the need for

continuation.

4.5.8 If there are any disputes around the decision to administer medicines covertly then this should be considered for referral to the Court of Protection.

4.6 E – Establish method of administration of covert medicines

4.6.1 Care home staff who are trained to administer medicines should consider the following points when covert administration has been deemed necessary:

- A resident should be offered their medicines openly each time (i.e. not covertly)- especially where fluctuating capacity is evident, unless this has been deemed to cause distress to the resident and has been agreed that this process would no longer be in their best interests.
- Care home staff should be aware of resident preferences for administration through the care plan and should only proceed to administer covertly after the appropriate steps have been taken.
- Apparatus should be available as required to crush or alter medicines (pestle and mortar/tablet crusher).
- Equipment used to crush medicines should be cleaned between each person to eliminate the risk of residents receiving traces of other residents' medicines, which could pose a problem if residents have allergies to medicines.
- Crush medicines individually and add individually to a small amount of food and not to the whole meal.
- The availability of food that is being used to disguise the medicine (e.g. jam, yoghurt, juice).

4.6.2 It is recommended that medicines that are to be administered covertly are mixed with the first mouthful of food, especially if the resident is prone to poor appetite. This increases the likelihood that the prescribed dose is taken. Not all food and drinks are suitable; e.g. drinks at extremes of temperature as stability of the medicine may be compromised. Refer to the pharmacist for advice on compatibility.

4.6.3 The medicine must be administered immediately after mixing it with food or drink. It must not be left for the resident to manage themselves. If the resident is able to feed themselves they should be observed to ensure that the medicine is consumed.[10] These steps are also important to ensure that there is no risk of the medicine being taken by other residents

4.6.4 Each time a medicine is administered covertly in accordance with the care plan it should be clearly documented in the Medicines Administration Records (MARs). Where administration is unsuccessful this must also be clearly documented and any consequences reported to the prescriber as appropriate.

If the dose is partially consumed, this should also be recorded as the dose is uncertain.

4.7 F – Frequency of review should be agreed

4.7.1 A resident may be mentally incapacitated for various reasons. These may be temporary, e.g. an acute infection or sedation as a side effect of a medicine; or because of a long term mental health illness, e.g. Alzheimer's disease.

4.7.2 National guidelines and frameworks do not state a suggested minimum timescale for review. Therefore, the need for continued covert administration should be reviewed regularly. The timescale for review should be agreed at the time of implementation of covert administration along with the 'best interests' decision and be in line with the provider organisation's covert medicines policy.

4.7.4 A review should take place at pre-agreed regular intervals and whenever there is a change in the medicine or treatment regimen, or if there is a change in the physical or mental state of the resident.

5 Care providers and handover plans

5.1 All care providers should ensure that there are robust handover plans in place for sharing information around covert medicines. Transfer of information should be timely and minimise the impact of the transfer on the resident. This should apply within and between community settings and the acute sector. The new care provider and prescriber should review paperwork received to ensure that correct procedures have been followed to authorise the covert administration of medicines. Handover information should include the following:

- Resident name, date of birth, GP.
- Details of next of kin, people nominated with power of attorney, relevant person's representative, Court Appointed Deputies.
- Contact information for place of discharge.
- Details of the capacity assessment with regards to medicines.
- Details of people involved in the best interest decision and outcome of decision.
- Medication list and detailed instructions on how to administer.
- Strategies to facilitate resident to take their medicines overtly, if appropriate.

6 Equality and diversity considerations

6.1 Good communication of information between health and social care practitioners and residents, and their families and care home staff, is essential. Treatment, care and support, and how this is communicated should be both age‑appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Residents and their families or care home staff, should have access to an interpreter or advocate if needed.

7 References

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8. Bailli. AG EWCOP 37 [Internet]. England and Wales Court of Protection Decisions; 2016 [cited 2018 Oct 23]. Available from:

http://www.bailii.org/ew/cases/EWCOP/2016/37.htm

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10. PrescQIPP Bulletin 101 Best practice guidance in covert administration of medication [Internet]. East Anglia Medicines Information Service; 2015 [cited 2018 Oct 23]. Available from: https://www.prescqipp.info/our-resources/bulletins/bulletin-101-care-homes-covert-administration/

11. Care Quality Commission. Regulation 12: Safe care and treatment. [Internet]. 2014 [cited 2018 Oct 23]. Available from: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment

8 Appendix A Useful Websites

What legal and pharmaceutical issues should be considered when administering medicines covertly? Published 16th March 2017, updated 7th November 2018. Available via: https://www.sps.nhs.uk/articles/what-legal-and-pharmaceutical-issues-should-be-considered-when-administering-medicines-covertly-2/

What are the considerations when crushing tablets or opening capsules in a care home setting? Published 15th January 2015, updated 22nd November 2018. Available via: https://www.sps.nhs.uk/articles/crushing-tablets-or-opening-capsules-in-a-care-home-setting/

CQC Adult Social Care Medicines Information: Administering medicines covertly. Last updated 28 September 2018. Available via: https://www.cqc.org.uk/guidance-providers/adult-social-care/administering-medicines-covertly

National Institute for Health and Care Excellence Quick Guides: Giving medicines covertly 2019. Available via: https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/giving-medicines-covertly

National Institute for Health and Care Excellence. Managing medicines in care homes, SC1. [Internet]. 2014 [cited 2018 Oct 23]. Available from: https://www.nice.org.uk/guidance/sc1/chapter/recommendations#care-home-staff-giving-medicines-to-residents-without-their-knowledge-covert-administration

9 Appendix B Covert administration of medicines checklist

<table>
<tr><td colspan="2">Name of resident</td><td colspan="3"></td></tr>
<tr><td>Date of Birth</td><td></td><td>NHS Number</td><td colspan="2"></td></tr>
<tr><td colspan="5">Has a review (including a full medication review) taken place to explore the reasons for refusal, have adjustments been made where possible and is the resident still refusing their medicines?
Yes/No</td></tr>
<tr><td colspan="5">Name of person(s) involved in review described above:
Name Designation Date</td></tr>
<tr><td colspan="5">Covert administration of medicines should only be considered as a last resort, when reasons why an individual is refusing their medicines have been fully explored and adjustments to medicines made.</td></tr>
<tr><td rowspan="3">A Assessment of capacity</td><td>Does the individual lack capacity to make decisions about their medicines?</td><td>Yes</td><td>No</td></tr>
<tr><td>Has the individual been assessed in accordance with the Mental Capacity Act 2005?</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">Name of person(s) who assessed mental capacity:
Name Designation Date</td></tr>
<tr><td colspan="5">NB If the person does not lack capacity in relation to taking medicines or has not been assessed in accordance with the Mental Capacity Act 2005, covert administration cannot be used. Please refer to guidance for advice on correct action to take.</td></tr>
<tr><td rowspan="3">B Best interest decision</td><td>Has a multidisciplinary team and resident’s representative made a decision that covert administration is the least restrictive option for the individual?</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">If no, covert administration cannot take place</td></tr>
<tr><td colspan="3">Name of person(s) involved in best interest decision:
Name Designation Date</td></tr>
<tr><td colspan="5">NB If the situation is clinically urgent, it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate to make an urgent decision so covert administration can take place. A formal meeting should be arranged as soon as possible afterwards.</td></tr>
</table>

C Check suitability of medicines for covert administration	Have all medicines been checked for suitability for covert administration by a pharmacist?	Yes	No
	If no, ensure this is done now		
	Name of person(s) consulted: Name Designation Date		
D Documentation	Has the decision to administer medication covertly, including capacity assessment **and** best interest decision been recorded in the individual's care plan	Yes Date	No
	If no, ensure this is done now Date completed:		
	Has the decision to administer medication covertly, including capacity assessment **and** best interest decision been recorded in the individual's notes at the GP practice?	Yes Date	No
	If no, ensure copy of checklist sent now Date sent:		
	Has an application been made to include covert administration as a condition of the DoLS	Yes Date	No
	If no, ensure this is done now Date completed:		
E Establish method	Do carers have written documentation from a pharmacist/prescriber detailing the correct method for administering the medicines covertly that has been individualised for that person?	Yes Date	No
	If no, seek advice from pharmacy team/prescriber before proceeding. Date advice received:		
F Frequency of review	Has a date for review of continued need for covert administration been agreed?	Yes	No
	If no, ensure this is done now		
	Date of covert administration of medicines review:		
Additional notes:			
Name of person completing checklist	**Designation**	**Date**	

A copy of this checklist should be scanned into the resident's notes at the GP practice and a copy held within the individual's care plan as evidence of the decisions made.

10 Appendix C DEPRIVATION OF LIBERTY SAFEGUARDS – COVERT ADMINISTRATION OF MEDICINES GUIDANCE NOTE November 2018

Introduction

This document provides additional guidance to healthcare professionals and care workers working with care homes in Greater Manchester, alongside the 'Greater Manchester Guidance for the Covert Administration of Medication' document.

Background

In the case of **AG v BMBC & Anor, before District Judge Bellamy[2016] EWCOP 37** it was declared, that the use of covert medication is an '*interference with the right to respect for private life under Article 8 of the ECHR…'*

To summarise, this case concerned an 92 year woman who was subject to covert administration of promethazine and diazepam (sedation) in which there were no 'conditions' relating to this medication contained in the care plan. The full judgement can be read here.

Case Law

This judgement highlighted:

a. Such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness.
b. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL (deprivation of liberty) within the meaning of Article 5 of the Convention
c. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL.
d. It must therefore attract the application of Section 1(6) of the Act and a consideration of the principle of less restriction and how that is to be achieved.
e. Care homes are to ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan should also be agreed and recorded after a best interest meeting. The meeting should be between healthcare professionals and family members.
f. The use of medication without consent or covertly whether for physical health or for mental health must always call for close scrutiny.

Therefore, the use of covert medication which is prescribed and administered in someone's best interests is now considered to be a deprivation of liberty and amounts to continuous supervision and control. Care homes therefore have a duty to apply for a standard authorisation in respect of any of their residents who are covertly medicated due to them lacking mental capacity to consent to medication.

Applying for a standard authorisation

If the resident is accommodated in a care home, the managing authority can make an application for DoLS by completing 'Appendix D'

The completed Form 1 must be securely emailed to the Local Authority DoLS team.

Decision making

If a decision is needed in respect to covert administration of medicines, practitioners should refer to the guidance set out in the 'Greater Manchester Guidance for the Covert Administration of Medication' document.

If it is ultimately deemed that covert administration of medicines is in a care home resident's best interest, the following must apply;

a. Where there is a covert administration of medicines policy in place or indeed anything similar there must be full consultation with healthcare professionals and family
b. The existence of such treatment must be clearly identified within the assessment and DoLS Standard Authorisation.
c. If the standard authorisation is to be for a period of longer than six months there should be a clear provision for regular, possibly monthly, reviews of the care and support plan.
d. Reviews should occur at regular intervals involving family and healthcare professionals, all the more so if the standard authorisation is to be for the maximum twelve month period.
e. Where appointed, an RPR should be fully involved in those discussions so that if appropriate an application for Part 8 Review can be made.
f. Any change of medication or treatment regime should also trigger a review where such medication is covertly administered.
g. Such matters can be achieved by placing appropriate conditions to which the standard authorisation is subject and would accord with chapter 8 of the deprivation of liberty safeguard's code of practice.

The Local Authority Supervisory Body will impose 'conditions' on all care homes which make reference to the above responsibilities in respect of how covert medication must be administered and managed.

11 Appendix D DEPRIVATION OF LIBERTY SAFEGUARDS –Deprivation of Liberty Safeguards Form 1. Request for Urgent/Standard Authorisation

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 REQUEST FOR AN URGENT/STANDARD AUTHORISATION					
Full name of person being deprived of their liberty			Sex		
Date of Birth *(or estimated age if unknown)*			Est. Age		
Name and Address of Managing Authority (care home or hospital) requesting this authorisation					
Person to contact at the care home or hospital, (include ward details if appropriate)	Name				
	Telephone				
	Email				
	Ward (*if appropriate)*				
	CQC Location Code				
Usual address of the person if different to the above:					
For permanent placements: please provide the date the person was admitted into your care.					
Date the placement started					
For Discharge to Assess (D2A) placements: please provide the date the person was admitted into your care.					
Date the placement started					
For one off respite placements or one-off time limited placements: please provide the start and expected end date of the person's stay.					
Start date		Expected end date			
For annual block respite placements: please give the total amount of nights the person will stay with you over the 12 month period and if known the dates of the current or next stay.					
Number of nights per year		Start date		End date	
SECTION A: Who is funding the placement? (Tick whichever applies) ✔					
Council		Local Authority and NHS (Jointly Funded)			
NHS					
Self-funded by the person		Funded through insurance policy/other			

If the person is self-funding please state the area/town in which they ordinarily live or used to live:	If the person is funded by a different Local Authority or fully funded by a different CCG please send your DOLS request to that Local Authority.

State the person's mental disorder/impairment of or disturbance in the functioning of the mind/brain (diagnosed/undiagnosed) *The form will be rejected without this information
Details:
If the person has any physical or sensory health conditions please state below:
Details:
If the person has any specific communication or language needs please state below:
Details:
Is the person considered to be "end of life", receiving palliative care or do they have a terminal illness?
Details:

What is the purpose for which a standard authorisation is required (Tick all that apply) ✔			
The delivery of personal care		Administration of medication/treatment	
The delivery of continence care		Delivery of pressure care/relief	
Support to maintain personal appearance		Support to encourage social inclusion	
Delivery of all meals and drinks		Delivery of domestic support	
Direct support with feeding		Support to prevent harm to self	
Other (please state)			

Please provide the date and reason the person was admitted into your care.	
Date placement started:	
Reason for placement:	

	SECTION B: Are any of the following factors present? (Tick any that apply) ✔	✔
1	Any restrictions in place are low level. The person is generally settled, content and accepting of the care and treatment provided. No real evidence of distress. Easily reassured. **Situation does not meet any of the triggers numbered 2 to 12 below.** (e.g. exits are locked/alarmed, movement sensors and bed rails may be provided, routine observations, general care and treatment is provided. Person largely settled and content.)	
2	The person becomes distressed when receiving care and treatment, not easily reassured.	
3	The person becomes distressed at or is objecting to being in the care home/hospital. (e.g. person makes attempts to leave or asks to go home or wishes to leave to go somewhere else and becomes upset when not allowed.	

4	The family are objecting to the person being accommodated in the care home/hospital (e.g. the family want the person to move to live elsewhere)	
5	The family disagree with the care and treatment that is being provided (e.g. the family disagree with the ways in which staff may restrict the person's freedom in order to keep the person safe)	
6	There are issues of incompatibility with other residents	
7	There is evidence of challenging behaviour that require significant restrictions	
8	The mental disorder is not consistent (e.g. it may go into remission and then return)	
9	The person sometimes has mental capacity to agree to their care and treatment and the need to be accommodated in the care home/hospital (fluctuating mental capacity). (e.g. they are able to understand the information, retain it, weigh the pros and cons of the available options and communicate their decision).	
10	Staff routinely administer covert medication and/or are using sedative medication or restraint techniques.	
11	The person is seated in a Kirton style chair or is fastened into seating for prolonged periods of time and is unable to get out without help from others.	
12	There are Adult safeguarding concerns	

For any boxes ticked in Section B above, you must provide details below of the circumstances and how the care staff manage the situation:

NEXT OF KIN CONTACT DETAILS	
Name	
Address	
Contact Number	

THERE IS AN ADVOCATE / IMCA INVOLVED	
Name	
Contact Number	

THERE IS SOMEONE WHO HOLDS A LASTING POWER OF ATTORNEY (**state** whether for property and finances **or** health and welfare **or** both)	
Name and contact details	

THERE IS SOMEONE WHO HAS BEEN APPOINTED BY THE COURT OF PROTECTION TO ACT AS PERSONAL WELFARE DEPUTY	
Name and contact details	

THE PERSON HAS MADE A VALID AND APPLICABLE ADVANCED DECISION TO REFUSE TREATMENT? (Tick one box) ✔					
Yes		No		Not known	

THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983) (Tick whichever applies) ✔					
Section 17 leave from a psychiatric hospital		Date started		Date due to end	
Is the person subject to Guardianship		Date started		Date due to end	

OTHER RELEVANT INFORMATION
Please include details of any changes previously given in Form 1 e.g. in the care plan, medical information, person's behaviour or visitors.

Signature		Print name	
Date		Time	

BY SUBMITTING THIS FORM YOU ARE ALSO CONFIRMING YOU HAVE INFORMED ANY INTERESTED PERSONS NAMED ABOVE OF THE REQUEST FOR A STANDARD AUTHORISATION

I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION		*(Please mark ☒ to confirm and complete below)* ☐	
Name of Person Informed:		**Date Informed:**	
Role of Informed:			

DEMOGRAPHIC INFORMATION Place a tick to indicate ethnicity and disability ✔					
White		Undeclared / Not Known		Physical Disability: Other	
Asian / Asian British		Other Ethnic Origin *(please state)*		Learning Disability (includes autism)	
Black / Black British		Physical Disability: Visual Impairment		Mental Health needs: Dementia	
Mixed / Multiple Ethnic groups		Physical Disability: Hearing Impairment		Mental Health needs: Other	
Not Stated		Physical Disability: Dual Sensory Loss		Other Disability (none of the above)	

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT:

A Standard Authorisation is required to start on this date

HOW TO CALCULATE THE DATES

Standard request only: The standard authorisation is due to start in 21 days' time. Day one is counted as being the date the form is received by the local authority.

Example:
Holly Cottage care home submits a standard request only. The local authority receives it on 9th April. Therefore you should date the standard authorisation as being due to start on 29th April.

Urgent authorisations plus a standard request: The urgent authorisation starts the day the local authority receives the form and can last for 7 days. Day one is counted as being the date the form is received by the local authority. The standard authorisation should be dated to begin the day after the urgent expires.

Example:
Bramble Lodge submits both an urgent authorisation and a standard authorisation request together. The urgent authorisation is required for 7 days. The local authority receives the joint request on 9th April. Therefore the urgent authorisation is due to expire on 15th April. The standard authorisation is due to start on 16th April.

ONLY COMPLETE THIS SECTION IF YOU ALSO NEED TO GRANT YOURSELVES AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK ALL OF THE FOLLOWING CONDITIONS ARE MET	
URGENT AUTHORISATION ***Place a cross in EACH box to confirm that the person appears to meet the particular condition***	
The person is aged 18 or over	
The person is suffering from a mental disorder	
The person is being accommodated here for the purpose of being given care or treatment.	
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	
The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment	
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Personal Welfare Deputy appointed by the Court of Protection under the Mental Capacity Act 2005	
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty	
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise	
The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given	
The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately before the request for the Standard Authorisation is made or has been determined	

AN URGENT AUTHORISATION IS NOW GRANTED
This Urgent Authorisation comes into force immediately.

It is to be in force for a period of: _____ days

The maximum period allowed is seven days.

This Urgent Authorisation will expire at the end of the day on: _____

Signed		Print name	
Date		Time	

REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION
If Supervisory Body is unable to complete the process to give a Standard Authorisation (which has been requested) before the expiry of the existing Urgent Authorisation

An Urgent Authorisation is in force and a Standard Authorisation has been requested for this person.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of [ ] DAYS (***up to a maximum of 7 days***)

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons):*

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature		Date	

RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the Urgent Authorisation is extended. **The Managing Authority <u>does not</u> complete this part of the form.**

The duration of this Urgent Authorisation has been extended by the Supervisory Body.

It is now in force for a **further** [ ] days

Important note: The period specified must not exceed seven days.

This Urgent Authorisation will now expire at the end of the day on: [ ]

SIGNED (on behalf of the Supervisory Body)	Signature		
	Print Name		
	Date		Time