Norfolk and Waveney
Integrated Care Board

Guidance on the use of covert administration of medication in care homes

<table>
<tr><td colspan="2">Norfolk and Waveney ICB – Medicines Optimisation Team</td><td>Version 4.2</td></tr>
<tr><td>Written by: Hayley Hurst (Medicines Optimisation Pharmacist)</td><td>Issue Date: November 2024</td><td>Review Date: November 2026</td></tr>
</table>

Guidance on the use of covert administration of medication in care homes

1. Introduction

1.1.1 Administration of medication covertly may be appropriate in exceptional circumstances where a resident lacks capacity and refuses to take medication offered to them in an overt manner.

2. Scope of guidance

2.1.1 This document provides guidance to care home staff who may be required to give medication covertly to a resident in their care. It explains the legal implications of covert administration of medication and to ensure the required documentation meets legal requirements.

2.1.2 This guidance does not cover people who may require covert administration in their own home.

3. Definition of covert administration of medication

3.1 Covert administration of medication is where medications are administered to a person, without their knowledge or consent, in a way to hide or disguise them, for example mixed with food or drink. Covert administration of medication should only be used in exceptional circumstances, for example if the person is at risk of causing harm to themselves or others, and only after legal requirements have been met. **Medication must never be given covertly to a person who has capacity to make their own decisions** even if it is felt the decision is unwise**.** Only a qualified independent prescriber is able to approve covert administration of medication although other healthcare professionals can be involved with the best interest decision.

3.2 For patients who have swallowing difficulties, medications are sometimes mixed with soft food or drink or tablets may be crushed and capsules opened. Medication administered in such a way is not considered covert if the person is

fully aware and consents to their medication being administered in this manner. The person receiving the medication must be advised if their medication is mixed with food or drink every time it is administered in this way. Medication must never be mixed with food or drink or altered in any way from its original form without advice from a pharmacist as not all medication is suitable to be administered in this way. Medication which has been crushed or manipulated from its original presentation makes it unlicensed. If your GP surgery has a practice pharmacist or Primary Care Network (PCN) pharmacist, they can offer advice on crushing tablets or opening capsules. Any local community pharmacy can also be contacted for advice on mixing medication with food and drink or crushing tablets.

4. Purpose

4.1 This guidance is intended for use by healthcare professionals or care home staff working in care homes within Norfolk and Waveney ICB who may be required to administer medication covertly as part of a care plan for a person in their care. The guidance should be adhered to every time covert medication is considered or reviewed. It is recommended that the supporting documentation, found in the appendices, should be completed for every person whom covert administration is deemed appropriate although each care home provider may have their own paperwork available.

4.2 All care home providers must have a policy detailing how covert medication is managed within their care setting. This guidance and supporting documentation provides advice around the decision making process to ensure legal requirements are met.

5. Exceptions to guidance

5.1 If an emergency situation arises within a care home and it is not possible to determine the person's wishes or obtain prior consent, a healthcare professional can give verbal approval for treatment to be given covertly if it is deemed immediately necessary to save their life or prevent serious deterioration to their health or wellbeing. Any treatment however must be considered the least restrictive option and must be in the person's best interest. Any intervention, including the use of covert administration of medication, in

such circumstances must be clearly documented including who took the decision, why the decision was made and what treatment was given. If the care home provider is in any doubt, immediate medical advice must be sought.

6. Education and training

6.1 All healthcare professionals involved in the decision making process to administer medication covertly and care home staff involved with administering medication should be aware of this guidance in addition to relevant local medication guidelines and polices. Care home staff must be appropriately trained on administering covert medication as part of their medicines management mandatory training.

7. Monitoring and review

7.1 This guidance and supporting documentation will be reviewed every two years by the local Medicines Optimisation team, or earlier in the event of changes to legislation or good practice.

7.2 The Medicines Optimisation team will review adherence to this guidance and supporting documentation as part of the ongoing work to support care homes and medication review processes.

8. Implementation and dissemination

8.1 Healthcare professionals and care providers must be aware of the requirements when carers are requested to administer medication covertly. Before covert administration is agreed, mental capacity must be assessed regarding capacity to consent to treatment, a thorough medication review undertaken and best decision process adhered to. All supporting documentation must be completed and copies available for both the GP surgery and care home provider. Documentation must be maintained and reviewed regularly to ensure it is up to date.

8.2 As part of the decision to administer medication covertly there must also be a discussion between the healthcare professional and care home provider as to whether a Deprivation of Liberty Safeguard (DoLS) is required. The responsibility of applying for a DoLS resides with the care home provider.

9. Key points regarding the use of covert administration of medication in care homes

9.1 General principles of covert administration

Covert administration is underpinned by the Human Rights Act 1998 and this must always be considered when determining whether to proceed. Individuals with capacity have the right to accept or refuse medical treatment, even if a refusal may lead to a detrimental outcome. **Covert medication must never be administered to somebody who has capacity to decide upon medical treatment.** When reviewing whether an individual requires covert administration of medication the first step is always to ascertain whether they have **capacity** to make a decision regarding their treatment.

If an individual is refusing to take prescribed medication and lacks capacity to make an informed decision regarding this, covert administration may be considered as the most appropriate option. Appendix 1 provides a useful oversight of the steps to ensure covert administration is implemented safely and legally. The following principles are recognised as good practice:

- **Last resort** – covert administration is the least restrictive option when all other options have been tried.
- **Medication specific** – covert administration should only be used for medication which is essential to the individual's health and wellbeing. It must be clearly documented which medication should be administered covertly; this may not always include every medication which has been prescribed. A full medication review rationalising treatment must be undertaken before initiating covert administration.
- **Time limited** – covert administration must only be used for the shortest possible time period.
- **Regularly reviewed** – the need for continued use of covert administration must be reviewed at regular time periods, or sooner if the condition of the individual changes. The individual's capacity to consent to treatment must also be reviewed regularly.

- **Transparent** – the decision making process must be easy to follow and clearly documented. The supporting documentation included within this guidance document should aid this process.
- **Inclusive** – the use of covert administration of medication must not be a decision taken alone. Discussions should be had with appropriate advocates of the individual, for example Lasting Power of Attorney (LPA) for health and welfare.
- **Best interest** – all decisions must be made in the individuals' best interest, considering the holistic impact on their health and wellbeing.

The Medicines Optimisation team will always review people with covert medication plans in place during routine visits to care homes. If medication is being administered to an individual without appropriate processes being followed or supporting documentation in place, a referral to the local safeguarding team will be made and police may be alerted as this is considered assault.

9.2 Considerations of covert administration of medication via enteral feeding tubes

Administration of medicines via enteral feeding tubes must be with the informed consent of the person to avoid any suggestion of covert administration. Medication administration via an enteral feeding tube to a person who lacks capacity must always be considered as covert administration and as such a mental capacity assessment and best interest decision relating to medication must be competed.

10. Decision process for Covert Administration - suggested care pathway with supporting documentation and flowchart (Appendices 1 – 7)

10.1 Explore alternatives to covert administration

Before covert administration of medication is considered, alternative strategies for managing medication refusal **must** be trialled This may include using an alternative form of medication, for example a licensed liquid medication, or altering the times medication is administered if refusal occurs at the same time of day. Other factors relating to refusal should also be considered, for example location where medication is administered or gender preference of staff who are administering the medication (appendix 2). If this is not possible or is not effective at reducing refusals of medication

then covert administration should only be considered in **exceptional circumstances** to prevent the person from omission of essential medication or to prevent harm to themselves or others.

Using medication to manage behavioural symptoms of dementia, for example antipsychotics, must only be used as a **last resort** if all other alternative strategies have been tried and the person is at risk of causing harm to themselves or others. Antipsychotics prescribed to manage dementia symptoms must be reviewed regularly, at least every 3 months, with a view to reducing and stopping as soon as possible. Long term antipsychotic use is not recommended as the risk to the person often outweighs the benefits.

11. Step 1: Assessing mental capacity (MCA assessments)

Covert administration can only be considered if a person lacks capacity regarding the need to take medication. Therefore, it is necessary for a Mental Capacity Assessment (MCA) to be undertaken using the five key statutory principles stipulated in the Mental Capacity Act 2005. It is important to remember that each MCA is decision specific and must therefore be completed for each issue which may have an impact on an individual's quality of life. An MCA assessment can be completed by an individual that knows the person, including senior care home staff and healthcare professionals. However, for the purposes of deciding whether covert administration of medication is the most suitable option for the person, the healthcare professional may wish to undertake a MCA assessment as they will understand the relevant information to the decision.

The five key principles in assessing capacity:

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not treated as unable to make a decision unless all practicable steps to help him or her to do so have been without success. Practicable steps may include using appropriate aids for communication or using an advocate.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.

4. An act done, or decision made, under the Mental Capacity Act 2005, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

11.1 Process of assessment

It is presumed that all individuals have capacity or the ability to make a decision unless proven otherwise. This can be assessed using a two-stage test.

Stage 1 – Functional test

People can lack capacity to make some decisions but have capacity to make others. Mental capacity can also fluctuate with time – someone may lack capacity at one point in time but may be able to make the same decision at a later point.

In order to have capacity to make decisions around their medication administration, the person must be able to complete all 4 of the below elements:

- UNDERSTAND: in simple language what the treatment is, its purpose and why it is being prescribed.
- RETAIN: the information for long enough to make an effective decision. This may not be at the time of the discussion but, for example, when it is time for the medication to be taken.
- WEIGH UP AND USE: the principal benefits, risks of medication, including side effects, and any alternatives which may be available. This should include, in broad terms, what will be the consequences of not receiving the proposed treatment.
- COMMUNICATE: their decision in any form.

If the person is unable to complete one element of the functional test, there needs to be consideration of the diagnostic test.

Stage 2 – Diagnostic Test

A range of difficulties can impact on our decision-making abilities both temporarily and permanently, however this needs to be considered in connection with the ability to

decide following the functional test. For example, does the person experience difficulty making the decision about their medication because of a significant cognitive impairment due to their dementia?

Does the person have an impairment of their mind or brain, whether as a result of an illness (this does not need to be a formal diagnosis), or external factors such as drug or alcohol dependency? Is there a link between the person's difficulty in making this decision, and their impairment?

When an individual lacks capacity, there is a need to distinguish between:

- Those individuals who are **ACCEPTING** necessary medication when administered overtly and therefore do **NOT** require covert administration.
- Those individuals who are **REFUSING** to take overtly administered medication.

It is also important to remember that in England, the relatives of an individual whom lacks capacity do not have the legal right to consent unless they hold legal rights through Lasting Power of Attorney (LPA) for health and welfare. Without a nominated LPA the decision for acting in the individual's best interest lies with the person(s) responsible for the individual's care.

If an individual has made an advanced directive/decision to refuse treatment this must be adhered to provided it is valid and complete. The individual must have stated clearly which treatments they are refusing (a general desire not to be treated is insufficient) and in which circumstances they refuse them. The advanced directive/decision must apply to the proposed current treatment and in the current circumstances.

11.2 Review of mental capacity

A person's mental capacity can change or fluctuate so it is important to review if treatment and covert administration is still necessary. Where there is fluctuating or limited capacity and where a person refuses to participate in an assessment, a healthcare professional **MUST** be involved and decisions may need to be sought from the Court of Protection if the case is particularly complex.

It is important that regular reviews are held between the healthcare professional, care home and patient's representative(s) to ensure covert administration of medication is still in the individual's best interest and that the necessary paperwork is updated

(appendix 3). The timescale of review will depend upon the circumstances of the individual, for example the individual's condition and medication prescribed at the time. In some circumstances, concordance with medication may allow an individual to regain capacity to enable them to make an informed decision about their care. As a minimum, covert administration should be reviewed at least every 6 months, or sooner if the person has fluctuating capacity or there is a change in the person's condition. The MCA should also be reassessed if there is any doubt the persons capacity has changed from the original assessment.

12. Step 2: Best interest decision

The individual must have been assessed as lacking capacity to understand the consequences of refusing their medication. The following steps must not proceed unless this has been determined through a MCA.

Best interest decisions should be objective whereby the decision maker considers the 'best course of action' for the individual who lacks capacity to make an informed decision themselves. The Mental Capacity Act 2005 provides a checklist which must be adhered to when making a decision for someone.

Best interest decisions involving medication must be made by the most appropriate prescribing healthcare professional in conjunction with the care home, family or advocates of the person and appropriate healthcare professionals. Ideally the discussion should be held face to face but if this is impractical, it may be appropriate to conduct via telephone or email. Where possible a pharmacist should be included at all stages of the process. If this is not possible, a pharmacist's advice must, as a minimum, be sought regarding the practical steps of administering medication covertly to ensure all medication is suitable to be administered in this way.

The nominated LPA can consent to covert administration on behalf of the person without the need for a best interest meeting. However, if there is conflict between the LPA and the HCPs, or the LPA is objecting to medication, a best interest meeting must be held. In this situation the LPA **must** be involved in the best decision process and must be informed of the outcome to ensure the process is transparent and inclusive. If the person does not have a nominated LPA, relatives or friends should be encouraged to be involved in the process as it is important to consider their views as

these may help to determine what may have been the person's wishes and what is in their best interest. It is important to remember, without LPA status, they hold no legal power to make a decision but they should be informed of outcome of the decision. In cases where there is nobody to consult with, a referral must be made for an Independent Mental Capacity Advocate (IMCA) who can act on behalf of the person.

Administering medication covertly is potentially abusive if legal obligations are not met and for this reason assurances are needed that this is the least restriction option. The best interest decision includes a risk benefit assessment which must be made by the prescribing healthcare professional in discussion with the person's relatives or advocates. The decision to administer medication covertly must be clearly documented (appendix 4) with the reason for doing so in both the patient's clinical notes and in the care plans; it is insufficient to simply state a diagnosis as the reason to give medication covertly.

As part of the best interest decision regarding covert administration, a full medication review, ideally undertaken with a pharmacist, must be conducted which assesses the following factors:

- Stopping unnecessary medications – this must be considered as the least restrictive option. Clinicians may be concerned with medico-legal challenges if medication is stopped but clear documentation will evidence any decisions made. Unnecessary medication may include those which are not essential to the health and wellbeing of the person, for example medications prescribed in primary prevention.
- Behaviour patterns – consider whether a change in time of frequency may reduce refusals of medications.
- Reduced food and fluid intake – mixing medication with food or drink may alter the taste and lead to a further decrease in oral intake and in turn malnutrition and dehydration. Alternative routes, more palatable formulations or alternative medications should be considered.
- Refusals due to dementia – care home staff may find dementia training beneficial. Carers may help improve acceptance of medication concordance by the use of persuasive techniques or through knowledge of the person's personal preferences.

If covert administration is deemed to be in the person's best interest it is necessary to determine at initiation when this decision will be reviewed. As a minimum this must be every six months but should be sooner if the person's condition changes. It is suggested that if a person has fluctuation capacity the review of covert medication should be at least every three months. If a medication is to be given covertly which may potentially alter the behaviour or function of the person, for example hypnotics or antipsychotics, a DoLS submission should also be considered.

12.1 Summary of best interest checklist – all conditions in the checklist must be met

- Consider all the relevant circumstances ensuring that age, appearance, behaviour, diagnosis etc. are not influencing the decision to assume covert medication is required
- Consider a delay until the person regains capacity
- Involve the person as much as possible
- Not to be motivated to bring about death
- Consider the individual's own past and present wishes and feelings
- Consider any advance decisions/directives
- Consider the beliefs and values of the individual
- Take into account views of the person's family and informal carers
- Take into account views of Independent Mental Capacity Advocate (IMCA) when necessary or other key people
- Show it is the least restrictive alternative or intervention

13. Step 3: Administration of Covert Medication

In order to administer medication covertly, the form of medication will often need to be altered. This may mean changing solid oral medications to liquid, crushing tablets or opening capsules in order to mix with food or drink. Not all medication is suitable to be given covertly, for example crushing a modified release preparation may affect how the medication is absorbed by the body and this could lead to an overdose. A pharmacist must always be consulted for advice on whether medication is appropriate to be given covertly. The pharmacist should consult with standard reference sources,

the Summary of Product Characteristics (SPC) for the medication prescribed and appropriate referenced sources to advise on suitability.

In the majority of situations, altering a medication by crushing or opening capsules is unlicensed. Adding medication to food or drink, unless specified in the SPC, will usually also make the medication unlicensed. **In accordance with the Medicines Act 1968, only an independent prescriber can authorise the use of unlicensed medication**. A care home must never alter the form of medication without written confirmation from a prescriber. If an unlicensed medication is required to be administered, written documentation from the prescribing healthcare professional must be obtained which details exactly how **each** medication should be given. This must be a personalised plan (appendix 5) and reflect the person's food and drink preferences, for example crush tablet and mix with yoghurt. It is not acceptable for the prescriber to provide a letter which simply states all medication to be given covertly without specific details. A copy of the written confirmation must be added to the resident's care plan and included with the Medicines Administration Record (MAR) chart. A copy should also be included in the clinical notes.

Care home staff must understand how to give medication covertly. Appropriate supervision, education and support should be provided to enable safe administration of the medication as authorised by the prescriber and advised by the pharmacist. All persons involved with the handling of medicines as part of a person's care are liable under civil law if medication is incorrectly administered.

If further advice is required on the suitability of medications to be administered covertly contact the practice pharmacist or Primary Care Network (PCN) pharmacist for advice.

13.1 Addition of new medication

If a new medication is prescribed this must be treated as an entirely new situation. However, if there are no significant changes to medications it may not be necessary to repeat the MCA or best interest decision but the nominated LPA and / or family must be notified of the decision to administer the medication covertly. An example of this may be where a 'when required' (PRN) medication is changed to a regular dose. If the medication is significantly altered, the full process must be reviewed.

14. Step 4: Practical points in administering medications covertly

It is important that dignity and respect is maintained at all times, particularly in a situation which could potentially be seen as abusive. Carer staff must be supported by healthcare professionals to be able to deliver care appropriately ensuring accountability is maintained.

Only carers who are trained to administer medicines must give medication covertly. It is suggested care homes use the 'carers agreement' (appendix 6). The following points must be considered when covert administration is deemed necessary.

- The law states a person must be offered their medicines overtly **every time**. This is especially important where a person may have fluctuating capacity. If it is deemed that offering medication overtly to the person at every dose is too distressing to the person or would increase the likelihood of refusing of food and drink containing medication, this must be discussed and documented as part of the best interest decision. It may also be appropriate to refer such situations to DoLS.
- The person's personal preferences for medication administration should always be followed. If, after following this guidance and necessary steps have been taken, medication is still refused then covert medication may be used (appendix 2).
- If medication is to be administered covertly, it should be mixed with the smallest volume of drink or food possible. Never mix with a full portion as the person may refuse to eat or drink the whole amount and it is then difficult to establish how much of the dose was consumed. Not all food and drinks are suitable to be used, for example tea and milk interact with some medications. This must be documented clearly and advice should be sought from a pharmacist if there is any uncertainty.
- Once medication has been mixed with food or drink, it must be administered immediately to the person. If the person requires help to eat or drink, the carer administering the medication must assist the person. This must not be delegated to another member of staff. If the person is able to feed themselves, the carer administering the medication must observe the person to ensure it is all the medication is taken.

- Food or drink containing medication must never be left unattended as this may be consumed by other residents and could result in harm.
- If medication is taken by the person after overt administration, the MAR chart must be signed in the usual manner. Each time medication is administered covertly it must be recorded on the MAR chart using the appropriate key code and documentation of details provided as evidence.
- Refusals of food and drink containing medication, including where food or drink has only partially been consumed, must also be documented on the MAR chart.
- Good record keeping, including MAR charts, is vital evidence for the prescriber when reviewing the continued need for covert administration of medication.

15. Step 5: Record Keeping

Accountability - everyone involved in the person's care is accountable. Covert administration of medication will be challenged by inspecting bodies unless appropriate records have been completed and kept up to date to support the process.

Documentation – once covert administration has been agreed appropriate documentation must be completed and kept up to date. It is **not** appropriate to act on a verbal direction or written instruction to administer covertly without a best interest decision unless in extreme circumstances where the person is at immediate risk of harm. Lack of clear documentation could be liable to legal challenge.

15.1 The prescribing healthcare professional – must have documentation of both mental capacity assessment and the best interest decision to support covert administration. Copies of these must be kept in the person's clinical records in the GP surgery and a copy shared with the care home.

15.2 Care home – must ensure they have the correct, up to date paperwork and that a regular review is undertaken. The home should receive a copy of the mental capacity assessment and best interest decision completed by the prescribing healthcare professional and these must be kept in the care plan. The home must also ensure advice for administration of medication covertly is sought from a pharmacist and that an individualised plan to administer medication covertly is available with copies in both the care plan and with the MAR chart. The home must also make kitchen staff aware if a person is having medication covertly as dietary changes may be required. If the

person’s condition deteriorates whilst covert administration is in place or if the person refuses food or fluids, this must be referred back to the prescriber immediately.

16. Step 6: Review of continued need

The need for continued covert administration should be reviewed regularly and within the timescales agreed at the point of the best interest decision. The frequency of review should be individualised for each person and should be determined by the physical state of the person. It would be expected that reviews should take place more frequently when covert administration has been initiated for the first time, if the person has fluctuating capacity of if it is anticipated that covert administration is likely to be needed for a short period of time. For individuals requiring prolonged periods of covert administration, a formal review should be undertaken at least every 6 months or sooner if the person’s condition changes (appendix 7).

If a person reaches the end of their life, the need for covert administration of medicines should be reviewed as part of a wider in-depth medication review assessing risk versus benefit of each medication. Relatives or advocates should be made fully aware of any decisions made.

17. Checklist of responsibilities

17.1 Prescribing Healthcare Professional

- **Covert administration pathway** included in this documentation must be adhered to.
- **Engagement with the home –** due to the legal implications with covert administration, prescribers must engage with the home to complete the process and the necessary paperwork. Failure to do so may result in a safeguarding referral as it could be deemed causing obstruction to care.
- **Mental Capacity Assessment (MCA)** – must be completed prior to proceeding with covert administration of medication. This can be completed by an **appropriate healthcare professional or care home staff member** but the prescriber must be satisfied a MCA has been completed (appendix 3). A copy of the MCA must be filed within the clinical notes and a copy given to the care home.

- **Best interest decision** – must be completed by a prescriber prior to covert administration (appendix 4). A copy of the documentation must be filed within the clinical notes and a copy given to the care home.
- **Medication review** – if covert administration is deemed necessary, a full medication review must be undertaken. Only medication essential to health / wellbeing should be given covertly. Consider stopping medication as the least restrictive option.
- **Individualised care plan for medication administration** – advice should always be sought from a pharmacist. This plan should ideally be signed by the pharmacist and the prescriber (appendix 5). It is helpful if these directions for administration are added to the prescribing directions on the clinical system; these directions will then be printed on the care home MAR charts.
- **Review ongoing need for covert administration** – dependent on the physical state of the individual. As a minimum a review should be undertaken every 6 months or sooner if the person's condition changes. Documentation must be updated at each review (appendix 7).

17.2 Pharmacist

- **Advice on the suitability of administering medication covertly** – must be sought from a pharmacist. Reference sources must be consulted (BNF, SPC etc.) as well as specialised reference sources (NEWT etc.). It may also be appropriate for a pharmacist to be involved with the medication review.
- **Individualised care plan for medication administration** – should be signed by the pharmacist providing the advice to the home and the prescriber (appendix 5).

17.3 Care home

- **Person's preferences** – must be ascertained and documented (appendix 2) this may help to reduce the need for covert administration of medication.
- **Mental Capacity Assessment** – must be undertaken if the care home feel a person may require covert administration of medication (appendix 3).
- **Best interest decision** – a meeting must be arranged for the prescriber, care home and family or advocate of the person to discuss the need for covert

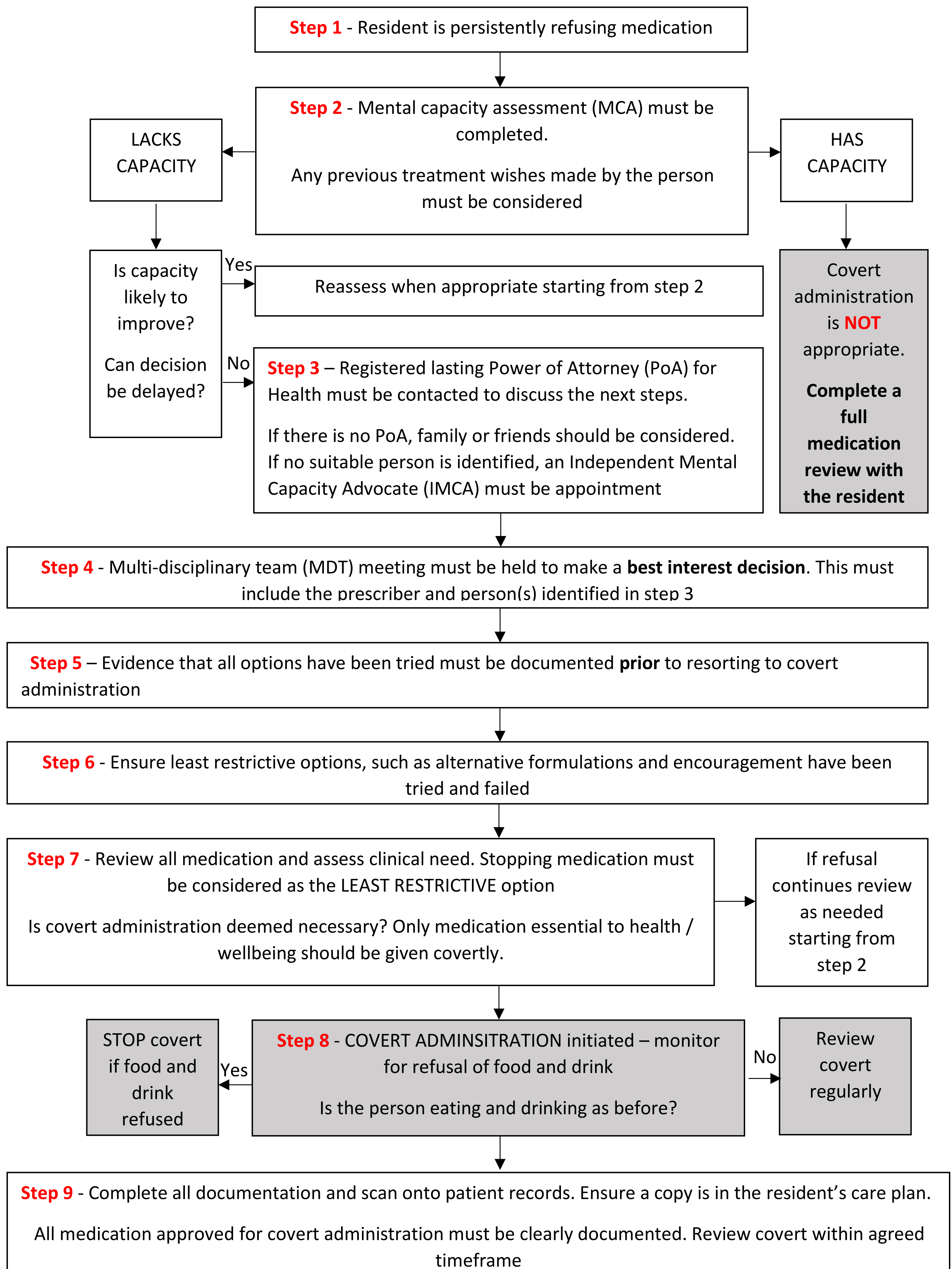
administration. Paperwork must be signed by the prescriber and a copy kept in the care plan (appendix 4).

- **Individualised plan to administer medication covertly** – advice must be sought from a pharmacist as not all medication is suitable to be administered in this way. A copy must be included in the care plans and with the MAR charts. (appendix 5).
- **Documentation** – care plans must be updated to reflect that covert administration is in place. MAR charts must be key coded appropriately to enable accurate audit and review of the continued need for covert administration. Care home managers must ensure the medication policy accurately reflects how covert administration is managed within the home.
- **DoLS referral** – should be made if deemed appropriate.
- **Carer's agreement** – should be signed by all staff administering medication covertly. This is to confirm they have read and understood this document and local policy and will adhere to the principles outlined in it.
- **Training** - Care home managers must ensure carers administering medication are aware of the implications of covert administration and ensure staff are competently trained to administer and complete necessary documentation.
- **Changes of dietary requirements** – must be communicated to kitchen staff must if a person requires covert administration of medication.
- **Regular reviews** – homes must request that covert administration is reviewed within the timeframe agreed during the best interest decision meeting. A review should be requested sooner if there are concerns that the person's health or wellbeing has deteriorated. Documentation must be completed by the prescriber at the time of the review (appendix 7). If healthcare professionals are not engaged in the review process, the medicines optimisation team in the appropriate locality must be notified. It may also be necessary to safeguard any lack of engagement given the legal implications with covert administration.

Medications should only be administered in accordance with the approved guidance provided by the prescriber and pharmacist.

Appendix 1 - Covert medication flow chart

This flow chart is to be used in conjunction with the 'Guidance on the use of covert administration of medication in care homes' document.



Appendix 2 – Individual preferences for medication administration

A copy of this form should be completed by the home and included in the resident's care plan and with the Medicines Administration Record (MAR) chart.

This form is to be used in conjunction with the covert administration of medicines in care homes guidance.

Name of resident:		Date mental capacity assessment (MCA) completed:	
Name of person who completed MCA:		Date of birth:	

Capacity assessment - Note briefly an answer to the below points. This is a good indicator of the patient's baseline and will help to form a decision whether covert administration is required.

How does this person usually communicate?	
How does this person usually indicate yes / ok?	
How does the person indicate no / stop?	
Consider factors that may be relevant in the assessment of capacity	
Suitable environment / time of day to try and administer medication	
Possible effects of medication, for example drowsiness	
Sensory or physical impairment	
Cultural factors	

Appendix 3 - Mental capacity assessment

This form must be completed by an **appropriate healthcare professional** (GP, Advanced Nurse Practitioner etc.) or **care home staff** for any resident requiring covert administration. Please provide a copy of this to the care home and scan a copy into the patient notes.

Name of patient:		Date of birth:	
Care home:		Date of assessment:	
Name of power of attorney for health (if nominated):			

Mental Capacity assessment for the administration of covert medication

What is the particular decision or action being assessed? Please provide as much detail as possible	

A mental capacity assessment must always be undertaken prior to proceeding with covert administration. Covert administration must only be considered in those individuals who lack capacity around medication.

Stage 1 - Functional tests of capacity	
Does the impairment or disturbance mean the person is unable to make a specific decision when they need to? If yes, give brief details	Yes / No

If the answer to the above question is no, the person does not lack capacity under the Mental Capacity and the use of covert administration must not proceed. **If the answer to the above question is yes, then below must be completed.**

Please indicate Yes / No for each point below and describe how this was assessed. It is not sufficient to state the diagnosis as a reason, for example 'has dementia'	
Is the person able to understand the information relevant to the decision?	Yes / No
Is the person able to retain that information?	Yes / No
Is the person able to use or weigh up that information as part of the process of making the decision?	Yes / No

Is the person able to communicate the decision?	Yes / No

If the answer to any of the above is 'No' the diagnostic test must be completed

Stage 2 – Diagnostic Test	
Does the person have impairment, or a disturbance in the functioning of their mind or brain? If yes, give details of the impairment or disturbance. **Stating just a diagnosis as the reason for covert is not sufficient**	Yes / No

'No' to any of the questions above demonstrates lack of capacity for this decision

Is capacity likely to fluctuate or improve?	Yes / No
If yes, can the decision be delayed?	Yes / No
Date of reassessment in the event of delaying	

The following must be completed for the evidenced decision

This person **LACKS** capacity to make the decision detailed above	
Name of assessor	
Signature	
Job title	
Expected review date	

This person **HAS** capacity to make the decision detailed above	
Name of assessor	
Signature	
Job title	
Expected review date	

Stage 3 – Review of MCA	
Date of review, name of prescriber & comments	
Date of review, name of prescriber & comments	

If the person lacks capacity, a best interest decision meeting must be held between the care home, patient's advocate and pharmacist and best interest paperwork completed

Appendix 4 - Best interest decision

This form must be completed by a suitably competent **independent prescriber** for any patient requiring covert administration. Please provide a copy of this to the care home and scan into the patient notes on the GP system.

This form should be completed once a mental capacity assessment has been undertaken and appropriate paperwork completed

Name of patient:		Date of birth:	
Care home:		Date of assessment:	
Name of power of attorney for health (if nominated):			

When was a Mental Capacity Assessment (MCA) for covert administration last completed? Covert administration **must only** be considered for a person who lacks capacity		
What treatment is being considered for covert administration? Each medication must be documented, it is not appropriate to state 'all medications'. Only medication essential to the person's health or wellbeing should be given covertly		
It has been confirmed that no advanced decision are in place concerning this treatment	Confirmed by:	
	Signature:	
1. Why is treatment necessary? 2. How will the person benefit? 3. Could treatment be stopped? Only essential medications should be given covertly. Stopping medication must be considered as the least restrictive option *Where appropriate refer to clinical guidelines*		

<table>
<tr><td colspan="2">What alternatives have been considered?
Why were these not successful?

For example, other techniques and strategies to manage the patient or alternative administration methods</td><td colspan="2"></td></tr>
<tr><td colspan="2">Is there a person nominated with the power to consent for example power of attorney for health? If yes, state name

If yes, have they been involved in the decision to administer medication covertly? If no, please give details of why</td><td colspan="2">Yes / No

Name of nominated person with power of attorney for health:</td></tr>
<tr><td colspan="2">Is the person subject to a Depravation of Liberty Safeguard (DoLS)?

If yes, the DoLS may need to be updated</td><td colspan="2">Yes / No</td></tr>
<tr><td colspan="2" rowspan="4">Who was involved in the decision?

A pharmacist must be consulted for advice on crushing tablets and / or mixing with food and drink as some medication may not be suitable. The care home must also have written confirmation of which medications are to be given covertly and confirmation of how they are to be administered.</td><td>Name & signature of prescriber:</td><td></td></tr>
<tr><td>Name & signature of care home staff:</td><td></td></tr>
<tr><td>Name & signature of patient’s relative or advocate:</td><td></td></tr>
<tr><td>Name & signature of pharmacist:</td><td></td></tr>
<tr><td colspan="2">How frequently will covert administration be reviewed?

This will be a patient specific decision but it is suggested a minimum of 6 months. Patients with fluctuating capacity will require more frequent reviews (at least 3 monthly)</td><td colspan="2"></td></tr>
<tr><td colspan="2">Prescriber name and designation:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Signature:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Date:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Date of review, name of prescriber and any comments</td><td></td></tr>
<tr><td colspan="3">Date of review, name of prescriber and any comments</td><td></td></tr>
</table>

Appendix 5 - Medication authorised for covert administration

Only medication listed below is authorised for covert administration. It must be clearly documented how staff are to administer medication covertly, for example tablet to be crushed and mixed with yoghurt. A pharmacist must be consulted for advice on how to administer the medication as not all medication is suitable to be crushed / mixed with food or drink etc.

Medication must be overtly offered to the resident before covert administration is used.

Medication Details Name, strength, & form e.g. Aspirin 75mg tablet	**Instructions for administration** clearly document how medication is to be administered for example if it is to be crushed and what food or drink to mix medication with	**Date advice given**

New medications should be added to the above table once commenced by an appropriate healthcare professional. Document a review below when table is updated.

Name & signature of independent prescriber authorising covert administration:	
Name & signature of Pharmacist and employing organisation consulted for advice:	
Date covert administration commenced:	
Date of review & reason:	
Date of review & reason:	

Appendix 6 – Carers agreement and guidance for carers administering medications

This form should be read in conjunction with the 'Guidance on the use of covert administration of medication in care homes' document, your local medication policy and the covert administration checklist.

A copy of this form should be completed for each person in the home with a covert plan agreed and should be kept in the person's care plan and with the MAR charts.

Once you have read these documents, you should sign the below as an agreement that you, as a member of care home staff administering medication:

- have understood its contents
- will abide by the information contained in both documents
- will not administer medication covertly unless it has been agreed by a healthcare professional and the correct paperwork is in place and within date
- covert medication will only be administered in accordance to the 'medication authorisation for covert administration' document and you will not deviate from this
- any concerns as a direct result of covert administration will be reported to the healthcare professional immediately
- documentation is completed as outlined in the guidance and local policy

Name of patient:		**Date of birth:**	
Date of birth:		**Date covert agreed:**	
Review date:		**Review date:**	

Name	**Job title**	**Date guidance read**

Name	Job title	Date guidance read

Checklist for care homes for covert administration

- Medication must always be offered overtly on **every occasion** before covert administration is implemented unless it is clearly stated on the best interest decision not to do so.
- If medication is accepted by the resident when offered overtly the administration should be signed on the MAR chart in the usual manner.
- If covert administration is used, the MAR chart should be annotated with the most appropriate key code. The key code used will depend on the MAR chart in use but these can be found printed on the bottom of the chart. Examples include ‘G’ or ‘O’. The reverse of the MAR chart must be completed to document covert administration.
- If medication is to be mixed with food or drink, the smallest amount possible must be used, for example a small teaspoon of yoghurt or jam. Never sprinkle the medication over an entire meal as there is a risk the resident will not consume it all.
- Multiple medications must never be mixed together. One medication must always be given at a time so it is easier to identify which medication has been taken.
- The senior staff member responsible for the medication round must be the person administering the medication, even if this is mixed with food or drink. **Under no circumstances must this be delegated**.
- If medication has been mixed with food or drink and the resident only partially consumes this, it is unlikely a full dose has been taken. An entry must be made on the reverse of the MAR chart to document refusal of food containing medication.
- If a resident has multiple medications prescribed, it may be necessary to ask the prescriber which medications are the most important to be administered and ensure these are always given first.
- **Medications should only be administered in accordance with the approved guidance provided by the pharmacist and prescriber. Always refer to the advice table.**

The prescriber must be notified if:

- Covert administration results in the resident refusing to eat or drink. This may lead to dehydration and/or malnutrition. Some medication may alter the taste of food and drink.
- The resident is suspected to have only taken a partial dose of medication. This tends to occur when the food or drink the medication is mixed in has not been fully consumed. This must be documented on the MAR chart
- There appears to be a deterioration in the resident's health or wellbeing.

Appendix 7 - Covert administration review form

This form must be completed by a suitably competent independent prescriber when reviewing a resident having medication administered covertly. Please provide a copy of this to the care home and scan into the patient notes on the GP surgery system.

Name of patient:		Date of birth:	
Care Home:		Date of review:	

Date Mental Capacity Assessment (MCA) for covert administration last completed and by whom? MCA must be repeated if the person's capacity may have changed			
Is medication still necessary? If yes, briefly explain why			
Is covert administration still necessary? If yes, briefly explain why			
Who was consulted as part of the review to administer medication covertly?			
Is any appropriate legal documentation still in place and valid, including Deprivation of Liberty Safeguards (DoLS)?			
Are there any changes to medication? If yes, please document and ensure the 'Medication for covert administration' has been updated.			
Date of next review: *This will be a patient specific decision but it is suggested a minimum of 6 months. Patients with fluctuating capacity will require more frequent reviews (**at least** 3 monthly)*			
Prescriber name and designation:		Signature:	
Care home staff name and designation:		Signature:	

18. References

1. Arden&GEM – Best practice guidance – mental capacity of the patient and covert medication. September 2018. https://www.knowledgeanglia.nhs.uk/LinkClick.aspx?fileticket=Bjnza0jMYUY%3d&tabid=519&portalid=1&mid=1233
2. UKMI PrescQIPP Bulletin 101 Best practice guidance in covert administration of medication. September 2015.
3. Care Quality Commission. Key lines of enquiry, prompts and ratings characteristics for adult social care services 20171020-adult-social-care-kloes-prompts-and-characteristics-showing-changes-final.pdf (cqc.org.uk) (accessed 26/09/24)
4. Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/section/1 (accessed 26/09/24)
5. Human Rights Act 1998 http://www.legislation.gov.uk/ukpga/1998/42/contents (accessed 26/09/24)
6. Mental Capacity Act – Code of Practice Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act (pages 53-54). http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf
7. College statement on covert administration of medicines. Psychiatric Bulletin 2004; 28: 385-386. http://pb.rcpsych.org/content/28/10/385 (accessed 26/09/24)
8. NMC. The Code: Professional standards of practice and behaviour for nurses and midwives. October 2018 https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
9. Royal Pharmaceutical Society and Royal College of Nursing. Professional Guidance on the administration of medicines in healthcare settings. January 2019. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567
10. NICE guidance SC1. Managing medicines in Care homes. March 2014. http://www.nice.org.uk/guidance/sc/SC1.jsp (accessed 26/09/24)

11. Covert medication - ever ethically justifiable? Psychiatric Bulletin 2002; 26: 123-126. http://pb.rcpsych.org/content/26/4/123.full (accessed 26/09/24)

12. UKMI PrescQIPP Bulletin 8 Optimising safe and appropriate medicines use. June 2013.

13. Wright et al. April 2019. Medication management of patients with nasogastric (NG), percutaneous endoscopic gastrostomy (PEG), or other enteral feeding tubes https://www.guidelines.co.uk/medication-management-of-patients-with-enteral-feeding-tubes/454634.article (accessed 11/11/19)

Title	Guidance on the use of covert administration of medication in care homes
Description of policy	To inform healthcare professionals
Scope	Primary care and care homes
Prepared by	Medicines Optimisation Team
Evidence base / Legislation	Level of Evidence: *A. based on national research-based evidence and is considered best evidence* ***B. mix of national and local consensus*** *C. based on local good practice and consensus in the absence of national research based information.*
Dissemination	Is there any reason why any part of this document should not be available on the public website? ☐ Yes / No ☒
Approved by	*TBC*
Authorised by	*TBC*
Review date and by whom	October 2026 - Medicines Optimisation Team
Date of issue	October 2026

Version Control (To be completed by policy owner)

Version	**Date**	**Author**	**Status**	**Comment**
0.1	June 20	HH	DRAFT	Adapted from PrescQIPP documents
1.0	September 2020	Medicines Optimisation Team	Final	Approved by TAG
1.1	January 2024	Medicines Optimisation Team – HH	Review	Logo changed. Email adress updated.
1.2	October 2024	Medicines Optimsation Team – HH	Review	Minor amendments to wording. References checked