NHS
Norfolk and Waveney
Integrated Care Board

Covert Administration – Executive Summary

Covert administration should only be used in exceptional circumstances where a person lacks capacity to understand the need to take prescribed medication and when all other attempts to administer medication have failed. **Covert administration must never be used where a person has capacity to refuse a medication.**

Covert administration must be:

- **Last resort** – all other options must have been exhausted.
- **Medication specific** - it should only be used for medication deemed essential. A full medication review should be undertaken.
- **Time limited** – should be used for the shortest possible time
- **Regularly reviewed** – at least 6 monthly/ more frequently if capacity fluctuates.
- **Transparent** – the decision making process must be clear to follow.
- **Inclusive** – discussions must take place with appropriate advocates prior to initiating covert administration. This includes Lasting Power of Attorney (LPA)
- **Best interest** – decisions must be in the individual's best interest.

Step 1: Mental capacity assessment (MCA) – this must be completed and the outcome documented prior to proceeding with covert administration. This can be completed by the care home or an appropriate Healthcare Professional.

Step 2: Best Interest Decision – a meeting must be held between the home, GP (or other suitable healthcare professional (HCP)) and family/ advocates of the person; ideally this should be face to face. A pharmacist's advice must be sought with regards to crushing medication / opening capsules or mixing medication with food.

Step 3: Administration of Covert Administration – the HCP alongside the pharmacist, should determine the most suitable form of medication for covert. Homes must be given clear guidance on how each medication is to be administered.

Step 4: Practical points for administering medication covertly – Only medication trained staff can administer medication covertly. All medication must be offered overtly every time unless agreed in the best interest meeting that this may cause distress; this must be clearly documented.

Step 5: Documentation - The HCP must ensure they have documentation of both the MCA and the Best Interest Decision within the clinical notes. The care home should also have these documents within the resident's care plan.

Step 6: Review – a formal review should take place at least every 6 months but this may be sooner. The frequency of review should be decided at the best interest meeting.

Responsibilities

Healthcare professional

- **Engagement with the home** – failure to do so may result in a safeguarding.
- **MCA** – must ensure this has been completed prior to proceeding with covert administration. The healthcare professional may choose to undertake this.
- **Best interest decision** – any decision must be discussed with the home and family, friends or advocates of the person. They must ensure the decision is clearly documented.
- **Medication Review** – a full medication review must be completed. Non-essential medication should be reviewed as stopping medication is deemed as the least restrictive option. Ideally this should be completed with a pharmacist.
- **Administration care plan** – the home must be provided with a clear plan for how each medication is to be administered; this can be delegated to a pharmacist.
- **Review ongoing need** – review at least 6 monthly or sooner if the person's condition changes. Documentation must be updated at each review.

Pharmacist

- **Review suitability of administering medication covertly**
- **Administration care plan** – provide the home with clear instructions for how to administer each medication covertly.

Care Home

- **Person's preferences** – to how they like to take their medication usually should be established and documented.
- **Mental Capacity Assessment** – should be completed and documented
- **Best Interest Decision** – facilitate a meeting between the healthcare professional, family / friends / advocate and home. Ensure the decision is clearly documented and a copy of this kept in the care plan.
- **Administration care plan** – details exactly how each medication is to be given. A copy of this must be kept with the MAR charts and care plan.
- **Documentation** – care plans must reflect covert administration is in place. MAR charts must be key coded appropriately to identify when covert administration has been used.
- **Deprivation on Liberties** – referral must be made
- **Carer's agreement** – all staff administering medication covertly should have read, understood and signed to confirm they will adhere to the guidance.
- **Training** – managers must ensure carers are aware of the legal implications of covert administration and are appropriately trained.
- **Changes to dietary requirements** – kitchen staff must be made aware if a person requires a change of diet to facilitate covert administration.
- **Regular review** – home must ensure a review is undertaken within the timeframe agreed at the best interest meeting. Review all documentation.