Birmingham and Solihull Mental Health NHS Foundation Trust

Covert Administration of Medicines Policy

Policy number and category	**C 10**	**Clinical**
Version number and date	**2**	**August 2024**
Ratifying committee or executive director	**Trust Clinical Governance Committee**	
Date ratified	**December 2024**	
Next anticipated review	**December 2027**	
Executive director	**Executive Medical Director**	
Policy lead	**Chief Pharmacist**	
Policy author *(if different from above)*	**Lead Pharmacist for Older Peoples Services**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

- To inform staff on the circumstances in which covert administration may be appropriate and how to meet the criteria for covert administration of medication to ensure it is legal, effective and in the best interest of the patient.
- To inform staff on the necessary documentation supporting covert medicines administration that includes all relevant information and discussion.
- To inform staff on the procedures that need to be followed when administering medication covertly and recording of the administration.
- To inform staff on the arrangements for an appeal.

Policy requirement (see Section 2)

- All staff involved in the covert administration of medication to a patient must be aware that this can **ONLY** be considered when the patient is confirmed to have a lack of capacity **specific** to making decisions about their medication.
- All patients refusing medication will be assessed by the responsible clinician in consultation with a full multidisciplinary team (MDT). This must include a pharmacist.
- All staff undertaking any part of the covert administration process must understand the legal and ethical implications associated with it.
- All staff administering medication covertly must ensure that the process is fully documented and agreed before medication is given.
- All staff administering medication covertly must only do so in line with a Treatment Plan clearly documented in the patient record.
- The use of Covert Administration of Medication will be audited by Pharmacy to ensure adherence to this policy and accepted good practice.

Contents

Change Record

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
14th August 2024	2.0	Siobhan Charmer/Nigel Barnes	Policy Review	Clinical Governance Committee

1: Introduction:

1.1 Rationale

This policy outlines the legal background to the covert administration of medication and outlines the process that should be followed to ensure that it is legal, appropriate and in the best interests of the patient. Covert administration not complying with this policy should not be carried out within BSMHFT.

This policy should be read in conjunction with the reference sources detailed in Section 6.

1.2 Scope

- This policy covers the covert administration of medicines in people aged 16 or over, who are inpatients within the Trust.
- This policy covers administration of medicines where there is intention that the administration is concealed from the patient and that the medicines are required to be deliberately disguised before administration to enable concealment.
- This policy covers all staff working in the Trust, including agency and bank staff, permanent and temporary staff, who are involved in any way with the covert administration of medicines. All staff must familiarise themselves with the correct procedures contained in this policy. Those staff in charge of wards/teams and departments are responsible for ensuring that their staff, especially new starters and locum staff, follow procedures in this policy. Copies of the policy should be available in all wards/teams and departments or via the Trust Intranet.
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1.3 Principles

Covert administration of medication occurs when medicines are administered in a disguised format. Medicines could be hidden in food, drink or given through a feeding tube without the knowledge or consent of the person receiving them. This means the person does not know they are taking a medicine. When a person has mental capacity to make the decision about whether to take a medicine, they have the right to refuse that medicine. They have this right, even if that refusal appears ill-judged to staff or family members who are caring for them.

Covert medication **CANNOT** be given to anyone with capacity to refuse medication even if that may lead to a detrimental outcome.

The Mental Health Act [1] (MHA) overrides the right to refuse treatment in specific circumstances. It gives authority to provide psychiatric treatment to a patient detained under its powers, without their consent, which may include authority to give psychiatric medication covertly. This does not override the need for all aspects of the policy to be followed and a Covert Administration Care Plan to be put in place.

Where covert administration is considered to be the most appropriate option, the following principles should be seen as good practice:

- Last resort - covert administration is the least restrictive option when all other options have been tried and should not be used routinely or without following the policy.
- Medication specific - the need must be identified for each medication prescribed by conducting a clinical medication review.

- Time limited - it should be used for as short a time as possible.
- Regularly reviewed - the continued need for covert administration must be regularly reviewed within specified time scales as should the person's capacity to consent.
- Transparent - the decision-making process must be easy to follow and clearly documented.
- Inclusive - the decision-making process must involve discussion and consultation with appropriate advocates for the patient. It must not be a decision taken alone.
- Best interest decision - all decisions must be in the person's best interest with due consideration to the holistic impact on the person's health and well-being.

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2: The policy:

- All staff involved in the covert administration of medication to a patient must be aware that this can **ONLY** be considered when the patient is confirmed to have a lack of capacity **specific** to making decisions about their medication.
- All patients refusing medication will be assessed by the responsible clinician in consultation with a full multidisciplinary team (MDT). This must include a pharmacist.
- All staff undertaking any part of the covert administration process must understand the legal and ethical implications associated with it.
- All staff administering medication covertly must ensure that the process is fully documented and agreed before medication is given.
- All staff administering medication covertly must only do so in line with a care plan clearly documented in the patient record.
- The use of Covert Administration of Medication will be audited by Pharmacy to ensure adherence to this policy and accepted good practice.
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3: The procedure:

3.1 Understand what covert administration is:

Covert administration of medication occurs when medicines are administered in a disguised format. Medicines could be hidden in food, drink or given through a feeding tube without the knowledge or consent of the person receiving them. This means the person does not know they are taking a medicine. This is different to facilitated administration, which is when medicines are incorporated into either food or drink to aid administration, with the full knowledge of the patient.

3.2 Medicines Optimisation and Non-Adherence

Many individuals do not take medication as prescribed for a variety of reasons. This can lead to treatment failure and relapse. Failure to follow a prescribed treatment may be

incorrectly interpreted as evidence of a mental illness or a lack of capacity. Staff need to determine the reasons for this non-compliance and support individuals who do not want to take the medication by considering alternative ways to meet the individual's needs, rather than making decisions for them.

Reasons for poor compliance may include:

- Lack of information about the medication or its purpose.
- Concerns about side-effects or the risk of dependency.
- Lack of understanding about need for long-term treatment.
- The patient may feel well and not see the need for treatment anymore or may not feel it is effective.
- Poor relationships with either the prescriber or caregivers.

There are some simple steps that should take place to improve concordance, including:

- Inclusion of service user, their family and carers in any decision to prescribe medication.
- Determine reasons why the service user does not want to take the medication and address the concerns.
- Regularly discuss medication with the service user and inform them of any changes.
- Offer alternatives (formulations or other medications) if clinically appropriate and allow a choice as this may increase the service user's feeling of control over their wellbeing.
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3.3 When might covert administration be appropriate or necessary?:

Covert administration is only likely to be necessary or appropriate where:

- assessment has been carried out to try to understand why the person is refusing to take their medicines and alternative methods of administration have been considered which might include a change in medication, a change in formulation, change in route of administration or a change in time of administration and
- a person actively and persistently refuses their medicine and
- that person is assessed under the Mental Capacity Act 2005 [2] to not have the capacity to understand the consequences of their refusal.
- the medicine has been discussed in a best interest meeting and is deemed essential to the person's health and wellbeing.

The effects of the use of covert administration of medication on the therapeutic alliance must be considered in detail, especially on patients who might regain capacity, or who might detect the use of covert administration.

The decision-making process must be easy to follow and clearly documented.

3.4 Evaluation of Suitability for Covert Administration

Appendix 2 - The Covert Medication Flowchart must be used in conjunction with the full Covert Administration of Medicines policy.

Step 1 - Capacity Assessment and Documentation

Before considering covert administration, you should test decisions and actions against the five key principles under the Mental Capacity Act 2005 [2] and apply the Code of Practice [3].

The first three principles relate to the process before or at the time of determining whether the patient lacks capacity.

> **Principle 1**: You should always start from the assumption that the patient has the capacity to make the decision in question.
>
> **Principle 2**: You should also be able to show that you have made every effort to encourage and support the patient to make the decision themselves.
>
> **Principle 3**: You must also remember that if a person makes a decision which you consider to be eccentric or unwise, this does not necessarily mean that the patient lacks the capacity to make the decision.

A patient will be considered to lack the capacity to make a specific decision about their medication at the time of the assessment, if they are unable to do ONE OR MORE of the following actions, AND there is evidence of a diagnosis of an impairment of the patient's mind or brain that is affecting their ability to make the decision:

- Understand a simple explanation of what the treatment is, what it should do and why it is being prescribed.
- Assess the benefits and risks of the treatment, and what alternatives there are.
- Understand in broad terms what will be the consequences of not receiving the proposed treatment.
- Retain the information long enough to make an effective decision.
- Communicate their decision and the reasons for their decision in any form (spoken, written, sign language etc.).

It is important to note that capacity may fluctuate with time and should be reassessed regularly. The capacity assessment should be recorded in the appropriate Mental Capacity section of RIO.

The Mental Health Act [1] (MHA) overrides the right to refuse treatment in specific circumstances. It gives authority to provide psychiatric treatment to a patient detained under its powers without their consent. This may include authority to give psychiatric medication covertly, however a specific case for the legal and ethical justification for this would need to be first established and further advice should be sought from the Mental Health Act Office.

Administering medication without knowledge is different to administering medication without consent and may impact on the therapeutic alliance or the person's willingness to accept food or drink if they suspect that covert administration is taking place. Consideration also needs to be given to whether a person would make a different decision about taking their physical health medication, if they were aware they were taking mental health medication that has side effects that affect their physical health, and how ongoing compliance with medication following discharge will be achieved for a person who was not aware they were receiving medication during their admission.

Treatment powers under the MHA are limited to treating a patient's **mental** health. Where the patient has capacity to make decisions about their treatment, it is **not** appropriate to give medicines covertly to treat any patient's physical health, even if they are under a MHA Section. It is however, permitted to administer a physical health medication under the MHA if it is being given to manage or treat side effects due to a mental health medication e.g. hyoscine used for clozapine induced hypersalivation.

This can be simplified as follows:

- Patient detained and medication is for mental health – use MHA
- Patient NOT detained and medication is for a mental health – use MCA
- Patient detained and medication only for physical health – use MCA
- Patient not detained and medication only for physical health – use MCA

For patients not detained under the MHA, DoLS authorisation or the permission of the Court should be obtained if covert administration of medicines is being considered, particularly if that medication will affect someone's behaviour, or act as a sedative, as these may be considered factors in depriving a person of their liberty. The covert administration of medicines must be clearly identified within the DoLS authorisation.

Step 2 – Best Interest Decision

Once it has been decided and documented that the patient lacks capacity to make decisions about medication, principles 4 and 5 of the Mental Capacity Act 2005 [2] should be used to support the decision as to whether covert administration should proceed, and a best interest meeting or discussion must be held.

> **Principle 4**: Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
>
> **Principle 5**: When making a decision on behalf of a person who lacks capacity, it should ideally be the least restrictive option of the person's rights and freedoms.

If it is not possible to arrange a separate meeting outside of the weekly MDT meeting, then it may be appropriate to incorporate the best interest discussion in the MDT meeting as long as sufficient time is allocated to carry out and document the requirements of the policy. Attendees should include the prescriber, a pharmacist, a nurse and either a family member, friend or advocate. If the patient has an attorney appointed under the MCA for health and welfare decisions, this person should be invited to the meeting. If a pharmacist cannot be present their advice should be sought before the decision to proceed to covert administration is made, in order to check the suitability of the medication to be administered in this way and implement any recommended changes.

If the situation is urgent, it may be acceptable for a less formal discussion to occur between the nursing staff, prescriber, pharmacist and family member or advocate to make an urgent decision, however this does not override the need for all aspects of the policy to be followed to ensure that the administration will be carried out legally, safely and consistently with a Covert Administration Assessment and Care Plan put in place. A more formal meeting should be arranged as soon as possible.

There should be a record of the name and role of all attendees. Where a pharmacist is unable to attend the meeting in person, the name of the pharmacist and the advice received should be recorded with the notes of the meeting.

The checklist below is taken from the Mental Capacity Act 2005 [2] and should guide discussions whether the patient is detained under the MHA or is informal/under DoLS:

- Consider **all** the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision or leading to discrimination.
- Consider delaying a decision until the person regains capacity, if likely.
- Involve the person as much as possible.
- If the decision is related to life sustaining treatment, it must not be motivated by an intention to hasten death.

- Consider the individual's own past and present wishes, feelings, values and beliefs.
- Consider advance statements if any exist.
- Take into account views of family and informal carers.
- Take into account the views of the Lasting Power of Attorney appointed for health and welfare decisions
- Take into account views of Independent Mental Capacity Advocate (IMCA), Relevant Person's Representative (RPA), or other key people if involved.
- Show it is the least restrictive alternative or intervention.

Stopping medication should be considered as a possible least restrictive option. If this is the case, the reason must be documented in the patient's notes. Patterns of behaviour need to be considered, and whether changes to administration would help e.g. timing, environment, specific carers, or formulations that can be given less often or are more palatable.

The team must consider the possible impact of the patient's discovering the attempts at covert medication, particularly with respect to subsequent refusal of diet and fluids, and impairment of the therapeutic relationship. These considerations might restrict the utility of covert medication to circumstances where the patient has on-going-impaired cognition, such that the covert administration is unlikely to be recognised both at the time of covert administration and subsequently.

Step 3 – Assessment of Medication

If the best interest decision is to proceed with covert administration, each medication needs to be assessed for both the clinical need and suitability for administering covertly. A pharmacist must either be present at the meeting, or consulted **before** any medication is given covertly. The following considerations should be addressed for each prescribed medication:

- Is the medication deemed vital or can it be stopped? The meeting should consider if the benefits of treatment are so great that they warrant administering medication covertly. A holistic view is required, and the team must also consider the impact of side effects of administered mental health medication, for example increased risks of stroke or metabolic side effects, and the risks of not administering any physical health medication that may help reduce risk of stroke or treat diabetes.
- Is the formulation suitable? Modified release and enteric-coated tablets are not suitable for covert use as they generally should not be crushed. If there is no alternative, the reason and anticipated consequences of doing this must be documented.
- Is a licensed liquid formulation available? These are usually easier to mix with food or liquids, though taste, volume of medication and colour should be considered when deciding what to mix them with.
- The Consultant Psychiatrist together with the Pharmacist will consider ethical, cultural or religious beliefs that could affect the choice of medicines. The advice and recommendations should be documented in the patient's medical notes.
- The proposed treatment and possible methods of administration should be discussed with the Pharmacist to ensure that medication will not be affected by incompatibility with food or drinks, crushing or dispersing in water.

- Any change to the formulation of a medication to aid administration will make the use of that medication unlicensed and this must be acknowledged in the patient notes by the prescriber, who takes sole responsibility for this.
- It may be appropriate to consult kitchen staff if dietary changes are needed to facilitate covert administration.
- It is the responsibility of the prescriber and pharmacist to ensure that covert administration will not cause unnecessary harm to the patient or the person administering it. Is the medicine cytotoxic? Preparing a cytotoxic medication for covert administration could pose a risk to staff members if not done appropriately. Is the medicine irritant? Crushing an irritant medication for covert administration could pose a risk to staff members if not done appropriately. Is the medication absorbed through the skin? This could cause risks for the staff member or foetus of a pregnant female staff member. Is the medication not suitable for crushing, e.g. modified release? Crushing a modified release medication could lead to an overdose for the patient.
- All reasonable efforts must be made to give the medication openly in its solid or liquid formulation unless doing so results in considerable distress for the patient.
- Where agreement between the doctor, nurse and pharmacist cannot be reached then covert administration **cannot** occur, but consideration must be given to the best interest decision and the requirement for treatment with the specified medicine.
- Whenever a new medication is added to a regime currently under a covert care plan, the care plan **must** be reviewed and include the new medication.

Step 4 – Documentation of Covert Administration

During or following the best interest meeting, the Covert Administration Assessment Checklist and Care Plan must be completed on the electronic RIO form [see Appendix 3 & 4 – paper copies].

These should document:

- Details of the capacity assessment.
- Whether the patient is currently detained under the MHA or is under DoLS.
- What alternative options have been trialled before considering covert administration.
- Details of any Advanced Decisions or Advanced Statements.
- Details of any authorisations for treatment e.g. 3-month rule, Consent to Treatment certificates, DoLS authorisation.
- What foods or drinks the patient is currently accepting that could be considered for facilitation of covert administration. Where a person is only accepting sealed food or drinks, consideration needs to be made as to whether it will be possible to administer medication covertly.
- What medication the patient is currently prescribed – this is a list of all current medication prescribed on EPMA.
- A review of all of the current medication and information about the need for each as carried out in Step 3.

- Whether alternative formulations can be used to facilitate covert administration, for example switching from modified release formulations to standard release tablets that can be crushed or liquids.
- Documentation of the agreement of the MDT members with the plan.
- Documentation of a family member/advocate involvement with the plan.
- Where covert medication is to be added to food or drink, the suitability of the drug-food combinations must be assessed by the pharmacist and indicated clearly in the plan.

Following the development of a covert administration care plan:

- An Eclipse form must be completed once the covert administration care plan has been agreed by the MDT. This is reflective of the fact this is a restrictive practice and requires additional scrutiny. Only one form for each care plan that is agreed for covert medicines administration is required, though it may be considered good practice to repeat this if any significant change is made to the plan. It should be agreed in the Best Interest meeting who will be responsible for completing the Eclipse.
- The care plan will be countersigned by the senior health professionals involved and this would usually involve a consultant psychiatrist and a senior registered nurse and a clinical pharmacist.
- The plan will record the names and views of carers who have been consulted.
- Staff should pass on information about covert administration of medication when transferring care, for example, a transfer to an acute trust for treatment.
- The form must include a record of any opposition to covert administration.
- The use of covert administration should be communicated in writing to the GP at the point of discharge.
- The care plan should be subject to **weekly** review, including that of capacity if the need for covert medication persists.
- Full reviews considering all aspects of the need for covert medicines administration should take place no less than every 3 months. This may be more frequent depending on the nature of the condition. All reviews must be recorded in the medical notes. They should consider the benefits of the treatment and whether it is still necessary to administer it covertly.
- While covert medication is being used, the list of medications considered ‘necessary’ must be updated to reflect any change to treatment.

Step 5 – Administration of Medication

- No drug should be administered covertly, or marked as for covert administration on EPMA, unless a covert care plan covering its administration is recorded on RIO.
- It is **NEVER** appropriate or permitted to administer medication covertly based on an adhoc written or verbal request.
- Each drug to be administered covertly must be indicated separately as such on EPMA. **NO** drug should be administered covertly unless covert administration is clearly indicated on the EPMA prescription.
- The method of administration should be clearly recorded on the inpatient prescription on EPMA. This should indicate what food/drink the medication should be administered in and if the medication needs to be crushed.

- If administered in food or drink, a member of staff must ensure that the food/drink is only ever administered or offered to the correct patient.
- Any concealed medication should be hidden within the smallest practical portion of the food to maximise the likelihood of the complete dose being taken. Concealed medication must not be mixed in a whole meal. Add the concealed medication to the first portion of the meal that is consumed, then once the concealed medication has been consumed, offer the rest of the food.
- A member of staff must monitor the patient until all of the food/drink which contains the medicine has been consumed, or until no more will/can be consumed. Any remaining medicine (plus food/drink vehicle) should be disposed of as medicines waste. If a member of staff is unable to monitor the patient, then covert administration is not suitable.
- The outcome of each administration episode must be clearly documented on the administration record on the EPMA system. Where a medication has not been openly accepted and has been refused, and subsequently the medication has been administered covertly, a problem with administration should be recorded, indicating Covert Administration – whole dose, partial dose or patient refused and adding any relevant notes. By recording covert administrations in this way, it is possible to differentiate between openly accepted and covertly administered doses at each review. Where only a partial dose of the medication was taken, or if it is not clear the whole dose has been taken, this must be clearly identifiable on EPMA to enable assessment of clinical effectiveness, side effects and inform whether dose changes are needed and can be safely implemented.
- The single biggest determinant of the success of covert administration is the consistency with which it is applied, and it is vital that the care plan is adhered to, especially with regards to the method of administration. Consistent timings of administration and administration in similar foods will result in steady drug levels which will allow adjustment of dosing based on the clinical presentation. Inconsistent application makes a clinical assessment much less reliable and can lead to incorrect evaluation of the therapeutic response. Same dose, same way, same time.
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3.5 MANAGEMENT ISSUE

Any medicines-related incident which occurs as a result of the covert administration of medicines should be reported via the Trust's incident reporting system, Eclipse, and following the Trust's Incident Reporting, Management and Investigations Policy.

3.6 APPEAL

If a member of staff, a relative, carer, friend or representative of the patient, or an IMCA wishes to raise concerns about the use of covert means to administer medication, or about the process by which it was decided to use such means, they can be referred to the Chief Mental Health Legislation Officer, Clinical Director for that clinical area, or the Pharmacological Therapies Committee.

3.7 ADVICE FOR NURSING STAFF

- As a general principle, by disguising medication in food or drink, the patient is being led to believe that they are not receiving medication when in fact they are. Registered practitioners will need to be sure that what they are doing is lawful under the MHA, MCA or DoLS and they will be accountable for their own

decisions and practice. It is therefore imperative that there is good record of discussions and decisions made by all relevant parties.

- The NMC no longer makes any individual recommendations about covert administration. They have instead published a joint statement with the Royal Pharmaceutical Society[4] relating to covert administration. The content is brief and refers to many other sources but reinforces the need for organisational policies to be in place and that they are followed.
- The Care Quality Commission (CQC) has also produced guidance [5,6] detailing what their expectations are around covert medicines administration. This advice has been incorporated into the Trust policy to ensure our practice meets the CQC expectations.

4: RESPONSIBILITIES:

Post(s)	**Responsibilities**	**Ref**
All Staff	To be aware of the policy and to follow it if administering medication covertly	
Service, Clinical and Corporate Directors	To follow and support the policy	
Policy Lead	To provide support for policy users and to update the policy as required	
Executive Director	To follow and support the policy	
Others…	To follow and support the policy	

5: DEVELOPMENT AND CONSULTATION PROCESS:

Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	Date(s)
Pharmacological Therapies Committee	August 2024
Clinical Governance Committee	November 2024
Professional Advisory Group - Medical	August 2024
Professional Advisory Group – Nursing	August 2024

Where received	Summary of feedback	Actions / Response

6: REFERENCE DOCUMENTS:

1 Mental Health Act 2007. Legislation.gov.uk [online] Available at: **https://legislation.gov.uk/ukpga/2007/12/contents** [Accessed 31/01/24].

2 Mental Capacity Act 2005 (2005), Legislation.gov.uk [online] Available at: **https://legislation.gov.uk/ukpga/2005/9/contents** [Accessed 31/01/24].

3 The Mental Capacity Act 2005 Code of Practice (updated 14/10/20), Office of the Public Guardian [online] Available at: **https://assets.publishing.service.gov.uk/media/5a750a3ce5274a59fa716ec7/OPG603-Health-care-workers-MCA-decisions.pdf** [Accessed 02/02/24].

4 Professional Guidance on the Administration of Medicines in Healthcare Settings Royal Pharmaceutical Society, Nursing and Midwifery Council (2019) [online] Available at: **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** [Accessed 31/01/23].

5 Brief Guide: Covert Medication in Mental Health Services (2018), Care Quality Commission (CQC) [online] Available at: **https://www.cqc.org.uk/sites/default/files/20180406_9001398_briefguide-covert_medication_mental_health_v2.pdf** [Accessed 31/01/23].

6 Covert Administration of Medicines – Guidance for Adult Social Care Providers, CQC (updated 3/11/22) [online] Available at: **https://www.cqc.org.uk/guidance-providers/adult-social-care/covert-administration-medicines** [Accessed 02/02/24].

7 Making Decisions a Guide for People Who Work in Health and Social Care (updated 10/05/2023), Office of the Public Guardian [online] Available at: **https://assets.publishing.service.gov.uk/media/5a750a3ce5274a59fa716ec7/OPG603-Health-care-workers-MCA-decisions.pdf** [Accessed 02/02/24].

8 The Code; Professional standards of practice and behaviour for nurses, midwives and nursing associates, Nursing and Midwifery Council (NMC) (2015, updated 2018) [online] Available at: **https://www.nmc.org.uk/standards/code/read-the-code-online/** [Accessed 02/02/24].

9 Medicines Management in Care Homes Quality Standard QS85, NICE (25/03/15) [online] Available at: **https://www.nice.org.uk/guidance/qs85** [Accessed 02/02/24].

7: BIBLIOGRAPHY:

No documents.

8: GLOSSARY:

- Covert – not openly acknowledged or displayed, i.e. hidden.
- Covert Administration (of medicines) – When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink.
- Facilitated administration (of medicines) – When medicines are incorporated into either food or drink to aid administration, with the full knowledge of the patient.
- Mental capacity – the ability to make one's own decisions. Legally, this is assumed to be true unless proven otherwise.

9: AUDIT AND ASSURANCE:

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangement
Compliance with policy including mental capacity, multidisciplinary decision making, EPMA recording and regular review of the need for covert administration	Clinical Directors and/or Chief Pharmacist	Audit	Every two years	Clinical Governance, PTC

10: APPENDICES

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	Covert Administration Policy		
Person Completing this policy	Siobhan Charmer	**Role or title**	Lead Pharmacist
Division	Corporate	**Service Area**	Wards and Teams
Date Started	January 2024	**Date completed**	August 2024
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
To provide a clear safe and legal framework to allow covert administration of medications within the Trust			
Who will benefit from the proposal?			
All staff and service users involved in the covert administration of medication.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
This policy affects service users who may require covert medicines administration and staff who are involved in considering its use and administering medicines covertly.			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
This policy covers any service where medicines may be administered covertly. It will reduce health inequalities by ensuring patients receive essential medicines in circumstances where they refuse such medication and they don't have capacity and where the multidisciplinary tam looking after them consider covert medicines administration to be in their best interests.			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? ***Eliminate discrimination?*** ***Eliminate harassment?*** ***Eliminate victimisation?***				***Promote good community relations?*** ***Promote positive attitudes towards disabled people?*** ***Consider more favourable treatment of disabled people?*** ***Promote involvement and consultation?*** ***Protect and promote human rights?***
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need. Modifications of dose or formulation may be required for younger or older patients.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by disability
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				

Gender	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by gender
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by marriage or civil partnership status
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by pregnancy.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by race or ethnicity. The methods of covert administration need to be sensitive to patient's religious faiths
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by race or ethnicity. The methods of covert administration need to be sensitive to patient's religious faiths

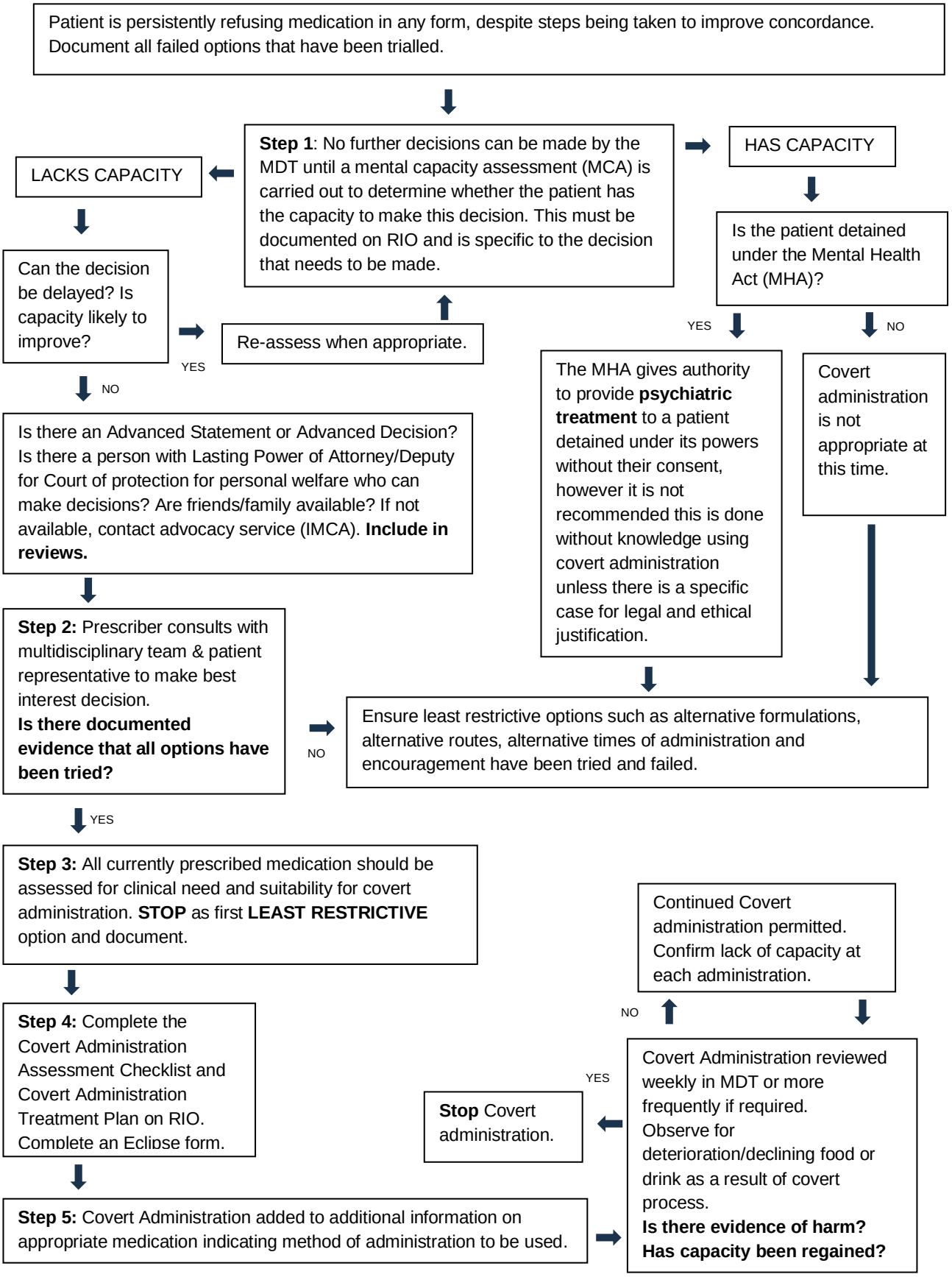
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by sexual orientation.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			Covert administration of medicines should be only provided to any patient on the basis of clinical need and should not be affected by gender reassignment.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	This policy is written to ensure that any covert administration of medication is legal and does not contravene service users human rights
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No** X		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
Ensure policy is circulated within the Trust and training is offered if needed
How will any impact or planned actions be monitored and reviewed?
Regular audit of all covert administration by pharmacy staff
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
N/A
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2: Covert Medication Flowchart

This Flowchart must be used in conjunction with the full Covert Administration of Medicines Policy



Appendix 3: Covert Administration Assessment Checklist

An electronic version of this checklist will be available on RIO and should be used instead of the paper version.

Patient Name:	RIO No:
Ward:	Consultant:

Checklist:

1. Is it clearly documented that the patient lacks capacity to provide informed consent to medications? (If the patient has capacity, covert administration is not appropriate unless under a MHA section and there is a specific case for legal and ethical justification for covert administration of psychiatric medication only).

Yes:	No:	Fluctuating:	Where documented?:		
			Mental Capacity 2	MC3a	Both

2.

Can the decision be delayed until the patient regains capacity?		Is capacity likely to improve?	
Yes:	No:	Yes:	No:

3. Is the patient currently detained under a MHA section or under DoLS?

MHA:	DoLS:

4. What other options have been trialled prior to considering covert administration?

5. Is there an Advanced Statement or Advanced Decision documented?

6. Are appropriate authorisations in place/required for any of the current medication? Consider 3-month rule, Consent to Treatment Certificates, DoLS authorisations as appropriate.

3-month rule	CTT Certificate(s) (state which)	DoLS authorisation	None required

7. What food or drinks is the patient currently accepting that may be a suitable vehicle for covert administration? NB if not accepting food or drinks, or only accepting sealed packing then covert administration is unlikely to be suitable at this time.

Food	Drinks

8. Details of MDT assessment of all currently prescribed medication on EPMA. (Please list all currently prescribed medication and use additional sheets if insufficient space).

Medication, form & dose	Details of the risk(s) if not administered	Are there less restrictive ways the medication could be administered other than covertly?	Requirement for covert administration agreed by MDT (Y/N)	Is the current prescribed form suitable for covert administration? If not, state recommended switch (**consultation with pharmacist required**, may require change in dose as well as form)	Medication to be stopped? Y/N	Medication to be continued but not to be administered covertly? Y/N	Medication to be administered covertly under – MHA or MCA?	To be reviewed (frequency)

9. Have the family/carers/advocate been involved in/informed of the decision (if applicable)?

Yes: (State who has been involved/informed)	No: (give reason)	Informed by who?

10. Has the decision and plan been discussed with Pharmacy? (Please note: covert administration should not be commenced until an assessment of suitability of medication for covert administration and a Covert Administration Care Plan has been completed, detailing how each medication should be administered).

Yes:	No: (Reason)	Comments	Recommended changes to medication form/dose implemented on EPMA by prescriber Y/N

11. Has the Checklist and Care Plan been completed on the patient's RIO record?

Yes:	No:

12. Has an Eclipse been completed?

Yes:	No:

Signature of Clinician:	Signature of Named Nurse (or proxy):
Signature of Pharmacist	Signature on behalf of family:

Date form completed:

Appendix 4: Covert Administration Treatment Plan

An electronic version of this checklist will be available on RIO and should be used instead of the paper version.

Patient Name:	Rio No:
Ward:	Consultant:

Background

The above patient has a diagnosis of …….. and has been assessed as lacking the capacity to refuse medication that the MDT feels are necessary to prevent a decline in their mental or physical health (or both).

Please be aware that one of the most effective components in the use of covert administration is the consistent application of the agreed methods of administration. Please ensure that medications are given in the same way at as close to the agreed times as possible. It is likely that less than the intended dose may be administered, and a period of consistent application is necessary to assess the clinical response, and therefore any further dose changes.

Evidence

This may be shown by a refusal to take offered medication, spitting out of taken medication, or evidence of discarded medications in the environment.

Solution

The MDT has decided that the least restrictive intervention is to give medication covertly. These medications may be administered as liquid or orodispersible tablets, or as tablets crushed and mixed with drinks or food.

Aim

To try and ensure medications are given consistently and at the prescribed times as far as possible.

Current Medication

The medication listed below is deemed to be necessary to maintain the wellbeing of this patient. Recommendations on the most effective method of administration are given below.

Medication	Dosage form	Covert administration method	EPMA additional information updated Y/N

	Signature	**Date**
Consultant		
Named Nurse		
Pharmacist		
Relative / Carer		