Covert Administration of Medication: Best Practice Guidance for Care Homes

Introduction

Covert administration of medicines is a complex issue and involves the administration of a medicine in a disguised form to a resident without their knowledge or consent.\(^1\)

Competent residents are entitled to refuse treatment even when this decision may adversely affect their health. Care staff should not administer medicines to a resident without their knowledge if they have the capacity to make a decision.\(^2\)

Taking the most appropriate actions for each resident based on their ability to understand the consequences and considering all options carefully is key to personalised care.

This guidance aims to support healthcare professionals and carers to manage challenges in dealing with adult residents who are non-compliant with treatment through direct refusal when openly offered to them.

Initially, it is important to understand why the resident is not accepting a medication prescribed to meet a clinical need. This may uncover a resolution that does not involve covert administration.

Refusal may be because the resident:

- does not understand what the medication is for
- lacks the understanding of the consequences of refusal
- does not understand what to do with the offered tablet or spoonful of liquid
- finds the taste of the preparation unpalatable
- has difficulty swallowing a large tablet or capsule

These residents are technically refusing to comply but their reasons may easily be rectified through discussion with them and their prescriber, appropriate changes made and support offered.

The covert administration of medicines is only likely to be appropriate or necessary in the case of residents who actively refuse medication and who are judged not to have the capacity to understand the consequences of their refusal.
Policies and Procedures

Care homes must have a clear written policy on the covert administration of medicines; consistency in practice is only possible if carers are given guidance that can be followed.

Details of the process must be managed and documented within each care home’s policies and procedures file. Content should include the initial assessment to verify if the resident has capacity. If they have capacity, covert administration cannot be used. If they lack capacity, the following stages then need to be followed:

- all other means of administration and the resident’s wishes should be considered
- all medication must be reviewed to ensure it is essential; if not the medication should be stopped
- there is joint decision making with all those involved in the patient’s care and wellbeing, including relatives or any person nominated to have lasting power of attorney
- there must be written evidence in the Care Plans to show assessment of capacity, assessment of need and who was involved in the assessment process
- the method of giving the medication covertly should be checked with a pharmacist to ensure the medication remains effective and the pharmaceutical integrity and stability are not affected ensuring the resident still benefits from the medication once crushed
- how to administer the medication covertly is clearly documented on the Medicines Administration Record (MAR) sheet
- systems are in place for a safe, optimal practice with a clear audit trail of events
- the need for covert administration is reviewed within time scales which reflect the physical state of each individual
- care home staff administering medication covertly are competent and confident and have on-going training and clinical supervision

Six Step Care Pathway

There are several ethical, legal, pharmaceutical (absorption, incompatibility, interactions, product licence) and patient issues that need to be considered before medicines are given covertly.

This guideline details the six step pathway that should be followed as best practice to support the decision to administer a medicine covertly. It provides a simplified approach whilst ensuring all legal requirements are satisfied.

Care staff contemplating the need for covert administration should consider:

1. the mental capacity of the resident
2. holding a best interest meeting
3. the suitability of the medication
4. the records kept
5. how the medication should be administered without the resident knowing
6. how and when the decision to administer covertly will be reviewed

These steps are represented simply in the flow chart, see Appendix 1; detailed information of each step is given here.
Step 1: Assessing Mental Capacity

Before covert administration is considered as an option, decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the five key principles set out below. It is important to remember that an assessment is task specific and consequently must be carried out for each individual issue which compromises a person’s quality of life.

The five key statutory principles in assessing capacity are:

1. A resident must be assumed to have capacity to make a decision unless it is established that he or she lacks capacity
2. A resident must not be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success; for example, an advocate or communication support
3. A resident must not be treated as unable to make a decision merely because he or she makes an unwise decision; everyone has the right to make what would appear to be an unwise decision
4. An act done or decision made, under this Act, 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 made to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the resident’s rights

In order to decide whether a resident has the capacity to make a particular decision there is a need to establish if the resident has an impairment of, or disturbance in, the functioning of their mind or brain. This clinical diagnosis provides the justification for proceeding.

A patient will be considered to lack mental capacity in law to make a decision or consent if he or she is unable to do one or more of the following four things:

- Understand in simple language what the treatment is, its purpose and why it is being prescribed
- Understand the principle benefits, risks and alternatives
- Understand in broad terms what will be the consequences of not receiving the proposed treatment
- Retain the information for long enough to make an effective decision or communicate their decision in any form

An advance decision to refuse particular treatment in anticipation of future incapacity must be followed if valid and complete. The resident must have made clear which treatments they are refusing (a general desire not to be treated is insufficient) and in what specific circumstances they refuse them; the advance decision must apply to the proposed current treatment and in the current circumstances. It is important that clinicians are made aware of advanced decisions and that carers are aware within care plans.

Within a care home the practical assessment of capacity for a specific decision should be made by the nurse or senior carer who is directly concerned with the resident at the time the decision is made. However, these assessments always benefit from the involvement of family, close friends and other carers, particularly if there is any doubt about the decision.

To support this process, a ‘Mental Capacity Assessment Form’, see Appendix 2, must be completed. This signed document should be kept in the resident’s Care Plan.
**Step 2: Best Interest Decision**

‘Best interests’ is a method for making decisions which aims to be objective and not the personal views of the decision-makers.

When a resident has been assessed as lacking capacity then their ‘best interests’ should be considered in an open discussion between:

- the GP responsible for the care of the resident
- the nurse or care staff giving the medication
- the pharmacist supplying the medication
- relatives or close friends
- any person nominated to have lasting power of attorney for welfare decisions

In cases where there is no-one to consult with there is a need to refer to the advocacy service.

This multi-disciplinary group should consider the past and present wishes of the resident and whether the medicine in question is essential for health of the resident or for the protection of others (i.e. if they are at risk of assault by the resident).

It is essential to always remember the potentially abusive nature of this process and for this reason assurance is needed that there is really no other option.

- The best interest decision includes a risk benefit assessment which should be made by the prescribing clinician in discussion with relatives / advocates. The option of stopping the medication should be considered as the least restrictive option, particularly where there are risks of food or drink being refused. This decision must be documented in patient’s clinical notes and care plan
- Patterns of behaviour need to be monitored as a person may refuse their medication at certain times of day. A review could establish whether the timing of administration could be altered or if there is a formulation that could be given less frequently
- Dementia commonly presents challenges to carers administering medication. Dementia training is essential to develop persuasive techniques. Personalised preferences such as particular carers, environment, ways of giving etc. should be clearly documented
- If a person is not eating or drinking very well, medication mixed in the food or drink could potentially be harmful as taste may be affected causing further refusal of meals and drinks
- The prescriber should consider an alternative route of administration of that medication (e.g. topical, parenteral) or an alternative medication (e.g. available in different forms which are more palatable)
- If covert administration remains the best decision for the resident directions on the prescription should be amended to reflect this

To support this process, a ‘Best Interest Decision Form’, see Appendix 3, must be completed. This signed document should be kept in the resident’s Care Plan.

For information on Independent Mental Capacity Advocacy (IMCA), ‘Just Advocacy’ can be contacted at:

- justadvocacy.org.uk
- 01276 28515
Step 3: Suitability of the Medication

If the best interest decision is to administer covertly, the suitability of the medication must then be considered.

- The properties of the medication should not be significantly affected by administering it covertly
- The crushing of tablets or releasing contents of capsules can automatically make the medication an unlicensed formulation (unless the licensing of the medication allows for such changes). Consequently the use of licensed preparations, if available, that can be given covertly without altering the formulation is the recommended option
- Under the Medicines Act 1968 a prescriber can authorise the use of an unlicensed medication. However, because the medication is being administered in an unlicensed manner, the prescriber, the pharmacist and the member of staff involved in administering the medicine will assume greater legal responsibility.
- If a licensed liquid preparation of the prescribed medication is available, this should preferably be used to mix with drink/food if appropriate
- The prescriber, pharmacist and administering carer should take reasonable steps to ensure administering medication covertly (including the crushing of tablets or emptying of capsule contents) will not cause harm to the patient.
- The pharmacist must ensure that the supply is made in the best interest of the resident and should provide advice on the most appropriate way to administer the medication. Not all medication can be crushed and some food and drink may affect the absorption of the medicine. The pharmacist should refer to the standard texts, the SPC for the medicines concerned and to appropriate reference sources to advise on suitability.

To support this process, the pharmacist should be asked to complete the ‘Covert Administration Medication Form’, see Appendix 4. This signed document should be kept in the resident’s Care Plan.

Step 4: Record Keeping

Covert administration of medication will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the resident’s care, therefore clear documentation is essential. It is not appropriate to act on an ‘ad hoc’ verbal direction or a written instruction to covertly administer as this could be liable to legal challenge.

Covert administration must comply with a local written policy. The NMC guidance recommends that there is a framework for multi-disciplinary discussion and that all decisions and actions taken at these meetings are recorded in the resident’s Care Plan and are then reviewed at appropriate, documented intervals.

The prescriber must have documentation of both mental capacity assessment for the understanding of medication issues and the best interest decision pathway to support covert administration. Copies of this documentation should be in the person’s clinical records in their GP surgery and a copy needs to be shared with the relevant care team.

Carers should produce a personalised instruction for each medicine to be given covertly in line with the advice of the pharmacist. This should be added to the care plan to ensure that all care staff administering the medication are aware of the reasons for, and the method of, covert administration for each medicine concerned.

Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet. Where administration is unsuccessful this must also be clearly documented and any consequences reported to the prescriber as appropriate.
Step 5: Administering Medication Covertly

It is important to remember that dignity and respect must be maintained at all times and carers must be supported by healthcare professionals to deliver care appropriately with accountability. Nurses and carers who are trained to administer medication should consider the following points when covert administration has been deemed necessary:

- A resident should be offered their medication openly each time, especially where fluctuating capacity is evident
- The carer should be aware of personal preferences for administration through the care plan; and only proceed to administer covertly after the appropriate steps have been taken
- In general, the medications which are to be administered covertly should be mixed with smallest volume of food or drink possible; not than the whole portion. This increases the likelihood that the prescribed dose is actually taken. Not all drinks are suitable, e.g. tea or milk could interact with some medication
- The medication must be administered immediately after mixing it with the food or drink. It must not be left for the resident to manage themselves; if the resident is able to feed themselves they should be observed to ensure that it is consumed
- Each time medication is administered covertly it should be clearly documented on the MAR sheet
- Refusal of the food or drink containing medication must be recorded on MAR sheet as ‘refused’. It should also be noted if it is partially consumed as the dose is then uncertain
- Good record keeping provides evidence to enable the prescriber to review the continued need for covert administration.

Step 6: Review of Continued Need

A resident may be mentally incapacitated for various reasons. These may be temporary, e.g. sedation as a side effect of a medication; or because of a long term mental health illness, e.g. Alzheimer’s disease. It is important to remember that capacity may fluctuate and that regular assessments by the clinical team are necessary. Initially, the treatment plan should normally be subject to weekly reviews. If the requirement for covert medication continues, full reviews at monthly intervals should take place.
Acknowledgements

NHS Nene Clinical Commissioning Group: Good Practice Guidance on Covert Administration of Medication

Sundus Bilal, NHS Berkshire East Clinical Commissioning Group; Good Practice Guidance 8: Covert Administration of Medicines

Resources

Surrey PAD: Crushing guidelines: ‘Therapeutic options for patients unable to take solid oral dosage form’


UK medicines information (UKMi): Q&A 365.3; ‘What legal and pharmaceutical issues should be considered when administering medicines covertly’

References

1 Nursing Midwifery Council, Covert administration of medicines: disguising medicine in food and drink:
www.nmc-uk.org/Nurses-and-Midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/

2 NICE guidelines [SC1] Published date: March 2014, Managing medicines in care homes:
https://www.nice.org.uk/guidance/sc1/chapter/recommendations#care-home-staff-giving-medicines-to-residents-without-their-knowledge-covert-administration


6 Smyth J, editor. The NEWT Guidelines for Administration of Medication to Patients with Enteral Feeding Tubes or Swallowing Difficulties. Betsi Cadwaladr University Local Health Board (East):
http://www.newtguidelines.com

7 Handbook of Drug Administration via Enteral Feeding Tubes third edition(2015), R White, V Bradnam:
http://www.pharmacy.cmu.ac.th/unit/unit_files/files_download/2012-03-26HandbkOfDrugAdminViaEnteralFeedingTubes%201stEd_WhiteAndBradn.pdf

8 Law and Ethics Bulletin: Covert administration of medicines. Pharm J 2003; 270:32

9 College Statement on Covert Administration of medicines:
https://www.rcpsych.ac.uk/pdf/covertmedicine.full.pdf
Appendix 1: Flow Chart for the Administration of Covert Medication in Care Homes

Resident is persistently refusing medication

Discuss with resident why medication is not being taken

Has capacity

Give medication according to resident’s wishes

Cannot make a decision

Prescriber consults with multidisciplinary team and resident’s representatives to make a best interest decision.

Is there evidence that all options have been tried?

Yes

Review medication with resident and family. Document any decisions to stop and prescribe alternative medication according to resident’s wishes. Covert administration is not appropriate

No

Stop covert administration

Lacks capacity

Can decision be delayed? Is capacity likely to improve?

Yes

Reassess when appropriate

No

Ensure least restrictive options such as alternative formulations and encouragement have been tried and have failed

Are family available to make a decision? Is there a person with registered Lasting Power of Attorney who can make a decision?

No

Contact Advocacy Service

Yes

Prescriber consults with multidisciplinary team and resident’s representatives to make a best interest decision.

Is there evidence that all options have been tried?

Yes

Complete documentation, including Pharmaceutical Advice, and incorporate into Care Plan, as this provides care staff with authorisation to covertly administer medication. Scan into patient notes in surgery.

Covert Administration

Document review process observing resident deterioration or refusal of food or drink as a result of covert process. Is there any evidence of harm?

Yes

Stop covert administration

No

Continue with regular reviews

All medication should be reviewed to assess clinical need. Stop non-essential medication as least restrictive option and document decisions.

Contact Advocacy Service

Ensure least restrictive options such as alternative formulations and encouragement have been tried and have failed

Unable to resolve

Covert administration is not appropriate

Has capacity

Review medication with resident and family. Document any decisions to stop and prescribe alternative medication according to resident’s wishes.
## Appendix 2: Mental Capacity Assessment Tool

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<thead>
<tr>
<th>Name of Resident</th>
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<tbody>
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<td><strong>NHS Number</strong></td>
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<tr>
<td><strong>Date of Birth</strong></td>
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### Pre capacity assessment - Note briefly an answer to the three points below, clearly identifying any impairment in communication

1. **Communication** - How does this resident communicate?

2. **Communication** - How does this resident indicate *yes* or *okay*?

3. **Communication** - How does this resident indicate *no* or *stop*?

Consider factors that may be relevant in the assessment of capacity, including:

- Suitable environment / time of day
- Possible effects of medication
- Sensory / physical impairment
- Cultural factors

### Assessment of capacity using the 2-stage test of capacity - Lack of capacity requires demonstration of both stage 1 and stage 2.

<table>
<thead>
<tr>
<th>First stage</th>
<th>Is there an impairment of, or disturbance in the functioning of the resident’s mind or brain?</th>
<th>Yes</th>
<th>No</th>
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<td></td>
<td>Give brief details if appropriate, e.g. cognitive impairment, mental disorder, dementia, delirium, intoxication, receptive dysphasia</td>
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If **no**, the resident will not lack capacity under the Act. (If there are doubts refer for further opinion). If **yes**, continue with the second stage. **REMEMBER:** Everyone has the right to make an irrational or illogical decision when they have capacity; full documentation of capacity would be needed to support this.
<table>
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<tr>
<th>Second stage</th>
<th>Is the impairment or disturbance sufficient that the resident lacks the capacity to make this particular decision?</th>
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**Hints and Tips** - There is a need to be clear about the decision or decisions to be made and what the options may be. Consider carefully how best to put across relevant information to the resident concerned. For example:

1. The decision that needs to be made;
2. Why the decision needs to be made;
3. The likely effects of each option available in relation to the decision.

How information is given will affect the ability of the resident to understand. Use broad terms and language that is appropriate to the person. It is not always necessary to explain everything in great detail. **Summarise evidence of discussion for each point below; it is not sufficient to state diagnosis such as ‘has dementia’**.

<table>
<thead>
<tr>
<th>Does the resident understand the information relevant to the decision? If no, give details of why not.</th>
<th>Yes ☐ No ☐</th>
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<tr>
<td>Is the resident able to retain the information and process it? If no, give details of why not.</td>
<td>Yes ☐ No ☐</td>
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<tr>
<td>Can the resident weigh up the pros and cons of a decision? If no, give details of why not.</td>
<td>Yes ☐ No ☐</td>
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<td>Can the resident communicate their decision by any means possible? If no, give details of why not.</td>
<td>Yes ☐ No ☐</td>
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A ‘no’ to any of the above questions will demonstrate lack of capacity for this decision.

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<tr>
<th>Is capacity likely to improve or fluctuate?</th>
<th>Yes ☐ No ☐</th>
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<tr>
<td>Can decision be delayed? <strong>If yes</strong>, reassess.</td>
<td>Yes ☐ No ☐</td>
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<tr>
<td>Date of reassessment</td>
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</table>

**PLEASE COMPLETE THE BOX FOR THE APPROPRIATE EVIDENCED DECISION**

<table>
<thead>
<tr>
<th>This resident <strong>LACKS</strong> the capacity to make the decision detailed above</th>
<th>This resident <strong>HAS</strong> the capacity to make the decision detailed above</th>
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<tr>
<td>Name of assessor</td>
<td>Name of assessor</td>
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<td>Signature</td>
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<tr>
<td>Role</td>
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<td>Expected review date</td>
<td>Expected review date</td>
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Appendix 3: Best Interest Checklist for Residents Lacking Capacity

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<th>Name of Resident</th>
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<tr>
<td>NHS Number</td>
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<td>Date of Birth</td>
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- **What treatment is being considered for covert administration?**
  - It has been confirmed that no advanced decisions are in place concerning this treatment.

  Confirmed by:  
  Signature:  

- **Why is this treatment necessary?**
  - How will the resident benefit?
  - Could this treatment be stopped?
  - Where appropriate, refer to clinical guidelines, e.g. NICE.

- **What alternatives did the team consider which were not successful?**
  - e.g. other ways to manage the resident or other ways to administer treatment.

  State the options tried.

- **Why were they not appropriate?**

- **Treatment may only be considered for a resident who lacks capacity.**

  - When was Mental Capacity Assessment (MCA) for this issue completed?

    Date:  
    Assessed by:  

  - Who was involved in the decision?
    - N.B. A qualified pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable
    - If there is any person with power to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable.

    Name of practitioner staff involved:
    Name of relatives, advocates or other carers involved:

  - When will the need for covert treatment be reviewed?
    - (This will be dependent on physical condition of each resident. Fluctuating capacity requires more frequent review - at least every three months)

    Date of first planned review:

  GP name:
  Signature:
  Date:
# Appendix 3 (continued): Instructions for Carers

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<th>Name of Resident</th>
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<td>NHS Number</td>
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<td>Date of Birth</td>
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### Name of Medication to be Administered:

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<th>Instructions for administration</th>
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<tr>
<td>Specify clearly how it is to be administered.</td>
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<td>Include instructions on directions for pharmacist to label if possible.</td>
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<td>Include any cautions such as temperature / types of food to avoid.</td>
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<th>Name of GP providing instruction for administering:</th>
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<th>Date of Commencement:</th>
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<th>Date of Review:</th>
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<th>Authorised by:</th>
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### Report to GP at next contact if:

- Covert administration results in a refusal to eat or drink
- It appears that the full dose of medication has not been taken (make a note on MAR sheet)
- There appears to be a deterioration in the patients health and well being

This information should be included in the resident's care plan and with the Medicines Administration Record (MAR) sheet.
'Covert' is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. Covert medication must never be given to someone who is capable of consenting to medical treatment. If a resident’s decision is thought to be unwise or eccentric it does not necessarily mean they lack capacity to consent. Administration of medication against a person's wish may be unlawful. An appropriate assessment must be performed by a medical practitioner to establish whether the resident lacks mental capacity. If it is determined that the resident does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the resident’s best interest.

**Statement from Pharmacist:**

Please find below advice as to the most appropriate means of administering the resident’s medication in a covert manner.

The crushing of tablets or releasing contents of capsules can automatically make the medication an unlicensed formulation (unless the licensing of the medication allows for such changes in formulation). Consequently the use of licensed preparations, if available, that can be given covertly without altering the formulation is the recommended option.

When mixing crushed medication with fruit juice, squash or water, small volumes of 30-40ml should be sufficient.

**Information is available from:**


or

Covert Administration Guidance from Pharmacist (continued)

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<th>Medication</th>
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Signature of Pharmacist

Name of Pharmacist

Job Title

GPhC registration Number

Date