



## Good Practice Guidance: Covert Administration of Medicines

This GPG is for all health and social care professionals involved in assessments and decisions for covert administration.

### Introduction

Medication should only be administered with a resident's consent. Consent can be verbal or non-verbal (e.g. nodding).

Covert administration is the term used when medicines are administered in a way, usually mixed in food or a drink, without the knowledge or consent of the resident receiving them. This should only be implemented in exceptional circumstances as explained below.

Sometimes medication is refused, and it is important to explore why and how often medication is refused before considering covert administration.

For example:

- Do they refuse medication at certain times of a day? Could the medication be given at a different time of the day?
- Do they appear to not like the taste?
- Do they appear to have swallowing difficulties?
- Could an alternative route of administration of that medication be considered? e.g. topicals, patches, liquids
- Are they refusing because they don't understand? Language barriers or maybe because of cognitive impairment?

Overt administration is different to Covert administration. Overt administration is the process in which the administration of medication is easily observable and clinically obvious. The medication may be added to food or drink to make it more palatable and/ or easier to take and this is done with the resident's consent.

### Policies and procedures

Care homes must have a clear policy on the covert administration of medicines; this could be part of the care home's main medicines management policy. Care homes may wish to seek legal advice on their policy for covert administration.

### Mental Capacity Act 2005

Every adult is deemed to have the mental capacity to consent or refuse treatment until proven otherwise as described in the Mental Capacity Act (MCA) 2005.

A competent adult has the legal right to refuse treatment, even if that refusal will adversely affect their health. Therefore, care staff must respect that resident's refusal as they would their consent. Administration of medication against a resident's wish if they have capacity may be unlawful.

Before considering covert administration, a mental capacity assessment must be carried out on the resident, ensuring principles of MCA 2005 are followed by a suitably trained healthcare professional. Details of the assessment must be recorded in the resident's care plan.

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It cannot be assumed that a resident lacks capacity because they have a medical condition or disability, unless they have had an injury or disturbance to their mind/brain and due to this injury, they:

- are unable to take in and retain the information about it provided by the treating staff, particularly as to the likely consequences of refusal
- are unable to understand that information
- are unable to weigh up the information as part of the process of arriving at a decision.
- are unable to communicate his/her decision (it can be by any form e.g. verbal, written, signed)

Whilst assessing capacity, consideration should be given to the resident’s background, whether they speak more than one language and their understanding of the English language.

Mental capacity may fluctuate, sometimes over short periods of time, e.g. due to an acute illness such as a UTI, COVID-19 or use of a short term sedating medication e.g. sleeping tablet. Capacity to consent should be assessed more frequently in such cases. Residents with long term conditions affecting capacity e.g. dementia, may require different time periods between reviews. Each resident should be assessed and reviewed according to their individual circumstances, and this agreed at the best interest meeting by the multi-disciplinary team (MDT) treating the resident (see Appendix 1- Covert Administration Assessment Form).

**Covert administration should only take place when:**

- a resident actively refuses their medicine(s), **AND**
- that resident is assessed not to have the mental capacity (determined by the Mental Capacity Act 2005) to understand the consequences of not taking their medicines, **AND**
- the medicine is considered to be essential to the resident’s health and wellbeing.

Consider the reasons a resident might be refusing to take their medication before covert administration:

- They do not understand what the medication is for
- They do not understand what could happen if they do not take the medication
- They do not like the taste of the medication
- They are having difficulty swallowing the medication
- They may have worries about side effects of medications e.g. needing to go to the toilet frequently if taking diuretics (water tablets)
- Care home staff may be unfamiliar to the resident or unaware of how the resident likes to take their medication

All options, including stopping the medication, should be considered in the resident's best interests before the decision is made to administer medicines covertly.

**Structured Medication Review**

It is good practice for a Structured Medication Review (SMR) to be undertaken by a clinician before assessing the most suitable method of administering each medication covertly.

A person-centred approach should be applied when considering each specific medication and include detailed assessment for each including:

- The past and present wishes of the resident in relation to the medication.

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- Whether the medication in question is essential for health of the resident (including any potential impact of the medication not being taken – verbal or a written report from the prescriber/pharmacist): e.g. the risk/benefits of the medication (the prescribing clinician should identify these).
- If stopping the medication is the least restrictive option.
- If the medication is for the protection of others e.g. If the resident is violent or aggressive and puts others at risk of harm.
- Assurance that no other option is available, for example:
  - Other alternative route of administration e.g. topicals, patches
  - Could the medication be given at a different time of the day?
  - Do they appear to not like the taste? Change formulation e.g. syrup, oro-dispersible

### Assessing suitability of the medication for Covert Administration

The suitability, safety and efficacy of each medication must be considered for covert administration. A best interest decision to administer a medication covertly applies each time a new medication is added, or a change is made to current medications.

It is important that care staff have sought the professional guidance of a pharmacist. As part of the SMR the safety and effectiveness of each medicine will be considered to ensure that the integrity and stability of the medication is not affected. For example, some medicines can become ineffective when mixed with certain foods or drink. Some formulations, such as modified release medications, may not be suitable for covert administration as they should not be crushed. (See Appendix 2 - Instructions for administration)

It is good practice for the prescriber to ensure that additional instructions for administering medication covertly are included on the prescription which should be printed on the label by the dispensing pharmacy and documented clearly on the Medicines Administration Record (MAR) chart. A record of the prescription instructions should also be included in the care plan.

Ideally any medicines administered covertly should be mixed in the first spoonful of food or drink. Care staff must be aware that for residents not eating or drinking, the mixing of medication with food or drink may alter food taste causing further refusal of meals and drinks.

### Advanced care planning

The issue of covert administration may be discussed when the resident has capacity so that decisions can be made in advance. Ideally these discussions should involve any family members, if possible. Any decisions made should be documented in the resident's medical records, care plans at the care home and any other records held by the resident such as Advance Decision to Refuse Treatment (ADRT/ living will), or advance care plan (ResPECT form).

### Best interest Decision

Best interest is a process for decision makers to think what the 'best course of action' is for the resident where the resident lacks mental capacity. It is not the personal views of the decision-makers. Instead, it considers both the current and future interests of the resident, weighs them up and decides which course of action is the most appropriate.

The best interest meeting should include a risk versus benefit assessment for the administration of medication covertly, which should be agreed by the prescribing clinician in discussion with the

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person holding the lasting power of attorney (LPA) for health and welfare, family, advocates, friends and those involved directly in the resident's care such as care staff, nurses, pharmacist, other MDT members e.g. dietitians, speech and language therapist.

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 resident's clinical notes and care plan with reasons for the decision and record those present at the meeting.

Where a patient is assessed and deemed to lack capacity, the resident may have previously indicated their wishes in the form of an ADRT or advance care plan (ResPECT form). Where the resident's advanced wishes are known, the care home should respect them, provided that the decision is clearly applicable to the present circumstances and there is no reason to believe that the resident has changed their mind. (See Appendix 1)

The local authority must be contacted if the individual is subject to a Deprivation of Liberty Safeguard Authorisation (DoLS). Where there is no DoLS, consideration must be given to initiating the process.

If one or more of the decision makers disagree with a decision at a Best Interest meeting that a specific medication should be given covertly, then an immediate application should be made to the Court of Protection for a formal decision

**The ultimate decision to administer medicines covertly must be in the resident's best interests and clearly documented in line with legal and professional requirements.**

### Documentation

The following must be clearly documented in the resident's care plan and GP Medical notes;

- Details of assessments (e.g. mental capacity assessment, risk assessments)
- Best interest decision outcomes (See Appendix 1)
- Written agreement of the decision to administer medication covertly
- The names of those individuals present or involved at the best interest meeting

The care plan and MAR chart should have clear instructions on how to administer each medication covertly (see Appendix 2). These instructions and advice for administration should be provided by a pharmacist. Where medication is not administered this must be recorded on the MAR chart and reported to the prescriber/GP.

Kitchen staff in care homes should also be made aware of a resident who is having medication administered covertly as some meals may need to be altered. Care is needed to ensure that food or drink to which medication is added is kept separately and disposed of safely in the medication disposal bin if not consumed.

### Review of ongoing need for Covert Administration

Residents may have fluctuating capacity, for example due to a urinary tract infection (UTI). Following antibiotic treatment of the UTI the resident's capacity may change, allowing them to make informed decisions about their treatment.

It is essential that a regular review of capacity, in line with the frequency and criteria agreed at the best interests meeting, is conducted to check ongoing appropriateness of covert administration. Reviews should be agreed based on the resident's individual circumstances at the time of a best

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interest meeting and documented into the resident's care plan and medical notes (See Appendix 1).

### Summary

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

- **Last resort** - covert administration is the last option when all other options have been tried.
- **Medication specific** – SMR should be completed first, and the need to continue each medication established.
- **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 resident's capacity to consent. (See Appendix 1.)
- **Transparent** - the decision-making process must be easy to follow and clearly documented both at the care home and GP practice notes.
- **Inclusive** - the decision-making process must involve discussion and consultation with appropriate healthcare professionals and advocates for the resident.
- **Best interest** - all decisions must be in the resident's best interest with due consideration to the overall effect on the resident's health and well-being

### References

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- NICE guidance SC1. Managing medicines in Care homes. March 2014. <https://www.nice.org.uk/guidance/sc1> (accessed 10/01/2023)
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**Appendix 1 - Covert Administration Assessment Form**

<b>Name of Resident</b>			
<b>Date of Birth</b>		<b>NHS Number</b>	
<b>Nominated GP</b>		<b>GP Address</b>	
<b>Care Home Address</b>		<b>Allergy Status</b>	
<b>What medications are being considered for covert administration?</b> Each medication must be documented, it is not appropriate to state 'all medications'			
<ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>		<ol style="list-style-type: none"> <li>6.</li> <li>7.</li> <li>8.</li> <li>9.</li> <li>10.</li> </ol>	
<b>Why is this treatment necessary?</b> Only essential medications should be given covertly. Stopping medication must be considered as the least restrictive option			
<b>What alternatives did the team consider? Reasons why were they not appropriate?</b>			
<b>Has the person expressed views in the past that are relevant to the present treatment? YES / NO</b> If yes, what were those views?			
<b>Has a Mental Capacity Assessment (MCA) been completed? YES / NO</b> Treatment may only be considered for a person who lacks capacity			
Name of person who completed MCA Role of person who completed MCA Signature Date			

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**Name of all staff involved in the best interest decision meeting to administer medication covertly (e.g. health care professionals)**

Name	Role	Signature	Date

**Name of relatives, advocates or other carers involved in the best interest decision meeting to administer medication covertly**

Name	Role	Signature	Date

**Best Interest decision and reasons for it**

**Has a qualified pharmacist provided advice on administration of covert administration? YES/NO**

Name of Pharmacist Employing organisation Signature Date	
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**Name and role of members of staff will be administering the medication. These members of staff must receive appropriate guidance on administration of this medication .**  
 How will they be administering the medication, e.g. mixed in yoghurt? How will this be recorded on the MAR chart

Name	Role	Date

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<p><b>Is there a person with power to consent on behalf of the service user e.g power of attorney for health?</b>  <b>YES/NO</b></p> <p>If yes, have they been involved in the decision to administer medication covertly?</p> <p>If no, please give details why?</p>	
<p><b>When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review). Date of first planned review</b></p>	
<b>GP name:</b>	
<b>Signature:</b>	
<b>Date:</b>	

<b>Regular reviews</b>			
Date of next review: This will be a patient specific decision			
Prescriber name and designation:		Signature	
Care home staff name and designation:		Signature	
Date of next review: This will be a patient specific decision			
Prescriber name and designation:		Signature	
Care home staff name and designation:		Signature	
Date of next review: This will be a patient specific decision			
Prescriber name and designation:		Signature	
Care home staff name and designation:		Signature	

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**Appendix 2 - Instructions for Covert Administration**

This information should be included in the patient’s care plan and with the medicines administration record (MAR) sheet.

<b>Name of Resident</b>			
<b>Date of Birth</b>		<b>NHS Number</b>	
<b>Nominated GP</b>		<b>GP Address</b>	
<b>Care Home Address</b>		<b>Allergy Status</b>	
<b>Name of medication to be administered:</b>	<b>Instructions for administration (information provided by a pharmacist)</b> Specify clearly how it is to be administered. Include advice on directions and any cautions such as temperature/types of food to avoid.		
<b>Name of pharmacist:</b>			
<b>Employing organisation:</b>			
<b>Start date:</b>			
<b>Date of review:</b>			

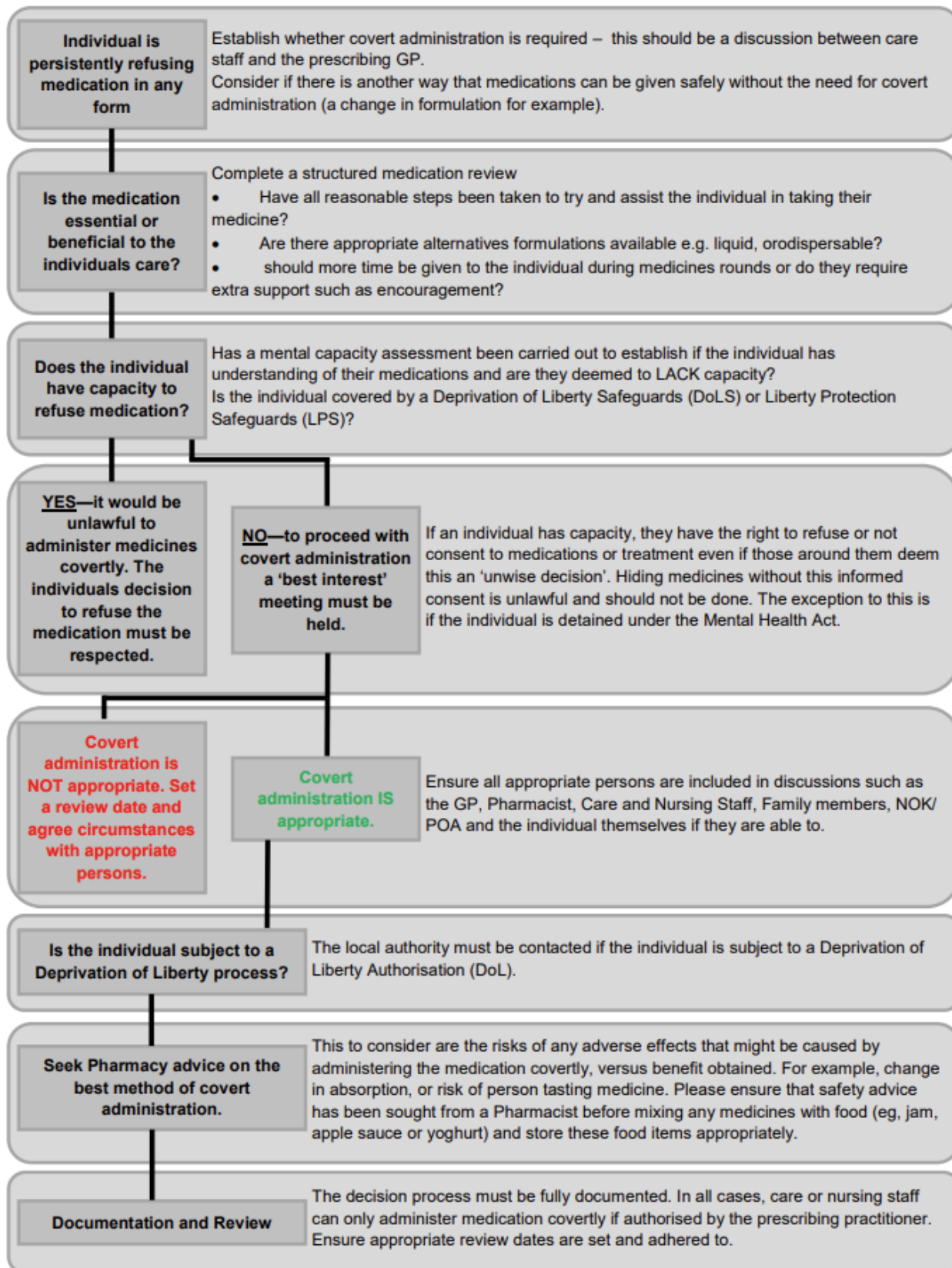
**Report to GP at next contact if:**

- 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 chart)
- There appears to be a deterioration in the resident’s health and wellbeing.

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## Covert Administration Flow Chart



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