

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**MENTAL CAPACITY AND THE COVERT ADMINISTRATION
OF MEDICINES**

1. INTRODUCTION

- 1.1. Covert administration of medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food or drink. As a result, the person is unknowingly taking medication. This practice is likely to arise because of the refusal to take medication when it is offered, but where treatment is necessary for the person's physical or mental health or for the safety of others.
- 1.2. These guidelines should be read in conjunction with current advice from relevant professional bodies such as the Nursing & Midwifery Council.
- 1.3. The Mental Capacity Act 2005 came into force on the 1st October 2007. Staff should refer to the principles of the MCA 2005 when interpreting or applying the principles of this document. In addition, staff should refer to the Trust *MCP2 Mental Capacity Act 2005 Policy* and *MCPG2 Mental Capacity Act 2005 Procedure*.

2. CAPACITY AND CONSENT

- 2.1. Consent to treatment involves receiving adequate information about the proposed treatment, having the capacity to assess and understand the nature of the treatment (its main benefits, risks and alternatives), and being able to make a free choice without undue pressure or coercion.
- 2.2. Generally a competent adult has the right to refuse treatment, even if that refusal may adversely affect them. Every adult will be deemed to have capacity to consent or refuse treatment, including medication. An unwise decision must be respected if the patient has capacity.
- 2.3. A Personal Welfare Lasting Power of Attorney enables appointed attorneys to make decisions about a person's life when they have lost the capacity to make those decisions themselves. This may include the power to give or refuse consent to medical treatment including medication administration. A Deputy appointed by the Court of Protection can also make decisions for the incapacitated person.
- 2.4. No-one else can give consent for an adult, someone over the age of 18 (or 16 in some circumstances).
- 2.5. For patients detained under the Mental Health Act, see the relevant legislation and code of practice, or seek advice from the Trust's Mental Health Act advisor.

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- 2.6. A Mental Health Act assessment should be considered if appropriate for a person with a mental disorder who requires treatment for that illness but who is refusing treatment.
- 2.7. Lack of capacity may be enduring, temporary or fluctuating. Lack of capacity means that the person 'has an impairment or disturbance that affects the way their mind or brain works', and this impairment or disturbance means that 'they are unable to make a specific decision at the time it needs to be made'.
- 2.8. Assessment of capacity should be fully documented in the person's healthcare record and repeated as necessary.
- 2.9. Under the Mental Capacity Act, which was implemented in 2007, capacity is defined as being able to :
- understand the relevant information
 - retain the information
 - use or weigh the information as part of a decision making process
 - communicate the decision
- 2.10. Staff must apply the principles contained in Section One of the Act. Anyone, doctor or nurse, can apply the test. It may be necessary to involve a consultant psychiatrist for more complex cases. If someone is found to lack capacity, any decision or action taken must demonstrate that the actions or decisions taken have been in the patient's best interests. In determining what is in a person's best interests the Act sets out a statutory checklist of factors which must always be taken into account when a decision is being made or an action done for a person lacking capacity.
- 2.11. Although this policy primarily relates to adults the principles are the same for children. Children who have sufficient understanding and intelligence to fully understand a suggested treatment also have the capacity to consent to that treatment (Fraser competence). Children aged 16 or 17 are presumed to have capacity unless shown otherwise. Some children under 16 may not have capacity to consent to or refuse a particular treatment, in which case the right to consent or refuse remains with those with parental responsibility.

3. COVERT ADMINISTRATION OF MEDICINES

- 3.1. Disguising medication in the absence of informed consent may be regarded as deception. However a clear distinction should always be made between those who have the capacity to refuse medication and whose refusal should be respected, and those who lack this capacity.
- 3.2. Among those who lack capacity a further distinction should be made between those for whom no disguising is necessary because they are unaware that they are receiving medication and others who would be aware if they were not deceived into thinking otherwise.

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- 3.3. The multidisciplinary team must first make every effort to obtain the person's consent, and to administer medicines openly; such efforts must continue.
- 3.4. The patient's known wishes, values, religious belief and views must be taken into consideration. The decision to administer covert medication should be based on necessity and capacity.
- 3.5. The covert administration of medicines may only be considered in the case of patients who actively refuse medication if:
- the person has been shown to lack capacity at the time
- and**
- if the covert administration of medication is considered necessary to save the person's life, to prevent deterioration or ensure improvement in the person's mental or physical health, or for the safety of others.
- 3.6. Medication must not be disguised for the convenience of the healthcare team.
- 3.7. The ultimate decision to administer medicines covertly must be one that has been informed and agreed by the multidisciplinary team, including the doctor caring for the person, and not by a single practitioner.
- 3.8. The team should consider the wishes of family and/or carers, and any views previously expressed by the person in the form of an advance statement, advance directive or living will. Where those wishes are known, all staff must respect them provided they are still clearly applicable to the present circumstances and there is no reason to believe the person has changed his/her mind. Family involvement should be positively encouraged.
- 3.9. All discussions and decisions must be fully documented in the person's healthcare record, and reviewed regularly, initially at least weekly or at a time interval agreed by the multidisciplinary team. It is important to recognise that mental illness might often cause a temporary or fluctuating incapacity and therefore regular assessment of capacity is required.
- 3.10. All practitioners involved should be fully aware of the purpose and implications of such treatment, and should have the opportunity to contribute to the multidisciplinary discussion. There must be clear expectation that the person will benefit, without significant harm.
- 3.11. The list of medicines agreed as being essential and therefore to be administered covertly should be documented in the healthcare record (see [Annex 1](#) for checklist). If there is a subsequent need for additional treatment this should be considered and documented separately.
- 3.12. Medication must be administered by the least restrictive means.
- 3.13. A patient admitted to an in-patient unit should have any previous decisions regarding covert administration of medicines reviewed as their capacity and circumstances may have changed.

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- 3.14. On discharge from hospital the decision to administer medicines covertly should be communicated to the home/carer but it is then their decision to follow local policies for continued covert administration of medicine, as this may no longer be relevant even if the patient still lacks capacity.
- 3.15. **Disguising medication in food or drink**
- 3.15.1. The method of disguising the medication shall be discussed and agreed with a pharmacist and then documented in the care plan, and on the prescription chart if the person is an inpatient.
- 3.15.2. Wherever possible, a suitable licensed liquid or soluble or dispersible or “melt” formulation should be used, or treatment changed to a different drug for the same indication that is suitably licensed.
- 3.15.3. Crushing tablets or opening capsules should be regarded as a last resort, as this renders the product unlicensed and is likely to alter the bioavailability of the medication. This necessitates prior discussion with a pharmacist.
- 3.15.4. Any method of administration which is outside the product license or that medication is unlicensed, and can only be authorised by a doctor. Healthcare professionals who recommend or who administer a medication by unlicensed methods may be liable if harm ensues.
- 3.15.5. The prescriber must document any authorisation to administer a medication by an unlicensed method, having first considered the patient’s safety, the requirement for that particular medication, and alternative treatments or means of administration.
- 3.15.6. The checklists included in [Annex 1](#) and [Annex 2](#) should be completed to document the decision to administer covert medication and its review at regular intervals.

4. FURTHER INFORMATION

Nursing & Midwifery Council. *Covert administration of medicines: Disguising medicine in food and drink*. 2007.

Royal Pharmaceutical Society of Great Britain. *Law and Ethics Bulletin on Covert Administration of Medicines*. Pharmaceutical Journal 2003; 270: 32.

Royal College of Psychiatrists. *Statement on Covert Administration of Medicines*. *The Psychiatrist*. 2004; 28(10): 385.

Nathan, A. *Consent and the New Mental Health Law*. Pharmaceutical Journal 2008; 280: 757

British Medical Association and Law Society. *Assessment of Mental Capacity, Guidance for Doctors and Lawyers*. 1995.

Treloar A al. *Concealing Medication in Patients’ Food*. Lancet 2001; 357: 62-4

Griffith R. *Tablet Crushing and the Law*”. Pharmaceutical Journal 2003; 271: 90-1

Mental Welfare Commission for Scotland. *Covert Medication. Legal and Practical Guidance*. 2006



COVERT ADMINISTRATION OF MEDICINES CHECKLIST

Name of patient:	NHS No:
Ward/unit:	Date of Birth:

What medicines are being considered for covert administration?	
Why are these medicines necessary? Where appropriate, refer to clinical guidelines	
What alternatives did the team consider? (e.g. other ways to manage the person or other ways to administer treatment) Why were these alternatives rejected?	
Treatment may only be considered for a person who lacks capacity. Outline the assessment of capacity.	Assessed by:
Treatment may only be given if it is likely to benefit the person. What benefit will the person receive?	
Is this the least restrictive way to treat the person? Give reasons.	

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Has the person expressed views in the past that are relevant to the present treatment? If so, what were those views?	
Who was involved in the decision? N.B. <i>A pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink.</i> N.B. If there is any person with power to consent (i.e. Personal Welfare LPA), then the treatment may only be administered covertly with that person's consent, unless this is impracticable.	Staff involved: Relatives or other carers involved:
Do any of those involved disagree with the proposed use of covert medication?	Yes/No
If so they must be informed of their right to challenge the treatment.	Date informed:
When will the need for covert treatment be reviewed?	Date of planned review:

Signed:

Name:

Designation:

Date:

SAMPLE - DO NOT USE



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REVIEW OF COVERT ADMINISTRATION

Name of patient:	NHS No:
Ward/unit:	Date of Birth:

Is treatment still necessary? If so, explain.	
Is covert administration still necessary? If so, explain why.	
Who was consulted as part of the review?	
When will the need for covert treatment be reviewed?	Date of planned review:

SAMPLE - DO NOT USE

Signed:

Name:

Designation:

Date: