NICE National Institute for Health and Care Excellence

scie social care institute for excellence

Giving medicines covertly: overcoming the challenges

Webinar starting at 1pm, 27 September 2019

Please ask any questions in the chat box being aware that comments in the chat box will be publicly available via the recording

Presenters

- Cherise Howson – Pharmacist, Croydon CCG; NICE Medicines Associate
- Celia Osuagwu – Pharmacist Specialist, Care Quality Commission, Medicines Optimisation Team
- Melanie Weatherley – CEO Walnut Care at Home, Chair Lincolnshire Care Association, Co-Chair Care Association Alliance, NICE Fellow 2019-2022

NICE guidance

NICE guidance that covers giving medicines covertly:

- Managing medicines in care homes (SC1)
- Managing medicines for adults receiving social care in the community (NG67)
- Decision making and mental capacity (NG108)
- Medicines management in care homes (QS 85)

Covert medication myth busting

- Covert medication is **NOT**
  - mixing medicine in food or drink at the service user's request
  - the first thing to do if a service user doesn't want to take their medication
  - a decision that can be taken by the care provider on their own
  - forbidden by CQC, NICE or any other regulator
  - necessarily giving medication via nasogastric/PEG tubes or giving medication in the form of patches
- It **IS**
  - an area of concern for many registered managers

Avoiding the need for covert medication

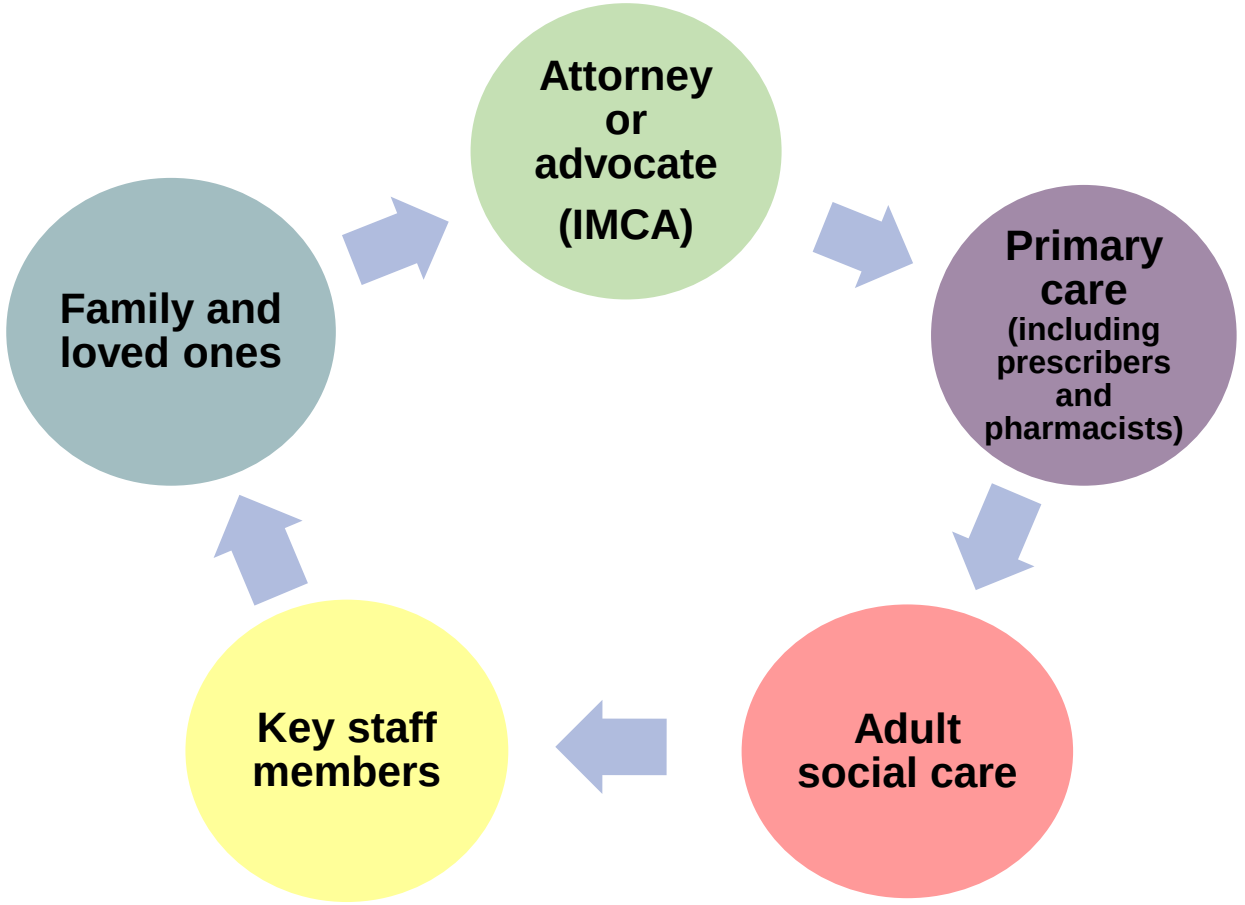
- Is the medication essential to the person's wellbeing?
  - medication review
  - Alternatives to using medicines
- Is it available in a more acceptable form?
  - Liquid or patch
- Could the administration be changed?
  - different staff, time, environment or presentation

These are examples of less restrictive interventions

The Pharmaceutical Journal
19 Sept 2016

> “Covert medication (is) a complex process requiring multidisciplinary assessment.”

Covert medication – others to involve



And any other relevant parties

Good record keeping is essential

- What did you do?
  - care plan
  - MAR
  - daily care notes
- Why did you do it?
  - issues
  - alternatives tried
  - best interests decision
- Who was involved?
- When will the decision be reviewed?
  - and who will follow up?
- Governance and escalation
  - policies and procedures
  - what to do if other professionals are not engaging

Core principles of covert administration

- Appropriate capacity assessment
- Medication review - Is the medicine essential?
- Why is the person refusing?
- Explore whether there are suitable alternative treatments
- Involve the pharmacy team
- Involve the multi-disciplinary team, family, representatives, advocates in the best interests meeting
- Agree the least restrictive option
- Document and plan review

The first step

Treating people without their knowledge as a last resort can be justified under the Mental Capacity Act (2005)

Where the person **lacks mental capacity** to take a valid decision to consent to or refuse treatment and the treatment is deemed in the **person's best interests** and **the necessary treatment cannot otherwise be administered**

When can covert administration be justified?

- Covert administration is only likely to be necessary or appropriate where:
  - a person actively refuses their medicine **and**
  - that person does not have capacity to understand the consequences of their refusal (determined under the Mental Capacity Act 2005) **and**
  - the medicine is deemed essential to their health and wellbeing

Mental Capacity Act 2005

- Health and social care practitioners should not administer medicines to a person without their knowledge (covert administration) if the person has capacity to make decisions about their treatment and care. (NICE guideline on Managing medicines in care homes)
- Before considering covert administration, you should test decisions and actions against the five key principles under the Mental Capacity Act 2005

Mental Capacity Act 2005

Principle one:

Every adult has the right to make his or her own decisions. You must assume they have capacity to do so unless it is proved otherwise

You must not assume someone lacks capacity because they have a particular medical condition or disability

Mental Capacity Act 2005

Principle two:

A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success

You should make every effort to encourage and support people to make the decision for themselves. If you establish lack of capacity, it is important to involve the person as far as possible in making decisions

Mental Capacity Act 2005

Principle three:

A person must not be treated as unable to make a decision merely because he or she makes an unwise decision

People have the right to make decisions that others might regard as unwise. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people

Mental Capacity Act 2005

Principle four:

Anything you do or decide for or on behalf of a person who lacks mental capacity must be in their best interests

Mental Capacity Act 2005

Principle five:

When making a decision or acting on behalf of a person who lacks capacity, you must consider:

- whether there is a way that would cause less restriction to the person's rights and freedoms of action
- whether there is a need to decide or act at all

Assessing mental capacity

The person is unable to make their own decision if they cannot do one or more of the following:

1. **Understand** what the medicine is for (information given to them about the medicine)
2. **Retain** the information for long enough to make an effective decision
3. **Understand** the benefits and risk of the medicine (weigh up the information available to make a decision) and understand what the consequences of not taking the medicine will be
4. **Communicate** their decision, using the means by which they would normally communicate

CQC Key Line of Enquiry

Mental Capacity Act 2005

S4.4: Are there clear procedures for giving medicines covertly, in line with the Mental Capacity Act 2005?

- Assessment that person lacks capacity to make decisions about medicines
- Best interest meeting to consider each individual medicine – should be the last resort
- Discussion with pharmacy about how to administer safely and ensure continued effectiveness

CQC Key Line of Enquiry

S4.6: How do staff assess the level of support a person needs to take their medicines safely, particularly where there are difficulties in communicating, when medicines are being administered covertly, and when undertaking risk enablement assessments designed to promote self-administration?

How do staff decide if a person needs to be given their medicines covertly? Is it always a last resort?

Provider responsibility

Health and social care practitioners should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the person who is receiving the medicine(s) and the staff involved in administering the medicines. (NICE guideline on Managing medicines in care homes)

Remember

- If the person has capacity they are entitled to refuse treatment for both physical and mental illness even when such a decision is considered to be unwise by others
- Giving medication covertly to someone who has capacity is a form of abuse
- People with a diagnosis such as mental illness or a learning disability do not necessarily lack capacity
- Some preventative medicines need to be given for several years to show any benefit and, depending on prognosis, the risk: benefit profile may not be favourable for that person
- Consider pharmaceutical issues e.g. absorption, interactions, palatability when administering medicines covertly

In this context of refusing medicines, who can assess mental capacity?

- Usually conducted by a senior carer or nurse involved in the daily administration of medicines to the person or other appropriately trained healthcare professional such as a GP or pharmacist
- In complex cases a specialist, such as a psychiatrist or psychologist, may need to be involved

Helping people to make decisions for themselves

- Does the person have the relevant information needed to make the decision?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Are there particular times of the day when a person's understanding is better or they are more likely to engage in conversation?
- Can anyone else help or support the person to understand information or make a choice?

Refusing medicines…..consider:

- Is medication mainly refused at certain times of the day.
- Is only particular medication refused?
- Are medicines consistently refused or taken some days and not others?
- What has been the consequence of refusing the medicine?
- Does the medication need discontinuing gradually or are there acceptable alternatives?
- Does the medicine have a side effect, e.g. confusion or drowsiness, which may have an adverse effect on cognitive function?
- Does the person have fluctuating capacity?

Best interest decision

Who should be involved? ……..MDT

- The person (past and present views, wishes, beliefs, and values)
- Care staff
- The health professional prescribing the medicine(s)
- Pharmacist (advise on most appropriate way to administer the medicine)
- Family member or advocate

Deprivation of liberty safeguards (DoLS)

- The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.
- **Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty**. These are called the Deprivation of Liberty Safeguards
- The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty
- **Care homes or hospitals must ask a local authority if they can deprive a person of their liberty**. This is called requesting a standard authorisation

Documentation and information

- The treatment plan must include recorded details of each medicine to be administered covertly, involving discussions with the multidisciplinary team and advice from the pharmacist
- Pharmacy teams may also provide additional written information regarding how to manipulate the medicine(s)

Case studies

- Getting it right

- Importance of planning how medicines will be administered without the resident knowing

Getting it wrong

- Medicine(s) just added to food and drink, no prescriber or pharmacist involved
- Mental capacity assessment
- No alternative methods of administration considered
- No clear decision making, no documentation
- “Advice received from pharmacist’’, no supporting documentation
- No clear documented process for administering the medication covertly
- No medication review
- No review date or “ongoing/indefinite’’ recorded

Best practice

- **Last resort** – least restrictive when all other options have been tried
- **Best interest** – all decisions must be in the person's best interest with due consideration to the holistic impact on health and well-being
- **Medicine specific** – need identified for each prescribed medicine
- **Time-limited** – used for as short period as possible
- **Regularly reviewed** – with specified timescales, as should the person's capacity to consent
- **Transparent** – easy to follow and clearly documented
- **Inclusive** – discussion and consultation with appropriate advocates for the person. Not a decision taken alone

- PrescQIPP- Best practice guidance in covert administration of medication (Bulletin 101, Sep 2015)

Best Practice

- Records of action to manage the condition or administer the medicine
- Mental capacity assessment recorded and regularly reviewed
- Records of the best interests meeting
- Deprivation of Liberty Safeguards (if applicable)
- Updated when new medicines are prescribed
- Regular reviews of whether covert administration is still needed
- Documentation of how medicines will be administered covertly with
- detailed and recorded pharmacist input
- The medicine policy should have a explanation of the covert administration process, in date (with a review date), read/understood and followed by all staff

Links and further information

NICE guidance

- Managing medicines in care homes (SC1)
- Managing medicines for adults receiving social care in the community (NG67)
- Decision making and mental capacity (NG108)
- Medicines management in care homes (QS 85)

Other relevant resources

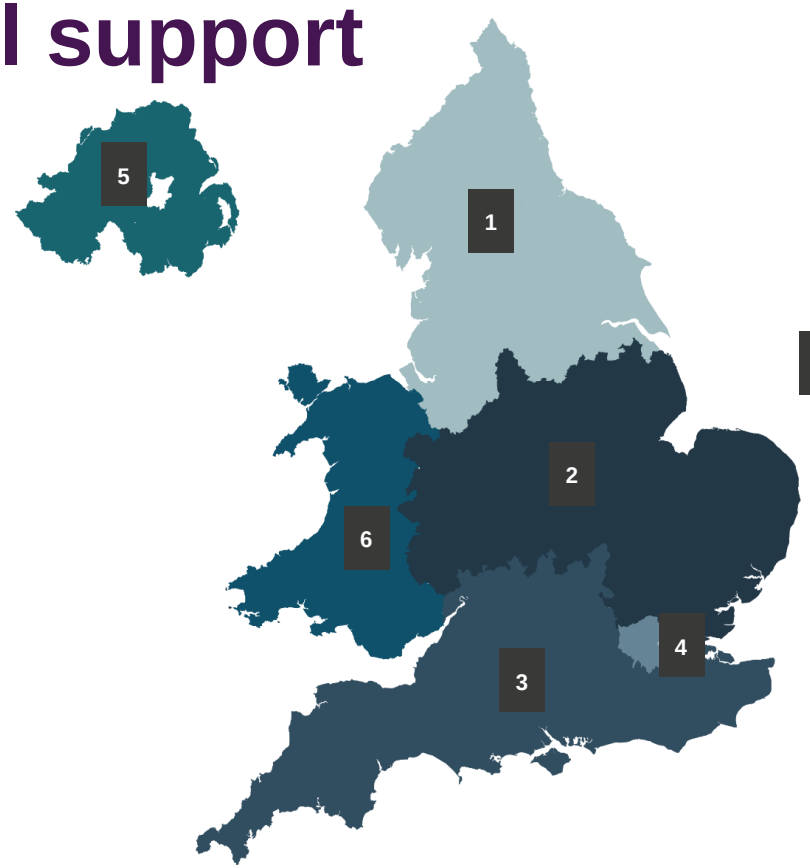
- Mental Capacity Act 2005 and the Code of Practice (available from the Office of the Public Guardian).
- Administering medicines covertly (Care Quality Commission)
- Medicines: information for adults social care services (Care Quality Commission)

Links and further information

- NICE adults' social care resources

- NICE/SCIE quick guides - A quick, easy way to access key information from NICE on social care topics, including:
  - Giving medicines covertly
  - Effective record keeping and ordering of medicines

NICE Field Team
regional support



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