PrescQIPP
Community Interest Company

Covert administration of medication

These guidelines detail the pathway that should be followed as best practice to support a decision to administer a medication covertly, thereby demonstrating that there is no other option available. An overview of the legal considerations around covert administration is provided as well as further resources to aid understanding of this complex issue.

Recommendations

- Prescribers should no longer use instructions to care home staff such as, "just mix with food" as a verbal or brief written instruction for covert administration of medications.
- Take the most appropriate action for each individual based on their capacity to understand the consequences of their decisions using a personalised care approach.
- Clarify the reason(s) for an individual's refusal to take their medication(s) as this understanding may present a resolution which does not involve covert administration.
- Review medication and consider whether deprescribing is appropriate for the individual as a first line approach.
- Test mental capacity against the five key statutory principles in assessing capacity before covert administration is considered as an option.
- The person directly concerned with the individual should use a Mental Capacity Act 2005 (MCA) assessment form to carry out the assessment (attachment 1).
- Complete a Best Interest Decision form for each individual refusing their medication. Each medication should be documented individually (attachment 2).
- Any organisation considering covert administration of medication should develop local policies to ensure best practice where covert administration takes place. This guidance has been produced to support the development of local policies.
- Agree the steps to be taken when considering covert administration of medication in individuals. The covert medication flow chart (attachment 3) can be used or locally adapted for this purpose.
- Covert administration should be used as a last resort, be medication specific, time limited, reviewed regularly, transparent, inclusive and in the person's best interest. The need for continued covert administration should be reviewed within time scales which reflect the physical and mental state of each individual.

Background

Covert administration is the administration of medicines in a disguised form without the knowledge of the person receiving them. Everyone has the right of refusal and current practice is inconsistent in recognising this right. Taking the most appropriate actions for each individual based on their capacity to understand the consequences of their decision is key to personalised care.[1]

There is now increased awareness of the need to review medication and consider deprescribing as a first line approach where risk/benefit assessment of need is considered. PrescQIPP Bulletin 254. Polypharmacy and deprescribing provides supporting evidence for clinicians in making such decisions.[2]

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There is a common misunderstanding around the practice of putting medication into food or drink to make it more palatable often at the request of the individual. This is overt administration and is a co-operative process that is transparent and open to scrutiny and audit, and by definition requires a capacity to understand what is being done. This could still be regarded as deceitful unless clear documentation supports the practice in the individual care plan.[3]

There is also a need to consider that covert administration is always assumed to be disguising oral medication.[3] Alternative routes of administration may be considered acceptable but the capacity to understand that a patch is delivering medication must be questioned and invasive routes such as suppositories may cause more distress and are equally not understood. Patches are often used for severe pain management in individuals with dementia who refuse oral medication and would therefore be considered in their best interest.[4] As capacity to understand their purpose is lacking, it is suggested that a best interest decision would be appropriate documentation for such people, as would the administration of a suppository or administering medicines via a feeding tube.[3] Decisions that are made must consider all options carefully for each individual.

In the context of care, it is important to explore the reasons why a person is refusing their medicines, as this might be resolved without resorting to covert administration. For example:

- A person may be refusing to take treatment because they find it difficult to swallow a large tablet or the taste of the liquid is unpalatable to them.
- A person may not understand what to do when they are presented with a tablet or a spoonful of a liquid possibly due to advancing dementia.
- Care home staff may be unfamiliar to the person and may not be respecting the wishes of the person for how they like their medication to be given to them.
- A person may have worries about side effects such as needing to go to the toilet frequently with diuretics and no-one has explained the benefits of taking the medicine.

These people are technically refusing to comply, but their reasons can be easily rectified through discussion with the person and prescriber, and appropriate support to manage the problem. This also emphasises the need for good personalised care plans which clearly detail personal preferences in order that consistent care can be delivered.

And finally, there is a lack of understanding in the use of “when required” medication, where refusal is often recorded when the medication is offered but declined.[5] Technically the person has refused but has made a decision which should be based on a judgement of “no requirement” as there is no medical need at that time. Unfortunately, this process may be managed very badly, unless the person is being told what it is they are being offered, what it is for, and the consequences of not taking it and has the capacity to understand. There is a lot more support needed to clarify the management of “when required” medication, which is beyond the scope of this guidance.

Purpose of the guidance

This guidance aims to support clinicians and carers who are trying to manage challenges in dealing with people who are non-compliant with medication through direct refusal. A decision to ignore a person’s refusal to take their medication could be legally challenged if appropriate steps have not been taken to exhaust all available options.

There is also a need to support a simplified approach to the implementation of due process, whilst ensuring that it satisfies legal requirements. It is therefore the intention of this guidance to provide simple tools to assist both healthcare professionals and carers supporting people in their care.

This guidance has been developed from reading existing good practice statements and the requirements of the law. Anyone considering covert medication should use this guidance to develop local policies and procedures.

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The guidance considers:

- The need to consider covert medication
- The legal framework for its use
- Practical guidance in how to administer
- A suggested care pathway for its use
- Some case examples.

Legislation

One of the reasons that unchallenged covert administration of medication continues within the care environment is a lack of understanding that it is potentially an unlawful act unless appropriate actions have been completed. Healthcare professionals must no longer expect carers to administer medication covertly from a verbal or written instruction to "just mix with food" or "give all medicines covertly". There may also be a lack of support from healthcare professionals due to a perception that complex and time-consuming processes are necessary. Awareness of legislation in this area of practice is essential, but complex decisions may require legal advice to protect the patient, care home staff and healthcare professional.

The British Medical Association (BMA) provides resources to support doctors with good decision making when providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf.[6] As the resources are based on the Mental Capacity Act (2005) they only apply to doctors in England and Wales. In Scotland, decision making in this area is covered by the Adults with Incapacity (Scotland) Act 2000. There is a separate Mental Capacity Act (2016) for Northern Ireland.

The Mental Capacity Act (MCA) 2005 (c. 9 Part 1 "The principles" Section 1) sets out a number of basic principles that must govern all decisions made and actions taken under its powers.[7] These are rooted in best practice and the common law and are designed to be fully compliant with the relevant sections of the Human Rights Act, 1998.[8,9] The MCA is accompanied by a statutory Code of Practice providing guidance on how it should be used. Certain people have a legal duty to have regard to the guidance in the Code of Practice, including anyone acting in a professional capacity.[10]

Due consideration must be given to the Human Rights Act 1998 and the following relevant sections of the Act have been highlighted by Royal College of Psychiatrists regarding covert administration.[11]

Article 2: 'Everyone's right to life shall be protected by law'

Where covert medication enables the provision of effective treatment to someone who would otherwise reject it, this article might be used to justify such a practice in the context of the wider issues considered.

Article 3: 'No one shall be subject to torture or inhuman or degrading treatment or punishment'

In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than the covert administration of medication. This substantiates the need to consider the consequences of alternative routes of administration.

Article 5: 'Everyone has the right to liberty and security of person'

To justify the invasion of privacy which covert medication entails, it must be clear that this invasion is justified by the need for effective treatment. This highlights the requirement for review of the clinical need to continue treatment by means of a risk/benefit discussion.

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Article 6: 'Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law'

It is essential that, if medication is administered covertly this is done following discussion, and with clear clinical records, so that a fair and public audit trail may be obtained when required or challenged by regulators.

Article 8: 'Everyone has the right to respect for his family life, his home and his correspondence'

See comments to Article 5 above.

Lasting Power of Attorney (LPA) is a legal tool that gives an adult the legal powers to make decisions for another person when they cannot make decisions for themselves. They can be appointed by the person, **while they have mental capacity**. Lasting Powers of Attorney are registered through the Office of the Public Guardian and in making decisions regarding medication must have been appointed to deal with health and welfare. An objection to covert medication by the LPA for health and welfare must be followed but this must be in the light of any advanced decisions which have been specified by the person.

However, if it becomes apparent that the LPA is not appearing to act in the person's best interests, the concern should be referred to the Office of Public Guardian to be considered by the Court of Protection.[12]

The Royal Pharmaceutical Society (RPS) and the Royal College of Nursing have jointly provided advice for nurses and other healthcare professionals on covert administration. Where deemed necessary, covert administration of medicines takes place within the context of existing legal and best practice frameworks.[13] Failing to document covert administration appropriately has led to nurses being subjected to Fitness to Practice hearings by the Nursing and Midwifery Council (NMC).[14]

Section 1.15 of the March 2014 NICE social care (SC1) guidance on managing medicines in care homes, makes it very clear that "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 resident who is receiving the medicine(s) and the care home staff involved in administering the medicines".[15] The full guidance also states that commissioners and providers of care should consider establishing a wider policy on the covert administration of medicines across health and social care organisations. This encourages integrated working and demonstrates the fact that carers need support from health professionals to deliver appropriate care. In developing such local policies, it is imperative to utilise the expertise of Mental Capacity Act leads within social care organisations to ensure that all legal requirements have been satisfied.[1]

General principles of covert administration

Human rights law is the first principle that determines the decision to proceed. The right to respect for private life means that individuals capable of making the decision have the right to accept or refuse medical treatment, even where a refusal could potentially lead to a detrimental outcome.[8] Medicines cannot be administered covertly to someone who is capable of making decisions about medical treatment.

So, the first step in the process is ascertaining the capacity of a person to make a decision about their medical treatment.

Where covert administration is being considered as the most appropriate option the following principles of The Mental Capacity Act 2005 should be applied:[3]

- **Last resort:** covert administration is the least restrictive when all other options have been tried.
- **Medication specific:** the need must be identified for each medication prescribed.

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- **Time limited:** it should be used for as short a time as possible and linked to the review timescales for each individual. Timescales should take into account the changes in people's health and social care needs, as possible improvements in behaviour may result in compliance when medication is offered overtly.
- **Regularly reviewed:** the continued need for covert administration must be regularly reviewed within specified time scales as should the person's capacity to consent. For example, review every time a new medicine is prescribed, or a dose changed, or at least every six months.
- **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:** 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. Key people should be involved in making a best interest decision (see step 2 in pathway below).

Suggested care pathway

The pathway is represented simply in a flow chart included in attachment 3. Below is a more detailed step by step explanation which provides the necessary background information.

Step 1

Assessing mental capacity (MCA assessments)

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.[7] 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 person must be assumed to have capacity to make a decision unless it is established that he or she lacks capacity.
2. A person is not to 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, advocates or communication support may be necessary.
3. A person is not to 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. This does not mean that the person does not have capacity.
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 had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Process of assessment

For the purposes of assessing capacity to understand medication there will be a need to first establish that a person is unable to make a decision because of an impairment of or disturbance in the functions of the mind or brain.[7] This clinical diagnosis provides the justification for proceeding. The second stage of assessment can only proceed if the answer to the first stage is "yes". Consideration should be given to the patient's country of origin and their understanding of English as well as how to meet their communication needs.

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A patient will be considered to lack mental capacity in law to make a decision or to consent if he or she is unable to:

- Understand in simple language (using their normal method of communication which may be non-verbal) what the treatment is, its purpose and why it is being prescribed
- Understand its 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.

Where an individual fails one or more parts of this test, then they do not have the relevant capacity at this time.[6]

An advance decision to refuse particular treatment in anticipation of future incapacity must be adhered to if valid and complete. The person 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 advance decisions and that carers are aware within care plans. This may be clarified by a previously appointed LPA.

When an emergency arises in a clinical setting and it is not possible to determine the person's wishes, they can be treated without their consent provided the treatment is immediately necessary to save their life or prevent a serious deterioration of their condition. The treatment provided must be the least restrictive option available. Any medical intervention must be considered to be in the person's best interest and should be clearly recorded noting who took the decision, why the decision was taken and what treatment was given and when.[6]

Who can carry out a mental capacity assessment?

It is important to note that capacity assessments are always "task specific" and an assessment specific to the patient's refusal of medication should be undertaken. This is usually completed by an appropriately trained senior carer or nurse involved in the daily administration of medicines to the patient. However, if the outcome of the assessment is not entirely clear, an appropriately trained healthcare professional (e.g. GP or specialist nurse) should be involved.[16]

The most appropriate person who can make a task specific assessment of an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.[7]

Difficult situations may arise where a person may have fluctuating capacity or limited capacity and there may be uncertainty. Occasionally an individual whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive explanation of the potential consequences of such a refusal, such as the possibility that any decision they may make will be challenged at a later date, will be sufficient for them to agree. However, if the individual flatly refuses, in most cases no one can be required to undergo an assessment. In such situations a healthcare professional must always be involved, and Court of Protection decisions may be necessary. Covert administration would not be appropriate until a decision is made.[6]

MCA assessments benefit from involvement of LPA, family, close friends or carers especially where there is any doubt about a decision.

One of the reasons why MCA assessments fail to be carried out by healthcare professionals is due to the complexity of some of the paperwork. To support the assessment process, a suggested MCA format has been produced from examples of forms used across many organisations. This has simplified the questions which are necessary to make the assessment legally valid. See attachment 1.

A copy of the MCA assessment should be available in an individual's care plan.

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Deprivation of Liberty (DoL)

The Deprivation of Liberty Safeguards (DoLS), is an amendment to the Mental Capacity Act 2005. In July 2018, the Government published a Mental Capacity (Amendment) Bill which passed into law in May 2019. In the amendment DoLS was replaced by the Liberty Protection Safeguards (LPS). Under LPS, there is a streamlined process for authorising deprivations of liberty. LPS are due to come into force on 1 April 2022, though existing DoLS authorisations will remain in place until they expire.[17]

The MCA allows restrictions and restraint to be used in caring for a person, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is aiming to prevent, and can include the use of some medication, for example, to calm a person or modify behaviour.[6,7]

The potential lack of compliance with legal frameworks was highlighted in a court case AG v BMBC & Anor [2016] EWCOP 37. District Judge Bellamy has given some useful, clarification as to the seriousness of the consideration that must be given to the use of covert medication, especially in the context of DoLS authorisation.[18]

In the case of most medication administered covertly, the need for DoLS would be considered within the context of each individual case and together with any other criteria which contributes to the potential to deprive a person of their liberty. Covert administration of medications to a patient may add to a package of care that amounts to a deprivation of their liberty. This is more likely if the medication alters mental state, mood or behaviour, and if it restricts a patient's freedom.[16]

As District Judge Bellamy noted, the covert administration of behaviour modifying medication is often associated with control, giving rise to a deprivation of liberty. It is clearly important that, where the results do give rise to such a deprivation, they are monitored and controlled by reference to the provisions of DoLS.[16] It should also be noted from this case that any changes in medication after the DoLS has been authorised would need a clear Mental Capacity Act 2005 Part 8 review process.[16]

Step 2

Best interest decision

The individual has been assessed to lack capacity to understand the consequences of refusing their medication. The next steps **cannot** be taken unless this has been determined.

'Best interests' is a method for making decisions which aims to be objective. It requires the decision makers to think what the 'best course of action' is for the person. It should not be the personal views of the decision-makers. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them.[6]

The Mental Capacity Act 2005 provides a checklist which must be followed when making a decision for someone.[7]

Summary of best interest checklist[19]

- Consider all the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision - and
- Consider a delay until the person regains capacity - and
- Involve the person as much as possible - and
- Not to be motivated to bring about death - and
- Consider the individual's own past and present wishes and feelings - and
- Consider any advance statements made - and
- Consider the beliefs and values of the individual - and

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- Take into account views of family and informal carers - and
- Take into account views of Independent Mental Capacity Advocate (IMCA) or other key people - and
- Show it is the least restrictive alternative or intervention.

A person may be mentally incapacitated for various reasons. These may be temporary reasons, such as the effect of sedative medicines, or longer-term reasons such as mental illness, coma or unconsciousness. It is important to remember that capacity may fluctuate, sometimes over short periods of time and should therefore be regularly assessed by the clinical team treating the person. There may be a need to consider delaying the decision to administer medication covertly if there is a significant chance that capacity will be regained and delaying the decision will not have life threatening risks.[6]

Who should be involved in making a best interest decision for medication issues?

Best interest decisions involving medication should be made by the prescribing practitioner in conjunction with a multidisciplinary team of healthcare professionals. Face to face meetings may not be necessary or always be possible but it is important that all key people have been consulted. With more input from care home pharmacists now, it may be possible for them to be the coordinator for the process, as well as checking the suitability of the medication to be administered in this way.[16]

The person's LPA/family/friends/carers/advocates must be involved in and informed of the decision to administer medication covertly (note however that nobody can consent for someone else; but the views of family/carers may be beneficial in determining a person's wishes and feelings and what is in their best interests). Where there is an appointed LPA this should be documented in the persons care plan and their input is essential. In cases where there is no-one to consult with, there is a need to refer to the advocacy service and an Independent Mental Capacity Advocate (IMCA) should be invited to represent the patient. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions (including about where they live and about serious medical treatment options). IMCAs are mainly instructed to represent people when there is no one independent of services, such as a family member or friend, who is able to represent the person.[16,19]

Factors to consider before deciding to covertly administer

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, and 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 with reasons for the decision. Clinicians are frequently concerned of medico-legal challenges in stopping medication but supporting documentation provides evidence for their decision.[1,19]

Patterns of behaviour need to be monitored. A person may refuse their medication at certain times of day. Can the timing of administration be altered? Is there a formulation which can be given less frequently?[16]

Dementia commonly presents challenges to carers administering medication. Dementia training is essential to develop persuasive techniques and document personalised preferences such as particular carers, environment, ways of giving etc.

Consideration should be given to whether a medicine may affect taste and ability to eat or drink, for example by causing dry mouth. This is particularly important for people who are already finding it difficult to eat and drink well. 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). As indicated in the initial introduction, the alternative route could still be considered covert and therefore should be documented.[3,12]

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Step 3

Suitability of the medication

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

A best interest decision is essential for each medication prescribed. Each time new medicines are started, the need must be assessed again in an MDT meeting.[3] In some circumstances, if it is not possible or practicable to have a face-to-face meeting, then a decision regarding covert medication can be made as long as a discussion has taken place with all the relevant people.[12]

Always check with a pharmacist to make sure that the properties of the medicine (e.g. bioavailability) will not be affected by administering it covertly. For example, modified release (e.g. MR/SR/CR/XL) and enteric coated (E/C) preparations are generally not suitable for covert administration as they cannot be crushed.[16,20]

For care staff administering medication in an unlicensed way (off-label use) it is essential that a pharmacist's advice has been sought and documented which supports this practice. This is also of importance for registered nurses who are working within their professional codes of conduct.[16,20]

The prescriber, pharmacist and administering professional/care home staff member 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 should refer to the standard texts, the SPC for the medicine(s) concerned, and specifically to appropriate reference sources to advise on suitability.[12,21]

The prescriber should ensure that additional instructions for administering covertly are included on the prescription which should be printed on the label by the dispensing pharmacy. Such as "capsule to be emptied and mixed with food as detailed in care plan when covert administration is necessary".[22]

Step 4

Record keeping

Good record keeping is essential for ensuring safety and quality of care. Covert administration of medication will be challenged by regulating bodies such as Care Quality Commission (CQC) unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the persons care and clear documentation is essential.[3]

It is not appropriate to act on an "ad hoc" verbal direction or a written instruction to covertly administer as this would not constitute appropriate documentation and could be subject the nurse administering the medicine covertly to a Fitness to Practice concern.[14]

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 person/care team.[3,11]

An appropriately trained member of care staff 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 carers are aware of the correct process. In many care homes a profile sheet for each resident supports the Medicines Administration Record (MAR) sheet. It would be useful to highlight on this profile sheet that covert administration may be necessary and to refer to the best interest decision documentation (attachment 2) for details of personal preferences.[16]

Each time medication is administered covertly in accordance with the care plan it should be clearly documented, for example, on the back of the MAR sheet or in line with the care home policy.[3]

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It is also useful for kitchen staff in care homes to be aware of a person who is being given medication covertly as dietary changes may be needed.

Where administration is unsuccessful this must be documented, and any consequences reported to the prescriber and the GP/specialist in time scales as agreed at the commencement of the treatment and within the best interest decision.[13]

Examples of documentation templates are included in the care homes webkit - https://www.prescqipp.info/our-resources/webkits/care-homes/

Step 5

Practical points for administering covertly

In the context of care, it is important to remember that dignity and respect must be maintained.

- Care home staff must be supported by healthcare and other professionals as necessary to be able to deliver care appropriately with due regard to their accountability.
- Consistency in practice is only possible if care home staff are given clear guidance that they can follow. For this reason, it is clear that provider organisations must develop process driven covert medication policies as detailed in NICE guidance SC1.[15]
- Care home staff who are trained to administer medication should consider the following points when covert administration has been deemed necessary.
  - Ideally a person should be offered their medication overtly each time, especially where fluctuating capacity is evident. This can be done with dignity, knowing the behaviour patterns of the person. In this way covert administration doesn't become the default and respects the principle that covert administration of medicines should be a last resort.[3,11]
  - The care home staff should be aware of personal preferences for administration through the care plan. Refusal after appropriate steps have been taken, as detailed in the care plan, can then proceed to covert.
  - In general, the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible (rather than the whole portion). This increases the likelihood that the prescribed dose is actually taken. Being able to quantify the dose administered as far as possible is important. Not all drinks are suitable, e.g. tea or milk interacts with some medication and this should be documented clearly.[16,20]
  - Different medications should not be mixed together in food or drink as this cannot be quantified and also could be unsuitable to be mixed together. There may be some cases where mixing different medicines together may need to be carried out in the best interest of the person. If this is the case, it should be agreed by a multidisciplinary team and clearly documented in the care plan.[16,20]
  - The medication must be administered immediately after mixing it with the food or drink. It must not be left for the person to manage themselves. If the person is able to feed themselves, observe to ensure that it is consumed.[20]
  - Each time medication is administered covertly in accordance with the care plan it should be clearly documented on the MAR sheet.[13]
  - Refusal of the food or drink containing medication must be recorded on the MAR sheet as refusal. It should also be noted if it is partially consumed as the dose is then uncertain.[13]
  - Refusal of covertly administered antibiotics could potentially result in hospital admission so the prescriber should be notified promptly.[13]
  - Good record keeping provides evidence to enable the prescriber to review the continued need for covert administration.[13,20]

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Step 6

Review of continued need

The need for continued covert administration should be reviewed within time scales which reflect the physical and mental state of each individual. This should be agreed at the time of implementing covert administration within the best interest decision. It is particularly important at end of life that relatives or advocates are made fully aware of the decisions that are made around medication, particularly if medication is stopped so that they are reassured.[12,20]

Where behaviour modifying medication is being administered, the best interest review process must be more frequent and well documented as reflected in previous legal cases.[12,17,18]

Referring back to the general principles, the least restrictive approach should be the first option that ultimately requires a review of risk/benefit in stopping the medication, especially if evidence of non-compliance demonstrates no apparent harm.[16]

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Further reading

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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-269-care-homes-covert-administration/
Implementation tools	

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