Supplement 3 *Croydon Clinical Commissioning Group*

Appendix 1 Covert Administration Medication Record Form

(Part 1- covering sheet- to be used in conjunction with Part 2)

Name of service user **Date of birth**

Date of meeting

An assessment by medical practitioner has been performed to • confirm service user lacks capacity to consent. • confirm the continued need for the above treatment following a medication review confirm that covert administration is essential	Assessment completed and appropriate document stored in service users notes Signature …… Name …….. Designation …… Date ……

Name all involved in the best interest meeting (e.g. health care professionals, carers, family etc.)

Name	Designation	Date
……	……	……..
……	……	……..
……	……	……
……	……	……

Is there a person with power to consent on behalf of the service user i.e. an attorney or Court appointed deputy? **Treatment may only be administered covertly with that person's consent unless it is impractical to consult**	Yes/No If Yes, name…… (relationship to service user) ……

Is there an advance decision in place refusing the relevant treatment Yes/No

Or has the service user expressed views in the past that are relevant to the present treatments? Y/N
If yes, what were those views?

Part 2 **Use a <u>separate sheet for each medication</u> that is being considered for covert administration** **(refer to checklist [App 4] when completing)**	
Name, form, strength and dose of medicine:	
Indication (i.e. what is the treatment for) try to be specific e.g. not just high blood pressure but give readings	
Describe why this treatment is necessary and what are the consequences of it not being taken?	
What alternatives have the multidisciplinary team considered? (e.g. other ways to manage the condition or administer treatment) Why were these alternatives rejected?	
What are the risks associated with this medicine e.g. side effects, consider if the taste might affect their attitude to eating/drinking.	
Record decision taken and rationale	
Name and signatures of those agreeing with decision	
Name and designation of anyone who disagrees with the decision –please state rationale and confirm that they are aware of their right to challenge the decision	
When will the need for covert administration be reviewed? Please refer to Administration of Covert medication Review Form (appendix 3) when review is performed	Date for first planned review

Continued overleaf

Name the pharmacist consulted and record advice given e.g. formulation advise, crushing advice, side effects, effectiveness of treatment Pharmacist name…… Place of work Date……..	Advice given (ask them to complete a summary on appendix 2 for all the medicines)
Which 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? Please also complete appendix 2 with this information. How will this be recorded on the MAR chart?	Names……. …….. …… …… …….. …… ……

Care Provider Manager‘s signature Name

Date

To be stored in service user’s notes

(Photocopy as necessary to provide a record for each medication)