Supplement 3

NHS
Croydon Clinical Commissioning Group

Appendix 4-Covert administration best interest meeting – checklist and aide memoire to best practice

Covert administration is the act of disguising medicine, usually in food or drink so that the person is unknowingly taking medication. Giving medication covertly without following the proper processes could be regarded as abuse.

This is not the same as someone asking for their medicine to be mixed with food or drink to make it easier or more palatable for them to take.

The decision to administer medicines covertly must be clearly justified in the record that documents the decisions from the best interest meeting. The management plan (i.e. how the medicines will be administered covertly) and also the names of those involved in the meeting must be documented.

The best interest meeting should include: care home staff, prescriber, pharmacist and family member/representative or advocate as well as any other involved party. Remember where the person has an attorney or Court appointed deputy for personal welfare decision, they are responsible for making the best interest decision. An independent mental capacity advocate (IMCA) may be required where there is no one other than paid carers to consult and the medication is deemed to be serious medical treatment. The best interest meeting must consider the best way to involve the person and take into account their views. .

All medicines have the potential to be harmful, especially in the older frail person, so it is important to carefully consider the need and benefit of each medicine against the risk as part of the best interest meeting. Many medicines can cause confusion, drowsiness or dizziness in older people- inappropriate administration may inadvertently result in a deprivation of liberty for that individual. (Code of Practice Deprivation of Liberty Safeguards 2009)

If agreement is reached that a medicine can be given covertly it must be remembered that it should **not** be considered routine, nor is it a transferable decision to another newly prescribed medicine. If a new medicine is prescribed then the process must be repeated.

The person should still be given every opportunity to understand the need for medical treatment and to make and communicate decisions.

The checklist overleaf has been developed to help members of the best interest meeting reach an informed and sound decision.

See overleaf for the checklist and further information:

NICE: Guidelines for Managing medicines in care homes*:* http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes

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	Appendix 4 -**Checklist for best interest meeting re consideration of covert administration:**		
	Action point	**Comments/rationale**	**Tick**
1.	Is it clear that a mental capacity assessment has been completed?	Remember there is always an assumption that a person has capacity and the reason for incapacity must be recorded Any covert administration of medicine to someone with capacity is trespass and would be considered abuse	
2.	Each medicine is considered separately	Even medicines prescribed synergistically for the same indication will have different risk: benefit profiles. It might be better to have a condition less well managed with fewer medicines given covertly Older people often have multiple co-morbidities and the benefits of treatment may vary. Refer to appropriate guidelines for medicines that are less appropriate for older people e.g. BNF chapter prescribing for the elderly, STOPP:START toolkit, Polypharmacy: Guidance for prescribing in frail adults-All Wales Strategy Group	
3.	Confirmation that the medicine is still indicated	For instance angina symptoms may no longer be a problem if the person is now less active. How long ago was the original diagnosis? Is it still relevant? Is there any monitoring that can help the decision e.g. check the blood pressure history for anti-hypertensives; check the HbA1c for diabetics Check that the medicine is not being given for the side effect of another e.g. constipation, nausea, oedema, headache Think whether it is so essential that it needs to be given by deception?	
4.	Have alternatives been discussed? What is the least restrictive in terms of the person's freedom?	Consider non-medical alternatives and which of these might be least restrictive. Why were alternatives rejected? Are some carers successful in getting consent for administration – can others learn from their approach?	
5.	What is the actual benefit of the medicine?	Record what the benefit will be. Consider NNT (numbers needed to treat) when considering benefit For preventative medicine, is the person's prognosis is good enough for them to benefit within their remaining lifetime e.g. post MI a statin may prevent a further major coronary event in one person out of 80 in the next 5 years The person has probably been without the medication for a while before covert was considered- has there been any deterioration whilst they haven't been taking the medicine?	
6.	Have the risks been discussed?	Include risk of refusing to eat or drink because of the change in taste. All medicines have risks which need to be considered e.g. aspirin can cause gastric bleeds, antipsychotics can increase risk of stroke, many medicines can increase risk of falls, many analgesics will increase risk of constipation.	
7.	Consideration of the past beliefs of the person towards medication	Research shows that over 20% of people in their own homes make a conscious decision not to take their medicines as intended by the prescriber. Could this person be exercising their right to refuse? For some people treatment which improves quality of life might be considered essential whilst others may have wanted as long a life as possible and as many interventions as available.	
8.	The date of review is documented	Ideally the decision will be kept under constant review and an agreed method of feedback available to care staff put in place. The date for the next formal review meeting needs to be agreed and documented. This will vary depending on the individual but would recommend no longer than 3 months.	
9.	A pharmacist has given written advice on the formulation, crushing and mixing with food or drink if appropriate.	Crushing a medicine will result in it being used off-licence. Some medicines can be dangerous if crushed e.g. slow-release preparations Some medicines may not be effective if crushed e.g. those that have to pass through the stomach before absorption.	
10.	Are the instructions clear on the MAR (medicines administration record)	Although covert administration should never be considered routine it is important that when it is necessary that the care staff have all the information available to do it in accordance with the best interest decision.	