

**Kent and Medway ICB**

# Covert Administration of Medicines

**Best Practice Guidance**

## Version History

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## Introduction

The purpose of this document is to give guidance and inform care home staff in adult social care settings of the **best practices in relation to the covert administration of medicines.**

The care home should have a covert administration policy and procedures in place following NICE (SC1 and QS85) and SCIE guidance that is specific to the care homes processes, that all members of the staff should adhere to.

**This best practice guidance does not remove the professionalism or accountability of healthcare staff. It is the responsibility of each professional to practice only within the bounds of their competence and ensure they continue to keep their professional development up to date.**

Covert administration of medicines is a complex issue and involves the administration of a medicine without the resident's knowledge or consent, disguised in food or drink to a resident who lacks capacity and resists it when given it openly, where a best interest meeting has been held with the appropriate people, and it is agreed to be in the best interest of the resident to do so.

Section 44. of The Mental Capacity Act 2005 makes it a criminal offense to wilfully neglect care. Therefore, for patients/residents lacking the capacity to accept or refuse medication, covert medication must be considered.

Covert administration of medicines can only occur in exceptional circumstances and applies exclusively to those people who lack capacity to consent to treatment under The Mental Capacity Act 2005 where careful assessment of the patient's needs through a best-interest meeting and the medication has been deemed essential to the person's health and wellbeing.

The refusal of medicine by a resident who has capacity must be respected. If a resident is refusing their medicines, they should be asked why they have decided to do this to establish if there are issues that can be addressed. The prescriber should be contacted to review the resident's treatment.

If an individual has the capacity to consent to treatment under **NO** circumstance can medication be administered covertly.

### The following stages need to be considered

#### 1. Consent and Capacity

*“The MCA says a person is unable to make a decision if they cannot do 1 or more of these things: understand the information relevant to the decision. retain that information for long enough to make the decision. use or weigh up that information as part of the process of making the decision. [Mental Capacity Act - Social care and support guide - NHS \(www.nhs.uk\)](https://www.nhs.uk)*

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Care staff should take the opportunity to discuss the issue of covert administration of medicines with residents in the early stages of Dementia, or when they have ‘capacity’ so that residents themselves can be involved in decisions in advance about any covert administration of medicines that may become necessary. End-of-life practitioners should help with advanced care planning needs.

A person with mental capacity has the legal right to refuse treatment, even if a refusal will adversely affect their health or shorten their life. Care staff must respect this decision.

It is also possible that the patient’s mental capacity fluctuates sometimes over short or long periods of time. This should influence the frequency of reviews done and should be determined in the best interest meeting considering individual circumstances.

**Failure to do so may amount not only to criminal battery or civil trespass but also to a breach of Article 8 of the European Convention on Human Rights, the right to respect for private and family life.**

The exception to this principle concerns treatment authorised under the relevant mental health legislation

- **The Mental Capacity Act 2005** defines mental incapacity and how it should be assessed. The Act states that there must be a presumption of capacity even when a person makes an unwise decision, unless it has been established that the person lacks the capacity to make a particular decision, and the treatment options must be the least restrictive possible on the person’s rights and freedom. [Mental Capacity Act 2005 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2005/9)
- **Deprivation of Liberty Safeguards (DoLS)** may be authorised to reasonably restrict a person’s liberty in their best interests if they are under continuous supervision and control and lack the mental capacity to decide on their care, accommodation, and treatment. Deprivation of Liberty Safeguards are statutory checks that aim to ensure that any care that restricts a person’s liberty is both appropriate and in their best interests for example the covert administration of sedatives.

If a resident has been deemed to not have the capacity, decisions can be made on their behalf in their best interest, and covert administration of agreed medications may be judged as being in their best interest (Appendix 1- Covert Medication Decision Form)

## 2. Best Interest Meeting

The purpose of the best interest meeting is to discuss the treatment options for the resident considering their capacity and whether it is in the resident’s best interests to have their medications administered covertly.

At a Best Practice Meeting the following representatives should be present to discuss and agree on the decision to covertly administer medication in the current circumstances.

- The care home staff (senior manager or nurse)
- GP
- Pharmacist (PCN, GP, or community pharmacist)
- A person who can communicate the views and interests of the resident.

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- the next of kin who can decide on behalf of the resident
- Independent Mental Capacity Advocate (IMCA) (depending on the resident's previously stated wishes and individual circumstances)
- Lasting power of attorney (LPA) for health and welfare if the patient has appointed one.
- Other relevant health professionals (Mental health team or District nurse)

**Failure to consult with the General Practitioner and Pharmacist before commencing the administration of covert medication regimens is likely to result in a referral to CQC and an adult safeguarding investigation.**

If a resident made an advance decision (while they had had mental capacity to do so) to refuse a particular medical treatment, then that must be followed, but refusal of life-sustaining treatment must be in writing.

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 if a discussion has taken place with all the relevant people. All discussions must be documented including who was involved in making the decision.

Please see additional information about conducting best practice meetings and undertaking a mental capacity assessment.

- Contact Medway Council for guidance and support.  
General enquires: 01634 333 333
- Kent County Council website  
[Mental Capacity Act forms and guidance - Kent County Council](#)

**2.1 Alternatives**

Administering medication covertly should not be considered routine, it is considered good practice to discuss alternatives with the residents' nominated prescribing doctor and/or pharmacist.

If the resident refuses medication at a specific time of day or is drowsy during the medication round, consider changing administration to a more appropriate time.

If for any reason the resident is unable to take medication, for example: Swallowing difficulties or Choking risks, then alternative formulations could be considered.

Crushing medicines and mixing medicines with food or drink (to make it more palatable or easier to swallow) for administration when the person has consented / or has capacity does not constitute covert administration (Note: crushing medications constitute off-label use of the medication, so factors around that will still apply)

**If all possible alternatives have been considered and exhausted only then should covert administration be considered.**

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A medication review must be completed with a prescriber to identify whether medicines are essential (including at the end of life). It may be possible to stop some non-essential medicines rather than to convert them to administer covertly.

**2.2 Administration**

The method of giving the medication covertly must be checked with a pharmacist who is in the best position to advise and to ensure the medication remains efficacious and its pharmaceutical integrity and stability are not affected so that the resident still benefits from the medication once crushed and mixed with food.

Administering medicines covertly outside of the product license has professional implications for prescribers, and this should be taken into consideration when prescribing medication covertly.

Only trained and competent staff should administer medications covertly.

If not involved in the decision, the community pharmacy should be informed of the agreed administration.

**3. Documentation**

Care Plans should show mental capacity assessment, assessment of need, and who was involved in the assessment process. Records of details are also to be included in any medicine profiles.

A written agreement of any decision made at the best interests meeting, the action taken, and the names of all parties involved should be obtained and documented in the resident's care plan and medicines profile. (Appendix 1: Covert Medication Decision Form).

Evidence of DoLS, if in place, should also be kept.

Any instructions and information related to the covert administration of medication must be documented in MAR/eMAR for easy accessibility. For example: crush a tablet and add it to a spoonful of yogurt. (Appendix 2: Covert medication administration record form).

**4. Regular reviews**

Review for the need for continued covert administration of medicines by the care home Manager or registered responsible person (GP or a Pharmacist), with a nurse or clinician, must be on a planned and regular basis, and recorded. (Appendix 3 - Covert Administration Review Form)

Mental capacity assessments should also be reviewed to continue to support any decisions made.

Each subsequent new medication added to the regime, or dose change to a current medication, should trigger a review. The decision to administer each additional new

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medicine covertly or any change in the administration regime must be communicated to the supervisory body or relevant resident’s representative and the DoLS.

The timescales of reviews should reflect the resident’s condition and what medications are being administered, whether this is for a short or long-term condition.

Initially reviews should be frequent e.g. weekly on the commencement of a covert administration and evidence of ongoing attempts to encourage compliance is essential.

**5. Training, Competency and Supervision**

It is important that care home staff administering medication covertly is, able to do so safely and effectively and should receive the appropriate level of training and supervision. The care home should have specific training, policies and procedures in place for covert administration of medicines. The training must be up to date and those administering should be signed off as competent to administer.

**6. Support Contacts**

- The Care Quality Commission Tel: 03000 616161  
[Care Quality Commission \(cqc.org.uk\)](http://www.cqc.org.uk)
- The Nursing and Midwifery Council: 0207 333 9333  
[The Nursing & Midwifery Council - The Nursing and Midwifery Council \(nmc.org.uk\)](http://www.nmc.org.uk)
- Integrated care team at Kent and Medway ICB  
[kmccg.medicinesoptimisation@nhs.net](mailto:kmccg.medicinesoptimisation@nhs.net)

**Further Information**

Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety.  
[https://services.cqc.org.uk/sites/default/files/gac\\_-\\_dec\\_2011\\_update.pdf](https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf)

Further information on the handling of medicines in Social Care’ can also be found on the Royal Pharmaceutical Society website: <https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines>

Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](http://www.legislation.gov.uk)

Royal College of Psychiatrists. <http://www.rcpsych.ac.uk>

NICE QS85 (derived from the NICE SC110 guidance)  
<https://www.nice.org.uk/guidance/qs85/chapter/Quality-statement-6-Covert-medicines-administration>

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NICE Guideline 108 on Decision-making and mental capacity <https://www.nice.org.uk/guidance/ng108>

The Royal College of Nursing provides professional guidance on the Administration of Medicines in healthcare settings which is available on their website [www.rcn.org.uk](http://www.rcn.org.uk).

[Covert administration of medicines - Care Quality Commission \(cqc.org.uk\)](http://cqc.org.uk)

CQC: [20171020-adult-social-care-kloes-prompts-and-characteristics-showing-changes-final.pdf](https://www.cqc.org.uk/publications-and-reports/20171020-adult-social-care-kloes-prompts-and-characteristics-showing-changes-final.pdf) (cqc.org.uk)

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## Appendix 1- Covert Medication Decision Form

Name of Resident		Date of birth	
Care home		Date	
Completed by		Position	
Capacity assessment completed	<b>YES/NO</b> if no this <b>must</b> be completed prior to covert administration being considered		
Name and signature of staff member completed mental capacity assessment			
Date mental capacity assessment completed			
Does patient have insight in to their condition? Do they have capacity to make a decision regarding medication?			
What other treatment has been considered? Why were these rejected? (e.g. alternative methods of administration or other ways to manage the person / behaviour)			
If known, what are the past views of the patient regarding treatment?			
List of medication being considered for covert administration	Why is the treatment essential and in the best interest of the patient		
The decision to administer medicines covertly has been discussed and agreed by			
	Name and signature	Date	
Named nurse			
GP			
Next of Kin/Advocate			
Other specify role			
<b>Review date</b>			

## Appendix 2- Covert Medication Administration Record Form

To be completed by a pharmacist

Name of Resident		Date of birth	
Care home		Date	
Name of pharmacist		Organisation	
Name of current medication form, strength, dose, and frequency	Details of any changes (e.g. preparation, new frequency/dose if appropriate)	Administration details (e.g. crush and mix with water/food etc)	


### Appendix 3 - Covert Administration Review Form

*This form is to be used to evidence a review for the continued need of covert administration. If significant changes to medications have been made since initial meeting, the covert medication plan should be fully updated.*

Name of Resident		Date of birth	
Care Home		Date of review	
Reason for review	Change to treatment / Review date / Change in circumstances		
Is covert administration still required	YES/NO		
Give reason for decision.			
Are all the relevant legal documentation still in place and up to date (DoLS/mental capacity assessment)			
Are all medications still necessary	YES/NO		
If no give details			
Name and role of persons involved in review			

Name and position of person leading review		Date	
Signature			
Name and position of 2 <sup>nd</sup> person completing the review		Date	
Signature			
Date of next review			