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Calderdale Multi-Agency Guidance on Covert Medication and

Deprivation of Liberty

Introduction

Following a recent Court of Protection judgement: (AG v BMBC & Anor [2016]) (the "BMBC case") concerning covert medication, Deprivation of Liberty and the Mental Capacity Act, the Calderdale Safeguarding Adults Board have issued this guidance. The case will be of interest to all professionals who work in this area, particularly health professionals, care home and homecare staff and social workers.

This guidance should be read in conjunction with the Mental Capacity Act 2005, the Care Act 2014, Care and Support Statutory guidance, Human Rights Act 1998, your agency's covert medication policy, Advance Decisions policy, the court judgement above, and the NICE Guidance on covert administration. See:

Quality statement 6: Covert medicines administration

What is Covert administration of medication?

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. (NICE guidance).

Patients with swallowing difficulties may need medication administered with soft food. Administering medication in this way would not be considered as covert if the patient is fully aware and has consented to having their medication administered in this way.

Examples of what is covert medication and what isn't:

1. Medication given via a Percutaneous endoscopic gastrostomy (PEG) feed **would not** be considered covert medication unless the person was refusing it and it was given without their knowledge
2. A person who lacks capacity to decide whether to take their medication but does so willingly **would not** be considered covert administration because the medication is not disguised.
   However, it must be remembered that if someone who lacks the capacity to consent to taking their prescribed medication is supported to take their medication in a different way or medium, say with yoghurt or a spoonful of food (in order to help them to swallow it) – then this is likely to be being done without their consent or knowledge. Although there may be no intent to hide the medication, the decision to give it in this way would be being made in the person's best interests, and not be a conscious choice of the person in question, and so consideration as to the safety of the route of administration would be a vital part of any such best interests decision making. In such cases, it would be good practice to follow the same steps outlined in this policy, to ensure that due

consideration is given as to the safety of any proposed care plans to assist a person to take their medication in any different ways or mediums that may affect the medication that is being given.

3. A person lacks capacity to consent to taking their medication, a best interest decision is made that they should have the medication and they are refusing it and the only way to ensure the person takes the medication is to hide it (in jam or yogurt for example) **would be** considered covert administration.

When can the covert administration of medication be used?

Covert administration of medication should only be used in exceptional circumstances and when deemed necessary and in accordance with the Mental Capacity Act. This means that only those people who have been subject to an assessment of their capacity to consent to taking medication and have been deemed to lack capacity. Medication should not be administered covertly until after a best interest meeting has been held, unless in urgent circumstances.

> A competent adult has the legal right to refuse treatment, even if a refusal will adversely affect his or her health or shorten his or her life. Therefore, care staff must respect a competent adult's refusal as much as they would his or her consent. Failure to do so may amount not only to criminal offence, but also to a breach of their human rights.

Who is responsible for carrying out the capacity assessment?

MCA Code of Practice states *"If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent… But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed."* Other practitioners and carers retain a responsibility to participate in discussions about this assessment.

The process of assessment

The Mental Capacity Act defines what it means to lack capacity for a certain decision

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain' s.2(1) MCA 2005

For the purposes of assessing capacity to consent to taking or refusing medication there is a need to firstly establish that a person is unable to make a decision

Unable to make a decision

Someone's ability to make a decision can be assessed by looking at the **functional elements** of decision making These are described in s.3(1) MCA 2005, which states that the person is unable to make a decision for himself if he or she is unable:

- To understand the information relevant to the decision; or
- To retain that information; or
- To use or weigh that information as part of the process of making the decision; or
- To communicate his decision (whether by talking, using sign language or any other means).

Is there an impairment of, or a disturbance in the functioning of the person's mind or brain?

This could be temporary or permanent, and could be caused by any medical condition that causes drowsiness or confusion (eg delirium, concussion, intoxication) – it does not necessarily have to be a diagnosed mental disorder (MCA s.2(2)) – but there must be a proper basis to consider that there is an impairment or disturbance. (NB. If the person has a very mild learning disability then careful consideration as to whether this constitutes a disturbance or impairment for the purpose of a capacity assessment must be given as it cannot be assumed to be a given.

If the cause is a temporary one, there would need to be consideration as to whether the decision could wait until the circumstances had changed before the decision is taken.

Is there a direct link between the two?

Having identified that someone appears unable to make the decision, and that they have and impairment of, or a disturbance in the functioning of their mind or brain, there needs to be enough reason to believe that there is a direct link between the two - that the inability to make the decision is because of the disturbance or impairment . This must be explicitly stated in any assessment of the person's capacity.

What are the specific issues in a mental capacity assessment regarding consent to medication?

The Mental Capacity Act states that a person is presumed to have capacity to make a decision unless it is demonstrated otherwise (by means of a mental capacity assessment).

For a decision relating to consent to take medication this means the person must:

- Understand in simple language what the treatment is, its purpose and why it is being prescribed
- Understand and weigh up its principal benefits, risks and alternatives
- Understand and weigh up 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 cannot demonstrate an understanding of one or more parts of this test, then they do not have the relevant capacity at this time.

If a person regains capacity to refuse medication you must not continue to give that medication covertly. Therefore, if the person administering the medication believes the person has regained capacity to decide whether to take the medication the decision reverts back to the individual as to whether to take it. In these circumstances the person prescribing the medication must be informed and the care plan amended.

Advance Decision to Refuse Treatment

In some cases, the resident may have indicated refusal at an earlier stage, while still competent, in the form of an Advance Decision to Refuse Treatment. Where the person's wishes are known, staff should respect them, provided that the decision in the Advance Decision to Refuse Treatment is clearly applicable to the present circumstances and there is no reason to believe that the resident has changed their mind. This is an important and complex issue and you should follow your agency policy on Advance Decisions.

Best Interest Decisions

In circumstances where there is evidence to rebut the presumption of capacity to make decisions regarding the refusing of medication, a decision specific capacity assessment should be undertaken in respect of the individual. If the individual has been assessed to lack capacity to refuse their medication then a decision to give medication covertly must not be made prior to a best interests decision making and discussion/meeting.

The Best Interests decision making meeting should involve all relevant people and must include the person's attorney / attorneys appointed under a Lasting Power of Attorney or Enduring Power of Attorney. Objection to covert medication by the person's Enduring Power of Attorney, Lasting Power of Attorney (health and welfare) or Court Appointed Deputy (health and welfare) must be followed, unless there is evidence to suggest that this decision is not in the person's best interests. Where the individual has no legally appointed representative, then regard must be given to the MCA Code of Practice and Care and Support Statutory guidance in respect of ensuring the individual has independent support with the decision-making process. If there is no one independent of services, such as a family member or friend, who is "appropriate to consult" An Independent Mental Capacity Advocate must be appointed.

'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.

Nice Guidance states that *"The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or independent mental capacity advocate depending on the resident's previously stated wishes and individual*

circumstances). If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting."

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

Summary of best interests' checklist (see Mental Capacity Code of Practice)

- 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**
- 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

If it is agreed that the covert administration of medication is in the person's best interests, this must be included within their medical & care home records with a clear management plan, including details of how the covert medication plan will be reviewed. This documentation must be easily accessible on viewing the person's records.

If the best interest meeting does not reach agreement, if the medication relates to serious medical treatment or chemical restraint, then legal advice should be sought in relation to placing the matter before the Court of Protection (COP) for the Court to make the decision.

Following a Best Interest decision to give covert medication

Following or as part of the best interest meeting NICE suggests ensuring *"that need for continued covert administration is regularly reviewed"* To achieve this NICE suggests the creation of a covert medication management plan, that would include the following:

- Medication review by the GP
- Medication review by the pharmacist to advise what form the medication must be in e.g. liquid, dispersible, whether it must be crushed and advise the staff how the medication can be covertly administered safely.
- Clear documentation of the decision of the best interests meeting.
- A plan to review the need for continued covert administration of medicines on a regular basis.

It is essential that the decision process is fully documented. The medicine administration chart must also be annotated with the necessary instructions for administering the medicine.

The care plan must clearly state the rational for the covert administration of medication and how this is to be administered, if it should always be covert of if attempts should be made to offer and inform the person of the administration of their medication, how many attempts and at what point should it be administered covertly. This is particularly important when transferring between care settings, for example on admission to hospital. It is recommended that GP practices flag the patient record to ensure the information is included in any admission documents.

The effects of the decision to give medication covertly must be reviewed especially for patient deterioration or declining food and drink. Reviews must also be carried out a regular basis as to the need for continued covert administration of medicines. A plan for review should be included in the documentation and the outcome of each review recorded.

It should be recorded in the care plan and MAR chart folder when the medication is given covertly and when it isn't and this information should be collated to aid medication reviews.

How does covert medication administration link to a deprivation of liberty?

Treatment without consent is potentially a restriction contributing to the objective factors creating a Deprivation of Liberty (DoL). Medication without consent and the covert administration of medication are aspects of continuous supervision and control that are relevant to the existence of a DoL and must be subject to the principle of least restrictive alternative. The existence of such treatment must be clearly identified within any application for a DoL, either for a urgent/standard authorisation or when informing a Local Authority or Clinical Commissioning Group of a potential DoL or in settings outside of care/nursing homes and hospitals (for example domiciliary care or supported living services)

However, it is important to point out that whilst the practice of covert medication is a restrictive one that may indicate or "tip the threshold" of someone's care towards a deprivation of their liberty, the legal basis for this particular act of care would be provided by the Mental Capacity Act itself – and following this guidance will ensure that any such act of care is lawful by virtue of the Mental Capacity Act . A Deprivation of Liberty Safeguards Authorisation is for the purpose of providing treatment or care for an individual in a particular place– **but the Authorisation itself does not authorise any individual act of care or treatment**.

The use of covert medication administration must always call for close scrutiny, especially in cases where the medication impacts on the person's behaviour/mental health or has a sedative effect. Covert medication administration in this case is a serious interference with the right to respect for private life under human rights legislation and there must accordingly be proper safeguards against arbitrariness.

The use of covert medication within a care plan must be clearly identified within the Deprivation of Liberty Safeguards (DoLS) assessment and authorisation. The DoLS authorisation should reflect a requirement to keep the use of covert medication regularly under review.

The managing authority (care provider) must notify the Supervisory Body of changes to the covert medication regime, including changes to the nature, strength or dosage of medications being administered covertly. Such changes should always trigger a review of the DoLS authorisation. The Managing Authority should also inform the Relevant Person's Representative of this in order to give them an opportunity to request a review of the DoLS authorisation.

If a standard DoLS authorisation is granted for a period longer than 6 months, there should be a clear provision for regular reviews of the care plan involving family and health professionals. The period of time between reviews should be determined by the circumstances of the individual case. It is not an absolute policy that standard authorisations should be limited to 6 months in all covert medication cases, but the more regular the reviews, the more likely justification there would be for a longer period of authorisation. One way of achieving this would be for the DoLS authorisation to be made subject to conditions about the need to keep the medication regime under regular review.

Expert pharmacy advice

A pharmacist will be able to consider the best method that meets patient's needs and preferences taking into account which will cause the least distress. A Pharmacist must be consulted in all covert medication decisions to ensure any medication given covertly is done safely, remains effective and that alternative ways of administration have been considered.

Covert Administration of Medication Aide Memoire

Patient is persistently refusing medication in any form

- Establish whether covert administration is required – discuss with GP and care staff and Consultant (if in hospital)
- Consider whether medications can be given without the need for covert administration.

Is the medication essential and of benefit to the patient?

- Review all medication to assess clinical need and benefit to the patient.
- Have all reasonable steps been taken to support the patient to take their medicine?
- Can alternative forms be tried e.g. liquid instead of tablets?
- Does the patient need more time and encouragement at medication times?
- Are all medications being refused or just one?

Does the patient have capacity to refuse medication? *(A mental capacity assessment must be carried out to establish if the patient lacks capacity to make this decision. NB capacity is assumed unless proven otherwise)*

If Yes: The patient's decision must be respected. Covert administration would be unlawful

If No: A "best interests" discussion must be held

Any adult who has mental capacity has the right to give or refuse consent to treatment or nursing intervention and this decision must be respected.

Ensure all appropriate people take part in the discussion, including the patient if they are able and wish to do so. Disguising medication in the absence of informed consent is unlawful. The exception to this is where the person is detained under the Mental Health Act.

If best interests decision concludes that Covert Administration is not appropriate:

Ensure review date and circumstances agreed and recorded

If best interests decision concludes that Covert Administration is appropriate then consider:

- Is the patient subject to a Deprivation of Liberty process? *The local authority must be contacted if the patient is subject to a DoL. Where there is no DoL, consideration must be given to initiating the process.*
- Obtain expert pharmacy advice regarding best method of covert administration. *This will take into account the risks of any adverse effects that might be caused by administering the medication covertly, versus benefit obtained. For example, change in absorption, or risk of person tasting medicine and subsequently refusing all food and drink.*
- **Documentation and review**: *The decision process must be fully documented. In all cases, care or nursing staff can only administer medication covertly if authorised by the prescribing practitioner. Ensure appropriate review dates are set and adhered to.*