NHS GG&C Mental Health Service

Covert Medication Policy

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MHS 53 MHS Covert Medication Policy

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0		First Draft	
1.1	09-06-15	Updated incorporating further comments from Acute, Community Nursing and Mental Health Services	
1.2	22-07-15	Updated for Acute Service, circulated for comments	
1.3	04-08-15	Updated comments from consultation	
1.4	14-08-15	Updated post circulation	
2.0	13/04/2018	1. General changes made to wording & terminology throughout document. 2. References updated. Appendix III 3. Changes &/or additions to text within document	SLWG
2.0	13/04/2018	**Section 1 -** will have read & understood the guidance published by the Mental Welfare Commission for Scotland's *"Good Practice Guide Covert Medication"* (February 2017) regarding the legal & practical issues in relation to covert medication. In conjunction with this clinical staff will also have read NHSGG&C *"Safe & Cost Effective Administration for Covert Medication & in Dysphagia*" (2017)	
2.0	13/04/2018	**Section 2** "It is generally" has now been replaced with "in most circumstances it is unlawful" The undernoted has been added to the text: "Where the individual is incapable of consenting, all other alternatives must have been explored & found to be impracticable. Investigation into the individual's previous concerns & wishes must also be made & taken into account during the decision making process"	
2.0	13/04/2018	**Section 3** The undernoted has been added; Mental disorder is described in the "Mental Health (Care & treatment) (Scotland) Act 2003" as including: ▪ Mental illness ▪ Learning disability ▪ Personality disorder Inability to communicate only results in incapacity if it cannot be overcome by translation or communication aids. All clinical staff must recognize that capacity may change or fluctuate over time. With regard to children, capacity develops according to their age. Any views expressed by a child must have that view taken into account in any decision making. This definition has been changed: "Covert Medication is the administration of any medical treatment in disguised form. Therefore an injectable medication or patch cannot by definition be 'covert'. The commonest way is via liquid or foodstuffs	
2.0	13/04/2018	**Section 5** The undernoted has been added: ... which would be critical to the patient's care that the only alternative is that the medication is given by deception...	

Version	Date	Brief Summary of Changes	Author(s)
2.0	13/04/2018	**Section 6** The undernoted has been added: ..Therefore the expertise of the Pharmacist is essential.. Referencing to a document from the Royal College of Psychiatrists' The undernoted has been added: "Pharmacists must be consulted as any alteration to the licensed dispensing guidance from the pharmaceutical manufacturers could result in harm & requires specialist advice	
2.0	13/04/2018	**Appendix I –** Responsible Physician has been changed to Responsible Medical Officer. Responsible Medical Officer has also been added as the individual who must inform any involved, who disagree, have a right to challenge the treatment. **Appendix II –** Responsible Physician has been changed to Responsible Medical Officer. 5 sections have had YES/NO* Circle as appropriate answers added.	
2.1	24/10/2018	Addition of link and statement regarding GGC Consent Policy	C Sellar
3.0	05/08/2022	Updated to reflect the introduction of the HEPMA system	

Contents

When reading this policy please consult the NHS Consent Policy when considering any aspect of consent

1. Purpose and Scope

This policy describes the responsibilities of clinical staff when considering the use of covert medication. The policy sets out a series of conditions that must be satisfied before administering covert medication and defines the process to be followed.

This policy must be used in conjunction with any appropriate national guidance from an appropriate professional body as well as local policies and procedures NHS Greater Glasgow & Clyde (NHSGG&C) have in place for safe and secure handling of medicines. Clinical staff involved with covert medication will have read & understood the guidance published by the Mental Welfare Commission for Scotland's *"Good Practice Guide Covert Medication"* (February 2017) regarding the legal & practical issues in relation to covert medication. In conjunction with this clinical staff will also have read NHSGG&C MHS MRG 02 *"Safe & Cost Effective Administration for Covert Medication & in Dysphagia*" (2022)

2. Statement of Policy

This policy has been developed from existing good practice statements and the requirements of Scottish Law.

There is current guidance from the Royal College of Psychiatrists (2004) and the Nursing and Midwifery Council. The Mental Welfare Commission for Scotland has issued guidance on treatment of physical health problems in people who lack the capacity to consent *("Right to Treat? Feb 2022*), and on consent for the treatment of mental disorder (Consent to Treatment, January 2017).

Part 5 of the Adults with Incapacity (Scotland) Act 2000 provides authority to give medical treatment to a person who lacks capacity, by means of a completed incapacity certificate. Where appropriate the decision to give treatment must be discussed with a Welfare Attorney, Welfare Guardian or someone who holds an intervention order about treatment as specified in Appendix IV.

Covert medication must never be given to someone who is capable of deciding about their medical treatment. In most circumstances it is unlawful to administer medication without consent. Where the individual is capable of consenting, all other alternatives must have been explored & found to be impracticable. Investigation into the individual's pervious concerns & wishes must also be made & taken into account during the decision making process. Staff must not give medication in a disguised form unless the adult has refused to take medication & their health is at risk because of this. Staff must record the health risk and the patient's refusal to take medication in the patient's records. Documentation must be completed as directed in the pathway shown in Appendix 1 ("*Initial Covert Medication Pathway"*) to ensure patient safety and effective continuity of care. The Responsible Medical Officer has the responsibility for ensuring the completion of the documentation, which must be kept in the main medical record. It is for local agreement in individual cases, following discussion with team members, if copies are required in other records.

The use of Covert Medication must be included in the patient's care plan.

3. Definitions

The following definitions apply to this document:

Clinical Staff refers to all health care staff, directly or indirectly, involved in administrating covert medication, including employees, bank, locum or agency staff working within NHS Greater Glasgow and Clyde.
Covert Medication is the administration of any medical treatment in disguised form. Therefore an injectable medication or patch cannot by definition be 'covert'. The commonest way is via liquid or foodstuffs
Incapacity under the 2000 Act, is defined as incapable of:

- acting ; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or

- retaining the memory of decisions

This must be because of a mental disorder, or an inability to communicate due to a physical disorder.

Mental disorder is described in the *"Mental Health (Care & treatment) (Scotland) Act 2003*" as including:

- Mental illness
- Learning disability
- Personality disorder

Inability to communicate only results in incapacity if it cannot be overcome by translation or communication aids.

All clinical staff must recognize that capacity may change or fluctuate over time.

With regard to children, capacity develops according to their age. Any views expressed by a child must have that view taken into account in any decision making.

4. The Law and Covert Medication

In Scotland the mechanisms for giving medical treatment to people who lack capacity is covered by two significant pieces of legislation which are:

- The Adults with Incapacity (Scotland) Act 2000 (AWI)
- The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA)

The 2000 Act (**AWI**) covers a variety of interventions for adults who lack capacity. It is based on a firm set of principles that govern all interventions, including covert treatment, these are:

- The intervention must be of benefit to the adult.
- The intervention must be the least restrictive in relation to the person's freedom in order to achieve the desired benefit.
- Interventions will take account of the past & present wishes of the adult.
- Interventions will take account of the views of relevant other parties.
- Interventions will encourage the adult to use existing skills & develop new skills.

5. Deciding Whether to Give Covert Medication

It is essential to consider the necessity of treatment, which would be critical to the patient's care that the only alternative is that the medication is given by deception. Clinical staff must base their decision on clinical evidence. Any benefit of covert medication needs to be balanced with the risk of giving medication covertly. Advanced statements & in all cases the person's past and present wishes will be taken into account. If the person has capacity to decide about medical treatment, then covert medication must not be considered.

If the person lacks capacity, the Responsible Medical Officer must certify incapacity on a Section 47 certificate (as required by the **AWI** Act 2000), or use appropriate documentation where the person is being treated under the **MHA** Act 2003.

The decision to use covert medication must be a multidisciplinary discussion which includes all clinical staff directly or indirectly involved in covert medication, and never without the expert guidance of a pharmacist. Practitioners who may be required to administer covert medication must make themselves fully aware of guidance from their own Professional Body. If the person has a welfare proxy (welfare attorney or guardian), that person must be consulted unless impracticable. Treatment cannot proceed if that person objects. If there is no welfare proxy, relatives & friends most closely involved must be consulted.

6. Covert Medication in Practice

If covert medication is considered the NHS GG&C "Initial Covert Medication Pathway" must be used (Appendix I). The medical practitioner primarily responsible for the person's care will take responsibility for documenting the care pathway in consultation with: the Multidisciplinary Team, welfare proxy &/or relatives & friends.

Pharmacists must be consulted as any alteration to the licensed dispensing guidance from the pharmaceutical manufacturers could result in harm & requires specialist advice.

With the introduction of HEPMA it is essential to indicate clearly on the patient's HEPMA record that they are subject to covert treatment and to describe for each drug the appropriate method of administration. This is achieved by adding

- Adding a patient note entitled 'Covert pathway' with the note detail indicating when the pathway was approved and when it is due for review
- Drug specific notes detailing how each drug is to be administered.

Information on how to create notes can found on the HEPMA support pages HEPMA (scot.nhs.uk)

NHSGG&C Covert Medication Care Pathway Review (Appendix II) must be utilised when the need for covert medication is reviewed.

The Royal College of Psychiatrists' Statement on Covert Administration of Medicines (2004) suggests weekly review.

The Mental Welfare Commission guidance refers to reviews being dependant on individual circumstances (P. 10, 2017), but states that the first review must happen within 1 week, which NHS GG&C will implement.

Any further, reviews must not be less frequently than every 4 weeks, or prior as circumstances dictate.

Appendix I

Initial Covert Medication Care Pathway

Name of Patient	**Date of Birth**
Location	**CHI**
Responsible Medical Officer	**Name**
What treatment is being considered for covert administration?	
Why is this treatment necessary? Where appropriate, refer to clinical guidelines e.g. SIGN	
What alternatives did the team consider? (e.g. other ways to manage the individual or other ways to administer treatment)	
Why were these alternatives rejected?	
Treatment may only be considered for a person who lacks capacity. Outline the assessment of capacity	**Assessed by -** **Designation –**
Treatment may only be administered under a certificate of incapacity (Section 47, AWI) or appropriate Mental Health Act documentation. What legal steps were followed?	**Legal Documentation Completed –** Adults With Incapacity Act, Section 47 Mental Health Care Treatment Act 2003 Date
Treatment may only be given if it is likely to benefit the person. What are the perceived benefits the person will receive? Is this the least restrictive way to treat the person? Give reasons	

What are the person's present views on the proposed treatment, if known? Do they have an advanced statement or living will? If yes, detail any reference to covert medication (i.e. – refusal to life prolonging treatment, antibiotics, etc.)	
Has the person expressed views in the past that are relevant to present treatment? If so what are those views?	
Who was involved in the decision The prescribing practitioner **must** ensure exact directions regarding the method of administration of medicines; (i.e. mixed with/crushing/disguising in food or drink) are clearly documented on the HEPMA system. A pharmacist **MUST** give advice on administration if this involves crushing tablets or combining with food and drink NB – If there is any person with power to consent (welfare attorney, welfare guardian), then the treatment may only be administered covertly with that person's consent, unless this is impracticable	**Clinical staff involved** **Name of pharmacist consulted** **Relatives or other carers involved.** **Do they have power of attorney**
Covert medication plan: Outline the method of covert administration for each medication. Medication 1 _____ Medication 2 _____ Medication 3 _____ Medication 4 _____ Medication 5 _____	**Method 1** _____ **Method 2** _____ **Method 3** _____ **Method 4** _____ **Method 5** _____ (Add more if necessary)
Do any of those involved disagree with the proposed use of covert medication? If so they must be informed of their right to challenge the treatment by the Responsible Medical Officer.	**Yes/No** **Date informed**
When will the need for covert medication be reviewed	**Date of first planned review**
Name – please print	Signature
Designation	Date

Appendix II

Covert Medication Care Pathway Review

Name of Patient	**Date of Birth**
Location	**CHI**
Responsible Medical Officer	**Name**
Has the patient's capacity changed? Specify Yes / No*	
Has the patient benefited from the treatment? Yes / No*	
Is the treatment still necessary? Yes / No* If so, explain why	
Is covert medication still necessary? Yes/ No* If so, explain why	
Is the method of administration still appropriate for patient compliance? Yes/ No*	
The prescribing practitioner **must** ensure exact directions regarding the method of administration of medicines; (i.e. mixed with/crushing/disguising in food or drink) are clearly documented on the HEPMA system	
Is legal documentation still in place and valid? Yes / No*	
Who was consulted as part of the review?	
Date of next review	
Name – please print	Signature
Designation	Date

(*circle appropriate response)

Appendix III

References

SCSWIS (2011)
Health Guidance Authorisation to Administer Medicines, Social Care and Social Work Inspection Scotland, 2011

Mental Welfare Commission for Scotland (2017)
Good Practice Guide. Covert Medication
https://www.mwcscot.org.uk/media/140485/covert_medication.pdf

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Nursing & Midwifery Council (2015)
The NMC Code: Professional Standards & Behaviour for Nurses & Midwives. NMC: London

Nursing & Midwifery Council (2006)
Standards of Proficiency for Nurse & Midwife Prescribers, NMC: London

Nursing & Midwifery Council (2007)
Standards for Medicines Management, NMC: London

Royal Pharmaceutical Society of Great Britain (2007)
The Handling of Medicines in Social Care, RPSGB: London

Royal College of Psychiatrists' (2004)
Statement on Covert Administration of Medicines: Published online 02.01.2011

Scottish Executive (2000)
The Adults with incapacity (Scotland) Act 2000, Scottish Executive: Edinburgh

Scottish Executive (2003)
Mental Health (Care & Treatment) (Scotland) Act 2003, Stationery Office, Edinburgh

Scottish Executive (2006)
Rights, Relationships & Recovery: The Report of the National Review of Mental Health Nursing in Scotland, Scottish Executive: Edinburgh

General Pharmaceutical Council (2010)
Standards of conduct, ethics and performance, May 2017

Mental Welfare Commission (2017)
Consent to Treatment, a guide for mental health practitioners

22Mental Welfare Commission (2011)
Right to Treat? Delivering physical health care to people who lack capacity and refuse or resist treatment.

NHS Greater Glasgow & Clyde (2022)
Safe & Cost Effective Administration for Cover Medication & in Dysphagia