SAFEGUARDING ADULTS

Good practice in medication (guidance for organisations who lack their own internal policy

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Introduction

This guidance has been produced to support health and social care providers in Barnsley to administer medication safely and comply with the law around use of covert medication, if they don't have an existing policy . Adults that are prescribed medication may require support to take them at the correct dose and time; it is not the role of health and social care staff to insist that adults take their medication if they have capacity and chose not to take the medication. However their right to refuse should be noted in their records and shared, as appropriate with relevant medical colleagues.

The guidance is not intended to replace existing medication policies; however it should be used as a reference document to ensure that existing policies are in line with best practice. Covert medication should not be given to adults who lack capacity without a decision being subject to a robust best interest decision in line with the Mental Capacity Act.

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1 Responsibilities of regulated care providers

1.1 Regulated care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people who require this service have their medicines at the times they need them and in a safe way.

1.2 In some service areas, individuals are encouraged to self-medicate as part of their care plan. Clear policies and procedures must be in place, and be followed, to support an individual safely and reduce the risk of harm arising from self-medication errors.

1.3 Care providers must have clear procedures which include arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses relating to medicines. This may include reporting to CQC, police, safeguarding and/or commissioners .

1.4 These arrangements should encourage local and where applicable, national reporting and learning and promote an honest, open and fair culture of safety.

2 Medication Errors – Reporting routes

2.1 The registered person must protect individuals against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Refer to NICE Guidance.

2.2 All medication errors should be reported in line with the regulated care providers, management of incidents policy as soon as possible after the incident.

2.3 Locally this may include raising a safeguarding concern (following screening with the decision support guidance - https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers/ or referral to commissioners if it does not meet the safeguarding threshold

2.4 Contact with CQC should be made in line with their guidance

. You must notify us about medicines errors in the following circumstances:

- death
- injury
- abuse, or allegation of abuse
- incident reported to or investigated by the police

Where relevant, make it clear that a medicine error was a known or possible cause or effect of the incident.

2.5 CQC definition of a medication error

A medicines error is any patient safety incident**,** where there has been an error while:

- prescribing
- preparing
- dispensing
- administering
- monitoring
- providing advice on medicines

It can be either:

- an error of commission (wrong medicine or wrong dose)
- an error of omission (omitted dose or failure to monitor

3 Best practice for the handling of medication errors

3.1 The organisation must have clear procedures for staff detailing how a medication error should be recorded, including specific processes for controlled drugs and reporting mechanisms to the CDAO (Controlled Drug Accountable Officer).
3.2 All medication errors including near misses must be recorded. This record must detail the impact of the error, any immediate action taken and record the date, time and names of staff and individual/s involved.
3.3 The error should be reviewed and an action plan put in place to ensure lessons are learnt and the risk of the error being repeated is reduced. It is also important to review the error in the context of previously recorded errors as a series of similar incidents may meet the criteria for a safeguarding concern.

4. Covert medication

4.1 Definition - Covert administration is 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**.**

4.2 Clinicians and carers **should not** administer medicines to a person without their knowledge **if the person has mental capacity to make decisions** about their treatment and care.
Covert administration can only be considered where the person has been deemed to lack capacity to consent to that specific treatment. It is not an all or nothing approach where a person is taking medication for more than one condition, their capacity to consent to treatment for each condition

needs to be assessed separately. This may lead to some medications being administered in the usual manner with right to refuse noted and other medications being considered for covert administration

4.3 A decision to administer medication covertly is very serious and should be made within the legal framework of the Mental Capacity Act in addition to complying with organisational and professional bodies', guidance and policies

4.4 A decision to administer medication covertly should never be taken in isolation and must always include a Prescriber, a Pharmacy Adviser, the people administering the medication and other people interested in the person's welfare (see Mental Capacity Act guidance on best interests and serious medical treatment)

4.5 Principles of covert medication

4.5 (1) Last resort:

The Prescriber must have considered all other equally valid alternatives for achieving the same treatment outcome, this consideration may identify other possibilities that are considered suitable for the person; all these possibilities must be attempted before covert administration is considered. The prescriber should have simplified the treatments as much as possible in order to use the minimum number of medicines and minimum dosages needed to achieve the desired therapeutic effect. Covert administration of medication should never be considered as routine. It is only appropriate for medication that is essential to control or prevent significant symptoms.
Covert administration should only be used when all other options have been tried. Ensure alternatives have been explored and use only for those medications that are necessary.

***4.5(2) Time limited*:**

Covert administration should be used for as short a time as possible. The person should regularly be offered the medication overtly to establish if potential for compliance has changed.

***4.5 (3) Regularly reviewed*:**

The necessity of covert medication should be regularly reviewed (at least monthly by the care provider and at least 3 monthly by the prescriber unless rationale provided to extend to no longer than 6 months).

***4.5 (4) Best interests*:**

All decisions should be made in the person's best interests using the Mental Capacity Act requirements. Due to the significantly restrictive nature of this method of medication administration the process must be formally documented

***4.5 (5) Transparent and Inclusive*:**

The best interest decision making process should be transparent and the decision should be made in consultation with all relevant people, and not taken by one person alone.

4.6 Process for agreeing on use of covert medication

4.6 (1) **Request medication review**

Find out why the person does not wish to take their medication and offer all practical alternatives including information/advice/support where needed

Consider whether you can:

- ✓ simplify and rationalise the medication regime
- ✓ offer the medication in an alternative form e.g. , liquid, patch, injection, etc
- ✓ offer a different time of administration e.g. would the person be more likely to accept the medication in the afternoon rather than the morning?
- ✓ find a successful method of approaching the person for administration. Are there certain members of staff who have a successful approach with the person? Share and learn

4.6 (2) **Assess Mental Capacity in relation to medication**

Presumption of capacity
There are five main principles:

- ✓ A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- ✓ The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- ✓ That individuals must retain the right to make what might be seen as eccentric or unwise decisions;
- ✓ Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
- ✓ Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

4.6 (3) Definition of consent
"Consent" is the voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of the treatment including the likelihood of its success and any alternative to it. Permission given under any unfair or undue pressure is not consent (Mental Health Act 1983 Code of Practice)

4.6 (4) Process for assessing capacity

The responsibility for completing the mental capacity assessment for the decision to administer medication covertly **sits with the prescriber for the medication**. It may be that for one individual there is more than one prescriber involved. Each should assess separately in relation to the specific condition that they prescribe for. The prescriber may request the assistance of staff and carers who know the person well and may delegate aspects of the approach to the capacity assessment to others; however they retain the final decision on determination of capacity.

The principles of the Mental Capacity Act (2005) should be followed. A capacity assessment should take place directly with the person before covert medication takes place. The assessment must determine that the adult is unable to:.

- ✓ Understand salient information relevant to their condition and the options for its treatment;
- ✓ Retain this information (if only briefly);
- ✓ Weigh up the information including the risks involved in accepting and refusing the treatment options;
- ✓ Communicate their decision.

All reasonable efforts must be made to help the person understand. It should be recognised that many people's capacity fluctuates during the day and so an optimal time of day should be chosen. In some cases several attempts may be required.

If the person is found to be able to complete all four elements of the mental capacity assessment then they should be assumed to possess the mental capacity to make the decision themselves, even if their decision appears unwise.

In these circumstances the decision must be respected, **and covert medication cannot be given**. It is important that this process is followed as presumptions about a person's mental capacity cannot be based solely on their diagnosis (MCA, 2005.)

Any adult with capacity to make the decision around medication has the right to give or refuse consent to treatment or support. To administer medication covertly to a competent adult would therefore be seen as both unethical and unlawful (an assault) and legislation allows for this to be treated as a criminal act.

If a person has mental capacity to make a decision, unless there is a legal framework in place to override this, their decision must be respected. It is the duty of everyone proposing to give treatment to use reasonable care and skill, not only in giving information prior to seeking a patient's consent, but also in meeting the continuing obligation to provide the person with adequate information about the proposed treatment and alternatives to it.

When a person is incapable of consent to treatment, medicines can be prescribed for them in their best interests under the common law doctrine of necessity. The treatment must be:

- ✓ Necessary to save life, or prevent a deterioration of, or ensure an improvement in, the patient's physical or mental health;

And

- ✓ Be in accordance with the practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question.

4.6 (5) Best interest decisions

When a person is found to lack capacity, a formal best interest process must be used and a decision must be reached. This must include the relevant people in the person's life, including families and carers as well as professionals. To whatever extent possible, the person must also be involved, with genuine value placed on their wishes and beliefs.

If the individual has made an Advance Decision to Refuse Treatment directly relevant to the medication suggested, or has donated a Health and Welfare Lasting Power of Attorney, then the decisions afforded through these legal mechanisms must be respected as the person's voice.

If there are concerns the Advance Decision or the decisions of a Health and Welfare Attorney is putting an individual at significant risk then seek further advice.

When a person lacks capacity and is un-befriended (has no family or friends to support them or there are concerns that they are unable to advocate for the adult), then consideration must be given to whether the decision meets the requirements for serious medical treatment as defined within the MCA Code of Practice? If this is the case a referral to must be made to appoint an Independent Mental Capacity Advocate (IMCA) who will represent the person through the best interests process.

As part of the Best Interests process the following additional aspects must be documented:

- ✓ What specific conditions are being treated;
- ✓ What treatments are being considered for each of those conditions;
- ✓ Who is the Prescriber for each of those treatments and conditions;
- ✓ Why the specific treatments are necessary;
- ✓ What alternative forms of treatment have been attempted and why those alternatives were
- ✓ rejected;
- ✓ Why it is in the Best Interests of the individual to receive such treatment.
- ✓ There should be a clear conclusion as to which treatments are being considered for covert
- ✓ administration and there should be a clear Options Appraisal which will include the options

- ✓ to provide all medication using normal overt administration methods only;
- ✓ to provide all medications covertly;
- ✓ a combination approach - this may result in a number of additional options to administer one or more medications overtly and one or more medications covertly.

Should a decision be reached to administer any or all medications covertly, the advice of a Pharmacist must be sought in relation to the practical manner in which covert administration will occur. Crushing tablets/opening capsules can also alter the pharmacological effects of medications and therefore requires careful planning with the pharmacist and prescriber to ensure this is done safely.

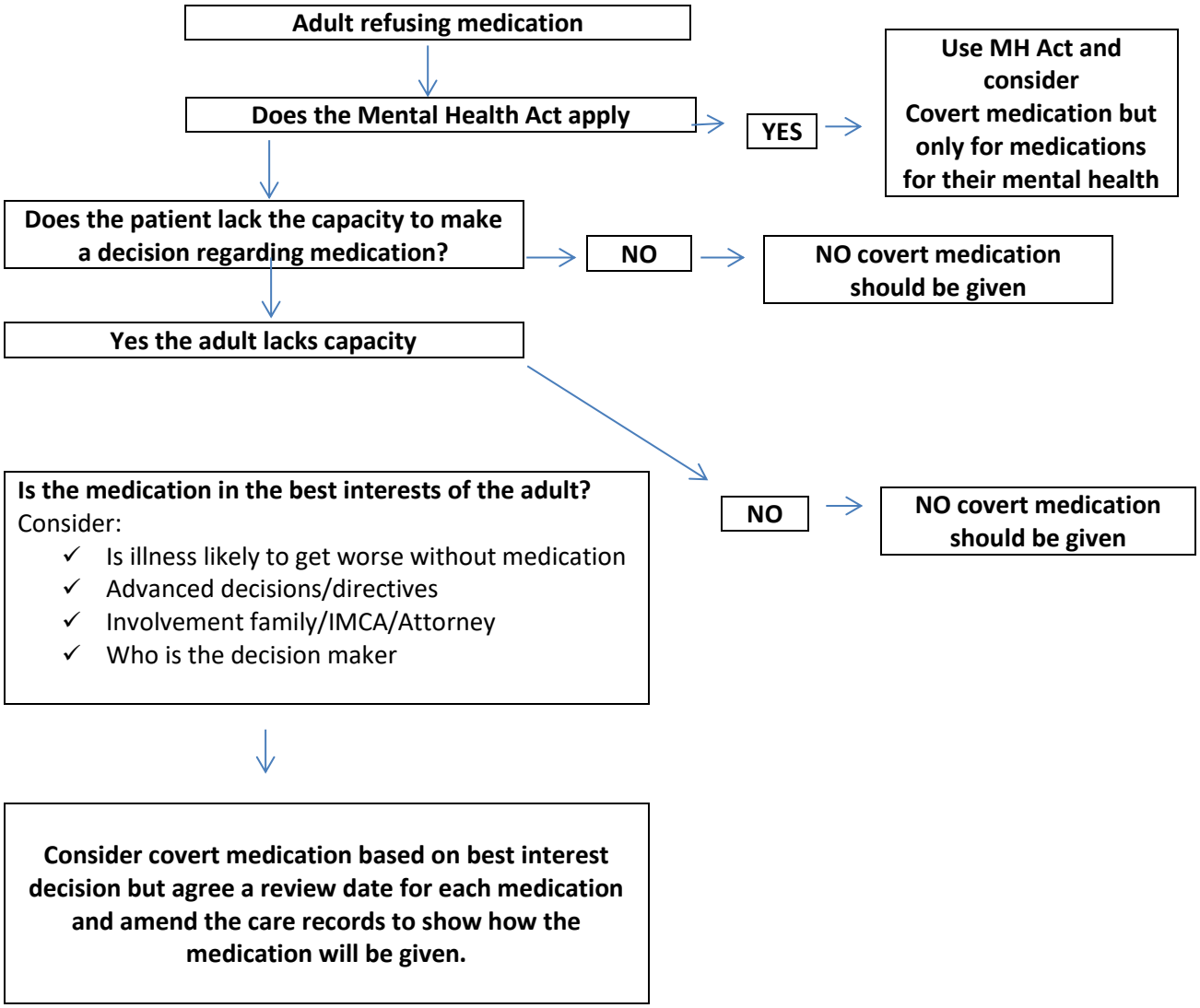
The advice should cover the alternative forms of the medication in a licensed form; the use of a licensed medication in an unlicensed form (by adding to food or drink) considering the nature of the food or drink in terms of heat; acidity and likelihood for chemical reactions.

Where medications are added to food or drink it is best to only put one medication in to the food or drink at a time. Where this is not possible the pharmacy advice will also need to include advice on the mixing of medications following the current national and local guidelines.

In addition to an action plan for the implementation of the decision, there should be a specified agreed procedure for the covert administration that the family or support staff will be expected to follow.

There must be clear review points and dates documented as part of the decision and at regular prescribing review appointments. The entire covert administration documentation must be reviewed in full and updated at least bi-annually with relevant parts being reviewed at each appointment.

4.6 (6) Summary flow chart



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