**Please note the content of this training scenario is correct as of September 17. It is up to individuals using the scenario to confirm if there have been any subsequent changes in case law or guidance requiring inclusion prior to use.**

## Scenario 9 (Nursing Home based)

Margaret has been resident in a nursing home for the past 2 years, recently staff have noticed that she is refusing her medication and becomes increasingly agitated when attempts are made to administer the medication. The Nurse has raised concerns around this behaviour as one medication in particular is essential for Margaret's wellbeing and if not administered could leave Margaret susceptible to seizures. Margaret has been diagnosed as suffering from mild dementia but can make simple decisions for herself such as choices of menu, clothing and activities

The care home manager (a nurse) discussed the concerns with Margaret's daughter who visits regularly and has suggested that the Doctor visit to review the medication.

## Questions

What would you do?

What legal implications might there be?

What do the procedures tell you?

## Trainers notes

**Practice guidance**

**What happened next in the scenario**

Margaret's daughter asked if her mother could be given the medication in her food to avoid her becoming agitated. The care home manager stated that the care home had a policy in place that indicated if Margaret was not able to consent then a best interest decision making process would be required which would involve consultation with the pharmacist and G.P. Prior to this an assessment of Margaret's capacity would be required. In addition Margaret's Daughter holds a lasting power of attorney for finances only and as a consequence she could not make decisions about treatment options. However she would be involved in the decision making process to present Margaret's past and present beliefs, values, wishes and feelings.

The care home manager and Margaret's daughter attempted to talk to Margaret about her medication in order to establish if she understood why she needed the medication and what would be the likely consequences of her refusing. It became evident that despite the use of simple language Margret was unable to understand or retain the information and was not able to communicate what would happen if she continued to refuse. The outcome of the discussion was that Margaret lacked the capacity to make a decision around taking anti-epileptic medication. As the likely consequence of this Margaret would be at an increased risk of suffering an epileptic seizure which would cause her significant harm should this be unwitnessed.

A best interest meeting was then convened, chaired by the care home manager, attended by Margaret's daughter, G.P and pharmacist. Benefits and burdens of the decision were discussed. It was established that administration of the medication covertly outweighed the risk of Margaret having seizures if the medication was stopped and that this was the least restrictive option. The pharmacist noted that the medication could be given in suspension form and could be given in a drink which would also have the added benefit of limiting Margaret's agitation when attempting to administer the medication in the

conventional manner. A review date was set for 3 months. All discussions were documented and entered into Margaret's care plan and MAR sheet.

Consideration was made to whether this decision constituted to a deprivation of Margaret's liberty. Margaret's mental capacity was assessed in relation to her ability to consent to remain resident at the nursing home to receive ongoing care and treatment. Margaret was not able to consent to residency at the nursing home to receive ongoing care and treatment. Margaret was free to wander throughout the home however, Margaret was not free to leave the nursing home on her own and there was continuous supervision because Margaret's whereabouts within the home was known by the staff at all times. It was therefore concluded that Margaret met the Acid Test Criteria and was being deprived of her liberty. A standard DOL's application was made to the Local authority as the supervisory body by the Nursing home as the managing authority. The nursing home at the same time reviewed Margaret's Care plan to ensure it was the least restrictive option whilst meeting Margaret's care and support needs in line with the MCA (2005). It was acknowledged that further assessments around Margaret's capacity to make other specific decisions would take place at the time in line with MCA (2005).

**Assessing mental capacity (MCA assessments)**

Before covert administration is considered as an option, decisions and actions carried out under the Mental Capacity Act 2005 should be tested against the five key principles set out below. It is important to remember that an assessment is task specific and consequently must be carried out for each individual issue which compromises a person's quality of life.

**The five key statutory principles in assessing capacity are:**

1. A person must be assumed to have capacity to make a decision unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. For example, advocates or communication support may be necessary.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision. Everyone has the right to make what would appear to be an unwise decision. This does not mean that the person does not have capacity.
4. An act done or decision made, under this Act, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

**Process of assessment**

For the purposes of assessing capacity to understand medication there will be a need to first establish that a person is unable to make a decision because of an impairment of or disturbance in the functions of the mind or brain. This clinical diagnosis provides the justification for proceeding.

The second stage of assessment can only proceed if the answer to the first stage is "yes".

Consideration should be given to the patient's country of origin and their understanding of English. Also the patients preferred communication method and any support needed for communication e.g speech and language therapy support.

*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*

An advance decision to refuse particular treatment in anticipation of future incapacity must be adhered to if valid and complete. The patient must have made clear which treatments they are refusing (a general desire not to be treated is insufficient) and in what specific circumstances they refuse them – the advance decision must apply to the proposed current treatment and in the current circumstances. It is important that clinicians are made aware of advanced decisions and that carers are aware within care plans.

**Who can carry out a mental capacity assessment?**

The person who can assess an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times (MCA: section 4.38).

Difficult situations may arise where a person may have fluctuating capacity or limited capacity and occasionally a person may refuse to participate in an assessment. In such situations a healthcare professional must always be involved and Court of Protection decisions may be necessary. MCA assessments benefit from involvement of family, close friends or carers especially where there is any doubt about a decision.

**Best interest decision**

'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.

**Who should be involved in making a best interest decision for medication issues?**

Best interest decisions involving medication should be made by the prescribing practitioner in conjunction with a multi-disciplinary team of healthcare professionals. If a pharmacist cannot be present their advice should be sought before the decision to proceed to covert administration is made, in order to check the suitability of the medication to be administered in this way. The person's family/friends/carers/advocates must be involved in and informed of the decision to administer medication covertly (note however that nobody can consent for someone else; but the views of family/carers may be beneficial in determining a person's wishes and feelings and what is in their best interests). In cases where there is no-one to consult with there is a need to refer to the advocacy service.

*Summary of best interest checklist*

- Consider all the relevant circumstances ensuring that age, appearance, behaviour etc. are not influencing the decision - and
- Consider the decision be delayed until the person regains capacity - and
- Involve the person as much as possible - and
- Decisions made should 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 (wishes and feelings) 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.

## Factors to consider before deciding to covertly administer

It is essential to always remember the potentially abusive nature of this process and for this reason assurance is needed that there is really no other option.

• The best interest decision includes a risk benefit assessment which should be made by the prescribing clinician, and in discussion with relatives/advocates. The option of stopping the medication should be considered as the least restrictive option, particularly where there are risks of food or drink being refused. This decision must be documented in patient's clinical notes and care plan with reasons for the decision.

• Patterns of behaviour need to be monitored. A person may refuse their medication at certain times of day. Can the timing of administration be altered? Is there a formulation which can be given less frequently?

• Dementia commonly presents challenges to carers administering medication. Dementia training is essential to develop persuasive techniques and document personalised preferences such as particular carers, environment, ways of giving etc.

• If a person is not eating or drinking very well, covert administration could be harmful as taste may be affected causing refusal of meals and drinks.

• The prescriber should consider an alternative route of administration of that medication (e.g. topical, parenteral) or an alternative medication (e.g. available in different forms which are more palatable).

### Record keeping

Covert administration of medication will be challenged by inspecting bodies unless appropriate records are in place to support the process. Accountability for the decisions made lies with everyone involved in the persons care and clear documentation is essential. It is not appropriate to act on an "ad hoc" verbal direction or a written instruction to covertly administer and this could be liable to legal challenge. The prescriber must have documentation of both mental capacity assessment for the understanding of medication issues and the best interest decision pathway to support covert administration. Copies of this documentation should be in the person's clinical records in their GP surgery and a copy needs to be shared with the relevant person/care team. Carers should produce a personalised instruction for each medicine to be given covertly in line with the advice of the pharmacist. This should be added to the care plan to ensure that all carers are aware of the correct process. It is also useful for kitchen staff to be aware of a person who is being given medication covertly as dietary changes may be needed.

In the first instance wherever possible, the individual should be offered their medication openly each time the medication is administered, especially where fluctuating capacity is evident. Each time the medication is administered covertly it should be clearly documented on the medication administration record. Good record keeping provides evidence to enable the prescriber to review the continued need for covert medication. Where administration is unsuccessful this must be documented and any consequences reported to the prescriber and the GP/specialist in time scales as agreed at the commencement of the treatment and within the best interest decision.

## Review of continued need

The need for continued covert administration should be reviewed within time scales which reflect the physical state of each individual. National Institute of Clinical Excellence (NICE) guidance proposes and it is recommended that a covert medication plan is developed and reviewed on regular basis; this may be weekly initially to ensure the plan for administration remains appropriate. Review timings should be agreed at the time of agreeing the implementing of covert administration within the best interest decision. It is important at end of life that relatives or advocates are made fully aware of the decisions that are made around medication so that they are reassured. Referring back to the general principles, the least restrictive approach should be the first option that ultimately requires a review of risk/benefit in stopping the medication, especially if evidence of noncompliance demonstrates no apparent harm.

**Deprivation of liberty**

In general terms, people live in care homes so that their care and support needs can be met. This may be a short term basis, such as respite, or for long periods, in some cases for the rest of the resident's life. Statutory bodies have various responsibilities under legislation such as the Care Act 2014 to provide care and support. It is important to keep in mind that the provision of care and support does not, itself, compel the adult concerned to accept it or provide authority to deprive the adult of their liberty in order to receive it.

If an adult is assessed as lacking the capacity to consent to residence in a residential/nursing home for the purposes of receiving care and treatment then in most cases they are being deprived of their liberty. The Cheshire West Supreme Court Ruling (2014) introduced the Acid Test criteria for determining deprivation of a person's liberty as, the person lacks capacity to consent to residency, is subject to continuous supervision and control for a not negligible period of time and is not free to leave is being deprived of their liberty.

The courts said if a restriction would affect an able bodied person despite the purpose it is considered a deprivation of liberty. The court gave no direction as to what a negligible length of time might be.

Deprivation of Liberty requires a legal procedure which is the Deprivation Of Liberty Safeguards DOL's in residential/nursing home and hospital settings.

In these circumstances the Residential/Nursing home who is the managing authority must apply to the local authority as the supervisory body for a DOL's assessment and authorisation of the deprivation of liberty. At the same time the Residential/Nursing home must ensure the plan of care for the individual is in the person's best interests and is the least restrictive option of care to meet the person's needs and is proportionate to the risk of any harm in line with the MCA (2005).

Covert medication is a serious interference with an individual's autonomy and right to self-determination under Article 8 (ECHR). It also contributes to depriving an individual of their liberty under Article 5. It is likely to be a contributory factor giving rise to the existing DOL. As a result of recent case law AG v BMBC SNH, July 2016 provided five key points in practical guidance around the use of covert medication and deprivation of liberty;

1. If a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed mediation and the person is refusing to take the medication then it should only be administered covertly in exceptional circumstances;

2 Before the medication is administered covertly there must be a best interest decision which includes the relevant health professionals and the person's family members
3. If it is agreed that the administration of covert medication is in their best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed.
4. All of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home.
5. If there is no agreement then there should be an immediate application to Court.

**References**

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