NHS
Hertfordshire and
West Essex
Integrated Care Board

Guidance on the Use of Covert Medication Administration in Care Homes

Index

1. Introduction - Purpose and Scope:

1.1 This document provides guidance to care home staff (Carers) and prescribers (General Practitioners or Non-Medical Prescribers) working within the Hertfordshire and West Essex Integrated Care System for when a resident in their care may require covertly administered medications (see 2. Covert Administration of Medication Definition)

1.2 The guidance explains the legal implications of covert administration of medication and helps to ensure the required documentation meets the legal requirements with practical steps to follow to ensure this is done safely.

1.3 The guidance should be adhered to every time covert administration of medication is considered or reviewed for a care home resident.

1.4 This guidance only applies to care homes residents over 18 years of age. It is intended to support the care homes own policies and procedures for covertly administered medication.

1.5 This guidance does not cover people who may require covert administration of medication in their own home.

1.6 This guidance does not cover the administration of medications in an emergency.

2. Covert Administration of Medication Definition:

2.1 Most care home residents have mental capacity to make the decision about whether to take a medicine and they have the right to refuse that medicine even if that refusal appears ill-judged to staff or family members who are caring for them.

2.2 However, in exceptional circumstances, medicine may be disguised in food, drink or given through a feeding tube by care staff without the knowledge or consent of the care home resident receiving them, this is known as covert administration of medication.

2.3 These exceptional circumstances may include where a resident has an illness that has impacted their mental capacity (e.g. Advanced Dementia). Where a resident lacks mental capacity, they may be unable to decide whether to take medications or not and may therefore be refusing to take them for this reason.

2.4 If a resident is having medication administered covertly, they will not know that they are taking a medicine, but the intention of administering medications this way is to ensure that they continue to have access to essential medical treatment that may help save their life, prevent deterioration in health or ensure improvement in the physical or mental health.

2.5 Any decision to covertly administer medication must be done in accordance with the Mental Capacity Act 2005.

3. Residents with Dysphagia:

3.1 For care home residents with dysphagia (swallowing difficulties), medication can sometimes be administered with soft food or in a drink. Administering medication in this way **would not be considered as covert** if the resident is fully aware and has consented to having their medication administered in this way.

3.2 It is essential to advise the resident with dysphagia that their medication has been mixed with food/liquid every time it is administered in this way, and this should be clearly documented in care plans. Advice on mixing medication with food/liquids should be sought from a pharmacist.

3.3 Where medication is mixed with food/liquids in this way, carers must ensure that the entire dose is administered. It should be noted that crushing medication renders each medication unlicensed in most cases.

4. Overt Medication Administration:

4.1 In certain circumstances and at the request of the resident, prescribers and carers may consider the idea of placing medication into food/drink for the sole purpose of making it more palatable.

4.2 This can only be considered for residents with capacity and should be done in cooperation with the resident and done with full transparency.

4.3 Clear documentation should be provided for this decision and should be easily available in the residents care plans otherwise this could be regarded as deceitful and is open to abuse.

5. Exploring Alternatives to Covert Administration of Medication:

5.1 It is important to explore why the resident is refusing medications and alternative strategies for managing medication refusal must be trialled before covert administration of medication is considered.

5.2 This may include: using an alternative form of medication, for example a resident having trouble in taking tablet/capsule form of medication may find liquid medication more suitable, or altering the times medications are administered if the refusal occurs at the same time of day.

5.3 It may also include: providing the resident with information on what the medication is for and why it is important to take. The resident should be provided with clear and easy to understand information on the medicine they are taking. The communication can include written or visual material. Pharmacist support can be sought for this.

5.4 Other factors relating to the medication refusal should also be considered, for example the location where medication is being administered or gender preference of staff who are administering the medication.

5.5 This is not an exhaustive list of alternatives that can be explored and is important to tailor support and care for medication taking to the individuals needs and wishes.

6. General Principles:

6.1 There are several legal, ethical, pharmaceutical, and patient issues that need to be considered when considering covert administration of medication.

6.2 It is important to consider the Mental Capacity Act (MCA) 2005, which provides a statutory framework to empower and protect people who may not be able to make their own decisions. It sets out basic principles that must govern all decisions made and actions taken under its powers. These are based on best practice and common law and are designed to be fully compliant with the relevant sections of the Human Rights Act, 1998.

6.3 The five key principles under the Mental Capacity Act 2005 to consider before deciding to covertly administer medication are the following-

1. *Every adult has the right to make his or her own decisions.* ***You must assume they have capacity to do so unless it is proved otherwise****. You must not assume someone lacks capacity because they have a medical condition or disability.*
2. *A person is not to be treated as unable to decide unless all practicable steps to help them do so have been taken without success. You should make every effort to encourage and support people to make the decision for themselves. If you establish lack of capacity, it is important to involve the person as far as possible in making decisions.*
3. *A person must not be treated as unable to decide merely because he or she makes an unwise decision. People have the right to make decisions that others might regard as unwise. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.*
4. *Anything you do or decide for or on behalf of a person who lacks mental capacity must be in their best interests.*
5. *When deciding or acting on behalf of a person who lacks capacity you must consider whether there is a way that would cause less restriction to the person's rights and freedoms of action and whether there is a need to decide or act at all.*

6.4 The Nursing and Midwifery Council (NMC) and British Medical Association (BMA) and Royal College of Psychiatrists recognise that there may be exceptional circumstances in which covert administration of medication may be considered (see 14. Further Guidance).

6.5 All decisions should be made as part of a multidisciplinary team (MDT) where applicable (this may include a pharmacist or other healthcare professional who provide care to the resident) and family or advocate if appropriate.

6.6 Covert administration of medication must be:

Last resort – all other options must have been exhausted.
Medication specific - it should only be used for medication deemed essential. A full medication review should be undertaken and each medication should be reviewed individually.
Time limited – should be used for the shortest possible time.

Transparent – the decision-making process must be clear to follow.
Inclusive – discussions must take place with appropriate advocates prior to initiating covert administration. This includes Lasting Power of Attorney (LPA).
Best interest – decisions must be in the individual's best interest.
Regularly reviewed – regularly reassess the need for continued covert administration and even more frequently if capacity fluctuates. An earlier date of review could be prompted if conditions have changed. Below are examples of suggested intervals of review:

- Monthly: *if new resident and/or situation not clear or care home new to conducting risk assessments.*
- 3 months, 6 months, 1 year; at discretion of clinician *if resident stable.*
- *Other date (specified); if resident situation not stable and depending on change of situation as agreed by the multidisciplinary team during assessment (e.g., changes in medication, discharge from hospital, SALT assessments).*

7. Deprivation of Liberty Safeguards (DoLS):

7.1 Please note at the time of writing DoLS will be replaced by the Liberty Protection Safeguards (LPS) via The Mental Capacity (Amendment) Act 2019.

7.2 As part of any decision to covertly administer medication there should be a discussion between the prescriber and care staff as to whether there is a need to also consider DoLS/LPS. In situations where the person resides in Care/Nursing Home the responsibility for making the application sits with the Care Provider (as the Managing Authority).

7.3 Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

7.4 DoLS are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restriction to be used – but only if they are necessary and proportionate and in the person's best interests.

7.5 DoLS are used when any restrictions or restraints mean that a person is being deprived of their liberty. Restrictions and restraint must be proportionate to the harm the carer is aiming to prevent, and can include the use of some medication, for example, to calm a person or modify behaviour.

7.6 DoLS has be a consideration if covert administration of medication becomes an impingement of the person's basic rights and freedoms. The need for DoLS would be considered within the context of each individual case and together with any other criteria that contributes to the potential to deprive a person of their liberty. Covert administration of medication alone may not constitute a deprivation of liberty but may add to a package of care that amounts to a deprivation of their liberty. This is more likely if the medication alters mental state, mood, or behaviour, and if it restricts a patient's freedom.

7.7 Residents with existing DoLS must have covertly administered medication declared and listed, and any change of medication or treatment should trigger a review. It is the care home manager's responsibility to ensure that a request for a DoLS review is sent to the local authority as another restriction is being placed on that individual.

8. Psychiatric Treatment:

8.1 The Mental Health Act (1983) provides for the administration of psychiatric treatment to patients who refuse such treatment, and in some situations, it may be clinically appropriate to covertly administer medication. This is usually agreed in consultation with by specialist Mental health teams.

8.2 Patients being treated under the Mental Health Act may not be treated for physical illness if they refuse treatment and have the mental capacity to do so unless the physical illness arises because of the resident's mental state.

8.3 For residents already receiving medications covertly under the Mental Health Act you may consult with the Mental health team caring for them to support any further covert administration of medication decision.

9. Advance Decisions:

9.1 An advance decision by the resident to refuse treatment in anticipation of future mental incapacity must be followed if valid and complete.

9.2 The resident must have made it clear which treatments they are refusing and in what specific circumstances they refuse them.

9.3 It is important that the carers make prescribers aware of any advance decision to not be treated and these should be well documented and recorded by both the care home and surgery.

10. The Process:

If medication is being administered covertly to a resident without appropriate processes being followed or supporting documentation in place this could be considered a criminal act and a referral to the local safeguarding team will be made.

Below summarises the key steps that should be adhered to and considered when agreeing covert medication administration for a care home resident:

a. **Structured Medication Review and Considering Other Options**
b. **Assessing Mental Capacity**
c. **Best Interest Decision and Meeting**
d. **Management Plan**
e. **Obtaining Authorisation**
f. **Record Keeping and Documentation**
g. **Regular Review**

a. Considering other Options and Structured Medication Review

- If a resident is actively refusing treatment, care home staff should make attempts to identify and alleviate any contributory factors.
- The prescribing GP or Non-medical prescriber should be made aware of this refusal.
- Both carers and the prescribers should discuss the reasons for refusal with the resident, explaining why the treatment has been prescribed and exploring other options (see 5. Exploring Alternatives to Covertly Administered Medication).
- This may also present a suitable opportunity for a Structured Medication Review (SMR) which may be completed by a GP, Non-Medical Prescriber or Pharmacist. Note: Most GP surgeries employ Pharmacists who may be able to undertake an SMR and you will require a Pharmacist to support in the later steps in order to check the suitability of medications being given (see Management Plan section below).
- An SMR will ensure that only the essential treatment is being prescribed and administered for the resident at that point in time.
- If the issues are resolved whilst conducting an SMR, covert administration may not be necessary, and it would not be necessary to proceed to the next steps.
- It is important to consider options that are least restrictive to the person's rights and freedom before considering covert administration of medication.

b. Assessing Mental Capacity

- Before considering covert administration of medication, lack of capacity should be formally established. This is when an individual does not have capacity to make a decision or consent to treatment in line with the Mental Capacity Act 2005 with all 5 MCA principles considered (see 6. General Principles).

- A Mental Capacity Act (MCA) assessment is usually completed by an appropriately trained senior carer or nurse involved in the daily administration of medication to the patient (see Appendix 2).
- The prescriber must be assured that the person delegated to conduct the assessment is appropriately trained and has access to all the relevant information required for the assessment.
- If there is any doubt on the outcome of the initial assessment then it may be appropriate for the trained senior carer or nurse to carry out a second assessment with the support from a trained healthcare professional (registered practitioner) such as a GP, Pharmacist or Specialist nurse, as well as the family and friends of the resident if appropriate. A multidisciplinary team meeting may be beneficial in such cases.
- The prescriber must take overall legal responsibility for the MCA assessment and determining whether medications should be administered covertly.

The process of assessment is a 'two-stage test of capacity':

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

If so:

- Is that impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?
-

A resident will be considered to lack mental capacity by law, to make a decision or consent, if he or she is unable to:

- Understand the information relevant to the decision (taking medications).
- Retain the information about it provided by the treating staff, particularly as to the likely consequences of refusal.
- Weigh up the information as part of the process of arriving at a decision
- Communicate his/her decision (it can be by any form for example, written).
-

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.

- A resident may lack mental capacity for temporary reasons, such as the effect of sedative medicines, coma, unconsciousness or the short-term effect of a disease in some cases e.g., delirium. It is important to remember that capacity may fluctuate, sometimes over short periods of time, and should therefore be regularly reassessed (see Regular Review section below).

c. Best Interest Decision and Meeting

- Any decision to covertly administer medicine needs to be formally agreed as being in the residents' best interest and the decision needs to be made objectively not based on personal views or opinions.
- Following a formal mental capacity assessment of a resident where it is agreed the resident is unable to make decisions about their treatment options, the responsible clinician must make a further decision to decide if covert medication administration is in the best interest of that resident. This follows the process in section 4 of the Mental Capacity Act 2005.
- A 'best interests' meeting is recommended by the National Institute for Health and Care Excellence (NICE). The purpose of this meeting is to agree whether administering medicines covertly to the resident is in their best interest. If the situation is urgent, it is acceptable for a less formal discussion to occur. This meeting can take place remotely.
- A best interests meeting should be attended by care home staff, a prescriber, any relevant health professionals (which may include a pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend, an Independent Mental Capacity Advocate (IMCA) or a representative appointed by court order 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.
- If a pharmacist cannot be present, their advice should be sought before the decision to proceed is made in order to check the suitability of the medication to be administered in this way (see Management Plan section below).
- A best interest decision should be documented using the form (see Appendix 3) and a copy of this should be kept in the resident's care plan and GP clinical notes.

Summary of Best Interests Checklist

- 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
- Consider any comments from family and informal carers (trying to glean what the person would have wanted if they were able to make this decision for themselves) - and
- Consider any views of Independent Mental Capacity Advocates (IMCA) or other key people involved – and
- Show evidence and document it is the least restrictive alternative or intervention.

d. Management Plan

- A covert administration medication management plan should be put in place during the best interest meeting or following this (see Appendix 4).
- This plan should include a pharmacist's review to advise whether the medicine is suitable to be given covertly, and if so how to do so safely. This review will need to consider pharmaceutical issues.
- The plan should also include medications that may be required in acute situations or for emergencies such as antibiotics to treat infections or medications for administered on a when required basis for agitation.
- The covert administration of medication management plan should include clear documentation of the decision of the best interests meeting.
- The plan should also have an agreed date for review and include details of what to do if the patient regains capacity.
- This plan should be made easily available for all staff who administer medications to the resident, either in the MAR charts or with reference being made to the plan in the MAR charts.

e. Obtaining Prescriber Authorisation

- Covert administration of medication involves altering medicines which makes their use unlicensed (off-label). It is important to get authorisation in writing, from the relevant prescriber to do this. Prescribing medicines for off-label use affects, and probably increases, the prescriber's professional and legal responsibility and liability.
- **Only an independent prescriber** can authorise off-label use of medicines. Although other healthcare staff or professionals may be able to offer advice, they cannot authorise the action.
- The authorisation from an independent prescriber should be documented in the covert administration of medication management plan.

f. Record Keeping and Documentation

- Good record keeping is essential for ensuring safety and quality of care. Covert administration of medication will be challenged by regulating bodies such as Care Quality Commission (CQC) 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, this would not constitute appropriate documentation.
- All forms including the MCA form, best interests form and covert administration of medication management plan must be kept by the provider (care home) for inclusion in the care plan for that resident.
- The prescribers should document the decision to covertly administer medication in the resident's GP clinical record and where possible the prescriber should scan any paper records of the MCA form, best interests form and covert administration of medication management plan, if this was not completed electronically.

Please Note: there is a 'read code' on SystmOne (Xacu1 – Best Interest Decision to allow covert administration of medicines under Mental Capacity Act), which can be used to document discussions in the patients notes and typing the keyword 'Covert' will offer this as an option for EMIS users.

- It is good practice for the prescriber to state that the medication may be given covertly/following the management plan on the medication directions of each medication repeat template, once this has been agreed.

g. Regular Review

- The need for continued covert administration of medication should be reviewed within time scales which reflect the physical state of each resident. This should be agreed at the very beginning.
- When covert administration of medication is reviewed it is good practice to complete a review form (see Appendix 5)**.**
- It is important at end of life that relatives or advocates are made fully aware of the decisions that are made around medication, particularly if medication is stopped, so that they are reassured.
- In some case's a review may be required earlier than anticipated and reasons for this must be documented. For example, where behaviour modifying medication is being administered, the best interest review process must be more frequent and well documented or where there is fluctuating capacity which will require frequent monitoring in order to ensure that human rights are respected.

11. Practical Considerations:

11.1 The resident should always be encouraged to take their medication in the normal way first.

11.2 It is useful for kitchen staff in care homes to be aware of a resident who is being given medication covertly as dietary changes may be needed.

11.3 In general, the medication(s) that are to be administered covertly should be mixed with the smallest volume of food or drink possible (rather than the whole portion). If possible, carers should try and add the medicine to the first mouthful of food so that the full dose is received.

11.4 Covert administration of medication must be done immediately after mixing it with food or drink. It must not be left for the person to manage themselves. If the resident can feed themselves, carers must observe the resident to ensure that it is consumed.

11.5 Different medicines should not be mixed together in food or drink as this cannot be quantified and may be unsuitable if mixed together. There may be some cases where mixing different medicines together may need to be carried out in the best interest of the person. If this is the case, it should be agreed by a multidisciplinary team and clearly documented in the covert administration of medication management plan.

11.6 Any new medication added to the covert administration of medication management plan must be assessed following all the steps above with the need for covert administration identified, and all legal processes must be followed.

11.7 It is essential that, should the resident who is receiving their medication covertly, be transferred to another care facility all relevant documentation (e.g., MCA assessment and Best Interest discussion) should accompany them including a verbal handover to the person or persons who will be responsible for their care.

11.8 When a resident arrives to the care home or to a new care venue, any covert administration of medication should be reviewed, and the necessary assessments, plans and documentation completed.

12. Education and Training:

12.1 All staff involved in the administering or prescribing of medicines to be administered covertly for care home residents across the Hertfordshire and West Essex Integrated Care System should be aware of this guidance and it should be used in conjunction with any relevant care home medication policies already in place.

12.2 In addition, care home staff must be appropriately trained on administering covert medication as part of their medicine's management mandatory training.

13. Further guidance:

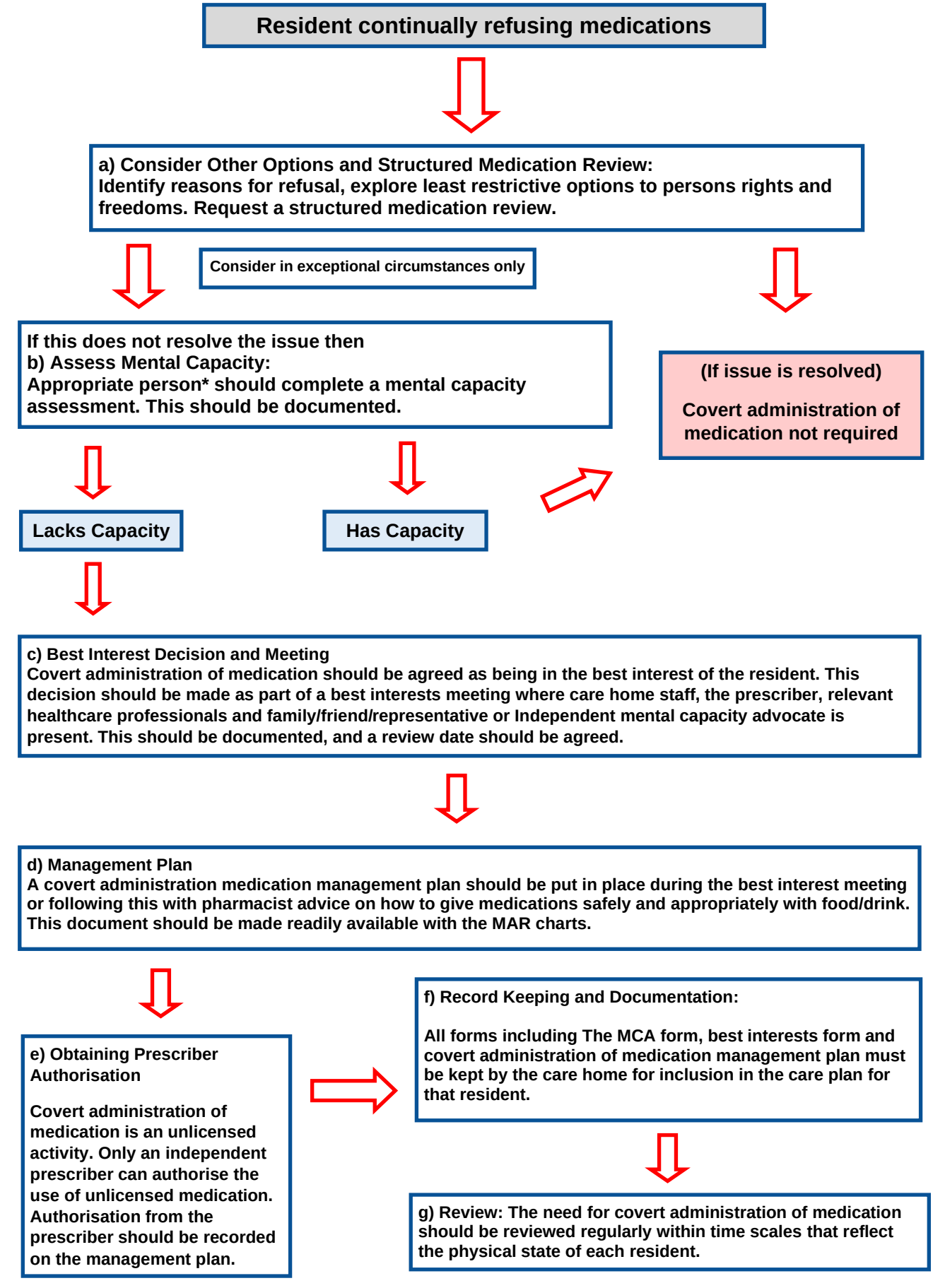
- The Nursing and Midwifery Council (NMC) guidance on covert administration of medicines: http://www.nmc-uk.org/Nurses-andmidwives/Regulation-in-practice/Medicines-management-and-prescribing/Covertadministration-of-medicines
- The British Medical Association (BMA) provides resources to support doctors to help in good decision-making when providing care and treatment for people who may lack the mental capacity to make decisions on their own behalf: bma-mental-capacity-act-toolkit-2016.pdf
- The full guidance on The Mental Capacity Act and legislation can be found here: Mental Capacity Act 2005 (legislation.gov.uk)
- Section 1.15 of this guideline provides advice for care home staff on covert administration of medicines to residents: National Institute for Health and Care Excellence (NICE): Social care guideline (SC1): Managing medicines in care homes.
- Section 1.8 provides guidance to support care workers with the decision-making and process for covert administration of medicines: National Institute for Health and Care Excellence (NICE) Guideline (NG67): Managing medicines for adults receiving social care in the community.
- The Care Quality Commission Regulation 12(2)(b) includes advice for care homes on the use of covert medicines https://www.cqc.org.uk/content/regulation-12-safe-care-and-treatment#guidance
- Royal College of Psychiatrists have produced guidance on issues to be considered when medicines are given covertly: www.rcpsych.ac.uk/covertmedicine.full.pdf (Membership required)
- PrescQipp have produced guidance for healthcare staff to follow to support with a decision to give a medicine covertly and supporting resources: PrescQIPP Bulletin 269: Care homes – covert administration (Membership required).
- Specialist Pharmacy Service (SPS) have produced guidance on the pharmaceutical issues to consider when administering medication covertly – Covert administration of medicines in adults: pharmaceutical issues, 14 January 2022.

14. Document review:

This guidance and supporting documentation will be reviewed every two years by the Medicines Optimisation Team at The Hertfordshire and West Essex Integrated Care System, or earlier in the event of changes to legislation or good practice.

15. Appendices

Appendix 1 - Covert Administration Flow Chart



**See section 10b for further details.*

Appendix 2 – MCA Form

Check your local guidance and care home medication policy which may provide you with an appropriate MCA form to use. Alternatively, you may use MCA forms provided by the local council.

Hertfordshire Council: Mental Capacity assessment form (hertfordshire.gov.uk)

Essex Council: Mental Capacity Assessment form (2).docx (live.com)

Appendix 3 – Best Decision Record Form

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of Patient			
Date of Birth		**Location**	

-What treatment is being considered for covert administration? (Consider inclusion of acute treatments for emergencies e.g., Antibiotics, Lorazepam) It has been confirmed that no advanced decisions are in place concerning this treatment.	
-Why is this treatment necessary? -How will the person benefit? -Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g., NICE.	
-What alternatives did the team consider which were not successful? Examples - other ways to manage the person, other ways to administer treatment, different formulations such as liquids or dispersible tablets -Why were they not appropriate?	
Treatment may only be considered for a person who lacks capacity. -When was Mental Capacity Assessment (MCA) for this issue completed?	**Date:** **Assessed by:** **Name:** **Signature:**
-Who was involved in the decision? N.B. A pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable **If there is any person with Lasting Power of Attorney to consent, then the treatment may only be administered covertly with that person's consent, unless this is impracticable**	**Name of health care professionals involved:** **Name of relatives, advocates or other carers involved:**
-When will the need for covert treatment be reviewed? (This will be dependent on physical condition of each patient. Fluctuating capacity requires more frequent review)	**Date of first planned review:**
Important – please note that covert administration usually involves altering medicines and this may be unlicensed (off-label) activity. By signing this form the prescriber is also authorising unlicensed (off-label) use of medication. At present this can only be done by an independent prescriber.	

Prescriber name: **Signature:** **Date:**

Appendix 4 - Covert Administration of Medication Management Plan

This information should be included in the patient's care plan and with the medicines administration record (MAR) sheet.

- Instructions for administration must specify clearly how each medicine is to be administered.
- If possible, the prescriber should include additional instructions on directions on the prescription for community pharmacists to add to dispensing label.
- Include any cautions such as temperature/types of food to avoid.

Practical points for care staff:

- ✓ Before administering medication covertly the patient should be encouraged to take it in the normal way.
- ✓ Care home staff should be aware of personal preferences for administration through the care plan.
- ✓ In general, the medication(s) which are to be administered covertly should be mixed with the smallest volume of food or drink possible.
- ✓ Try and add the medicine to the first mouthful of food so that the full dose is received.
- ✓ The medication must be administered immediately after mixing it with food or drink.
- ✓ Consider the taste and other possible effects of the medicine, particularly if tablets are crushed or contents removed from capsules
- ✓ Different medicines should not be mixed together in food or drink as this cannot be quantified and also could be unsuitable to be mixed together.
- ✓ Covert administration must be recorded on the MAR chart (e.g. sign and use a specific code if necessary)

Name of Patient			
Date of Birth		**Location**	

Medication	**Form**	**Advice (How to administer medication)**

Pharmacist signature: **Date:**
Senior Carer/Nurse Signature: **Date:**
Prescriber signature: **Date:**

Report to GP at next contact if:

- Covert administration results in a refusal to eat or drink
- It appears that the full dose of medication has not been taken (make a note on MAR chart)
- There appears to be a deterioration in the patient's health and well-being.

Appendix 5 – Review Form for Covert Administration

Please provide a copy of this form to the carer(s) supporting the patient and scan into patient notes in surgery.

Name of Patient		**Date of Birth**	
Location		**Date of Review**	

Is the medication still necessary? **If so, explain why**	
Is covert administration still necessary? **If so, explain why**	
Who was consulted as part of the review?	
Is legal documentation still in place and valid? **(MCA assessment and evidence of Best Interest discussion)**	
Date of next review:	

Prescriber/Pharmacist name: **Signature:**
Date:

Senior Carer/Nurse name: **Signature:**
Date:

Version	V1.0
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Date ratified	December 2022 by the Medicines Optimisation Delivery and Implementation Group
Review date	December 2024

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Hertfordshire and West Essex ICB would also like to thank Bedfordshire, Luton and Milton Keynes ICB for providing part of the content contained in this document.