

Good Practice Guidance for Care Homes			
Covert Medication Care Documentation Form			
Name		Date of Birth:	
Care home:		Date:	
Completed by:		Position:	
<b>Assessing Capacity:</b> Does the person have impairment, or a disturbance in the functioning of their mind or brain?  Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?		Yes/No <i>if yes: a best interests decision must be documented</i>  Yes/No <i>if yes: a best interests decision must be documented</i>	
<b>Functional tests of capacity</b> To be able to make a decision a person must be able to: <ul style="list-style-type: none"> <li>understand the information relevant to the decision,</li> <li>retain that information,</li> <li>use or weigh that information as part of the process of making the decision</li> <li>communicate the decision.</li> </ul>		<i>Describe how assessed</i>	
What medication is being considered for covert administration? <b>List all medication being considered</b>			
Why is this medication necessary or what benefit is there for the patient? Where appropriate refer to clinical guidelines, e.g. NICE. Is it the least restrictive option?			
What alternatives have been considered? (e.g. alternative methods of administration or other ways to manage the person / behaviour)			
What is the person's past or present views of the proposed treatment, if known?			
Is there a person nominated with the power to consent (e.g. welfare attorney/welfare guardian)? If yes have they been consulted with regard to covert administration?		Yes/No <i>if yes a best interests decision must be documented</i>  Yes/No <i>if yes a best interests decision must be documented</i>	
Is the person subject to a DoLs? If yes does the safeguard need to be updated? Could the medication administration be considered a DoL?			
Who was involved in the decision to administer medicine covertly?  All persons involved in decision, including the prescriber, person with lasting power of attorney, family and care home representative should print their name, relationship to named person and sign this form		<b>Name and signatures of persons involved in decision</b>	
Has anyone opposed the decision to administer covertly?		<b>Yes/No.</b> <i>If Yes give details of who and why they oppose?</i>	

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A Pharmacist must be involved to give advice if administration involves crushing tablets, opening capsules or combining medicines in any way with food or drink.	<b>Name of Pharmacist:</b> <b>Name of Pharmacy/organisation:</b> <b>Date:</b>
Describe the method for administering in food agreed with pharmacist (each medication should be administered separately) e.g. If tablet administration is refused, the tablet can be administered covertly by crushing tablets and mixing with one teaspoon of yogurt.	
When more than one medication is to be administered at the same time of day, specify the most appropriate order (e.g. most clinically significant medication first)	
When will a review of the covert administration arrangements be made? (specify time frame and circumstances) e.g. monthly or when a new medicine is started)	<b>Date of planned review:</b>

MOVP – 003 – V3 – Good – Practice – Covert – Medication care form	Status: Approved	Next Review Date: May 2023
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