

Covert medication care pathway

Name of patient

DOB

Location

<p>What treatment is being considered for covert administration? Name the actual medication(s).</p>	
<p>Why is this treatment necessary? Where appropriate, refer to clinical guidelines, e.g. SIGN.</p>	
<p>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?</p>	
<p>Treatment may only be considered for an individual who lacks capacity. Outline the assessment of capacity.</p>	<p>Assessed by:</p>
<p>Treatment may only be administered under a certificate of incapacity (Section 47, AWI) or appropriate Mental Health Act documentation. What legal steps were followed?</p>	<p>Legal documentation completed: AWI S47 MHC&TSA Date:</p>
<p>Treatment may only be given if it is likely to benefit the individual. What benefit will the individual receive from each medication administered covertly?</p>	
<p>Is this the least restrictive way to treat the individual? Give reasons.</p>	
<p>What are the individual's present and past views of the proposed treatment, if known?</p>	
<p>Who was involved in the decision? <i>N.B. A qualified pharmacist must give advice on safe administration if this involves crushing tablets or combining</i></p>	<p>Practitioner staff involved: Pharmacy advice obtained from:</p>

<p><i>medication with food and drink.</i></p> <p><i>N.B. If there is any person with the power to consent (welfare attorney, welfare guardian), then the treatment may only be administered covertly with that person's consent unless this is impracticable.</i></p>	<p>Relatives or other carers involved:</p>
<p>Do any of those involved disagree with the proposed use of covert medication?</p> <p>If so, they must be informed of their right to challenge the treatment.</p>	<p>Yes/No</p> <p>Date informed</p>
<p>When will the need for covert treatment be reviewed?</p>	<p>Date of first planned review:</p>
<p>Covert medication plan: outline method of covert administration for each medication</p> <p>Medication1 Method of covert administration</p> <p>Medication 2 Method of covert administration</p> <p>Medication3 Method of covert administration</p> <p>Medication4 Method of covert administration</p> <p><i>(add more if necessary)</i></p>	

Signed:

(Name)

(Designation)

(Date)