Covert administration of medications essay

Prescription and administration of medicines Is a key element of client care. Prescription drug use has Increased hugely In recent years. Every day 7, 000 doses of medication are administered in a typical NASH hospital (Audit Commission 2002). In 1993, 1. 9 billion prescriptions were written and in 2001 the number had risen to 3. 1 billion cited by Cringer and Holcomb (2008).

Prescribes are bound by law and by the demands of good practice to consider the extent to which a person can make decisions regarding taking medications for themselves. The study of adult clients with Intellectual disabilities Is no exception. Although as adults they are legally eligible to consent or not to consent to their own treatment, persons with Intellectual disabilities due to their mental incapacity are often judged to not have the ability to make such informed decisions.

X is a 52 year old man with Down syndrome, profound intellectual disability, with a lifelong history of challenging behavior. He has recently been admitted to reside on a full time basis in a community based home with five other men with varying degrees of Intellectual disability following the death f his mother, he is under the care of a nursing and medical team. A number of weeks ago X presenting with severe aggression towards peers and staff and self- injury, he was seen by the consultant psychiatrist and prescribed an atypical antispasmodic drug to treat his behavior problems.

Antispasmodic drugs are used frequently for clients with intellectual disability to help control various behavioral problems, these drugs work by changing the activity of certain natural substances in the brain (Debt and

Fraser, 1994). It is noted In Ax's care plan that he has in the past effused to take tablets, following discussion by the nursing team and since being dispensed nurses have administered the tablet concealed within foodstuffs. X is not aware that this is being done, it has however been noted in his drug administration carded that " due to his level of intellectual disability client can neither consent nor refuse treatment".

X has had an excellent response to the medication, with staff seeing a significant decrease In his presenting challenging behavior. No written local policy exists which deals with the administration of medications covertly In this ay. After SIX weeks x was reviewed by the consultant psychiatrist and she recommended that he continue taking the medication for a further six weeks, it was brought to her attention at this point that X was being administered his medication covertly within foodstuffs.

The psychiatrist had to consider recharging his medication for a further six weeks with the knowledge that no efforts have been made to give the medication openly in Its normal tablet form, however following discussion with staff, the medication was recharged as the psychiatrist believed that staff have Ax's best interests in mind and consider the administration of the medication to be essential for his health and well-being and for the safety of others. The author intends to discuss this case outlining the legal, ethical and professional issues it raises for all staff involved.

As a general principle of law, every human being of adult years and sound mind has a right to determine what shall be done with his or her body. The main legal issues that surround decision making for persons with intellectual

disabilities are of capacity and consent. Every adult is presumed to have the capacity, but it is a resumption that can be rebutted. Once persons have reached adult age it is assumed in law that they are capable of making decisions. However, if a person has some form of intellectual disability and it can be demonstrated that they are not capable then different rules apply.

Here a person must be able to understand the nature of the action and its consequences to be able to take a legal decision. Capacity is determined by a test of understanding not wisdom, Law Commission (1995). A person lacks capacity if some impairment or disturbance of mental functioning, such s intellectual disability or dementia renders the person unable to make a decision whether to consent to or refuse treatment, then the law allows medicines to be given in the absence of a valid consent in the person’s best interest (House of Lords, 1989).

Kay, Rose and Turnbuckle (1995) have stated that the term profound disability means that the individual will require maximum assistance in most if not all aspects of everyday life, in terms of 24-hour care and supervision, the person may have difficulty in understanding, communicating, eating and drinking, continence and obligation.

In the previous mentioned case due to the clients profound degree of intellectual disability he would be deemed incapable of consenting to the treatment and the medication would have proven to be necessary in his best interest, that is in the reduction of challenging behaviors, which can be objectively Justified by examining behavioral records in his care plan, were

the covert administration malicious then a criminal offence under the Offences Against the Person Act 1861 would be committed.

Tremolo, Beats and Philipp (2000) conducted a study on the overt administration of medications to patients with dementia in institutions and in the community in the I-J and found that 71% of respondents working in residential, nursing and inpatient units questioned, reported that medications were sometimes given in a covert way. Kirkwood and Engaged (2005) conducted a similar study in Norwegian nursing home units and special care units for people with dementia, their findings saw that 43% of wards within the study reported that at least one patient was sometimes given drugs covertly.

Both studies reported that covet administration as often done secretly and without discussion, probably for fear of professional retribution, Kirkwood and Engaged (2005) concluded that even if, as most careers and some authorities thought, covert administration can be Justified, the poor recording and secrecy surrounding the practice was a huge cause of concern. No opportunity for formal discussion had taken place between the multidisciplinary team informing them of the issues surrounding the administration of the antispasmodic drug in the case of X and it is not documented if any other methods of administering the medication was tried.

Best practice guidelines are available to assist those administering medications covertly from the Mental Welfare Commission for Scotland (2006) in the form of the “ Covert Medication Pathway’, this would be essential in this case. Tremolo, Beck and Paton (2001) state that the

opportunity for legal redress is a key element of the UK Human Rights Act 1998, the completion of this care pathway legal redress is possible. The Law Commission (1995) has the view that treatment should be made available to severely incapacitated clients Judged according to their best interests and administered in the least restrictive manner.

In exceptional circumstances this may require the administration of medications within foodstuffs, when the client is not aware that that is being done. I would advocate that the Mental Health Act (2001), Article 60, a & b and the Adults with Incapacity Act (Scotland) 2000, (HOMOS, 2000) be considered in this case, a treatment plan should be drawn up between the senior nurse or manager on duty, general practitioner and consultant psychiatrist and reasons for the plan should be discussed by the multidisciplinary team and a record of the discussion made.

This helps to impose a duty of care on those who administer the medication. In the case of X he was unable to consent to his treatment due to his intellectual disability and on consideration of his case the prescribing consultant agreed that the covert administration of his medication was in his best interest, however it is this authors view that some formal discussion should have taken place with involvement from all members of the multidisciplinary team before the medication was administered in such a way, this would have ensured that the intervention was objectively Justified.

Ethical Issues: Persons with intellectual disabilities are increasingly being encouraged to take a ore active role in decisions about their psychological and medical treatment, raising complex questions concerning their ability to

consent. Informed consent is a problem for people with intellectual disability as they are seen as being less competent to provide consent than the general population. A person with intellectual disability will have difficulty providing informed consent throughout their lifetime.

The Adults with Incapacity (Scotland) Act 2000 recognizes that being born with an intellectual disability may limit a person’s ability to act or make some or all decisions for themselves, depending on the severity of their condition. This problem permeates many other fields, such as work with older people. However, among older people problems with informed consent may be limited to particular life stages as discussed by Wong, Upon and Huh’, (2005) who posit that ethical, legal and clinical considerations become more complex when the mental incapacity is temporary and when the covert medication actually serves to restore autonomy.

Xa client with profound intellectual disability had presented with severe aggression towards peers and staff and self- injury which required him to be prescribed an atypical antispasmodic drug as recommended by the consultant psychiatrist. Infield and Tongue (1995) while developing their “ Developmental Behavior Checklist” found that behavioral and emotional difficulties requiring some form of medical intervention have consistently shown to be two to three times more common in persons with intellectual disabilities than in the rest of the population.

The medication was given to X covertly concealed within foodstuffs for the duration of his treatment and was only brought to the psychiatrist’s attention at a planned review after six weeks. Nurses administering the covert

medication to X noted that “ due to his level of intellectual disability client can either consent nor refuse treatment”. The common argument of those who support the use of covert treatment is that it is the least distressing method of treating someone who will otherwise come to harm.

This is mostly put alongside a pragmatic things and therefore will not be able to learn that the medication must indeed be taken as discussed by Witty and Deviate (2005). Evidence of the reporting of covert administration of medications is constrained by ethical concerns over capacity and consent, even if, as most careers believe, covert medication can be Justified. Tremolo,

Beats and Philipp (2000) discuss the poor recording and secrecy surrounding the practice in institutions as a cause for concern. Chug, Choc and Wong (2001) propose that most accept the case for covert treatment in those who cannot give consent, particularly patients with dementia or intellectual disability, this is also demonstrated in research studies carried out by Tremolo, Beck and Paton, (2001) and Kirkwood and Engaged, (2005).

Ultimately, a choice had to be made by the psychiatrist to recharge X for the medication knowing that it would continue to be given covertly, the author sees this choice as being between a larger beneficence (control of symptoms and continuation of treatment) and a smaller malevolence (necessary treatment but without the client’s knowledge and consent or any discussion around the topic).

The Department of Health & Welsh Office (1999) states that “ treatment for those who lack capacity may be prescribed in their best interests under the common law doctrine of necessity and thus necessary to save life or prevent

deterioration or ensure an improvement in the patient’s physical or mental health”. Chug et al (2001) finds further Justification for the non-consensual administration of treatment by enshrining the principle that adults who are unable to fully understand the nature and effect of medical intervention should not be deprived of treatment.

Keller, Griffith, Bell, Short and Deadheads (1996) raise other discussion over the covert treatment of a patient who actually accepted that it helped him, but which resulted in an enquiry committee against the prescribing psychiatrist and suspension of the nurse, in spite of the fact that the treatment was not found to be unethical. Welsh and Deal (2002) ask that instead of a confusing debate, should professionals look at deontological principles? Do we need to look at the rightness or wrongness of covert administration of medicine, they ask do we need to worry how a medicine is given as long as it is helping a person?

Do the ends Justify the means as with utilitarian perspectives? Others believe covert administration amounts to “ winning a battle but losing a war” (Levin, 2005). Wright (2002) suggests that the practice of covertly administering medications is one that has potential to endanger public safety and breach legal and professional requirements. The psychiatrist in the case of X decided to recharge the medication knowing that it would be given covertly, therefore agreeing that yes the ends do Justify the means.

Wong et al (2005) also holds with this view that stopping treatment that has proven to significantly decrease a presenting behavior is contrary to the ethical principle of non-maleficent and that the covert administration is the

least disturbing for the client and those around him. The author would however recommend that additional safeguards should be put in place by introducing the “ Covert Medication Pathway’ as devised by the Mental Welfare Commission for Scotland (2006) to Ax’s care plan, this will allow for all members of the multidisciplinary team to have input and clarity in Ax’s care.

Professional: document entitled “ Covert administration of medicines- disguising medicine in food and drink”, which specifically deals with the circumstances surrounding the afore mentioned case, give guidance that those involved in the administration of medicines in a covert way do so within the boundaries of their professional frameworks. All nurses in Ireland are guiding by The Code of Professional Conduct laid down by An Board Latrines (2000), this states that “ any circumstance which could place patients/ clients in Jeopardy or which militate against safe standards of practice should be add known to appropriate persons or authorities”.

Though no formal policy existed in this case the nursing staff had documented that “ due to his level of intellectual disability client can neither consent nor refuse treatment”, therefore it is proposed by the author that they had considered but not formally discussed the decision that was made to administer the medication covertly. An Board Latrines imposes standards on the administration of medications and in Standard 1. Of the Guidance to Nurses and Midwives on Medication Management (2007) it clearly lays out the point that if there s any question in relation to a medication that clarification should take place at the time with the health care professional involved before the medication is administered, this did not occur in this

case as it was not brought to the attention of the prescribing psychiatrist until several weeks later at a review appointment.

The author proposes that the nurses involved in the covert administration of the medication although acting in the client's best interest did not act in a professional manner, they are bound by An Board Latrines standards and what a respected body f professional opinion would have done in the same circumstances. The NC (2008) standards generally follow the principles laid down by law and agree that there may be particular cases where covert administration may be considered without informed consent to prevent the client missing out on essential treatment.

The client in this case could not give his consent due to his intellectual disability, however no formal discussion took place, the NC (2008) advise that in the case of covert administration to an incapable adult there would be a need to demonstrate that the decision to administer medicines in this way was not to be considered routine and should be a contingency measure, with each client's needs being assessed individually and undertaken in accordance with written local policy.

Tremolo, Beck and Paton (2001) suggest that covert administration should only occur if shown to be safe and Justified in the person's best interest and that documentation of proper consultation and recording of decisions and actions are made so that legal scrutiny is possible, decisions should be recorded in a formal way so that they are open to inspection and criticism.

The Mental Welfare Commission for Scotland (2006) have produced the " Covert Medication Pathway' which would be of great value in this case, it is

seen as being of best practice and would allow for discussion by all members of the team, with specific reference to outlining the assessment of capacity for the client, the benefit to the client, who was involved in the decision and who if any of those involved disagreed with the proposed use of covert administration of medicines and on completion of the care pathway a review date is set for further discussion of the particular case.

The author suggest that the proposed treatment plan should include input from a pharmacist to ensure that the antispasmodic drug may be mixed with distributed, metabolites and excreted” as stated by Tremolo et al (2001). Once formal discussion has taken place, consulting the prescribes, nursing staff, client advocate, pharmacist, a client specific care pathway completed and where it is documented that there is no alternative to administering the medication covertly in the client’s best interest, nurses can administer the medication in accordance with the practice accepted by An Board Latrines Guidance to Nurses and Midwives on Medication

Management (2007) and the drugs product license. Keller, Griffith, Bell, Short and Deadheads (1996) discuss a case where a nurse was suspended for administering a tranquillest medication in disguise on the instructions of a consultant, this nurse was reported as believing that she was acting in the patients best interest and that she agreed with the consultant that it was the correct approach, however no formal written documentation was kept.

Tremolo et al (2001) argue that the practice of covert administration of medications remains mainly unregulated because of a lack of legal r professional guidelines and of the secrecy surrounding the practice due to

fear of professional recrimination. The author advocates the completion of a “ Covert Medication Pathway’ for any client that receives medication in this way, this will allow for open and frank discussion of each individual case and will ensure that all staff are protected and the client will have the benefit from the therapeutic qualities of his medication.

Conclusion: The practice of covertly administering medications is one that has potential to endanger public safety and breach legal and professional requirements, Wright 2002). Where there is no alternative and the client cannot give informed consent, careers must demonstrate that they have fully considered the safety issues of giving a medicine in this way by consulting the prescribes, the pharmacist and the client or client advocate where possible, and administer the medication in accordance with the practice accepted by a responsible body of professional opinion such as the Covert Medication Pathway (2006) and the drugs product license.

In that way the career will avoid liability and the client will safely continue to benefit from the hermeneutic effects of the medication In an effort to provide a good quality of life to clients who are incapacitated due to intellectual disability potentially controversial care decisions will occur.

While the need to provide good care to those who cannot choose is an inescapable duty, it is essential that all members of the multidisciplinary team are consulted and that they recognize the nature of what they are doing and document and discuss decisions with colleagues, clients or advocates in an open and balanced way, this will allow for decisions to be open to criticism and inspection.