NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

Covert Administration of Medication for Patients in Care Homes.

Version:	Final 2.0
Approved By:	Quality and Patient Safety Committee
Date Approved:	
Name of originator/author:	Erica Carmody Catherine Ellwood Jo. Harrison, Specialist Clinical Portfolio Manager
Name of responsible committee/individual:	QPSC
Name of executive lead:	Jayne Sivakumar (Chief Nurse)
Date issued:	Approved by Barnsley CCG Governing Body 14.1.2021
Review Date:	**14.1.23**
Target Audience:	General Practice and Care Home Staff.

THIS POLICY HAS BEEN SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT

Amendment Log

Version No	Type of Change	Date	Description of change
V0.1	Initial draft iteration	01.12.2016	
V0.2	Specialist review	03.02.2017	Additional information regarding Mental Capacity Act Removal of duplicate information Update of flow charts to match policy text Reformatting Addition of cover sheet and contents page Completion of Equality Impact Assessment.
V0.3	Additional information and formatting	16.02.2017	Additional information to support understanding of acronyms used Reformatting of flow charts
V1.0	Iteration of final version		Additional information added to flow charts appendices 1 and 2 at request of Q&PSC. Policy agreed by Q&PSC for dissemination and implementation.
V2.0	Review	21/06/2019	1.2 MCA Section 5 limitations added 2.1 Statement added re: restraint 3. Process requirements strengthened for compliance with legislation 3.5 Information about LPA/CAD added for reference 4. CQC and OPG information added Appendix 3 added : Covert medication care plan
V3.0	Review	16/07/2020	Appendix 5 added: Practical guidance for Administration of Medication to Residents with swallowing difficulties

Contents

1. Introduction

1.1 The giving or withholding of medication should not be the primary method of influencing or controlling a resident's behaviour**. Other recognised skills, such as de-escalation or distraction techniques should always be the first choice in attempting to manage behaviour that challenges.**

1.2 The covert administration of medicines should only be used in exceptional circumstances, when that means of administration is judged necessary and proportionate, in accordance with the principles of the Mental Capacity Act 2005 and the limitations in Section 5 of the Act and the Deprivation of Liberty Safeguards, 2008. (NICE QS85).

1.3 The scope of this policy extends to the use of oral medications in all but emergency and life-saving situations.

1.4 This policy should still be applied in situations such as infection outbreaks / epidemics / pandemics. (NB: It is acknowledged at such times that assessing capacity may be more difficult due to lack of face to face contact. At such times, advice can be sought from the Local Authority or CCG Safeguarding / MCA Lead).

2. The Legal Framework

2.1 Covert administration of medication is a serious interference with a person's autonomy and right to self- determination under Article 8 of the European Convention of Human Rights. In all cases where the administration of covert medication is care planned an application to the Supervisory Body must be made for a Deprivation of Liberty Safeguards (DoLS) authorisation, or a review of any existing authorisation that may be in place. This is particularly important for medication that has a sedative effect, as this can be viewed as restraint.

3. The Process

NB – if a resident is accepting medication but has swallowing difficulties, this is not to be seen as a refusal. Please refer to Appendix 5: Practical guidance for Administration of Medication to Residents with swallowing difficulties

3.1 If a resident is refusing medication, the care home worker must provide them with relevant information which may enable the resident to reconsider their decision. This must be in a format that the person finds easier to understand. If the resident continues to refuse medication, the care home worker must try to ascertain the reason for medication refusal and record this on the Medicine Administration Record (MAR) chart and daily care records. The care home worker must then inform the Registered Manager.

3.2 The delegated person (e.g. shift leader/ in charge) must contact the prescriber for advice. If the medication being refused falls within part of a defined course of treatment, the prescriber needs to be informed after the first refusal.

3.3 Following refusal of medication that is essential to health and well-being, or for all other medications, refusal for two consecutive days or more, a mental capacity assessment in relation to consenting to the administration of medication should be completed. This should be done by the prescriber, who should also undertake a full medication review to support appropriate clinical management and ensure that only those medications that are currently necessary are prescribed.

3.4 If it is assessed that the resident has capacity to make an independent decision, medicines **must not** be administered covertly.

3.5 If the resident is assessed as lacking capacity to consent to the administration of medication a BEST INTEREST discussion MUST take place. This must include the prescriber (decision maker), multi-disciplinary team involved in the resident's care, anyone with authority to make decisions on their behalf, the Relevant Person's Representative (if subject to a Deprivation of Liberty Safeguards (DoLS) Authorisation), those close to the resident and any Advocate, to decide if the medication is to be administered covertly. This must be thoroughly documented (via the covert medication plan (appendix 3).

NB: The only person's with delegated authority to make a decision on behalf of a person who lacks capacity are those who hold a valid Lasting Power of Attorney (LPA) or who are a Court Appointed Deputy (CAD) for Health and Welfare. They must show proof of this at the time the decision needs to be made by producing an LPA form which is stamped 'VALIDATED-OPG – otherwise the prescriber remains the decision maker. To check if someone has LPA/CAD go to https://www.gov.uk/find-someones-attorney-or-deputy
If it is felt that the LPA/CAD is not acting in the person's best interests or there is any concern / dispute about their decision making an application to Court of Protection would need to be considered.

3.6 If the situation is urgent, a best interests decision will need to be made by the person administering the medication at the care home and the prescriber via a discussion when it is not safe or appropriate to delay or avoid administration of the medication. However, a formal meeting should be arranged as soon as possible afterwards (no longer than within 5 working days). Examples of such situations are life critical medications (e.g. for Epilepsy/Diabetes/CVD etc. and short course antibiotics)

3.7 If the patient has cognitive impairment, seeking guidance from the Memory Team & Support Services should be considered in terms of exploring approaches that might work best for the individual.

3.8 It is important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that the need for continued covert administration is regularly reviewed.

3.9 Medications should not be altered to make them easier to swallow or to hide them without input from a pharmacist or prescriber. Inappropriate changes to the form of the medication may affect the way that it works. Appropriate information regarding stability of medication when administered covertly should be obtained from the GP, practice pharmacist, or CCG/PCN * care home pharmacist. This information should be documented on the care plan and the Administration of Covert Medication Form at Appendix 4. This should then be attached to the front of the Medicine Administration Record (MAR chart).

** CCG Clinical Commissioning Group*
** PCN Primary Care Network*

3.10 Regular review dates (at least 6 monthly) MUST be set to review the resident's mental capacity to make decisions regarding medication -Best Interest decisions made on their behalf and covert administration of medication management plans. Any change of medication or treatment regime MUST also trigger a review where such medication is covertly administered. A medication review may also be triggered by conditions set at any Deprivation of Liberty Safeguards Authorisation review.

4. Further guidance

Further guidance can be found at:

AG, Re [2016] EWCOP 37 (6 July 2016)
http://www.bailii.org/ew/cases/EWCOP/2016/37.html

National Institute for Health and Care Excellence (NICE). March 2015. Medicines Management in Care Homes. Quality Standard QS85
https://www.nice.org.uk/guidance/qs85

Office of the Public Guardian
https://www.gov.uk/government/organisations/office-of-the-public-guardian

CQC: Brief guide to covert medication in mental health services
https://www.cqc.org.uk/sites/default/files/20180406_9001398_briefguide-covert_medication_mental_health_v2.pdf

Equality Impact Assessment 2013

Title of policy or service	Covert administration of medication for patients in care homes.	
Name and role of officers completing the assessment	Erica Carmody, Clinical Practice Pharmacist/Medication Review Pharmacist Catherine Ellwood, Medicines Management Technician Jo Harrison, Specialist Clinical Portfolio Manager	
Date assessment started / completed	16/07/2020	

1. Outline	
Give a brief summary of your policy or service. • **Aims** • **Objectives** • **Links to other policies, including partners, national or regional**	The policy aims to provide guidance for prescribers and those administering medication in the care home environment regarding clinical and legal considerations to be taken into account when administering medications covertly. Due regard has been taken of the requirements of the Mental Capacity Act (2005), recent case law (AG, Re [2016] EWCOP 37. July 2016) and National Institute for Health and Care Excellence (NICE). March 2015. Medicines Management in Care Homes. Quality Standard QS85.

2. Gathering of Information

This is the core of the analysis; what information do you have that might impact on protected groups, with consideration of the General Equality Duty

	What key impact have you identified?			**What action do you need to take to address these issues?**	**What difference will this make?**
	Positive impact	**Neutral impact**	**Negative impact**		
Human rights	Y				
Age	Y				
Carers		Y			
Disability	Y				

Sex		Y			
Race		Y			
Religion or belief		Y			
Sexual orientation		Y			
Gender reassignment		Y			
Pregnancy and maternity		Y			
Marriage and civil partnership (only eliminating discrimination)		Y			
Other relevant group		Y			

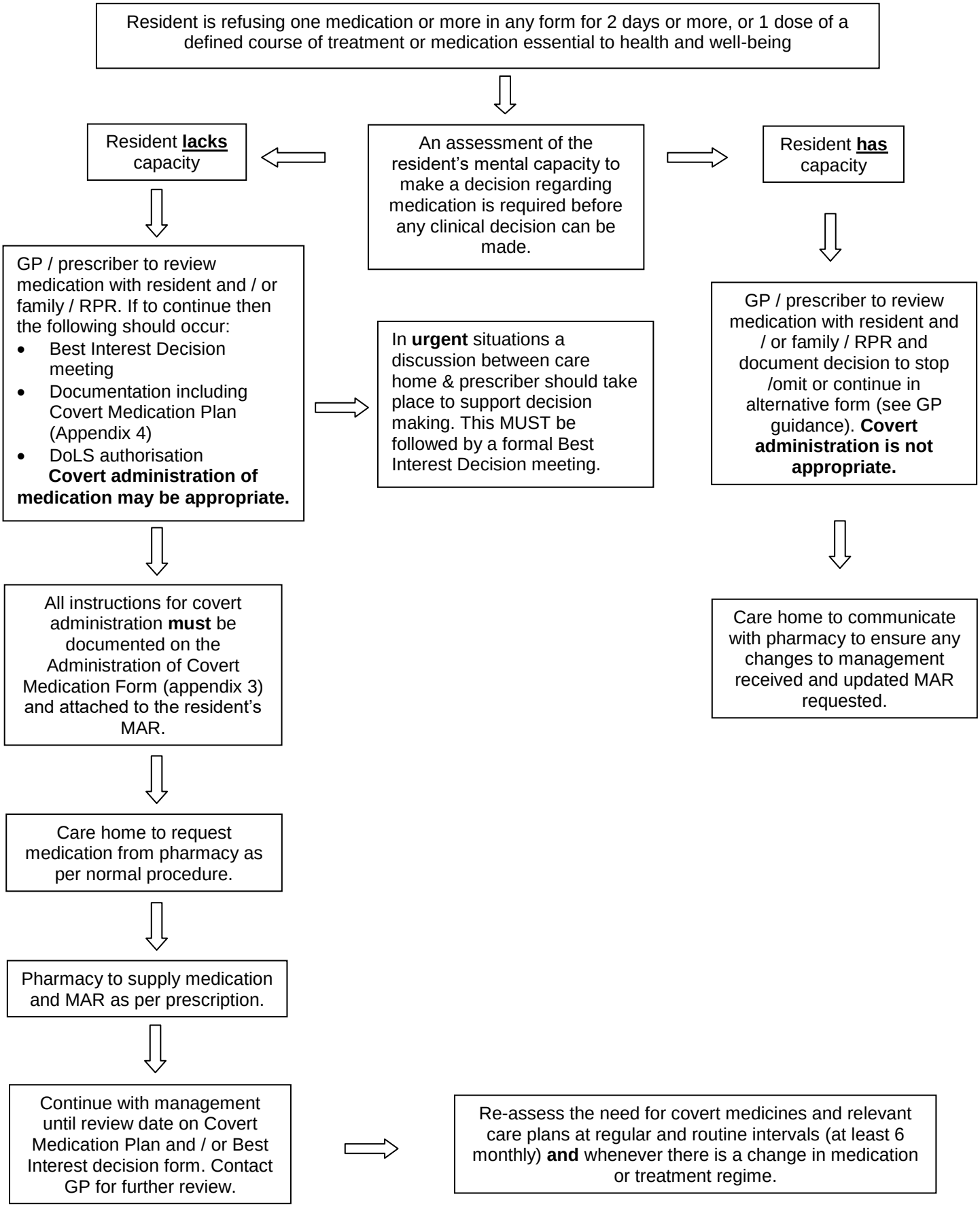
Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action Plan				
Issues Identified	**Actions required**	**How will you measure impact / progress?**	**Timescale**	**Officer responsible**
Nil	Nil	Not required	N/A	N/A

4. Monitoring, review and publication			
When will the policy and EIA be reviewed and by whom?	The EIA will be reviewed when the policy is reviewed. This will be in 2 years or sooner if there is a change in legislation.		
Lead Officer	Jo Harrison Colin Brotherstone-Barnett	**Review date:**	February 2019

Appendix 1

Covert Medication: Care Homes Flowchart.



Appendix 2

Covert Medication: GP Flowchart.

Resident is refusing one medication or more in any form for 2 days or more, or 1 dose of a defined course of treatment or medication essential to health and well-being.

⇩

Care home staff to make an assessment of the resident's mental capacity to make a decision regarding medication before any clinical decision can be made.

⇦ Resident **lacks** capacity

⇨ Resident **has** capacity

⇩

GP / prescriber to review medication with resident and / or family / RPR. If to continue then the following should occur:

- Best Interest Decision meeting
- Documentation including Covert Medication Plan (Appendix 4)
- DoLS authorisation

Covert administration of medication may be appropriate.

⇩

Contact practice pharmacist or CCG care home pharmacist (01226 433669). Can the medication be safely administered covertly? Points to consider:

- Can the meds be safely crushed or alternative type of preparation available?
- Substance to be mixed in?
- Method of administration?
-

⇩

Record information in notes and on the Administration of Covert Medication Form (appendix 3). This **must** be attached to the resident's MAR.

⇩

Issue prescriptions stating "covert admin" and with specific covert administration advice in the instructions to the pharmacy.

⇨

Re-assess the need for covert medicines at regular and routine intervals (at least 6 monthly) **and** whenever there is a change in medication or treatment regime.

⇨

Ensure all documentation including Covert Medication Plan and Administration of Covert Medication Form are completed and filed in care home records and scanned onto GP System

⇨

Clinical decision making process for each medication:

- Is there a clinical need for this medication?
- Can this medication be safely omitted for any given time?
- Is there an alternative drug / formulation that is acceptable to the resident?
- How should this medication be given **if** covert administration is appropriate?

In **urgent** situations a discussion between care home & prescriber should take place to support decision making. This MUST be followed by a formal Best Interest Decision meeting.

⇦

GP / prescriber to review medication with resident and / or family / RPR and document decision to stop /omit or continue in alternative form (see GP guidance). **Covert administration is not appropriate.**

⇩

Document decisions made in patient's notes and ensure review date is applied if appropriate.

⇩

Regular and routine review of mental capacity and need for medications. Record in patient notes.

Covert Medication Plan

Part 1: Proposed oral medication and rationale for covert administration (following a full medication review and possible discontinuation of any medications no longer required)					
1. Name of resident		2. D.o.B.		3. Name of care home / room number	
4. Prescribed medication and dosage (list) **NB: If the medication is to be modified in any way (e.g. crushed or combined with food) a qualified pharmacist must give advice**					
5. Medication / dosage Treated condition Instructions for administration			Medication / dosage Treated condition Instructions for administration		
Medication / dosage Treated condition Instructions for administration			Medication / dosage Treated condition Instructions for administration		
Medication / dosage Treated condition Instructions for administration			Medication / dosage Treated condition Instructions for administration		

Medication / dosage Treated condition Instructions for administration	Medication / dosage Treated condition Instructions for administration
Medication / dosage Treated condition Instructions for administration	Medication / dosage Treated condition Instructions for administration
6a. Prescriber Name:	6b. CCG Pharmacist Name:
7a. Has a mental capacity assessment been carried out? YES / NO *(delete as applicable)* If **YES**: Name of assessor: Role: Date of assessment: If **NO** this process must be stopped until one has been carried out	7b. If so, does the assessment determine a reasonable belief that the person lacks capacity to consent / agree to taking the prescribed medication? YES / NO *(delete as applicable)* If **YES** proceed to next section If **NO** the process must be stopped as this indicates that the person may have capacity to make the decision
8a. What are the benefits of taking the prescribed medication? (list)	8b. What are the risks / burdens of taking the prescribed medication? (list)

8c. What are the benefits of not taking the prescribed medication? (list)	8d. What are the risks / burdens of not taking the prescribed medication? (list)
9. In your clinical opinion do the benefits outweigh the risks? YES / NO *(delete as applicable)* If **NO** please reconsider this decision	
10. Are there any realistic alternatives to the prescribed medication? YES / NO *(delete as applicable)* If **YES** please state why these have been discounted?	
11. What unsuccessful alternative approaches have been tried to encourage the person to agree to take the medication? Why were alternative approaches unsuccessful?	
12. Are you satisfied that covert administration is the only alternative? YES / NO *(delete as applicable)* **If NO** – reconsider decision	
Part 2: Best Interest decision	
14. Does the person have an appointed Lasting Power of Attorney or Court Appointed Deputy for Health and Welfare? YES / NO *(delete as applicable)* If **YES** the LPA / CAD can make the decision in the person's best interests – go to 15 If **No** the prescriber is the decision maker and must take the views of those involved into account – go to 16	

<table>
<tr><td colspan="3">15. Name of LPA / CAD:

Office of the Public Guardian (OPG) reference number:

NB: If no proof of LPA/CAD is given at the time of the decision the prescriber will be the decision maker</td></tr>
<tr><td rowspan="3">16. People involved in this decision</td><td>Name:

Relationship:

Sign:</td><td>Name:

Relationship:

Sign:</td></tr>
<tr><td>Name:

Relationship:

Sign:</td><td>Name:

Relationship:

Sign:</td></tr>
<tr><td>Name:

Relationship:

Sign:</td><td>Name:

Relationship:

Sign:</td></tr>
<tr><td colspan="3">17. Based on the information and appraisal of the risks and benefits in section 8 it is decided that it IS / IS NOT (delete as applicable) in the above named person’s best interests to have medication covertly administered.</td></tr>
<tr><td colspan="3">18. Date of decision:</td></tr>
<tr><td colspan="3">19. This decision will be reviewed in weeks / months. (Regular review dates (at least 6 monthly) MUST be set to review the resident’s mental capacity to make decisions regarding medication, Best Interest decisions made on their behalf and covert administration of medication management plans. Any change of medication or treatment regime MUST also trigger a review where such medication is covertly administered. A medication review may also be triggered by conditions set at any Deprivation of Liberty Safeguards Authorisation review).</td></tr>
</table>

PART 3: Review (must be carried out by a Prescriber) **Date of Review:**	
20a. Has a mental capacity assessment been carried out? YES / NO *(delete as applicable)* If **YES**: Name of assessor: Role: Date of assessment: If **NO** this process must be stopped until one has been carried out	20b. If so, does the assessment determine a reasonable belief that the person lacks capacity to consent / agree to taking the prescribed medication? YES / NO *(delete as applicable)* If **YES** proceed to next section If **NO** the process must be stopped as this indicates that the person may have capacity to make the decision
Have there been any changes to existing medication needs? YES / NO *(delete as applicable)* **If NO the above plan can continue until the next review in weeks/ months** **If YES complete a full new plan**	

Appendix 4

Administration of Covert Medication Form

This document should be completed for any covert administration of medication after a Best Interest Decision has been made. This form **must** be attached to the resident's MAR chart. This must be reviewed at least 6 monthly or whenever there is a change in medication or treatment regime.

Name of medication to be administered.	Specific instructions for administration. Include any cautions such as temperature or types of food to avoid.	Name of pharmacist / GP providing instruction for administration.	Date of commencement.	Date of review.	Authorised by:

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

Appendix 5

Good Practice Guidance for Care homes

Practical guidance for Administration of Medication to Residents with swallowing difficulties

The guidance applies to residents:

- Who find it difficult to swallow tablets or capsules
- Who have been assessed by speech and language as requiring a modified diet and fluids
- Who require medication to be administered via a feeding tube

This guidance does not cover the management of patients who are refusing medication.

For patients where oral medication usage is further complicated by psychological conditions such as learning disabilities, severe mental illness and dementia a multidisciplinary team should be involved in a best interest decision about the need to continue the medication, and how any medication administration should be managed.

Patients with dysphagia should be referred to the speech and language team.

Protocol for patient unable to swallow tablets:

- Arrange a meeting with the resident and all the care staff involved with the resident, to establish the extent of swallowing difficulties. Consider if the resident can swallow similar sized food or if they can manage liquids (without a thickening agent).
- Consult with prescriber, explaining the problems associated with administering each medication and request a medication review. A copy of this communication should be kept in the care plan.
- The prescriber will then arrange for a suitable medication review which may involve liaison with a pharmacist.
- The prescriber will amend the prescription to enable safe administration. This will usually be:
    - a switch to a liquid (if available and suitable) or
    - guidance with dosage instructions on how to administer the medication e.g. “may be added to food to facilitate swallow” or “may be crushed and mixed with food to facilitate swallow” or
    - a switch to an alternative medication.

Procedure for Administration:

- The preferred option (if the medication is suitable to be administered with food) is to administer the tablet or capsule whole in yoghurt or apple sauce.
  Consider whether the resident can manage to swallow a similar sized piece of food to the tablet or capsule and refer to speech and language therapist for further advice if needed.
  Tablets less than 4mm diameter can usually be safely swallowed in yoghurt.

- Some medicines are available as a licensed liquid; if the resident can safely manage liquids the GP may switch the medication to a liquid. Many liquid medicines however may not be suitable for patients requiring thickened fluids.
- If a liquid medication is not available some capsules can be opened and sprinkled on yogurt and some tablets can be crushed and mixed with yogurt. Sometimes this may result in an unpleasant taste that the resident cannot tolerate.
- Residents must consent to having their medication administered in this manner.
- Residents who do not have capacity must have a best interest's decision to administer in this way.
- Instruction to alter the tablet or capsule must be on the label and documented in the patient's care plan.
- The procedure for administration should be clearly documented; this needs to be individually tailored to include the vehicle the medication is administered in e.g. water, juice, jam, yogurt at room temperature.
- Medication must be prepared immediately prior to administration.
- Each medicine must be administered separately.

The following are summaries on processes of administration

Dispersing Tablets in water:

- Place the tablet(s) in a small quantity of water, allow to disperse this can take a few minutes; alternatively, the water can be agitated with a spoon to speed up the process.
- Each different medication should be separately dissolved and administered.

Crushing Tablets:

- A tablet crusher must be used for this process. A separate tablet crusher must be used for each different tablet and for each service user which must be thoroughly cleaned and dried in between each administration process.
- Crush the tablet using a tablet crusher; add the crushed tablet to a small amount of a suitable soft food, alternatively add a little water or squash to the crusher for the resident to take as a liquid.
- Each different medication should be separately crushed and administered.

Opening capsules:

- Open capsule and sprinkle contents into either a small volume of soft food water or squash
- Each different medication should be separately administered via a feeding tube:
- Feeding tubes should be flushed with water before and after each medication is administered. If a liquid medicine is thick or syrupy, dilution may be required. Some patients are fluid restricted; this needs to be taken into account.

- When administering crushed or opened capsules via a feeding tube, add the powder to 15-30ml water and mix well. Draw into a 50ml oral syringe and administer. If you have used a tablet crusher, rinse this with water and administer the rinsing also.

Suggested protocol for administering medicines via feeding tubes:

1. Stop the feed (leaving a break if necessary)
2. Flush the tube with 30ml water
3. Prepare the first medicine for administration and give it.
4. Flush with 10ml water
5. Repeat stages 3 and 4 with subsequent medicines
6. Flush with 30ml water
7. Re-start the feeding (leaving a break if necessary)

CARE STAFF CAN ONLY ADMINISTER MEDICINES IN THIS MANNER ON THE INSTRUCTION OF THE PRESCRIBER

A WRITTEN INSTRUCTION TO CRUSH OR DISPERSE TABLETS OR TO OPEN CAPSULES MUST BE DOCUMENTED IN THE PATIENT'S CARE PLAN. (Nursing staff should refer to Nursing & Midwifery Council (NMC) guidance)

See Appendix 6 for Good Practice for Care Homes, permission to administer medication in food to facilitate swallowing

See Appendix 7 for Administration of Medication

Appendix 6

Good Practice Guidance for Care Homes

Permission to administer medication in food to facilitate swallowing

Name:		Date of Birth:	
Address:		Date:	
Completed by:		Position:	

Assessing Capacity: 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 (if yes a best interests decision must be documented) Yes/No (if yes a best interests decision must be documented)
Functional tests of capacity To be able to make a decision a person must be able to: • understand the information relevant to the decision, • retain that information, • use or weigh that information as part of the process of making the decision, or • Communicate the decision.	Describe how assessed
If a person has capacity to consent, verbal permission to add medication to food must be gained prior to each administration. Person to sign that they agree that with the principal of administering medicine with food to facilitate swallowing, and that medication may be unlicensed in this manner	**Name:** **Signature:** **Date:**
If person is lacking capacity to consent to medication being administered in food. A best interest's decision involving the prescriber, person with lasting power of attorney , family and care home representative must be made e.g. why this medication is necessary or what benefit is there for the patient?	**Name and signatures of persons involved in decision**
What medication is being considered for administration in food to facilitate swallowing?	
Have alternative options been considered?	list
A Barnsley CCG pharmacist must be involved to give advice if administration involves crushing tablets, opening capsules or combining medicines in any way with food or drink.	**Name of Pharmacist:** **Date:**
Review Date:	

Appendix 7

Administration of Medication Form

This document should be completed for any administration of medication to aid swallowing after a Best Interest Decision has been made. This form **must** be attached to the resident's MAR chart. This must be reviewed whenever there is a change in medication or treatment regime.

Name of medication to be administered.	Specific instructions for administration. Include any cautions such as temperature or types of food to avoid.	Name of pharmacist / GP providing instruction for administration.	Date of commencement.	Date of review.	Authorised by:

Appendix F - Equality Impact Assessment

Title of Policy or Service:	Barnsley Clinical Commissioning Group Covert Administration of Medication Policy	
Name and Role of Officer(s) Completing **the Assessment:**	Erica Carmody	
Date of Assessment:		
Type of EIA Completed:	**Initial EIA 'Screening'** ☐ ***or*** **'Full' EIA process** √	*(select one option)* *Full*

1. Outline	
Give a brief summary of your policy or service • including partners,	This policy aims to support BCCG in the discharge of its duties and responsibilities as an NHS Commissioner and to gain assurance that the principles of the MCA 2005 Code of Practice, and DoLS 2008 Code of Practice are being applied to situation where a decision about covertly administering medication is considered.

national or regional	
What Outcomes do you want to achieve	The organisation meets governance and standards required relating to the relevant legal frameworks.
Give details of evidence, data or research used to inform the analysis of impact	The Policy is based on National Legislation, Policies And Guidance.
Give details of all consultation and engagement activities used to inform the analysis of impact	None

Identifying impact:

- **Positive Impact:** will actively promote the standards and values of the CCG;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact: causes or fails to mitigate unacceptable behaviour. If such an impact is identified, the EIA should ensure, that as far as possible, it is eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive or negative) give details below:	
	Positive Impact	Neutral impact	Negative impact	How does this impact and what action, if any, do you need to take to address these issues?	What difference will this make?
Human rights	Yes	☐	☐	Protects the Human Rights of vulnerable people over the age of 16 in Barnsley.	Implementation of the Policy should ensure the CCG meets the positive obligations required under the MCA/DoLS Legislation.
Age	Yes	☐	☐	Ensures everyone over the age of 16 falls within scope as per legislation.	Those who refuse medication and do not have capacity will receive a best interests review
Carers	Yes	☐	☐	Takes into account a person's representative in terms of making decisions on behalf of or expressing wishes and feelings on behalf of a	Increase the number of carers included within decision making.

				person who may lack capacity.	
Disability	Yes	☐	☐	A greater number of disabled people have medication prescribed. The Policy helps to support those who may be at risk.	Those who refuse medication and do not have capacity will receive a best interests review
Sex	Yes	☐	☐	A greater proportion of elderly patient receiving medications are female. The Policy helps to support those who may be at risk.	Those who refuse medication and do not have capacity will receive a best interests review
Race	☐	Yes	☐		
Religion or Belief	☐	Yes			
Sexual Orientation	☐	Yes	☐		
Gender Reassignment	☐	Yes	☐		
Pregnancy and Maternity	☐	Yes	☐		
Marriage and Civil Partnership (only eliminating discrimination)	☐	Yes	☐		
Other Relevant Groups	☐	Yes	☐		

HR Policies only:	☐	☐	☐		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to the action plan below.

3. Action Plan

Issues/Impact Identified	Actions Required	How will you Measure Impact/Progress	Timescale	Officer Responsible
No actions required				

4. Monitoring, Review and Publication

When will the Proposal be Reviewed and by Whom?	**Lead/Reviewing Officer:**		**Date of next Review:**	

Once completed, this form **must** be emailed to the Equality Lead barnsleyccg.equality@nhs.net for sign off:

Adapted from North of England Commissioning Support Unit Practical Guidance for Administration of Medication to Residents with Swallowing Difficulties.

Equality Lead signature:	
Date:	05/01/2021