|  |  |
| --- | --- |
| **Full Name of Service User**:  **DOB:** | |
| **Address:** | |
| **Date of meeting** |  |
| **Attendees at meeting** | 1.  2.  3.  4.  5.  6.  7. |
| 1. **Is it likely that the person may regain capacity; can the decision be delayed until that time? If not, why not?**   YES / NO (delete as appropriate)  (Give details) | |
| 1. **Has there been an assessment to confirm whether the service user lacks the capacity to give consent?**   YES / NO (delete as appropriate)  Date of assessment: | |
| 1. **Has the person a nominated lasting power of attorney? Have they been consulted?**   YES / NO (delete as appropriate)  (Give details) | |
| 1. **What is the medication proposed to be administered covertly and how will this carried out?**   A.  B.  C.  D.  E.  F. | |
| **5. Why is the medication required?** | |
| **6. What is the justification for proposed action/treatment?** | |
| **7. Has the prescriber of medication been consulted (if not present at the best interest meeting)?**  YES / NO (delete as appropriate)  If no, has the prescriber of the medication given written confirmation?  YES / NO (delete as appropriate)  If yes, state where this is. If no, do not proceed until this is received. | |
| **8. Has the prescriber of medication been consulted (if not present at the best interest meeting)?**  YES / NO (delete as appropriate)  If no, has the prescriber of the medication given written confirmation?  YES / NO (delete as appropriate)  If yes, state where this is. If no, do not proceed until this is received. | |
| **9. Has the prescriber of the medication been consulted to identify any risks relating to the proposed actions?**  YES / NO (delete as appropriate)  Give details | |
| **10. Has relevant training been provided to those who will administer the medication covertly?**  YES / NO (delete as appropriate)  Give details | |
| **11. How will the administration be recorded on the MAR chart?** | |
| **12. What is the outcome/decision of this meeting? Including proposed start date**. | |
| **13. Provide date/s and outcomes of when reviews have/will take place; including discussions with person.** | |
| **14. If the decision to covertly administer medication has been agreed, a DOLs authorisation must be completed.**  Date applied:  Date authorised: | |

The undersigned believe this to be a fair representation of the discussions that took place. We have reasonable grounds for believing that the proposed actions are in the best interests of the person concerned at this point of time:

|  |  |
| --- | --- |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |
|  | |
| Date: |  |
| Name: |  |
| Signature: |  |
| Relation to person: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Date** |  |  |  |  |  |  |  |  |  |  |  |  |
| **Initials** |  |  |  |  |  |  |  |  |  |  |  |  |

The supervisor must ensure this is reviewed (minimum monthly). If there are any changes, all parties will need to review, amend, agree and re-sign this form.