# HYWEL DDA UNIVERSITY HEALTH BOARD

# Electroconvulsive Therapy Procedure

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| Brief Summary of Document: | This procedure provides a framework for Hywel Dda University Health Board staff who work with individuals with mental health difficulties to guide practice and ensure respect and rights of autonomy of service users in respect of the use of electro-convulsive therapy. |
| Scope | This procedure provides a framework for Hywel Dda University Health Board staff such as doctors within the mental health service, mental health nurses and anaesthetists on how to prepare to treat an individual suffering from severe depression, catatonia or a severe episode of mania with electroconvulsive therapy. |

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| To be read in conjunction with: | 289 - Record Keeping For Nurses and Midwives Policy<br>293 - Smoke Free Policy<br>008 - Consent to Examination or Treatment Policy<br>196 - Escort Policy For Adult Inpatients<br>010 - Health and Safety Policy<br>509- Management of External Agency Visits Inspections Accreditations Procedure<br>195- Clinical Record Keeping Policy |

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| Owning committee/group | MH&LD Quality, Safety & Experience Sub-Committee |

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| 1 | | 31/8/2010 |
| 2 | New procedure | 1/6/2013 |
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| 4 | Minor amendments – (comments from Sarah Roberts) | 12/04/2018 |

Glossary of terms

| Term | Definition |
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| ECT | Electro Convulsive Therapy |
| NICE | National Institute for Health and Care Excellence |
| ECTAS | ECT Accreditation Service |
| IMCA | Independent Mental Capacity Advocate |
| SOAD | Second Opinion Appointed Doctor |
| HIW | Healthcare Inspectorate Wales |
| RC | Responsible Clinician |
| RCPsych | Royal College of Psychiatrists |
| ASA | American Society of Anaesthetists |
| SSRI | Selective serotonin reuptake inhibitor |
| MAOI | Monoamine-oxidase inhibitor |
| HAM D. | Hamilton Depression Scale |
| MOCA | Montreal Cognitive Assessment |
| NART | National Adult Reading Test |

| Keywords | ECT, electroconvulsive therapy |
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## CONTENTS

## 1. INTRODUCTION

Electroconvulsive Therapy (ECT) is an important and valued treatment, usually but not exclusively for severe depression. It is supported by the National Institute for Health and Care Excellence (NICE) Technology Appraisal Guidance no. TA59, Guidance on the Use of Electroconvulsive Therapy. This includes short term treatment for catatonia and prolonged or severe manic episode. The section on depression has been replaced by an update included in Depression in Adults: recognition and management (NICE Clinical Guideline CG90, 2009). This procedure provides a framework for Hywel Dda University Health Board (the Health Board) staff who work with individuals with mental health difficulties to guide practice and ensure respect and rights of autonomy of service users in respect of the use of electro-convulsive therapy. This procedure is also written taking into account the Human Rights Act (1998) in particular Article 3, good practice with regard to health and safety, information sharing and confidentiality

## 2. SCOPE

.This procedure provides a framework for Hywel Dda University Health Board staff such as doctors and nurses within the mental health service, and anaesthetists on how to prepare to treat an individual suffering from severe depression, catatonia or a severe episode of mania with electroconvulsive therapy which will be performed at the ECT Clinic in Hafan Derwen.

## 3. AIMS

The aim is to provide electroconvulsive Therapy to all patients requiring this treatment within a safe, ethical, and legal framework.

## 4. OBJECTIVES

The objectives of the service are:

- To provide information to all patients making sure they have knowledge and understanding of the ECT treatment, the purpose, nature, likely effects and risks including the likelihood of its success and any alternatives to it and of the likely consequences of not receiving it.
- To respect the individual's human rights at all times. This includes dignity, comfort and whenever possible privacy.
- To provide a core team of competent staff to support safe and effective care delivery at each ECT clinic session.
- To provide appropriate training as required by the Royal College of Psychiatrists for doctors in training (as detailed in the core curriculum).
- To provide advice to colleagues on the use of ECT and regular updates as necessary.

To provide appropriate training for qualified nurses and other health care professionals that may need to access the service for a service user, thus providing up to date knowledge of ECT practices.

## 5. ACCREDITATION

Hywel Dda University Health Board (UHB) is required to participate in reviews of systems, care and treatment by external agencies. The reviews may be routine or risk based visits, inspections or for accreditation purposes as stated in the Management of external agency visits inspections accreditation procedure (UHB policy 509). Every 3 years the UHB ECT clinic is assessed by the ECT Accreditation Service (ECTAS), developed by Royal College of Psychiatrists, and is accredited for the period stated on the certificate. It also involves a self-review of the clinic every year to make sure good standards are achieved. Royal College of Psychiatrists (RCPsych) and ECTAS standards are followed, and are intended to provide staff

with a clear and comprehensive description of best practice in the administration of ECT. They cover the following topics;

- The ECT Clinic and Facilities
- Staff and Training
- Assessment and Preparation
- Consent and Information Giving
- Anaesthetic Practice
- The Administration of ECT
- Recovery, Monitoring and Follow up
- Special Precautions
- Protocols

(RCPsych, ECT Accreditation Service ECTAS, Standards for the administration of ECT, Thirteenth edition, April 2016)

## 6. PRINCIPLES OF PRACTICE OF ELECTROCONVULSIVE THERAPY

### 6.1. Definition

ECT is a therapy in which the passage of electricity across the brain is used to produce an epileptic form seizure.

### 6.2. Indications for ECT

ECT will be delivered in line with NICE guidance, Royal College of Psychiatrists Guidelines, and within ECT Accreditation Service Standards. It is recommend by NICE that electroconvulsive therapy is used to achieve rapid but short term improvement of severe symptoms after other treatment options have been unsuccessful or when the condition is considered to be potentially life threatening in individuals with severe depression, catatonia, prolonged/severe manic episode.

## 7. ASSESSMENT AND REFERRAL FOR ECT

During the review of the patient's current mental and physical state, if ECT is to be considered as a treatment option, the Electroconvulsive Therapy Care Pathway documentation booklet (Appendix 3) needs to be commenced and ECT team contacted. Responsibility for filling in the care pathway lies with the Consultant who is referring the patient for ECT treatment, with input from the nominated deputy and the nursing team.

## 8. WHEN TO DISCONTINUE TREATMENT

The extent of clinical improvement over the first few treatments is closely correlated with the extent of eventual improvement.

If no clinical improvement is seen after 6 adequate treatments, it is highly unlikely that more treatment will bring about either significant clinical improvement or eventual recovery and therefore treatment should stop. The Consultant responsible for ECT should discuss this with the referring Consultant.

It may be reasonable to give up to 12 treatments to patients who display definite but slight or temporary improvement over the first few treatments – a small but significant minority of depressed patients respond fully to treatments beyond the eighth of a course, having shown only modest improvements with earlier treatments.

In patients who have switched from unsuccessful unilateral treatment to bilateral ECT, it is reasonable to discount the previous unilateral treatments and to assess their need for treatment afresh using the same principles as for bilateral ECT as there is some evidence that those who subsequently recover with bilateral ECT require a similar number of treatments to those initially treated with bilateral ECT from the outset.

## 9. CONSENT TO TREATMENT (APPENDIX 4)

Full valid consent must be obtained prior to the administrations of ECT in all cases where the individual has the capacity to grant or refuse consent. Consent must be freely given and based on an adequate understanding of the purpose, nature, likely effects and risks of treatment, including the likelihood of its success and any alternatives to it, and of the likely consequences of not receiving it. Consent should be obtained without pressure or coercion, which may occur as a result of the circumstances and clinical setting. The individual should be reminded of their right to withdraw consent at any time. More detail regarding this can be found in the Health Board's 008 - Consent to Examination or Treatment policy.

The option to elect for ECT should be discussed well before the treatment date and the patient given written information as well as verbal information. See Appendix 1 for Hywel Dda ECT Patient Information leaflet and Appendix 2 for the Royal College of Psychiatrists Patient Information Leaflet.

Time should be given to the patient to consult with those of his/her choosing prior to signing the consent form. The involvement of patient, family, advocate, and/or carers to facilitate informed discussion is strongly encouraged and they should be made aware of the Advocacy West Wales Service.

In all situations where informed discussion and consent is not possible advance decisions, the Mental Health Act (MHA), and the Mental Capacity Act (MCA) should be taken fully into account and the individual's family, advocate, and/or carer should be consulted, as per the Health Board's 374 - Mental Capacity Act 2005 Policy

## 10. PRESCRIPTION OF ECT ( APPENDIX 6)

Once the decision has been made to treat a patient with ECT and consent obtained then ECT should be prescribed in the care pathway by the responsible Consultant or nominated Deputy. ECT should be prescribed one at a time where practical up to a maximum of 12 treatments.

For information on choice of bilateral/unilateral ECT refer to Chapter 15 of the ECT handbook of Royal College of Psychiatrists available on line or in library.
(The ECT Handbook, 3rd edition, Waite and Easton 2012 RCPsych publications)

## 11. PRE-TREATMENT CLINICAL ASSESSMENT (MEDICAL STAFF)

Patients must be assessed prior to their first treatment (once ECT has been prescribed).

A detailed medical history and full physical examination are necessary. Relevant investigations must be performed and forms completed. See Appendix 3 - ECT Care Pathway.

## 12. ADMINISTRATION OF ECT

For further information on the administration of ECT refer to Appendix 7.

## 13. MAINTENANCE AND CONTINUATION ECT

For further information on maintenance and continuation of ECT refer to Appendix 8.

## 14. ECT FOR SPECIAL POPULATIONS

For further information on ECT for special populations refer to Appendix 9.

- Young people
- ECT in pregnancy
- ECT for older adults

## 15. DENTAL PRECAUTIONS

For further information on the dental precautions refer to Appendix 10.

## 16. OUTPATIENT POLICY

For further information on the outpatient policy refer to Appendix 11.

## 17. ALLOCATION OF TIME SLOTS

On each treatment session morning a member of the ECT staff must liaise with the wards, checks the list and make any adjustments if necessary.

The ECT treatment Nurse is responsible for the order in which patients will be treated.

New patients will ideally be first on the list.

Other groups of patients may require a higher priority on the list e.g. those with diabetes, increased anxiety, those requiring a pre-med. or those who require additional support to access treatment.

Outpatients or patients who are travelling from other inpatient sites must have an appointment time between 9.30am and 10am unless otherwise agreed with the ECT team.

The Department will endeavour to be mindful of the need for privacy and dignity particularly during the recovery phase of the treatment, as the recovery room is currently exempt from the requirement to have single sex accommodation.

The ward should have the patient ready to attend the Department 30 minutes before the allocated appointment time, with the required pre treatment checks completed (see check sheet in the Integrated Care Pathway appendix 3).

The Department will contact the ward and inform them that the patient can now attend for treatment.

No patient will wait longer than 30 minutes in the ECT waiting room. Should this occur then an explanation must be given to the patient and the escorting nurse by the ECT staff. An entry will be made in the patient's medical notes, ECT Session log and in the clinical notes.

## 18. ESCORT OF INPATIENTS FROM HAFAN DERWEN SITE

The nurse in charge of the shift needs to take into account the following points when selecting a member of the ward team to escort a patient.

The patient must be escorted to the ECT clinic by a clinical member of staff (i.e. ward nurse) who must stay with them at all times, including in the waiting area.

The escorting nurse must be a registered nurse who is known to the patient, is aware of the patient's legal and consent status, and has an understanding of ECT.

The escort must be able to act as an advocate for the patient, listening/assessing concerns and feeding these back to the members of the ECT team and ward team.

The escorting nurse must ensure that the patient's belongings and valuables are documented and properly stored.

## 19. ESCORTING INPATIENTS FROM OTHER UNITS WITHIN THE COUNTY

Prior to a patient starting a course of ECT treatment the following factors should be taken into account as part of a risk assessment.

1. Has the patient had ECT before?
2. If yes, what was the outcome?
3. How low in mood is the patient? e.g. suicidal risk assessment.
4. Should the patient be transferred to a site nearer to the ECT Department? This may be necessary if the patient is physically very frail and it is felt to be inappropriate for him/her to travel to the department. Similarly, if the patient is felt to be at risk of self harm during transit. Agreements are in place for both adults and older adults to facilitate transfer of patients and their care/Consultant responsibility to the Hafan Derwen site in these circumstances.
5. What risks are involved for an escorting nurse?
6. It is unacceptable for a nurse to escort more than one patient.

Having assessed the risk and decided that it is reasonable to continue, any Registered Nurse or Doctor can escort/accompany an inpatient for treatment. The Nurse/Doctor MUST have received knowledge of what the treatment entails, be at least basic life support trained and understand what their role and responsibilities are. They should also be known by the patient.

## 20. ROLES OF TEAM MEMBERS

For further information on the roles of team members refer to Appendix 12.

## 21. MANAGEMENT OF PATIENTS IN RECOVERY ROOM

Patients must be observed on a one to one basis by an anaesthetist, recovery nurse or other properly trained members of staff until they have regained airway control and cardiovascular stability and are able to communicate.

The following needs to be recorded:

1. Level on consciousness
2. Oxygen saturation
3. Blood pressure
4. Heat rate
5. Temperature

Patient dignity and privacy should be considered at all times. For all patients, the name, hospital number, time of admission, time of discharge and destination should be recorded in the integrated care pathway.

**Criteria to be followed before discharge of patients**

1. The patient is fully conscious, able to maintain a clear airway and exhibits protective airway reflexes.
2. Respiration and oxygenation are satisfactory.
3. The cardiovascular system is stable with no unexplained cardiac irregularity. The specific values of pulse and blood pressure should approximate to normal pre-operative values or to be at an acceptable level.
4. Temperature should be within acceptable limits.

If discharge criteria are not achieved, the patient should remain in the recovery room and the anaesthetist informed.

## 22. INDUCTION AND TRAINING OF STAFF

All new nursing staff to the clinic will undergo an agreed induction / training package to be completed by the clinic staff in conjunction with the in-service training department. Medical staff will receive induction under the supervision of the Consultant Psychiatrist.

All qualified nurses dedicated to the recovery room should attend a period of training and observation in a general hospital.

All the nursing staff are encouraged to attend courses which are appropriate to their personal/professional development.

Both formal and informal teaching is given to learners and nursing assistants and all other professional disciplines prior to the observation of ECT. This is necessary requirement to provide a high standard of care for patients receiving ECT.

Training of junior doctors in the administration of ECT is given by the Consultant Psychiatrist/ Associate Psychiatrist for ECT who should attend one session per week for monitoring and training purposes.

## 23. FACILITIES OF THE CLINIC

Facilities must meet all standards of ECT Accreditation Service of the Royal College of Psychiatrists.

## 24. HEALTH AND SAFETY

All staff are reminded that it is their duty to be familiar with the Health Board Policy 010 - Health and Safety Policy.

Moving and Handling: all patients attending ECT with mobility issues will have a moving and handling assessment sheet in place.

In event of emergency a hoist can be accessed from Alun Ward.

## 25. RESPONSIBILITIES

### 25.1. Mental Health and Learning Disabilities

The ECT Service is managed within Mental Health and Learning Disabilities Directorate Hywel Dda University Health Board.

25.2. **Chief Executive**
The Chief Executive has the overall responsibility for the ECT service for the Health Board and must ensure that responsibility to manage ECT within the Health Board is delegated to an appropriate executive lead.

25.3. **Medical Director- Compliance Quality and Assurance**
The Medical Director is executive lead and has responsibilities to ensure there are safe systems in place for effective delivery of the clinical standards described in the Health Board policy.

25.4. **Senior Manager**
A delegated Senior Manager of Mental Health Services (Head of Service) is responsible for the operational management and development of the ECT Service.

25.5. **Consultant Psychiatrist**
The Consultant Psychiatrist has overall responsibility for leading ECT and will ensure adherence to the standards and policies set out by the RCPsych, ECTAS and the Health Board.

25.6. **ECT Clinical Staff**
The clinical staff will ensure that they adhere to all RCPsych,ECTAS and ECT Policy and standards implementing safe and smooth delivery of the ECT Service.

## 26. CLINICAL GOVERNANCE ARRANGEMENTS
The ECT Service is committed to providing a quality clinical service in line with Evidence Based Practice and functions within the divisional and local Clinical Governance Frameworks.

## 27. STANDARDS OF RECORD KEEPING
All records, including electronic, are kept in accordance with Health Board, Directorate and professional guidelines. A range of medical record policies are available to guide storage, transport and regulation for Health Care Records such as Clinical Record Keeping Policy 195 and Record Keeping for Nurses and Midwives 289.

## 28. COMPLAINTS
Any complaints received by the ECT Service are dealt with in accordance with Health Board Policy. The ECT Department will provide the necessary help and support to clients and relatives within this process.

## 29. CONFIDENTIALITY AND INFORMATION SHARING
Confidentiality is a fundamental principle of clinical ethics for all health care professionals and underpins a rudimentary expectancy that private and personal information given in confidence by a patient/carer to a member of staff, will only be used for a given purpose. This information may be released to others on a need to know basis with the patient's consent.

All staff must adhere to Health Board policies and procedures/guidance and also their professional body's policy/guidance in relation to confidentiality and consent.

## 30. AUDIT
The ECT department must have an active audit programme, which must include:

- An annual audit of ECT (this is standard practice). Information will be fed into the medical audit programme annually

- An on-going audit of adherence to the treatment protocol
- Data collection of the characteristics of the patients attending the clinic, diagnosis, reason for ECT being the treatment of choice for them, type of treatment given, number of treatment and outcome. Data will be examined annually and fed into medical audit programme
- Audit of patients' subjective experience of ECT and 'patient friendliness' of clinic procedure
- Copies of all audits are sent to Clinical Governance Support Unit (CGSU) and a CGSU representative or clinical audit facilitator attends ECT implementation group meetings.

31. **IMPLEMENTATION**

The implementation of this policy will be monitored by the ECT Service in the form of clinical audit of the Integrated ECT Care Pathway and Patient Questionnaire. This will be reviewed on an annual basis to ensure it is able to demonstrate that the ECT Service meets the needs of the Service users.

32. **FURTHER INFORMATION**

Human Rights Act (1998)
Mental Capacity Act 2005
ECT Integrated Care Pathway
ECTAS Standards

33. **DOCUMENTATION**

All ECT treatment records are kept in the ECT Care Pathway and on the mental health clinical recording system (currently Care Partner).

Photocopy of treatment record kept in ECT suite for audit purposes.

At the end of the ECT course, the ICP is kept at the clinic after the ward doctor has signed the completion form. The ICP for ECT is used to provide audit information
Written information regarding ECT includes the department's information leaflet and also in the Appendices is the Royal College of Psychiatrists information leaflet.

34. **APPENDIX 1A – HYWEL DDA UNIVERSITY HEALTH BOARD PATIENT INFORMATION LEAFLET FOR PATIENTS REFERRED TO ECT**
**MENTAL HEALTH AND LEARNING DISABILITIES SERVICE.**

**PATIENT INFORMATION LEAFLET**

**ECT (ELECTRO CONVULSIVE THERAPY)**

**WRITTEN BY CHRISTINE LEWIS & Dr. C.YEATES.**
**(BASED ON INFORMATION FROM ROYAL COLLEGE OF PSYCHIATRISTS)**

**April 2014-04-30**
**REVIEWED April 2017**

## INTRODUCTION

This leaflet will try to answer some of the questions you may have about ECT. It will talk about what ECT is and why it is used, what it is like to have ECT and the risks and benefits from the treatment.

There is a lot of information in this leaflet, which you may find difficult to read all at once. Please don't be concerned if you can't read it all at once. Pick out the sections that seem important to you and come back to the other bits later. You may find it helpful to write your questions down as you think of them.

## WHY IS ECT USED?

Most people who have ECT are suffering from depression. You may have been given tablets for depression but found that you have not completely recovered. Or maybe it is taking a long time to recover. ECT is useful in these situations. In severe cases ECT may be the best treatment and it can be life saving. ECT is also used for illnesses such as bipolar disorder if you feel 'high' or 'manic'.

## WHY HAS ECT BEEN RECOMMENDED FOR ME?

ECT is given for many reasons. Some of the most common ones are listed below. If you are not sure why you are being offered ECT, please don't be afraid to ask. If you find it difficult to remember things please feel free to ask several times.

- You may be suffering with severe depression
- You may not have felt better with antidepressant drugs
- You may not be able to take antidepressant drugs because of the side effects
- You may have responded well to ECT in the past
- You may feel so overwhelmed by your depression that you find it very difficult to function.

## HOW DOES ECT WORK?

During ECT, a small amount of electric current is passed through your brain. This current produces a seizure, which affects the whole brain. This includes the centres that control thinking, mood, appetite and sleep. Repeated treatments are thought to improve the communications between the nerves in your brain. This helps you to begin to recover from your illness.

In bilateral ECT, the electrical current is passed through the whole brain. In unilateral ECT it is just passed across one side. Both of them cause a seizure in the whole of the brain.

It is still not clear which type of ECT is 'best'. Bilateral ECT works more quickly and effectively and is the most widely used in Britain; however it appears to cause more side effects, in particular, for some people, on their memory. Unilateral ECT has fewer side effects but does not appear to be as effective. It is also more difficult to do properly. Treatment is usually started with bilateral ECT and only switched to unilateral if negative side effects are experienced. The choice of bilateral or unilateral ECT will ultimately depend on your needs and wishes, your doctor's opinion and the skills of the ECT team.

**HOW WELL DOES ECT WORK?**

The evidence suggests that ECT may be effective in up to three-quarters of people who are treated. People who have responded well to ECT say that they 'feel like themselves again' and that 'life is worth living again'. Severely depressed patients should feel more optimistic and less suicidal. Feeling low and hopeless not being able to sleep, eat or concentrate properly should all improve.

**WHAT ECT CANNOT DO**

ECT will relieve the symptoms of your depression. If you are experiencing problems with relationships or at home or work, these problems may still be present after your treatment and you may need further help with them. Hopefully, if your symptoms of depression are better you will feel more able to deal with other problems.

ECT is not usually used to treat mild depression, personality disorder or most forms of schizophrenia. You are advised to always ask your doctor why ECT is being considered as a treatment for you.

**WHAT IS A COURSE OF ECT?**

ECT is usually given twice a week. It is not possible to say exactly how many treatments you will need. You may start to feel better after 2 or 3 treatment sessions but it can take longer for some people. Most people need between 6 and 12 treatments to get fully better. This would take between 3 to 6 weeks which is often faster than antidepressants. You will probably also notice ups and downs during the course of treatment, but overall things should gradually improve. If you have any worries about how ECT is working for you do not hesitate to talk to staff about this.

**WHAT WILL ACTUALLY HAPPEN WHEN I HAVE ECT?**

ECT is administered in the ECT suite at Hafan Derwen, Carmarthen on Monday and Thursday, starting at around 9.30am.

You can have it as an inpatient or an outpatient. You team will discuss with you which is best for you.

If you are having an ECT as an outpatient, you should have someone else drive you to the appointment. For 24 hours after your treatment you should not:

- Drive a car, motorcycle or ride a bike
- Operate machinery
- Drink alcohol
- Avoid making important decisions or signing important documents.
- Be left in sole charge of young children until the following morning
  - You should have a responsible adult with you for 24 hours after the treatment.

You will need to fast (have nothing to eat or drink) from midnight the night before you have the treatment. This includes having no breakfast on the morning of your treatment. The fasting period ensures there is no food in your stomach whilst you are having the anaesthetic.

You should carry on taking all medication, especially heart and blood pressure tablets, as normal 2 hours before your ECT with no more than 50mls of water. You should not take any diabetic medication and this will be fully discussed with you before your treatment.

You should wear comfortable clothes for the treatment. You will be asked to remove any loose jewellery, hair slides or false teeth if you have them. Please remove nail varnish and make up before coming for your treatment. You are advised not to bring any valuables with you. Before you go into the ECT department, it is wise to go to the toilet and empty your bladder.

The treatment takes place in a dedicated room and only takes a few minutes. There will be several people in the department when you get there. This will include:

- An anaesthetist
- A theatre technician who helps the anaesthetist
- A doctor who administers the treatment
- A lead nurse who runs the ECT department
- A recovery nurse, and
- A nurse who escorts you.

Sometimes, student trainees e.g. nursing or medical may be present as part of their training. You will be asked if you would prefer them not to be present. Other patients will not be able to see you.

You will be asked to lie down and the anaesthetist will ask you to hold out your hand so you can be given an anaesthetic injection. This will make you go to sleep and causes your muscles to relax. You will be given some oxygen to breathe as you go off to sleep.

Once you are fast asleep, a controlled electric current will be passed through your brain. This will cause a mild fit in your brain. There will be some movement of your body but this should be mild because of the relaxant injection you have had.

When you wake up you will be in the recovery room. Once you are wide-awake you will be offered light refreshments in the post treatment waiting area.

**HOW WILL I FEEL IMMEDIATELY AFTER ECT?**

You may find that you wake up with no side effects at all and simply feel very relaxed. You may wake up somewhat confused, have a headache or feel quite weepy. A nurse will be with you when you wake up to offer you reassurance and make you as comfortable as possible. You will be offered painkillers if necessary.

If you are an inpatient, a nurse will take you back to the ward as soon as you feel well enough. If you are an outpatient, your friend or relative who is collecting you will have been given a time to come back to the ECT suite to collect you. This will usually be around lunchtime and you will need to be seen by a doctor to check that all is well before you leave. Once you get home, you should take it easy.

**WHAT ARE THE SIDE EFFECTS OF ECT?**

You may feel confused just after you wake up but this generally clears up within an hour or so. You may find that your memory of recent events is upset and dates, names of friends, public events, addresses or telephone numbers may be temporarily forgotten. In most cases this memory loss goes away within a few days or weeks. Sometimes, patients can experience memory problems for several months. In rarer case, patients can lose memories of events that have happens in their lives which are longer lasting.

Depression interferes with your memory and usually the benefits of ECT outweigh any negative effects the treatment may have on your memory. If you feel you are developing problems with your memory, it is possible to consider the use of unilateral ECT so please discuss any worries with your doctor or nurse.

We will monitor your memory but please tell us of you have any worries.

**ARE THERE ANY SERIOUS RISKS FROM THE TREATMENT?**

ECT is among the safest medical treatments given under general anaesthesia. The risk of death or serious injury with ECT is slight, about one in 50,000 treatments.

As with any procedure that uses general anaesthetic there may be increased risks for people with medical problems such as heart disease, chest problems, high blood pressure . For this reason, before starting treatment you will have a thorough physical examination, which will include various tests such as blood and ECG. You will be asked about any other medication that you are taking. The anaesthetist and other specialists will discuss any problems with you if necessary.

The decision to provide the treatment will be made after weighing up the risks and benefits. It is still possible to have ECT if you have a physical illness and if there are any particular concerns, we can administer ECT in a general hospital where there are more facilities available.

**WHAT OTHER TREATMENTS COULD I HAVE?**

There may be antidepressant drugs and other psychological therapy treatments available to treat your particular condition and it is possible that some of them will work as well as ECT. Sometimes ECT is required before other treatments can be effective. Your doctor will discuss the advantages and disadvantages with you. Please ask as many questions that you have. You may find it useful to write them down before your appointment to help remember them .ECT is given as part of your overall care and treatment plan which may also include medication, psychological and occupational therapies.

**WILL I HAVE TO GIVE MY CONSENT?**

At some stage before the treatment takes place, you will be asked by your doctor to sign a consent form for ECT. Before you sign the form, you should be content that:

- Your doctor has explained what the treatment involves
- You understand why you are having it, and
- You have been able to ask any questions you may have.

**CAN I REFUSE TO HAVE ECT?**

You can refuse to have ECT and you may withdraw your consent at any time, even before the first treatment is given. You can do this verbally. Signing the consent form does not commit you to receiving the treatment. It is a record that an explanation has been given you about the

treatment and that you understand what is going to happen to you. Withdrawal of your consent to ECT will not change in any way your right to continued treatment with the best alternative methods.

**PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT**

Sometimes people become so unwell that they are unable to take on board all of the issues concerned and are unable to give proper consent to treatment. If this happens and the clinical team believes that ECT will help, the Mental Health Act can be used to make an assessment to see whether giving ECT without consent would be in the patient's best interests. When this does become necessary, staff explain exactly what is happening and anyone detained under the Mental Health Act (or "sectioned") has the right to appeal against this. Patients are also able to have an Advocate to help them make their wishes known at any stage throughout their treatment, whether or not the Mental Health Act is used in their case.

**ARE THERE ANY RISKS IN NOT HAVING ECT AS RECOMMENDED?**

If you choose not to have ECT, you may experience longer and possibly more severe periods of illness than if you had the treatment. Alternatives to ECT include drug therapy and psychological therapies, neither of which are without their own risks and complications and may take longer to work. Your doctor will discuss all the options with you.

**FINALLY**

ECT has been proved to work although it is still uncertain exactly how it does.

You may find conflicting information about ECT, especially on the Internet which can be confusing. We have based our leaflet on the evidence that we have but there are still people who hold very strong views both for and against ECT. If you are in any doubt, please discuss these concerns with your doctor. You may wish to get information from several sources before you make up your own mind.

**UNACCEPTABLE BEHAVIOUR**

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who continue to abuse our staff.

**GIVING YOUR INFORMED CONSENT**

Before a doctor or other health professional examines or treats you, they need your consent. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision may be needed. You will then be asked to sign a consent form. Before you give your consent the health professionals looking after you must ensure you know enough to enable you to decide about treatment. It is up to you to choose whether or not to consent to what is being proposed. Always ask as many questions as you like. As well as giving you information health professionals must listen and do their best to answer your questions. As a reminder, you can write your questions down.

The person you ask should do his or her best to answer, but if they do not know they should find someone else who is able to discuss your concerns. More information on consent is available in the Trust's leaflet 'About the Consent Form: Information for Patients'. Please feel free to ask for a copy.

**COMPLAINTS AND COMPLIMENTS**

We actively wish to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all timesPlease speak to a member of the ECT team

If you have any concerns, speak to the local service manager (such as the ward sister or senior therapist) who will be able to assist and hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet “Putting things right” which will provide you with information on how to raise a concern.. In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Your local Community Health Council can be contacted as follows:

The Chief Officer
Carmarthenshire CHC
Suite 5 First Floor
Ty Myrddin,
Old Station Road,
Carmarthen
SA31 1BT
Tel: (01267) 231384
Carmarthen@chcwales.org.uk

The Chief Officer
Pembrokeshire CHC
Havens head Business Park
Milford Haven
Pembrokeshire SA73 3LS
Tel: (01646) 697610 Fax 01646697256
Pembrokeshire@chcwales.org.uk

The Chief Officer
Ceredigion CHC
Welsh Government Building,
Rhodfa Padarn
Llanbadarn Fawr,
Aberystwyth
SY23 3UR
Tel: (01970) 697610
Ceredigion@chcwales.org.uk

The Community Health Council Complaints Advocate can provide free and independent patient information and advice during the process of your complaint. Contact them directly on 0845 6650763.

**THE DATA PROTECTION ACT / GENERAL DATA PROTECTION REGULATIONS 2016 OR ANY SUBSEQUENT LEGISLATION TO THE SAME EFFECT’**

Under the Data Protection Act / General Data Protection Regulations 2016 or any subsequent legislation to the same effect we are committed to protecting the privacy of patient information. If you require access to your medical health records, you would have to complete a application form and then return this to the Medial Legal Department, Hywel Dda University Health Board, Amman Valley Hospital, Folland Road, Glanamman, SA18 2BQ. Staff will be able to provide you with this form by referring to the access to health records trust policy. You are entitled to receive a copy but should note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

**FINALLY**

# HYWEL DDA UNIVERSITY HEALTH BOARD

We want to know when things go wrong, so we can quickly put them right for you, learn from your experience and improve our services. If you have any comments or suggestions about how things may be improved please talk to a member of staff or post them in one of our suggestion boxes.

Date: 30/04/2010
Review date: April 2014.
Ref: ECT/CL&DRY/01

## 35. APPENDIX 2 - ROYAL COLLEGE OF PSYCHIATRISTS – ECT PATIENT INFORMATION LEAFLET

This leaflet is for anyone who wants to know more about ECT (Electro-convulsive therapy). It discussed how it works, why it is used, its effects and side-effects, and alternative treatments.

ECT remains a controversial treatment and some of the conflicting views about it are described. If your questions are not answered in this leaflet, there are some references and sources of further information at the end of the leaflet.

Where there are areas of uncertainty, we have listed other sources of information that you can use. Important concerns are the effectiveness and side-effects of ECT and how it compares with other treatments. At the time of writing, these references are available free and in full on the Internet.

**What is ECT?**
ECT is a treatment for a small number of severe mental illnesses. It was originally developed in the 1930s and was used widely during the 1950s and 1960s for a variety of conditions. It is now clear that ECT should only be used in a smaller number of more serious conditions.

ECT consists of passing an electrical current through the brain to produce an epileptic fit – hence the name, electro-convulsive. On the face of it, this sounds bizarre. Why should anyone ever have thought that this was a sensible way to treat a mental disorder? The idea developed from the observation that, in the days before there was any kind of effective medication, some people with depression or schizophrenia, and who also had epilepsy, seemed to feel better after having a fit. Research suggests that the effect is due to the fit rather than the electrical current.

**Q How often is it used?**
It is now used less often. Between 1985 and 2002 its use in England more than halved, possibly because of better psychological and drug treatments for depression.

**Q How does ECT work?**
No-one is certain how ECT works, and there are a number of theories.

Many doctors believe that severe depression is caused by problems with certain brain chemicals. It is thought that ECT causes the release of these chemicals and, probably more importantly, makes the chemicals more likely to work and so help recovery.

Recent research has suggested that ECT can stimulate the growth of new blood vessels in certain areas of the brain.

**Q Does ECT really work?**
It has been suggested that ECT works not because of the fit, but because of all the other things – like the extra attention and support and the anaesthetic – that happen to someone having it.

Several studies have compared standard ECT with "sham" or placebo ECT. In placebo ECT, the patient has exactly the same things done to them – including going to the ECT rooms and

having the anaesthetic and muscle relaxant – but no electrical current is passed and there is no fit. In these studies, those patients who had standard ECT were much more likely to recover, and did so more quickly than those who had the placebo treatment. Those who didn't have adequate fits did less well than those who did.

Interestingly, a number of the patients having "sham" treatment recovered too, even though they were very unwell; it's clear that the extra support has an effect. However, ECT has been shown to have an extra effect in severe depression – it seems, in the short term, to be more helpful than medication.

**Pros & Cons of ECT**

**Q Who is ECT likely to help?**

The National Institute for Health and Care Excellence (NICE) have looked in detail at the use of ECT and have said that it should be used only in severe depression, severe mania or catatonia. ECT is most often used for severe depression, usually only when other treatments have failed.

**Q Who is ECT unlikely to help?**

ECT is unlikely to help those with mild to moderate depression or most other psychiatric conditions. It has no role in the general treatment of schizophrenia.

**Q Why is it given when there are other treatments available?**

It would normally be offered if:
several different medications have been tried but have not helped
the side-effects of antidepressants are too severe
you have found ECT helpful in the past
your life is in danger because you are not eating or drinking enough
you are trying to kill yourself

**Q What are the side effects of ECT?**

ECT is a major procedure involving, over a few weeks, several epileptic seizures and several anaesthetics. It is used for people with severe illness who are very unwell and whose life may be in danger. As with any treatment, ECT can cause a number of side-effects. Some of these are mild and some are more severe.

**Short-term**

Many people complain of a headache immediately after ECT and of aching in their muscles. They may feel muzzy-headed and generally out of sorts, or even a bit sick. Some become distressed after the treatment and may be tearful or frightened during recovery. For most people, however, these effects settle within a few hours, particularly with help and support from nursing staff, simple pain killers and some light refreshment.

There may be some temporary loss of memory for the time immediately before and after the ECT.

Older people may be quite confused for two or three hours after a treatment. This can be reduced by changing the way the ECT is given (such as passing the current over only one side of the brain rather than across the whole brain).

There is a small physical risk from having a general anaesthetic – death or serious injury occurs in about 1 in 50,000 treatments – less than the risks in childbirth.

**Long-term**
The greater concern is that of the long-term side effects, particularly memory problems. Surveys conducted by scientists and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10. User-led surveys have found much more, maybe in half of those having ECT. Some surveys conducted by those strongly against ECT say there are severe side-effects in everyone.

Some difficulties with memory are probably present in everyone receiving ECT. Some people – some would say many – also have problems with memory for past events, even very significant ones such as the birth of a child. Most people find these memories return when the course of ECT has finished and a few weeks have passed. However, some people do complain that their memory has been permanently affected, that their memories never come back. It is not clear how much of this is due to the ECT and how much is due to the depressive illness or other factors.

Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they were before ECT. They say that they have never got over the experience and feel permanently harmed.

What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their memory.

**Q What if ECT is not given?**
You may take longer to recover.
If you are very depressed and are not eating or drinking enough, you may become physically ill or die.
There is an increased risk of suicide if your depression is severe and has not been helped by other treatments.

**Q What are the alternatives?**
If someone with severe depression refuses ECT there are a number of possibilities. The medication may be changed, new medication added or intensive psychotherapy offered, although this should already have been tried. Given time, some episodes of severe depression will get better on their own, although being severely depressed carries a significant risk of suicide.

**Deciding to have (or not to have) ECT**
**Q Giving consent to having ECT**
Like any significant treatments in medicine or surgery, you will be asked to give consent, or permission for the ECT to be done.

The ECT treatment, the reasons for doing it and the possible benefits and side-effects should be explained in a way that you can understand. If you decide to go ahead, you then sign a consent form. It is a record that ECT has been explained to you, that you understand what is going to happen, and that you give your consent to it. However, you can withdraw your consent at any point, even before the first treatment.

**Q What if I really don't want ECT?**

If you have very strong feelings about ECT, you should make them known to the doctors and nurses caring for you, but also friends, family or other advocates who can speak for you.

Doctors must consider these views when they think about what to do.

If you have made it very clear that you do not wish to have ECT then you should not receive it. It may be helpful to write an 'advance directive' to make clear how you want to be treated if you become unwell again.

**Q Can ECT be given to me without my permission?**

Most ECT treatments are given to people who have agreed to it. This means that they have had:

- a full discussion of what ECT involves
- why it is being considered in their case
- the advantages and disadvantages
- a discussion of side-effects.

It is the responsibility of the doctors and nurses involved to make sure that this discussion has been had – and to document it.

Sometimes, however, people become so unwell that they are unable to take on board all of the issues – perhaps because they are severely withdrawn or have ideas about themselves that stop them fully understanding their position (e.g they believe what is happening to them is a punishment they deserve).

In these circumstances, it may be impossible for them to give proper agreement or consent. When this happens, it is still possible to give ECT. The legal provisions for this differ from country to country, even within the United Kingdom.

In England and Wales the patient must first be assessed by their own GP (family doctor) and a social worker, and then must have a second opinion from an independent specialist who is not directly involved in their care. The clinical team should also speak to family and other carers, to consider their views and any views the patient may have expressed before. So, if someone is judged to lack the ability to give consent, it is possible to give them ECT even if they are refusing it. In 2002 about 1 in 6 people who had ECT were judged to be not able to give consent to it, but it is not clear how many of these were actively refusing.

**How is ECT given?**

ECT should only used to treat severe illnesses, so usually the person having it will be in hospital, although a few people have found it helpful to have ECT as day patients.

The seizure is made to happen by passing an electrical current across the person's brain in a carefully controlled way from a special ECT machine.

An anaesthetic and muscle relaxant are given so that the patient is not conscious when the ECT is given; the muscle spasms that would normally be part of a fit – and which could produce serious injuries - are reduced to small, rhythmic movements in the arms, legs and body.

By adjusting the dose of electricity, the ECT team will try to cause a seizure between 20 and 50 seconds long.

**Q Is there any preparation?**

In the days before a course of ECT is started, your doctor will arrange for you to have some tests to make sure it is safe for you to have a general anaesthetic. These may include:

- a chest X-ray
- a record of your heart working (ECG)
- blood tests

You will be asked not to have anything to eat or drink for 6 hours before the ECT. This is so that that the anaesthetic can be given safely.

**Q Where is ECT done?**

ECT should always be done in a special set of rooms that are not used for any other purpose, usually called the “ECT suite”. There should be separate rooms for people to wait, have their treatment, wake up fully from the anaesthetic and then recover properly before leaving.

There should be enough qualified staff to look after the person all the time they are there so that any confusion or distress can be helped.

**Q What happens during ECT?**

You should arrive at the ECT suite with an experienced nurse who you know and who is able to explain what is happening. Many ECT suites are happy for family members to be there. You should be met by a member of the ECT staff who will do routine physical checks if they have not already been done. The staff member will check that you are still willing to have ECT and if you have any further questions.

When you are ready you will be accompanied into the treatment area and be helped onto a trolley.

The anaesthetist and anaesthetic assistant will connect monitoring equipment to check your heart rate, blood pressure, oxygen levels, etc. You may also be connected to an EEG machine, to check the brain waves.

A needle will then be put into your hand, through which the anaesthetist will give the anaesthetic drug and, once you are asleep, a muscle relaxant. While you are going off to sleep, the anaesthetist will also give you oxygen to breathe.

Once you are asleep and fully relaxed a doctor will give the ECT treatment. The muscle relaxant wears off quickly (within a couple of minutes) and, as soon as the anaesthetist is happy that you are waking up, you will be taken through to the recovery area where an experienced nurse will monitor you until you are fully awake.

When you wake up, you will be in the recovery room with a nurse. He or she will take your blood pressure and ask you simple questions to check on how awake you are. There will be a small monitor on your finger to measure the oxygen in your blood and you may wake up with an oxygen mask. You will probably take a while to wake up and may not know quite where you are at first. You may feel a bit sick. After half an hour or so, these effects should have worn off.

Most ECT units have a second area for light refreshments. The person will leave the suite when their physical state is stable and they feel ready to do so.

The whole process usually takes around half an hour.

**Q. What are bilateral and unilateral ECT?**

In bilateral ECT, the electrical current is passed across the whole brain; in unilateral ECT, it is just passed across one side. Both of them cause a seizure in the whole of the brain.

Bilateral ECT seems to work more quickly and effectively and it's probably the most widely used in Britain; however, it seems to cause more side effects. Unilateral ECT has fewer side-effects, but may not be as effective; it is also more difficult to do properly.

Sometimes ECT clinics will start a course of treatment with bilateral ECT and switch to unilateral if the patient experiences side-effects. Alternatively they may start with unilateral and switch to bilateral if the person isn't getting better.

**Q How often and many times is ECT given?**

Most units give ECT twice per week, often on a Monday and Thursday, or Tuesday and Friday. It is impossible to predict how many treatments someone will need. However, in general, it will take 2 or 3 treatments before any effect is seen, and 4 to 5 treatments for noticeable improvement.

A course will, on average, be 6 to 8 treatments, although as many as 12 may be needed. If someone has shown no response at all after 12 treatments it is unlikely that ECT is going to help. A doctor should see the person after each treatment and their consultant should see them after every two. ECT should be stopped as soon as the person has made a recovery or if they say they don't want to have it any more.

**Q What happens after a course of ECT?**

Even when someone finds it effective, ECT is only a part of recovering from depression. Like antidepressants, it can help to ease problems so that the sufferer is able to look at why they became unwell. Hopefully they can then take steps to continue their recovery and perhaps find ways to make sure the situation doesn't happen again. Psychotherapy and counselling can help and many sufferers find their own ways to help themselves. Certainly people who have ECT, and then do not have other forms of help, are likely to quickly become unwell again.

**The ECT Controversy**

There are many areas in which people disagree over ECT, including whether it should even be done at all. People tend to have very strong feelings about ECT, often based on their own experiences. The main areas of disagreement are over whether it works, how it works and what the side effects are.

**Q Why is ECT still being given?**

ECT is now used much less and is mostly a treatment for severe depression. This is almost certainly because modern treatments for depression like psychotherapy (talking treatments), antidepressants and other psychological and social supports are much more effective than they were in the past.

Even so, depression can for some people still be very severe and life-threatening, with extreme withdrawal and reluctance, or inability to eat, drink or communicate properly.

Occasionally people may also develop strange ideas (delusions) about themselves or others. If other treatments have not have worked, it may be worth considering ECT.

**Q What do patients think of ECT?**

A UK review of a number of studies in 2003 found that the proportion of people who had had ECT and found it helpful ranged from a low of 30% to a high of over 80% in another. The authors commented that studies reporting lower satisfaction tended to have been user-led, those reporting higher satisfaction tended to have been doctor-led. In both user and doctor-led studies between 30% and 50% complained of memory loss.

**Q What do those in favour of ECT say?**

Many doctors will say that they have seen ECT relieve very severe depressive illnesses when other treatments have failed. Bearing in mind that 15% of people with severe depression will kill themselves, they feel that ECT has saved patients' lives, and so that the overall benefits are greater than the risks. Some people who have had ECT will agree and may even ask for it if they find themselves becoming depressed again.

**Q What do those against ECT say?**

There are many different views and many different reasons why people object to ECT. Some say that ECT is an inhumane and degrading treatment, which belongs to the past. They say that the side-effects are severe and that psychiatrists have either accidentally or deliberately ignored how severe they can be. They say that ECT permanently damages both the brain and the mind, and if it does work at all, does so in a way that is ultimately harmful for the patient. Many would want to see it banned.

**Q What happens in other countries?**

At the moment, ECT is part of standard psychiatric practice in Britain and the majority of countries worldwide. Some countries (and some states in America also) have restricted its use more than in the UK.

**Q How do I know if ECT is done properly locally?**

The Royal College of Psychiatrists has set up the ECT Accreditation Service (ECTAS) to provide an independent assessment of the quality of ECT services. ECTAS sets very high standards for ECT, and visits all the ECT units who have registered with it. The visiting team involves psychiatrists, anaesthetists, nurses and lay people. It publishes the results of its findings and also provides a forum for sharing best clinical practice. Membership of ECTAS is not compulsory but every ECT unit should be able to tell you:

- if they have signed up to ECTAS;
- the result of their most recent report;

who to speak to if you are concerned that your local unit has not been assessed.

**Q Where can I get more information?**

Many ECT suites provide their own information packs and they should be able to give written information to patients or their family/carers before a course starts. The information in these packs is often strongly in favour of ECT.

The Internet has many sites discussing ECT that are produced by professionals, organisations, people who have had ECT, or others with particular opinions. There are more negative than positive websites.

Updated May 2008

**Further Information**

**National Institute for Health and Care Excellence (NICE).**

Technology Appraisal Guidance no. 59, 2009: Guidance on the Use of Electroconvulsive Therapy www.nice.org.uk/guidance/TA59

Note that the recommendations on treating depression have been updated by the NICE guideline on depression (CG90), see below.

Clinical Guidelines no. 90, 2009: Depression in Adults: diagnosis and management. https://www.nice.org.uk/guidance/cg90

Rose, D., Fleischmann, P., Wykes, T., Leese, M. & Bindman, J. (2003) Patients' perspectives on electroconvulsive therapy: systematic review
BMJ 2003;326;1363-1368

Eranti,S. V. & McLoughlin, D.M (2003) Electroconvulsive therapy - state of the art. the British Journal of Psychiatry 182: 8-9

Ebmeier, K. et al (2006) Recent development and current controversies in depression. Lancet, 367,153-167

**Scottish ECT Accreditation Network (SEAN).**

SEAN has a role in ensuring that there is a continued process of clinical audit and monitoring of all NHS ECT sites in Scotland. A site designed to complement the work of SEAN, by enabling communication of the latest information on ECT in Scotland can be found at: http://www.sean.org.uk/

**Electroconvulsive Therapy Accreditation Services (ECTAS).**

Launched in May 2003, ECTAS aims to assure and improve the quality of the administration of ECT; awards an accreditation rating to clinics that meet essential standard.
www.rcpsych.ac.uk/crtu/centreforqualityimprovement/electroconvulsivetherapy.aspx

**References**

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Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet 361: 799-808

Department of Health Statistical survey (2007) Electro Convulsive Therapy: Survey covering the period from January 2002 to March 2002, England. DH: London
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statistichealthcare/DH_4000216

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This leaflet was produced by the Royal College of Psychiatrists' Public Education Editorial Board.

Author: Dr Richard Barnes

With input from the Royal College of Psychiatrists' Special Committee on ECT and related treatments.

About our leaflets
Readers comments

Revised May 2008

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For a catalogue of public education materials or copies of our leaflets contact:

Leaflets Department
The Royal College of Psychiatrists
17 Belgrave Square, London SW1X 8PG

Charity registration number 228636

36. **APPENDIX 3 – ECT INTEGRATED CARE PATHWAY**

## Mental Health & Learning Disability Division

This Integrated Care Pathway
serves as a guide to treatment and progress.
Professional judgement should always be used and will
override, but any variations in care
must be clearly documented.

Version Date: 31st October 2014

# ELECTROCONVULSIVE THERAPY CARE PATHWAY

Patient I.D Label

| |
|---|
| Name: |
| Unit No: |
| DOB: |
| Ethnic Origin: |

Consultant: ……..

Department: ……

**Signature Sheet**

**All disciplines writing in this ICP must sign below prior to writing in the ICP**

| Full Name (print) | Job Title | Signature | Initials | Date of Entry |
|---|---|---|---|---|
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## Nursing Proforma care plan for a patient prescribed ECT (1/2)

**IDENTIFIED PROBLEM:**
Patient has been suffering from …… and has been prescribed ECT.

**DESIRED OUTCOME:** To relieve the patient's symptoms and ECT Treatment to be carried out safely without complications.

| **Prescribed action** | **Signed Date** | | | | | |
|---|---|---|---|---|---|---|
| | **1st** | **2nd** | **3rd** | **4th** | **5th** | **6th** |
| If the patient receiving ECT for the first time arrange for relevant blood tests to be carried out by the path lab at least 48 hrs beforehand i.e. FBC, U&E's and Pseudo cholinesterase levels also arrange ECG to be performed: x-ray to be done if relevant i.e. if any chest problems | | | | | | |
| Inform Lead ECT Nurse of forthcoming patient prescribed ECT, ensure that patient/family are informed of the procedure, risks and benefits to alleviate anxieties and also support link nurses in completing the Integrated Care Pathway Information Leaflet regarding ECT to be given to patient. | | | | | | |
| Ensure consent form is signed by Doctor and patient. If patient is on a Section of MHA ensure that Mental Health Act Administration Team is informed and that Form CO4/CO6/CO5 completed after SOAD has assessed patient. | | | | | | |
| Inform and remind patient and staff that nothing is to be taken by mouth from midnight before ECT. Occasionally a patient may not comply with this request, in this case they should be constantly observed by nursing staff. | | | | | | |
| All medication should be taken as normal 2 hrs prior to ECT with no more than 50mls water with the exception of diabetic medication which must not be taken. It is essential to continue to take heart and blood pressure medication. | | | | | | |
| If the psychiatric medical staff wish to omit or discontinue any drugs which they feel may be having an adverse effect on the production of seizures during ECT then that is their decision and their responsibility. Link Nurses to make sure if this is the case it is clearly written in the Integrated Care Pathway. | | | | | | |
| Necessary checklists, blood pressure temperature, pulse to be performed prior on the morning of ECT treatment and written into Integrated Care Pathway. | | | | | | |

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## Nursing Proforma care plan for a patient prescribed ECT (2/2)

| **Prescribed action** | **Signed Date** | | | | | |
|---|---|---|---|---|---|---|
| | **1st** | **2nd** | **3rd** | **4th** | **5th** | **6th** |
| M.O.C.A to be completed prior mid course and 3 months after completion of ECT treatment. Link Nurse to identify nominated appropriate person to complete and to contact and also write into discharge care plan. | | | | | | |
| The patient (whenever possible) to be escorted by a qualified, familiar nurse to ECT Suite. This escorting nurse should be aware of the patients legal and consent status and has an understanding of ECT and the necessary checklists is adhered to and completed. The patient should be encouraged to empty their bladder before leaving the ward. | | | | | | |
| The escorting nurse is to stay with patient during ECT and afterwards in the recovery room constantly reassuring and orientating the recovery patient. The escorting nurse should also support the recovery nurse where appropriate to assist in bed making an taking observations. | | | | | | |
| The escorting nurse makes sure that patients have received their dentures, property and valuables before leaving the ECT department and patients are offered refreshments. | | | | | | |
| On return to the ward the patient should be closely observed, blood pressure and pulse to be recorded 2 hourly initially thereafter if normal discontinue. Patients also to be offered a snack as blood sugars may be low. | | | | | | |
| Record review date as indicated by Doctor and enter progress in patients joint file. Any adverse effects should be reported to Nurse in Charge i.e. abnormal confusion, memory problems etc. | | | | | | |
| The Link Nurses identified will make sure integrated care pathway for ECT is completed appropriately and to contact lead ECT Nurse if any problems or concerns arise. | | | | | | |

**ECT History**

Previous ECT: Yes ☐ No ☐

If yes, Unilateral ☐ Bilateral ☐

How many previous courses: …….

Response to previous ECT……..

……Diagnosis:

Severe Depressive illness ☐ Catatonia ☐ Mania ☐ Other ☐

Please tick all that are relevant: First choice treatment due to:

Food/fluid refusal …….. Suicidal risk …….. Severe distress……..
History of good response to ECT and poor response to other treatments ……..
*Within NICE Guidelines: YES/NO* *Patient informed: YES/NO.*

*Reason why outside NICE Guidelines*……....

……...

……...

**Mental State Assessment: (to be completed by person consultant psychiatrist or their deputy):**

Please record the patients CGI Score:

- ❑ 1 = Very much improved
- ❑ 2 = Much improved
- ❑ 3 = Minimally improved
- ❑ 4 = No change
- ❑ 5 = Minimally worse
- ❑ 6 = Much worse
- ❑ 7 = Very much worse

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## Integrated Care Pathway for patients Receiving Electroconvulsive Therapy

### Prior to commencement of ECT

Mental Health Act Status: Informal □ Detained □

ECT should only be used after other treatments have been considered, or in an emergency situation.
Is this an emergency situation? Yes □ No □

If other treatments have been considered, indicate which treatments.
……

……

Alternative treatment benefits & side effects have been discussed: Yes…No…

Date …… Time …… Signed: Dr ……..

*Consent: Unless it is an emergency, before any patient can undergo ECT, they must either give their consent to their approved clinician in charge of the treatment / nominated deputy or have the treatment agreed to by a second opinion appointed doctor from Healthcare Inspectorate Wales on a form CO6.*

### Patients Consent

I …… of ……..

……

hereby consent to undergo to administration of ECT (Electroconvulsive therapy), the nature, purpose and likely effects of which have been explained to me by Dr …….. ….I also consent to the administration of anaesthetic and/or a relaxant or sedative for this purpose. I confirm that I have been given written information re ECT and I understand that and assurance has not been given that the treatment will be administered by a specific practitioner and understand that I may withdraw my consent at any time. I understand that the maximum number of treatments that I will receive will be twelve.

Date …… Time …… Signed:……

### Doctors Explanation

I confirm that I have explained to the patient the nature, purpose, benefits, risks and likely effect of this treatment. A test of capacity has taken place and the patient is able/not able to offer their consent. I have also given the patient an information leaflet about ECT. I have discussed the effects of bilateral/unilateral (delete as appropriate) ECT treatment and offered the choice to the patient.

Date ……Time… …Print & Sign: Dr ……

**Record of discussion with relative/advocate (where appropriate)**

I…… Of……..

and being the…… (state nature of relationship)

of ……. (patient's name) confirm that an explanation of the nature, purpose and likely effects of ECT (Electroconvulsive therapy) has been given to me by Dr…… and that I approve of the treatment being given to my ……..

*Note:* Remember that except in the case of a minor, no relative can give consent. While it is recommended that there will be a relative's approval the patient shall always be consulted about this first.

# HYWEL DDA UNIVERSITY HEALTH BOARD

**Mental Health Act Status Form**

This section is to be completed by the patient's Approved Clinician in charge of the treatment / nominated deputy.
Is there an advanced decision known to exist,
Yes ☐ No ☐
Has the advanced decision been taken into consideration?

Yes ☐ No ☐ Date change

In Legal Status

| | |
|---|---|
| ❑ Informal, consenting, and has capacity to consent form signed (without implicit or explicit coercion ) | |
| ❑ Informal, patient who lacks capacity but the Doctor in charge has decided that ECT is in their best interest as per MCA 2005. | |
| ❑ Detained under Section _____, consenting has capacity. Consent form signed, Form CO4 completed . | |
| ❑ Detained or Informal patient has capacity who is under 18: Form CO5 completed by SOAD. | |
| ❑ Detained under Section _____, unable to consent, lacks capacity. Second opinion obtained, Form CO6 completed by Second Opinion Appointed Doctor. | |
| ❑ Detained under Section _____, emergency treatment, form for Section 62 completed. | |
| ❑ Community Treatment Order CTO, patient has capacity to consent to treatment, Form CO8 | |

| | |
|---|---|
| **MHA documentation complete and on Care Partner?** **?** | Yes ☐ No ☐ |
| **If second opinion sought, number of treatments approved** | |

| | |
|---|---|
| D Legal Status at Completion | |
| Has legal status changed during treatment<br><br>*NB) The CO4 Form for a detained capacitated patient will be invalidated if he becomes incapacitated.<br>The CO6 Form for a detained incapacitated patient will be invalidated if he becomes capacitated. | Yes ☐<br>No ☐ |
| Date of change, if applicable | |

Is relevant MHA documentation complete and on Care Partner?: Yes ☐ No ☐
1) Informal without capacity to consent, complete on page *27.
2) Outpatient disclaimer form, complete form on page *29.
3)

## Incapacity Test Procedure Form

If a patient lacks mental capacity to give consent i.e. Inability to understand and retain information and fails the capacity test. ECT can be given in the best interest of the patient but a second opinion form of consent from a Psychiatric Consultant not involved in the patients care should be obtained. Criteria to be followed:-

| | | | Date: |
|---|---|---|---|
| 1. | Informal - no capacity ……. | ☐ | …… |
| 2. | Capacity test performed …… | ☐ | …….. |
| 3. | Second opinion from consultant (not involved in patient care) ……. | ☐ | …….. |
| 4. | Family liaised/IMCA with and in agreement … | ☐ | …….. |
| 5. | Multi-disciplinary Team agreement …….. | ☐ | …….. |
| 6. | All details recorded in medical notes …… | ☐ | …….. |
| 7. | Patient not resisting treatment …….. | ☐ | …….. |
| 8. | Capacity test documented into Medical Notes | ☐ | …….. |

Signed: . ……. Designation: ……..

Printed: ……

If patient shows any resistance before or during the course of ECT above option is not applicable and the Mental Act Assessment should be considered.

**ASSESSMENT OF PATIENT'S CAPACITY**

**I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:**

- ☐ the patient is unable to comprehend and retain information material to the decision; and/or
- ☐ the patient is unable to use and weigh this information in the decision-making process; and communicate the decision.
- ☐ They meet the diagnostic criteria due to an impairment of, or a disturbance in the functioning of the mind or brain.

Date: ……

## Outpatient ECT

Having Electroconvulsive Therapy (ECT) involves receiving a general anaesthetic. I understand that I must fast from 12 midnight the evening before my treatment is due.

I am also aware that I may have to remain in hospital overnight following my treatment. I understand that If I leave on the day of my treatment I must remain in the ECT Department for 3 hours post anaesthesia when after I must have a suitable adult to collect me and remain with me until the following morning.

I should not sign any legal documents for at least the next 24 hours.

I must refrain from drinking alcohol or operating any type of electrical equipment or machinery for at least 24 hours.

I must not drive a vehicle for the course of ECT, or until advised by my doctor.

I (print name) …….. have read and understand the conditions of my receiving outpatient ECT and will adhere to them whilst undergoing my course of treatment.

Signature of patient: ……..

I, next of kin/relative/friend (delete as appropriate) am aware of the above conditions will ensure they are adhered to.

Signature: ……

Date: ……

## Physical Examination

(a full examination must be carried out prior to ECT by a doctor)

| BP | Pulse | Weight | Temperature |
|---|---|---|---|
| | | | |

| CVS: | |
|---|---|
| Peripheral pulses | JVP |
| Apex beat | Heart Sounds/murmurs |
| Oedema | Regular □ Irregular □ |

| RESPIRATORY: | |
|---|---|
| Resp Rate | Trachea |
| Chest Expansion | Air entry |
| Breath Sounds | Percussion |

| ABDOMINAL: | |
|---|---|
| Abdomen | Bowel sounds |
| Is the patient pregnant? | |

| **CNS** | |
|---|---|
| Consciousness | Pupils |
| Cranial Nerves | Fundi |
| PERIPHERAL NERVOUS SYSTEM: | |
| Power and Tone | Reflexes |
| Gait/mobility | Motor system |
| Involuntary/movements | Sensory System |

| TEETH: | |
|---|---|
| Dentures ❑ | Own teeth ❑ |
| Crowns/bridgework ❑ | Mouth opening/neck movement ❑ |

## Investigations

Please document results
(Please ensure all results are in the patient's file)

| **Investigations** | **Results** |
|---|---|
| U & E's | |
| LFTs | |
| FBC | |
| TFTs | |
| Random BSL | |
| Dipstick | |
| ECG | |
| Saturated Oxygen (air) | |
| Pseudo cholinesterase | |
| **Date:** | |

❑ CXR - If significant cardiovascular or respiratory disease is present, including hypertension

Results

| **Other investigations** | **Results** |
|---|---|
| ❑ Lithium level (all patients on lithium) | |
| ❑ Hepatitis B& C Serology | |
| ❑ Cerebral CT Scan | |
| ❑Sickle-cell test (Afro-Caribbean, Middle Eastern patients unless previously investigated) | |
| **Date:** | |

Tick appropriate box:

| | | | |
|---|---|---|---|
| Anaesthetic Risk ASA Grade | I | ☐ | Normal, healthy patient |
| | II | ☐ | Mild systemic disease (doesn't limit activity) |
| | III | ☐ | Severe systemic disease (limits activity) |
| | IV | ☐ | Severe systemic disease that is a constant threat to life |
| | V | ☐ | Moribund |

If grading is 3 or more patient is to be referred to the anaesthetist for assessment

**Past medical and surgical history, allergies and any concerns. Is the patient considered high risk? [Please state]**

**Any concerns need to be discussed with the anaesthetist before the administration of ECT:**

**General impression and any co-existing medical or surgical conditions**

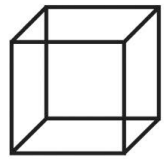
MMSE Score _____ out of _____ (see following pages)

**MONTREAL COGNITIVE ASSESSMENT (MOCA)**
Version 7.1 Original Version

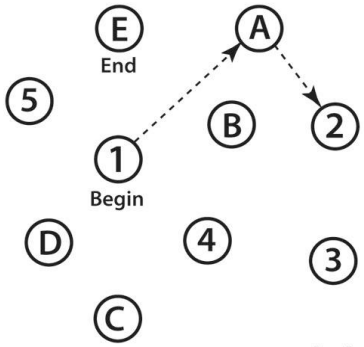
NAME :
Education : Date of birth :
Sex : DATE :

**VISUOSPATIAL / EXECUTIVE** — POINTS

Copy cube

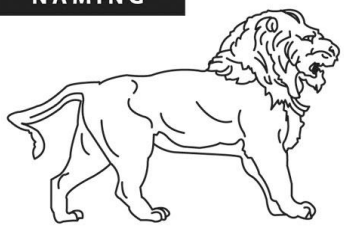


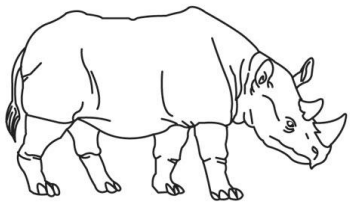
Draw CLOCK (Ten past eleven) ( 3 points )

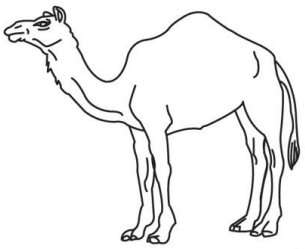



[ ] [ ] [ ] Contour [ ] Numbers [ ] Hands __/5

**NAMING**







[ ] [ ] [ ] __/3

**MEMORY** Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

| | FACE | VELVET | CHURCH | DAISY | RED |
|---|---|---|---|---|---|
| 1st trial | | | | | |
| 2nd trial | | | | | |

No points

**ATTENTION** Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** __/3

**LANGUAGE** Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) __/1

**ABSTRACTION** Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

**DELAYED RECALL** __/5

| | Has to recall words WITH NO CUE | FACE [ ] | VELVET [ ] | CHURCH [ ] | DAISY [ ] | RED [ ] | Points for UNCUED recall only |
|---|---|---|---|---|---|---|---|
| **Optional** | Category cue | | | | | | |
| | Multiple choice cue | | | | | | |

**ORIENTATION** [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD **www.mocatest.org** Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

## Current Medication

### (inc. prn medications)

| Drug | Dose | Frequency | Commenced on |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If medication has been omitted/or discontinued for any reason prior to ECT. Please specify:- or discuss with anaesthetist/ECT Team

RECENTLY DISCONTINUED MEDICATION (That is in last four weeks)

| Drug | Dose | Frequency | Date discontinued |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

RECENTLY ILLICIT DRUG USE (list details below)

| |
|---|
| |

I CONFIRM THE ECT PRESCRIPTION SHEET AND ANAESTHETIC WORK UP ARE FULLY COMPLETE:-

Dr Print/ Sign. _____ Date: _____

**THIS FORM IS TO BE COMPLETED BY A QUALIFIED NURSE AND BROUGHT TO THE ECT DEPARTMENT ON THE FIRST TREATMENT**

**AGE IN YEARS: …….**

| PLEASE TICK | NO | YES |
|---|---|---|
| 1. Do you have bronchitis, asthma or other chest disease? | | |
| 2. Have you ever had a heart attack, palpitations, rheumatic fever or any other heart problem? | | |
| 3. Do you have high blood pressure? | | |
| 4. Do you get chest pain? Do you get more breathless than others of your age, or do you get breathless during the night? | | |
| 5. Do you smoke cigarettes; if so, how many? ……. | | |
| 6. Do you have arthritis or muscle disease? | | |
| 7. Have you ever had a blood clot in your legs or lungs? | | |
| 8. Do you have anaemia ? | | |
| 9. Do you bruise or bleed more than other people? | | |
| 10. Have you ever had diabetes or sugar in urine? | | |
| 11. Have you ever had kidney or bladder trouble? | | |
| 12. Have you ever had jaundice or liver disease? | | |
| 13. Have you ever had epilepsy or fits? | | |
| 14. Will a responsible adult be available to you: | | |
| (a) Collect you and accompany you from the hospital (by car or by taxi?) | | |
| (b) Stay with you overnight after ECT? | | |
| 15. Do you have reasonable access to a telephone? | | |
| 16. Do you have heartburn, acid indigestion or hiatus hernia? | | |
| 17. Have you ever taken steroids? | | |
| 18. Do you have any reactions or allergies to any food, medication, elastoplasts, etc? | | |
| 19. Are you on any medication [drugs, tablets, medicines, capsules, injections, inhalers at present? | | |
| 20. Could you be pregnant? | | |
| 21. Have you ever had a general anaesthetic? | | |
| 22. If so, have you had any problems with anaesthetic? | | |
| 23. Has any close relative had problems with anaesthetic? | | |
| 24. Any other medical problems? | | |

# HYWEL DDA UNIVERSITY HEALTH BOARD

## Treatment 1 ECT Treatment Checklist

Ward nurse to complete items 1-13 by √, X, R (refused), N/A
ECT nurse to re-check and attend items 13-22
Urine test abnormalities: ……..
Could patient be pregnant? □ N/A □ Yes □ No
Does patient have/wear: □ dentures □ capped teeth □ hearing aid
□ spectacles □ oral piercing
Ward: …….. or □ Outpatient Date……...

| | |
|---|---|
| Blood sugar if Diabetic | Result…….. |
| Any abnormality in urine / dipstick. | |
| 1. Correct patient (check with patient & accompanying nurse. | |
| 2. Correct case notes/prescription | |
| 3. ECT record complete | |
| 4. ECT nurse informed of any abnormalities | |
| 5. Consent form signed or MHA documentation in case notes. | |
| 6. Investigation results in case notes. | |
| 7. BP | |
| Sats | |
| Pulse | |
| Temp | |
| 8. When did patient last pass urine (date/time) | |
| When did patient last eat/drink (date/time) Must be nil by mouth since 3am | |
| 10. Make up/nail varnish removed. | |
| 11. Hair washed night before, not wearing gel etc. | |
| 12, Jewellery & hair pins removed. | |
| 13. Encouraged to empty bladder/bowels. | |
| 14. Oral body piercing removed. | |
| 15. Artificial eyes/contact lenses removed. | |
| 16. Anaesthetist informed of any abnormalities | |
| 17. Hearing aids/spectacles removed | |
| 18. Dentures removed / Identity bracelet worn. | |
| 19. Electrode sites prepared | |
| 20. Prescription chart present | |
| 21. Check consent form is still valid | |
| 22. Check patient still agrees | |

Signed (1-13) Signed(13-22)

**Treatment 1**

**Integrated Care Pathway:**

**For Patients receiving Electroconvulsive Therapy**

**ECT Prescription:** (to be completed prior to each treatment by Approved clinician in charge of the treatment / nominated deputy) *.

Session: …**ONE** …….. Dates: ……. ……Time: ……

ECT prescribed: Bi-lateral □ Unilateral: Left □ Right □

Frequency of treatment: Twice Weekly □ Weekly □ Other (specify) ……...

Inpatient □ Outpatient □ Any side effects from ECT……

…….

Any variation in the ASA grade please state here…….

Mental state prior to treatment …….

Please record the patients CGI Score:

- ❑ 1 = Very much improved
- ❑ 2 = Much improved
- ❑ 3 = Minimally improved
- ❑ 4 = No change
- ❑ 5 = Minimally worse
- ❑ 6 = Much worse
- ❑ 7 = Very much worse

……Print & Sign Dr ……..

ECT TREATMENT RECORD

| ECT TREATMENT<br>ECT Equipment used | | | |
|---|---|---|---|
| Machine ❑ | | Unilateral ❑ | |
| Paddles ❑ | | Bilateral ❑ | |
| **Anaesthetic Given** | | | |
| | Dose | | Dose |
| Propofol | | Atropine | |
| Thiopentone | | Ephedrine | |
| Suxamethonium | | Other | |
| IV Cannulae | Site | | Size |
| **Monitoring**<br>ECG ❑<br>Pulse Oximetry ❑<br>Blood Pressure ❑<br>$Co_2$ ❑ | | **Other items**<br>Bite Gag Yes ❑ No ❑<br>Airway Yes ❑ No ❑<br>LMA Yes ❑ No ❑ | |
| WHO check list: | | | |
| Any other comments: | | | |

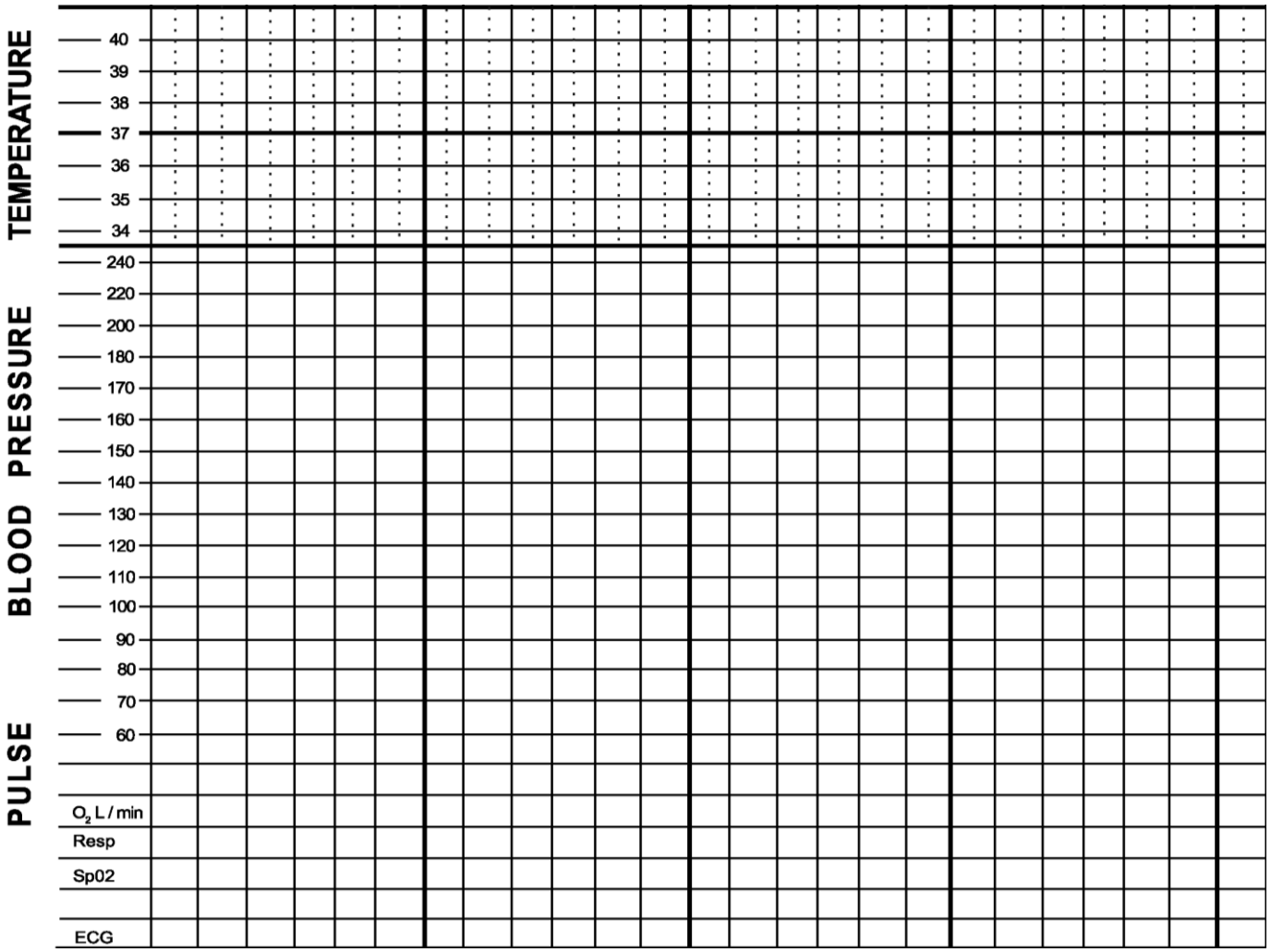
Nature of ventilation _____Signed (Nurse) _____

Treatment 1

| Administration | |
|---|---|
| **Stimulation No 1**<br>Electrode placement<br>Dose setting/dose delivered seizure pattern (bilateral) visible seizure duration (secs)<br>EEG seizure duration<br>Seizure quality | |
| **Stimulation No 2**<br>Electrode placement<br>Dose setting/dose delivered seizure pattern (bilateral) visible seizure duration (secs)<br>EEG seizure duration<br>Seizure quality | |
| **Stimulation No 3**<br>Electrode placement<br>Dose setting/dose delivered seizure pattern (bilateral) visible seizure duration (secs)<br>EEG seizure duration<br>Seizure quality | |
| Seizure threshold (first treatment only - if applicable) | |
| Plan for next session | |
| Post ECT side effects and comments from ECT staff to patient's team | |
| **Anaesthetist :**<br>**Name & Signature.** | Date |
| **Administering doctor's Name & Signature.** | Date |
| **ECT Nurse :**<br>**Name & Signature.** | Date |

| **RECOVERY CARE PLAN [Treatment 1]: Patients Name: _____** | | | |
|---|---|---|---|
| Named nurse & Initials: | | Time patient in | Time taken to recover |
| Conscious: | Yes ☐ No ☐ | Time removed: | |

| | | | | | |
|---|---|---|---|---|---|
| Airway: | Oral ☐ | LMA ☐ | | | |
| Suction: | Yes ☐ | No ☐ | | | |
| IV cannula(e): | Yes ☐ | No ☐ | Removed: Yes ☐ | No ☐ | signature |
| Drugs Given in Recovery, (Time, dose, route & signature) | | | | | |



| 36.1.1.1. Prior to Discharge | 36.1. | | |
|---|---|---|---|
| 36.1.1.5. Valuables returned | | | |
| BP, pulse and blood loss stable and within normal range | | | |
| Minimal nausea and no vomiting | | | |
| Discomfort is within patient's own acceptable limits | | | |
| Mobile without feeling faint | | | |
| Taken food and fluids | | | |
| Has their post-operative instructions | | | |
| Has someone to take them home | | | |
| Has someone to stay with them overnight | | | |

| | |
|---|---|
| Reg. Practitioner Initials | |
| Date & Time | |
| Time of Discharge | |
| | |

| ORIENTATION CHECK LIST | | | | | |
|---|---|---|---|---|---|
| | Pre | | | 90 min | Comments |
| | Correct | Incorrect | | Correct | Incorrect | |
| What is your name? | ☐ | ☐ | | ☐ | ☐ | |
| What day of the week is this? | ☐ | ☐ | | ☐ | ☐ | |
| What year is this? | ☐ | ☐ | | ☐ | ☐ | |
| What month is this? | ☐ | ☐ | | ☐ | ☐ | |
| What date is it today? | ☐ | ☐ | | ☐ | ☐ | |
| What country are we in? | ☐ | ☐ | | ☐ | ☐ | |
| What town are we in? | ☐ | ☐ | | ☐ | ☐ | |
| What is the name of this hospital? | ☐ | ☐ | | ☐ | ☐ | |
| What is the name of this ward? | ☐ | ☐ | | ☐ | ☐ | |
| What is the name of your doctor? | ☐ | ☐ | | ☐ | ☐ | |

- **Patient's comments on their experience of treatment: i.e. Memory problems, side effects. Please enter below.**
- ……
- ……
- ……

……

# HYWEL DDA UNIVERSITY HEALTH BOARD

## ECT Treatment Record

| | | | First stimulation | | Second stimulation | | Third stimulation | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Treatment number | Date | Bilateral or unilateral | Stimulus dose | EEG monitored seizure duration | Stimulus dose | EEG monitored seizure duration | Stimulus Dose | EEG Monitored seizure duration | Additional comments | Signature of Psychiatrist |
| 1. | | | | | | | | | | |
| 2. | | | | | | | | | | |
| 3. | | | | | | | | | | |
| 4. | | | | | | | | | | |
| 5. | | | | | | | | | | |
| 6. | | | | | | | | | | |
| 7. | | | | | | | | | | |
| 8. | | | | | | | | | | |
| 9. | | | | | | | | | | |
| 10. | | | | | | | | | | |
| 11. | | | | | | | | | | |
| 12. | | | | | | | | | | |

## Anaesthetic Record

| Treatment Number | Date | Anaesthetic | Relaxant | Anaesthetist | ODP/ODA | Remarks Problems and Complications |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |
| 10. | | | | | | |
| 11. | | | | | | |
| 12. | | | | | | |

# HYWEL DDA UNIVERSITY HEALTH BOARD

## Outpatient ECT Discharge Form

Name: ……

Address: …….

Date of Birth: …….Psychiatric Unit No: ……

The above person attended for and received Electro-convulsive therapy this morning which involved a general anaesthetic.

**Anaesthetic Complications** **Yes** □ **No** □
Comments:

**Treatment Complications** **Yes** □ **No** □
Comments:

**Pre-ECT Observations**

Temp …….. Pulse …….. SATS …… BP

**Pre-discharge Observations**

Temp …….. Pulse …….. SATS …… BP

**Patient Review**

I, Dr …….. (print name), have reviewed the above patient and feel it is appropriate for them to be discharged from our care.

Signature of Doctor: ……..
Date: ……. Ward: ……

I, Dr …….. (print name), have reviewed the above patient and feel it is inappropriate for them to be discharged from our care, therefore they have taken discharge against medical advice.

Signature of Doctor: …….
Date: ……. Ward: ……

HYWEL DDA UNIVERSITY HEALTH BOARD

**Integrated Care Pathway:**

**For Patients receiving Electroconvulsive Therapy**

**Discontinuation of Treatment**

Decision made to discontinue treatment (include reasons for discontinuation):

This should be completed by the patient's Consultant Psychiatrist/or deputy.

Number of Sessions of ECT administered and reasons for discontinuation.

Please record the patients CGI Score:

- ❑ 1 = Very much improved
- ❑ 2 = Much improved
- ❑ 3 = Minimally improved
- ❑ 4 = No change
- ❑ 5 = Minimally worse
- ❑ 6 = Much worse
- ❑ 7 = Very much worse

On discontinuation of treatment the patient has had a clinical interview to establish any cognitive side effects. Evidence of these must be documented here.

Date: …… Time: …… Signed: ……

(NB: If discontinued earlier than expected, complete variance record sheet).

HasECT been successfull? □ Yes □ No

If No, State reason: □ Poor Clinical response □ Physical health problems

□ Adverse event □ Patient withdrew consent

# HYWEL DDA UNIVERSITY HEALTH BOARD

## 3 MONTH FOLLOW UP POST ECT

**Patient Name**

Date of Birth

Unit No:

1. **Assessment of patient's clinical status/symptomatic response**

2. **Patient's reports of side effects attributed to ECT since completion of treatment**

3. **Patient's current cognitive examination using the MOCA assessment and score**

**SIGNED:**

DATE:

**PLEASE SEND COPY TO THE ECT DEPARTMENT.**

## 37. APPENDIX 4 - CONSENT

Full valid consent must be obtained prior to the administrations of ECT in all cases where the individual has the capacity to grant or refuse consent. Consent must be freely given and based on an adequate understanding of the purpose, nature, likely effects and risks of treatment, including the likelihood of its success and any alternatives to it, and of the likely consequences of not receiving it. Consent should be obtained without pressure or coercion, which may occur as a result of the circumstances and clinical setting. The individual should be reminded of their right to withdraw consent at any time.

The option to elect for ECT should be discussed well before the treatment date and the patient given written information as well as verbal information. Please see Appendix I for Hywel Dda ECT Patient Information leaflet and Appendix 2 for the Royal College of Psychiatrists Patient Information Leaflet.

Time should be given to the patient to consult with those of his/her choosing prior to signing the consent form. The involvement of patient, family, advocate, and/or carers to facilitate informed discussion is strongly encouraged.

In all situations where informed discussion and consent is not possible advance decisions should be taken fully into account and the individual's family, advocate, and/or carer should be consulted.

**a. The Informal Patient With Capacity**

Capacious Patients who refuses ECT cannot be given treatment.

**b. If a patient lacks capacity to give consent,**

ECT can be given in accordance with the Mental Capacity Act 2005 but the following good practice guidelines must be adhered to:

- Service users' opinion needs to be included and recorded.
- Consultation with other members of the multi-disciplinary team.
- Consultation with a member of the patient's family.
- Consultation with an IMCA for any Un- befriended patient is essential and is desirable for other incapacitated patients.
- Consider obtaining a second opinion from a consultant psychiatrist not involved in the patients care.

The capacity test and all discussions/opinions must be recorded in the case notes.

If there is any evidence of non-compliance on the patients part then treatment should not be given and consideration given to use of the Mental Health Act (Appendix 5) in this situation or when there is any question of deprivation of liberty.

All decisions must be in the best interests of the incapacitated patient.

**17 DETAINED PATIENTS (PART IV OF MHA SECTION 58A).**

**a. Adult patients with capacity to give consent.**

A patient detained under certain sections of the MHA (with the exception of Section 4, 5, 135, 136, 35 and 45a) who is capable of giving consent and consenting (as described above) can be given ECT. The patient should sign a consent form. The patients Approved Clinician in charge of the treatment or in some cases the Second Opinion Appointed Doctor (SOAD) must

sign Form CO4 for patient who are detained under the mental health act and who has capacity to consent to treatment and include on the form the proposed maximum number of applications of ECT, whether the treatment is unilateral or bilateral and the medications to be administered for ECT. It should be indicated clearly if the certificate is to apply to any or all of the treatment for a specified period. All discussions should be documented in the patient's medical notes particularly in relation to his or her capacity to consent.

If the patient withdraws consent which has been given, or if there is a break in the continuity of the patient's detention, or if there is a change of approved clinician in charge of the treatment then consent should be given again and a new Form CO4 should be signed. The CO4 certificate will be invalidated should the patient loses capacity to make such decision.

Any patient who has capacity and refuses treatment cannot be given ECT.

**18 PATIENTS WITH CAPACITY/COMPETENCE WHO ARE UNDER 18 YEARS OLD**

Any patients who has not attained the age of 18, whether detained or informal, can only have ECT provided that a SOAD has duly completed a Form CO5

**19 PATIENTS WITHOUT CAPACITY.**

When a patient refuses consent, or, it is withdrawn, or patients wishes appear to fluctuate, or, the patient is considered to lack capacity then the approved clinician in charge of the treatment must comply with the requirements of Section 58A. .A treatment plan should be written in medical notes and a second opinion sought from a Healthcare Inspectorate Wales (HIW) . For treatment to proceed the SOAD must provide a duly completed Form CO6, which should detail the number of treatments allowed.

**a. Urgent treatment under S62 of the Mental Health Act.**

In an urgent situation it is possible to give ECT as an urgent treatment under Section 62 of MHA. The decision to treat under Section 62 is the responsibility of the patient's approved clinician in charge of the treatment or, in his absence, of the doctor for the time being in charge of the charge of the patient's care. Once they are satisfied that the criteria set out in Section 62 have been met, a Section 62 form specifically for ECT should be completed. An entry should also be made in the patients notes. Where possible others involved in the patient's care should be consulted and an opinion sought from a consultant colleague.

Only the first two criteria of Section 62 apply to ECT.

## 38. APPENDIX 5 - CONTACT NUMBERS

**Anaesthetics Department West Wales General Hospital, Carmarthen.**

Patients in whom physical illness may cause concern should be discussed with a Consultant Anaesthetist prior to treatment in Carmarthen Clinic. One of the 2 Consultant Anaesthetists who regularly participate in the ECT clinic should be consulted.

All can be contacted at the Anaesthetic Department, West Wales General Hospital, Carmarthen, telephone (01267) 235151.

Queries can also be addressed to the Consultant Psychiatrist in charge of the ECT Clinic, who is based at Wellfield Resource Centre, Wellfield Road, Carmarthen Carmarthenshire Telephone (01267236017).

ECT Nurse E.C.T. Dept, Hafan Derwen, Parc Dewi Sant, Carmarthen.
Telephone: 01267 237481 Ex 4764

## 20 APPENDIX 6 – PROTOCOL FOR PRESCRIBING PATIENTS FOR ECT.

### 38.1. Protocol on prescribing patients for ECT.

The patient must be given comprehensive information about the proposed treatment by the treating team as part of the consenting process.

A patient information leaflet must be given to the patient and this recorded on the consent form.

The patients must be given the opportunity if clinically appropriate to visit the ECT department and to discuss the treatment with the ECT team prior to treatment.

A formal documented assessment must be done on all patients referred for ECT by their treating team guided by thorough completion of the ECT referral form.

The patient's Mental Health Act status and ethnicity must be recorded.
A detailed medical history, thorough examination, including history of drug allergies, mental state examination, and assessment of cognitive functioning including a Montreal Cognitive Assessment must be completed and documented.

A full assessment of the patient's teeth and dental work (caps, crowns, bridges, titanium implants and dentures etc) should be carried out and documented in the ECT pathway. The assessment means that the patient may be seen by a dentist prior to treatment, see Appendix 3 – ECT Care Pathway.

A clear statement must be included on why ECT is prescribed and an assessment of the risk / benefit balance of having ECT be recorded.

The ECT anaesthetist will assess and record the patient's anaesthetic risk (ASA grade) prior to the first treatment. The Prescriber must complete the section on each prescription form relating to any suspicions that the ASA grade may have changed.

Physical investigations should be completed in accordance with the guidance on the referral form.

Most regular medications except insulin should be taken with a sip of water not less than 2 hours before treatment, otherwise the patient should be nil by mouth from midnight. Exceptions might be benzodiazepines or anti-convulsants as decided by the treating team with advice from the ECT team.

The ward and ECT department checklists in the ECT pack should be thoroughly completed, ensuring the patient had voided their bladder shortly before treatment, that physical observations are checked, blood glucose is checked in known diabetics and that the patients' identity is checked.

Before treatment, the patient must be introduced to the ECT team and given the opportunity to ask questions.

Explanations of all procedures carried out by the ECT nurse, doctor and anaesthetist throughout the patients' time in the department are to be given.

## 39. APPENDIX 7 – ADMINISTRATION OF ECT

STIMULUS DOSING PROCEDURE

**Aims:**

- To ensure that the patient has an adequate seizure i.e. a generalised tonic clonic convulsion (observed physically and/or via EEG as polyspike/3H3 spike and wave activity).
- To ensure dose suprathreshold to maximise efficiency of treatment.
- To avoid too high doses to minimise cognitive side effects.

**The First Treatment**:
Start at 50 mc
Or
75 mc if:

1. Patient MALE.
2. Patient over 65 years
3. Patient on benzodiazepines/antiepileptic.
4. ECT has been administered in the previous 3 months.

Observe the patient and EEG and time seizure length via EEG.

If patient fails to have an adequate seizure restimulate at 2 increments (i.e. 50 mc) above previous dose.

If 3 stimulations do not result in an adequate seizure, abandon the treatment session.

Aim to establish the seizure threshold dose i.e. the lowest stimulus dose which induces an adequate seizure.

It is advisable to allow at least 20 sec. prior to restimulation to allow for latent period between stimulus and onset of seizure activity.

**Second Treatment:**
The first treatment should have established approximate threshold dose if not continue dose titration.

If the threshold dose has been established stimulate as follows:-

a) For bilateral ECT the dose should exceed the threshold dose by 50% or ST x 1.5 (i.e. ST + 50%). Where emergency treatment is necessary to save life the initial dose should be at least 50-100% above the initial seizure threshold. If clinical improvement is inadequate after 4-6 treatments then doses of up to 150% above seizure threshold (Two and a half times) may be considered.

b) For unilateral ECT the dose should be 3-6 x the threshold dose. The initial electrical dose should be at least 200% above the initial seizure threshold.(3 times).If clinical improvement is definite but slight or temporary after 4-6 treatments, then doses up to 500% above the seizure threshold(6 times) may be indicated.

**Subsequent Treatment:**
Treatment should continue at the same stimulus dose unless progressive shortening of seizure length occurs i.e. marked shortening between 2 consecutive treatments.

The stimulus dose should then be increased by one increment i.e. 25 mc.

**Termination of prolonged seizures**
A prolonged seizure is one that last 2 minutes or more and should be terminated promptly in consultation with anaesthetist.

**EEG monitoring**
All our machines have facility for 2 channel EEG monitoring on screen and printed record.
Timing of seizure by clock.
The ECT nurse monitors the duration of seizure on Stop-clock.

## 40. APPENDIX 8 – MAINTENANCE AND CONTINUATION ECT

The latest NICE guideline on Depression (CG90, October 2009, updated April 2016) recognises the use of continuation and maintenance ECT in some cases. Some studies reflect it as at least as effective as pharmacotherapy.

Continuation ECT refers to the gradual reduction in frequency of ECT treatments at the end of a course of ECT to observe the ongoing need and to lead into maintenance ECT if appropriate.

Maintenance ECT refers to regular treatments, usually but not necessarily once monthly, given to those who have relapsed in spite of prophylactic medication on more than one occasion and who usually will have needed repeated courses of ECT and been non-responsive to pharmacotherapy.

The decision to prescribe ECT should be discussed with the patient and family by the prescribing team.

The prescribing Responsible Clinician should discuss with the ECT consultant.

An informal second consultant opinion should be sought for informal patients.

All discussions, reasons for prescription of maintenance ECT and assessment of capacity should be recorded.

Capacitated patients should give recorded consent for up to 12 treatments and consent should be reviewed before each treatment. Consent may be withdrawn at any time.

Mental state, response to treatment and any adverse effects should be reviewed and recorded between treatments. This includes any physical problems which may have arisen since the start of maintenance treatment and which should be discussed with the anaesthetist and ECT team if necessary.

The need to continue with maintenance ECT should be reviewed fully after 12 treatments and the decision to continue should be based on a full assessment of benefits, risks, and adverse effects.

For detained patients the Mental Health Act provisions apply as for any other ECT given under Part IV.

Discontinuation of Maintenance ECT, unless because of adverse effects or withdrawal of consent, may involve a gradual reduction in frequency and monitoring of response as felt appropriate by the clinical team in discussion with the patient and ECT team.

### 40.1. Assessment

- Full case reviews to include correct diagnosis, ECT of proven benefit and alternative options explored.
- Informed consent to be sought after provision of a separate information sheet on a specific consent form for continuation ECT.
- The patient should then have a full routine medical screening and examination with investigations as necessary.
- Baseline standardised assessment of illness severity e.g. HAM D.

- Ensure any contraindications have been ruled out

40.1.1. Prescribing ECT

- Treatment plan
- Consideration to be given to the intended length of the course
- Team should agree on relapse signature which can be used in deciding frequency of treatment.
- Plan should clearly document in the notes together with record of discussion with patient and family of purpose, benefits and adverse effects etc.

40.1.2. ECT Procedure

- Administration as per RCPsych guidelines on ECT in inpatient or outpatient setting.
- Stimulus dosing should be used.
- As it is suggested that clinical response is more important than seizure duration shorter seizures may be acceptable if patient remains well.
- Once clinical recovery achieved these twice weekly ECT then reduces frequency to minimum required to maintain clinical response. E.g.:-
    - Reduce to weekly
    - Reduce to every 10 days
    - Reduce to every 2 weeks
    - Reduce to every 3 weeks
    - Reduce to monthly
- Before each change in frequency a review should take place to include objective information from staff and family/carers.
- Deterioration in mental state suggestive of relapse at any frequency should result in return to previous frequency until improvement re-established.

40.1.3. Review during the course

- Once initial recovery achieved full baseline psychometric assessment should be performed.
- Routine monthly cognitive assessments e.g. Montreal Cognitive Assessment (MoCA) to assess for anysubjective cognitive impairment – can be done on the day of treatment before administration.
- Full anaesthetic review with tests as appropriate every 6 months.
- Full repeat of all psychometric tests except NART every 12 months
- Regular review by nursing and medical staff.
- Informal verbal consent before each treatment.
- Written consent every 6 months

40.1.4. Discontinuation of ECT for Adverse Effects or lack of response

- Adverse reaction to ECT or anaesthetic would lead to discussion between the ECT team, anaesthetist and prescribing RC and team as to whether ECT should be discontinued.
- Lack of response to ECT. If there is no response at all to 6 properly administered bilateral ECT treatments then discontinuation should be considered. If there has been a slight or temporary response ECT may be continued.
- The date of discontinuation, number of treatments and reason for discontinuation should be recorded in the appropriate section in the ICP for ECT.

40.1.5. Stopping continuation of ECT

- Relapse is most likely within first 12 months so it is wise to continue for this long with reviews as above.
- After this time a full review can be undertaken if there is a need for long term continuation.
- There is currently no way of predicting the likelihood of relapse, hence the need for documenting relapse signature and close supervision after the course.
- Return of symptoms following discontinuation of a course of continuation of ECT would indicate consideration of maintenance ECT with regular review as above and annual review of its role.

## 41. APPENDIX 9 – ECT FOR SPECIAL POPULATIONS

### 41.1. Young People

- The adult admission ward is not an ideal setting for the care of adolescents.
- However, if admission is unavoidable, and ECT indicated, special provisions apply in addition to those for the adult patient:
    - Adolescents aged 16-18 are able to consent and refuse treatment in the same way as an adult but parental approval is advised
    - Independent second opinion should be sought
    - The RCPsych recommends that for those under 16yrs two further opinions are sought: one from a child and adolescent psychiatrist and one from another psychiatrist from a different clinical unit. For those under 16yrs parental consent is necessary.
- A SOAD is required for a person under 18 and a Form CO5 completed

The provisions of the Mental Health Act have no lower age limit.

- ECT clinic appointments should be timed so that the young person is at the beginning of the list.
- Dose titration should begin at 25 mc as young people may have low seizure threshold.

Submission of data to the Royal College of Psychiatrists is required for under 18yr olds. The monitoring of young people should include monitoring of physical changes and cognitive functions during the course of treatment: refer to ICP.

### 41.2. ECT in Pregnancy

- In pregnancy, ECT may be the preferred treatment of choice because of its speed of action.
- There is little known about the effects of ECT in the first trimester of pregnancy.
- ECT in the second or third trimesters may present more technical difficulties for the anaesthetist as the risk of inhalation of stomach contents increases.
- The patient's obstetrician and the anaesthetist should be involved before a decision is taken to proceed to treatment.

### 41.3. ECT for Older Adults

- Older people may be more likely to suffer the types of illness which respond to ECT and may be more subject to stupor, refusal to eat and drink and severe psychosis
- People should not be denied access to ECT solely on grounds of age.
- All coexisting medical and surgical conditions should be assessed as part of a comprehensive psychical workup to include all relevant investigations and where possible stabilised or treated prior to ECT.
- The higher seizure threshold should be taken into account when stimulus dosing i.e. by starting with a stimulus of 75 mc in those over 65 and also be considered in the choice of anaesthetic agent.
- The monitoring of older people should include monitoring of physical changes and cognitive function during the course of treatment – refer to ICP.
- ECT technique should be modified if necessary to minimise any cognitive adverse effects during the course of ECT, considering the use of unilateral ECT if appropriate.

## 42. APPENDIX 10 – DENTAL PRECAUTIONS

Whilst filling out the ECT pathway for your patient, as the doctor you will need to complete a full assessment of the condition of your patient's teeth and dental work. As part of the Physical and Mental Assessment, there is an example below of what you will need to complete and comment on.

If your patient is consenting to treatment, part of the consent form, requires you to document any "adverse risks to your patient from ECT including any risks to their teeth."

The standard practice for ECT is for all patients to have some form of bite block inserted during the application of Electro Convulsive Therapy. The way the bite block is applied, may vary, depending on the type of dental work that has been carried out and should be decided after assessment by the Psychiatrist and Anaesthetist on the day of ECT. Patients should be reminded of any potential damage to their teeth. However, the ECT treating team will minimise the risk by re-assessing the patient's dental work and using the appropriate device on the day of each session.

The assessment should take in to account the following examples:

- A patient with full set of teeth and previous caps or crowns. Anaesthetist to use the usual bite block.
- A patient with missing teeth and a partial denture. Consider leaving in the denture to guard the remaining teeth.
- A patient with missing teeth and no partial denture. Rolled up gauze should be placed in the adjacent to the teeth and at the back of the gums to support the TM joint. Also consider referral to the Facio Maxillary team for an opinion if the remaining teeth are in a poor condition or loose. Remaining teeth may be required to be removed.
- Full dentures: Remove these and use the usual bite block.
- Protruding upper incisors': These are at risk of forward displacement during the seizure. Therefore, rolled up gauze should be placed at the back of the mouth by the posterior molars and also the mid molars.
- Implants: A referral to the Facio-maxillary team should be considered as part of the work up for ECT. A full history should be obtained from the dentist if possible. Consideration should be given to producing a personal gum shield to protect the implants. Consider unilateral ECT if Zygoma bars are present.
- Veneers: Use the usual bite block. Check after the seizure for any splinters.

The anaesthetist should record the lack of or any damage to the teeth and the use of any extra precautions. For further information please consult the ECT Team.

## 43. APPENDIX 11 – ECT FOR OUTPATIENTS

### 43.1. Guidelines for Prescribing Outpatient ECT

Serious consideration should be given prior to prescribing a course of outpatient ECT.

Factors that would influence the decision:-

- Past and present medical conditions i.e. cardiac and chest problems
- Previous anaesthetic complications
- Previous ECT and any side-effects/complications
- Domestic situation i.e. (Do they live alone?) (Is support at home available for 24hrs post treatment and between treatments)?
- Reliability in taking or not taking medication as prescribed (e.g. benzodiazepines)
- Ability to retain information given to them e.g. (To fast from 12mn)
- Any history or ongoing suicidal ideation. Be aware that suicidal risk may increase in the early stages of treatment as level of depression may remain static but volition may improve.
- Employment situation i.e. (Do they intend to carry on working during their course of treatment?) Consider what their job is and how they are going to get there the day after treatment, as they are not insured to drive their car for 24hrs post anaesthetic.

If all these factors have been considered and it is felt appropriate to go ahead with outpatient treatment then the following procedure should be followed.

### 43.2. Outpatient Procedure

Prior to receiving outpatient ECT an appointment should be arranged for the patient to attend the ward to have all necessary investigations carried out. This should be done before the day of treatment to allow results to be obtained and any concerns or problems dealt with and passed on to the ECT Team. Where possible the patient and their relative should be given the opportunity to discuss the treatment and go over any concerns or worries they may have with the ECT Nurse preferably on the day they attend the above appointment.

ECT information should have been given to the patient before attending this appointment. To include patient information leaflet Appendix 1 and outpatient ECT leaflet Appendix 2.

If treatment is to go ahead then a letter informing the patients GP should be sent. The patient should be advised to attend the ECT. Dept at 09:00 am - 09:15 am on the day of the treatment. They should also be reminded that they must not drive and should be accompanied by the person who is going to collect them and remain with them that night if they are going home the same day. The patient and their relative/friend should be asked to read and sign an outpatient information form to ensure they are aware of all important information Appendix 3

Following treatment the patient should remain in the ECT Department until at least 2- 3 hours post anaesthesia when they should be seen by a Doctor to establish that they are mentally and physically fit to leave. An outpatient discharge form, Appendix 3, should he completed and filed in the case notes. If the Doctor feels that the patient is not fit to be discharged from the hospital then they should be asked to sign a discharge against medical advice form or assessed for detention under the Mental Health Act (if appropriate). A discharge against medical advice form (DAMA) can be found in the ECT clinic.

If the patient is leaving they should be reminded not to drive as they will not be insured.

No patient should leave either on the day of treatment or the following day until a Doctor has seen him or her and a discharge form completed. It is not be the responsibility of the nursing staff to say that this person is fit for discharge .

All patients receiving outpatient ECT must be reviewed at least as often as inpatients. Any significant changes should be passed on to ECT Team.

Should the patient develop suicidal ideation during the course of their treatment then serious consideration should be given to the patient continuing their treatment on inpatient basis.

At the end of the course of treatment a letter should be again sent to the GP detailing the treatment and outcome.

## 44. APPENDIX 12 – ROLES OF TEAM MEMBERS

### THE ROLES OF TEAM MEMBERS

#### 44.1. Consultant

- The Lead consultant is responsible for ensuring that ECT is delivered in an acceptable setting and to the standards required by the Royal College of Psychiatrists.
- This includes the development of treatment protocols, advice and liaison and audit.
- The ECT Medical Team will supervise the training of junior staff in the theory and practice of ECT. It is expected that the ECT rota arrangements will provide continuity and a chance to follow the patient through a course of treatment.
- The Medical Team should ensure liaison with the prescribing team if there are any procedural or clinical difficulties.
- In order to carry out these duties and allow for continued professional development one session per week of medical time has been allocated.
- The Associate Psychiatrist deputises for the lead consultation and administers ECT.

#### 44.2. SHO Training Grade Doctors

- ECT is administered by an SHO as part of a rotational training in psychiatry or general practice, on a rota basis for one session per week.
- The trainee should first undergo an induction programme including theoretical introduction, written information and a practical demonstration.
- Initial treatments should be supervised by the lead consultant or associate psychiatrist or nominated trained SHO, until such time as the trainee is confident of the procedure (a minimum of six ECTs is advised).
- Before each ECT the doctor should check the validity of consent, ensure that the treatment has been prescribed and take account of any comments from the clinical team.
- He/she should then follow the treatment protocol, after discussion with the supervisor if necessary.
- The ECT report should be completed to include type of ECT (bi- or uni- lateral) machine settings, length of seizure and description of any untoward effects.
- The treating psychiatrist should be prepared to help deal with any emergencies as they arise and should not leave the ECT suite without first consulting with the anaesthetist/ ECT nurse and remain contactable.
- SHO should have completed CPR training and regular updates as per Health Board guidelines.

#### 44.3. Anaesthetist

- To decide whether the patient is fit for anaesthesia
- To administer anaesthesia and associated drugs.
- The ECT nurse(s) and the treating psychiatrist will provide assistance in preparing a patient for treatment and guide care until the patient recovers.

##### 44.3.1. Prior to ECT

- Check equipment and draw up anaesthetic drugs
- Check all relevant forms in the ECT ICP and ECG if patient's first treatment.
- Check dentition, e.g. loose teeth, dentures crowns or caps etc and protect as appropriate.
- Mouth gag inserted if necessary.
- Monitoring of pulse and O2 saturation via pulse oximeter.

- .Insertion of IV access .
- The anaesthetic agent of choice is presently low dose propofol (Diprivan).
- Muscle Relaxation is achieved with Suxamethonium.
- Hyperventilation with 100% oxygen prior to ECT is suggested to improve the efficacy of treatment.
- If no seizure is obtained, one or two more attempts at stimulation may be requested, and oxygenation, extra anaesthetic given as necessary following discussion between treating doctor and anaesthetist.

Seizures lasting more than two minutes should be terminated either by the use of more induction agent or IV diazepam.

44.3.2. Following ECT

- The anaesthetist will wait until the patient breathes spontaneously and is in control of the airway before transfer to the recovery room.
- The patient should be monitored by a nurse, trained in CPR, until he/she regains consciousness. Regular checks of pulse and BP should be made until stable.
- On the instruction of the anaesthetist, the nurse will remove the IV cannula. .
- Details of the anaesthetic should be entered in the ICP.

44.4. **ECT Treatment Room Nurse**

44.4.1. Prior to ECT

- Check pre-op checklist documentation have been completed in the ECT pathway and that case notes, ECT record, prescription chart, blood pressure chart, section forms accompany patient. Insert data into ECT machine i.e. Unit No. D.O.B. number of treatment etc.
- For consenting patients ensure continuing consent and sign form.
- Make sure that property and valuables are recorded and signed by the patient and identity bracelet is fitted onto patient's arm.
- Assist patient onto trolley, providing reassurance and ensuring they are comfortable.
- Ensure shoes are removed and placed safely.
- Ensure dentures are removed and placed in denture pot.
- Ensure glasses, hearing aid, hair clips and excessive jewellery are removed to a labelled container and stored safely.
- Ensure restrictive clothing around the neck is loosened.
- Check the time of the patient's last intake of food/drink.
- Report to anaesthetist, psychiatrist concerning any problems or developments as reported by ward staff.
- Inform anaesthetist if patient is having ECT under a section of M.H.A.

44.4.2. During ECT

- Provide reassurance and explanation throughout procedure.
- Assist psychiatrist as required with :-
- Applying EEG electrodes
- Applying gel to ECT electrodes.
- Preparing patient's skin i.e. clean electrode site with Alco wipe, wipe off excess with tissue.
- Assist anaesthetist/anaesthetic technician as required with introduction of venflon and mouth gag when patient is anaesthetised.

- Placing probe on patient's finger to monitor oxygenated blood and pulse etc.
- Nurse may be requested to press button to deliver agreed stimulus while psychiatrist holds ECT electrodes in place. This depends on type of machine in use.
- Hold patient's wrists gently, whilst ECT is administered to prevent injury.
- Observe number of seconds from when the last/longest sound of the ECT machine stops, until when you think visible signs of seizure have ended with a stopwatch. NOTE: Seizure may only be visible in extremities or facial muscles in some patients.
- Remain at patient's side until anaesthetist confirms that patient has started breathing again and is ready to be taken into the recovery room. Remain available to assist the anaesthetist with any immediate recovery complications.
- Remove EEG electrodes and wipe excess gel from patient's head. Assist with turning patient onto left side, after confirmation from anaesthetist ask the anaesthetist to inform recovery staff of amount in litres of oxygen in recovery to administer.
- Assist recovery nurse as required.
- Make note and liaise with relevant personnel concerning any problems that occurred in session and document in the ECT pathway.

44.4.3. Post ECT

- Complete all documentation in the ECT Care pathway.
- Make sure all patients' case notes return to wards and ICP.
- Dispose of any needles, syringes and drugs in treatment room - safely.
- Switch off machine.
- Secure all drugs in security cupboard.
- Assist recovery nurse as required.
- Check stock levels in department and also expiry dates.
- Tidy and secure area. Put away equipment.
- File all EEG records appropriately.
- Complete all records/ documents kept in department.

44.5. **ECT Recovery Room Nurse**

- The recovery nurse cares for the patient immediately when they arrive in the recovery room.
- Maintain the patient's airway. The patient will have guedel airway in situ. This should remain until the patient's swallow reflex appears to have returned.
- Apply pulse Oximeter probe and monitor till sufficiently conscious. Observe the patient's respirations and level of consciousness. Inform anaesthetist if the patient is experiencing difficulties. Complete recovery vital signs and record in ECT pathway.
- Attempts to orientate the patient to his/her surroundings.
- Initially sit the patient up using the back rest on the trolley when you feel he/she is sufficiently aware of his/her surroundings.
- Move the trolley along to allow space for the next trolley to be sited by the oxygen and suction machine.
- When the patient is sufficiently orientated, assist him/her with replacing dentures, glasses etc.
- Remove the venflon, applying pressure with a swab initially to the site for a couple of minutes to stop bruising.
- When you feel that the patient is sufficiently orientated, assist him/her with putting on shoes, getting off the trolley and walking to the sitting area.

- The nurse escort should stay close to the patient at all times and encourage the patient to have a drink and biscuits depending on their level of co-ordination i.e. take care that they do not spill hot tea on themselves. The relatives of outpatients should be made aware of this also.
- Facilitate escorting of patient back to ward.
- Sheets and pillowcases on the trolley should be changed for each patient.
- If the patient complains of a headache, paracetamol can be given. Record on prescription sheet, which should be with patient's notes.
- Complete Recovery Care Plan and prior to discharge form.
- The ODP or equivalent whose sole role is to assist the anaesthetist.