

ELECTROCONVULSIVE THERAPY (ECT) POLICY

Version:	5
Ratified by:	Senior Management Team
Date ratified:	January 2017
Title of originator/author:	ECT Lead Consultant
Title of responsible committee/group:	Clinical Governance Group
Date issued:	January 2017
Review date:	January 2020
Relevant Staff Groups:	Mental Health Medical Staff and ECT Clinic Staff

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DOCUMENT CONTROL

Reference NA/Aug15/ECT	Version 5	Status Final	Author ECT Lead Consultant
Amendments	Updates to DVLA guidance and addition of new 'Guidelines for Patient Referral and Escort Duties', plus Amendments to reflect Equality and Diversity.		
Document objectives: The purpose of this document is to provide a policy to ensure safe and consistent provision of ECT reflecting current best practice and legal requirements.			
Intended recipients: Mental health medical and nursing staff.			
Committee/Group Consulted: IQUIS Best Practice Group, CPRG			
Monitoring arrangements and indicators: The Trust's ECT service is subject to ongoing monitoring via the national ECTAS scheme.			
Training/resource implications: Training requirements as recommended by the ECTAS scheme.			
Approving body and date	Clinical governance Group	Date: November 2016	
Formal Impact Assessment	Impact Part 1	Date: August 2016	
Clinical Audit Standards	YES	Date: TBA	
Ratification Body and date	Senior Managers Operational Group	Date: January 2017	
Date of issue	January 2017		
Review date	January 2020		
Contact for review	ECT Lead Consultant		
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1. INTRODUCTION

- 1.1 Electroconvulsive Therapy (ECT) is a well established, high effective and safe treatment for severe mental illness, including severe treatment resistant depression, treatment resistant mania and also catatonia. The use of ECT in selected patient groups is recommended by the Royal College of Psychiatrists and is supported by National Institute for Clinical Excellence (NICE) Clinical Guidelines.
- 1.2 ECT can be a life saving treatment when other options are unavailable because of contraindications, other clinical factors or where other treatments have been ineffective.
- 1.3 ECT involves the application of an electrical current to the brain to induce an epileptic fit. The treatment is undertaken under a general anaesthetic, with a muscle relaxant to modify the seizure.

2. PURPOSE & SCOPE

- 2.1 The purpose of this policy is to ensure that the Trust provides a high quality, safe and effective ECT service, which meets legal obligations and nationally agreed standards.
- 2.2 The Policy and the ECT protocol (Appendix A) provide assurance that the Trust meets legal requirements in relation to capacity and consent and the use of the Mental Health Act (MHA) and Mental Capacity Act (MCA). It also sets standards in relation to the ECT Clinic facilities, the assessment and preparation of patients, the administration of ECT, anaesthetic practice, recovery and monitoring and special precautions in particular patient groups. Clinical audit standards for ECT (Appendix B) are based on national guidance including relevant NICE Clinical Guidelines (Technology Appraisal 59, 2003 and Clinical Guidelines 90, Depression in Adults, 2009).
- 2.3 The Royal College of Psychiatrists provides an Electroconvulsive Therapy Accreditation Service (ECTAS). This service oversees the national accreditation of ECT clinics according to agreed standards in line with both the ECT handbook (Royal College of Psychiatrists, 2013) and with NICE. The procedures and requirements of this policy meet ECTAS standards.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate.
- 3.2 The **Lead Director** is the Medical Director.

- 3.3 The **Author** is the ECT Clinic Lead Consultant Psychiatrist and will be responsible for producing written drafts of the document, for consulting with others and amending the draft as appropriate. The document will be reviewed at least every three years or sooner if there is a major change to law, legislation or circumstances arise which have significant impact on this document.
- 3.4 Responsibility for implementing the policy is devolved to **Heads of Division**.
- 3.5 The Head of **Corporate Business** has responsibility for holding the central database of procedural documents, including this policy, and for providing quarterly reports to the Regulation Governance Group highlighting which policies are due for review. The Corporate Governance Team also has responsibility for dissemination of the final document and archiving old versions.
- 3.6 **All medical, pharmacy and inpatient nursing staff** including temporary staff are individually responsible for their actions including complying with this policy. All staff who may be involved in the use of ECT must adhere to this policy and appendices, including all ECT Clinic staff and also inpatient and community staff who refer patients for ECT.
- 3.7 The **Improving the Quality of Mental Health Inpatient Services Best Practice Group** has responsibility for undertaking audit and signing off key recommendations.

4. EXPLANATION OF TERMS USED

ECT Electroconvulsive Therapy

ECTAS Royal College of Psychiatrists Electroconvulsive Therapy Accreditation Service

IQUIS Improving the Quality of Mental Health Inpatient Services Best Practice Group

MHA Mental Health Act (1983)

MCA Mental Capacity Act (2005)

Section 58 The Section of the MHA dealing with treatment requiring consent or a second opinion. Section 58A deals specifically with ECT.

Section 62 The Section of the MHA dealing with emergency treatment.

SOAD Second Opinion Appointed Doctor, authorised by the Care Quality Commission to provide an independent second medical opinion on whether it is appropriate for medical treatment for mental disorder to be given under the MHA.

5. ECT PROCEDURES

5.1 Consent and capacity

- 5.1.1 Patients undergoing ECT are provided with appropriate written information to allow them to give informed consent (Appendix C). The patient must be able to understand the information given to them and it must be in a language or format they can easily understand; this may necessitate the use of a professional interpreter. Trust consent forms comply with Department of Health guidelines: Consent Form 1 for consenting patients with capacity (Appendix D) and Consent Form 2 for patients lacking capacity (Appendix E). Consent status is confirmed before each individual ECT treatment (Appendix F).
- 5.1.2 ECT must be considered together with capacity and consent within the current legal framework, which includes the Mental Capacity Act (2005) and the Mental Health Act (1983 with 2007 amendments). Procedures for detained patients (Section 58A and Section 62 of the MHA), are described in paragraphs 5.1.5 – 5.1.8 below, including the use of Forms T4 & 6, the role of the Second Opinion Appointed Doctor (SOAD) and the implications of a valid Advanced Directive.
- 5.1.3 Patients who have capacity and are refusing cannot be given ECT regardless of their legal status (except under Section 62 if ECT is immediately necessary to either save the patient's life or prevent a serious deterioration in their condition). This additional safeguard for ECT was introduced in Section 58A (2007 amendments) which states that "If the patient is capable of understanding the nature, purpose and likely effects of the treatment, then ECT cannot be given without his consent. If the patient lacks capacity then ECT must be certified as "appropriate" and must not conflict with an advance decision (which the registered medical practitioner concerned is satisfied is valid and applicable) or with a decision made by a donee or deputy or by the Court of Protection."
- 5.1.4 **Capacity Assessment:**
- The Mental Capacity Act (2005) states that there should be an initial presumption that every adult has capacity. In order to have capacity to make a particular decision the patient must be able to:
 - understand the information relevant to the decision.
 - retain that information long enough to make a decision.
 - weigh up the pros and cons of the information and come to a decision and
 - communicate their decision.

- A valid and applicable advance decision refusing ECT must be respected; it holds the same status as a refusal by a capacitated patient. If it relates to life saving treatment, then the advance decision must be made by a person with the capacity to do so, in writing, signed by the author and witnessed. It must also relate specifically to the treatment being considered and contain the words “even if life at risk”.
- If a person lacks capacity then an Independent Mental Capacity Advocate (IMCA) must be appointed when the decision being made concerns ECT and the person has no-one (or only paid carers) who can be consulted as part of the best interests decision making process.
- It is not permissible to assume consent in informal patients who lack capacity, but who appear to comply with treatment. Compliance does not equate to consent.

5.1.5 Patients **with Capacity who are Consenting** to ECT:

- Outpatients and informal inpatients must sign the Trust Consent Form (Consent Form 1, Appendix D)
- Detained patients under Section 2, 3 or 37 of the Mental Health Act (MHA) must sign the Trust Consent Form (Consent Form 1, Appendix D) and the Approved Clinician in charge of treatment must also complete and sign Form T4 (Section 58A(3))
- No detained child or young person under 18 may be given ECT for mental disorder unless it is approved by a SOAD (the Approved Clinician cannot authorise).
- Ongoing consent cannot be assumed and before each treatment the ward staff, and particularly the doctor, must ensure the consent remains valid. The ECT clinic staff will also check with the patient that they continue to consent to treatment (Appendix F).

5.1.6 Patients **lacking Capacity**:

- **Informal Patient:** the doctor will need to comply with the Mental Capacity Act and may consider whether use of the Mental Health Act / SOAD is indicated. Until then Consent Form 2 (Appendix E) must be completed, which involves the family +/- an informal second opinion. Emergency ECT can be given on a best interest basis in to save the patient’s life.
- **Detained Patient:** ECT may be given if approved by a SOAD on Form T6 (Section 58A(5)), a process that includes consideration of any valid Advanced Directive. If awaiting the SOAD would jeopardise the patient’s life, one or two emergency treatments may be given under the provisions of Section 62. The Royal College of Psychiatrists position is that it is good practice for the Approved Clinician in charge of treatment to discuss the case with a colleague and document this discussion in the notes i.e. treat as a second opinion. A separate Section 62 Form must be completed for each individual ECT treatment. If there is a delay in the SOAD attending despite a timely request, it is permissible to complete further Section 62 forms to ensure that ECT treatment continues until properly sanctioned. If capacity returns during the

course of treatment, then further treatments cannot be given, unless the patient consents (they must sign the Trust Consent Form 1 (Appendix D)) and the Approved Clinician completes Form T4.

5.1.7 **Summary table of Consent and Capacity with required forms:**
Assessment of patients over 18 years for ECT in England and Wales.

Legal Status	Has Capacity?	Resisting or objecting?	Recommended action
Informal	Yes	No	Treat under normal rules of written consent (Consent Form 1, Appendix D)
	Yes	Yes	Cannot treat with ECT
	No	No	It may be possible to treat under Section 5 of the Mental Capacity Act. Independent opinion (informal) advised. (sign consent form 2, Appendix E)
	No	Yes	Not appropriate to use the Mental Capacity Act. If ECT is to proceed, the patient may need to be detained under the Mental Health Act + SOAD
Detained (where Part IV of the Mental Health Act applies)	Yes	No	Treat with written consent that must be certified on (form T4)
	Yes	Yes	Cannot treat with ECT except to save life or prevent serious deterioration (Section 62)
	No	No	Treat if approved by SOAD from CQC on (Form T6)
	No	Yes	Treat if approved by SOAD from CQC on (Form T6)

(From the royal College of Psychiatrists ECT Handbook, 3rd edition, 2013)

5.1.8 Statutory forms are available on the Trust intranet or from [http://www.mentalhealthlaw.co.uk/Mental Health Act 1983 Statutory Forms](http://www.mentalhealthlaw.co.uk/Mental_Health_Act_1983_Statutory_Forms)) (click here to download all forms):

Form T1: is used as consent to treatment for invasive procedures.
Form T2: is for detained but consenting patients for medication.
Form T3: is the SOAD Certificate for approving medication [Form T4 to T6 apply only to ECT].
Form T4: Is for use in a detained patient, who has capacity and is consenting to ECT treatment.
Form T5: Concerns ECT treatment in the under 18 years of age.
Form T6: Is the SOAD Certificate for those lacking capacity.

5.1.9 Complete records are made on the patient electronic record (RiO). However, all consent forms are also retained in paper format in the ECT clinic files along with the ECT Prescription and Record Sheets (Appendix H).

5.2 Preparation of the patient for ECT

- 5.2.1 Preparation for ECT is crucial and must include the patient's own consultant in the referring medical team (or another psychiatrist on the Specialist Register) giving a full explanation of the procedure to the patient and, whenever applicable to the family / carer. This explanation must include discussion of potential benefits and risks, including side effects. Information must be given to the patient in a language or format they can easily understand; this may necessitate the use of a professional interpreter.
- 5.2.2 Informed consent must be obtained from the patient before commencing the course of ECT (see 5.1 above). An entry must be made in the Electronic Patient Record confirming assessment of capacity, the provision of relevant information and the consenting process. All relevant paperwork (Consent Forms and Forms T4 or T6) must accompany the patient to the clinic.
- 5.2.3 Since some medical conditions can increase the risk associated with ECT, it is important that all patients being considered for ECT are clinically evaluated before treatment. The information given to the patient during the consent procedures must include relevant individual risk factors as well as more general information. All patients must have had a comprehensive physical assessment and clinical investigations as indicated. These include an ECG for all patients over 50 (or, in younger people, if there are cardiac or respiratory problems). A Full Blood Count, Urea & Electrolytes and Creatinine should be taken in all patients. All this information must be documented in the Specialist ECT Assessment forms (Assessment>Specialist>ECT>Preparation for ECT).
- 5.2.4 Other clinical investigations should be undertaken as appropriate, including Chest X-ray, blood Glucose, Clotting Studies and Sickie Test.
- 5.2.5 Patients must have all relevant documentation entered into the Rio Core Assessment, Care Plan and Specialist ECT Assessment forms.

- 5.2.6 All patients must be graded by the prescribing doctor, as per the ASA (American Society of Anaesthesiologists) Guidelines. Details of this grading system can be found on the ECT Prescription Sheet (See Appendix H).
- 5.2.7 The doctor at the ECT clinic or the patient's usual consultant (or their deputy) must prescribe each individual ECT treatment on the appropriate Trust form (ECT Prescription Sheet - Appendix H). The ECT Clinic medical staff will determine the dose of ECT to administer (See ECT Protocol – Appendix A, Section 6).
- 5.2.8 The patient's own consultant (referring medical team) must indicate whether they wish the patient to receive unilateral or bilateral treatment; this must be documented on Consent Form 1 (Appendix D), along with the maximum number of treatments to be given. These decisions may be taken in collaboration with one of the ECT clinic doctors.
- 5.2.9 Referrals for ECT must be made in writing using the Trust ECT Clinic email address ('ECT' in the Global Address List). Referrals must be made at least two working days in advance and the referral must be acknowledged and accepted by the ECT Clinic team prior to the patient being sent for ECT.
- 5.2.10 The referring medical team must inform the ECT clinic staff of any special consideration regarding the patient (e.g. physical needs or disturbed behaviour), and highlight any potential problems.
- 5.2.11 Every effort should be made to identify and treat (or at least stabilise) physical conditions prior to ECT. In high risk patients an appropriate medical or surgical opinion should be sought to clarify the degree of risk and to identify ways of minimising the risk. An anaesthetic opinion may be sought at this stage. There should be discussion with the ECT Clinic team. In some patients it may be necessary to administer ECT in a general hospital site (i.e. Musgrove Park Hospital). Although ECT is generally a low risk procedure, cardiac and neurological risk factors are relevant in that, in addition to the anaesthetic itself, the ECT itself has direct physiological effects: (a) sinus bradycardia, sometimes asystole and then a compensatory tachycardia and (b) increase in intracranial pressure, cerebral blood flow and cerebro-vascular permeability. Patients with unstable cardiac disease and space occupying cerebral tumours leading to raised intracranial pressure are therefore at increased risk.
- 5.2.12 Cardiac pacemakers must be checked before ECT commences. Other relevant conditions include oesophageal reflux, insulin dependent diabetes, advanced glaucoma, and also bone / joint disease conferring an increased risk of fracture.
- 5.2.13 On the day of treatment, the patient must be nil by mouth from midnight, although they can take their morning medications with a few sips of water. If the patient is receiving medication likely to reduce seizure activity, the ECT clinic staff should be informed and whenever practical the anticonvulsant dose should be minimised prior to starting a course of ECT. Omission of a regularly prescribed

benzodiazepine for the whole day prior to ECT is generally not recommended and can sometimes lead to withdrawal symptoms and agitation. However, benzodiazepine night sedation should generally be omitted on the evening prior to ECT. On arrival in the ECT Clinic the patient will be encouraged to empty their bladder.

5.3 Environment and facilities

5.3.1 ECT is provided at Wellsprings Clinic on the Cheddon Road campus in Taunton. The ECT suite consists of separate entrance and exit, with a waiting area, treatment room, recovery area and post-recovery sitting room. This is a purpose-built facility and meets ECTAS standards. ECT is conducted on Tuesday and Friday mornings.

5.3.2 The ECT Suite must be equipped to provide safe treatment. Equipment must include:

- an ECT machine of modern design, serviced as per the manufacturer's guidelines and possessing a dual-channel EEG facility (Thymatron)
- a tipping trolley for all patients,
- bottled oxygen, and back-up cylinders,
- resuscitation equipment (including equipment and resuscitation drugs as stated in the Trust Resuscitation Policy and other medications as advised by the Head of Medicines Management),
- a defibrillator,
- an electro-cardiograph
- suction in both the treatment room and recovery area.

5.3.3 ECT is given in accordance with the ECT machine manufacturer's guidelines and the stimulus dosing guidelines (See ECT Protocol – Appendix A, Section 6).

5.4 Staffing

5.4.1 Safe ECT requires a well trained multidisciplinary team who meet the training requirements set out in Section 5.4 and Section 6.

5.4.2 Anaesthetic staff

5.4.3 There must be a Consultant or Associate Specialist Anaesthetist and also dedicated support from an Operating Department Assistant, dually-trained anaesthetic nurse or another professional deemed to be qualified by the Head of the Department of Anaesthesia. The anaesthetic cannot be performed by a trainee anaesthetist.

5.4.4 **Nursing staff**

5.4.5 Nursing cover for safe ECT requires the presence of registered mental health nurses who meet the competencies and training requirements stated in Section 6. The minimum staffing requirement is a lead clinic nurse and at least one other registered mental health nurse. Additional nursing staff may be required depending on the nature and number of patients treated in the ECT clinic session.

5.4.6 Inpatients must be conveyed to the ECT clinic by a registered nurse who will remain with them in the waiting area, during treatment in the recovery room and following recovery. The nurse accompanying the patient to ECT must be familiar with the legal status and the physical and mental state of the patient. Outpatients do not need to be escorted by a registered nurse but must be accompanied by a named responsible adult in all cases; however this is subject to individual risk assessment (See ECT Protocol, Appendix A, Section 1). Nursing staff in the ECT Clinic must complete the Day Patient Aftercare Form (Appendix G) before the patient leaves the department.

5.4.7 Nursing staff in the ECT clinic will be under the supervision of the Lead Clinic Nurse. If the Lead Clinic Nurse believes that the number of staff or patients compromise safe practice, he/she will consult with the anaesthetist and psychiatrist with a view to cancelling the session.

5.4.8 Patients are nursed on a 1:1 basis in recovery, until fully-oriented and safe to sit up. They will then be escorted to the ECT Clinic lounge, where they will be offered refreshments, as appropriate. Patients will be retained in this area until they are feeling well enough to return either to the inpatient environment, or if an outpatient, to return home.

5.4.9 The Lead Clinic Nurse is responsible for preparing the treatment room and recovery area and to ensure that:

- clean linen is available for trolleys
- suction and oxygen is available, and functioning, in the recovery and treatment areas
- resuscitation equipment, drugs, and defibrillator are available
- equipment in 5.3.2 above has been checked and this has been recorded in the ECT and recovery room checklist
- the ECT machine is checked and prepared for use, and electrolyte gel is ready for the electrodes
- anaesthetic drugs and bite blocks are available together with monitoring equipment
- the pre-operative checklist is completed for each patient, and pulse blood pressure and temperature is recorded
- the identity of patients receiving treatment is confirmed with the patient and the escorting nurse or the accompanying responsible adult and a name band attached
- the ECT Prescription and Consent Form are valid

- a record of treatment is maintained in the ECT record folder situated in the ECT Clinic.

5.4.10 Nursing staff are responsible for caring for the recovering patient as follows:

- recognise the deteriorating patient and inform the Lead Nurse and anaesthetist of any relevant change in the patient's condition
- recognise a threatened airway and respond appropriately
- record physiological observations (oxygen saturation, pulse, blood pressure respiratory rate and temperature) initially once every 5 minutes
- allow the patient to sleep until the effect of the anaesthetic has worn off
- re-orientate the patient to reality as his/her level of consciousness increases.
- ease the patient to a sitting position on the side of the bed
- once the patient's observations are satisfactory, at least two staff must walk the patient to the lounge area and offer refreshments
- assist the patient with personal appearance, re-arranging clothing, replacing teeth etc.
- Continue to observe the patient and assess for physical complaints such as headache, pain, dizziness etc. and report any concerns to the ECT Clinic doctor for analgesia or any other appropriate intervention
- re-assess physiological observations and ensure these are satisfactory prior to removing the iv cannula and allowing the patient to leave the department

5.4.11 **Medical staff**

5.4.12 The ECT Clinic psychiatrist must be trained and competent in ECT procedures. Competency to perform ECT is determined by the ECT Clinic Lead Consultant. At present, there are no national standards for competency in delivering ECT, so the Trust accepted standards devised by the Scottish ECT Network. These are appended at Appendix I. The Royal College ECT handbook now contains similar competency standards. The Trust's ECT Clinic Lead Consultant will themselves have demonstrated competency in ECT within their CPD Portfolio.

5.4.13 ECT is routinely delivered by consultant psychiatrists or associate specialists in psychiatry as well as advanced psychiatric trainees undertaking a special interest session. Core psychiatric trainees working on the campus will be encouraged to learn about the safe administration of ECT and develop competencies needed for unsupervised practice.

5.4.14 The ECT Clinic psychiatrist is required to remain in the ECT Suite until all patients are fit to leave.

5.4.15 Consultant and associate specialist psychiatrists will have ECT recognised within their Job Plans.

5.4.16 The Royal College of Psychiatrists' position is that referring doctors who consent patients must be competent in the theory and practices of ECT. In Somerset

consent must be undertaken by the referring consultant or by another psychiatrist on the Specialist Register.

5.5 Documentation

5.5.1 There is a dedicated ECT section on RiO (Assessments > Specialist > ECT) and this must be completed for each patient referred for ECT. Some paper records are also used in parallel with the electronic system:

- Patient Information Sheets (Appendix C)
- Patient Consent Forms (Appendices D - E)
- ECT Prescription and Record Sheets (Appendix H)

5.5.2 The RIO forms provide a framework for the key actions and decisions required for deciding on and arranging safe and effective ECT. There are six fields which follow the patient through treatment. These are listed below and must be completed by the staff listed in brackets below:

- Deciding on ECT (Referring Medical Team – on referral)
- Pre-treatment Update (Referring Medical Team – twice weekly prior to each ECT treatment)
- Pre-treatment Update (Referring Nursing Team – on the morning before each ECT treatment)
- ECT Treatment (ECT Clinic Nursing Staff – on arrival in the ECT Clinic)
- ECT Treatment (ECT Medical Team – after completion of each ECT treatment)
- Summary of ECT Course (Referring consultant / medical team – at the end of a course of ECT)

6. TRAINING REQUIREMENTS

6.1 To provide good quality, safe ECT, it is essential that all ECT Clinic medical and nursing staff attend the annual conference run by The Royal College of Psychiatrists, at a frequency no less than every other year.

6.2 All ECT clinic staff are required to undergo Immediate Life Support training (ILS) and to have an annual refresher.

6.3 Competency requirements have been adopted for medical staff in line with Royal College of Psychiatry recommendations (Appendix I).

6.4 Nursing staff should be trained and competent in performing an electrocardiogram (ECG).

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has

identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 Process for Monitoring Compliance

8.2 Audit of this policy is incorporated into the Trust Clinical Audit plan and appropriately prioritised according to an agreed system for determining the frequency of audit. Clinical audit standards are included in Appendix B. These standards are based on the recommendations in the NICE Technology Appraisal (TA59, 2003) and, for patients with depressive illness, the NICE Clinical Guidelines on Depression in Adults (CG90, 2009). The responsibility for undertaking audit and signing off key recommendations is held by the Medical Audit Group and is overseen by the Clinical and Social Care Effectiveness Group.

8.3 The ECT Clinic and the operation of this policy are also subject to external evaluation and accreditation by ECTAS.

8.4 Complaints which are relevant to ECT are reviewed and amendments made to this policy as appropriate. Any learning points are forwarded to the IQUIS Best Practice Group and disseminated across the Trust as appropriate.

8.5 Clinical incidents, national ECTAS standards and other learning points are discussed in the ECT Business Meeting and amendments are incorporated into this policy when indicated. Any learning points are forwarded to the IQUIS Best Practice Group and disseminated across the Trust as appropriate.

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent

Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 11:	General
Regulation 12:	Statement of purpose
Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents
Regulation 22A:	Form of notifications to the Commission (although this is in Part 5, it relates to regulations in Part 4).

10.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

Relevant National Requirements

See section 11 below

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References

- National Institute for Clinical Excellence, Technology Appraisal 59, Guidance on the use of electroconvulsive therapy. April 2003.
- National Institute for Clinical Excellence, Clinical Guidelines 90, Depression in Adults. The Treatment and Management of Depression in Adults. Updated edition. October 2009
- The Royal College of Psychiatrists' ECT Handbook, Third Edition, 2013.

Cross reference to other procedural documents

Consent and Capacity to Consent to Treatment Policy
Hand Hygiene Policy
Infection Prevention and Control Policy
Learning Development and Mandatory Training Policy
Record Keeping and Records Management Policy
Resuscitation Policy
Risk Management Policy and Procedure
Staff Mandatory Training Matrix (Training Needs Analysis)
Untoward Event Reporting Policy and procedure
Serious Incidents Requiring Investigation

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

12 APPENDICES

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	ECT Clinic Protocol
Appendix B	Clinical Audit Standards
Appendix C	Royal College of Psychiatrists Patient Leaflet
Appendix D	Consent Form 1 – Patient Agreement to ECT
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**SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
ECT CLINIC PROTOCOL**

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- 8. COGNITIVE ADVERSE EFFECTS**

1. OUTPATIENT ECT

- 1.1 Extra care needs to be taken with outpatients undergoing ECT. Outpatients must be escorted both to and from the ECT clinic by a named responsible adult. The named responsible adult and/or the patient must confirm in writing that they will observe the limitation on drinking alcohol, operating machinery and signing legal documents 24 hours following discharge. Outpatients must be escorted from the waiting room through ECT and recovery by registered nurse, ODA (Operating Department Assistant) or doctor.
- 1.2 Appendix J provides details concerning the roles and responsibilities of the member of staff escorting the patient to ECT. A registered nurse will be required unless the patient is progressing well, is reasonably settled and there are no specific identified risks.
- 1.3 As the patient will be coming from their own environment, extra care must be taken to ensure that the patient has been nil by mouth. As part of the pre-ECT work up, outpatients and their carers will have been provided with the Trust's leaflet on Outpatient ECT. The community staff, and clinic staff, must ensure that the patient on leaving the ECT Clinic is returning to a place where there is an appropriate adult to care for them, and that they must not operate machinery during the remainder of the day. Patients should be advised not to drive for a 3 month period. The ECT Clinic nurse must complete the Day Patient Aftercare Form (ECT Policy - Appendix G).
- 1.4 The Patient's consultant must assess the patient's suitability to undergo ECT on an outpatient basis.
- 1.5 The patient's consultant must explain nature of the treatment to the patient and ensure consent form is completed.

- 1.6 The patient's consultant must ensure all physical investigations are carried out prior to treatment (e.g. bloods, ECG).
- 1.7 A member of the CMHT must visit the patient at home to assess home environment and determine suitability for outpatient ECT (e.g. family support).
- 1.8 A member of the CMHT must ensure the patient is aware of the need to refrain from eating and drinking from midnight prior to treatment.
- 1.9 Travel arrangements must be made to ensure the patient is accompanied to and from hospital.
- 1.10 The date for the commencement of ECT must be arranged between the patient, CMHT staff (usually the care coordinator), ECT clinic staff and the patient's consultant.
- 1.11 The patient must have an up-to-date Care Plan. The Rio Core Assessment must include all relevant information, e.g. diagnosis, current medication, allergies, physical health, support at home etc. The patient should be advised to bring with them any medications or inhaler that they may require.
- 1.12 On arrival for first treatment, the patient must be seen and assessed by the anaesthetist.
- 1.13 The patient must remain in the ECT Clinic for at least two hours following treatment or longer if it is felt by staff that they are not in a fit condition to travel.

2. DRIVING

- 2.1 Royal College of Psychiatrists guidance is that patients should not drive for three months after completing a course of ECT. This is in line with general guidance for depression. Patients are required to inform DVLA about the nature of their illness, and that they are receiving ECT treatment.
- 2.2 Patients receiving maintenance ECT in whom depression is in remission for 3 months need only refrain from driving for 48 hours after each ECT treatment.

3. UNILATERAL VERSUS BILATERAL TREATMENT

- 3.1 The choice of unilateral -v- bilateral electrode placement remains a decision largely to be taken by the patient's own consultant from the referring medical team. The Royal College of Psychiatrists' Patient Information Leaflets (Appendix C) makes reference to electrode placement and this issue must be discussed with the patient when obtaining consent.
- 3.2 Unilateral electrode placement confers a lower risk of cognitive adverse effects. However, the potential advantage that unilateral ECT confers in terms of side

effects is offset by the requirement for an increased dose to achieve an equivalent therapeutic effect and often a greater number of treatments need to be given due to a slower onset of action.

- 3.3 More information can be found in the Royal College of Psychiatrists' ECT Handbook (2nd Edition). It is recommended that the patient's medical staff liaise with staff at the ECT Clinic when deciding on electrode placement and that there should be flexibility during the course, i.e. moving from unilateral to bilateral or vice-versa depending on the clinical state of the patient.

4. **CONTINUATION AND MAINTENANCE TREATMENT**

- 4.1 Continuation ECT is defined as ECT used to prevent relapse of an index episode of illness. It is prophylactic ECT used over the first 6 months of remission.

- 4.2 Maintenance ECT is defined as ECT used to prevent further episodes or recurrence of illness over a longer period. Maintenance ECT is usually reserved for those whose illness recurs after continuation ECT. It may also be considered for patients who express a preference for it.

- 4.3 Continuation ECT should be considered for patients who have a relapsing or refractory depression that has previously responded well to ECT, but for whom standard pharmacological and psychological continuation treatment is ineffective or inappropriate. Indicators include:

- the index episode responded well to ECT
- there is early relapse (0-6 months) despite adequate continuation drug treatment or an inability to tolerate continuation drug treatment
- the patient's attitude and circumstance are conducive to safe administration
- past history of repeated relapse because of poor adherence to medication
- patient preference

- 4.4 Continuation and maintenance ECT requires a properly documented assessment of the potential risks and benefits of treatment for which valid informed consent has been obtained. Patients who are considering continuation treatment will have the personal experience of previous ECT, which will help them to weigh the potential benefits and adverse effects of treatment.

5. **DISCONTINUATION OF ECT**

- 5.1 ECT will be discontinued for a variety of reasons. These include:

- satisfactory therapeutic response
- withdrawal of patient consent.
- deteriorating physical health posing unacceptable anaesthetic risk.
- development of unacceptable side-effects.

- 5.2 The decision to discontinue treatment must be made by the patient's own consultant in the referring medical team, together with the patient and, if

appropriate, their carer. This information must be communicated to ECT Clinic staff and the information concerning discontinuation must also be included on the dedicated ECT field in RiO (i.e. in “Summary of the ECT Course”).

- 5.3 The aim of ECT should be remission of symptoms with a minimum of side effects. Some improvement in symptoms of depression after 6 treatments predicts subsequent remission. The majority of remissions occur before the ninth treatment. However 40% of patients who have not responded after six treatments go on to remission. No definitive advice can be given to cease ECT if there is no response after six treatments, but if there has been no response at all at that stage, then the referring consultant may wish to reassess the need for ECT and consult with the patient. A patient who has had no response at all after 12 treatments is unlikely to have a sustained response to ECT. The decision to stop ECT needs to be taken in the context of the severity of the condition, the range of other treatments still available and the clinical risks in the individual patient.
- 5.4 Assessment of satisfactory response should include a validated standardised clinical instrument. The most practical is the Clinical Global Impression (CGI) scale. This has the advantage that it is not specific to any one disorder. The CGI should be used at baseline, during the course of ECT and when treatment has been completed. Outcome measures must be done by the referring clinical team.

6. STIMULUS DOSING GUIDELINES (THYMATRON DGX)

- 6.1 Best practice dictates that patients receiving ECT undergo a stimulus dosing regime. The observed seizure is timed to the end of bilateral lower limb movement. The ECT machine allows for EEG monitoring of the seizure length. EEG seizures should have at least two of the following three elements: a recruitment phase, 3 per second spike and wave activity and post-ictal suppression (compared to the baseline test EEG). The aim is to induce a bilateral modified seizure of at least 15 seconds duration
- 6.2 The aim is to establish the lowest energy setting for an effective seizure. A seizure occurs at Seizure Threshold (ST), with effective ECT needing a higher dose, the Treatment Dose (TD). For bilateral ECT the TD is 1.5 – 2 times the ST and for unilateral ECT the TD is 5-8 times the ST.

6.3 FIRST STIMULATION:

	LEVEL	%
Age under 25 Female Unilateral	1	5
Female bilateral; Male Unilateral	2	10
Male Bilateral	3	15
	4	20
	5	45
	6	60
	7	70
	8	100
	9	150
	10	225

Add one level: if on benzodiazepines/anticonvulsants; if ECT within one month; aged 65+. (these are NOT additive).

6.4 **SECOND STIMULATION:** If inadequate seizure on first stimulation after 20 seconds, add one level and re-stimulate.

6.5 **THIRD STIMULATION:** If inadequate seizure on second stimulation after 20 seconds, add a further 2 levels. No more than 3 stimulations are to be given per treatment session.

6.7 **NEXT TREATMENT SESSION:** If seizure occurred on the first or second stimulation, this shows the ST. The TD will be the ST +1 level for Bilateral ECT and the ST +3 levels for Unilateral. If the seizure occurred on the third stimulation, then re-stimulate at 2 levels lower to try and establish the ST. If no seizure was elicited on the third stimulation, add one level and continue titration.

6.8 **THIRD AND SUBSEQUENT TREATMENTS:** ST rises during treatment. If the duration of the seizure reduces by 20% or more, increase by one level. If cognitive side effects are problematical reduce by one level or consider changing to unilateral stimulation. For poor response increase by 1 level (2 levels for Unilateral).

Note: EEG should be the standard, not clinical observation. Thymatron EEGs have an ictal line to assist in interpretation. With an EEG, it is prudent to run off a baseline measure before application of ECT.

7. MANAGEMENT OF LONG FITS

7.1 A seizure of above two minutes duration should be terminated with Diazemuls or more of the anaesthetic drug, whichever the Anaesthetist prefers, this medication should be drawn up at 90 seconds so it is ready to be given at 120 seconds.

8. COGNITIVE ADVERSE EFFECTS

- 8.1 Cognitive adverse effects are a major concern for many patients. Orientation and memory should be assessed before and at intervals throughout the course of treatment, then again at the end of treatment. Severe depressive illness, particularly in older adults, can affect memory, and tests of memory carried out before and after ECT may show improvements, presumably because the memory deficits associated with depression have improved in response to treatment.
- 8.2 Electroconvulsive therapy causes dysfunction in a wide variety of cognitive skills that is over and above that caused by the patient's pre-existing depression. This is clearly and significantly present in the first few days after ECT but then begins to improve and usually remits within 2-3 weeks of the end of a course of ECT. However, autobiographical memory can be affected by ECT for up to 6 months after the end of an ECT course; there are also reports of more severe and more persistent dysfunction
- 8.3 Specific standardised tools do not exist. It is recommended that teams responsible for the patient's on-going care ask the patient about any memory difficulties and document these discussions. Evidence can be collected from simple assessments such as the Folstein Mini Mental State Examination. Observed deterioration in cognitive function must be the subject of discussion between ECT clinic staff and the patient's own consultant in the referring medical team. Possible interventions include ceasing the ECT, reducing the dose, changing from bilateral to unilateral stimulation and reducing the frequency of the treatments.

ECT CLINICAL AUDIT STANDARDS			
Standard	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
1	100%	None	ECT is very occasionally used in those with a schizophrenic illness, who are markedly unwell, and who have failed to respond to a range of conventional treatments. Use of ECT in these cases must be endorsed by a second senior doctor and discussed with family members (and these discussions are to be documented).
2	100%	Patient choice	If a patient has previously had a positive experience and positive response to ECT, their electing for this treatment should be taken into account.
3	100%	None	Risks are increased in pregnancy, older people, children and young persons. The risk assessment should include risks associated with anaesthetic, current co morbidities, anticipated adverse events, including cognitive impairment, and the risk of no treatment

ECT CLINICAL AUDIT STANDARDS

Standard	Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
<p>4</p> <p>Consent procedures. Valid consent should be obtained and consent procedures should involve advocates/carers where appropriate and should take into account advance directives</p>	100%	Valid consent will not be obtainable where the patient lacks capacity, and may not be obtained where treatment is under the Mental Health Act	None
<p>5</p> <p>Provision of information to patient and others. Information should be provided to the patient and where appropriate to advocates/carers, which includes information about general and specific risks of ECT, and indicates that the patient is able to withdraw consent at any point.</p>	100%	None	None
<p>6</p> <p>Reassessment after each treatment. The patient's condition should be reassessed after each treatment</p>	100%	None	None
<p>7</p> <p>Reassessment of cognitive status. Cognitive function should be reassessed on an ongoing basis and at least at the end of any course of treatment</p>	100%	None	None

ECT CLINICAL AUDIT STANDARDS

Standard		Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
8	<p>Repeat courses of ECT. A repeat course of ECT should only be considered where the diagnostic criteria for treatment are met and the patient has previously responded well to ECT, or where all other options are less satisfactory</p>	100%	None	None
9	<p>Individuals having ECT should be asked to comment on adequacy of consent procedures, information and reassessment. User satisfaction with procedures should be carried out on a routine basis</p>	100%	None	None
10	<p>Treatment should be stopped if a response is achieved, adverse effects occur or the patient withdraws consent</p>	100%	Valid consent will not be obtainable where the patient lacks capacity, and may not be obtained where treatment is under the Mental Health Act	The reasons are to be recorded in progress notes detailing the adverse effects
11	<p>ECT should not be used as a maintenance treatment for depressive illness</p>	100%	Good past response to ECT and failure to respond to all other reasonable treatment options, with patient consent	Patient choice should be an important factor in agreeing to maintenance ECT.



Information on ECT

This leaflet is for anyone who wants to know more about ECT (Electro-convulsive therapy). It discusses 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 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.

It can change patterns of blood flow through the brain. It can change the metabolism of areas of the brain which may be affected by depression. 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 cells and nerve pathways 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 does have a benefit as might be expected. 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 of Health and Clinical Excellence (NICE) have looked in detail at the use of ECT and have said that it should be used only in depression, resistant mania or catatonia.

They say ECT should be considered for acute treatment of severe depression that is life-threatening and when a rapid response is required, or when other treatments have failed.

It should not be used routinely in moderate depression, but should be considered for people with moderate depression if their depression has not responded to multiple drug treatments and psychological treatment.

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?

ECT has been shown to be the most effective treatment for severe depression. 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 seriously considering suicide.

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 dizzy-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 80,000 treatments, around the same level of risk in dental anaesthesia. However, as ECT is given in a course of treatments, the risk per course of treatment will be around 1 in 10 000.

▪ Long-term

The greater concern is that of the long-term side effects, particularly memory problems. Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10. Service 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. 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 declines 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 an advocate 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. You could write an 'advance decision to refuse ECT' to make clear how you want to be treated if you become unwell again. Alternatively you could appoint someone to be your Health and Welfare Attorney to make decisions on your behalf when you are not able to decide for yourself.

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.

You cannot be given ECT against your wishes, even if you are sectioned under the Mental Health Act. 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 their illness 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, ECT can be given under the Mental Health Act which requires the agreement of two doctors and another professional who is usually a social worker. There must then be 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.

Sometimes - if a person doesn't have the capacity to give an informed consent - the team may decide the ECT can be given under the Mental Capacity Act. This is unusual, as in most cases, the Mental Health Act provides the most appropriate protection for a patient's rights. The Mental Capacity Act can only be used if the patient lacks capacity and a "decision maker" (usually the consultant in charge of their care) decides that ECT is in the patient's "best interests".

It is expected the decision maker will consult with other people to try to find out what the person's views would have been. This would usually include family members and other people close to them. The decision maker should also make "all reasonable attempts" to help the patient to regain capacity to consent (if this is possible). An independent

specialist is not needed, though the clinical team may request a second opinion from another consultant.

Whether ECT is given under the Mental Health Act or the Mental Capacity Act, regular assessments of the patient's ability to understand their treatment must be made. Once they are able to give consent, the treatment can only continue if they do consent and must stop if they refuse.

In Scotland, the principles above are the same, although the laws involved are the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults With Capacity Act (Scotland) 2000.

How is ECT given?

ECT is generally used to treat severe illnesses, so the person having it will often be in hospital. If you do not need to be an in-patient, it should be possible for you to attend as a day patient to have ECT. You may need to check if this is available to you from your local service.

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 produce a seizure lasting between 20 and 50 seconds.

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 tracing 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 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, so you may wish to check with your local team that this is possible, if it is reassuring for you. 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 ECT team will connect monitoring equipment to check your heart rate, blood pressure, oxygen levels, ECG and EEG during the fit.
- 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; your fit will last between around 20 to 50 seconds. 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. You will be free to leave the suite when the staff are happy that your physical state is stable and you 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, there has been concern that it may cause more side-effects.

Unilateral ECT is now used less. It had been thought to cause less memory loss, but recent research has shown that it is necessary to use much larger doses of electricity to make unilateral ECT as effective as bilateral ECT. If the dose of electricity is increased to make it equally effective, the risks of memory loss are as great as with bilateral ECT.

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.

You may wish to speak to the doctor who is suggesting ECT for you to decide whether unilateral or bilateral ECT is best for you.

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 you see any difference, 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, particularly if you have been depressed for a long time. If after 12 treatments you feel no better, it is unlikely that ECT is going to help and the course would usually stop. A member of the mental health team should see you after each treatment to see how you are responding to treatment and check that you are not experiencing any serious side-effects. Your consultant should see you after every two. ECT should be stopped as soon as you have made a recovery, or if you say you 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 you are able to look at why you became unwell. Hopefully you can then take steps to continue your recovery and perhaps find ways to make sure the situation doesn't happen again. Psychotherapy and counselling can help and many people 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?

In 2003 researchers analysed all the work which had been done on patients' experiences of ECT. They found that the proportion of people who had had ECT and found it helpful ranged from 30% to 80%. The researchers commented that studies reporting lower satisfaction tended to have been conducted by patients and those reporting higher satisfaction were carried out by doctors. Between 30% and 50% of patients complained of difficulties with memory after ECT.

Q What do those in favour of ECT say?

Many doctors and nurses 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 therefore 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, though only a small number have prohibited its use.

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, and nurses. 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.

A list of accredited sites is available on the **Royal College of Psychiatrists' website**.

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.

Further Information

National Institute for Health and Clinical Excellence (NICE)

- Electroconvulsive therapy (ECT): the clinical effectiveness and cost effectiveness of electroconvulsive therapy (ECT) for depressive illness, schizophrenia, catatonia and mania. (TA59 2003)
- Depression: the treatment and management of depression in adults (CG 90 2009)

Scottish ECT Accreditation Network (SEAN): A site designed to complement the work of SEAN, by enabling communication of the latest information on ECT in Scotland.

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.

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This leaflet was produced by the Royal College of Psychiatrists' Public Education Editorial Board.<http://www.rcpsych.ac.uk/systempages/donate/donatenow.aspx>

Original author: Dr Richard Barnes

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

This leaflet reflects the best available evidence available at the time of writing.

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Please note that we are unable to offer advice on individual cases. Please see our FAQ for advice on getting help.

CONSENT FORM 1

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

**Adult Patient agreement to ELECTROCONVULSIVE
THERAPY**

<p style="text-align: center;">Patient details (or pre-printed label)</p> <p>Patient's surname/family name.....</p> <p>Patient's first names</p> <p>Date of birth</p> <p>NHS number (or other identifier).....</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Consultant Name.....</p>

To be retained in patient's notes

Patient identifier/label:

NAME OF PROPOSED PROCEDURE OR COURSE OF TREATMENT (include brief explanation if medical term not clear)

A course of Electroconvulsive therapy, up to a maximum of sessions

BILATERAL / UNILATERAL - please specify:

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in Department of Health consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits: Improvement in depression

Other (please specify)

Serious risks: Death (approx. 1 death per 80,000 treatments)

Memory loss

Other (please specify)

.....
Common, transient side effects – headache; muscle aches; nausea; fatigue; weakness; disorientation and confusion

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following patient information leaflet/DVD has been provided

Signed:..... Date

Name (PRINT) Job title

Contact details (if patient wishes to discuss options later)

.....

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date.....

Name (PRINT)

Patient identifier/label:

Copy of Page 2 of Consent Form accepted by patient: yes/no (please ring)

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

Patient's signatureDate.....

Name (PRINT)

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signature Date

Name (PRINT)

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed:..... Date

Name (PRINT) Job title

Important notes: (tick if applicable)

See also advance directive/living will (e.g. Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign /date here)

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent, also available at www.doh.gov.uk/consent

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, some-one with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form.

A patient will not be legally competent to give consent if they are unable:

(a) to understand the information relevant to the decision

- (b) to retain that information
- (c) to use or weigh that information as part of the process of making the decision
- (d) to communicate his decision (whether by talking, using sign language or other means)

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

CONSENT FORM 2

Somerset Partnership NHS Foundation Trust

**Form for adults who are unable to
consent to Electroconvulsive Treatment**

<p style="text-align: center;">Patient details (or pre-printed label)</p> <p>Patient's surname/family name.....</p> <p>Patient's first names</p> <p>Date of birth</p> <p>NHS number (or other identifier).....</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Consultant Name</p>
--

To be retained in patient's notes

Patient identifier/label:

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

A course of Electroconvulsive therapy up to a maximum oftreatments

Bilateral/Unilateral (please specify)

(**NB** see Guidance to Health Professionals on Page for details of situations where Court approval must first be sought)

B 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 understand the information relevant to the decision; and/or**
- the patient is unable to retain this information; and/or**
- the patient is unable to use and weigh this information as part of the process of making the decision; and/or**
- the patient is unable to communicate his decision**(whether by talking, using sign language or other means);

Further details : (for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful)

.....

.....

.....

.....

.....

C Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance decision. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

.....

.....

.....

.....

.....

.....

.....

.....

.....

D Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter, IMCA or other advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare. If an IMCA has been involved, please indicate this below, and note where their written report may be located.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of.....(patient's name). I/We understand that she/he is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name

Relationship to patient.....

Address (if not the same as patient)

.....
.....

Signature

Date.....

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)

Yes No

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature:.....Date

Name (PRINT)Job title

Where second opinion sought, she/he should sign below to confirm agreement:

Signature:.....Date

Name (PRINT)Job title

Guidance to Health Professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult has capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the Mental Health Act 1983, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's Reference guide to consent for examination or treatment (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following must apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND
- the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to understand information relevant to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to retain this information; and/or
- unable to use and weigh this information as part of the decision-making process: and/or
- unable to communicate his decision

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may

often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Change in Capacity status-If the patient's condition alters during the treatment course such that they are deemed to become capacitous, Consent form 1 (Appendix D) will need to be completed. Additionally, if Section 58A (3) applies, a Form T4 will also need completed

Best interests

A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests' decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose physical condition is identical, may therefore have different best interests

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient's capacity or best interests.

**CONSENT FORM 3
(FOR USE IN THE CLINIC BY THE ECT TEAM)**

**Confirmation of consent to ECT
(Electro convulsive Therapy)**

To be completed by patient and ECT clinic staff prior to each session of ECT

- Confirmation of consent to ECT Session
I consent to receiving today's ECT Treatment

Signed:..... Date ..

Name (PRINT)

Consent obtained by:

Signed.....

Name (PRINT)..... Job Title.....

- Confirmation of consent to ECT Session
On behalf of the team treating the patient, I have confirmed with the patient that s/he wants the procedure to go ahead.

Signed:..... Date ..

Name (PRINT) Job title

- Confirmation of consent to ECT Session.....
On behalf of the team treating the patient, I have confirmed with the patient that she/he wants the procedure to go ahead.

Signed..... Date ..

Name (PRINT) Job title

- Confirmation of consent to ECT Session.....
On behalf of the team treating the patient, I have confirmed with the patient that s/he wants the procedure to go ahead.

Signed..... Date ..

Name (PRINT) Job title

**ECT DAY PATIENT AFTERCARE FORM
(FOR USE IN THE CLINIC BY THE ECT TEAM)**

In order to ensure the safety of Day patients following ECT, the following advice must be followed: -

- 1) The patient must be accompanied home by a responsible adult following ECT
- 2) The patient must have appropriate supervision by a responsible adult for 24 hours after ECT treatment
- 3) The patient must not operate machinery for at least 24 hours following ECT and must not drive for 3 months after ECT (except in maintenance ECT when they must cease driving for a minimum of 24 hours)
- 4) The patient must not drink alcohol for at least 24 hours following ECT
- 5) The patient must not sign any legal documents for at least 24 hours following ECT
- 6) The patient must not be responsible for providing childcare and arrangements are in place for dependent children.

ECT Treatment Number.....

I have read and understood the advice for safe aftercare of ECT patients and agree to follow this advice.

Patient's signature :

Carer's signature:

Patient's name (print):

Carer's name (print):

Date:

Date:

ECT SESSION RECORD FORM

Name _____

Prescription:	Session No:	ASA Grading* (✓)	Session No:	ASA Grading* (✓)
Uni/Bilateral		I II III IV V		I II III IV V
Date				
Signature of ECT Clinic Doctor				
Legal Status				

Date of Treatment:		
Anaesthetic agent, dose:		
Muscle relaxant, dose:		
Comments:		
Complications:		
Anaesthetist's Signature:		
1 st Stimulation Dose setting Impedance reeding: Seizure Pattern: Duration (secs): Visible Clonus EEG		
2 nd Stimulation Dose setting Impedance reeding: Seizure Pattern: Duration (secs): Visible Clonus EEG		
3 rd Stimulation Dose setting Impedance reeding: Seizure Pattern: Duration (secs): Visible Clonus EEG		
Plan for next session:		
Post-ECT side-effects:		
ECT Psychiatrist's Signature		

***AMERICAN SOCIETY OF ANAESTHESIOLOGY (ASA) CLASSIFICATION**

- Grade I** No organic, physiological or psychiatric disturbances
- Grade II** Mild/moderate systemic disturbance caused either by the condition to be treated surgically or other diseases, e.g. mild diabetes, anaemia, slightly limiting heart disease, obesity, chronic bronchitis
- Grade III** Severe systemic disturbance, e.g. severe limiting organic heart disease, insulin dependent diabetes, angina, previous myocardial infarction
- Grade IV** Severe, already life-threatening systemic disorders, e.g. organic heart disease with cardiac insufficiency, advanced pulmonary, hepatic, renal or endocrine insufficiency
- Grade V** Patient who has little chance of survival, e.g. rupture of the abdominal aortic aneurism with profound shock.

**ECT Competencies for Medical Staff
Royal college of Psychiatrists 2013**

Levels of Competency

1. Fully conversant (FC)
2. Working Knowledge (WK)
3. Awareness (A)

Areas of Competency

1. Theory and Background
2. Practical Aspects of ECT administration
3. Other Aspects of ECT practice

Required Competencies (see over)

The trainee by year 3 ought to be able to administer ECT without direct supervision, prepare patients for ECT, and explain to patients and relatives about ECT, its indications and broad place within psychiatric treatment. Trainees ought to be able to monitor a patient's mental state and cognitive functioning during a course of ECT.

Consultants and trainees by the end of year 6 ought to have a good understanding of the place of ECT in modern clinical practice sufficient to obtain informed consent from patients, i.e. to reach Level 1 Competency in Theory and Background.

Only consultants responsible for the ECT clinic or senior trainees (ST4-6) with a special interest in the administration of ECT would be expected to have Level 1 competency in the Practical Aspects of the administration of ECT together with achievements in other aspects of ECT practice.

Assessments

Verbal

1. FC (Fully Conversant). Is able to explain accurately all the important features to a level that shows sufficient understanding that would allow them to competently and independently apply the knowledge.
4. WK (Working Knowledge). Is able to explain the key features to a level that shows sufficient understanding that would allow them to apply the knowledge in common situations and access further information if necessary.
5. A (Awareness). Is aware of the topic, but not to a level that provides a WK, and knows where to get further information if necessary.

Observed

1. FC (Fully Conversant). Is able to carry out the procedure to a level that shows sufficient skill and understanding that would allow them to function competently and independently.
2. WK (Working Knowledge). Is able to carry out the procedure to a level that shows sufficient skills and understanding, which would allow them to carry it out in usual situations but to know their limitations and access further help if necessary.
3. A (Awareness). Is aware of the topic, but not to a level that provides a WK, and knows where to get further information if necessary.

Click Below to download the assessment form

<http://www.rcpsych.ac.uk/pdf/ECTcompetenciesJan2013.pdf>

Doctors Name and Grade

Required competencies;

Competency	Level	Competency Number
Foundation doctors		
Theory & Background	Awareness	1-6
Practical aspects of ECT	Not required	
Other aspects of ECT practice a	Not required	
Other aspects of ECT practice b	Not required	
ST1-3		
Theory and Background	Working Knowledge	1, 3-6
	Awareness	2
Practical aspects of ECT	Fully Conversant	1-5, 7
	Working Knowledge	6
Other aspects of ECT practice a	1-5 to be achieved	
Other aspects of ECT practice b	Not require	
ST4-6 & Prescribing Consultants		
Theory and Background	Fully Conversant	1-6
Practical aspects of ECT	Working Knowledge	1-7
Other aspects of ECT practice a	Not required	
Other aspects of ECT practice b	Not required	
ECT Consultants & ST4-6 with Special Interest		
Theory and Background	Fully Conversant	1-16
Practical aspects of ECT	Fully Conversant	1- 7
Other aspects of ECT practice a	Not required	
Other aspects of ECT practice b	1 to be achieved	

Assessments

1. Theory and Background

	Competency	How evidenced	Level	Date	Signature (ECT Consultant)
1	Demonstrate a knowledge of NICE Guidelines relevant to ECT, including TA59	Verbally			
2	Demonstrate an awareness of Royal College guidelines, including ECTAS and SEAN	Verbally			
3	Demonstrate a knowledge of local policies and procedures, including a. emergency ECT b. outpatient ECT c. high risk patient d. continue to ECT e. when ECT should be discontinued f. choice of unilateral and bilateral treatment	Verbally			
4	Demonstrate a knowledge of the Consent to treatment requirements, including MCA and MHA documentation/requirements	Verbally			
5	ECT process: Able to describe a. indications for ECT b. the contra-indications to ECT c. the possible side effects, risks and benefits of ECT d. the pre-treatment preparations required to be undertaken by referring doctor e. the procedure for the administration of ECT.	Verbally			
6	Mechanisms of action: Knowledge of: a. current theories of mechanism of action of ECT b. physiological effects of ECT	Verbally			

2. Practical Aspects of ECT

	Competency	How evidenced	Level	Date	Signature (ECT Consultant)
1	Clinic protocol: a. understand clinic dosing protocol b. understand when to re-stimulate c. understand procedure for prolonged seizure	Verbally			
2	Using the ECT machine: a. attaching EEG leads b. apply electrodes bilateral c. apply electrodes unilateral Impedance testing	Observed			
3	Delivering the dose: a. set correct stimulus	Observed			
4	Monitoring: a. observe motor seizure b. observe EEG monitoring c. understand how to interpret EEG	Observed			
5	Recording: Correct recording of treatment in patient record	Observed			
6	Knowledge of anaesthetics and muscle relaxants used in ECT	Verbally			
7	Basic resuscitation training Note: Fully conversant = training in last year Working knowledge = last 5 yrs	Written			

3. Other Aspects of ECT practice

a)

	Competency	How evidenced	Level	Date	Signature (ECT Consultant)
1	Attended Induction to ECT	Observed			
2	Observed clinical application of ECT	Observed			
3	Supervised clinical application 1	Observed			
4	Supervised clinical application 2	Observed			
5	Supervised clinical application 3	Observed			
6	Supervised clinical application 4	Observed			
7	Supervised clinical application 5	Observed			
8	Supervised clinical application 6	Observed			
9	Additional clinical application 1	Observed			
10	Additional clinical application 2	Observed			
11	Additional clinical application 3	Observed			
12	Additional clinical application 4	Observed			

b)

	Competency	How evidenced	Level	Date	Signature (ECT Consultant)
1	Participation in audit of ECT	Audit reports			
2	Participation in one day of CPD relating to ECT each year	CPD returns			
3	Able to advise consultant colleagues on: a. relative merits of bilateral/unilateral treatment b. suitability of patient for ECT c. drug treatments during ECT d. management of side effects during ECT	Practice			

4	Able to advise colleagues on suitability of patient for ECT	Practice			
5	Involved in regular review of policies and procedures in ECT clinic	Practice			
6	Evidence of training and supervising doctors in training of ECT practice	Practice			

ECT GUIDELINES FOR PATIENT REFERRAL AND ESCORT DUTIES

NOTE: These guidelines have been produced to incorporate guidelines from Royal College of Psychiatrists – The ECT Handbook (2nd ed)

ESCORT NURSES

All patients being escorted for ECT, inpatients and outpatients must be escorted by a staff member trained in Basic Life Support / Immediate Life Support.

The escorting nurse should have:

- A good knowledge of the ECT process, especially the possible side effects (both common and rare) and the nursing actions required in the event of their occurrence
- All escorting staff will be orientated around the clinic environment, especially the location of emergency equipment .

For escorting nurses it is preferable that they should know the patient they are escorting and be aware of their legal status, consent and any possible medical complications. They are required to carry out pre- ECT nursing checks to ensure patients are properly prepared. These checks should include the recording of the patients pulse, respirations, SATS, temperature and blood glucose monitoring (if appropriate). Physical observations should be recorded on RiO prior to the patient arriving at the clinic to allow the ECT medical and nursing team to assess baseline observations prior to the commencement of the patient's treatment. Please ensure that all the relevant documentation is available to take to the ECT clinic including:

- * Medication Administration Record/ print out of electronic prescribing
- * Consent form
- * MHA Paper Work.

The escorting nurse should remain with their patient throughout the whole of the treatment process and provide support during the recovery phase with the recovery nurse working in the clinic until escorted back to the ward. In the cases of out-patients receiving treatment – the escorting nurse should ensure that the patients care is handed over to suitably trained person or a responsible adult when treatment has finished.

Student Nurses may accompany the patient **IN ADDITION** to the escorting nurse if they would normally be involved in the patient's care. Please telephone in advance to arrange this visit, since **only one student per session** can be accommodated, providing the patient is consenting.

GENERAL ARRANGEMENTS

ECT is carried out at Wellsprings Clinic every **Tuesday and Friday morning commencing at 9.00 am.**

Transport must be booked by the referring team **to arrive at the Wellsprings Clinic by 9.00 am.**

Please note that the patient will not be allowed to leave the treatment centre to return home or to their inpatient ward for **possibly up to 2-3 hours after treatment.**

There is no guarantee that patients will receive ECT in any particular order, as this will be decided on the day according to clinical needs. Since the return time therefore cannot be predicted, hospital car service or ambulance transport may be inappropriate. Taxis would be more appropriate because it would cause less disruption to the patient.

Please e-mail the ECT Team as soon as ECT is prescribed for one of your patients. By doing so, it enables us to fully prepare for the patients treatment and ensure that all necessary checks are in place. This is a group e-mail found under Somerset Partnership –ECT.

Once a course of ECT has started we will expect to see the patient every Tuesday and Friday unless the referring team inform us of a change of treatment plan. It would be additionally helpful if ECT attendance could be confirmed on the day **before** treatment by e-mailing the ECT Team and copying in Paula Potts (Rydon Ward manager). If ECT is cancelled or changed please inform us **as soon as possible** as we will need to inform the Anaesthetic Department.

Outpatients should be provided with an information sheet for patients receiving ECT. It is the responsibility of the prescribing doctor to ensure that all the relevant paper work is in place and delivered to the ECT Clinic (most crucially the consent to treatment) prior to treatment commencing.

PRE-ANAESTHETIC ADVICE:

All patients **must not have anything to eat or drink for at least 6 hours before treatment, and normally from midnight on the night before treatment.**

The patient's clothing should be loose and comfortable and provide easy access to limbs for monitoring purposes.

Medication should be given as normal on the morning of treatment, with small sips of water to enable swallowing before 7 am- WITH THE EXCEPTION OF Insulin and antidiabetic tablets –e.g. Metformin, Gliclazide and similar drugs, which should be omitted as the patient is to be fasted.

Psychiatric medication should be given on the morning of treatment, and only omitted at the discretion of the psychiatrist if it is felt that administering them will interfere with the effectiveness of the ECT treatment – e.g. Diazepam and anti- convulsant medication which are thought to elevate the seizure threshold. If you are unsure please arrange to discuss this with ECT staff who will be happy to offer advice and guidance on medication.

If you are running late please phone the Wellsprings Clinic on: 01823 368257.

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