

**DORSET HEALTHCARE NHS TRUST ECT POLICY**

**AREA** Trust Wide

**POLICY SPONSOR:** Lead Consultant for ECT

**IMPLEMENTED** October 2003

**REVISED** June 2006

**DUE FOR REVIEW:** June 2009

		<b>Date Approved</b>
<b>TO BE APPROVED BY:</b>	MAC	June 2006
	NAC	July 2006
	Joint Governance Team	July 2006

**DISSEMINATED TO:** Consultant Psychiatrists  
Operational Directors  
Hospital/Unit Managers  
Modern Matrons/Senior Clinical Nurses  
Ward Managers  
CMHT Managers

<b>Added to Intranet by:</b>	Eileen Weatherill	<b>Date added:</b>	29/09/2006
<b>Directorate:</b>	Risk Management		

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## **1.0 Introduction**

- 1.1 Electro-Convulsive Therapy (ECT) is a well established treatment for a variety of mental disorders.
- 1.2 Dorset Healthcare NHS Trust has a dedicated department which makes ECT available to clinicians and service users.
- 1.3 Dorset Healthcare NHS Trust is committed to maintaining the highest standards in the delivery of ECT.
- 1.4 This policy has been written and will be updated in line with available evidence and best-practice guidelines (see references).

## **2.0 The ECT Team, Roles & Responsibilities**

- 2.1 The ECT Team is based in the Purbeck Suite of St Ann's Hospital.
- 2.2 The ECT comprises:
  - Lead ECT Nurse
  - Registered Mental Health Nurses Registered Nurse and Mental Health Support Worker.
  - Consultant Psychiatrist (Lead for ECT)
  - Consultant and Staff Grade Anaesthetists
  - ODA / ODPs
- 2.3 Roles and Responsibilities of Lead ECT Nurse:
  - 2.3.1 To be responsible for the successful and effective day to day operational management of ECT Department.
  - 2.3.2 To be responsible for the provision of high standards of nursing care and treatment in conjunction with other professionals through the multi-disciplinary assessment and treatment programmes.
  - 2.3.3 To ensure effective on-going supervision and professional development of nursing staff in ECT Department.
  - 2.3.4 To provide training opportunities and information resource for all Trust staff.
  - 2.3.5 To provide advise on management of patients pre and post ECT treatment to nursing staff.
  - 2.3.6 To lead the Royal College of Psychiatrists ECT Accreditation Service (ECTAS) and Professional Development Unit (PDU) process.

- 2.3.7 To attend the national forum for nurses (NALNECT)
- 2.3.8 To attend the South England Special Interest group ECT.
- 2.3.9 To attend the Wessex ECT Committee quarterly.
- 2.3.10 To remain up to date with developments in ECT and attend the Royal College of Psychiatrist's ECT Training Events.
- 2.3.11 To ensure that the department adheres to the medical devices Policy with regular maintenance by the EBME department and pre clinic checks of all devices used.

#### 2.4 Roles and Responsibilities of Lead Consultant:

- 2.4.1 To advise about appropriate treatment facilities.
- 2.4.2 To develop and maintain up-to-date treatment protocols.
- 2.4.3 To oversee training and supervision of psychiatric medical staff in the ECT Suite.
- 2.4.4 To ensure that there is appropriate audit and monitoring of the ECT Suite.
- 2.4.5 To attend the ECT Department weekly after training junior staff to ensure continued good practice.
- 2.4.6 To provide advice regarding ECT to Consultant colleagues.
- 2.4.7 To attend the Wessex ECT Committee quarterly.
- 2.4.8 To remain up to date with developments in ECT and attend the Royal College of Psychiatrist's ECT Training Events.

#### 2.5 Roles and Responsibilities of Consultant Anaesthetist:

2.5.1 The anaesthesia service for ECT should be supervised by a named Consultant Anaesthetist, with regular clinical input to anaesthesia for ECT. The named Consultant Anaesthetist should perform the following roles:

- ❖ Supervise and assist in patient assessment and offer advice on the preparation of patients for general anaesthesia.
- ❖ Advise on current standards of anaesthetic monitoring, drugs, equipment and personnel as published by the Royal College of

Anaesthetists or the Association of Anaesthetists of Great Britain and Ireland.

- ❖ Liaise with Lead Consultant Psychiatrist and Lead ECT Nurse regarding service developments and drawing up or updating guidelines, policies and protocols relevant to the local provision of anaesthesia services for ECT.
- ❖ Contribute to teaching and training of anaesthetic and psychiatry trainees in aspects of patient care contributing to the safe provision of general anaesthesia for ECT.
- ❖ Maintain knowledge and experience through continuing professional education and development on aspects of ECT relevant to the provision of anaesthesia.

## 2.6 Roles and Responsibilities of other Team members:

- 2.6.1 To assist in the provision of high standards of care and treatment in conjunction with other professionals.
- 2.6.2 To be responsible for keeping up to date with developments in ECT.
- 2.6.3 To be responsible for their own professional development with the support of study days and attendances of appropriate conferences and Dorset Healthcare Trust training.
- 2.6.4 To assist in the provision of information and training resource for ECT treatment and active participation in training process.
- 2.6.5 To assist in the ECTAS and PDU process.
- 2.6.6 The Registered Nurses to deputise in the absence of the Lead Nurse.

## 3.0 Indications for ECT

- 3.1 ECT is indicated for the following psychiatric disorders (1):
  - a) Severe Depressive Illness
  - b) Catatonia
  - c) A prolonged or severe manic episode

3.2 ECT should not be used routinely in the management of schizophrenia.

3.3 ECT is not recommended as a continuation or maintenance therapy in depressive disorder (1). This practice should only take place in limited clinical circumstances.

### 3.3.1 Continuation ECT can be considered when:

- ❖ The index episode of illness responded well to ECT.
- ❖ There is early relapse despite adequate continuation drug treatment, or an inability to tolerate continuation drug treatment.
- ❖ The patient's attitude and circumstances are conducive to safe administration.

Refer to Protocol for Continuation ECT (Appendix 1)

3.3.2 Maintenance ECT is treatment six months after successful treatment in order to prevent relapse (4). It follows on from Continuation ECT (follow Protocol for Continuation ECT)

3.3.3 When considering Continuation or Maintenance ECT the following are recommended:

- ❖ Full review of case and diagnosis.
- ❖ Second opinion from Consultant colleague.

### 3.4 Special Patient Groups:

#### 3.4.1 Use of ECT in pregnancy:

- ❖ Whilst not an absolute contraindication it is unlikely that ECT would be used in pregnant women. A comprehensive assessment would be required. Automatic ASA Grade III would mean treatment being given in one of the Acute Trusts with the necessary support available. Early discussions with the ECT Department is recommended.

#### 3.4.2 Use of ECT in Children and Adolescents (under 18s):

- ❖ There is limited information regarding ECT in this group, though it has been used for similar situations to adults. Potential cases should be discussed with the ECT Department.

## 4.0 Consent to Treatment

4.1 Consent can only be obtained by a psychiatrist with adequate knowledge of the nature and effects of ECT and with respect to the patient's rights. Consent for ECT should only be sought by either Consultant, Associate Specialist, Specialist Registrar or a doctor with approval. Only these grades can countersign the Consent form. Book can be completed by any grade of doctor.

the  
Section 12  
The ECT Work-Up

4.2 Patients should be provided with appropriate information to allow them to give consent. This includes:

- ❖ The nature of the treatment and a description of the process
- ❖ The purpose and benefits of treatment, including likelihood of success
- ❖ The risks and likelihood of adverse effects, including cognitive impairment
- ❖ The likely consequences of not having ECT
- ❖ Treatment alternatives and confirmation that these will be available if the patient decides not to have ECT
- ❖ The patients rights

4.3 The discussion with patients and relatives/carers should be documented in the case notes. Consideration should be given to independent advocacy.

4.4 The patient/relative/carer should be given a copy of the Trust's information booklet 'Your questions answered about ECT treatment'.

4.5 The first step in gaining consent is an assessment of capacity to consent which should be recorded on the consent form.

4.6 Patients who have the capacity to consent to ECT and who are willing to do so should sign the Department of Health Consent Form (modified for ECT). Prior to each treatment consent will be reconfirmed. One

4.7 Patients who are thought by the clinical team to require treatment with ECT, have the capacity to consent to such treatment but are refusing to do so, should be detained under the Mental Health Act and a second opinion obtained from The Mental Health Act Commission.

4.8 Patients who are thought by the clinical team to require treatment with ECT, lack the capacity to consent and are not compliant with treatment plan should be detained under the Mental Health Act and a second opinion obtained from the Mental Health Act Commission. that

4.9 Patients who are thought by the clinical team to require treatment with ECT, lack the capacity to consent but appear to be fully compliant with the proposed treatment plan can be treated under common law. Importantly, in these cases the absence of active resistance should not be taken to indicate compliance. It is not envisaged that many patients would receive ECT this way. Consideration must be given to the European Court on Human Rights rulings on 'deprivation of liberty' and 'restriction of movement'. It is good practice to seek a second opinion from a consultant colleague in all such cases.

4.10 Consent form 4 should be completed for all patients who are unable to consent to treatment.

4.11 With reference to patients described in sections 5.7 and 5.8, if the delay incurred by the legal process places the patient at risk of serious deterioration, then ECT may be given under common law or Section 62.

4.12 While relatives/guardians cannot given consent on behalf of a patient, it is good practice to involve them in a discussion about and document this clearly in the case notes. ECT

4.13 All patients should receive a copy of Page 2 of the Consent form One.

4.14 Patients who have not had ECT before should have the opportunity of visiting the ECT suite at a time agreed with the ECT staff so that details of the treatment can be explained to them. full

4.15 Patients should not receive more than 12 treatments without a Consultant second opinion and will need to be re-consented.

4.16 If at any point during a course of treatment the patient withdraws consent but later chooses to have further treatment a new consent will have to be completed. form

## 5.0 Pre-treatment Work-Up Guidelines

5.1 Patients can receive ECT on an inpatient or outpatient basis. The same pre-treatment work-up book must be completed.

5.2 For additional guidance on outpatients refer to Protocol for Outpatients ECT in Appendix 2. The basic principles are as follows:

- ❖ The risks of self harm/neglect are low
- ❖ The service user must have fasted for six hours prior to treatment
- ❖ The patient recovers well post anaesthetic
- ❖ Have escorted transport home from hospital
- ❖ The service user does not live alone
- ❖ Have an allocated ward who will take responsibility for the patient should there be a problem following ECT which means that the patient cannot return home. The senior nurse on the relevant ward must be aware that outpatient ECT is happening.

5.3 The SHO or other psychiatrist should fully assess all patients by history and examination prior to commencement of ECT. The physical examination findings must be entered in the ECT Work-up book.

5.4 Investigations for ECT:

5.4.1 Standard Investigations

Indications for FBC	Indications for U&E&Cr	Indications for ECG
<ul style="list-style-type: none"> <li>All patients</li> </ul>	<ul style="list-style-type: none"> <li>All medically fit patients &gt;60 years</li> <li>All patients with a history of hypertension</li> <li>Patients with renal disease</li> <li>Diabetics</li> <li>Cachectic patients</li> </ul> Patients on the following medications: Diuretics, Lithium, NSAIDS, Digoxin, MAOIs, Cardiac or vaso-active drugs	<ul style="list-style-type: none"> <li>All medically fit patients &gt; 45 yrs</li> <li>Patients with known cardiac disease (including ischaemic heart disease, hypertension, irregular pulse or heart murmur)</li> <li>Diabetics &gt; 40 years</li> <li>Patients with known respiratory disease</li> </ul>

Urinalysis on all patients.

#### 5.4.2 Non-standard investigations:

- ❖ Blood glucose levels: Diabetics and if urinalysis positive for sugar.
- ❖ Liver Function Tests: Known liver disease, alcoholics, cachectic patients, drug abuse or recent overdose.
- ❖ Thyroid function tests: Known history of thyroid disorder, patients on thyroxine and patients dysrhythmias (particularly fast AF).
- ❖ Hepatitis status for patients known to use intravenous drugs.
- ❖ Sickle test: Afro-Caribbean, Eastern Mediterranean, Asian and Middle Eastern patients.
- ❖ Chest X-Ray: Patients with suspected chest infection, a known history of severe COPD, cardiac disease including: congestive cardiac failure, pulmonary embolism (PE).
- ❖ Respiratory Function Tests: Severe COPD or patients with shortness of breath at rest

5.5 Diabetics undergoing ECT: All diabetics should have FBC, U&E&Cr, urinalysis and ECG prior to treatment. Blood glucose should be measured if urinalysis is positive for glucose. There is only a short period of starvation and so disruption of diabetic management is minimal. Where possible insulin dependant diabetics should be placed first on the list. Insulin should not be given on the morning of the treatment until the first calorific meal after ECT. Long acting evening insulin may need to be reduced the evening before ECT. There is probably no need to adjust oral hypoglycaemic agents during ECT. However, as least twice daily glucostix are necessary.

5.6 Patients with known hiatus hernia or symptomatic gastric reflux disease: The patient should receive their routine antacid medication on the morning of treatment. If not on current treatment they should be given 150mg Ranitidine orally the night before the treatment. If the patient has severe symptoms of gastric reflux disease they should also be given a further dose of ranitidine 150mg orally and metaclopramide 10mg two

hours before the ECT  
before the

treatment plus 30mls of 0.3M Sodium Citrate just  
treatment.

5.7 The following are contra-indications to ECT:

- ❖ Recent myocardial infarction (within 3 months and depending on severity)
- ❖ Deep vein thrombosis (until anticoagulated to reduce risk of PE.
- ❖ Acute respiratory tract infection (especially 1<sup>st</sup> 72 hours)
- ❖ Uncontrolled cardiac failure
- ❖ Recent CVA (within 1 month, depending on severity)
- ❖ Raised intracranial pressure, untreated cerebral aneurysm
- ❖ Unstable major fracture
- ❖ Untreated phaeochromocytoma

5.8 The following conditions need assessment and, where possible, stabilisation prior to treatment:

- ❖ All medical conditions
- ❖ Uncontrolled hypertension (systolic > 180mmHg, diastolic >100mmHg)
- ❖ Dysrhythmias
- ❖ Any abnormal investigations
- ❖ Dehydration

5.9 The following patients should be referred for specific anaesthetic assessment:

- ❖ ASA Grade III (severe systemic disease)
- ❖ ASA Grade IV (severe systemic disease that is a constant threat to life)
- ❖ Recent Myocardial infarction (within 6 months)
- ❖ Angina
- ❖ History of aortic stenosis
- ❖ Known severe adverse reaction to previous anaesthetics
- ❖ Symptomatic hiatus hernia
- ❖ Any patient whose condition or results give cause for concern
- ❖ Patients with a body mass index (BMI) >35

5.9.1 For patients graded ASA III or more, transfer to an acute hospital for ECT treatment may be necessary. Case by case discussion with a consultant anaesthetist should precede decision to provide treatment at another site, taking into individual patient's needs and the disadvantages including possible hazards of transfer. It may be possible to complete the ECT course in the 'remote' site if any account the transport and to consider after initial

5.9.2 Advice on medical and anaesthetic problems. Patients whose condition or results give cause for concern should be discussed with the anaesthetist well in advance of the proposed ECT treatment to avoid last-minute cancellations.

If

advice is needed on fitness for anaesthesia for ECT, please contact the  
Anaesthetist at St. Ann's on Tuesday and Friday mornings 09:00-11:00, or  
at other times contact the Consultant anaesthetist responsible for ECT  
in the Anaesthetic Department at Poole on 01202 442443.

**THE PATIENT'S TREATMENT WILL HAVE TO BE CANCELLED IF ECT WORK UP BOOK  
IS NOT FULLY COMPLETED**

**6.0 Prescribing ECT**

6.1 The prescription sheet within the Dorset Healthcare NHS Trust ECT Work-up book should be completed fully by the relevant CMHT doctor.

6.2 No more than two treatments at one time to be prescribed thereby ensuring that the number of treatments given is entirely related to the patient's response.

6.3 The patient's response to treatment should be recorded with each prescription. This should include the patient's subjective experience of side effects and objective cognitive side effects.

6.4 Responsibility for prescribing lies with the patient's consultant.

6.5 ECT should not normally be given more than twice per week since increased frequency is associated with increased cognitive impairment (2). In exceptional circumstances it may be possible to administer ECT three times per week.

6.6 If there is a requirement for a course of more than 12 treatments, a second opinion from another consultant should be sought.

6.7 The final decision on whether to give ECT on a treatment day lies with the ECT Department staff. Should a patient be denied treatment, the reason(s) are recorded on the Reason for ECT Treatment Refusal Form which is placed on the patient's notes.

**7.0 Delivery of ECT**

7.1 ECT treatment sessions occur each Tuesday and Friday morning in the ECT suite. In exceptional circumstances treatment may be carried out in one of the two Acute Trust Hospitals.

7.2 ECT department staff will visit each ward prior to a session to identify patients for treatment that morning and check the Work-up book

is complete. If the paperwork is not 100% complete the patient will remain on the ward and not receive treatment that day.

will remain on the

7.3 In general the patient's usual medication should be continued throughout the course of ECT including any medication required during the period nil by mouth. In particular, this applies to endocrine, cardiovascular and respiratory treatment. Medication for hypertension, angina, arrhythmia and asthma should be given with a sip of water two hours prior to treatment.

a sip

Carbamazepine and Benzodiazepines should not be given in the twelve hours prior to ECT. Long-acting Benzodiazepines should be avoided during a course of ECT if possible.

7.4 Insulin dependent diabetics should be first on the list, their insulin being given after treatment.

7.5 All patients must be fasted from food for six hours. *This includes chewing gum.* They may have clear fluids up to three hours before treatment.

7.6 There must be no smoking before ECT.

7.7 Pre-treatment the patient should be encouraged to pass urine.

7.8 A trained anaesthetist always administers the anaesthetic. A psychiatrist trained in ECT or psychiatrist under supervision administers the treatment.

7.9 A stimulus dosing protocol is used to ensure optimal therapeutic dosage while minimising side-effects. There are two protocols; one for patients taking anti-epileptic drugs and one for patients who are not (Stimulus Dosing Charts, Appendix 3). The protocol is subject to updating by the ECT Department.

7.10 Some patients may experience either a missed seizure or prolonged seizure. Protocols to manage these events are posted in the ECT Treatment Room.

## 8.0 Post-treatment Management

8.1 The patient receives 1:1 monitoring by a CPR and recovery trained nurse immediately post anaesthetic and should remain in the recovery area until consciousness and orientation have been fully regained. The patient's pulse, BP and respiration rate should be recorded regularly.

8.2 When the ECT staff are satisfied the patient has fully recovered the patient will be escorted back to the ward by a trained member of the staff.

ward

8.3 Outpatients will be discharged to a responsible adult who can take them home. When there is a delay in complete recovery the outpatient will be transferred to a ward for further monitoring until they can be discharged home.

8.4 The patient's response to treatment should be assessed and clearly documented following each treatment (1). An assessment tool such as the Geriatric Depression Rating Scale, Hamilton Rating Scale for Depression, Beck's Depressive Inventory or similar tool should be used before and after the course of treatment. This is the responsibility of the medical team not the ECT staff.

8.5 The patient's clinical status and symptomatic response should be recorded 3 and 6 months after treatment.

8.6 In line with minimum requirements (1), as part of monitoring the patient's cognitive state, the MMSE should be administered before and after the course of treatment at 3 and 6 months. This is the responsibility of the medical team not the ECT staff.

## 9.0 Training

9.1 All staff working in the ECT Department will receive training in the theory and practice of ECT.

9.2 All new staff nurses employed at St Ann's are required as part of their induction to spend at least one session in the ECT department in order to learn and familiarise themselves with the practice and protocols. It is the responsibility of ward managers to ensure that this happens.

9.3 All nursing staff working in the department are trained in Basic Life Support and undertake annual refresher courses. Additionally, qualified staff are trained in defibrillation, use of a combitube, airway management and other relevant skills with annual refreshers and updates.

9.4 The ECT department is a training placement for student psychiatric nurses.

9.5 Operating Department Practitioners (ODPs) who work in the ECT suite have a separate system of training and updates.

9.6 All Senior House Officers (SHOs) working in the Trust attend the bi-yearly ECT Induction Programme. All SHOs new to the Trust rostered to give ECT attend three supervised sessions with the Lead Consultant for ECT. SHOs are assessed on 'Basic Competence in ECT' (Appendix 4) by direct observation and a multiple choice questionnaire. A certificate of basic competence, valid for one year, will be awarded to SHOs

passing the training assessment. Unsuccessful SHOs will be given further training during supervised sessions and re-assessed.

9.7 The Lead Consultant will be available weekly to give supervision to doctors administering ECT.

9.8 The ECT Department is aware that other grades of doctor would also benefit from further training and updates about ECT practice. The Lead Consultant will circulate information about external courses on ECT to medical staff. The ECT Department will aim to organise one internal update course per year for grades above SHO.

## 10.0 Monitoring of Standards

10.1 The ECT Department is subject to both internal and external scrutiny.

10.2 The Royal College of Psychiatrists ECT Accreditation Service (ECTAS) has accredited the ECT Department at St Ann's Hospital. This status is under regular review by ECTAS. The Trust is committed to supporting the staff with the necessary resources to maintain accredited status.

10.2 The ECT department aims to maintain the highest standards and to monitor this through annual audit. One component of this will reflect the satisfaction of patients and their families together with any suggestions for improvement.

10.3 The ECT Department will produce an annual report.

## 11.0 References

1. National Institute for Clinical Excellence. Final assessment report: Electroconvulsive therapy (ECT) for Depressive Illness, Schizophrenia, Catatonia and Mania. Guidance No. 59. 2nd May 2003.
2. Efficacy and Safety of Electroconvulsive therapy in Depressive Disorders: a systematic review and meta-analysis. The UK ECT Review Group. The Lancet. Vol 361. 8th March 2003.
3. The ECT Handbook. Second Edition. Council Report CR128 – Royal College of Psychiatrists 2005.
4. The practice of Electrode Convulsive Therapy. Task Force Report of the American Psychiatric Association. 2<sup>nd</sup> Edition 2001.

5. Interim statement from The Royal College of Anaesthetists on electro-convulsive therapy provided in 'remote' sites. <http://www.rcoa.ac.uk/index.asp?PageID=402>

## APPENDIX 1

# DORSET HEALTHCARE NHS TRUST

## ECT DEPARTMENT

### PROTOCOL FOR CONTINUATION ECT

Continuation ECT should be considered for patients who have relapsing or refractory depression that has previously responded well to ECT and where psychological and pharmacological treatment has proved ineffective.

This may include the following groups:

1. Those who ask for it.
2. Those who frequently relapse through poor compliance.
3. Those with poor medication tolerance.
4. Those with post ECT treatment relapse that do not respond to medication (0-12 months).

#### Exclusion Criteria

1. Recent myocardial infarction or CVA.
2. Raised intracranial pressure.
3. Acute respiratory infection.
4. Past ECT confusion.
5. Neurodegenerative disorder.

#### Assessment

A full review should occur ensuring a correct diagnosis, that treatment will be beneficial and that all alternatives have been explored. Consent should be sought in the usual manner. Full medical screening should take place as per policy (local policy specific to ECT Department) and where possible, severity of illness measured with appropriate measuring tool e.g. Becks or Hamilton scale. Though not a statutory requirement, a second opinion ensures best practice.

#### Treatment Plan

1. Only two treatments prescribed and full review to take place after each second treatment.

2. Cognitive impairment to be checked on a regular basis.
3. Frequency of treatment established.
4. Patient's family or advocate to be involved wherever possible.
5. Consideration should be given to the possibility of medication changes between extended treatment times.
6. Information should be sought from community workers involved in the case and from the GP.

#### Review

1. Monthly cognitive assessment advisable.
2. Side effects noted.
3. Full anaesthetic review at least six monthly.

#### Stopping Continuation ECT

Treatment should be reduced as a stable state is reached and no relapse occurs. A CPA should occur to formulate a treatment plan, observation of signs of deterioration is a key. All relevant professionals should attend.

#### Legal Issues

Treatment given under the MHA is difficult to continue. Informal status and informed consent are preferable for continuation treatment.

In the event of continuation Treatment being prescribed under the MHA advice should be sought from the Mental Health Act Office.

## **APPENDIX 2**

### **Protocol for Outpatient ECT Treatment**

The Purbeck Suite at St. Ann's Hospital provides Electro-Convulsive Therapy to patients at St Ann's and other inpatient units across Dorset Healthcare N.H.S. Trust. ECT is also provided for a relatively small number of outpatients.

The following protocol is for the referral, pre assessment, treatment and aftercare of patients requiring outpatient ECT.

#### **1 Referrals**

- 1.1 Referrals to the Purbeck Suite for outpatient ECT treatment will be made by letter or fax using the referral form attached. Alternatively, this information can be communicated over the telephone.
- 1.2 The referrer will ensure that arrangements are made for the transfer of the integrated records to the Purbeck Suite prior to treatment.
- 1.3 On receipt of a referral form, ECT staff will contact the patient/carer to arrange an appointment for a pre ECT assessment check. The clinic times will be between 11am and 1 pm on Tuesday, Wednesdays and Fridays, excluding bank holidays.

#### **2 Pre ECT Assessment Clinic**

- 2.1 The assessment check will include the necessary investigations (i.e. E.C.G., blood screen) and a general physical examination if not already complete, will be undertaken by the junior doctor to the patient's C.M.H.T. The ECT workup book will be completed and signed.
- 2.2 The additional function of the clinic visit will be:
  - ❖ To identify additional patient needs and agree action
  - ❖ To identify additional carer needs and agree action
  - ❖ To give the patient/ carer the opportunity to talk through concerns, to fully informed about the ECT process, and given the information leaflet.
  - ❖ To agree the initial and subsequent treatment dates, and for the patient to be given an appointment card stating these times.
  - ❖ To agree transport arrangements. If the patient's carer is unable to arrange this, then the patients' care co-ordinator will be contacted to agree what action needs to be taken.
  - ❖ To give the patient/ carer a detailed explanation of post –ECT precautions and a record of this.
  - ❖ To ensure that an appointment time is made with the referring C.M.H.T. for review and where appropriate additional prescriptions etc.

- ❖ If there is no carer to support the patient at home immediately after treatment then arrangements will be made for the patient to go to the ward of the patients' own CMHT. The nurse in charge will be notified of this.

### **3 ECT Treatment**

- 3.1 ECT treatments are carried out on Tuesdays and Fridays.
- 3.2 Patients need to follow the same procedure as inpatients regarding pre treatment precautions i.e. nil by mouth from midnight, and medication.
- 3.3 Outpatients are required to attend the clinic at 9am on the above days.
  - 3.3.1 Outpatients are first on the treatment list.

### **4 Aftercare**

- 4.1 Patients who have had their treatment and have had good recovery and no adverse effects will normally be discharged at around 11am on day of treatment.
- 4.2 Patients who have had some adverse reaction after treatment or there is no carer to support them at home will be discharged to their parent ward and then discharged to home from there at the appropriate time.
- 4.3 Prior to discharge from the clinic patients are again advised not to drive, use heavy machinery, smoke, drink alcohol.

**B J Matthews**  
**Revised April 2006**

# DORSET HEALTHCARE NHS TRUST

## ECT DEPARTMENT

<b>Purbeck Suite</b>	
<b>ECT Referral Form</b>	
<b>Name of Patient</b>	
<b>Address</b>	
<b>Tel No</b>	
<b>DOB</b>	
<b>Name of carer:</b>	
<b>Will the carer accompany the patient on first visit</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Date patient is arriving for pre-ECT assessment clinic</b>	Tuesday Wednesday Friday
<b>Name of care co-ordinator:</b>	
<b>Consultant</b>	
<b>Consent forms completed by whom?</b>	
<b>ECT workup book to be completed by and when?</b>	Completed By _____ Date _____
<b>Is transport required?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Signed</b>	
<b>Print name / date</b>	

### WHEN COMPLETED SEND / FAX OR PHONE THESE DETAILS TO:

The Purbeck Suite  
St Ann's Hospital  
69 Haven Road  
Poole  
BH13 7LN

Tel: 01202 708881 (ext 2040)  
Fax: 01202 492871

Email: [brian.matthews@dorsethc-tr.swest.nhs.co.uk](mailto:brian.matthews@dorsethc-tr.swest.nhs.co.uk)

**PATHWAY FOR OUTPATIENTS ECT**

TO BE COMPLETED BY MEMBER OF THE ECT STAFF

PATIENT'S NAME .. .. .

REFERRAL FROM a) CMHT b) WARD  
a) or b) signed .. .. .

1 MAKE APPOINTMENT FOR PATIENT CLINIC  
date / time signed .. .. .

2 CONSENT FORMS COMPLETED  
completed signed .. .. .

3 MEDICAL STAFF TO COMPLETE ECT WORKUP BOOK  
completed signed .. .. .

4 ECG TO BE TAKEN  
completed signed .. .. .

5 PHLEBOTOMIST TO ATTEND PATIENT  
completed signed .. .. .

6 PATIENT NEEDS IDENTIFIED AND ACTION AGREED  
completed signed .. .. .

7 CARERS NEEDS IDENTIFIED AND ACTION AGREED  
completed signed .. .. .

8 PATIENT INFORMED OF ECT PROCESS AND GIVEN LEAFLET  
completed signed .. .. .

9 DATES OF TREATMENT AGREED AND RECORDED FOR PATIENT

completed signed .....

10 TRANSPORT ARRANGEMENTS DISCUSSED AND AGREED WITH CONFIRMED BOOKING OF HOSPITAL TRANSPORT AS NEEDED

completed signed .....

11 PRECAUTIONS RELATED TO POST ECT TREATMENT DISCUSSED WITH PATIENT AND CARER WITH RECORD OF SAME

completed signed .....

12 INDEMNITY PAPER SIGNED BY PATIENT / CARER

completed signed .....

13 ARRANGE WITH THE WARD THE TRANSFER OF OUTPATIENT TO THEIR CARE WHERE NECESSARY

completed signed .....

14 ARRANGE FOR MEDICAL TEAM TO SEE PATIENT PRIOR TO GOING HOME FOR MENTAL AND PHYSICAL ASSESSMENT WITH RECORD OF SAM.

completed signed .....

15 ARRANGE PRESCRIBING TIMES AND FOLLOWUP BY CMHT WITH REVIEWS

completed signed .....

16 REQUEST PATIENTS MEDICAL NOTES TO BE SENT TO ECT DEPT

completed signed .....

17 NOTIFY MEDICAL RECORDS OF NEW OUTPATIENT PLUS NECESSARY DATA

completed signed .....

**DORSET HEALTHCARE NHS TRUST**  
**GUIDANCE FOR ALL ECT DAY PATIENTS**

If you are having outpatient ECT please take time to read this leaflet carefully and show it to whoever will be looking after you when you go home. You will have just had a general anaesthetic, therefore you must:

- Be supervised by an adult at least until the following morning.
- Not leave hospital if you are feeling unsteady on your feet or confused.
- Not drive, ride a bike or operate any machinery or appliances for 24 hours.
- Not be left in sole charge of children until the following morning.
- Not sign any legal document or make important decisions for 24 hours.
- Not consume alcohol for 24 hours

If you are concerned about how you are feeling do not hesitate to contact your care co-ordinator or, during the evening, an emergency G.P. If you are having difficulty getting help you could go to the A&E department and ask to speak with the psychiatrist on call for the hospital. Some people may develop a headache after treatment. This often responds to paracetamol ( 2x 500 mg ).

1) I confirm that I have read and understood the above guidelines.

Signed ..... Date .....

I will be taken home by.....

Name Consultant / Nurse:.....

Signature..... Date .....

2) Patient name:.....

I confirm that I have read and understood the above guidelines.

Signed ..... Date .....

I will be taken home by.....

Name Nurse:.....

Signature..... Date .....

3) Patient name:.....

I confirm that I have read and understood the above guidelines.

Signed ..... Date .....

I will be taken home by.....

Name Nurse:.....

Signature..... Date .....

- 4) Patient name:.....  
I confirm that I have read and understood the above guidelines.  
Signed ..... Date .....  
I will be taken home by.....  
Name Nurse: .....  
Signature..... Date .....
- 5) Patient name:.....  
I confirm that I have read and understood the above guidelines.  
Signed ..... Date .....  
I will be taken home by.....  
Name Nurse.....  
Signature..... Date .....
- 6) Patient name.....  
I confirm that I have read and understood the above guidelines.  
Signed ..... Date .....  
I will be taken home by.....  
Name Nurse:.....  
Signature..... Date .....
- 7) Patient name.....  
I confirm that I have read and understood the above guidelines.  
Signed ..... Date .....  
I will be taken home by.....  
Name Nurse.....  
Signature..... Date .....
- 8) Patient name.....  
I confirm that I have read and understood the above guidelines.  
Signed ..... Date .....

I will be taken home by.....

Name Nurse.....

Signature..... Date .....

9) Patient name.....

I confirm that I have read and understood the above guidelines.

Signed ..... Date .....

I will be taken home by.....

Name Nurse.....

Signature..... Date .....

10) Patient name.....

I confirm that I have read and understood the above guidelines.

Signed ..... Date .....

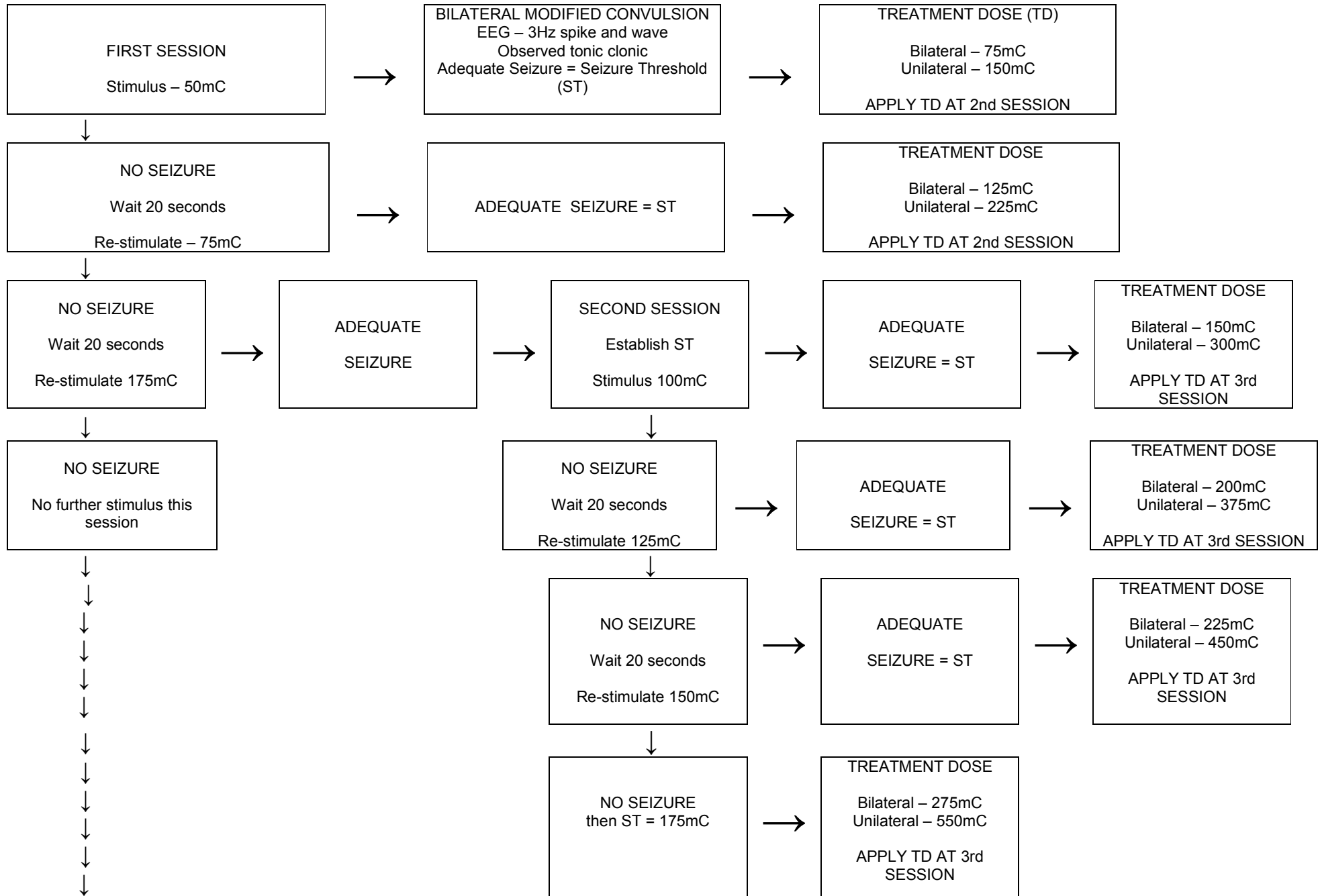
I will be taken home by.....

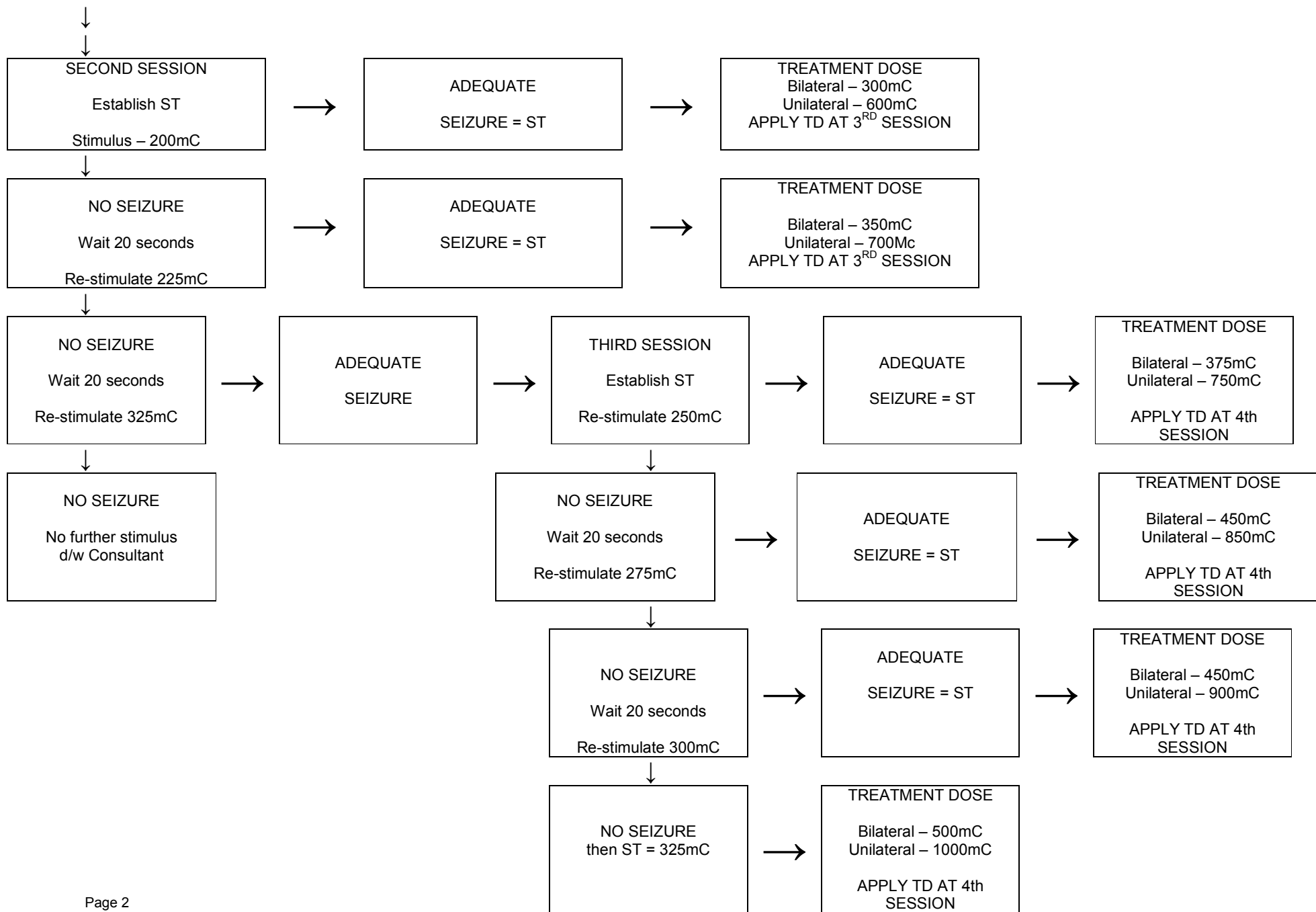
Name Nurse.....

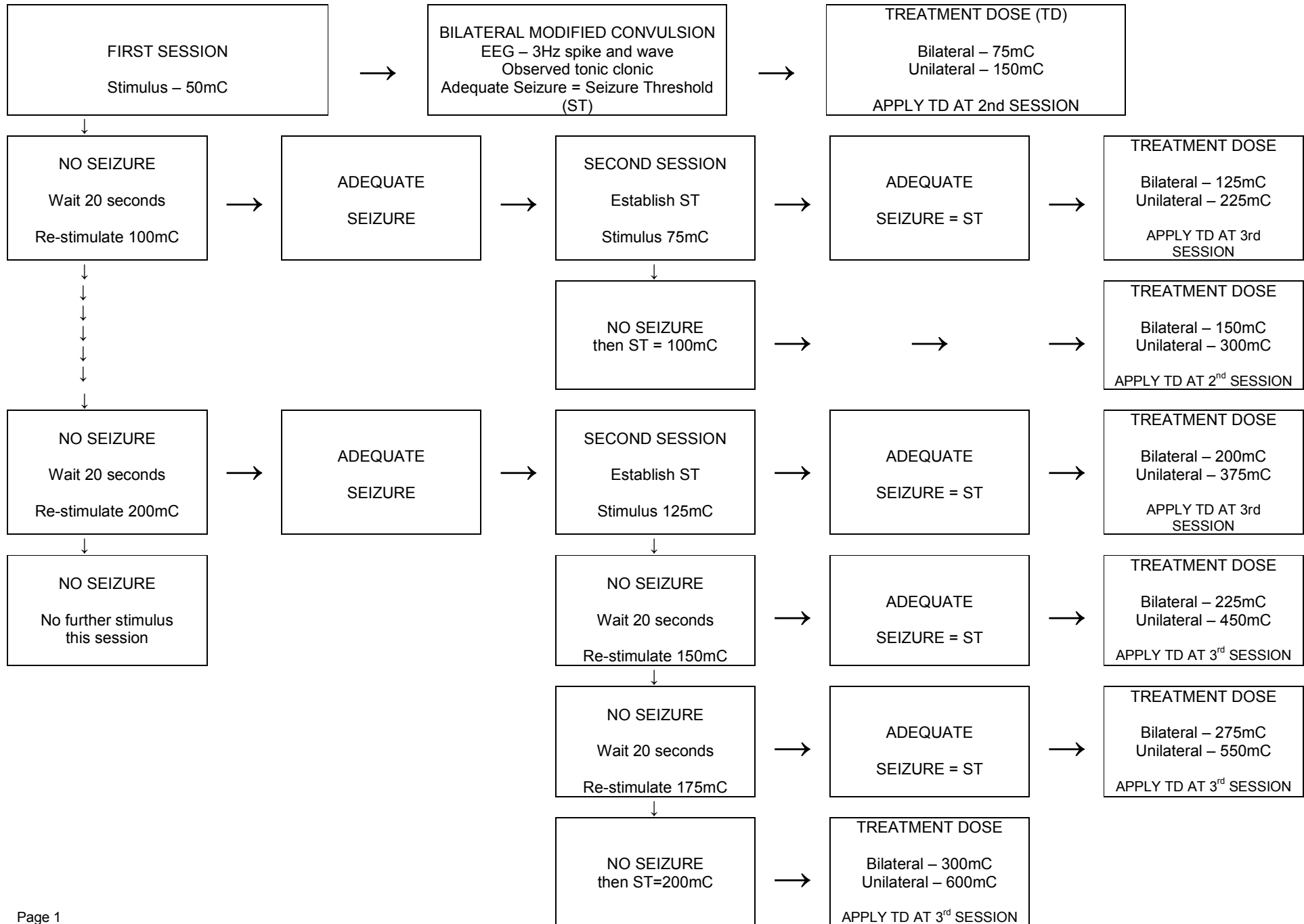
Signature..... Date .....

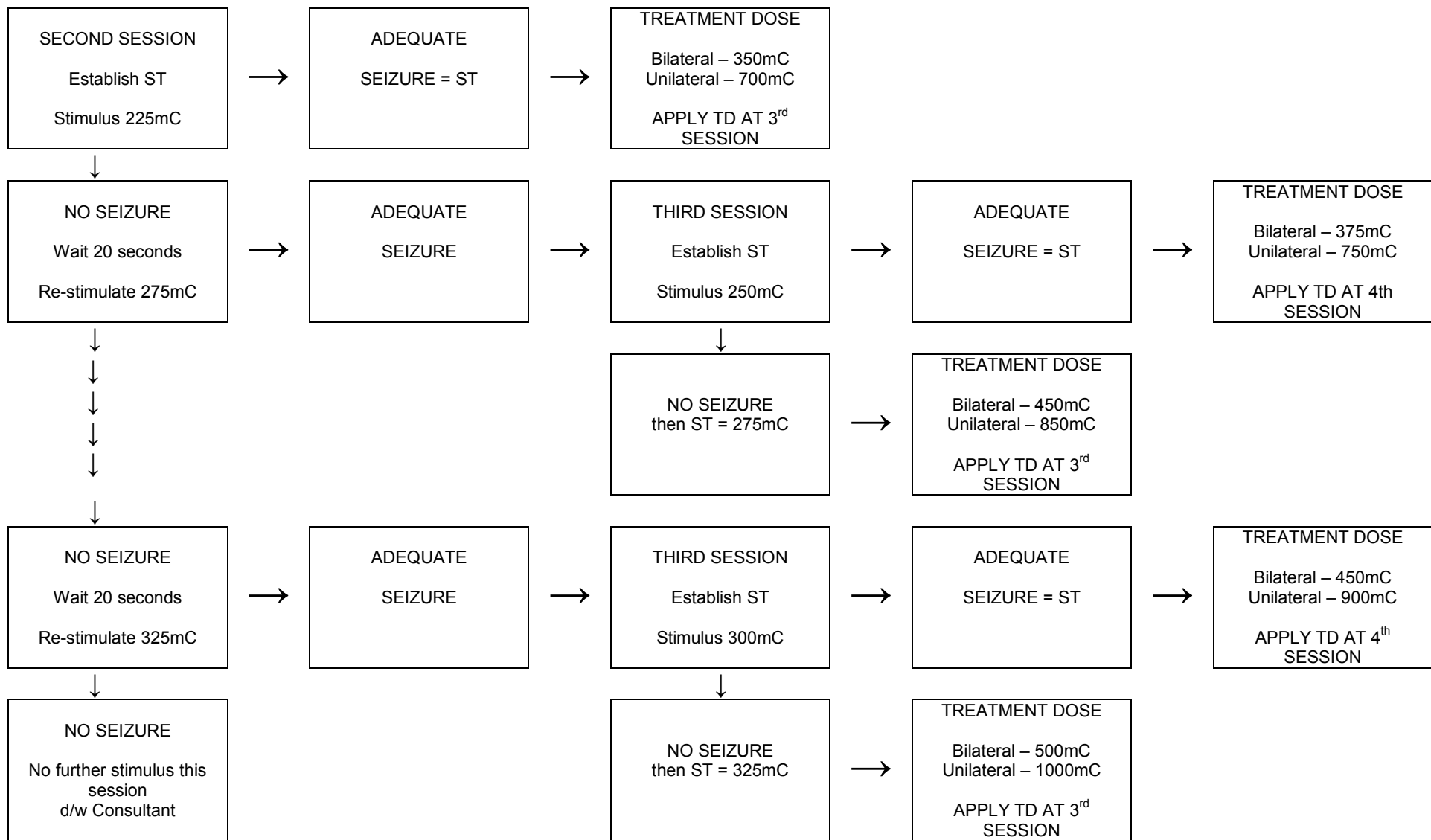
APPENDIX 3

STIMULUS DOSING CHART – NO ANTI-EPILEPTIC DRUGS









## **APPENDIX 4**

### **BASIC COMPETENCE IN ECT**

#### **Knowledge**

- 1 Indications for ECT.
- 2 Key paper - Efficacy and safety of electro convulsive therapy in depressive disorders: a systematic review and meta-analysis. The UK ECT Review Group. Lancet Vol 361, p799, 2003.
- 3 Key paper – Patients’ perspective on electroconvulsive therapy: systematic review. Rose et al, BMJ, Vol 326, p1363, 2003.
- 4 NICE – Guidance on use of ECT, 2003.
- 5 ECT procedure and protocols.
- 6 Anaesthesia for ECT.
- 7 Adverse effects.
- 8 The Law and consent to treatment.

#### **Skills**

- 1 Check through Workup Book and patients notes – prescription of ECT, drug chart, medical condition, mood monitoring questionnaire, cognitive monitoring, clinical response and legal status.
- 2 Welcoming and settling the patient.
- 3 Understanding of Spectrum 5000 machine.
- 4 Electrode placement for bilateral and unilateral ECT.
- 5 Stimulus dosing - establishing seizure threshold and calculating treatment doses.
- 6 Seizure monitoring – visual and EEG.
- 7 Missed seizure protocol.
- 8 Prolonged seizure protocol.
- 9 Post ECT recovery procedures.

## DORSET HEALTHCARE NHS TRUST EQUALITY IMPACT ASSESSMENT FORM

<b>Department/Service area:</b>	<b>Trust Wide</b>
<b>Policy Sponsor:</b>	<b>Lead Consultant for ECT</b>
<b>Name of the policy/protocol: (please attach a copy)</b>	<b>ECT Policy</b>
<b>Intended Outcome/s of Policy:</b>	<b>To ensure appropriate, safe and effective use of ECT</b>

**This form is designed to be filled in using the Impact Assessment Flowchart for guidance.  
Please see appendix 1.**

Groups.	Positive Impact		Negative Impact		Evidence / justification for your decision.	If no evidence of high negative impact has been identified, the Equality Impact Assessment has been completed.
	High	Low	High	Low		
Gender and transgender groups.		X				It is the Policy Sponsors responsibility to complete and attach an equality impact assessment each time a policy is written or reviewed prior to sending it to the relevant
People from Black and Minority Ethnic groups.		X				
People who have a disability.		X				
People who identify themselves as lesbian, gay or bisexual.		X				
People from different age groups.		X				
People who belong to a religion or have particular beliefs.		X				

committees for comment and amendment its final destination being the joint governance team for approval. It will then be the Risk Managements Directorate responsibility to update the intranet with the approved policy.

A signed hard copy and electronic copy should be kept within your department for audit purposes.

**Signed by Writer/Reviewer:** ..... **Signed by Sponsor:** .....  
**Name (print)** ..... **Name (print) Dr Shaun Kerwick.**  
**Date completed: 19/06/2006**

If you have identified evidence of high negative impact for any of the above groups, action must be taken to minimise/eliminate it. This may mean consultation with the appropriate organisations (appendix 4.) and developing an action plan (appendix 2.)

Groups.	EVIDENCE OF CONSULTATION		
	Name of Appropriate Body	Date Consulted	Outcome/agreed action
Gender and transgender groups.			
People from Black and Ethnic Minority groups.			
People who have a disability.			
People who identify themselves as gay, lesbian or bisexual.			
People from different age groups.			
People who belong to a religion or have particular beliefs.			

Please return a copy of this form and the completed action plan to the Director of Risk Management.

agement.

A signed hard copy and electronic copy should be kept within your department for audit purposes.

**Signed by Writer/Reviewer:** ..... **Signed by Sponsor:** .....  
**Name (print)** ..... **Name (print)** .....  
**Date completed:** .../.../....  
**Signed on behalf of the Trade Unions** .....  
**Name (print)** ..... **Date completed** .....

**Date of next policy review:** .....