

ELECTROCONVULSIVE THERAPY (ECT) PROCEDURAL GUIDELINES

PROCEDURE REFERENCE NUMBER	CLPG26	
VERSION NUMBER	1	
REPLACES SEPT DOCUMENT	CLP26 - SEPT ECT Policy	
REPLACES NEP DOCUMENT	NEP ECT Policy	
KEY CHANGES FROM PREVIOUS VERSION	New merged Procedure	
AUTHOR	Lead ECT Consultant, [REDACTED]	
CONSULTATION GROUPS	Adults and Older People's Services Specialist Services Quality Committee	
IMPLEMENTATION DATE	August 2019	
AMENDMENT DATE(S)	N/A	
LAST REVIEW DATE	N/A	
NEXT REVIEW DATE	August 2022	
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY COMMITTEE	24 th July 2019	
RATIFIED BY QUALITY COMMITTEE	15 th August 2019	
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PROCEDURAL GUIDELINES SUMMARY		
This Procedure provides clinical and operational details on the ECT Service within EPUT and details how the service functions and is managed.		
The Trust monitors the implementation of and compliance with this operational policy in the following ways;		
Audit and team meetings		
Services	Applicable	Comments
EXAMPLE: MH&LD	✓	

**The Director responsible for monitoring and reviewing this policy is
The Executive Medical Director**

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Assurance Statement

The purpose of this procedural guideline is to ensure that the guidelines set out in the ECT policy are detailed in a way that is understood by all staff, thereby, the policy can be fully implemented, monitored and reviewed within the organisation.

1.0 INTRODUCTION

- 1.1. These Procedural Guidelines support and should be read in conjunction with The Trust's ECT policy and in accordance with NICE Guidelines and Technology Appraisals, the ECT Handbook from the Royal College of Psychiatrists (Third Edition) and the Electroconvulsive Therapy Accreditation Service (ECTAS) Standards (Fourteenth Edition), Nursing Guidelines for ECT from Royal College of Nursing and the Guidelines from the Royal College of Anaesthetists (4th Edition) reflected in local operational working guideline.
- 1.2. The use of ECT as an effective treatment for particular mental illnesses is well-accepted and supported by a considerable body of evidence. This policy will apply to all health-care professionals who participate within any aspect of the provision of ECT.
- 1.3. This guideline reflects current standards in practice of ECT as per ECTAS Standards (14th Edition) and is liable to be updated as standards and practices change.

2.0 MANAGEMENT OF THE ECT SERVICE

- 2.1 The ECT Service of each clinic will be managed by an ECT Manager who will have an overall responsibility for the management of the ECT Clinic and will ensure that the ECT practice is conducted in accordance with trust policies, procedures and protocols. The ECT Manager reports to their respective Service Manager.
- 2.2 The Trust has an ECT Lead Consultant Psychiatrist, who has overall responsibility of the clinical practice of ECT and training and supervision responsibilities for trainee doctors. The Lead Consultant will be supported by a second ECT Consultant. The ECT Lead Consultant will also be responsible for updating the related policies, procedures and protocols. The ECT Lead Consultant is line managed by the Clinical Director for ECT.

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- 2.3 The Lead Consultant Anaesthetist for ECT treatment will be responsible for the allocation, training and supervision of anaesthetic staff and contributing to the updating of related procedures and protocols.

3.0 REFERRAL

- 3.1 The Consultant Psychiatrist responsible for the Service User or the team doctor is required to liaise with the ECT Manager as soon as possible, when ECT is considered as a treatment option. This timely referral to the ECT Service is essential to prevent any delays or cancellations.
- 3.2 The ECT Referral Process details can be found on the intranet and on request from the ECT Treatment Unit.
- 3.3 All patients referred for ECT should have a documented comprehensive medical history with particular attention to cardiovascular history, surgery history, and history of any adverse effects to previous anaesthesia and a full physical examination. A list of current medications and current mental state examination including evidence of a baseline cognitive functioning should also be available.
- 3.4 Referrals to the ECT Service will be accepted by the ECT Manager from the treating Consultant Psychiatrist or the team doctor.
- 3.5 Up to seven working days should be allowed for further ECT assessment and initiation of treatment of non-urgent cases to allow Service Users to discuss with relatives and visit the treatment centre if required.
- 3.6 Some Service Users may need urgent ECT due to their clinical needs. It may be possible to assess and treat such Service Users on the same session, provided they are fit for anaesthesia. The responsible team should liaise with the ECT Manager at least 24 hrs prior to the next treatment session to facilitate such treatment.

4.0 PRESCRIPTION OF ECT

- 4.1 Each Service User who is prescribed ECT must be under the care of the prescribing Consultant Psychiatrist, who must document the decision, indication and rationale for ECT in the clinical notes.
- 4.2 The Consent, ECT Prescription Form and Clinical Response Forms should be fully completed and be signed by the prescribing Consultant Psychiatrist or designated deputy.
- 4.3 No more than two treatments should be prescribed at any one time.
- 4.4 The number and laterality of ECT treatments should be discussed with the Service User.

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- 4.5 The Service User must be reviewed by the treating team after each treatment. Before each subsequent ECT treatment the Prescribing Consultant or deputy should record the Service User's response to the treatment. The record should also include the Service User's subjective experience of any side effects and cognitive difficulties. As the responsibility for prescribing each ECT treatment rests with the Prescribing Consultant, the prescription for the next ECT treatment should be signed and dated by the Prescribing Consultant or a nominated deputy.

5.0 ASSESSMENT FOR ECT

- 5.1 Prior to the first ECT, all Service Users must undergo a full anaesthetic assessment. In order to complete this assessment the Anaesthetist will require the following:
- Fully completed ECT Referral Form,
 - Results of all appropriate physical investigations,
 - Access to the Clinical Notes
 - Appointment with Service User for an anaesthetic assessment
- 5.2 The referring member of the psychiatric team will be responsible for informing the ECT Manager of any potential medical, anaesthetic or medication issues prior to anaesthetic assessment. This enables the ECT Manager to arrange for an appropriate anaesthetic assessment and to make special arrangements where appropriate.
- 5.3 The Anaesthetist will then complete an individual Anaesthetic Assessment Form and advise the nursing and medical staff on any specific instructions. These instructions should be followed in order to prevent delays or cancellations of the Service User's ECT treatment.
- 5.4 At this time the Anaesthetist will also make a decision regarding the anaesthetic risk to the Service User and whether their physical health dictates that they require ECT to be administered in the General Hospital Operating Theatres. The anaesthetist will advise the treating team about the Service User's regular medication that needs to be given on the ward before ECT.
- 5.5 A comprehensive list of investigations required can be found in the ECT Guidance.

6.0 CONSENT

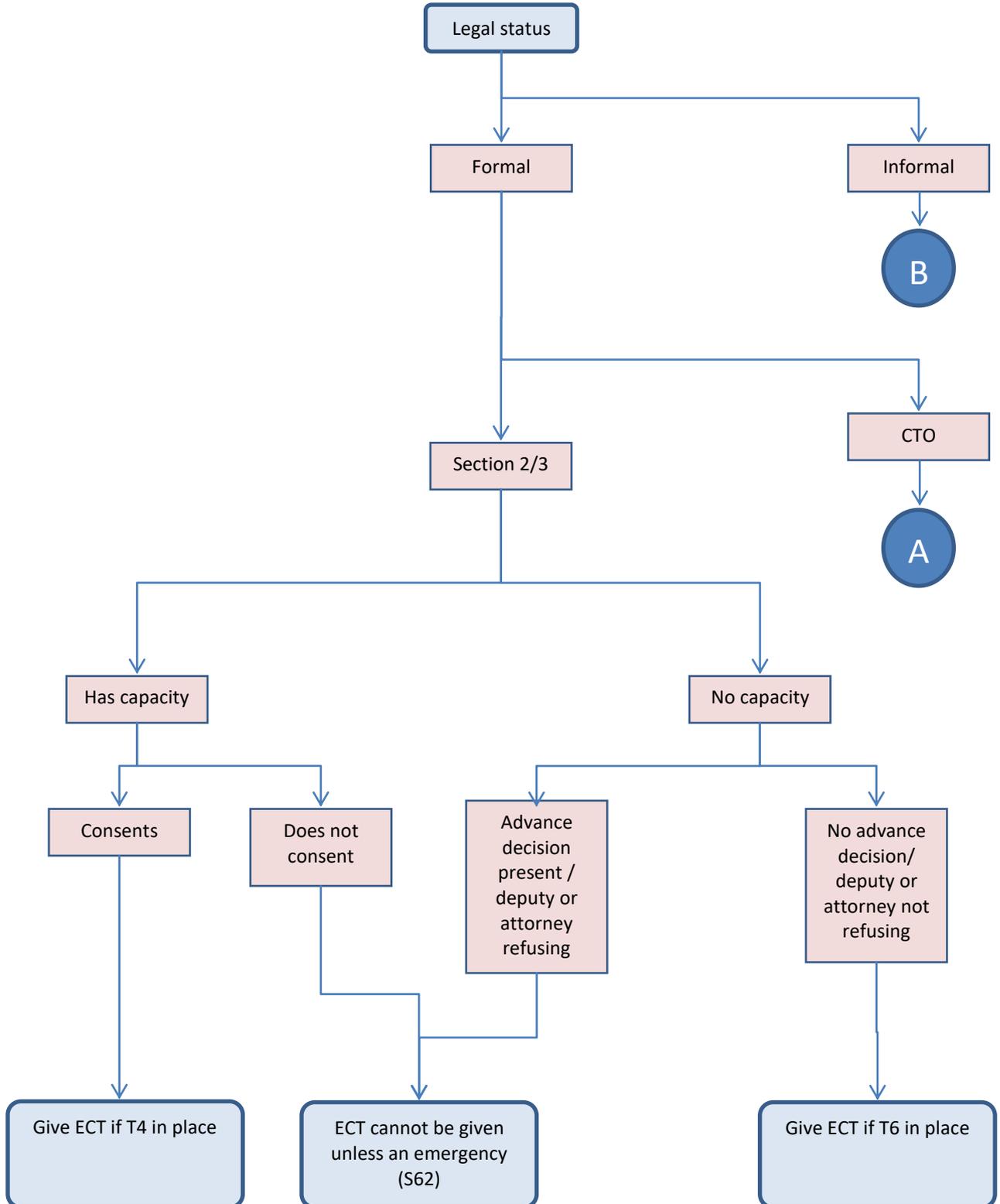
- 6.1 Consent must be obtained and recorded in clinical notes for all Service Users that have capacity to consent. Consent takes the form of written consent prior to a course of ECT and verbal consent prior to each individual ECT being administered. Assessment of capacity and consent should be recorded using the relevant forms. The referring Consultant Psychiatrist and his junior Doctor is responsible to ensure that consent is obtained and recorded

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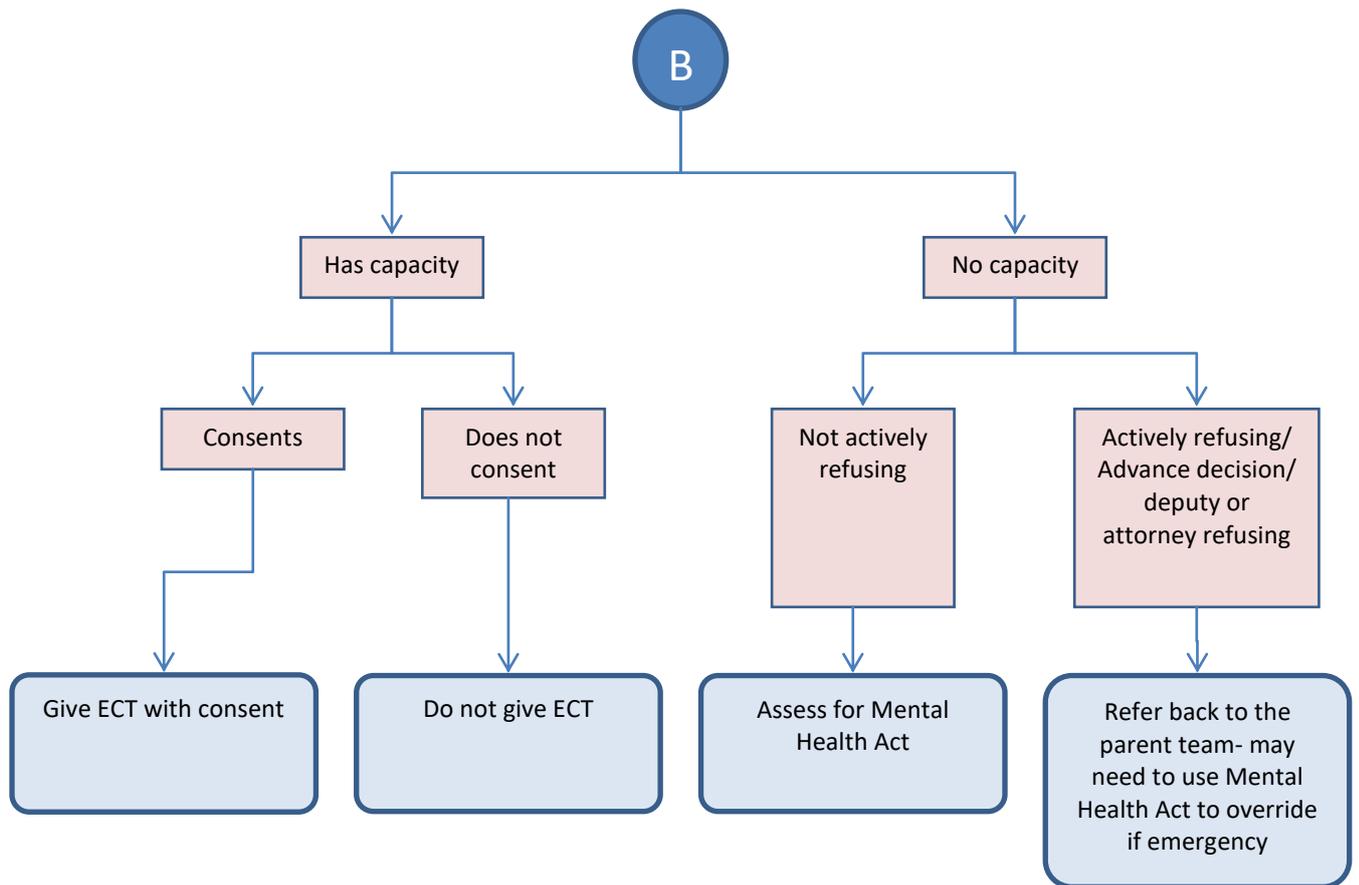
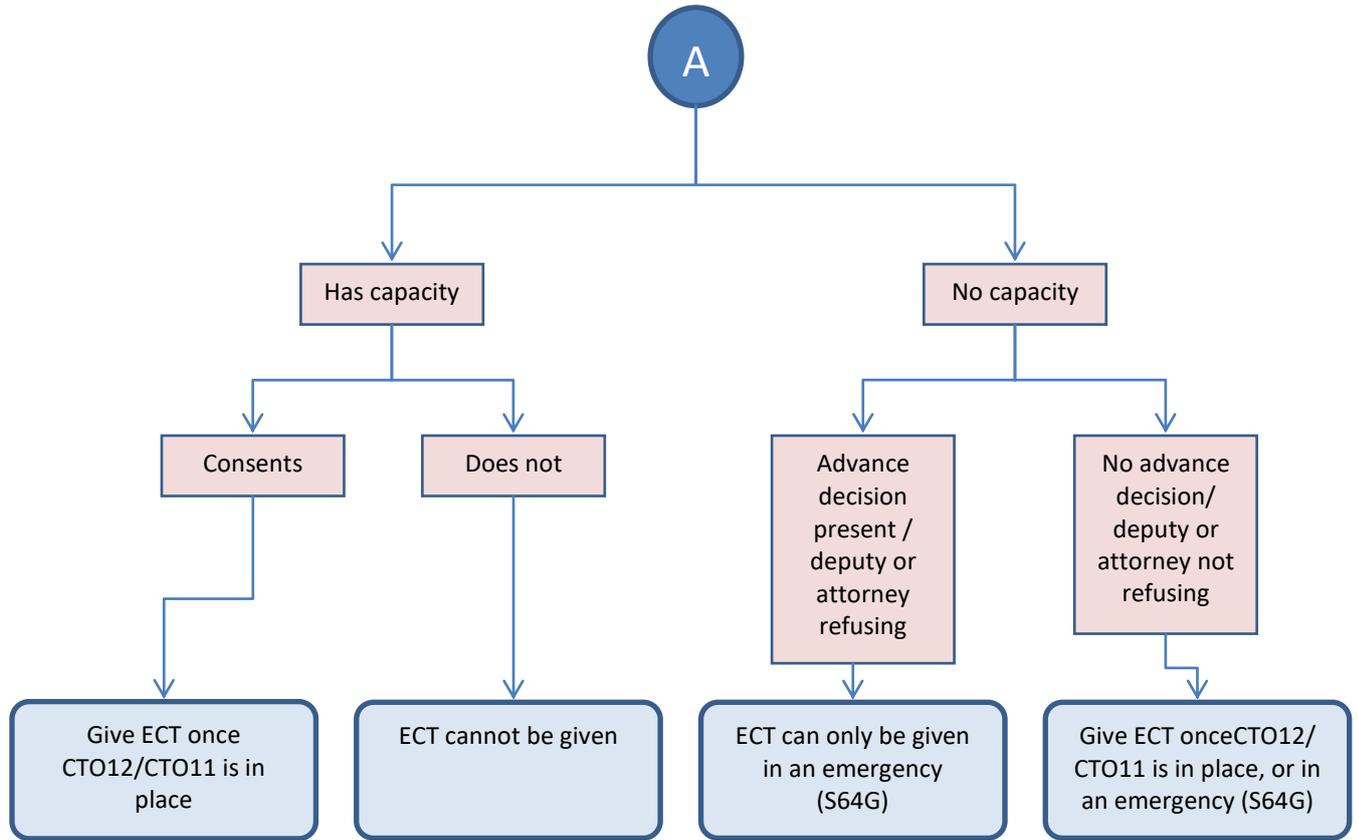
- 6.2 Consent is obtained by a Psychiatrist with adequate knowledge of the nature and effects of ECT. Informed Consent presumes that the Clinician obtaining the consent should have a working knowledge of the procedure for which the consent is sought. The clinician should also be conversant with the Mental Capacity Act.
- 6.3 The Service User has a right to withdraw consent at any time. The Service User has the right to confer with an Advocate, Care staff, family members and others about ECT, before providing written consent.
- 6.4 The patient's consent should never be obtained through any form of coercion, e.g. implying the Mental Health Act will be applied if the patient refuses.
- 6.5 Should the Service User lack capacity, Code of Practice for Mental Health Act and Mental Capacity Act should be adhered to.
- 6.6 If the Service User has capacity and refuses treatment, ECT cannot be administered even if the Service User is detained under the Mental Health Act.
- 6.7 The active involvement of relatives, carers and advocates is encouraged to facilitate informed decision.
- 6.8 Except in the case of emergencies sufficient time should elapse between anaesthetic assessment and treatment to allow the Service User to give fully informed consent and to consult with relatives and carers.
- 6.9 The Service User must be offered The Trust ECT Information Leaflet to read and consider.
- 6.10 Service Users who have not previously had ECT should be offered the opportunity to visit the ECT Clinic Treatment Unit.
- 6.11 ECT should only be considered for young people with very severe depression and either life threatening symptoms (such as suicidal behaviour) or intractable and severe symptoms that have not responded to other treatments
- 6.12 ECT is not recommended in the treatment of depression in children (5-11 years)

7.0 LEGAL STATUS, CONSENT & CAPACITY

7.1 Overview of consent, capacity and legal status:



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7.2 Informal Patients:

Informal patients must give written consent to ECT, on the ECT consent document. The consent should be taken by the referring Psychiatrist. Consent should be given without any duress and the patient should be advised that consent can be withdrawn by them at any time. The ECT consent form is used to initiate the consent process prior to commencing ECT, but the patient will be asked to confirm the consent at the time of each application.

Consent procedures should take into account the provisions of the Mental Capacity Act where ever these apply.

Informal patients who do not have capacity and for whom ECT is recommended are by definition unable to give consent. Consideration should be given to such patients being assessed under the Mental Health Act and if detained treated accordingly.

Informal patients who have an Advance Decision refusing ECT cannot be given ECT. The patient or their representative has the responsibility to notify the clinician about any Advance Decision.

7.3 Patients with a valid advance directive prohibiting resuscitation

Patients with a valid advance directive prohibiting resuscitation should be identified. A discussion should be had with them by the most senior ECT clinician present prior to anaesthetic being administered to clarify whether such a decision applies even in the circumstances of ECT.

The discussion should be recorded in the patient's electronic record. Any issues arising from this discussion may need to be discussed with the ECT Clinical Director prior to ECT commencing unless in an emergency.

7.4 Patient Detained in Hospital under the MHA 1983

ECT is covered under section 58A of the MHA 1983. Chapter 25 of the MHA Code of Practice refers to ECT treatment and to medication administered as part of ECT. It applies to detained patients and to all patients under 18. (Whether or not they are detained).

Patients with Capacity to Consent:

ECT cannot be given to a capacious patient unless they give a valid consent, except in an urgent case.

For ECT to be given to a capacious patient under the Mental Health Act, the Approved Clinician in charge of the patient's treatment or the SOAD must provide a certificate under Part 4 of the Act on Form T4 stating that the patient has capacity to give a valid consent and that the patient has given their consent.

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Patients without Capacity to Consent:

For a patient lacking capacity and under the Mental Health Act to be legally given ECT treatment, a SOAD must provide a certificate under Part 4 of the Act on Form T6 (except in urgent cases). The T6 should confirm that the patient lacks capacity to consent to ECT, the proposed treatment is considered appropriate, that there is no valid and applicable Advance Decision made under the Mental Capacity Act refusing treatment, no authorised attorney objects to the treatment on the patient's behalf, that the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

7.5 Consent and information giving for Young People under 18 years of Age

7.5.1 The Mental Health Act Guidance 2007 is considered in all instances when prescribing ECT for a young person under 18 years of age (England and Wales only)

7.5.2 For all young people under 18 years of age, a Second Opinion Appointed Doctor (SOAD) is consulted for ECT, regardless of the young person's capacity to consent (England and Wales only ECTAS **4.20.4**)

7.5.3 Provision should be made to treat younger patients separately from sessions involving adults.

7.5.4 When consideration is being given to administer ECT for any patient under 18 years, the referring consultant should firstly discuss the referral with the ECT Lead Consultant.

7.5.5 If treatment is agreed for the young person, the ECT Lead Consultant will plan treatment as per the guidance set out in the Royal College of Psychiatry Handbook.

7.6 Patients on CTO (Community Treatment Order)

For patients (over 18) on CTO ECT cannot be given under the Mental Health Act unless the patient has been recalled.

For patients recalled to Hospital: ECT can be given where revoked when a part 4A Certificate approves continued treatment or treatment is already being given on the basis of a Part 4A Certificate, even though it is not authorised for administration on recall, if the RC in charge of the treatment considers that discontinuing such treatment would cause the patient serious suffering. The treatment may however be administered pending a new certificate being provided by a SOAD.

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7.7 Urgent Cases where Certificates are not required (Sec 62 MHA 1983)

Section 58A does not apply in urgent cases where treatment is immediately necessary. Part 4A Certificate is not required in cases where treatment is immediately necessary.

ECT can be given under Sec 62 MHA 1983 if the treatment is immediately necessary to save the patient's life OR to prevent a serious deterioration of the patient's condition.

The treatment can only be given for as long as immediately necessary. When the treatment ceases to be immediately necessary the usual requirements for certificates apply.

8.0 RESPONSIBILITIES

8.1 Referring/Prescribing Psychiatrist

- i. It is the responsibility of all referring Psychiatrists to familiarise themselves with the relevant documentation for completion before, during, and after ECT treatment.
- ii. The referring Consultant Psychiatrist, must document the decision, indication and rationale for ECT in the clinical notes.
- iii. The prescribing psychiatrist will discuss with the Service User the advantages and disadvantages of Unilateral and Bilateral electrode placement.
- iv. The responsibility for prescribing each ECT treatment rests with the Prescribing Consultant and the prescription for the next ECT treatment should be signed and dated prior to the next treatment session.
- v. The Service User must be reviewed by the Prescribing Consultant or deputy before each subsequent ECT treatment and Service User's response to the treatment, side effects and cognitive difficulties should be recorded.

8.2 Clinical Director for ECT

The Clinical Director for ECT provides medical line management for the ECT Lead Psychiatrists and ECT Clinician.

He/she along with operational management has a role in ensuring that clinical policies/procedures relating to ECT are up to date and appropriate and works alongside the clinical lead on medical matters relating to ECT. He/she reports directly to the Executive Medical Director.

8.3 ECT Lead Psychiatrists

The ECT Clinical Lead will provide advice regarding provision of appropriate treatment and to ensure that the ECT practice is conducted in accordance with the Trust Policies and Procedures, NICE guidance and ECTAS standards.

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The ECT Lead Psychiatrist will fulfil the following responsibilities:

- i. Ensure that ECT practice is conducted in accordance with Trust Policies and Procedural Guidelines, NICE Guidance and ECTAS Standards
- ii. Undertake further development of the service and have regular reviews of treatment protocols and practice

8.4 Consultant Anaesthetist

The Consultant Anaesthetist will fulfil the following responsibilities:

- i. Assist ECT Core Staff in the preparation and review of Policies, Protocols and guidance etc.
- ii. Ensure that 'Recommendations for standards of monitoring during anaesthesia and recovery' from Association of Anaesthetists of Great Britain and Ireland (2015) and any further updates are followed.
- iii. Assess any new Service User prior to first ECT treatment and advice on any further investigations
- iv. Ensure that each Service User is fit for anaesthetic on the morning of treatment;
- v. Train Anaesthetic staff for ECT and co-ordinate Anaesthetist rota for ECT.
- vi. Ensure oxygen is administered before ECT in order to produce optimum oxygen saturation and a short period of hyperventilation can be administered before stimulation.
- vii. Ensure anaesthesia is administered on a trolley or bed that can be swiftly tipped to a head down position.
- viii. Before induction, the anaesthetist or assistant checks that any dentures have been removed or are secure.
- ix. When the Service User is induced, the anaesthetist or assistant inserts a bite block as appropriate.
- x. The anaesthetist ensures that the Service User is protected during the seizure, by ensuring: airways are patent and Oxygen saturations are satisfactory; cardio-vascular status is not compromised; the bite block is in-situ, and adequately protecting teeth and gums; appropriate doses of muscle-relaxants are used and ensures Service User remains under adequate levels of anaesthesia
- xi. Liaise with Administering Psychiatrist should he believe the seizure should be terminated.
- xii. Ensure that the Service User is able to safely be transferred to the recovery area and provide the Recovery Nurse with any specific information that they require;
- xiii. To remain within the ECT Department until all Service Users are fully conscious and the Recovery Nurse is happy with their progress.

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8.5 Operating Department Practitioner (ODP)

The Operating Department Practitioner will fulfil the following responsibilities

- i. To check all anaesthetic equipment and anaesthetic sundries in the treatment room;
- ii. Assist the Anaesthetist in Service User monitoring during treatment;
- iii. Assist the Anaesthetist when the cannula is inserted and ensure that the cannula is securely fixed;
- iv. Assist Anaesthetist if an endotracheal tube or laryngeal mask is required;
- v. Provide any other assistance as required to the anaesthetist.

8.6 ECT Manager

- i. The ECT Manager will take overall responsibility for the management of the ECT clinic and will ensure that the ECT practice is conducted in accordance with the trust policies, procedural guidelines, NICE guidance and ECTAS standards.
- ii. The ECT Manager will liaise with ECT Lead Consultant to ensure further development and regular reviews of ECT practice
- iii. The designated ECT Manager should be assessed as being competent to carry out the role e.g.: having attended ECT Nurse Competency Training by the Royal College of Psychiatrists and National Association of Lead Nurses for ECT (NALNECT) or equivalent training.
- iv. The ECT Manager will fulfil the following other responsibilities:
 - Accept Service User referrals for the ECT Treatment Unit;
 - Ensure the Health & Safety of the clinic environment;
 - Ensure the provision of managerial supervision, training, personal development planning and performance appraisal of ECT nursing staff, in ensuring and maintaining a capable team;
 - Manage the budget for the ECT Service.
 - Ensure the up-to-date training assurance for the ECT staff.
 - Regular liaison with other professionals, e.g.: theatre staff, equipment and pharmacy technicians, acute mental health teams;
 - Report any issues and problems relating to ECT practice to the ECT Clinical Lead Consultants / ECT Consultant Anaesthetist / Service Manager for ECT Service as appropriate;
 - Undertake periodic review of the Service Operational Policy and nursing procedures / protocols, ensuring that these reflect national guidance.
 - Manage the ECT nursing staff rota and sickness management
 - Maintain and arrange servicing and repair of the ECT equipment

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8.7 Responsibilities of the Ward Manager

- i. Ward Managers are required to follow the ECT process as detailed within the policy. Particular attention should be given to ensure that ward staff know how to prepare and escort ECT Service Users.
- ii. Ensure that the Service User fully understands the ECT procedure and has sufficient opportunity to ask questions.
- iii. Ensure that staff administers medication and any additional medication as advised by the Anaesthetist.
- iv. Inform all ward staff, Service User and the relatives and ensure that the Service User has fasted for a minimum of six hours. This includes chewing gum and sweets.
- v. Ensure that the Named Nurse has communicated with the Service User about the treatment and its possible side effects.

8.8 Responsibilities of Nurse in Charge of the Ward (on morning of treatment):

- i. Give any medication recommended by the Anaesthetist between 6am and 7am with a sip of water.
- ii. Confirm that the Service User has fasted. If they have not, contact ECT staff immediately and inform them what the Service User has eaten or drunk.
- iii. Request the Service User to avoid smoking prior to ECT.
- iv. Record the Service User's vital signs (blood pressure, pulse and respiration) on the Service User's Pre-Treatment Checklist.
- v. Advise the Service User to remove nail varnish, make-up and remove non-essential jewellery (ensure safe storage of valuables).
- vi. Be available to answer any questions the Service User may have regarding side effects of ECT.
- vii. Nurse in Charge of the ward must ensure that the Escort Nurse is suitably trained, known to the Service User, and aware of the Service User's clinical history.

8.9 Responsibilities of Escort Nurse:

- i. The Escort Nurse must stay with the Service User at all times, and follow the instruction of ECT staff.
- ii. Service Users returning to their ward by hospital transport outside the Unit must be escorted by a suitably trained nurse.
- iii. Any behavioural problems / special observations must be notified to ECT staff to ensure sufficient staff.
- iv. Ensure all documentation is present and correct including ECT prescription record, signed Consent to Treatment Form, Mental Health Act documents, ECT Record Form and Pre-Treatment Checklist. In addition it is important to include the Service User's clinical notes, medication charts and results of any investigations.
- v. Advise the Service User to wear comfortable clothing for the treatment session.

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- vi. Prompt the Service User to empty bladder and bowels prior to the ECT treatment.
- vii. On arrival at the ECT Department the Escort Nurse will advise the ECT department of any last-minute changes so that the Anaesthetist can be consulted.
- viii. During post-recovery the Escort Nurse will carefully observe the Service User and report any irregularities to the Recovery Nurse or ECT Clinic Nurse.
- ix. After recovery, the Escort Nurse will offer the Service User some light refreshment.
- x. If the Service User needs to go to the toilet the Escort Nurse must accompany the Service User, and ensure that they are near enough to assist them in case of dizziness (the disabled toilet cubicle has sufficient room for a Service User and nursing staff).
- xi. Check with the ECT staff before arranging to leave the Unit or calling for transport, in order to ensure that the Service User is fit to leave the Department, and that the Service User's cannula site has been checked.
- xii. Collect all the Service User's belongings and documentation and be advised by ECT staff as to any instructions prior to next ECT so that these can be relayed to the ward.

9.0 DAY SERVICE USER

9.1 Service Users that are attending ECT on a day Service User basis will follow the same referral pattern as ward Service Users but will require some additional safeguards. It is therefore vital to ensure the following additional arrangements are in place before the Service User commences treatment and after a treatment session.

9.2 Before Treatment

- 9.2.1 The ECT Manager should be contacted to discuss whether or not a Service User is a suitable candidate for attending as a day Service User.
- 9.2.2 Additional time should be allotted when referral is being considered
- 9.2.3 The Service User will be seen by the anaesthetist to assess whether or not the Service User is physically fit enough to have a general anaesthetic as a day Service User.
- 9.2.4 Service Users and their Carers must be given an ECT information booklet and be given the opportunity to raise any issues.
- 9.2.5 The Service User's Carer (a competent adult) should accompany the Service User to their assessment so that they can understand their responsibilities within the ECT process.

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- 9.2.6 The Service User must be able to follow nursing and medical instructions regarding all aspects of their ECT care.
- 9.2.7 The Service User must sign the Day Service User Form. This is to prove that they have read and understood the conditions regarding their having ECT as a day Service User.
- 9.2.8 Arrangements must be in place to ensure that the Service User has a responsible adult to care for them prior to ECT and for 24 hours following treatment.
- 9.2.9 A responsible adult must sign the Day Service User Form to prove that they are aware of day Service User care and will ensure adherence to this.
- 9.2.10 The referring Practitioner must liaise with the ECT team to ensure that satisfactory management/ arrangements are in place for review prior to next ECT.

9.3 After Treatment

- 9.3.1 All Day Service Users will have an assessment before discharge performed by the recovery nurse and the administering psychiatrist. The final decision for Fitness for Discharge will rest with the administering psychiatrist.
- 9.3.2 The Day Service User should not be discharged from the ECT Treatment Centre until
- Fully mentally and physically fit to leave
 - Vital parameters have stabilised
 - The 'Fitness to Discharge' has been recorded in the Clinical records by the administering psychiatrist
- 9.3.3 The Service User is reminded about:
- Need for a Responsible Adult to accompany the Service User to their home and stay with them for at least 24 hours following treatment.
 - The DVLA recommends that you should not drive during a course of treatment for severe depression (this includes ECT treatment). Please refer to: www.direct.gov.uk
 - Not to have sole responsibility for the care of children, operate machinery, or drink alcohol or sign any financially legal or binding documents within 24 hours of their ECT treatment.
 - If the Service User is deemed by the administering psychiatrist in consultation with the Consultant Anaesthetist not fit for discharge, appropriate arrangements are made for Service User admission for further observation and treatment.

10.0 MAINTENANCE ECT

10.1 Introduction

Both continuation and maintenance ECT are prophylactic treatments but the terms are not synonymous. Continuation ECT is conventionally defined as ECT administered within six months of remission of the index illness to prevent early relapse. Maintenance ECT is administered to prevent recurrence of the illness beyond six months after the index episode.

The Royal College of Psychiatrists (2005) and the American Psychiatric Association (APA, 2001) both recommend that continuation and maintenance ECT be offered as treatment options. The National Institute for Clinical Excellence, however, does not recommend the use of continuation or maintenance ECT because there are as yet no data from randomised controlled trials to confirm or refute the efficacy of such treatment (NICE, 2003)

The following is based on a sample protocol from the Royal College of Psychiatrists but is more specific with regard to physical examination and investigations, consent and escorting of patients.

10.2 Responsibilities of the referring team

10.2.1 The named consultant should record in the patient's notes the reasons for proposing continuation/maintenance ECT as opposed to alternative treatments.

10.2.2 The decision should be discussed fully with the patient and his or her family or carers.

10.2.3 A second opinion should be sought in each case. This must be formal in the case of patients detained under the Mental Health Act but may be informal in the case of patients not detained.

10.2.4 The decision to recommend continuation/maintenance ECT should be discussed with the lead consultant for ECT.

10.2.5 A statement of the patient's capacity to consent to continuation/maintenance ECT should be recorded prior to commencement of the treatment.

10.2.6 A consent form stipulating the number of treatments should be completed. The maximum number that may be stipulated on one consent form is 12 treatments. The consent form is valid for six months.

10.2.7 A decision must be reached as to the frequency of treatment. It is recommended that weekly treatment is considered for continuation ECT and weekly to monthly treatment for maintenance ECT.

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- 10.2.8 As is the standard with ECT for acute illness, the patient should be reviewed after every treatment to assess improvement and decide if treatment is to continue. This review may be carried out by the patient's care co-ordinator and does not have to be by the consultant, though it is recommended that the consultant be informed of the outcome of each review.
- 10.2.9 Assessment of cognitive function should be carried out at least six-monthly, and at a minimum should consist of the MOCA.
- 10.2.10 Consent should be renewed after 12 treatments or six months, whichever is sooner. A further statement of capacity and second opinion should also be sought and recorded at this time.
- 10.2.11 The patient must undergo the usual physical examination and clinical investigations before commencement of the treatment. How frequently the examination and investigations should be repeated during the course of treatment will depend on the patient's premorbid physical condition and on the duration of the course of ECT. Where the patient does not have significant physical health problems it is recommended that a full physical examination is carried out by a doctor from the referring team every six months.
- 10.2.12 In between maintenance treatments the physical health of a patient in the community remains the responsibility of the patient's General Practitioner.

10.3 Responsibilities of the team administering ECT

- 10.3.1 If the patient is not a hospital inpatient, the team administering ECT must ensure that he or she is escorted to the ECT suite on the morning of the treatment. This escort need not be a member of staff (e.g. community psychiatric nurse) but must be a responsible adult.
- 10.3.2 The team has the discretion not to proceed with the treatment if it judges that the patient's physical condition is such that the ECT could potentially be harmful. The team must inform both the General Practitioner and the referring team of this.
- 10.3.3 The team must ensure that the patient is accompanied home from the ECT suite and has a responsible adult with him or her for at least 24 hours afterwards. If such an accompaniment cannot be guaranteed then in line with anaesthetic guidelines regarding short term anaesthetic, the treatment should not be carried out.

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11.0 PREPARATION FOR ECT

- 11.1 Consent must be obtained and recorded in clinical notes for all Service Users that have capacity to consent.
- 11.2 The Service User must be offered The Trust ECT Information Leaflet and allowed sufficient time to consult with relatives and carers.
- 11.3 Service Users who have not previously had ECT should be offered the opportunity to visit the ECT Clinic Treatment Unit.
- 11.4 The Service User must have a physical health assessment completed by the referring consultant or their deputy and documented on the ECT referral form (Form 01)
- 11.5 The Service User must fast from midnight or at least 6 hours prior to treatment. This includes chewing gum and sweets.
- 11.6 The Anaesthetist performing the initial pre-ECT assessment might make alterations to the medication administration times, e.g.: administering anti-hypertensive the night before the ECT treatment. The anaesthetist will also suggest the withholding of certain medication.
- 11.7 Service Users who are being treated for hypertension should be administered their morning anti-hypertensive medication with minimal water (maximum 30mls) between 06.00 and 07.00 hours on the morning of ECT treatment.
- 11.8 For Service Users with diabetes, the short period of starvation will cause minimal disruption to their diabetic management.
- Insulin dependent diabetic Service Users need to have their individual insulin requirements and ECT management individually assessed by the Anaesthetist;
 - Insulin should not be given on the morning of ECT treatment until the first substantial meal following ECT;
 - Long acting evening insulin may need to be reduced on the evening before ECT administration;
 - Unless advised otherwise, there is no need to adjust oral hypoglycaemic agents during ECT;
 - Service Users with tablet or diet controlled diabetes need to have their blood sugar (BM) checked prior to each ECT treatment and recorded in the notes or on the BM chart.
- 11.9 For Service Users with symptomatic gastric reflux disease, a prescription of antacid medication (usually ranitidine 150 mg the evening before and the morning of treatment) should be provided. Dependent on clinical needs, the Anaesthetist may decide to intubate the Service User who suffers from severe symptoms of gastric reflux.

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11.10 For service users having their first ECT treatment, cognitive function should be assessed and documented.

12.0 ADMINISTRATION OF ECT:

12.1 Before ECT

12.1.1 The Service User will be reviewed by the ECT staff to confirm that the Service User has been assessed and ECT prescribed by the treating team.

12.1.2 The ECT staff will ensure that hearing aids, spectacles, dentures, contact lenses, hairpins have been removed before administration of ECT. The presence of any capped teeth and pacemaker is brought to the attention of the anaesthetist.

12.1.3 The ECT staff will confirm from the Service User and the nurse that the Service User has been appropriately prepared for anaesthesia and that the instructions from the anaesthetist have been adhered to.

12.1.4 The time that the Service User last ate/drank will be asked for and recorded.

12.1.5 Consent for ECT will be verified prior to each administration and the Service User will be asked about any coercion to have ECT.

12.2 Procedure for Administration

12.2.1 The seizure threshold will be established by the treating psychiatrist as per the local protocol.

12.2.2 A dose of 1.5 to 2 times the seizure threshold will be necessary for bilateral ECT and a dose of 3 to 6 times the seizure threshold will be necessary for Right Unilateral ECT.

12.2.3 The aim is to induce generalised tonic-clonic seizure activity for at least the minimum duration as specified by the Royal College of Psychiatrists ECT Handbook.

12.2.4 The treatment doses may need to be modified based on the clinical response and any side effects

12.2.5 If there is evidence of significant cognitive impairment at any stage, consider, in discussion with the person with depression, changing from bilateral to unilateral electrode placement, reducing the stimulus dose or stopping treatments depending on the balance of risks and benefits

12.2.6 ECT will be administered twice a week and should a general holiday intervene, alternative arrangements will be made.

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12.2.7 Anaesthetic techniques to decrease seizure threshold and improve the quality of the seizure such as use of oxygen, hyperventilation, and appropriate induction agent will be used.

12.3 During Recovery

12.3.1 Vital signs such as blood pressure, heart rate, temperature, oxygen saturations, etc. will be monitored before and at periodic intervals after treatment until the Service User is fully recovered from anaesthesia.

12.3.2 During recovery The Service User will be gently reoriented and reassured.

12.3.3 Orientation should be assessed after each treatment

12.3.4 Patients in recovery are asked about any side effects such as headaches and this is recorded and necessary prophylactic treatment is given in subsequent treatment.

12.3.5 After recovery, the Service User is offered light snacks and fluids as soon as it is possible and safe.

13.0 POST ECT REVIEW

13.1 The Prescribing Psychiatrists are required to follow the best evidence in treating depression, as described in NICE Guideline CG90-Depression after a course of ECT

13.2 It is considered good practice to monitor a Service User's response to ECT every 3-4 treatments as well as at the end of treatment and further at three-month and six-month intervals post-ECT.

13.3 Such a Post-ECT Review would assess the following:

- The Service User's clinical status/symptomatic response.
- Subjective complaints of cognitive and non-cognitive side effects
- Short term memory and cognitive functioning for all Service Users using tools such as the MOCA before, during and after (3 and 6 months) ECT treatment.
- Autobiographical memory loss using a memory log.
- Response to ECT using valid outcome measures such as the Hamilton Rating Scale for Depression, Becks Depression Inventory, Geriatric Depression Scale or the Patient Health Questionnaire 9 (PHQ-9).

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14.0 CHILD AND ADOLESCENT AND SERVICE USERS WITH LEARNING DISABILITIES

- 14.1 Provision should be made to treat younger patients separately from sessions involving adults.
- 14.2 When consideration is being given to administer ECT for any patient under 18 years, the referring consultant should firstly discuss the referral with the ECT Lead Consultant.
- 14.3 If treatment is agreed for the young person, the ECT Lead Consultant will plan treatment as per the guidance set out in Royal College of Psychiatry Handbook.
- 14.4 There have been no randomised controlled trials on ECT in patients with learning disabilities; evidence is based on case series or case reports. ECT should only be used if the psychiatric illness is refractory to treatment, or medication cannot be tolerated or the patient's condition has deteriorated severely. There are no absolute contraindications to ECT in patients with learning disabilities.
- 14.5 The high prevalence of epilepsy in this patient group is not a contraindication but use of anticonvulsant drugs has implications for seizure threshold.

15.0 TRAINING

- 15.1 All members of the ECT Team will be expected to develop specialist skills and knowledge relevant to the ECT Service. The team will be expected to participate in a range of in-house and external educational and development opportunities, as distinct from and complementary to The Trust's programme of mandatory training.
- 15.2 The responsibility for providing training and adequate supervision for medical staff rests with the ECT Clinical Lead Psychiatrists, and the responsibility for providing training and adequate supervision to ECT nursing staff rests with the ECT Manager.

16.0 ASSURING QUALITY

- 16.1 The ECT Service is subject to internal and external (PMETB, ECTAS, CQC, Royal College of Psychiatrists, Royal College of Nursing) scrutiny.
- 16.2 The ECT Service aims to maintain the highest standards of ECT practice adhering to evidence-based practice, PMETB, ECTAS, Royal College of Psychiatrists and Royal College of Nursing guidelines and recommendations. ECT practice will be monitored through a process of annual audit.

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17.0 CLINICAL PROTOCOLS RELATED TO ECT

- 17.1 Protocols have been developed for specific clinical scenarios in accordance to the current knowledge and recommendations from Royal College of Psychiatrist's ECTAS guidelines and the ECT Handbook; Royal College of Anaesthesia's guidelines and NICE recommendations.
- 17.2 The ECT teams will adhere to the local clinical protocols developed for use in specific clinical scenarios.

18.0 COMPLYING WITH LEGISLATION

18.1 Responsibilities under the Mental Health Act 1983:

18.1.1 All detained Service Users will have a designated Approved Clinician. All detained Service Users will be given information about their detention, their legal rights and right to appeal against detention in accordance with Section 132 of the Mental Health Act 2007. Support will be given to enable detained Service Users to exercise their rights.

18.1.2 The amendments to the Mental Health Act 1983, made by the Mental Health Act 2007, have made it unlawful to provide ECT to a detained Service User with capacity who does not consent to the treatment or where ECT conflicts with an advance decision (which the registered medical practitioner concerned is satisfied is valid and applicable) or with a decision made by a patient's deputy or by the Court of Protection. Where a detained Service User is deemed not to have capacity, the Trust's "Mental Capacity Assessment Form" should be completed. In an emergency, treatment can be administered if it fulfils the Section 62 requirement under the MHA of being immediately necessary to save the patient's life; or which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition. It is both good practice and legally responsible to obtain a second opinion from a senior consultant psychiatrist before further ECT is considered.

18.1.3 Should the prescribing psychiatrist consider ECT for a Service User under 18 years of age, consideration must be given to the MHA Code of Practice 2015 Chapter 36. All young people under 18 years of age must receive a formal second opinion for ECT regardless of capacity to consent. Please also refer to the relevant Trust Protocol and Trust Policy GC 58 (Under 18's and the Mental Health Act)

18.2 Human Rights Act 1998:

18.2.1 The team will continue to work to the principles of best practice, which involves compliance with and respect for Convention rights in all aspects of service provision.

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18.2.2 The Acute Care and ECT Team will work to the principles of fairness, respect for human dignity and inclusiveness, whilst adhering to Mental Health Act and Trust Policies, procedures and guidelines.

18.3 Mental Capacity Act 2005:

18.3.1 The principles of the MCA are that capacity will be presumed unless there is evidence to suggest otherwise. The purpose of the MCA is to ensure that individuals without capacity, or for whom it is suspected may not be equipped to consider complex decisions, are safeguarded and any action taken is in their best interests. Capacity is time specific and decision specific and is based upon four key elements – the ability to understand, consider, and retain the information and the ability to appreciate the consequences of the decision being made.

19.0 GENDER, ETHNICITY AND DIVERSITY

- 19.1 The ECT department will offer the service in a non-discriminatory way by accepting and being willing to work with an individual's understanding of their own issues.
- 19.2 This involves acknowledging an individual's culture and life experience, taking into account race, religion, gender, disability, sexuality and social class.
- 19.3 Service Users will be assisted in accessing specific services that are relevant to them and their individual needs.
- 19.4 In order to meet the specific needs of people from black and minority ethnic communities ECT will provide mental health information and health promotion leaflets in the main minority ethnic languages.
- 19.5 The ECT department will have access to interpreters and the staff will use this service when required.

20.0 SPIRITUAL GUIDANCE / CHAPLAINCY

- 20.1 Each ECT Team will respect and facilitate the Service User's wishes for obtaining spiritual guidance and support

21.0 CARER INVOLVEMENT

- 21.1 Carers (subject to the Service User's consent) will be actively encouraged to become involved in their loved ones treatment and care.
- 21.2 Individual nurses and other professionals working within the unit will endeavour to act as the Service User's advocate at all times.

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22.0 HEALTH AND SAFETY

22.1 Prevention and Management of Aggression and Violence:

22.1.1 The ECT Department will have an up-to-date risk assessment to determine the potential threat to staff of violence and aggression. All practical steps will be taken to protect staff from violence and aggression.

22.1.2 Ward Nursing staff must liaise with the ECT Manager to ensure that adequate levels of control and restraint staff are available when required at the ECT Treatment Unit; this arrangement should be finalised before the Service User attends the Treatment Unit.

23.0 SMOKE-FREE ENVIRONMENT

Smoking is not permitted inside the buildings or in the grounds of any Trust premises by any persons.

24.0 REFERENCE TO OTHER GUIDANCE ON ECT

24.1 When using this Policy, reference should be made to the following documents:

- National Institute for Health & Clinical Excellence (NICE) Guidelines:
- TA59 – ‘Guidance on the use of electroconvulsive therapy’
- CG38 – ‘Bipolar disorder. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care’
- CG90 – ‘The Treatment and Management of Depression in Adults (2015)’.
- CG82 – ‘Schizophrenia. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care’ (replaces CG1)

24.2 Royal College of Psychiatrists – www.rcpsych.ac.uk

- The ECT Handbook (Third Edition)
- The ECTAS Standards and Guidance (14th Edition)

24.3 Royal College of Anaesthetists – www.rcoa.ac.uk

- Recommendations for standards of monitoring during Anaesthesia and recovery (4th Edition 2007)
- Guidance for Electro-Convulsive Therapy provided in Remote Sites

24.4 Code of Practice – Mental Health Act 1983 – Department of Health (DoH) 2015

24.5 Mental Capacity Act – Code of Practice – Department for Constitutional Affairs 2007

24.6 Royal College of Nursing Guidance to ECT

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24.7 ECT intranet has comprehensive information including ECT referrals, ECT contact details and ECT documentation.

END