ELECTRO CONVULSIVE THERAPY (ECT)

Guidelines

Berkshire Healthcare NHS Foundation Trust

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Designated Leads: Dr M Mundasad - ECT Lead Consultant
Dr G Harrison - ECT Anaesthetist
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Berkshire Healthcare NHS Foundation Trust

CCR013
Version 9
POLICY DEVELOPMENT

CCR013 - Electro Convulsive Therapy (ECT)

History:
Version 9: Re-issued June 2013 following the relocation of Ward 10, Wexham Park Hospital to Prospect Park Hospital. Full review to remain as May 2015.

Issued April 2013 - Revised to reflect revised MHA requirements and revised Standards of Best Practice from ECTAS.
Revised Appendices meet new standards in ECT.
Care Pathway has not been attached to the policy, allowing for ongoing development of the Care Pathway that aims to meet and maintain ever-changing standards.
Reflection of staff changes in Trust ECT Team.

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Updated to reflect CQC compliance -Section 3 Definition and Section 7 NICE Guidance.

Version 7: Issued April 2011
Revised to reflect revised MHA requirements and revised standards of best practice from ECTAS.
Revised Appendices meet new standards in ECT.
Care Pathway has not been attached to the policy, allowing for ongoing development of the Care Pathway that aims to meet and maintain ever-changing standards.
Reflection of staff changes in trust ECT Team.

Version 6: Revised to reflect revised MHA requirements.

Version 5: Appendices revised to meet new standards in ECT. Minor policy changes to reflect changes in standards. Removal of the Care Pathway to allow for ongoing development of the care pathway that aims to meet and maintain ever-changing standards.
Reflection of staff changes in trust ECT Team.

Designated Lead: Deputy Director of Nursing West

Policy Consultants:
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Distributed for comments: Policy Scrutiny Group - 3rd April 2013

Assessed for compliance with the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.
This policy supports compliance with the Care Quality Commission’s Essential Standards of Quality and Safety Outcome 2, Regulation 18 and Outcome 4, Regulation 9.
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1. INTRODUCTION

1.1 The purpose of these guidelines is to ensure that all those involved in prescribing and administration of this treatment are adequately prepared for their responsibilities, and to ensure that the patient receives the highest standards of care from all staff involved.

1.2 All staff working in the ECT department must have knowledge of manual handling appropriate to this clinic, and should be aware of the necessary health and safety guidelines to follow, which will include safe usage and maintenance of the equipment in use, and of the need to follow universal precautions within the department. All staff must be up to date with mandatory training as per Trust guidance.

1.3 All staff involved in the department have a responsibility to ensure that these guidelines are adhered to and report any deficits to the ECT lead staff.

1.4 All the staff should be familiar with guidelines appended to this document.

2. BHFT PHILOSOPHY REGARDING ECT

2.1 Berkshire Healthcare NHS Foundation Trust and through them the staff working in the ECT suite, believe in delivering ECT treatment as safely and effectively as possible, whilst always maintaining the patients dignity and autonomy.

3. DEFINITION

3.1 Electro-Convulsive Therapy (ECT) is the induction of a seizure by administration of an electric current to the brain.

3.2 ECT is an effective treatment of some mental disorders, in particular depressive illness. It is sometimes indicated in drug resistant cases or when the illness is so severe as to be life threatening.

3.3 ECT treatment has been used in the treatment of psychiatric illness for many years.

3.4 The Royal College of Psychiatrists has produced a set of guidelines specifying:-

- Indication for treatment
- Consent to treatment
- Consent to general anaesthetic
- The delivery of treatment

4. STAFF RESPONSIBILITIES

PPH ECT department has a team of specially trained staff who work in the department regularly. In the absence of these there is a small cohort of staff in each area, trained in ECT and ready to provide cover, these staff regularly update their practice.
4.1 Psychiatrists

- **Psychiatrists** involved in the administration of ECT will have received the necessary training in its technique by ECT Lead Consultant (or nominee).

- BHFT must have a Consultant Psychiatrist nominated as having responsibilities for the training and supervision of administration of ECT.

- **Psychiatrists** must ensure that they are familiar with and have knowledge of the contents of the Royal College of Psychiatrists ECT Handbook which should be available in each ECT department.

- **Psychiatrists** must scrutinize all relevant Mental Health Act (MHA) documentation and/or consent forms at each treatment.

- **Psychiatric** referring team must ensure as far as possible, that the patient understands the nature, purpose and likely effects of the treatment, involving where necessary and/or appropriate, the patient’s relatives/carers.

- **Psychiatric** referring team must ensure that the ECT Care Pathway is fully completed prior to a course of treatment being given, and updated as necessary.

- **Psychiatric** referring team must assess the patient after every second ECT treatments, only two prescriptions/ requests may be completed at any one time.

- **Psychiatric** referring team must inform the Anaesthetist of any relevant clinical information about the patients.

- When deciding to administer ECT to a patient on an outpatient basis, the **Psychiatric** referring team must follow the guidelines set out in this document.

4.2 Nursing Staff

- All nurses involved in ECT will be aware of the preparation and recovery of patients receiving ECT.

- Will support patients, carers and relatives during the treatment.

- Will ensure that, as far as possible, patients understand the procedure and, where applicable, that their consent to treatment is considered valid.

- Will ensure that all the necessary documentation, paperwork and clinical notes accompany the patient to the ECT suite.

- Will assess the validity of the patient’s consent prior to each treatment, and inform the Psychiatrist of any concerns.

- All Patients will have a capacity assessment completed and documented within 24 hours prior to ECT being given - (the Trust suggests the use of MCA form on RiO in MCA and information sharing and consent section).
• Ward Managers should apply due consideration to the staffing rota to ensure that an adequate number of qualified staff are on-duty on ECT treatment days so enabling the ECT suite to be adequately staffed, and to ensure that staff from the patient’s base ward, where possible, accompany the patient throughout their treatment.

• Will implement any medically prescribed/recommended care or treatment following the administration of ECT.

• Will tidy the ECT suite, and clean, turn off or disconnect equipment following infection control guidelines as per BHFT.

• Will as necessary, safely dispose of any used clinical equipment, and restock the department as necessary.

• Will aim to have a bank of qualified 1st level nurses at PPH that are trained in the facilitation and running of the department to provide cover in the absence of ECT lead staff.

• For Out-Patient ECT follow the guidelines appended.

4.3 Anaesthetists

The anaesthetic staff are provided by Royal Berkshire district General Hospital via SLA and must be ALS trained.

• The role of the anaesthetist is to assess patients suitability and provide anaesthesia for patients receiving ECT.

• Anaesthesia should be given by a regularly attending small cohort of staff. Junior training grade doctors must be supervised.

• Anaesthetic care should be led by a named Consultant who should have dedicated sessional time for ECT.

• They will follow the recommendation for standards of monitoring during anaesthesia and recovery as per the Association of Anaesthetist GB and IR Guidelines.

4.4 Operating Department Practitioner

An Anaesthetic Practitioner must be present for all treatments, The ODP staff are provided by Royal Berkshire district General Hospital via SLA and must be ILS trained and will:

• Ensure that the anaesthetic and associated equipment is prepared and checked prior to the commencement of treatment sessions.

• Prepare the necessary drugs for use by the anaesthetist.

• Assist the anaesthetist as necessary.
• At the end of the treatment session, dispose of any anaesthetic equipment and re-stock as necessary and turn off or disconnect equipment as needed.

4.5 Recovery Nurses

• Recovery staff are provided by Royal Berkshire district General Hospital via SLA and must be trained to national recovery standards and will:-
  • Be Basic Life Support trained minimum.
  • Ensure the equipment in the recovery area is prepared ready for use, prior to ECT commencing.
  • Receive the patient from and carry out orders of the anaesthetist, supported by a hand over from the anaesthetist.
  • Monitor patients vital signs and ensure a patent airway is maintained.
  • Clean and remake beds and recovery area after each patient leaves the area.
  • Re-stock recovery area and report any deficiencies to ECT lead staff.

5. SHARPS

It is the responsibility of every member of staff to safely dispose of all sharps and contaminated products they have used, in the receptacles provided as per BHFT Policy HS008/ICC005 Management of Needlesticks and Contamination Injuries.

6. REFERENCES

Royal College of Psychiatrists (Current addition) *The ECT Handbook*: London: Royal College of Psychiatrists.
RCP ECTAS.
Nice Guidelines 2003 Revised Treatment for Depression Guidelines 2010 CG90


7. NICE CG 90 OCTOBER 2009 STIPULATES THE FOLLOWING:

• Assess clinical status after each ECT treatment using a formal valid outcome measure, and stop treatment when remission has been achieved, or sooner if side effects outweigh the potential benefits.

• Assess cognitive function before the first ECT treatment and monitor at least every three to four treatments, and at the end of a course of treatment.

• Assessment of cognitive function should include:
  • Orientation and time to reorientation after each treatment
  • Measures of new learning, retrograde amnesia and subjective memory impairment carried out at least 24 hours after a treatment.
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 treatment depending on the balance of risks and benefits.

If a person’s depression has responded to a course of ECT, antidepressant medication should be started or continued to prevent relapse. Consider lithium augmentation of antidepressants.

8. ELECTRO-CONVULSIVE THERAPY (ECT) TREATMENT GUIDELINES

Electro-convulsive therapy usually results in rapid improvement in depressive symptoms. Marked improvement or full remission is typically obtained after 6 to 10 treatments, administered over 3-6 weeks. It is for this reason that ECT remains one of the most effective available treatments for depression as well as some other psychiatric conditions.

The Trust aims to provide, with application of these guidelines, the implementation of ECT treatment at the highest standards of safety and efficacy in compliance with the guidelines reported by the Second Report of the Royal College of Psychiatrists Special Committee on ECT and NICE Guidelines as well as other relevant scientific documents.

This clinic works in accordance with RCP ECTAS standards.

8.1 Clinical Indications

The ECT Handbook; 2005 (by the Royal College of Psychiatrists’ Special Committee on ECT) recommends the use of ECT in depressive disorders, some specific subgroups of schizophrenia including catatonic states. NICE guidelines also include severe mania in this list.

A full description of all possible clinical indications for ECT is beyond the scope of this document and it is recommended that the prescribing physicians are fully conversant with the ECT Handbook and NICE Guidelines.

Clinicians willing to use ECT for clinical indications not included in the ECT handbook should do so only following a research protocol previously approved by the local ethics committee.

8.2 Preparation for ECT and issues related to Consent

8.2.1 Patients should be given a full explanation of ECT, this is the responsibility of the patients’ psychiatrist, not the ECT clinical staff. A verbal explanation should be supplemented with written material - a copy of the Trust’s and the Royal College of Psychiatry - Patient Fact Sheet (Appendix 2).

Patients should be advised not to make life changing decisions or sign any legal documents while under going this course of treatment.

Patients should be advised not to drive while receiving this course of treatment and until advised by their doctor

Patients should be advised not to drink alcohol during this course of treatment.
8.2.2 The patient’s psychiatrist should determine patient’s capacity to give informed consent. Informed consent should be based on understanding the purpose, the nature, likely effects and the risk of treatment in broad terms. There should be a clear discussion with patients with a risk/benefit analysis, reasons for considering ECT and alternatives available. This should include the consequences of not receiving ECT at all. Specific attention should be paid to information regarding side effects notably the relative risks of the possible impact of ECT on both working memory/cognitive function and autobiographical memory and possible risk to teeth. There should be a record of this placed in the patients notes.

The prescriber should be familiar with Trust policy on Consent and capacity see trust policy CCR035R, (Trust suggest use of MCA form on RiO in MCA and information sharing and consent section).

Every patient will receive a capacity to consent to ECT assessment, within 24 hours prior to each treatment, this should also be recorded in their notes.

8.2.3 If the patient cannot consent or is refusing ECT treatment, all the procedures established by the Mental Health Act (1983) revised (2008), Code of Practice and Mental Capacity Act 2005, revised 2007 should be implemented. Any patient prescribed ECT while detained under the MHA, for lack of capacity must receive a capacity assessment by their psychiatrist or nominated deputy, not earlier than 24 hours, prior to each ECT treatment and must state why they lack capacity. A record of this and their opinion regarding capacity, should be entered in the notes and may be used to support any further necessary assessments on the day of treatment.

8.2.4 If the patient can give informed consent, the patient will have to provide a signed consent for a stated number of treatments. This consent is to be recorded in the ECT Care Pathway. Consent can be withdrawn at any time and is best regarded as an ongoing process. Confirmation of consent will be obtained prior to each treatment.

8.2.5 If the patient is willing and compliant or requesting ECT but lacks the capacity to consent treatment may be considered under the least restrictive option, by using the MCA. In this regard a best interest meeting as per policy CCR035R must be held prior to a course of treatment, if during this meeting it is deemed in the ‘Best Interest’ of the patient to have ECT, treatment can proceed up until the patient regains capacity to consent, the course of treatment is finished, or the patient gives any indication of refusal. In the case of refusal MHA options may need to be explored.
In the case of Maintenance ECT a Best Interest Meeting should be held 6 monthly or following a significant change in presentation.

8.2.6 Advance Directives are statements made by an individual that express decisions about the healthcare, in anticipation of a time when they may not be competent to make or communicate such decisions. Clinicians are legally obliged to take informed and unambiguous advance refusals of treatment made by a competent individual into account unless:

(1) It does not apply to the circumstances that have arisen;

(2) The Mental Health Act is used to override the individual’s intentions about treatment;

(3) It requires the clinician to do something illegal or
It requires treatment that the clinician considers not to be in the individual's best interests. Advance consents are not legally binding because specific medical treatment cannot be demanded but clinicians should generally take such wishes into account.

8.2.7 It is good practice to inform the patient’s relatives, providing the patient gives consent for their relative to be informed. If a patient cannot give consent their relatives should not sign the consent form as no relative can give consent on behalf of an adult.

8.2.8 If a course of ECT is stopped and re-started, a new consent procedure should be carried out after a gap of more than 2 weeks.

8.2.9 A full medical history and physical examination is always necessary and should be recorded in the ECT Care Pathway. Any physical illness should be fully investigated and treated as far as possible, before commencement of ECT. Liaison between psychiatric and anaesthetic staff is critical and it may be necessary to arrange for investigations or referral to specialists before treatment commences. Results of investigations should be available before treatment.

8.2.10 Physical illness: A decision to treat patients with significant physical illness will always depend on the consideration of risks versus benefits and follow discussion with the anaesthetist and ECT clinic staff. Opinion on medical condition and suitability for ECT may be discussed with appropriate physician if required. For high ASA grade patients, consideration should be given for ECT to be arranged at DGH This will be a team decision but in this regard the Anaesthetist will make the final decision.

8.2.11 Drugs that may interfere with ECT:-

Use of benzodiazepines, if possible, should be avoided during ECT course, especially in 24 hours before ECT treatment. If anti-convulsants are being used as antiepileptic agents then the dose and drug should not be changed. If these drugs are being used as mood stabilisers then they may continue as before. However if the previous dose was a high dose a gradual reduction in dose may be considered before treatment. If, in spite of adequate stimulation, the seizure remains inadequate then a further reduction in dose or complete withdrawal of anti-convulsant should be considered. (See Appendix 9).

9. ECT ADMINISTRATION

9.1 Preliminaries

9.1.1 Before administering ECT the psychiatrist should verify that:-

- The ECT prescription form has been completed.
- An assessment of capacity has been made.
- That all necessary section papers are in the patients notes and contents of the forms complied with. This is to include T4,T6 or Section 62 as applicable.
- For emergency ECT a Sec 62 must be completed for each treatment according to local guidance and available to view prior to ECT.

9.1.2 If the prescribed dose of ECT is considered too high or too low or if the treating team has not prescribed or advised on the dose and/or type of ECT to be administered then the psychiatrist administering ECT should discuss this with the patients treating team.
Depending upon the outcome of this discussion the ECT administering doctor will alter the prescription, proceed with treatment accordingly and will document it in the notes.

9.1.3 Should the psychiatrist administering ECT be unable to contact the consultant responsible for the care of the patient or his/her deputy, the psychiatrist administering ECT should amend the prescription in accordance with Trust policy/guidelines, proceed accordingly and provide an explanation of his/her decision in the medical notes of the patient.

9.2 Preparation of machine - (this Clinic uses Thymatron System IV)

9.2.1 The psychiatrist administering ECT will:-

- Be familiar with the use of equipment.
- Have had sufficient training before administering ECT without supervision.
- Should check that the machine has been switched on.
- That there is enough paper in the Chart Recorder door.
- Confirm that all automatic internal test procedures have been successfully completed and machine displays preset.
- Select the prescribed treatment dosage.

9.3 Preparing the scalp

9.3.1 Adequate preparation of the skin for EEG and stimulus electrodes placement is of paramount importance. Poor electrical coupling will cause high impedance values that would lead to unreadable EEC traces, due to artefacts, and/or failure to deliver ECT.

9.4 Placement of electrodes

9.4.1 Bilateral ECT (BL)

Bilateral Frontotemporal Electrode Placement.

The electrodes are to be placed 3 cm above the midpoint of the distance between the auditory meatus and the external canthus on each side of the head.

9.4.2 Right Unilateral ECT (d/Elia Placement) (RUL)

One electrode will be placed at the standard right frontotemporal position (see below) and the other electrode will be placed near the vertex (about 3 cm from it) vertically above the meatus on the same (right) side as the other electrode.
9.4.3 Diagram of electrodes’ placement

9.4.5 Titration Method

9.4.6 The Titration method involves a gross measure of the patient’s seizure threshold during the first treatment session i.e., the minimum amount of electrical stimulation required to induce a seizure in a particular person at that particular time is determined. As a general policy for the Trust all patients should go through dose titration at the beginning of the course of ECT treatment. If for any reason titration is to be bypassed then prescribing team should highlight the reasons.

9.4.7 For titration purposes the 1st electrical stimulation is started with dose a dose of 50mC and the dose is gradually increased as per chart 3.5.7 till a seizure is produced.

9.4.8 In one treatment session a maximum of 3 electrical stimulations can be given.

9.4.9 During the first session if a seizure is produced on 3rd electrical stimulation with dose of 125 mC then on the next session the missed dose of 100mC should be tried first before finally accepting 125 mC as stimulus threshold.

9.4.10 No Seizure: If there is no seizure and further electrical stimulation is required then after each stimulation it is recommended approximately 20-30 seconds before repeating the next one (delayed response).

9.4.11 Aborted Seizure: Following an aborted or less than adequate seizure, before re-stimulating the subject, a minimum period of 60 seconds should lapse between stimulations because of the relative refractory period in which seizures are difficult to elicit.
9.4.12 Dose Titration Chart for Thymatron

<table>
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<td></td>
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<td>1 (Adults)</td>
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<tr>
<td></td>
<td>2</td>
<td>76</td>
</tr>
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<td></td>
<td>3</td>
<td>126</td>
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<td>2 If no seizure on first ECT Treatment</td>
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<td>176</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>277</td>
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<td></td>
<td>3</td>
<td>378</td>
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<td>3 If no seizure on ECT Treatments 1 &amp; 2</td>
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<td>479</td>
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<tr>
<td></td>
<td>2</td>
<td>604</td>
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9.4.13 Dose Titration - Bilateral ECT (BL)

- Follow above chart in 3.5.7.
- Once ST is determined, increase dose by 1.5 – 2 times for subsequent treatments and maintain this dose.
- Increase dose by 25 mC if seizure length falls progressively by 50%.
- Decrease dose by 25 mC if cognitive side-effects are troublesome.
- Consider switching to unilateral ECT if cognitive side-effects continue.
- Terminate seizures lasting > 120 seconds on EEG.

9.4.14 Dose Titration - Unilateral ECT (RUL) (Right Handed Patient)

- Follow above titration with RUL ECT.
- Once ST has been established the treatment dose should usually be 5-6 times the ST.
- Reduce treatment dose if cognitive side-effects are troublesome.
- Switch to BL ECT if ineffective after 4 treatments.
- Terminate seizures lasting > 120 secs on EEG.

9.4.15 Dose Titration - Unilateral ECT (LUL) (Left Handed Patient)

- Measure ST and give subsequent treatments as RUL ECT at X 2 of ST (on the assumption that most people, especially males, will still be left dominant).
- If no side-effects, then increase to x3 then x4 then x5 ST on subsequent ECT days.
- If cognitive side-effects develop with low doses RUL ECT assume right cerebral dominance and switch to LUL (Left Uni Lateral) ECT and repeat the process, starting at x2 ST.
- If no improvement after 4 unilateral ECTs at x5 ST switch to BL ECT.
- If cognitive side-effects are troublesome at x2 or x3 ST consider a switch to low dose BL ECT.
9.4.16 Changes in ECT Dose

<table>
<thead>
<tr>
<th></th>
<th>BL ECT</th>
<th>RUL ECT</th>
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<td></td>
<td>• Reduce dose or frequency if cognitive S/Es troublesome</td>
<td>• Reduce dose or frequency if cognitive S/Es troublesome</td>
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<td></td>
<td>• Consider switch to RUL if cognitive S/E develop</td>
<td>• Increase dose by 75mC if no response after 4 ECT’s</td>
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<td></td>
<td>• Increase dose by 75mC if BL ECT ineffective after 4 ECT’s</td>
<td>• Consider switch to BL ECT if ineffective</td>
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9.4.17 Adequate Seizure

Dose selection for the subsequent treatments should take as a reference the attainment of seizures on the EEG recording of not less than 20 seconds (unless they are “short fitters”). Other variables to be considered are clinical response, side effects, post ictal suppression, regularity and amplitude of the EEG trace, reductions in seizure length and awareness that the seizure threshold rises by approximately 10% following each treatment session.

Present criteria for an effective seizure includes visible generalised bilateral tonic clonic seizure (unless heavily masked with muscle relaxant) of at least 15 seconds. EEG criteria include synchronous, well developed, symmetrical ictal activity with high amplitude, a distinct spike and slow wave mid-ictal phase, pronounced post-ictal suppression. Also a substantial tachycardia.

9.5 ECT Outcome

If the patient fails to fit adequately, medications (anticonvulsants such as Benzodiazepines, Lamotrigine and Carbamazepine) and the anaesthetic dose should be reviewed. The cuff method may be used at subsequent treatments.

9.5.1 Prolonged Seizure: Any seizure lasting for more than 120 seconds is defined as a prolonged seizure. If the seizure lasts more than 120 seconds it should be terminated with either a further dose of induction agent or with intravenous Benzodiazepines (see anaesthetic protocol). Medication should be reviewed particularly SSRIs and Lithium, the anaesthetic induction dose could be increased and the stimulus reduced at the next treatment.

9.5.2 Tardive Seizure: One should be aware of the possibility of Tardive Seizure this is a seizure which appears after recovery from an electrically induced fit. Recovery staff should be aware of this possibility in recovery area and on the ward and it should be managed like any other seizure.

Outcome of each treatment including type of seizure (unilateral or bilateral, generalised or localised, tonic / clonic), physical duration, EEG duration and any untoward observation or event and any advice for subsequent treatment should be recorded on the ECT Care Pathway as well as in medical notes.

Each treatment in a course of ECT must be prescribed separately. Clinical progress (definite, possible or absent) and side effects (e.g. confused, memory impairment) should
be recorded on the ECT Care Pathway /clinical notes prior to each subsequent prescription.

If side effects are prominent the dose should be reduced in 25mC steps to a level where clinical benefit is maintained and side effects are minimised. If clinical benefit is maintained but with prominent side effects even at the lowest dose of 150mC, unilateral ECT should be considered.

The overall outcome of the course of ECT should be recorded in the clinical notes by the responsible psychiatric team within 4-5 days of completing a course of ECT. This should be supported by use of appropriate rating scales CGI and MMSE.

In case of Urgent ECT, e.g. under Section 62 of the Mental Health Act or when a patients mental or physical condition indicates, Titration may be bypassed. In this situation it would be better to start BL with a dose of 150 - 200mC. However, RUL with a dose of 400mC would also be appropriate.

9.6 Discontinuation

If in spite of an adequate fit, if there is no clinical improvement at all by any means (including trial of change from UL to BL, if relevant) the course should be discontinued after 6 treatments.

If there is severe post ictal confusion, notable delay in reorientation or significant memory disturbances related to ECT and the following adjustments have been made; medication reviewed, ECT stimulus dose reviewed and a change form UL to BL treatment should be discontinued.

When coming towards the end of a course of ECT it can be difficult to know exactly when to give the last treatment. The need for ongoing treatments should be assessed after each individual treatment and whenever possible the patient should be involved in the decision to stop. There is no evidence to support the practice of giving two extra ECT sessions after the patient is considered well enough to cease ECT.

If the team wish to deviate from these guidelines they should take advice from the ECT lead nurse or an ECT lead consultant to discuss the matter.

Patient’s memory and cognitive functioning, subjective experience and clinical status/symptomatic response and an assessment of autobiographical memory, should be recorded by the clinical team on completion of ECT, 3 and 6 months post treatment course, this can be supported by the ECT team.

Continuation/Maintenance ECT see Appendix 1.

10. MEDICAL STAFF TRAINING

All new trainees will receive a formal teaching session prior to administering ECT. This must include full instruction and use of the ECT Care Pathway

All trainees should have, through Trust website, access to the Trust Policy and Guidelines on ECT and be informed where copies of The Royal College Guidelines i.e. ECT Handbook can be found.
Trainees should be individually supervised for at least 3 treatment sessions by ECT Lead Consultant or nominee. An assessment of competence should be made during the third session. The trainee should have been awarded a certificate of competence by the Lead Consultant before administering ECT independently, without consultant supervision.

Any enquiry or clarification relating to this document should be directed to Kay Sayers ECT Lead Nurse Manager or an ECT Lead Consultant.

11. ECT ANAESTHETIC GUIDELINES

11.1 DNACPR during a course of ECT from point of intervention until leaving the suite

Please refer to BHFT Policy CCR007b Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy.

11.2 Equipment necessary for ECT

- Thymatron system IV ECT machine and accessories
- Pulse oximetry
- ECG monitor
- Blood pressure monitor
- Capnography
- Stethoscope
- Thermometer stored in treatment area
- Blood glucose glucometer stored in the treatment area
- Tipping beds / trolleys
- Suction machines
- Oxygen ( piped or cylinders + at least one spare )
- Mask and self inflating bag
- Peripheral nerve stimulator

11.3 Resuscitation Equipment:

- Trolley holding defibrillator and all necessary drugs.
- Up-to-date Resuscitation, Anaphylaxis, and MH treatment Algorithms, drug locations.
- Ice packs and Dantrolene which is stored in the resus trolley with appropriate amounts of sterile water, mixing is as per manufacturers' guidance and will be carried out by ECT staff only.
- Telephone to contact emergency services must be in place.

(See pages 12-15 of the Care Pathway)

This Clinic uses the adapted form of the WORLD HEALTH ORGANISATION SAFETY CHECKLIST

The medical assessment checklist (page 15 of the care pathway) should be completed by the referring team for all patients intended for ECT Treatment.
12. RELATIVE CONTRAINDICATIONS

- Severe CVS diseases – aortic stenosis, untreated heart block, uncontrolled hypertension, atrial fibrillation with rate > 100 bpm
- Severe respiratory / liver / renal disease
- Muscle diseases
- Pregnancy (obstetric advice first)
- MI or CVA within 3 months (preferable to wait 6 months)
- Phaeochromocytoma
- Acute DVT or thrombophlebitis (need anticoagulation first)
- Intracranial aneurysms or tumours associated with raised intracranial pressure
- Acute close angle glaucoma (get ophthalmology opinion first)
- Upper airway obstruction
- Malignant hyperpyrexia

13. ALL PATIENTS

Should be seen by an anaesthetist (ideally the one to give the GA) before undergoing ECT. The anaesthetist will assess the anaesthetic risk and is responsible for deciding if a patient is unfit for anaesthesia. Advice must always be available from a Lead Anaesthetic Consultant.

14. DRUGS TO CONSIDER WITHDRAWING BEFORE ECT RELEVANT IN ANAESTHESIA

(Refer to Appendix 8).

15. ECT RECOVERY GUIDELINES

15.1 Equipment

- Pulse oximetry
- ECG monitor
- Blood pressure monitor
- Stethoscope
- Thermometer stored in treatment area
- Blood glucose glucometer stored in the treatment area
- Tipping beds / trolleys
- Suction machines
- Oxygen cylinders + at least one spare
- Mask and self inflating bag

15.2 Resuscitation Equipment

- Trolley holding defibrillator and all necessary drugs in the ECT suite.
- Up-to-date Resuscitation, Anaphylaxis, and MH treatment Algorithms, drug locations.
- Ice packs and Dantrolene.
- Telephone to contact emergency services must be in place.
15.3 Recovery Area

There will be a specially designated recovery area located adjacent to ECT treatment room.

16. STAFF

- At least one nurse in recovery should be appropriately trained to national standards.
- Should be able to assess patients vital signs and initiate management to improve them
- Should observe patients on a 1 to 1 basis until they have regained airway control, CVS stability, and they are able to communicate.
- The number of staff in the recovery area must exceed the number of patients by one of which is the patients escort nurse.
- Anaesthetist must be immediately available until all patients have met criteria for discharge to sitting area.

17. PATIENT CARE

The patient will be handed over to the recovery staff by the anaesthetist. The patient should be:

- Breathing
- Cardiovascularly stable (heart rate & BP satisfactory, and no arrhythmias)
- Oxygen given 3-4 l/min by mask (or nasal specs)
- Monitoring attached - minimum should be heart rate and pulse oximetry (SpO2). ECG monitoring preferable.
- Records - all measurements must be recorded in a designated area on the anaesthetic sheet
- Side effects / problems should be documented.

18. NURSING OPERATIONAL GUIDELINES

18.1 Introduction:

Routine ECT (Electro Convulsion Therapy) is a treatment available twice a week, with clinics generally starting at 8am. First patient treatment at 08.30

18.2 Staffing:

Prospect Park Hospital ECT department is staffed only at the times of treatment, Tuesday am and Friday am.; Out of these hours please contact the patient’s base ward and/or ECT nurse on 01189605008.

18.3 The Skill Mix for each session consists of:

- ECT Trained Nurse
- Psychiatrist
- Anaesthetist
- Operating Theatre Practitioner
- General Trained Recovery Nurse
18.4 Preparing the patient for ECT

If ECT is identified as a treatment option, the team responsible for this person’s care must ensure that the patient, family or carers are fully informed of the process. Relevant information leaflets should be given as per policy.

All patients referred for ECT will be offered a pre treatment visit giving the patient an opportunity for them to meet the team, look around the department and receive full pre-anaesthetic assessment.

Pre-treatment visits at PPH are to be carried out following treatment sessions. Approximately 10.30 onwards by appointment with the ECT Department.

In case of emergency ECT, a pre anaesthetic check can be done immediately prior to 1st treatment.

All referrals to ECT must have blood tests, ECG and investigations as per anaesthetic guidelines.

All the above tests must be performed and documented and the results available with the patient on the day of pre treatment assessment along with physical and psychiatric notes. Ensure the ECT care pathway is completed in full and signed by patient (where applicable) and the Doctor.

19. PATIENTS RECEIVING TREATMENT UNDER THE MHA OR MCA

The following is for guidance only and anyone prescribing ECT for a detained patient is advised to read the revised MHA code of conduct sections 23 and 24 with reference to ECT and refer to the Trust Rules and Procedures.

If the patient is detained under for example Section 2, 3 or 37, has capacity and is consenting, the RC must complete a Form T4 58A (3) which must be filed in the patients notes and available for ECT staff to view.

Where a patient under these Sections is not consenting, and has the capacity to consent (refer to trust MCA guidelines CCR035R) ECT cannot be given. Where a patient under these Sections lacks capacity, a SOAD must complete form T6 58A (5) which must be filed in the case notes and available for ECT staff to view.

Should a detained patient without capacity, regain capacity to consent and refuse treatment, ECT may not continue to be given despite form T6.

Patients receiving ECT with use of section 62 or the MCA must have the appropriate documentation within their health records. A separate form for each emergency treatment under section 62, must be completed and filed in the notes prior to treatment being given and be available to view by ECT staff.
19.1 **Day of ECT: In-Patients**

Ensure the patient has been nil by mouth from midnight prior to treatment.

In-patients will be brought to the suite by ward staff when requested or at a specified time.

A qualified member of staff or appropriate escort must accompany the patient to the suite. This nurse should have a good awareness of the patient. They should help the ECT team establish a baseline of the person’s behaviour and any special needs.

The ECT pre treatment checklist, capacity assessment and confirmation of consent must be completed prior to leaving the ward and brought to the clinic, along with patient’s ECT Care Pathway, Medication chart and any other relevant information.

In cases of severe physical illness (i.e. with high ASA score) and when anaesthetically appropriate, the ECT will be administered at one of Berkshires Acute Hospitals. Responsibility for this will remain with the Anaesthetist, ECT nurse and Psychiatrist.

Patients can leave the clinic after meeting the discharge criteria as per the ECT post treatment discharge checklist, which is to be completed by the escorting staff. Patients will be discharged/ signed out by either the ECT Lead Nurse Manager, Deputy Lead for ECT or the Anaesthetist.

19.2 **ECT at District General Hospital Sites**

Treatment is coordinated by ECT staff following guidance documentation available via the department.

The referring Team must negotiate bed availability at the DGH site.

20. **ADMINISTERING ECT TO OUT- PATIENTS**

ECT (Electro Convulsion Therapy) is a treatment available twice a week at PPH. Both in-patients and out-patients can be prescribed and administered the treatment.

Out-patients will need to be assessed and prepared for the treatment as thoroughly as in-patients, and it needs to be recognised that there are a number of risks associated with out-patient administration, which are usually associated with post treatment activities.

It is important for all staff to be aware of the necessary preparation of the patient and their relatives and carers.

All Staff should be aware of, and follow the guidance below:

- If ECT is identified as a treatment option, the team responsible for this person’s care must ensure that the patient, family or carers are fully informed of the process. Relevant information leaflets should be given as per policy.
• All patients referred for ECT should be offered a pre-treatment visit giving the patient an opportunity for them to meet the team, look around the department and receive full pre-anaesthetic assessment.

• Pre-treatment visits at PPH are to be carried out following treatment sessions - approximately 10.30 am onwards by arrangement with the ECT Department.

• All referrals to ECT must have blood tests, ECG and any other investigations as per anaesthetic guidelines.

• All the above tests must be performed and documented and the results available with patient on day of pre treatment assessment along with physical medical notes and psychiatric notes. Ensure the ECT care pathway is completed and signed by patient (where applicable) and the Doctor.

• Checks for any contra indications MUST be made by the prescribing doctor.

• Out-patients will attend the ECT suite at PPH.

• ECT staff is to be made aware of any communication needs e.g. deafness, language etc that the patient may have so that appropriate arrangements can be made to meet these.

• Completed Care Pathway and Notes, should be forwarded to the ECT clinic prior to commencing treatment.

• The patient must be 'nil by mouth' from midnight on the night before the treatment. The reasons for this must be explained to them. They should not chew gum.

• Required medications may be taken with a sip of water.

• Out-patients should aim to arrive 30 minutes before start of ECT treatment session.

• Patients can go directly to the clinic where the team will complete the pre-ECT checklist.

• Treatment will not be given if the patient is alone or has not made provisions to have a responsible adult with them at home for a 24 hour period following the anaesthetic. This period of time is a requirement of anyone undergoing an anaesthetic and is part of the ECT policy anaesthetic guidance.

• Any patient not meeting the criteria may need to be considered for admission before the treatment can be given.

• Patients will be allowed home when they meet the discharge criteria, this includes completion of the discharge checklist and signing out by the ECT lead nurse or anaesthetist, they MUST be accompanied by a responsible adult. This

• Patients MUST be informed and confirm, that they are not to, cook or operate machinery until the day after their treatment.
• **The patient must agree:** Not to make life changing decisions or sign any legal documents while under going this course of treatment.

• **The patient must agree not** to drive while receiving this course of treatment and until advised by their doctor

**Please note:**

• Diabetic patients must bring their own insulin where indicated. Full guidance for use of insulin on the day of ECT will be given during the pre-treatment visit.

• Guidance for use of any other medication, i.e., Physical drugs will be given during the pre-treatment visit.

21. **PATIENTS PRE TREATMENT VISIT TO THE ECT SUITE**

Ideally all patients should have the opportunity to visit the ECT Suite prior to treatment.

This will provide the patient the opportunity to look around the unit, meet the staff, ask questions and gain any further information regarding ECT that they may require.

ECT staff will carry out relevant memory assessment where possible, dependant on patient mental state.

Relatives/ carers are welcome to attend.

An Anaesthetic Assessment will be carried out to assess:

- Medical fitness for GA + identification of specific problems.
- Medical notes + details of previous GA ( if any )
- Investigation results present and whether they are acceptable
- Medications:–
  - prescription of pre-anaesthetic drugs
  - request usual drugs to be given prior to ECT
  - consideration of withdrawal of drugs likely to reduce seizure

- To identify any Allergies.
- Anaesthetic description, e.g., venous access, monitoring and preoxygenation
- To allow for post ECT problem discussion e.g., headache.
- Day case aftercare to be assessed as adequate /as per guidelines.

However it should be noted that not all patients will agree/want to visit the ECT suite, especially those that are being compulsorily treated.

22. **ADMINISTRATION OF ECT TO MINORS**

It is anticipated that ECT for minors will only occur on very rare occasions. It should be realised that ECT for Minors is more controversial and less thoroughly investigated for its safety and long term untoward effects than for adults. **The following is for guidance only.** If a Child & Adolescent Psychiatrist wants to consider ECT for a minor, it should as a last option.
a) ECT treatment to minors will only be offered following a full and extensive discussion with and within the ECT team. This discussion will include the minor’s Consultant Psychiatrist and should aim to ensure that ECT is absolutely necessary.

b) The Minor’s consultant psychiatrist will be responsible for setting a detailed written plan of care.

c) The Minor’s consultant will be responsible for making a thorough assessment of the minor’s capacity to consent, and will follow all other principals and procedures related to the consent of minors.

d) The decision for ECT should be made with the involvement of the patient’s family/carer and the multidisciplinary team. Written information regarding ECT should be provided to the patient and their family/carers as per trust ECT policy.

e) It is advised that a 2nd opinion is sought when deciding on ECT treatment for a minor. This should involve a second child and adolescent specialist and SOAD where necessary.

f) The Minor will need to be assessed and prepared for the treatment following Trust ECT guidelines and using the ECT Care Pathway.

g) Treatment of individuals of 16yrs and below, must be carried out with the support of a Paediatric Medical ward and allocated Paediatric nurse.

h) Anaesthesia and recovery will be as per paediatric guidelines.

i) Treatment for minors will only be carried out under the supervision of the ECT Lead Nurse and an ECT Lead Consultant Psychiatrist.

j) The prescribing doctor and the ECT team should be aware of low seizure threshold in minors. The Titration dose should start from 25mC in all these cases.

k) There is a higher risk of prolonged fits in minors and Trust policy/guidelines should be followed if this occurs.

l) All staff should be aware of any communication needs e.g. deafness and language difficulties. An appropriate plan to facilitate communication must be in place.

m) It may be appropriate to refer Minors under the age of 16yrs to a centre that specialises in paediatric ECT.

Please note: Any person under the age of 18 will require SOAD visit and all treatments must be supported by form T5. This requires consent and second opinion. Please refer to revised MHA Code of Practice 2008 for full information.

23. **ADMINISTRATION OF ECT IN OLDER PEOPLE AND PHYSICALLY FRAIL PATIENTS**

Older Age and physical frailty are not contraindications to ECT but due to the increased likelihood of co-morbidities in this group, there may be an increased risk associated with
ECT. The following guidelines should be kept in mind when prescribing ECT for this group of patients:

a) Trust ECT policy and general guidelines have been written with full consideration for treatment of older persons and physically frail patients and these should be fully adhered to at all times.

b) When prescribing ECT for older persons and frail patients their physical state should be thoroughly assessed and investigated (refer to Trust ECT policy). If required, discuss particular concerns about physical state with the anaesthetist who may request opinion from a physician or other relevant specialist. A patient's general medical records must be obtained from the relevant general hospital (e.g., Royal Berkshire Hospital for West Berks patients, or Heatherwood and Wexham Park Hospitals NHS Foundation Trust for East Berks patients).

c) The anaesthetist will be responsible for carefully assessing and documenting ASA grade. For high ASA grade patients the anaesthetist may decide that the first, or all ECT treatments, will be provided at the relevant local general hospital (e.g., Royal Berkshire Hospital for West Berks patients and Wexham Park Hospital for East Berks patients).

d) There may be an increase in the seizure threshold associated with older people, especially males, but this is not always the case. Therefore, ECT dose prescribing should follow the Trust ECT policy recommendations, including the protocol for dose titration.

e) Particular attention should be paid to cognitive functions and these should be monitored as advised in the Trust ECT Care Pathway. There should also be careful attention to dose adjustment and electrode placement when prescribing ECT.

f) It is important to remember an older person with coexisting medical problems may experience a change in their physical condition during the course of ECT (many weeks in some cases) and therefore should be appropriately monitored.

g) For this group of patients, staff involved in administering ECT should be acutely aware of manual handling skills and consider such things as joint replacements and patients general reduced mobility/flexibility.

24. ADMINISTRATION OF CONTINUATION/MAINTENANCE ECT

These treatments are not currently recommended by the NICE guidelines 2003. Therefore a second opinion from another consultant psychiatrist is required before making a decision.

Continuation ECT refers to: Treatment which continues after an acute course of ECT to prevent relapse. Further elaboration may be done as spelled out in care pathway.

Maintenance ECT refers to: Treatment given to treat or prevent a recurrence of prolonged illness used in cases where patients begin to deteriorate after completion of continuation ECT.
24.1 These treatments may be appropriate for:

- Those patients with relapsing or refractory depressive disorder who responded well to ECT in the past.
- For treatment of Relapsing depression which is severe and causing significant impairment to quality of life or disruption to daily living.
- And / or where standard pharmacological therapies are ineffective or inappropriate.
- Where Psychological Therapies are ineffective or inappropriate.
- Patients with early (0-6 months) post ECT relapses not responding to medication.
- Patients who repeatedly relapse due to non compliance to medication.
- Patients who request ECT.

24.2 Condition for use

- The treating team must ensure that ECT has been effective for the patient in the past
- Alternative options have been adequately explored.
- The treating team must specify on the consent form whether using continuation or maintenance ECT and give an indication of length of intended course
- Patients must be re-consented every six months, or 12 treatments which ever is the lesser, this is to include assessment of capacity to consent (where appropriate) though ongoing assessment will be made at each session, prior to consent being taken.
- Any patient receiving ECT in there ‘Best Interest’ must have a Best Interest meeting every six months minimum.
- Reassessment of physical state must be repeated every six months (physical, ECG, new GP print out, new blood test etc)
- Intermediate mental health and cognitive assessments and ECT prescriptions/requests must be completed every two treatments.
- Consideration has been given to the expected length of course, that this has been discussed with the patient and or carers/relatives and recorded in the notes
- The treating team will make the ECT dept aware of medication changes (these may affect treatment).
- Every six months there should be a detailed review of the management plan by the treating Consultant Psychiatrist.
- Before commencement of such treatment ECT staff should be informed immediately and all aspects of BHFT ECT policy and guideline and appendices remain applicable

The frequency of treatment will be decided by the referring Team.

The aim will be to reduce the frequency of ECT to the minimum required to maintain clinical response.
### 24.3 Continuation ECT

- Reduce to weekly
- Reduce to 10 days
- Reduce to fortnightly
- Reduce to three weekly
- Reduce to monthly

It may in some cases be possible to reduce frequency further.

### 24.4 Maintenance ECT

It may be appropriate to commence treatment at a lower frequency, e.g., fortnightly then continue with the above plan.

### 24.5 Cessation

Since relapse is most likely within the first 12 months of recovery it is recommended to continue with ECT for at least 1 year after recovery, with reviews as above. A full review of the need for long term ECT should then take place and should include consultation with the patient, carers and staff involved.

We suggest close clinical supervision after stopping continuation ECT and any relapse may indicate consideration for maintenance treatment.
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
MENTAL HEALTH DEPARTMENT

CLIENT INFORMATION BOOKLET
ELECTRO CONVULSIVE THERAPY
(ECT)

For this leaflet please contact the ECT Department on 0118 9605008
Appendix 2

THE ROYAL COLLEGE OF PSYCHIATRISTS

PATIENT FACT SHEET

ECT (ELECTRO CONVULSIVE THERAPY)

1. WHAT IS ECT?

ECT (Electroconvulsive Therapy) is a treatment used in psychiatry for severe mental illness/distress. It was originally developed in the 1930s and was used very widely during the 1950s and 1960s for a variety of conditions. Since then its use has declined.

ECT has changed a lot in recent years and modern ECT is undertaken only occasionally in severe illnesses. Usually the person having it will be in hospital, though many units can now offer ECT as a day case treatment.

ECT remains a controversial treatment, which some people have very strong feelings about. There are those who claim it can be a life-saving procedure while others feel it should be banned.

Q. How is ECT given?

ECT is a way of causing someone to have a seizure, and it is this seizure that is needed for the treatment to work. 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. The current can be given to the whole brain (bilateral ECT) or just one side (unilateral ECT). The seizure itself is very similar to the seizures that occur in people with certain types of epilepsy, but it is caused on purpose in very controlled circumstances. ECT does not cause epilepsy.

Just like in a surgical operation, the person will have an anaesthetic before the treatment and will also receive a muscle relaxant so the physical effects of the seizure are as small as possible. By finding the right dose of electricity, the ECT team will try to cause a seizure between 10 and 50 seconds long.

A senior anaesthetist gives the anaesthetic and the person will have heart, blood pressure, breathing, oxygen levels, etc monitored while they are asleep. Many units also monitor the brain waves during the seizure using an electroencephalograph (EEG) machine. The person is unconscious for around 5 minutes, though they take longer to fully recover from the anaesthetic.

Most units give ECT twice a week.

Q. Where is ECT given?

ECT should always be given in a special ECT suite. This suite should have separate places for people to wait, have their treatment, wake up fully from the anaesthetic and then recover properly before leaving the suite. There should also be enough properly qualified staff to look after the person all the time they are there so any distress is kept to a minimum.
Q. What happens during ECT?

From the point of view of the person having ECT, they should arrive at the ECT suite with an experienced nurse who they know and who is able to explain what is happening to them. Many ECT suites are happy for family members to be there. When the person arrives in the suite they should be met by a member of the ECT staff, who will do routine physical checks if these have not already been done. The staff member will also check that the person is still happy to have ECT and there will be someone else to answer any particular questions.

When the person is ready they will be accompanied into the treatment area and be helped onto a trolley. The anaesthetist and anaesthetic assistant will connect monitoring equipment to check their heart rate, blood pressure, oxygen levels, etc. They may also be connected to an EEG machine, to check the brain waves (a way of measuring normal brain activity). A needle will then be put into a small vein, probably on the back of their hand, though which the anaesthetist will give the anaesthetic drug and, once they are asleep, a muscle relaxant. While the person is going off to sleep the anaesthetist will also give them oxygen to breathe. Once the person is asleep and fully relaxed a doctor will give the treatment. The muscle relaxant wears off quickly (within a couple of minutes) and as soon as the anaesthetist is happy that the person is waking up, they will move through to the recovery area, where an experienced nurse will monitor them until fully awake. Most ECT suites have a second area for light refreshments. The person will leave the suite when they feel ready and when everyone is happy they are OK. The whole process usually takes around half an hour.

Q. What about 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.

Although there is a lot of research being done, it's still not clear which type of ECT is "best". Bilateral ECT seems to work more quickly and effectively and it's probably the most widely used in Britain; however, bilateral ECT seems to cause more side effects. Unilateral ECT has fewer side effects, but may not be as effective; unilateral ECT is also more difficult to do properly. Sometimes ECT clinics will start a course of treatment with bilateral ECT and switch to unilateral if the patient experiences side effects. Alternatively they may start with unilateral and switch to bilateral if recovery isn't happening.

The choice of bilateral or unilateral ECT will depend on the needs and wishes of the patient, the opinion of their doctor and the skills of the ECT team.

Q. How many times is ECT given?

Most units give ECT twice per week, often on a Monday and Thursday, or Tuesday and Friday. It is impossible to predict how many treatments someone will need, however, in general it will take 2 or 3 treatments before any response is seen and people start to improve after 4 to 5 treatments. Some people having ECT report others tell them they are looking better before they feel so themselves. On average, a course will usually last for 6 to 8 treatments though some times as many as 12 may be needed. If someone has shown no response at all after 12 treatments it is unlikely that ECT is going to help.
A doctor should see the person after each treatment and their consultant see them after every two. ECT should be stopped as soon as the person has made a recovery or at any time if they withdraw their consent.

Q. What happens after ECT?

Even when someone finds it effective, ECT is only a part of the treatment. It can help to ease problems so that the sufferer is able to look at why they became unwell. Hopefully they can then take steps to continue their recovery and perhaps find ways to make sure the situation doesn't happen again. Psychotherapy and counselling might help and many sufferers also find their own ways to help themselves. Medication is usually needed to help to maintain the benefits. Certainly people who have ECT and then do not have other forms of help are at very high risk of quickly becoming unwell again.

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

If you have very strong feelings about ECT you should make them known to relevant people, who would include the doctors and nurses caring for you, but also friends, family or other advocates who can speak for you. Doctors must consider these views when they think about what to do. If you have made it very clear that you do not wish to have ECT then you should not receive it.

Q. How do I know if ECT is carried out 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 how ECT is given, and visits all the ECT suites signed up to it. The visiting team involves psychiatrists, anaesthetists, nurses and lay people. It publishes the results of its findings and also provides a forum for sharing best clinical practice. Membership of ECTAS is not currently compulsory but your ECT suite will be able to tell you if they have signed up to ECTAS, what their most recent report was and who to speak to if you are concerned that your local suite has not been assessed.

2. THE PROS AND CONS OF ECT

Q. Who might benefit from ECT?

Recently, the National Institute of Clinical Excellence (NICE) have looked in detail at the use of ECT and have agreed it is an effective treatment for severe depression, severe mania and catatonia. In general ECT is mostly used for severe depression, though some research suggests it may be helpful in Parkinson's disease and possibly other neurological conditions.

Q. Who would not benefit from ECT?

ECT is unlikely to help those with mild depression or most other psychiatric conditions including personality disorders. NICE have specifically stated that it has no role in the general treatment of schizophrenia.

Q. What are the side effects of ECT?

This is one of the areas of greatest disagreement.
ECT is a major procedure where, over a few weeks, someone has several seizures and several anaesthetics. It is used for people with severe illness/distress who are very unwell, sometimes life-threateningly. As may then be expected, ECT can cause a number of side effects, some mild and some more severe.

There are a number of less severe side effects that relate to each individual treatment. Many people complain of a headache immediately after ECT and of a general aching in their muscles. They may feel muzzy-headed and generally out of sorts, or even nauseous. Some are quite 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 the help of paracetamol, some light refreshment and a supportive environment.

The greater concern is for the long-term side effects, like irreversible memory loss or personality change. Surveys conducted by scientists and members of the medical profession usually find a low level of severe side effects, maybe around 1 in 10. Those conducted by user groups have found much more, maybe half of those having them. Some surveys conducted by those strongly against ECT say there are severe side effects in everyone. Clearly, no one is certain.

Older people may be quite confused after a treatment and this can persist for two or three hours. It is possible to change the way the ECT is done (such as using unilateral ECT) to reduce this.

Many people complain of problems with memory – indeed some difficulties with memory are probably present in everyone with severe depression receiving ECT. This is usually a loss of memory for the treatment itself and maybe an hour or two before and after. Some people – some would say many – also have problems with memory for past events, even very significant ones such as the birth of a child. Most people find these memories return when the course of ECT has finished and a few weeks have passed. There are people who complain their memory has been permanently affected and the 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 – such as how the person feels about the treatment they have had, or even how they feel about themselves.

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

Q. What may happen if ECT is not given?

ECT is never the only alternative, although the doctor prescribing it may feel it represents the best chance of recovery. If someone with severe depression declines ECT there are a number of possibilities. The medication may be changed or new drugs added. A referral for counselling or psychotherapy may be appropriate. Alternatively, the doctors and nurses may look at ways of helping the person change aspects of their life that are causing the depression. Usually, a combination of all 3 of these will be used.

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.
There have been several research studies comparing standard ECT with "sham" ECT. In "sham" ECT, the patient has exactly the same things done to them – including going to the suite and 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 much quicker than those who had "sham" treatment. Also those who didn't have adequate fits did less well than those who did.

Interestingly, a number of the patients having "sham" treatment recovered too, even though they were very unwell; it's clear that the extra support has an important role too. However, when prescribed to the right people, ECT has been shown to be the most effective treatment for severe depression.

Q. How does ECT work?

No one is certain how ECT works. There is a lot of evidence that ECT causes changes in the way the brain works, but there is disagreement about the exact effects that lead to improvement.

Those who support ECT say that in very severe types of depression certain parts of the brain are not working normally, because of changes in the brain chemicals that allow nerves to "talk" to each other. ECT alters the way these chemicals are acting in the brain and so help a recovery.

People against ECT say it works by 'concussing' and damaging the brain, or even that it has no effect at all other than to make patients say they feel better in order to avoid having it.

3. CONTROVERSIES IN ECT

Q. How is ECT controversial?

There are many areas of disagreement about ECT, including whether it should even be used at all. The main areas of disagreement are over whether it works, how it works and what the side effects are. Some of the arguments about this are covered in "The Pros and Cons of ECT".

Q. Why is ECT still being given?

ECT is used much less than in the past and is mostly now a treatment for severe depression. This is almost certainly because modern treatments for depression like anti-depressants, psychotherapy (talking treatments) and other psychological and social supports are much more effective than in the past. Even so depression can still be very severe indeed 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. In these circumstances, where other treatments may not have worked, ECT may be considered a worthwhile alternative. The scientific evidence we have is that ECT is still the most powerful treatment for severe depression.

Some people who have had ECT before and found it helpful, request it if they become unwell again.

Q. When is ECT given without consent?

The majority of ECT treatments are given to people who have consented to it. This means that they have had a full discussion of what ECT involves, why it is being considered in their case and all the advantages and disadvantages, including a discussion of side effects. Sometimes,
however, people become so unwell that they are unable to take on-board all of the issues – perhaps because they are severely withdrawn or have ideas about themselves that stop them fully understanding their position (e.g. they believe what is happening to them is a punishment they deserve). In these circumstances it is impossible for them to give proper consent.

When this happens, if the clinical team think that ECT would still help, it is possible to give ECT – but only after the patient has first been assessed by their own GP and a social worker, and then has had a second opinion from an independent specialist. The clinical team should also speak to family and other advocates, to consider their views and any views the patient may have expressed before. This process almost always involves the use of the Mental Health Act, which means the patient, and their family, have a right of appeal against parts of their treatment. Giving ECT to someone who is actually refusing to have it, whilst possible in the above circumstances, is actually very rare.

Some people who have had ECT complain that they were not properly informed of the risks and benefits, and say that they wouldn't have had ECT if they had known more. It is the responsibility of the team looking after the patient to be sure that they are fully informed about all the relevant things to do with ECT.

Q. Why do people disagree so strongly?

People tend to have very strong feelings about ECT, often based on their own experiences. Many doctors will say they have seen patients successfully treated with it and have found very severe depressive illnesses completely lifted. Some will even say that it has saved people's lives. People who have had ECT will also express these views.

Some who have had ECT complain of severe side effects, or say it has been used inappropriately in their case, or not properly explained or even forced on them. Others (including a variety of mental health professionals) feel there is something basically wrong, cruel or inhumane about ECT and these widely ranging views means that obtaining agreement is often difficult.

Q. Isn't ECT banned?

ECT has never been banned in Britain or in the USA. Some countries in Europe and the rest of the world (and some states in America also) have restricted its use. The reasons behind these restrictions are complicated. At the moment, ECT is part of standard psychiatric practice in Britain and the majority of countries worldwide.

Q. What do the people in favour of ECT say?

Those in favour of ECT say it is an effective treatment, particularly for severe depression, which works when other treatments have not. They believe it causes a clinical improvement, which may be very significant indeed, and they say it can be life saving. They feel it is an important option in psychiatric practice and the overall benefits are greater than the risks. There is much research being done to improve ECT practice and reduce its side-effects.

Q. What do the people against ECT say?

There are many different views and many different reasons why people object to ECT and it is wrong to generalise. However, many 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. Most would see it banned.

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. If the suite has been approved by ECTAS, then they will have ensured the information is balanced.

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. You may wish to get information from several sources before making up your own mind.

Since people often express their views on ECT very forcefully (either against or for) it can be hard to be sure what to believe. Most do agree, however, that people who are considering ECT – and their families and others – should try to understand as much as possible about it so they can make a decision that is right for them.
Appendix 3

GUIDELINES FOR REFERRING PATIENTS FOR ELECTRO CONVULSIVE THERAPY AT PROSPECT PARK HOSPITAL

First contact:
When a patient has been identified as needing ECT treatment a member of the referring team will contact the ECT team via phone or email, it is suggested you email all those listed below to allow for A/L sickness or other time off and to ensure someone receives this information. We suggest you request an email read receipt.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kay Sayers</td>
<td>ECT Lead Nurse Manager</td>
<td><a href="mailto:Kay.sayers@berkshire.nhs.uk">Kay.sayers@berkshire.nhs.uk</a></td>
</tr>
<tr>
<td>Janet Worroll</td>
<td>ECT Lead Nurse Manager</td>
<td><a href="mailto:Janet.worroll@berkshire.nhs.uk">Janet.worroll@berkshire.nhs.uk</a></td>
</tr>
<tr>
<td>Dr M Mundasad</td>
<td>ECT Lead Consultant</td>
<td><a href="mailto:Mangla.mundasad@berkshire.nhs.uk">Mangla.mundasad@berkshire.nhs.uk</a></td>
</tr>
<tr>
<td>01189 605365</td>
<td>Secretary to Dr Mundasad</td>
<td><a href="mailto:Janet.Powell@berkshire.nhs.uk">Janet.Powell@berkshire.nhs.uk</a></td>
</tr>
<tr>
<td>Gill Harrison</td>
<td>ECT Anaesthetist</td>
<td><a href="mailto:Anaesthetics.office@royalberkshire.nhs.uk">Anaesthetics.office@royalberkshire.nhs.uk</a></td>
</tr>
<tr>
<td>Andrew Burgess</td>
<td>Head of In-Patient &amp; Urgent Care Services</td>
<td><a href="mailto:Andrew.burgess@berkshire.nhs.uk">Andrew.burgess@berkshire.nhs.uk</a></td>
</tr>
<tr>
<td>Barbara Breakspear</td>
<td>Secretary to Andrew Burgess</td>
<td><a href="mailto:Barbara.Breakspear@berkshire.nhs.uk">Barbara.Breakspear@berkshire.nhs.uk</a></td>
</tr>
</tbody>
</table>

The ECT team will commence initial liaison by contacting:

The referrer, a representative or the patient themselves (out patients only, and only if a phone number is received) they will then receive a call, checking relevant information and offering an appropriate time and date for the patient to attend a Pre-anaesthetic assessment (dependant on receiving the information listed below)

This pre assessment will be in the ECT clinic, Pimpernel Suit, Prospect Park Hospital, Reading.

In case of emergency ECT this assessment can be carried out immediately prior to first ECT treatment.

The referrer will be asked to ensure that all of the following are with the ECT team prior to the assessment:

- Completed care pathway (available on the Berkshire Shared drive)
- Psychiatric case notes
- Physical case notes (to be obtained via your local medical records dept)
- GP summery of physical medical history if physical case notes are not available
- Any relevant MHA documentation/information.

On the day of pre assessment all of the above will be reviewed and a date to commence treatment given, except in the case of urgent ECT.

The patient will be given a tour of the unit and any further details highlighted such as: 24 hour supervision for out patients, nursing escorts, travel arrangements for all and any final question or concerns addressed.
Appendix 4

GUIDELINES FOR ESCORTING A PATIENT FOR ECT AT PROSPECT PARK

This procedure (where relevant) should be read in conjunction with the Trust’s policy on Mental Health Act, 1983 s17 Leave and the Observation Policy.

This procedure relates to the escort of patients from Berkshire NHS foundation trust wards to Prospect Park Hospital for the purpose of receiving ECT Treatment.

At the point when a patient has been accepted for ECT Treatment at PPH, the referring consultant psychiatrist (or a doctor nominated by him/her) and a qualified nurse with direct responsibility for the patient, determines the required escort in accordance with trust policy. **Limits set under s17 Mental Health Act, 1983 always take precedence.**

This decision is recorded in the patients case notes, and a plan of care is constructed which sets out clearly the escort requirements and any other relevant information.

In determining the level of escort required, the service user’s history, presenting behaviour and level of risk must be taken into account. Additionally, consideration is given to the level of experience and confidence of those undertaking the escort and also the relationship between the patient and member(s) of staff. Where possible the patient is fully involved in this process.

Specific areas to consider:-

- The sex of the patient.
- Cultural/ethnicity issues.
- Is more than one escort needed? Consider carefully why this is a requirement, what is the exact purpose of having a multiple escort?
- Size of vehicle required.
- Is this duty suitable for;
  - NHSP staff
  - student nurses

Care Planning

In most circumstances the patient will be transported to PPH in a taxi supplied by South Central Ambulance service and the ECT team should be aware of this. If this mode of transport is not suitable, please indicate specifically what type of transport should be used and why.

The level of observation prescribed, as per the observation policy plus the ECT policy, is taken into account when determining the need for escort levels etc.

**At the time of leaving the ward, all the staff involved in escort duties must be clear about the responsibilities of undertaking the escort, and understand any conditions which may apply. Importantly, the escorts must understand what is expected of them in case of a psychiatric/medical crisis, or if the patient attempts to leave the escorting staff.**

Mental Health Act, 1983 Considerations

For any detained patient, a current s17 leave form must be visually checked by a registered nurse prior to the patient leaving his/her unit.
General Information

Where more than one patient is being escorted for treatment, circumstance may arise where one patient is an in-patient on an “adult ward”, and another, an in-patient on a Older People’s ward. On these occasions it is not necessary for each patient to have a qualified nurse escort from his/her respective care area or indeed for both members of staff to have basic life support training – just one will suffice. Nursing staff from each area should discuss escort requirements and determine the level of escort required. It will not be generally necessary for each patient to have an individual escort although it is desirable that the escort knows the patient. The number of escorts required is a risk determined factor, and should be negotiated between the in-patient wards as required.
Appendix 5

ASSESSMENT ON COMPLETION OF ECT TREATMENT

All patients stopping, completing or discontinuing ECT treatment should have post treatment assessment as follows

Patient name …………………………………………………………………………………………………………………………………………………

Date of Birth …………………………………………………………………………………………………………………………………………………

Records Number ………………… MMSE score………………………………

CGI Score …………………………………………………………………………………………………………………………………………………

CGI Therapeutic Effect

1 Unchanged / worse. 3 Moderate improvement. Partial remission of symptoms
2 Minimal improvement. 4 Marked improvement. Almost or complete remission of symptoms

• Please state the patients clinical response at the end of their course.

• Your patients view of his/her response to this treatment.

• Are there any subjective reports/evidence of memory impairment please make a brief assessment of autobiographical memory and state comments.

• Are there any objective reports/evidence of memory impairment (especially autobiographical memory).

Signature………………………………………………………………………………………………………………………………………………

Print name………………………………………………………………………………………………………………………………………………

Designation………………………………………………………………………………………………………………………………………………

Date …………………………………………………………………………………………………………………………………………………

When complete please send this form to:-
ECT Department, Pimpernel Suite, Prospect Park Hospital

A 3 and 6 month post ECT follow up reminder will be sent at the appropriate time.
3 MONTH REVIEW POST ECT

All patients stopping, completing or discontinuing ECT treatment should have a 3 month review post ECT assessment as follows:-

Patient Name ………………………………………………………………………………………………………..

Date of Birth …………………………………………………………………………………………………………..

Records number …………………………………… MMSE score……………………

CGI Score …

**CGI Therapeutic Effect**

1 Unchanged / worse.  
2 Minimal improvement.  
3 Moderate improvement. Partial remission of symptoms  
4 Marked improvement. Almost or complete remission of symptoms

• Please state the patients’ clinical status/symptomatic response.

• Your patients’ report of side effects attributed to ECT since stopping ECT.

• Any reports of residual memory problems subjective or objective.

Signature………………………………………………………………………………………………………………

Print name………………………………………………………………………………………………………………

Designation………………………………………………………………………………………………………………

Date ……………………………………………………………………………………………………………………..

When complete please send this form to:-  
ECT Department, Pimpernel Suite, Prospect Park Hospital
6 MONTH REVIEW POST ECT

All patients stopping, completing or discontinuing ECT treatment should have a 6 month review post ECT assessment as follows

Patient Name .................................................................................................................................

Date of Birth ................................................................................................................................

Records Number .................................................. MMSE score.................................

CGI Score .....................................................................................................................................

**CGI Therapeutic Effect**

1 Unchanged / worse. 3 Moderate improvement. Partial remission of symptoms
2 Minimal improvement. 4 Marked improvement. Almost or complete remission of symptoms

- Please state the patients’ clinical status/symptomatic response.

- Your patients’ report of side effects attributed to ECT since stopping ECT.

- Any reports of residual memory problems subjective or objective.

Signature...........................................................................................................................................

Print name......................................................................................................................................

Designation......................................................................................................................................

Date ..............................................................................................................................................

When complete please send this form to:-
ECT Department, Pimpernel Suite, Prospect Park Hospital
Appendix 6

Outpatient ECT Discharge Information

ECT Department Prospect Park Hospital 01189605008
Prospect park Hospital 01189 605000
Heatherwood Hospital 01344 623333
St Marks Hospital 01628632012

Should you need advice regarding today’s treatment please phone the ECT department or the hospital that you are attached to and ask for your ward.

You are asked to confirm you will;

- Not to make any legal or life changing decisions during this course of ECT and post treatment until advised that it is safe to do so, by your doctor.
- Not Drive any sort of vehicle during this course of treatment and until told it is safe to do so by your consultant
- Not consume alcohol during the course of this treatment.

Today you have received ECT. This has involved a general anesthetic; therefore you should refrain from the following for at least 24hrs.
- Operating machinery or electrical/gas appliances.
- You should have a responsible adult to remain with you for the first 24hrs following treatment.

If you suffer any adverse effects then contact your GP in the first instance and pass on the information on this sheet.

If you have any concerns relating to your treatment or develop a cold or physical illness then contact the ECT department.

Prior to your next treatment remember to fast from 12midnight and take only the medication indicated to you by your consultant, with a sip of water.

Please note Patient advocacy information and contact phone numbers are available in the department.
Appendix 7

GP INFORMATION LETTER

Date……………………

Dear Dr…………………………

We are writing to inform you that:

Your patient…………………………………………………………………………………………

Has been prescribed a course of ECT treatment by

Dr……………………………………………………………………………………………………

He/she will be receiving this treatment on Tuesday and Friday mornings as an outpatient.

Provisional start for this will be ………………………………………

This procedure involves a general anaesthetic.

He/She will have 24 hr post ECT supervision by a responsible adult who signs to accept this duty of care prior to commencement of each treatment.

Full written information regarding this procedure has been given to the patient at the time of gaining consent.

A discharge information letter is given to all patients. This contains relevant hospital contact numbers.

Many thanks

ECT Team
Prospect Park Hospital
Honey End Lane
Tilehurst
Reading
RG30 4EJ
Appendix 8

[Diagram of electro-convulsive therapy (ECT) rules and procedures]

SOAD = second opinion appointed doctor

Designed in Sections 2.1, 2.3, 37, 38, 40, 47 or 48 (with or without modifications)
Appendix 9

INFORMATION FOR PRESCRIBERS
DRUGS AND ECT TREATMENT

See also RBBH Guidelines - available in the ECT Clinic.

**DRUGS TO BE GIVEN ON MORNING OF TREATMENT** - with a sip of water:

Cardiac, antihypertensives, H2 rec. antagonists

**OTHERS** : anticonvulsants

**FOR EPILEPTICS**, aspirin, warfarin (INR 2.5 is safe), inhalers, thyroxine

**PREMEDICATION DRUGS PRESCRIBED BY ANAESTHETIST MUST BE GIVEN @0800**.
Paracetamol can be given 0800 if headache is a problem after ECT.

**DRUGS NOT TO BE GIVEN UNTIL AFTER TREATMENT**:
Diabetic Insulin/tablet medications - these will be given post ECT when the patient has eaten+ no nausea/vomiting.

**DIURETICS**

**DRUGS THAT MAY AFFECT THE OUTCOME OF ECT TREATMENT**
**DRUGS THAT MAY SHORTEN THE SEIZURE OR RAISE SEIZURE THRESHOLD**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>COMMENTS / OTHER REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td>continue if for treatment of epilepsy. Consider dose reduction if used as mood stabiliser and fits are poor duration/quality.</td>
</tr>
<tr>
<td>Na valproate</td>
<td>can raise thiopentone plasma levels</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>can antagonise nondepolarising muscle relaxants</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>used to terminate prolonged seizure when other agents fail (see protocol)</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>can antagonise nondepolarising muscle relaxants</td>
</tr>
<tr>
<td>Vigabatrim</td>
<td>may shorten seizure</td>
</tr>
<tr>
<td></td>
<td>can cause nonspecific slow wave ECG</td>
</tr>
</tbody>
</table>

**First Generation Antipsychotics**

Commonly cause extrapyramidal side effects. May cause Neuroleptic Malignant syndrome.

Chlorpromazine                  | may cause ECG changes                                                                  |
Flupenthixol                    | care with Parkinsons disease. Can prolong QT interval.                                   |
Promazine                       | may prolong suxamethonium                                                              |
**Atypical antipsychotics**

Cause less extrapyramidal side effects than first generation antipsychotics rarely associated with Neuroleptic malignant syndrome first 2/12 treatment.

Olanzapine )
Risperidone )
Quetiapine )

all may prolong QT interval

**Anxiolytics & Sedatives**

**Benzodiazepines**

Shorten seizure and also raise seizure threshold.

Omit the night before ECT/ consider stopping ( not abruptly or may get withdrawal OR seizure threshold may suddenly drop.)

( Promethazine is preferable)

**B Blockers**

Can reduce seizure length

Atenolol
Esmolol
Labetolol

**Hypnotic non-benzodiazepines**

Omit the night before ECT

Zopiclone)
Zolpidem )

**Induction Agents**

Usually the higher the induction dose of any agent the shorter the seizure.

Propofol increases seizure threshold and requires higher treatment doses (mc)
may be associated with increased incidence of missed seizure.
propofol may require 2\textsuperscript{nd} stimuli which are more likely to cause cognitive side effects may shorten seizure by 40-50% so that patient requires a longer course of ECT obtunds the CVS effects of ECT ( less hypertension)

Thiopentone a barbiturate - seizures usually longer+ higher patient response rate and less cognitive side effects compared with propofol .
may be associated with mod/severe hypertension after ECT arrhythmias more common than with other agents but not usually a problem anticonvulsant and may be used to terminate a prolonged seizure.

Sevoflurane trialled as induction agent (@ 6-8%)
haemodynamically equal to thiopentone rarely/never used
**DRUGS THAT MAY PROLONG THE SEIZURE OR LOWER SEIZURE THRESHOLD**

**Atypical antipsychotics**

**Clozapine**
reduces seizure threshold
withdraw 12hrs before ECT treatment (omit am dose)
monitor drug levels and blood counts (neutropaenia, fatal agranulcytosis)
increased salivation
may cause tachycardia, raised BP, fatal myocarditis, cardiomyopathy - esp in first 2/12 of treatment.

**Lithium**
can cause status epilepticus or confusional states usually at toxic doses.
blood levels must be monitored 0.4-1 mmol. (toxic>2mmol)
can cause hypokalaemia and ECG changes.
Can prolong muscle relaxants (suxamethonium)

**SSRIs**
usually minimal effect on seizure duration
may cause hyponatraemia. Do not stop abruptly.

Fluoxetine usually prolongs seizure
Paroxetine rarely prolongs

**Xanthine Derivatives**

**Caffeine**
used in the USA (not UK) to prolong seizures if necessary
present in hot drinks and lucozade, Red Bull

**Theophylline**
bronchodilator used in asthma.
can cause status epilepticus.

**Tricyclics antidepressants**
some lower seizure threshold
arrhythmias, heart block, postural hypotension, tachycardia, - all reported

**Amitriptyline**
is especially associated with heart block

**Induction Agents**

**Etomidate**
lowers seizure threshold
often produces longer seizures with better quality cf. with other agents
should be considered for patients with high seizure thresholds
causes less hypotension than other agents but raised BP with ECT not usually seen
pain on injection and may cause extraneous muscle movement
*suppresses adrenocortical function*

**Methohexitone**
now an unlicensed induction agent. Occasionally used for `short fitters`.
was induction agent of choice for ECT (withdrawn 2002) as is convulsant.
may allow longer seizures than thiopentone.
### DRUGS NOT USUALLY AFFECTING SEIZURE LENGTH

**Antidepressants**
- Venlafaxine: serotonin and noradrenaline reuptake inhibitor. can cause arrhythmias and raised BP. doses > 300mg/day can be associated with asystole high doses are epileptogenic

**MAOI**
- can be continued (ephedrine must not be used for treatment of hypotension).

**Reversible MAOI**
- Moclobemide: can cause agitation or confusional states.

**SSRI**
- Citalopram
- escitalopram
- Sertraline

### DRUGS NOT AFFECTING ECT TREATMENT

**Antimuscarinics**
- Hyoscine
- Orphenadrine
- Procyclidine
- Trihexphenindyl (benzhexol)

**Statins**

Harrison / Vinestock May 2010 4th draft. Ref. ECT Policy
COMMENTS / FEEDBACK (This form can be photocopied as needed)

CCR013 - Electro Convulsive Therapy (ECT)

Name ____________________________________ Date _______________

Address __________________________________________________________________________________________________

Return comments for consideration three months prior to review date to the designated lead or Governance Administrator, 2nd Floor, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ. Tel: 01344 415623

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General comments:
1. Title of policy/ programme/ service being analysed

**ELECTRO CONVULSIVE THERAPY (ECT) POLICY**

2. Please state the aims and objectives of this work and what steps have been taken to ensure that the Trust has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics.

To facilitate and support in education of and use of this specialised service, its procedures and processes.

3. Who is likely to be affected? e.g. staff, patients, service users

BHFT staff, patients and relatives that may need to access this service and wish to gain information about ECT and its procedures.

4. What evidence do you have of any potential adverse impact on groups with protected characteristics? No adverse impact identified.

Include any supporting evidence e.g. research, data or feedback from engagement activities

<table>
<thead>
<tr>
<th>4.1 Disability</th>
<th>Consider building access, communication requirements, making reasonable adjustments for individuals etc</th>
</tr>
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<tbody>
<tr>
<td>People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV</td>
<td>No adverse impact identified.</td>
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<tr>
<th>4.2 Sex</th>
<th>Consider gender preference in key worker, single sex accommodation etc</th>
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<tbody>
<tr>
<td>Men and Women</td>
<td>No adverse impact identified.</td>
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</tbody>
</table>

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<tr>
<th>4.3 Race</th>
<th>Consider cultural traditions, food requirements, communication styles, language needs etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>People of different ethnic backgrounds, including Roma Gypsies and Travelers</td>
<td>No adverse impact identified.</td>
</tr>
</tbody>
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<tr>
<th>4.4 Age</th>
<th>Consider access to services or employment based on need/merit not age, effective communication strategies etc</th>
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</thead>
<tbody>
<tr>
<td>This applies to people over the age of 18 years. This can include safeguarding, consent and child welfare</td>
<td>No adverse impact identified.</td>
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<tr>
<th>4.5 Trans</th>
<th>Consider privacy of data, harassment, access to unisex toilets &amp; bathing areas etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who have undergone gender reassignment (sex change) and those who identify as trans</td>
<td>No adverse impact identified.</td>
</tr>
</tbody>
</table>
| 4.6 | **Sexual orientation**  
This will include lesbian, gay and bisexual people as well as heterosexual people. | Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc  
No adverse impact identified. |
|———|———|———|
| 4.7 | **Religion or belief**  
Includes religions, beliefs or no religion or belief | Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc  
No adverse impact identified. |
| 4.8 | **Marriage and Civil Partnership**  
Refers to legally recognised partnerships (employment policies only) | Consider whether civil partners are included in benefit and leave policies etc  
No adverse impact identified. |
| 4.9 | **Pregnancy and maternity**  
Refers to the pregnancy period and the first year after birth | Consider impact on working arrangements, part-time working, infant caring responsibilities etc  
No adverse impact identified. |
| 4.10 | **Carers**  
This relates to general caring responsibilities for someone of any age. | Consider impact on part-time working, shift-patterns, options for flexi working etc  
No adverse impact identified. |
| 4.11 | **Other disadvantaged groups**  
This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV. | Consider ease of access, location of service, historic take-up of service etc  
No adverse impact identified. |
| 5 | **Action planning for improvement** | Please outline what mitigating actions have been considered to eliminate any adverse impact?  
If no mitigating action can be taken, please give reasons.  
Please state if there are any opportunities to advance equality of opportunity?  
An Equality Action Plan template is appended to assist in meeting the requirements of the general duty |
| Sign off | Name of person who carried out this analysis: ECT Lead Nurse Manager  
Date analysis completed: May 2013  
Date analysis was approved by responsible Director: Ratified by the Safety, Experience and Clinical Effectiveness Group on 7th May 2013 |