## Electroconvulsive Therapy (ECT)

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Abbreviations used in this document:

AAGBI  -  Association of Anaesthetists of Great Britain and Ireland
ASA     -  American Society of Anaesthetists
CPR     -  Cardio Pulmonary Resuscitation
ECT     -  Electro-convulsive Therapy
ILS     -  Immediate Life Support
LPFT    -  Lincolnshire Partnership Foundation NHS Trust
MH      -  Malignant Hyperthermia
MHA     -  Mental Health Act 1983 (as amended by the Mental Health Act 2007)
MHRA    -  Medicine Healthcare Products Regulatory Agency
NICE    -  National Institute for Clinical Excellence
ODP     -  Operating Department Practitioner
PHC     -  Peter Hodgkinson Centre
RCP     -  Royal College of Physicians
SOAD    -  Second Opinion Appointed Doctors
ST      -  Seizure Threshold
1. Introduction

- There is substantive evidence that Electro-Convulsive Therapy (ECT) is an effective treatment for a severe depressive illness, a prolonged or severe manic episode and catatonia (NICE 2003 Guidance on ECT & NICE 2009 Depression Guidelines).
- LPFT has a single, specialist ECT suite at the Peter Hodgkinson Centre, Lincoln.
- The service has a lead consultant psychiatrist, a lead nurse and a lead consultant anaesthetist. There is a team of ECT nurses. Anaesthetists and ODPs from the United Lincolnshire NHS Trust attend treatments on a rota basis. Psychiatric and General Practice trainees administer ECT with supervision from the ECT consultant.
- This core team is supported by a back up rota of Acute Care Nurses.
- ECT sessions are held twice weekly with additional sessions in an emergency.
- Although ECT can be given to any individual, LPFT does not routinely provide ECT to patients under the age of 18 (see 6.9)
- ECT can be provided to both inpatients and outpatients.
- This policy delineates the responsibilities of the referring/prescribing team and those of the ECT team.

2. Purpose and Scope

The purpose of this policy is to ensure:
- Provision of safe effective services that cause least disruption to patients and carers.
- Full compliance with the Mental Health Act 1983 (as amended by the Mental Health Act 2007).
- Full compliance with the Mental Capacity Act 2005.
- Provision of ECT as per the best available evidence. The Policy is based on NICE Standards (2003 & 2009) & Standards set by the Royal College of Psychiatrists ECT Accreditation Service (ECTAS)

The Policy & ECT Team provide guidance on the use of ECT, but the ultimate judgment with regard to any clinical procedure or treatment is made by clinicians in light of clinical information and the diagnostic and treatment options available.

This Policy will be reviewed in the light of new knowledge.

3. Duties

Prescribing psychiatrist
- To adhere to the guidelines in this policy
- To discuss ECT and Anaesthesia with the patient (including side effects and risks) & to provide written information.
- To assess the patient's capacity to consent to treatment
- To carry out a full physical history, examination & investigations
- Use of the MHA and Mental Capacity Act if appropriate
- To monitor the patient throughout the course of ECT

Lead Consultant Psychiatrist for ECT
- To adhere to the guidelines in this policy
- Responsible for the delivery of ECT within LPFT
- To ensure that all psychiatric and general practice trainees delivering ECT have appropriate training and receive ongoing supervision.
Lead Nurse for ECT
- To adhere to the guidelines in this policy
- To manage the ECT service and the team of ECT nurses and Acute Care Nurses who provide a back-up to the ECT rota.

Lead Consultant Anaesthetist for ECT
- To adhere to the guidelines in this policy

Anaesthetists on ECT rota
- To adhere to the guidelines in this policy
- To have at least one year’s experience in anaesthesia (Section 4)

Doctors administering ECT
- To adhere to the guidelines in this policy.
- To ensure that the patient’s physical status and consent or MHA status is satisfactory prior to treatment.
- To avail themselves of training opportunities provided by the ECT Consultant

Nurses assisting with ECT
- To adhere to the guidelines in this policy
- To ensure their training requirements are up to date.

4. Training:
- The Royal College of Psychiatrists through ECTAS sets Standards for training for all staff involved in ECT
- LPFT is committed to supporting training of ECT clinicians and will support attendance at local and national training events
- The ECT Consultant and lead nurse are subject to appraisal as per LPFT policy and will maintain their own competence as per ECTAS Guidance.
- The ECT Consultant is responsible for the training of trainee doctors. Prior to participating in the ECT rota all trainee doctors will receive an induction in ECT. They will receive the LPFT ECT Handbook for Trainees which summarises Royal College Guidance on competency (Appendix 2)
- Trainee doctors receive ongoing supervision from the ECT Consultant through participation in the ECT rota.
- Once deemed competent, trainee doctors are able to deliver ECT independently.
- Nursing staff will undergo initial and then annual refresher training in post anaesthesia airway management, CPR/ immediate life support & legislative matters relevant to ECT.
- All ECT recovery nurses will be ILS trained.
- All ECT recovery nurses will attend annual recovery training consisting of a full days training in the theatres at Lincoln County Hospital. All staff will have competencies in:
  a) Airway management
  b) Removal of artificial airways
  c) Delivery of oxygen via appropriate routes and rates
  d) Use of suction
- Anaesthetists and ODPs are subject to supervision and training as required by their own regulatory bodies and employing Trust.
- Anaesthetists on the rota will be regular attendees at ECT, and will have at least three years experience in anaesthesia.
- Anaesthetists are usually staff grade level or above with experience in delivering anaesthesia for ECT. In exceptional circumstances, if approved by a consultant, an anaesthetist may undertake this work if within the last three years of their training.
Medical & nursing students may on occasion attend ECT sessions under supervision of the ECT Team.

5. **Indications for use**

NICE 2003 Guidance on ECT & NICE 2009 Depression Guidelines recommend that ECT be considered if the patient:

- Has a severe depressive illness and a number of drug treatments have failed
- Is suffering the manic phase of a manic depressive psychosis
- Is suffering from catatonic schizophrenia
- Has responded well to ECT in the past
- Their physical health is in danger because severe mental health symptoms prevent them from eating and/or drinking sufficiently
- Is suicidal
- Patient choice.

6. **Risk Assessment and Special Groups**

A record should be made of any risk factors associated with ECT as well as potential benefits and these should be discussed with all patients. Risks and benefits of alternative treatments or of not treating must be discussed. The patient should be offered written information such as the LPFT Information Leaflet 'ECT & You' (Appendix 3)

6.1 **Elderly Patients:**
- Physical ill health and associated medication may be problematic in this age group. The anaesthetist should be alerted if there are health concerns.
- Elderly patients are more susceptible to confusion during ECT. The prescribing consultant should consider unilateral ECT.
- Confusion is especially pertinent if considering outpatient ECT.
- Cognitive function should be monitored throughout the course of ECT

6.2 **Pregnant Patients:**
- There is little research on ECT during pregnancy. Benefits of ECT may include avoidance of psychotropic drugs, especially during the first trimester.
- NICE Guidelines on antenatal and postnatal mental health recommend that ECT is considered for pregnant women with severe depression, a severe mixed affective state, mania or catatonia and whose physical health and/or that of the foetus is at serious risk.

**Adverse Effects of ECT include:**
- Induction of premature labour with contractions and bleeding due to Oxytocin release during a seizure.
- Foetal distress (bradycardia). ECT activates both parasympathetic and sympathetic systems releasing acetylcholine and catecholamines resulting in vasoconstriction within the uterus and placenta with potential hypoxaemia of the foetus.
- Maternal hypoxaemia. The pregnant woman has reduced functional residual capacity due to the enlarged uterus with increased oxygen requirements.
- Some pregnant women have reduced pseudocholinesterase activity resulting in prolonged action of suxamethonium.

**Management of Pregnant Woman:**
- As well as the standard pre-ECT assessments, an obstetric assessment must be performed prior to treatment.
- The patient must be booked under a consultant obstetrician.
There should be discussion between the referring psychiatrist and obstetrician regarding the risk and benefits of ECT and alternative treatments.

A management plan must be created for each patient. This must include plans for an obstetric emergency.

The anaesthetist must assess the patient prior to treatment.

Prior to 24 weeks gestation, the procedure could be carried out at the ECT suite if considered low risk. After 24 weeks, the procedure should occur on the Labour ward at Lincoln County Hospital so that foetal monitoring and treatment are available.

Pre-Medication

- Acid aspiration prophylaxis is routine after the first trimester. Ranitidine 150mgs is given at 2200 the night before and at 0700 on the morning of treatment. Metoclopramide 10mgs is given at 0700 on the morning of treatment. Sodium Citrate 0.3M 30mls is given in the ECT suite about 15 minutes prior to induction of anaesthesia.
- The anticholinergic of choice to protect against bradycardia and limit respiratory secretions is Glycopyrronium bromide.
- Consider using a wedge to displace the uterus laterally from the 16th week of pregnancy onwards. This decreases the incidence of supine hypotensive syndrome.
- Oxygenate for at least three minutes prior to induction of anaesthesia and hyperventilate in order to prevent hypercapnia.
- Consider LMA airways for women up to the 13th week of pregnancy.
- Consider endotracheal intubation in woman from the 14th week of pregnancy onwards.

6.3 ASA 3 and 4 Patients

- These patients must be discussed with the lead ECT Consultant Anaesthetist at Lincoln County Hospital (01522 512512 Anaesthetic Secretaries Ext 3690). High risk patients may be transferred to Lincoln County Hospital theatres for treatment.

6.4 Patients with Pacemakers

- Monitoring for potential pacemaker interference by medical staff experienced in pacemaker management is advisable during the first ECT sessions
- Contact the Senior Chief Cardiac Physiologist Ext 3465/3823.

6.5 Patients with Cochlear Implants

- ECT may destroy the cochlear or the implant. ECT should not be given to these patients unless cleared by an otolarynologist

6.6 Patients with Brain Implants

- Must be discussed with the Consultant Psychiatrist & Consultant Anaesthetist prior to ECT.

6.7 Diabetic Patients

- Diabetics should be first on the list. BM measurement should be taken on arrival. Inform anaesthetist of result.

Diet Controlled

- No special actions

Tablet Controlled

- Omit breakfast and oral hypoglycaemics. Give breakfast and usual medication after recovery from anaesthesia.
Insulin Controlled
- Must be discussed with the anaesthetist prior to first treatment (Anaesthetic Secretaries Ext 3690). Ask patient to bring insulin with them. Continue night time insulin, but omit morning insulin prior to ECT. Give morning insulin with breakfast after recovery.

6.8 Hypertensive Patients
- All patients must have blood pressure checked and recorded in the ECT Record prior to treatment. If greater than 180 mmHg systolic or 110 mmHg diastolic or both, allow patient to rest and check twice more at 5 minute intervals. If still above these limits, check if they have missed any medication for hypertension. Discuss with the anaesthetist
- Anti hypertensive medication should not be omitted prior to ECT
- If hypertensive, or if the blood pressure rises significantly during ECT, consider the use of Propofol as the anaesthetic induction agent

6.9 Learning Disability:
- The management of patients with learning disabilities mirrors other patients.
- Issues of capacity and consent may need special consideration. Both the Mental Capacity Act 2005 and MHA are likely to be pertinent.

6.10 Patients Under 18
- Although ECT can be given to any individual, LPFT does not routinely provide ECT to children & adolescents.
- Giving ECT to under 18s is considered beyond the ‘zone of parental control’ according to the MHA. This means that parents cannot consent on behalf of the child. No child under 18, whether detained or informal, should be given ECT without the approval of a Second Opinion Doctor even if the child consents, except in an emergency. Such consent and appropriateness of the treatment must be certified by a SOAD who will complete Form 5.
- If the child is informal, there must also be authority to treat the child, except in an emergency. For patients who have attained 16 years and over, such authority can be provided under s.5 of the Mental Capacity Act 2005. Court authorisation should be obtained for children under the age of 16. In any event if ECT is thought to be an appropriate form of treatment for an individual under 18, this must be discussed with the Corporate & Legal Services Department prior to treatment except in an emergency.
- It is highly unlikely that treatment would be on an outpatient basis. Admission should always be considered to allow a more thorough assessment of therapeutic options.

7. Protocol for Physical & Anaesthetic Assessment prior to ECT
- A full physical history and examination must be performed.
- Examination and investigations must be carried out in a timely manner, generally within 72 hours of the first treatment. However the prescribing doctor should use his/her clinical judgement to determine the timing of these investigations.
- ECG, FBC, U&E, LFTs & random glucose are essential for all patients.
- A chest x-ray should be performed when clinically indicated.
- Lithium Levels & Sickle cell tests are performed when indicated.
- A Venous Thrombo Embolism (VTE) Screen should be carried out on all patients
- Patients are graded by ASA Grade (see LPFT ECT Record for ASA Guidance – Appendix 1)
- Patients graded ASA 1 or 2 are usually reviewed by the anaesthetist when they arrive in the ECT department on the morning of their first treatment.
- Patients graded ASA 3 or 4 should be reviewed by the anaesthetist prior to arrival for their first treatment.
The referrer should discuss the following patients with the anaesthetist and consider a pre-anaesthetic assessment:
- ASA 3 or 4 patient (section 6.3)
- Pregnant patients (section 6.2)
- Patients with Body Mass Index (BMI) >= 40
- Patients with insulin dependent diabetes (section 6.6)
- Patients with pacemakers (section 6.4)
- History of airway problems/ difficulty with intubation
- Personal or family history of suxamethonium apnoea (section 14.3)
- History of allergy to neuromuscular blockers
- History of Malignant Hyperthermia (section 14.4)

For Lincoln inpatients an assessment can be organised by contacting the anaesthetic department at Lincoln County Hospital on 01522 512512 Ext 3690.
For Grantham inpatients, contact the Grantham anaesthetic department on 01476 565232 Ext 4800.
For Boston inpatients, contact the Boston anaesthetic department on 01205 364801 Ext 5293.
For outpatients the same arrangements apply in each area, although individuals considered to be ASA 3 or 4 should not be receiving outpatient ECT.

The psychiatrist administering ECT and the anaesthetist must be satisfied with the physical workup prior to administering a treatment. Treatment will not proceed if either deems the patient unfit for an anaesthetic.

8. ECT & Prescribed Medication

In general most medication prescribed for a general medical condition is continued during a course of ECT unless the anaesthetist requests that it is omitted.
The decision on whether to continue medication is based on a risk benefit analysis for each individual
When medication is given prior to ECT, it is given with a few sips of water.
Treatments for hypertension should not be stopped on the morning of treatment.
Patients with insulin dependent diabetes mellitus should be discussed with the anaesthetist prior to ECT. An individual treatment plan must be in place (section 6.6)
Oral hypoglycaemics are omitted on the morning of ECT and given with food and fluids after recovery from anaesthesia.
Medicines which are not normally given on an empty stomach (e.g. non-steroidal anti-inflammatory drugs) are omitted on the morning of ECT.
Drugs for oesophageal reflux should not be taken prior to ECT.
Protein pump inhibitors should be taken the night before or at least six hours before treatment.
H2 receptor antagonists can be taken on the morning of ECT.
Anticonvulsants raise seizure threshold and may shorten seizure duration. They should not be stopped prior to treatment – whether being used as an anticonvulsant or mood stabiliser. A higher stimulus dose may be required.
Long established benzodiazepines should not be stopped suddenly before ECT. There is a risk of a dramatic lowering the seizure threshold.
Lithium may result in long seizures. Lithium should be continued, but consider a lower stimulus at the first treatment. Pre-treatment screening must include a lithium level.
No special precautions are required for antipsychotics, except Clozapine which may lower the seizure threshold markedly. A lower stimulus is advisable and clozapine withheld for 12 hours prior to each ECT session.
A number of reports suggest that SSRIs may be related to prolonged seizure activity. Stopping the drug immediately prior to ECT is of no benefit because the drugs have a long half life. Consider a lower stimulus at the first treatment.
9. ECT & DNAR

In situations in which a Patient has a DNAR statement in place, this will be suspended whilst the patient is under anaesthesia & in the ECT Suite.

10. Protocols regarding Capacity, Consent and the Mental Health Act 1983

The assessment of capacity and the process of obtaining consent is the responsibility of both the consultant psychiatrist prescribing ECT and the psychiatrist administering ECT

The prescribing consultant must provide the patient with information regarding ECT and anaesthesia. The right to withdraw consent at any time must be emphasised

The prescribing psychiatrist is responsible for implementing the MHA if appropriate.

Assessment of capacity should be undertaken in line with the Mental Capacity Act 2005.

Ongoing Consent & Capacity should be assessed between each treatment by the prescribing psychiatrist. This assessment should be documented in the LPFT ECT Record.

Ultimately the responsibility for determining Capacity and Consent lies with the treating doctor. If the treating psychiatrist and/or anaesthetist doubt the validity of the patient’s consent, MHA or Mental Capacity Act documentation, treatment will not proceed.

10.1 Informal patients with capacity

The Consent Form in the LPFT ECT Record is completed by the prescriber. The maximum number of treatments (usually 12) should be stated on the consent form. A copy should be given to the patient. Should the patient require more than the stated maximum a new consent form must be completed.

If an informal patient with capacity refuses ECT, it cannot be given. Consideration may be given to detention under the MHA for treatment to proceed - see section 10.3.

10.2 Informal patients who lack capacity to consent

Where the patient lacks capacity to consent to ECT, ECT may be deemed to be in his/her best interests as defined by the Mental Capacity Act 2005. A Mental Capacity Assessment and a Best Interests Checklist must be completed (available on LPFT intranet).

If ECT is considered to be in the patient's best interests, and the patient is truly passive, ECT may be given under the Mental Capacity Act, unless there is a valid & applicable Advance Decision to Refuse ECT or a Lasting Power of Attorney.

The prescribing consultant should ascertain whether either exists. If the patient has made an Advance Decision to Refuse ECT then ECT cannot be given, except in
an emergency. Consideration could be given to detention under the MHA 07 for Emergency Treatment only - see section 9.4 below.

If the patient is resistant to treatment, ECT cannot be given under the Mental Capacity Act. Consideration may be given to detention under the MHA for ECT to proceed - see section 10.4.

10.3 Patients detained under the Mental Health Act with capacity

All patients detained under the MHA should receive a copy of the Care Quality Commission booklet "ECT: Your rights about Consent to Treatment"

When a patient is detained under a treatment section of the MHA, and has the capacity to consent to treatment, and does consent to treatment, Form T4 should be completed.

If the patient refuses ECT, ECT can only be given in an emergency situation (under Section 62) to save the patient's life or prevent a serious deterioration of their condition. Form T6a must be completed. If in doubt whether treatment constitutes an emergency consult the Corporate & Legal Services Department.

10.4 Patients detained under the Mental Health Act who lack capacity to consent

When a patient is detained under the MHA and lacks capacity to consent to ECT, a Second Opinion Appointed Doctor (SOAD) from the Care Quality Commission must be requested. The SOAD will complete form T6 authorising treatment.

Before the SOAD completes form T6, ECT can only be given in an emergency (under Section 62) to save the patient's life or prevent a serious deterioration of their condition. Form T6a must be completed. If in doubt whether treatment constitutes an emergency consult the Corporate & Legal Services Department.

The Responsible Clinician should attempt to ascertain whether the patient has made a valid and applicable Advance Decision to Refuse ECT or has a lasting Power of Attorney. If an Advance Decision to Refuse ECT exists then ECT can only be given in an emergency.

11. Protocols for the Prescription of ECT (including prescribing outside of NICE guidelines)


- Ultimately the responsibility for proceeding with ECT lies with the psychiatrist administering the treatment

**Every effort should be made to prescribe ECT within NICE guidelines (2003; 2009) Prescribing outside of NICE guidance would require:**

- The prescribing psychiatrist to discuss this with the ECT consultant
- A detailed documented assessment of potential risks and benefits of treatment
- A second opinion from an independent psychiatrist when the indication for ECT is potentially controversial or where any variance from NICE guidance is being considered
- During the course of treatment, the patients response to treatment and any side effects should be assessed at least weekly
The prescribing consultant and the ECT consultant should discuss at regular intervals the patients progress/side effects and need to continue treatment. Where appropriate the treatment should be discussed with the patients NOK/carer. This should be clearly documented.

11.1 **Electrode Placement (see also 15.2):**
- The prescribing team selects electrode placement.
- No definitive guidance on electrode placement exists, although Kellner et al 2010 have reviewed the subject.
- When speed of recovery is essential (e.g. marked suicidality, life threatening reduction in food or fluid intake) bilateral placement is preferred.
- Unilateral electrode placement is associated with less cognitive impairment as a side effect and may be appropriate particularly in the elderly.
- Right unilateral ECT is preferred for right handed individuals. For left handed people bilateral electrode placement is preferred.

11.2 **Frequency of Treatments:**
- For both bilateral and unilateral ECT treatment is usually twice weekly. This may be reduced to weekly to manage treatment emergent cognitive side effects.

11.3 **Dosage of ECT:**
- This will be determined by medical staff at the ECT unit according to the Estimation of Seizure Threshold for the Thymatron ECT Machine Guidelines (Section 15.5)
- Factors influencing dosage are outlined section 15.5.
- The prescriber may request a higher dose of electricity in an emergency or changes in dosage during a course of treatment based on progress or side effects.

12. **Protocols for Pre-ECT Procedure**

12.1 **Inpatients from the Peter Hodgkinson Centre (i.e. on site):**
- Verbal referrals can be accepted.
- The referring team must complete the physical examination and ensure all investigations are obtained prior to the first treatment.
- Ward staff must record all observations in the LPFT ECT Record as per the pre-ECT nursing checklist (Appendix 1)
- Ward staff must ensure the patient is nil by mouth prior to ECT.
- Patients should be escorted by a member of the ward staff who is familiar with the patient. The escort should stay with the patient throughout the treatment & recovery period.
- Staff acting as escorts should be able to deal with queries raised by patients in respect of clinical care or consent issues. If unable to answer questions adequately he/she must inform the ECT staff on arrival at the ECT department.
- It is the responsibility of the nurse in charge of ECT to ensure a trained nurse escorts the patient back to the ward if necessary.

12.2 **In-patients travelling from other inpatient areas (i.e. off site):**
- Verbal referrals can be accepted.
- The referring team must complete the physical examination and ensure all investigations are obtained prior to the first treatment.
- Ward staff must record all observations in the LPFT ECT record as per the pre-ECT nursing checklist (Appendix 1)
- It is the responsibility of ward staff to ensure transport is booked both to and from the ECT department.
The ward must liaise with the ECT department regarding arrival time.
Ward staff must ensure the patient is nil by mouth prior to ECT.
In-patients travelling from non PHC wards must have a trained nurse escort.
The trained nurse escort must be ILS trained.
The nurse escort must have a mobile phone.
If more than one patient is travelling from the same ward, each patient will require an
escort i.e. 1:1. However if patients are sharing the same transport, only one of the
escorts is required to be a trained nurse.
Trained nurse escorts should not be the driver of the vehicle transporting patients to
and from the ECT department.
Patients should be escorted by a member of the ward staff who is familiar with the
patient. The escort should stay with the patient throughout the treatment & recovery
period.
Staff acting as escorts should be able to deal with queries raised by patients in
respect of clinical care or consent issues. If unable to answer questions adequately
he/she must inform the ECT staff on arrival at the ECT department.

12.3 Outpatients
The referring doctor must inform the ECT team of the referral. Preferably 48 hours
notice is given to allow patients to visit the ECT department if they wish.
Transport arrangements must be clarified at the time of referral.
Outpatients must have adequate social and professional support in place prior to
treatment commencing.
The referring doctor should inform the patient’s GP that treatment is being provided
as an outpatient.
A full physical examination is essential and must not be compromised by the
outpatient status. This may be performed by an appropriately qualified ECT Nurse at
the ECT department.
All investigations must be carried out with results available for the first
treatment session.
Outpatients must be ASA Grades 1 or 2 physical status.
The referring consultant must obtain consent and complete the LPFT ECT Record
prior to treatment (Appendix 1).
Outpatients must agree to:
- Care from a responsible adult for 24 hours post ECT.
- Not drive a motor vehicle, sign legal documents or travel alone during the
course of ECT unless advised otherwise by their prescribing consultant.
- Fast prior to anaesthesia.
- No alcohol for 24 hours both before & after treatment

The referring doctor must offer a copy of LPFT’s Patient Information Sheet on ECT
and Anaesthesia with emphasis on the section on Outpatient ECT (Appendix 3)
Both patient and doctor must sign the Outpatient ECT documentation in the LPFT
ECT Record
The referring doctor must identify the responsible adult who will remain with the
patient post treatment. The responsible adult must sign the appropriate form in the
LPFT ECT Record.
Outpatients should be reviewed by the prescribing medical team at least weekly.
The referrer should inform the ECT team of the end of the course of treatment.
Pre treatment nursing checks are the same as those required by an inpatient but will
be undertaken by the ECT team.
The patient should remain in hospital until considered by ECT staff fit for discharge.
This may include admission to the Day Hospital for further observation if necessary
(see ECT record and pathway appendix 5).
All patients are encouraged not to bring any items of value with them as the
trust will not take responsibility for these. Any other belongings e.g. glasses
will remain with the patient at all times.
13. Protocol for ‘Out of Hours’ ECT

- ECT normally occurs on Tuesday and Friday mornings at the Peter Hodgkinson Centre, Lincoln. In an emergency it is possible to arrange ECT on other days including weekends and public holidays.
- The necessity for emergency ECT must be determined by a consultant psychiatrist.
- Emergency ECT must be administered by an experienced team of practitioners.
- Physical examination, appropriate investigations and valid consent/ correct MHA documentation must not be compromised by the emergency situation. Concerns about the physical health of the patient must be discussed with the anaesthetist prior to treatment.
- The referring psychiatrist should contact the ECT staff to make appropriate arrangements. The referring psychiatrist is responsible for arranging both anaesthetic and psychiatric input. He/she should contact the on-call anaesthetist at Lincoln County Hospital. Either the referring psychiatrist or the on-call psychiatric trainee at the Peter Hodgkinson Centre may administer the treatment.
- In the absence of the ECT consultant psychiatrist the psychiatrist delivering the treatment must be competent to administer the treatment (Appendix 2).

14. Protocols for Anaesthesia

14.1 Induction of Anaesthesia

- The anaesthesia consultant lead for ECT is Dr. J. Craggs. It is recommended that all anaesthetists undertaking anaesthesia for ECT familiarise themselves with the section on Electroconvulsive Therapy, Chapter 69 – Anaesthesia in Remote Locations, from Miller’s Anaesthesia (sixth edition). This is available in Lincoln County Hospital library or from Dr. Craggs, Consultant Anaesthetist.
- On arrival in the ECT department all equipment should be checked in accordance with the Association of Anaesthetists publication “Checking Anaesthetic Equipment 3” 2004. This check should be recorded in the LPFT ECT Record (Appendix 1). Make sure you know how to tip the table head down.
- Minimum monitoring standards apply as set out in the Association of Anaesthetists publication “Recommendations for Standards of Monitoring during Anaesthesia and Recovery” 2012

A - Induction and Maintenance of Anaesthesia
1. Pulse oximetry
2. Non invasive blood pressure monitor
3. Electrocardiograph
4. Airway gases: oxygen, carbon dioxide (and vapour if indicated)
5. Airway pressure (if indicated)
- The following must also be available
  • A nerve stimulator whenever a muscle relaxant is used
  • A means of measuring the patient’s temperature

B - Recovery from Anaesthesia
- A high standard of monitoring should be maintained until the patient is fully recovered from anaesthesia. Clinical observations must be supplemented by the following monitoring devices.
1. Pulse oximetry
2. Non-invasive blood pressure monitor
It is essential that all drugs are checked prior to commencing anaesthesia including the provision of emergency drugs for the treatment of prolonged seizure, severe hypertensive response and anaphylaxis.

Introduce yourself and confirm with the team the correct patient is present. Familiarise yourself with patient details including current ECT history, medical history, current medications, dentition (remove dentures), degree of starvation (6 hours food, 2 hours clear fluids).

A secure IV access should be established. Flush the cannula with saline. All monitoring should be applied prior to commencing anaesthesia including the EEG electrodes. Consider the use of a peripheral nerve stimulator placed on the ulna border of the wrist. This gives knowledge of the onset and offset of suxamethonium and will give the earliest indication of suxamethonium apnoea.

Pre-oxygenate the patient.

Glycopyrrolate 0.2 mg IV should be considered prior to induction to reduce salivation and prevent bradycardia especially if repeat doses of suxamethonium are used. Do not use atropine as this is a potent cause of confusion especially in the elderly. Flush the cannula with saline.

Give the patient 0.75 – 1.5 mg/Kg of propofol as the induction agent. Flush the cannula with saline.

Administer suxamethonium 0.5 mg/Kg (this may need to be adjusted according to response after the first treatment). Flush the cannula with saline.

Hyperventilate with 100% oxygen using a bag and mask technique with the aid of a Guedel airway or soft bite block with a ventilating channel.

Ensure a soft bite block is in place prior to commencement of treatment. If more than 2 stimuli are required it may be necessary to administer further doses of propofol and suxamethonium (typically 50% of induction doses). Do not forget glycopyrrolate if this occurs.

Re-establish airway control until respiration returns.

Check blood pressure after treatment.

### 14.2 Management of Failed Intubation

**Primary Intubation:**
- Direct Laryngoscopy
- If poor view – bougie
- Re-position head, smaller tube
- Not more than 3 attempts (but maintain oxygenation)
- Oxygenate & ventilate with facemask. Call for help.

**Secondary Intubation:**
- LMA
- Not more than 2 attempts (but maintain oxygenation)

**Oxygenate and wake patient:**
- Facemask oxygenation & ventilation.

**Can’t intubate, can’t ventilate:**
- Cannula cricothyroidotomy.

### 14.3 Management of Suxamethonium (Scoline) apnoea

There are 2 scenarios to consider:

Firstly there may be a history of suxamethonium apnoea. Arrangements should be made to carry out ECT at Lincoln County Hospital. This is because advanced airway control and ventilation is required and the equipment is available to ensure that this is safer and also machines at hand to reduce the incidence of awareness. A bed should be pre-booked on the Day Surgery Unit (ext 3089). Liaise with the Bed Manager (bleep 3903) and the lead Anaesthetist Consultant for ECT (ext 3690).
If there is a family history of suxamethonium apnoea, there may be time to obtain genetic typing of the patient but if not then suxamethonium apnoea is assumed and managed as above.

Secondly suxamethonium apnoea may be discovered during treatment. This should be picked up by use of the nerve stimulator. Ensure that the patient receives sedation. Secure the airway with an endotracheal tube. Call for anaesthetic assistance and contact Intensive Care. Obtain a portable ventilator and infusion device to maintain anaesthesia. Arrange transfer by paramedic ambulance to Lincoln County Hospital Intensive Care Unit (ext 2173) or if full to the main theatres.

14.4 **Management of a Malignant Hyperthermia Crisis**  
(The Association of Anaesthetists of Great Britain and Ireland 2007)

Successful treatment of a Malignant Hyperthermia (MH) crisis depends on early diagnosis and aggressive treatment. The onset of a reaction can be within minutes of induction or may be more insidious. Previous uneventful anaesthesia does not exclude MH. The steps below are intended as an aide memoire. Presentation may vary and treatment should be modified accordingly. Know where the dantrolene is stored in your theatre. Treatment can be optimised by teamwork.

**Diagnosis - consider MH if:**
1. Unexplained, unexpected increase in end-tidal CO2 together with
2. Unexplained, unexpected tachycardia together with
3. Unexplained, unexpected increase in oxygen consumption Masseter muscle spasm, and especially more generalised muscle rigidity after suxamethonium, indicate a high risk of MH susceptibility but are usually self-limiting.

**Take measures to halt the MH process:**
1. Call for help.
2. Remove trigger drugs, turn off vaporisers, use high fresh gas flows (oxygen), use a new, clean non-rebreathing circuit, hyperventilate. Maintain anaesthesia with intravenous agents such as propofol until ECT completed.
3. One ampoule of 20mg dantrolene is available to start immediate therapy. This should be diluted in 60mls water. While this is being done, send for further supplies of dantrolene in main theatres at Lincoln County Hospital (extension 3352). Dantrolene: give 2-3 mg.kg⁻¹ i.v. initially and then 1 mg.kg⁻¹ PRN.
4. Use active body cooling but avoid vasoconstriction. Convert active warming devices to active cooling; give cold intravenous infusions, cold peritoneal lavage, and extracorporeal heat exchange.
5. Contact Intensive Care, arrange transfer with paramedic ambulance.

**Monitor:**

ECG, SpO2, end-tidal CO2, invasive arterial BP, CVP, core and peripheral temperature, urine output and pH, arterial blood gases, potassium, haematocrit, platelets, clotting indices, creatine kinase (peaks at 12-24 h).

**Treat the effects of MH:**
1. Hypoxaemia and acidosis: 100% O2, hyperventilate, sodium bicarbonate.
2. Hyperkalaemia: sodium bicarbonate, glucose & insulin, i.v. calcium chloride (if in extremis).
3. Myoglobinenaemia: forced alkaline diuresis (aim for urine output >3 ml.kg⁻¹.h⁻¹, urine pH >7.0).
5. Cardiac arrhythmias: procainamide, magnesium, amiodarone (avoid calcium channel blockers – interaction with dantrolene).
ICU management:
2. Assess for renal failure and compartment syndrome.
3. Give further dantrolene as necessary (recrudescence can occur for up to 24 hours).
4. Consider other diagnoses, e.g. sepsis, phaeochromocytoma, myopathy.

Late management:
1. Counsel patient and/or family regarding implications of MH.
2. Refer patient to MH Unit.

14.5 Management of Suspected Anaphylaxis during Anaesthesia:

1. Stop administration of all agents likely to have caused the anaphylaxis.
2. Call for help
3. Elevate legs
4. Maintain airway, give 100% oxygen and lie patient flat with legs elevated.
5. Give epinephrine (adrenaline). This may be given intramuscularly in a dose of 0.5 - 1 mg (0.5 - 1 ml of 1:1,000) and may be repeated every 10 minutes according to the arterial pressure and pulse until improvement occurs.

Alternatively, 50 -100 micrograms intravenously (0.5 - 1 ml of 1:10,000) over 1 minute has been recommended for hypotension with titration of further doses as required.

Never give undiluted epinephrine 1:1000 intravenously

In a patient with cardiovascular collapse, 0.5 - 1 mg (5 - 10 ml of 1:10,000) may be required intravenously in divided doses by titration. This should be given at a rate of 0.1 mg/minute stopping when a response has been obtained.

5. Start rapid intravenous infusion with colloids or crystalloids.
   Adult patients may require 2 to 4 litres of crystalloid.

Secondary Therapy
1. Give antihistamines (chlorpheniramine 10-20 mg by slow intravenous infusion)
2. Give corticosteroids (100 - 500 mg hydrocortisone slowly IV).
3. Bronchodilators may be required for persistent bronchospasm.

14.6 Cardio Pulmonary Resuscitation (CPR)

- Check for any risk to you, the patient or others.
- The patient is assessed as unresponsive and absence of normal breathing.
- Ask for 9 999 call to be made.
- Commence CPR 30: 2 with oxygen and airways adjuncts.
- Attach automated external defibrillator (AED).
- Follow AED voice prompts.
- Continue resuscitation until Paramedics arrive.
- Complete Adverse Incident Form and send to Clinical Risk Management team.
- Inform the patient’s consultant, GP and family of transfer.
- Ensure comprehensive notes are made in the patient’s medical records.

15. Protocols for the Delivery of ECT

15.1 ECT Machine/Backup Machine:
- ECT is administered by constant current, brief pulse ECT machines that deliver a range of doses of electricity measured in millicolombes (mc).
- LPFT utilises a Thymatron System IV ECT machine
- The ECT machine is maintained and serviced as per the manufacturer’s recommendations.
- If this machine is unavailable the ECT department keeps a back up Spectrum 5000 ECT machine within the department. This likewise is serviced as per the manufacturer’s recommendations.
15.2 Electrode Placement:

- For bilateral ECT bi-temporal positioning of the electrodes is recommended.

- For unilateral ECT the recommended position of the electrodes is the temporo-parietal or d’Elia positioning on the non-dominant hemisphere.

15.3 Strategy for Selection of Electrical Dose:

- The ECT psychiatrist selects the stimulus dose.
- The selection of electrical dose for an individual patient is governed by the patient’s seizure threshold (ST). The ST is the dose of electricity required to produce a generalised seizure of at least 20 seconds duration.
- The ST cannot be reliably predicted for individual patients through demographic or clinical factors.
- The ST increases with age, male sex, previous ECT and drug treatment with benzodiazepines and anti-convulsants.
- Anaesthetic drugs raise the seizure threshold to different extents. This is especially the case with propofol and less so with Etomidate.
- Antipsychotics (especially Clozapine) and antidepressants lower the ST.
- Dose titration establishes the ST.
- A low dose of electricity is given at the first treatment session. The dose of electricity is then increased until a generalised seizure of at least 20 seconds duration is achieved (detailed in 15.6).
- The aim is for the dose of electrical charge in subsequent treatments to be clearly supra threshold whilst avoiding grossly supra threshold doses, thus maximising efficacy whilst minimising cognitive side effects.
- Dose titration should be used in routine ECT.
- When treatment is started in an emergency, it is advisable to treat with a clearly supra threshold dose to ensure a therapeutic effect.
- When a patient has had a recent course of ECT and is known to have a high ST, treatment may commence with a higher dose.
15.4 **Bilateral ECT:**
- Once the ST is established the electrical dose should continue at least 50% above (i.e. 1½ times) the ST at future sessions.
- When emergency treatment is been given to obtain a rapid clinical response, the dose should be at least 50 – 100% above (i.e. 1.5 – 2 times) the ST.
- If clinical progress is inadequate after 4-6 treatments, doses up to 150% above (i.e. 2.5 times the ST) are indicated.

15.5 **Unilateral ECT:**
- Once the ST is established the electrical dose should continue up to 500% above (i.e. 4-6 times) the ST at subsequent treatments.

15.6 **Estimation of Seizure Threshold for the Thymatron System IV ECT Machine:**
- The Seizure Threshold (ST) is established through use of the Dose Titration Table.
- An adequate seizure is defined as bilateral EEG spike wave activity lasting more than 20 seconds. This may or may not be accompanied by motor activity.
- No more than 3 stimulations should be applied at any one treatment session.
- When the back up Spectrum 5000 machine is used, the dose should approximate to the dose in MC in the Dose Titration Table below.

<table>
<thead>
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<th>Recommended starting points</th>
<th>Level</th>
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<tr>
<td>Unilateral ECT</td>
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<tr>
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<td></td>
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</table>

**First Treatment Session**

**First Stimulation**

Start at dose level for age and electrode placement unless:-
- Start one level higher if:
  - Patient is on benzodiazepines or anticonvulsants
  - Previous course of ECT in past month
  - Emergency ECT
- Consider lower level if the patient is taking medication that lowers the ST e.g. Lithium, Clozapine, SSRIs.
- Always start at level 1 if patient is aged under 18.
- Accept as ST dose if seizure is adequate.

**Second Stimulation**

- If outcome of first stimulation is unsatisfactory wait at least 30 seconds, oxygenate patient and re-stimulate one level higher.
- Accept as ST dose if seizure is adequate.
**Third Stimulation**
- If outcome of second stimulation is unsatisfactory, wait at least 30 seconds, oxygenate patient and re-stimulate three levels higher (i.e. skip two levels).
- If the seizure is adequate, at the **second treatment session** start with the first skipped dose level to clarify the ST dose.
- If the third stimulation is inadequate, go up one level at the **second treatment session** and continue titration.

- **Second Treatment Session**
  - Where the ST dose has been established (i.e. adequate seizure at 1\(^{st}\) or 2\(^{nd}\) stimulation at 1\(^{st}\) treatment session), proceed with the treatment dose:
    - **Bilateral is ST + 1 level**
  - **Unilateral is ST + 3 levels**
    - Where the ST dose has not been established (i.e. adequate or inadequate 3\(^{rd}\) stimulation at 1\(^{st}\) treatment session), continue with the titration procedure.

- **Third and subsequent Treatment Sessions**
  - Initially continue with the treatment dose
  - Clinical monitoring is the best guide to any adjustment of the electrical dose during a course of treatment.
  - A higher dose is required with inadequate clinical improvement after 4-6 treatments. Increase by one level for bilateral ECT or two levels for unilateral ECT.
  - A change in anaesthetic agent may require a change in dose. Propofol may be used if hypertension is problematic during treatment. Propofol raises the seizure threshold, so a higher electrical dose may be necessary.
  - The emergence of significant cognitive side effects is managed by a lower electrical dose, a reduced frequency of treatment or a switch to unilateral ECT.
  - Bilateral ECT should be considered when a patient is not responding to unilateral ECT.

15.7 **Missed Seizures:**
- If satisfactory EEG seizure activity has not been induced the patient should be re-stimulated with a higher electrical dose whilst unconscious. Up to three stimuli can be given in one session provided there are no anaesthetic contraindications.
- There should be a gap of at least 30 seconds between each stimulation. During this time the patient is oxygenated.
- Stimulation may fail to induce a convulsion later on in the course of treatment if there has been an increase in ST because of ECT or other variables such as the prescription of an anticonvulsant drug. A small increase (1 level) would be appropriate if the idea is to establish a new ST. If the patient is severely ill, estimate the new ST as 2 levels higher than the failed stimulus.
- An unexpected missed seizure should prompt a review of ECT, anaesthetic technique and psychotropic drug treatment, to identify factors that may be modified to improve the induction of seizure activity at the next treatment session.
- Consider use of Etomidate in place of Propofol.

15.8 **Monitoring Seizure Activity:**
- In the absence of a muscle relaxant ECT induces generalised cerebral activity resulting in a tonic clonic convulsion. Following an initial tonic contraction of the muscles there is a longer clonic phase of bilateral rhythmic contraction and relaxation of the muscles of the limbs.
- The Thymatron machine monitors cerebral seizure activity by a two channel EEG – one channel for each side of the brain.
- The typical EEG seizure is characterised by 3 phases:
  
  1. **Initial disorganised activity – widespread high frequency spikes**
2. Slower spike & wave complexes around 3 hertz (Cycles per second)
3. A phase of relative or complete suppression of electrical activity

- The ECT machine commences timing at the end of the electrical stimulation.
- The seizure is timed from the end of stimulation to the end of bilateral seizure activity.
- Frequently no motor activity will be observed due to the prescription of the muscle relaxant. When motor activity does occur it should be timed from the end of stimulation until the cessation of bilateral activity.
- The EEG record takes precedence over observed motor activity in monitoring seizure activity and should be used routinely.

15.9 Termination of Prolonged Seizures:
- A prolonged convulsion is one that lasts 2 minutes or more. Prolonged convulsions are associated with cognitive side effects with no increase in efficacy.
- Prolonged seizures should be terminated by an additional dose of induction agent or by intravenous administration of a benzodiazepine in consultation with the anaesthetist.

15.10 Tardive Seizures:
- Late onset of seizure activity may occur in the recovery room. The anaesthetist should be alerted immediately.
o Tardive seizures should be terminated by slow intravenous administration of a benzodiazepine drug given by the anaesthetist.

16. Protocol for Recovery in ECT Department

o There must be at least one trained nurse in the recovery area at all times.

o The number of staff in the recovery area must exceed the number of unconscious patients by one.

o Pulse, blood pressure, pulse oximetry, respirations and patients colour will be monitored according to the patient’s needs.

o All observations will be recorded in the LPFT ECT Record/pathway.

o The Anaesthetist, ODP and Psychiatrist should remain in the ECT suite until all patients have fully recovered consciousness and are stable.

o The nurse in charge of recovery ensures that patients are not discharged until fully recovered.

o All personal belongings including dentures, jewellery, etc are returned to the patient before leaving the recovery area.

o On leaving the recovery area patients will be escorted to the post recovery area and offered something to eat and drink. A member of staff must be present in the post recovery area at all times.

17. Protocol for Monitoring Progress during the Course of ECT

NICE Guidance 2003 & 2009 and ECTAS Standards 2011 recommend that patients are reviewed between each treatment.

o The prescriber/ referrer should document the patient’s:

  - Clinical progress
  - Cognitive functioning & other side effects
  - Capacity and ongoing consent to treatment or MHA status

o In the LPFT -ECT Record (after each treatment)

o Clinical progress & side effects influence the dose of electricity at future treatments.

o The Clinical Global Improvement Scale (CGI) after each individual treatment. A copy of the CGI is included in the LPFT ECT Record (Appendix 1)

o Cognitive Functioning should be monitored by the Mini Mental State Examination (MMSE) throughout treatment, and 1, 3 & 6 months after the course. The ECT Team can provide a nurse to carry out the 3 & 6 month assessments.

o Other Rating Scales/ procedures can be used in addition to the CGI & MMSE at the discretion of the prescriber – e.g. the Montgomery Asberg Depression Rating Scale (MADRS).

18. Protocol for Discontinuing ECT

o A set number of treatments should not be prescribed. The need for ongoing treatment should be assessed after each treatment.

o Treatment should be stopped when:

  - A clinical response has been achieved
  - If there has been no improvement after 6 properly given bilateral treatments, the course should be abandoned. If there has been some slight or temporary improvement by 6 treatments, consider continuing up to 12 bilateral treatments before discontinuing ECT.
  - For patients who have not responded to unilateral ECT, consider switching to bilateral ECT. The ineffective unilateral treatments should be disregarded in relation to the total number of treatments given.
The patient is no longer physically fit for ECT or anaesthesia.
There are side effects unacceptable to the patient.
Legal grounds for treatment no longer exist i.e the patient has withdrawn consent, it is no longer in their best interests (if being treated under the Mental Capacity Act) or the grounds for treating under the MHA are no longer met. This must be assessed before each treatment.

19. Protocol for Continuation and Maintenance ECT

- Following successful treatment of depression by ECT, relapse can occur despite ongoing medication. **Continuation ECT** is defined as prophylactic treatment for six months following remission. **Maintenance ECT** is given beyond this to prevent recurrent episodes. Both may be considered although neither is endorsed by NICE.
- Prior to continuation or maintenance ECT there should be a full case review. This should include consideration of diagnosis, past response to ECT and alternative therapies.
- A second opinion may be sought from a consultant colleague.
- The referring consultant should record the reason for proposing continuation or maintenance ECT. Risks and benefits should be recorded.
- The decision should be discussed with the patient and, with consent, the family/carers.
- A statement of capacity should be recorded prior to treatment.
- For patients detained under the MHA who decline ECT, or lack capacity to consent, a second opinion is needed from the Care Quality Commission.
- The decision to recommend continuation or maintenance ECT should be discussed with the ECT consultant.
- Consent Form 1 must stipulate the number of treatments. Written consent should be gained at least every six months or every 12 treatments, which ever is sooner.
- Patients should undergo a full physical workup prior to ECT. This should be repeated every six months/ 12 treatments or as clinically appropriate.
- Efficacy, cognitive function, side effects and ongoing capacity & consent should be documented after each treatment.
- With improvement the frequency of ECT is reduced to the minimum required to maintain response.

20. Consultation, Approval and Ratification Process

- This policy was initially discussed and consulted upon at the LPFT ECT Steering Group. It was then consulted upon in line with COR11.
- The policy will be approved and ratified in accordance with COR11.

21. Review and Revision Arrangements including Version Control

- This policy will be reviewed by the LPFT ECT Working Group annually or as the need arises due to changes in legislation or guidance. The Consultant Psychiatrists for ECT and Anaesthesia and the Lead Nurse for the ECT Department will be members of this group.
- Corporate and Legal Services will maintain a version control sheet, as per COR11.
22. Dissemination and Implementation of Policy

- The policy will be disseminated as per COR11.
- Implementation of the policy will be ensured through the training detailed in section 4.
- Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this policy.

23. Policy Control including Archiving Arrangements

- Corporate and Legal Services will retain a copy of each policy for a minimum of 10 year in line with the recommendations contained within 'Records Management NHS Code of Practice' (2006)

24. Monitoring Compliance and Effectiveness

<table>
<thead>
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<th>Systems Criteria</th>
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<td>ECT Working Group</td>
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<tr>
<td>ECTAS Royal College of Psychiatrists Standards</td>
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</table>
25. **References**
   - Freedman CP (Ed) Royal College of Psychiatrist 1995
     The ECT Handbook: The Second Report of the Royal College of Psychiatrists Special Committee on ECT
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   - General Hospital Psychiatry (1994) **16** (5), 348-353.
   - NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health.

27. **Associated Documentation**

   **Appendix 1** - LPFT ECT Record and pathway
   **Appendix 2** - LPFT ECT Handbook for Trainees
   **Appendix 3** - ECT & You - A LPFT Guide to Electroconvulsive Therapy (ECT)
     & Anaesthesia for ECT
LPFT ECT RECORD AND PATHWAY

ECT DEPARTMENT
Peter Hodgkinson Centre
Lincoln
Tel: 01522 573509

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- Pre Anaesthetic Assessment (Page 5)
- Consent, Capacity, Mental Health Act status (Page 6)
- Out Patient Documentation (Page 7)
- Prescription, Treatment and Follow-up Documentation (Page 11)
- Outcome of ECT (Page 24)
- Appendix 1 – ASA Grades (Page 26)
- Appendix 2 – CGI Scale (Page 27)
- Appendix 3 – MADRS (Page 28)
- Appendix 4 – Pre ECT Nursing Checklist (Page 30)
- Appendix 5 - Flow chart for out-patient discharge (Page 31)

This record must be completed prior to the start of ECT.
Acknowledgement

This Record was developed with reference to guidance issued by the:

- ECTAS Standards (2011)
- LPFT ECT Policy
- ECT Policy and paperwork from South West Yorkshire Mental Health NHS Trust

It also complies with the Department of Health’s recommendations Regarding Consent to Examination and Treatment (2001) And the Mental Health Act (1983 ammended in 2007).

The Trust would like to acknowledge and thank
Dr Peter Elwood, Consultant Psychiatrist,
Dr James Craggs, Consultant Anaesthetist
and members of the
Lincolnshire Partnership NHS Foundation Trust
ECT Implementation Working Group for their contribution towards the development of this record.

March 2012
## PATIENT DETAILS

Surname: 
First Name(s): 
Date of Birth: 
Home Address: 
Tel: 
NHS No: 

| Location: | Inpatient: | Ward: 
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Consultant: 
Ethnicity: 
Sex: 

## DIAGNOSIS: MADRS

Mini Mental State Examination Score pre treatment

Reason why ECT is being used for this condition following NICE Guidance on ECT 2003

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<th>DIAGNOSIS (please tick)</th>
<th>INDICATIONS FOR ECT (please tick)</th>
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<td>Depression unresponsive to other treatments</td>
<td>Patient choice</td>
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<tr>
<td>Depression where rapid response is essential</td>
<td>Good response to previous ECT</td>
</tr>
<tr>
<td>Mania</td>
<td>Poor response to adequate trial of other treatments</td>
</tr>
<tr>
<td>Catatonia</td>
<td>Potentially life threatening condition</td>
</tr>
<tr>
<td>Maintenance ECT</td>
<td>Other – (specify)</td>
</tr>
</tbody>
</table>

Other e.g. ECT prescribed outside of NICE guidelines | if prescribed outside of NICE guidelines has the patient been informed Yes/No |

## MEDICATION AT START OF TREATMENT

Psychotropic Medication: 
Other Medication: 

Discontinued medication/substances:

Medical/Surgical history
<table>
<thead>
<tr>
<th>Allergies?</th>
<th>YES</th>
<th>NO</th>
<th>N/K</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Smoker?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pregnant?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug abuse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV +VE?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cochlear/Brain implants?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

**PREVIOUS ECT**

Has the patient received ECT before?  
Yes ☐ No ☐ N/K ☐

Date of last course/comments:

<table>
<thead>
<tr>
<th>RESULTS OF PHYSICAL EXAMINATION</th>
<th>Date of Examination</th>
</tr>
</thead>
</table>

Weight.........kg  Height: ..........m  BMI: ..........  Pulse: ..........  BP....../.....  Temp:........

**DENTAL HISTORY**

<table>
<thead>
<tr>
<th>Dentures</th>
<th>Yes ☐ No ☐ N/K</th>
<th>Bridges and Crowns</th>
<th>Yes ☐ No ☐ N/K</th>
<th>History of Cosmetic Surgery</th>
<th>Yes ☐ No ☐ N/K</th>
</tr>
</thead>
</table>

**INVESTIGATIONS PERFORMED**

<table>
<thead>
<tr>
<th>INVESTIGATION</th>
<th>DATE</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBC, U&amp;E, LFTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Random Glucose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VTE Screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CXR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NB:** ECG and bloods for all patients - Generally within 72 hours of 1st ECT  
CXR when clinically indicated.
ASA (American Society of Anesthesiologists) SCORE (Appendix 1)

1. Healthy Patient
2. Mild Systemic Disease
3. Severe Systemic Disease
4. Systemic Disease that is a threat to life

If patient scores ASA 3 or 4, an anaesthetic assessment prior to the first ECT must be requested. Contact the Anaesthetic Department:
- Lincoln County Hospital 01522 512512 Ext 3690
- Pilgrim Hospital, Boston 01205 364801 Ext 5293
- Grantham Hospital 01476 565232 Ext 4800

Patients with the following should be discussed with the Lincoln Anaesthetic Department irrespective of ASA status.
- Pregnant patients
- Patients with Body Mass Index (BMI) ≥ 40
- Patients with insulin dependent diabetes
- Patients with pacemakers
- History of airway problems / difficulty with intubation
- Personal or family history of suxamethonium apnoea
- History of allergy to neuromuscular blockers
- History of malignant hyperthermia

DNAR ORDERS

- Has the patient a DNAR Order – Yes/ No?
- This will be suspended whilst the patient is under anaesthesia. Has this been communicated to all relevant parties – Yes/ No?

Pre ECT Anaesthetic Assessment

Anaesthetic history:

FINDINGS:

Name: Signature: Designation: Date:
CONSENT / CAPACITY / MENTAL HEALTH ACT STATUS
AT FIRST TREATMENT

For patients with capacity consenting to ECT

a) NHS Consent Form 1 completed with number of treatments specified and side effects including cognitive impairment and dental risks discussed

b) Relatives consulted

c) Written Information offered

For patients lacking capacity and not resisting medical treatment

a) Treatment appropriate under Mental Capacity Act 2005

b) NHS Consent Form 4 completed

c) Relatives consulted

d) Advance Decision To Refuse ECT applicable

For patients detained under the Mental Health Act 1983

Patient detained under Section .............

Please tick as appropriate:

a) Patient gives informed consent:, MHA Forms T4 completed with number of treatments specified, side effects including cognitive impairment and dental risks discussed

b) Patient declines treatment or lacks capacity to consent, SOAD contacted and MHA Form T6 completed

c) Emergency treatment required under section 62 of the MHA. Form T6a completed.

d) Relatives consulted

e) Advance Decision to Refuse ECT applicable

If second opinion sought, number of treatments approved ..................................................

Name:  Signature:  Designation:  Date:
Lincolnshire Partnership Foundation NHS Trust
Consent Form for Electroconvulsive Therapy (ECT) – Trust Copy

Patient’s Name……………………... Prescribing Consultant Psychiatrist……………………………………
DOB……………………… Doctor obtaining Consent…………… Designation………………
NHS Number………………… Care Coordinator……………… Designation………………
Address…………………… Special requirements……………………………………

Proposed Treatment
ECT under General Anaesthetic - Bilateral or Unilateral…………………………
Maximum Number of treatments………………

Statement of Doctor Obtaining Consent
I have explained the process of ECT to this patient including:

- The risk/intended benefit balance of ECT
- The likely consequences of not having ECT
- Serious or frequently occurring side effects – Inc. memory impairment, anaesthetic & dental risks
- That ECT involves a general anaesthetic
- Alternative treatments to ECT

I have given the patient the opportunity to ask questions & voice any concerns about the treatment

I have offered the patient a copy of ‘ECT & You – An LPFT Guide to ECT & Anaesthesia for ECT’

Signed………………………… Name………………………… Designation……………… Date………

Contact details (if patient wants further discussion)………………………………………………………………

Statement of Interpreter (where appropriate)
I have interpreted the above to the patient to the best of my ability, and in a way in which I believe s/he can understand.

Signed………………………… Name……………………………………………………… Date………

Statement of Patient
- I agree to a course of ECT as described on this form
- I understand that there is no guarantee that a particular person will perform the procedure. The person will however have appropriate training & experience
- I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before treatment
- I have been offered a copy of ‘ECT & You’ which explains the nature, purpose & effects of ECT
- I understand that any additional procedures to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health
- I have been told about additional procedures that may become necessary during my treatment
- I have listed below procedures which I do not wish to be performed without further discussion

Signed………………………… Name……………………………………………………… Date………

A Witness should sign below if the patient is unable to sign, but has indicated his/ her consent

Signature…………… Name…………… Relationship to patient……………… Date…………
Lincolnshire Partnership Foundation NHS Trust
Consent Form for Electroconvulsive Therapy (ECT) – Patient Copy

Patient’s Name……………………………… Prescribing Consultant Psychiatrist………………
DOB………………………………………Doctor obtaining Consent……………………… Designation………
NHS Number……………………………Care Coordinator…………………………Designation………
Address…………………………………Special requirements……………………………………

Proposed Treatment
ECT under General Anaesthetic - Bilateral or Unilateral…………………………
Maximum Number of treatments………………

Statement of Doctor Obtaining Consent
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- I have listed below procedures which I do not wish to be performed without further discussion

Signed…………………………. Name……………………………………………………… Date……….

A Witness should sign below if the patient is unable to sign, but has indicated his/ her consent

Signature……………… Name……………… Relationship to patient……………… Date………….
OUTPATIENT ECT: Name……………………… DOB………………
Hospital Copy

a) Patient Agreement for the Provision of ECT as an outpatient:-

During your course of outpatient ECT:-

a) You must not eat or drink from midnight on the day of your treatment.

b) You must not drive any vehicle during the course of treatment – or longer if advised by your consultant psychiatrist.

c) You must be supervised by a responsible adult for 24 hours after treatment. You must not operate dangerous machinery, sign legal documents or go out alone.

d) You must not drink alcohol or eat food containing alcohol for 24 hours before & after treatment

e) You must stay in the ECT Department until the ECT staff are satisfied that you have recovered from your anaesthetic and you are fit to be discharged. In some instances it may be necessary to transfer you to the Day Hospital for further observation.

f) Do not bring items of value as Lincolnshire Partnership NHS Foundation Trust cannot accept responsibility for their loss.

g) Outside of normal working hours report any major side effects or problems to your GP, Crisis Resolution Team or contact NHS Direct immediately.

Patient Statement: I understand and agree to the above requirements

Patient Name…………………………………..Patient Signature…………………………………Date………………

b) Responsible Adult Agreement to provide 24 hour care following ECT:-

a) I am willing to be responsible for the above patient for the 24 hour period after ECT treatment.

b) I have received & understood the explanation of the care needed following the procedure.

c) I have received an explanation of the purpose and side effects of the procedure.

d) I am aware of whom I should contact should I have concerns, or require support.

Responsible Adult Statement: I understand and confirm the above

Name …………………………………….. Signature …………………………..Date:

Staff Statement: I confirm that I have explained to both the patient & his/her responsible adult the requirements for outpatient ECT.

Name……………………………….Signature………………………..Designation………………………..Date:

During the course of treatment, if the responsible adult changes, ECT staff will complete a new form and insert it in the patient’s notes.
**Patient’s Copy**

**a) Patient Agreement for the Provision of ECT as an outpatient:**

During your course of outpatient ECT:-

a) You must not eat or drink from midnight on the day of your treatment.

b) You must not drive any vehicle during the course of treatment – or longer if advised by your Consultant psychiatrist.

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d) I am aware of whom I should contact should I have concerns, or require support.

**Responsible Adult Statement:** I understand and confirm the above

Name …………………………………. Signature ……………………………………..Date:

**Staff Statement:** I confirm that I have explained to **both the patient & his/her responsible adult** the requirements for outpatient ECT.

Name……………………………….Signature…………………………Designation………..Date:………..

During the course of treatment, if the responsible adult changes, ECT staff will complete a new form and insert it in the patient’s notes.
RECORD OF PRESCRIPTION, TREATMENT AND FOLLOW-UP

- All sections of the Prescription, Treatment and Follow-up Records must be completed.
- The degree of clinical improvement and/or the emergence of cognitive side effects will influence the electrical dose during the course of treatment.
- On going physical health needs must be monitored with repeat examination and/or investigations as necessary.
- On going assessment of Capacity, Consent and/or the patient’s Mental Health Act status must occur before each treatment. This is the responsibility of both the Prescriber & the Psychiatrist Administering ECT. The Psychiatrist Administering ECT will reaffirm & record the Consent/ Capacity– thus confirming that the patient is either consenting to or declining further treatment.

PRESCRIPTION 1

<table>
<thead>
<tr>
<th>ECT Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment No:</td>
</tr>
<tr>
<td>----------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre ECT Nursing Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECT Checklist Completed</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric Record of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity/ Consent reaffirmed</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
</tbody>
</table>

Comments:

<table>
<thead>
<tr>
<th>Anaesthetic Treatment Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetic Equipment Check</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
</tbody>
</table>

Comments:

<table>
<thead>
<tr>
<th>Recovery Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Patient Entered Recovery Room</td>
</tr>
<tr>
<td>------------------</td>
</tr>
</tbody>
</table>

Name: ........................................ Signature: .................................
Designation: ...................................... Date: ......................................
### Clinical Review Post Prescription 1 / Prior to Further Prescription

<table>
<thead>
<tr>
<th>Patient's Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental State Examination</td>
<td></td>
</tr>
<tr>
<td>CGI/MADRS score</td>
<td></td>
</tr>
<tr>
<td>Side Effects</td>
<td></td>
</tr>
<tr>
<td>Cognitive Functioning</td>
<td></td>
</tr>
<tr>
<td>Changes in Prescribed Medication</td>
<td></td>
</tr>
<tr>
<td>Changes in ASA grade</td>
<td></td>
</tr>
<tr>
<td>Current Mental Health Act Status/Capacity/Consent</td>
<td></td>
</tr>
</tbody>
</table>

**Comments including any patient queries/concerns:**

| Name: ................................................ | Signature: ................................................ |
| Designation: ....................................... | Date: ..................................................... |

### PRESCRIPTION 2

#### ECT Treatment

<table>
<thead>
<tr>
<th>Treatment No.</th>
<th>Date of Treatment</th>
<th>BL/RUL/UUL</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

#### Pre ECT Nursing Report

<table>
<thead>
<tr>
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<th>Temp</th>
<th>BP</th>
<th>Pulse</th>
<th>Resp Rate</th>
<th>BM if applicable</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

#### Psychiatric Record of Treatment

<table>
<thead>
<tr>
<th>Capacity/Consent reaffirmed</th>
<th>Electrical Dose (millicoulombs)</th>
<th>Duration of BL EEG Seizure (Secs)</th>
<th>Duration of Observed BL Seizure (Secs)</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
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</table>

**Comments:**

#### Anaesthetic Treatment Record

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<thead>
<tr>
<th>Anaesthetic Equipment Check</th>
<th>Pre Medication Drug and Dose</th>
<th>Anaesthetic Drug and Dose</th>
<th>Muscle Relaxant Drug and Dose</th>
<th>Other Medication Drug and Dose</th>
<th>Obs prior to leaving Tx Room</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
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</table>

**Comments:**

#### Recovery Record

<table>
<thead>
<tr>
<th>Time Patient Entered Recovery Room</th>
<th>................................................</th>
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</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>Pulse</th>
<th>Resp</th>
<th>Sats</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments eg. Side effects, additional medication**

| Name: ................................................ | Signature: ................................................ |
| Designation: ....................................... | Date: ..................................................... |

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Clinical Review Post Prescription 2 / Prior to Further Prescription

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<td>CGI/MADRS score</td>
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<td>Side Effects</td>
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<td>Cognitive Functioning</td>
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<tr>
<td>Changes in Prescribed Medication</td>
</tr>
<tr>
<td>Changes in ASA grade</td>
</tr>
<tr>
<td>Current Mental Health Act Status/Capacity/Consent</td>
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Comments including any patient queries/concerns:

Name: .............................................. Signature: ..............................................

Designation: .............................................. Date: ..............................................

PRESCRIPTION 3

ECT Treatment

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<tr>
<th>Treatment No.</th>
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<th>BL/RUL/LUL</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
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</table>

ECT Checklist Nursing Report

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<th>Temp</th>
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<th>Pulse</th>
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<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
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</table>

Psychiatric Record of Treatment

<table>
<thead>
<tr>
<th>Capacity/Consent reaffirmed</th>
<th>Duration of BL EEG Seizure (Secs)</th>
<th>Name</th>
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<th>Designation</th>
<th>Date</th>
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Comments:

Anaesthetic Treatment Record

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<thead>
<tr>
<th>Anaesthetic Equipment</th>
<th>Pre Medication Drug and Dose</th>
<th>Anaesthetic Drug and Dose</th>
<th>Muscle Relaxant Drug and Dose</th>
<th>Other Medication Drug and Dose</th>
<th>OBS prior to leaving Tx Room</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
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Comments:

Recovery Record

<table>
<thead>
<tr>
<th>Time Patient Entered Recovery Room</th>
<th>........................................</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>Pulse</th>
<th>Resps</th>
<th>Sats</th>
</tr>
</thead>
</table>

Comments eg. Side effects, additional medication

Name: .............................................. Signature: ..............................................

Designation: .............................................. Date: ..............................................
Clinical Review Post Prescription 3 / Prior to Further Prescription

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<tr>
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</tr>
<tr>
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</table>

Comments including any patient queries/concerns:

Name: ........................................ Signature: ........................................

Designation: ........................................ Date: ........................................

PRESCRIPTION 4

ECT Treatment

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<tr>
<th>Treatment No.</th>
<th>Date of Treatment</th>
<th>BL/RUL/LUL</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
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</table>

Pre ECT Nursing Report

<table>
<thead>
<tr>
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<th>Tamp</th>
<th>BP</th>
<th>Pulse</th>
<th>Resp Rate</th>
<th>BM if applicable</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
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</table>

Psychiatric Record of Treatment

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<thead>
<tr>
<th>Capacity/Consent reaffirmed</th>
<th>Electrical Dose (millioulombs)</th>
<th>Duration of BL EEG Seizure (Secs)</th>
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</thead>
</table>

Comments:

Anaesthetic Treatment Record

<table>
<thead>
<tr>
<th>Anaesthetic Equipment Check</th>
<th>Pre Medication Drug and Dose</th>
<th>Anaesthetic Drug and Dose</th>
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Recovery Record

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<th>BP</th>
<th>Pulse</th>
<th>Resp</th>
<th>Sats</th>
<th>Comments eg. Side effects, additional medication</th>
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Name: ........................................ Signature: ........................................

Designation: ........................................ Date: ........................................
Clinical Review Post Prescription 4 / Prior to Further Prescription

<table>
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Name: .................................................. Signature: ..................................................
Designation: .................................................. Date: ..................................................

PRESCRIPTION 5

ECT Treatment

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Pre ECT Nursing Report

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<th>BMI if applicable</th>
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<th>Designation</th>
<th>Date</th>
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Psychiatric Record of Treatment

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<th>Electrical Dose (milli coulombs)</th>
<th>Duration of BL EEG Seizure (Secs)</th>
<th>Duration of Observed BL Seizure (Secs)</th>
<th>Name</th>
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Comments:

Anaesthetic Treatment Record

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<th>Anaesthetic Drug and Dose</th>
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<th>Other Medication Drug and Dose</th>
<th>Obs prior to leaving Tx Room</th>
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Comments:

Recovery Record

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<tbody>
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<td>Sats</td>
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<td>Comments eg. Side effects, additional medication</td>
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<td>CGI/MADRS score</td>
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<tr>
<td>Side Effects</td>
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<td>Cognitive Functioning</td>
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<tr>
<td>Changes in Prescribed Medication</td>
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<tr>
<td>Changes in ASA grade</td>
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Designation: ………………………………….. Date: ……………………………………..

### PRESCRIPTION 6

#### ECT Treatment

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Comments:

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Comments:

#### Recovery Record

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*Comments eg. Side effects, additional medication

Name: …………………………………..……….. Signature: ……………………………………..

Designation: ………………………………….. Date: ……………………………………..
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<td>Side Effects</td>
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<td>Cognitive Functioning</td>
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<tr>
<td>Changes in Prescribed Medication</td>
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<td>Changes in ASA grade</td>
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**Designation: ..........................................................**  
**Date: ........................................................................**

### PRESCRIPTION 7

#### ECT Treatment

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Comments:

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*Comments eg. Side effects, additional medication

**Name: ..........................................................**  
**Signature: ..........................................................**

**Designation: ..........................................................**  
**Date: ........................................................................**
**Clinical Review Post Prescription 7 / Prior to Further Prescription**

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**PRESCRIPTION 8**

### ECT Treatment

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Comments:

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Comments eg. Side effects, additional medication

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## Clinical Review Post Prescription 8 / Prior to Further Prescription

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| Date: | …………………………………..… |

### PRESCRIPTION 9

#### ECT Treatment

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Comments:

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Comments:

#### Recovery Record

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Comments eg: Side effects, additional medication

| Name: | …………………………………..… |
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| Designation: | …………………………………..… |
| Date: | …………………………………..… |

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### Clinical Review Post Prescription 9 / Prior to Further Prescription

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Designation: .......................................................... Date: ..........................................................

### PRESCRIPTION 10

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Comments:

#### Recovery Record

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Comments eg. Side effects, additional medication

Name: .......................................................... Signature: ..........................................................

Designation: .......................................................... Date: ..........................................................
## Clinical Review Post Prescription 10 / Prior to Further Prescription

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**Comments including any patient queries/concerns:**

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## PRESCRIPTION 11

### ECT Treatment

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### Pre ECT Nursing Report

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**Comments:**

### Anaesthetic Treatment Record

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**Comments:**

### Recovery Record

**Time Patient Entered Recovery Room**: ……………………………

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Comments eg: Side effects, additional medication

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Clinical Review Post Prescription 11 / Prior to Further Prescription

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<td>Current Mental Health Act Status/Capacity/Consent</td>
<td></td>
</tr>
<tr>
<td>Comments including any patient queries/concerns:</td>
<td></td>
</tr>
</tbody>
</table>

Name: ........................................... Signature: ...........................................
Designation: ........................................... Date: ...........................................

PRESCRIPTION 12

ECT Treatment

<table>
<thead>
<tr>
<th>Treatment No.</th>
<th>Date of Treatment</th>
<th>BL/RUL/LUL</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

Pre ECT Nursing Report

<table>
<thead>
<tr>
<th>ECT Checklist</th>
<th>Completed</th>
<th>Temp</th>
<th>BP</th>
<th>Pulse</th>
<th>Resp</th>
<th>Rate</th>
<th>BMI</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

Psychiatric Record of Treatment

<table>
<thead>
<tr>
<th>Capacity/Consent reaffirmed</th>
<th>Electrical Dose (millicoulombs)</th>
<th>Duration of Bl. EEG Seizure (Secs)</th>
<th>Duration of Observed Bl. Seizure (Secs)</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

Comments:

Anaesthetic Treatment Record

<table>
<thead>
<tr>
<th>Anaesthetic Equipment Check</th>
<th>Pre Medication Drug and Dose</th>
<th>Anaesthetic Drug and Dose</th>
<th>Muscle Relaxant Drug and Dose</th>
<th>Other Medication Drug and Dose</th>
<th>Obs prior to leaving Tx Room</th>
<th>Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

Comments:

Recovery Record

<table>
<thead>
<tr>
<th>Time Patient Entered Recovery Room</th>
<th>Time</th>
<th>BP</th>
<th>Pulse</th>
<th>Resps</th>
<th>Sats</th>
<th>Comments eg. Side effects, additional medication</th>
</tr>
</thead>
</table>

Name: ........................................... Signature: ...........................................
Designation: ........................................... Date: ...........................................
Clinical Review Post Prescription 12 / Prior to Further Prescription

<table>
<thead>
<tr>
<th>Patient’s Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental State Exam.</td>
<td></td>
</tr>
<tr>
<td>CGI/MADRS score</td>
<td></td>
</tr>
<tr>
<td>Side Effects</td>
<td></td>
</tr>
<tr>
<td>Cognitive Function</td>
<td></td>
</tr>
<tr>
<td>Changes in Prescrib</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Changes in ASA grade</td>
<td></td>
</tr>
<tr>
<td>Current Mental Health Act Status/Capacity/Consent</td>
<td></td>
</tr>
<tr>
<td>Comments including any patient queries/concerns:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designation:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Should the number of treatments exceed 12, a new record must be completed in its entirety, including a full physical examination if deemed clinically appropriate. A new consent form should be completed.
Outcome of Course of ECT

Name……………………
DOB……………………
Hospital Number…………..
Address……………………

• Assessments post ECT to be completed by the Prescribing Team

Date of 1st Treatment…………
Date of last Treatment…………
Number of Treatments…………
IP or OP or Combination of both?.........
Consenting or Detained?..........

<table>
<thead>
<tr>
<th>Outcome of course of ECT</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Good Response – Patient’s perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Good Response – Staff perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partial Response – Patient perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Partial Response Staff perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Course stopped due to lack of Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Course stopped due to Side Effects</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At First Treatment 3-4 Days After Final Treatment

CGI Severity of Illness Score

CGI Global Improvement Score

CGI Efficacy Index Score X

MMSE

MADRS

Name of assessor

Signature

Designation

Date
Assessments at 2 months Post ECT – completed by the ECT Dept.

<table>
<thead>
<tr>
<th>Visit Accepted Yes/No</th>
<th>3 Months Post ECT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MADRS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SU Questionnaire Completed Yes/No</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Additional Comments</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of assessor</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

Estimation of ASA Grade

| Characterisation of ‘mild’ and ‘severe’ co-morbidity, corresponding to ASA grades 2 and 3, For cardiovascular, respiratory and renal co-morbidities. |
|-------------------------------------------------------------|-------------------------------------------------------------|
| **Cardiovascular Disease**                                  | **Cardiovascular Disease**                                  |
| ASA Grade 2: “A patient with mild systemic disease”         | ASA Grade 3: “A patient with severe systemic disease”        |
| Current Angina                                              | Occasional use of GTN sprays (2-3 times per month). Does not include patients with unstable angina who would be ASA 3 |
| Exercise tolerance                                         | Not limiting activity                                       |
| Hypertension                                                | Regular use of GTN spray (2-3 times per week) or unstable angina |
| Diabetes                                                    | Not well controlled, requiring multiple anti-hypertensive medications |
| Previous coronary revascularisation                        | Not well controlled, diabetic complications (e.g. claudication, impaired renal function) |
| Respiratory disease                                         | Respiratory disease                                         |
| COAD/COPD                                                   | Productive cough; wheeze well controlled by inhalers; occasional episodes of acute chest infection |
| Asthma                                                      | Breathlessness on minimal exertion (for example, stair climbing, carrying shopping); distressingly wheezy much of the time; several episodes per year of acute chest infection |
| Renal disease                                               | Poorly controlled; limiting life-style; on high dose of inhaler/oral steroids; frequent hospital admission on account of asthma exacerbation |
| Elevated creatinine (creatinine > 100umol/litre and < 200 umol/litre); some dietary restrictions | Documented poor renal function (creatinine > 200umol/litre); regular dialysis programme (peritoneal or haemodialysis) |

COAD, chronic Obstructive Airways Disease
COPD, Chronic Obstructive Pulmonary Disease
GTN, Glyceryl Trinitrate

Appendix 2  MONITORING PROGRESS

Clinical reviews should occur after each ECT treatment in accordance with NICE Guidelines (April 2003) & ECTAS Standards (2011). The ECT prescription chart has space for progress to be recorded. The clinician responsible for prescribing ECT should monitor progress by use of the Clinical Global Improvement Scale (CGI). The MDRS may be used in addition to the CGI.

Clinical Global Improvement Scale

1. **Severity of Illness Score**
   Considering your clinical experience of this particular population, how mentally ill is the patient at this time?
   - 1 = Normal/ Not at all ill
   - 2 = Borderline mentally ill
   - 3 = Mildly ill
   - 4 = Moderately ill
   - 5 = Markedly ill
   - 6 = Severely ill
   - 7 = Among the most extremely ill patients

2. **Global Improvement**
   Rate total improvement whether or not, in your judgement, it is due entirely to ECT. Compared to his/her condition at onset of ECT, how much has he/ she changed?
   - 1 = Very much improved
   - 2 = Much improved
   - 3 = Minimally improved
   - 4 = No change
   - 5 = Minimally worse
   - 6 = Much worse
   - 7 = Very much worse

3. **Efficacy Index**
   Rate this on the basis of ECT only. Select the terms which best describe the degrees of Therapeutic Effect & Side Effects. Record the number in the box where the 2 lines intersect.

<table>
<thead>
<tr>
<th>Therapeutic Effect</th>
<th>None</th>
<th>Do not significantly Interfere with functioning</th>
<th>Significantly Interfere with functioning</th>
<th>Outweighs Therapeutic effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marked – Vast improvement. Complete or nearly complete remission of symptoms</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>04</td>
</tr>
<tr>
<td>Moderate – Decided improvement. Partial remission of symptoms</td>
<td>05</td>
<td>06</td>
<td>07</td>
<td>08</td>
</tr>
<tr>
<td>Slight improvement – Slight improvement which doesn’t alter care of patient</td>
<td>09</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Unchanged or worse</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>
Appendix 3 MONITORING PROGRESS

Clinical reviews should occur after each ECT treatment in accordance with NICE Guidelines (April 2003) & ECTAS Standards (2011). In addition to the Clinical Global Impression Scale (CGI) may wish to record progress using the Montgomery and Asberg Depression Rating Scale (MADRS).

The MADRS is sensitive to treatment effects and includes 10 commonly occurring symptoms. The rater should decide whether the rating lies on defined scale steps (0, 2, 4, 6) or between them (1, 3, 5).

<table>
<thead>
<tr>
<th>MADRS Depression Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Apparent Sadness</strong></td>
</tr>
<tr>
<td>Representing despondency, gloom and despair (more than just transient low spirits), reflected in speech, facial expression and posture. Rate by depth, and inability to brighten up.</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td><strong>2. Reported Sadness</strong></td>
</tr>
<tr>
<td>Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondence, or the feeling of being beyond help and without hope. Rate according to intensity, duration and the extent to which the mood is reported to be influenced by events.</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td><strong>3. Inner Tension</strong></td>
</tr>
<tr>
<td>Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td><strong>4. Reduced Sleep</strong></td>
</tr>
<tr>
<td>Representing the experience of reduced duration or depth of sleep compared to the subject’s own normal pattern when well.</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td><strong>5. Reduced Appetite</strong></td>
</tr>
<tr>
<td>Representing the feeling of a loss of appetite compared with when well. Rate by loss of desire for food, or the need to force oneself to eat.</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>
### MADRS Depression Rating Scale

#### 6. Concentration Difficulties
Representing difficulties in collecting one’s thoughts, mounting to incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No difficulties in concentrating.</td>
</tr>
<tr>
<td>2</td>
<td>Occasional difficulties in concentrating one’s thoughts.</td>
</tr>
<tr>
<td>4</td>
<td>Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation.</td>
</tr>
<tr>
<td>6</td>
<td>Unable to read or converse without great difficulty.</td>
</tr>
</tbody>
</table>

#### 7. Lassitude
Representing a difficulty in getting started or slowness initiating and performing everyday activities.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Hardly any difficulty in getting started. No sluggishness.</td>
</tr>
<tr>
<td>2</td>
<td>Difficulties in starting activities.</td>
</tr>
<tr>
<td>4</td>
<td>Difficulties in starting simple routine activities which are carried out with effort.</td>
</tr>
<tr>
<td>6</td>
<td>Complete lassitude. Unable to do anything without help.</td>
</tr>
</tbody>
</table>

#### 8. Inability to Feel
Representing the subjective experience of reduced interest in the surroundings or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal interest in the surroundings and in other people.</td>
</tr>
<tr>
<td>2</td>
<td>Reduced ability to enjoy usual interests.</td>
</tr>
<tr>
<td>4</td>
<td>Loss of interest in the surroundings. Loss of feelings for friends and acquaintances.</td>
</tr>
<tr>
<td>6</td>
<td>The experience of being emotionally paralysed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.</td>
</tr>
</tbody>
</table>

#### 9. Pessimistic Thoughts
Representing thoughts of guilt, inferiority, self-reproach, sinfulness and remorse.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No pessimistic thoughts.</td>
</tr>
<tr>
<td>2</td>
<td>Fluctuating ideas of failure, self-reproach or self-depreciation.</td>
</tr>
<tr>
<td>4</td>
<td>Persistent self-accusations or definite but still rational ideals of guilt or sin. Increasingly pessimistic about the future.</td>
</tr>
<tr>
<td>6</td>
<td>Delusions of ruin, remorse or redeemable sin. Self-accusations which are absurd and unshakeable.</td>
</tr>
</tbody>
</table>

#### 10. Suicidal Thoughts
Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and preparations for suicide. Suicidal attempts should not in themselves influence the rating.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Enjoys life or takes it as it comes.</td>
</tr>
<tr>
<td>2</td>
<td>Weary of life. Only fleeting suicidal thoughts.</td>
</tr>
<tr>
<td>4</td>
<td>Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention.</td>
</tr>
<tr>
<td>6</td>
<td>Explicit plans for suicide when there is an opportunity. Active preparations for suicide.</td>
</tr>
</tbody>
</table>

#### SCORE INTERPRETATION GUIDE

- **0 – 6** Normal / Recovered
- **7 – 19** Mild Depression
- **20 – 34** Moderate Depression
- **35 – 60** Severe Depression

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Appendix 4

PRE-ECT Nursing Checklist

- For Completion by Ward Nurse for inpatients prior to ECT
- For Completion by ECT Nurse for outpatients prior to ECT

Patient nil by mouth – for at least 6 hours
Medication should be given with minimal water – unless directed otherwise by Doctor

TPR & BP carried out – record on relevant Treatment page as Pre ECT Nursing Report
BM if applicable – record on relevant treatment page as Pre ECT Nursing Report
Hair clean and unlacquered, clips and slides removed, hair worn loose
Finger and toe nails unvarnished
Oral check for loose teeth, caps and fillings
Dentures removed
Removal of Hearing Aid
Clothing loose fitting
Removal of watches, jewellery, and placed into safe custody
Identity Bracelet applied
Trust ECT Record available for ECT staff
Patient’s case notes accompany the patient to ECT and are available to ECT staff
NHS Consent Form available and consent reaffirmed
MHA Section Papers available
MHA Forms T4, T4a or T6 available
Urgent Treatment Form available (MHA Section 62)

Any problems identified whilst carrying out this checklist must be reported to the ECT staff. In particular observe for changes in the patient’s consent or refusal to undergo ECT.
Appendix 5

FLOW CHART FOR THE DISCHARGE OF OUT-PATIENTS FROM THE ECT DEPARTMENT

Assess patient for discharge

Is the patient fit to be discharged?

**YES**

Discharge following LPFT ECT outpatient protocol

**NO**

- Continue to monitor patient and re-assess
- Discuss any concerns with Anaesthetist and/or on-call SHO*
- If patient stable but requires further observation discuss with Day Hospital staff and transfer patient to the Day Hospital
- Before patient is discharged from the Day Hospital please discuss with on-call SHO*
- Discharge following LPFT ECT outpatient discharge protocol

*please note: the on-call Dr is responsible for ECT
ECT HANDBOOK FOR TRAINEES

Dr. Peter Elwood
Consultant Psychiatrist
Peter Hodgkinson Centre, Lincoln
01522 573548

May 2010
Introduction

Psychiatric and GP Trainees working on the Lincolnshire rotation will have some involvement with ECT during their training. Most trainees will be involved in the preparation of patients for ECT. Whilst based in Lincoln, Trainees will administer ECT on a Rota basis. The following handbook provides an introduction to LPFT ECT services. It should be read along with the following:

- ECT Competencies – Available on the Royal College website
- LPFT ECT Policy – available on the LPFT website. This policy is based on The ECT Handbook 2nd Edition. It is essential reading for all Trainees involved with ECT.
- Mental Capacity Act 2005
- Mental Health Act 2007

Learning Objectives / Opportunities

The practice of ECT provides a number of learning opportunities for trainees including:

- Theory and practice of ECT
- Historical aspects of psychiatry.
- An opportunity to utilise rating scales to monitor recovery from a major mental disorder.
- The assessment of capacity and the consent process, and the use of the Mental Health and Capacity Acts.
- Audit of a psychiatric treatment

Roles of Trainees in the provision of ECT.

Preparation of patients for ECT. ECT is given to both inpatients and outpatients. The majority of patients have capacity and consent to treatment. There will be those who lack capacity and who are having treatment under the Mental Health Act 2007, or occasionally the Mental Capacity Act 2005. Whilst the decision to prescribe ECT is made by a senior Psychiatrist, Trainees will be involved in the assessment of capacity and in obtaining informed consent. Trainees should be able to explain the process of ECT to patients and their relatives.

Trainees will carry out a physical workup prior to ECT.

Monitoring patients’ progress during a course of ECT. Trainees will assess clinical progress and side effects that may develop during the course of treatment. There is the opportunity to use rating scales in order to assess progress.

Administration of ECT. Lincoln based Trainees provide ECT on a rota basis. ECT is given on Tuesday, Wednesday and Fridays in the ECT Department at the Peter Hodgkinson Centre. Treatment sessions commence at 9.00am and usually finish by about 1100am. Typically the department offers treatment to approximately three patients per session. Wednesdays are generally the quieter day.

The on-call doctor for the Peter Hodgkinson Centre on Tuesdays, Wednesdays and Fridays covers ECT. Should he/she be unable to attend an ECT session it is the Trainee’s responsibility to ensure that a replacement attends in their place and to inform the ECT Dept (01522 573509) or the ECT Manager Ally Bates (07799035305) of that change prior to the treatment session.

It is worthwhile confirming with Ally Bates that there is an ECT list the day before your on call.
Training/Supervision

Dr. Peter Elwood, Consultant Psychiatrist has consultant responsibility for the ECT department. He provides an initial induction for all new Trainees to Lincoln. He then provides supervision on an ongoing basis. Trainees new to Lincoln must not give ECT unsupervised prior to receiving induction/authorisation from Dr. Elwood. This applies to Trainees new to psychiatry and also to those who have had previous experience of ECT elsewhere. Short term locums are not to be involved in the ECT rota unless deemed competent and given permission by Dr Elwood.

With new intakes of Trainees Dr Elwood holds an initial induction session as part of the LPFT Induction package. At this session Trainees will receive copies of:

- The current LPFT ECT Policy
- The LPFT ECT Booklet
- The LPFT Handbook for Trainees

Whilst the Policy appears wordy, it covers all aspects of ECT including the administration of ECT. It is essential reading.

Dr Elwood will then supervise Trainees on an individual basis, or in small groups at future ECT sessions until they are deemed competent to give ECT independently. The Royal College gives guidance on competencies that trainees should achieve – these are summarised at the end of this handbook.

Dr. Elwood generally attends the ECT Department on Fridays. Ongoing supervision is provided through the ECT Rota. Whilst initial supervision sessions focus primarily on the provision of ECT, future sessions can cover other aspects of Psychiatry such as treatment resistant depression, Mental Health Act and Capacity Act issues etc.

When individual Trainees join the Training Scheme at different times, the same requirements stand. Individual appointments can be arranged through Dr Elwood’s secretary (01522 573548).

Generally speaking this process has worked well both with respect to education and service provision. There are however periods when the rota becomes ‘stretched’. With a large intake of new Trainees, there may be few existing Trainees to provide ECT whilst the newcomers are being ‘induced’. During these periods it is appreciated if experienced trainees can help by providing additional sessions – remember we were all once newcomers!

There have been occasions when individual Trainees have requested to opt out of the ECT Rota. There is also debate about the relevance of ECT to GP Trainees. If an individual opts out of the Rota, he/she is responsible for insuring that another Trainee covers his/her sessions – as would be the case for other aspects of service provision. It is essential that the ECT dept is informed of the replacement prior to each treatment session.

Audit

ECT is audited on an annual basis for it’s adherence to NICE Guidance. Trainees are very welcome to become involved in this audit. Alternatively Dr Elwood welcomes any other audit ideas and is happy to assist with projects.
ECT Competencies – Royal College of Psychiatrists

The Royal College gives guidance on competencies that trainees should achieve at different stages of their training. The degree of expertise required of doctors for different aspects of ECT are summarised below. Please see the College Website for a detailed description. There are downloadable forms that can be signed off for use in trainees’ portfolios.

By Year 3 all Trainees should be able to:
- Administer ECT without direct supervision
- Prepare patients for ECT
- Explain ECT to patients & relatives
- Monitor a patient’s mental state & cognitive functioning throughout a course of ECT

The College describes ‘competencies’ in the following ‘domains’ relating to ECT:

1. Theory & Background
   - NICE Guidelines
   - Royal College Standards eg ECTAS & SEAN
   - LPFT Protocols
   - Consent Process
   - ECT Process
   - Mechanism of action

2. Practical Aspects of ECT
   - Clinic Protocol
   - Use of the ECT machine
   - Dosage of ECT
   - Monitoring motor seizure & EEG
   - Recording treatment
   - Anaesthesia
   - Basic resuscitation training

3. Other Aspects of ECT a)
   - Observed clinical application of ECT – Induction & Supervision by ECT Consultant

4. Other Aspects of ECT b)
   - Participation in audit of ECT
   - Participation in one day of CPD relating to ECT per year
   - Able to advise consultant colleagues
   - Involved in regular review of ECT policies & procedures
   - Evidence of training & supervising doctors in training in ECT practice

Psychiatrists at different levels of training are expected to have different levels of competency within each of these domains as per the table below. The level of competency can be summarised as:

- **Fully Conversant** - Able to explain the subject or carry out the procedure both competently & independently.
- **Working Knowledge** – Sufficient understanding of & ability to perform the procedure in most common situations. Aware of own limitations & how to access further information.
- **Awareness** – Is aware of the subject & knows where to access further information.

<table>
<thead>
<tr>
<th>Theory &amp; Background</th>
<th>Foundation Doctors</th>
<th>ST 1-3</th>
<th>ST 4-6 &amp; Prescribing Consultants</th>
<th>ECT Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>Working Knowledge</td>
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These are minimum standards and there is no reason why doctors should not ‘upgrade’ their knowledge for a particular level of training. For example an ST 1-3 Trainee may want to participate in audit, or a Foundation Trainee may be part of the ECT Rota and hence need to be conversant with the practical aspects of ECT delivery. The apparent discrepancy in knowledge for the practical aspects of ECT reflects the fact that ST 1-3 psychiatrists are part of an ECT Rota, whereas their senior colleagues usually are not.

The Royal College does not include GP Trainees in the above. If participating in the Rota, GP Trainees should meet the competencies of ST 1-3 psychiatrists.

**ECT Department - Contacts**

The Lead Nurse for ECT is **Ally Bates (07799035305)**

She is based in the Peter Hodgkinson Centre. **Tel 01522 573509**

**Dr Peter Elwood** is the ECT Consultant Psychiatrist

His secretary is contactable at the Peter Hodgkinson Centre, Greetwell Road, Lincoln LN2 5UA **Tel 01522 573548.**

**Dr Jim Craggs**, Consultant Anaesthetist at ULHT/ Lincoln County Hospital is the Anaesthetic Lead.

He is contactable on **01522 512512 Ext 3690**

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Dr Peter Elwood, Consultant Psychiatrist

May 2010
ECT & YOU

A LPFT Guide to Electro-convulsive Therapy (ECT) & Anaesthesia for ECT

This leaflet aims to provide you with answers to questions you may have about Electro-Convulsive Therapy (ECT) and Anaesthesia. If after reading this leaflet, you are still unsure of any part of the procedure or the general anaesthetic please ask for advice from staff.

Electroconvulsive Therapy (ECT)

What is ECT?

ECT is used to help people who are suffering from a severe depressive illness. Occasionally it is used in other psychiatric conditions such as mania or rare forms of schizophrenia. ECT stimulates the brain with a safe dose of electricity under an anaesthetic. The electricity produces a controlled fit, which is thought to correct a chemical imbalance in the brain. This reduces the length and severity of the illness. The improvements produced by ECT usually need to be maintained with antidepressant medication.

Why has ECT been recommended for me?

ECT is given for a number of reasons. Your consultant psychiatrist may recommend that have ECT if:

- You have a severe depressive illness and a number of different drug treatments have been tried without success.
- You have tried several different antidepressants but have had to stop them because of their side effects.
- You are suffering the manic phase of a manic depressive psychosis.
- You are suffering one of the less common forms of schizophrenia.
- You have responded well to ECT in the past.
- Your life is in danger because your mental health problem is so severe it prevents you from eating or drinking sufficiently.
- Your mental health problems are causing you to feel suicidal.

Who gives ECT?

Your own Psychiatrist will prescribe ECT. He/ she then refers you to the ECT Department at the Peter Hodgkinson Centre, Greetwell Road, Lincoln LN2 5UA (01522 573553). The ECT Team is responsible for giving you the treatment.

The team consists of nurses and doctors trained in ECT. A Consultant Psychiatrist and a Consultant Anaesthetist have medical responsibility for the team. ECT is given by Psychiatrists on a rota basis. These Psychiatrists have had training in ECT from the Consultant for ECT. Anaesthetists attend ECT sessions on a rota basis. During a course of treatment you will therefore meet a number of doctors.

Medical and nursing students occasionally attend ECT sessions as part of their training. They are not actively involved in the treatment.

What will happen if I have ECT?

ECT is given under a general anaesthetic which means you are asleep and feel no pain during the treatment. Your psychiatrist must be sure that you are fit for an anaesthetic. He/ she will examine you. You will have a blood test
and ECG (heart tracing). You may need a Chest X-Ray. You will be assessed by the anaesthetist. This usually happens immediately before your first treatment, but may occur earlier if there are any general medical concerns.

You will be asked to have nothing to eat or drink from midnight the day before treatment.

The treatment takes place in the ECT department, in a separate room and lasts a few minutes. Other patients cannot see you having the treatment.

A nurse will accompany you to the treatment room and ask you to lie down. Your blood pressure, pulse and the amount of oxygen in your blood is monitored before and during treatment. None of the equipment used to monitor you is painful. The anaesthetist will give you an anaesthetic by an injection, usually in the back of your hand. Soon after this you will start to fall into a controlled sleep as the anaesthetic begins to work. A drug which relaxes your muscles is given at this point. Oxygen is given to you to breathe as you fall asleep.

Once you are asleep the psychiatrist gives you the treatment. This takes a few minutes. Very soon afterwards you will start to come round from the anaesthetic. When the doctor is satisfied that you have recovered sufficiently, you will be taken into the recovery room where you will fully wake up. A specially trained nurse will be with you to make sure you feel as comfortable as possible.

Following the treatment you will be given something to eat and drink.

**How should I prepare for ECT?**

- Wear comfortable, loose clothes without any tight belts.
- Remove jewellery.
- Remove nail varnish.
- Remove contact lenses.
- If you wear dentures, you will be asked to remove them just before ECT commences.
- Alert staff to any body piercings you may have.
- Mobile phones must be switched off in the department.
- Toilets are provided in the ECT department.

**Will ECT work for me?**

ECT is very successful for people with certain kinds of mental health problems. Your doctor will carefully consider all the individual aspects of your case before recommending the treatment. ECT is only recommended if you are likely to benefit from it. The majority of depressed patients who have ECT respond to it. There is however no absolute guarantee that you will respond to the treatment.

**How many treatments will I need?**

ECT is usually given twice a week. It is not possible to say exactly how many treatments you may need. Some people get better with as few as two or three treatments others may need as many as 12 or rarely more.

**Will the cure be permanent?**

ECT is good at reducing the length of your current illness, but cannot stop it coming back. You will probably be prescribed medication both during and after the course of ECT. This makes a recurrence of illness less likely.

**What is meant by a ‘controlled fit’?**

ECT stimulates the brain resulting in a fit. During the anaesthetic the doctors give you a drug that relaxes the muscles throughout your body. This means that the fit is very mild in nature resulting in slight twitching of your muscles rather than the vigorous shaking that occurs in an uncontrolled fit. Your psychiatrist monitors your brain activity via a screen on the ECT equipment.

**Will it hurt?**

ECT is carried out under general anaesthesia and is painless. Some people find the injection associated with the anaesthetic uncomfortable.

**Is ECT Safe?**
Although no medical procedure can be 100% safe, research shows ECT is one of the safest. The main risks are those of a general anaesthetic. You will be medically examined to ensure that you are well enough to have the treatment and to reduce these risks.

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

After treatment you may feel a little confused or have a mild headache. You may notice some memory problems. Usually this is confined to the time treatment. Occasionally these problems may persist. Important memories seem to be retained and new memories will not be forgotten. Your psychiatrist should discuss this with you before prescribing ECT.

**Why am I asked about crowns, bridges and loose teeth?**

During your treatment, every possible care will be taken to protect your teeth. However, crowns, bridges and loose teeth are not as strong as healthy teeth and, despite precautions, may be damaged by ECT. Please tell staff about any past dental surgery.

**Will I need to give my consent (agreement)?**

You will be asked by your psychiatrist to sign a consent form before the treatment. By signing the form you are agreeing to have a course of ECT. Before signing the form, your psychiatrist will explain what the treatment involves and why you are having it. This is an opportunity for you to raise any concerns with him/her and discuss alternative treatment approaches. Please ask a relative or friend to become involved in this discussion if you wish. The consent form is a record that the treatment has been explained to you, and that you are able to understand to your satisfaction what is going to happen to you.

Before your treatment you will be seen by the anaesthetist who will also require your consent. This usually happens immediately before your first treatment, but may occur earlier if there are any general medical concerns.

After agreeing to treatment, you still have the right to change your mind and withdraw your agreement at any time during the course of treatment.

Occasionally ECT is given without your agreement. This may be the case if your illness affects your capacity (ability) to make treatment decisions and you are generally not resistive to medical interventions. Your doctor must consider ECT to be in your best interests.

**Can I refuse to have ECT?**

You have the right to refuse ECT. Your psychiatrist may however think that you are so ill that you should be treated under the Mental Health Act. This may be the case if your illness is affecting your capacity (ability) to make decisions about your treatment.

You may have previously made an Advance Decision to refuse ECT. If so, it is important that you or a relative/friend/advocate tell your doctor about this.

**What if I have been detained under the Mental Health Act?**

If you are detained under a treatment section of the Mental Health Act you could be given ECT without your consent in certain situation. In this case, another psychiatrist from the Care Quality Commission must agree that the treatment is necessary. This psychiatrist is independent of your own psychiatrist. He/she will meet you to consider whether ECT is the right treatment for you. Occasionally the first and second treatments may be given without this second opinion, but this is only in an emergency when the delay in obtaining a second opinion would be harmful to your health.

Your doctor must be told of any Advance Decision to refuse ECT. ECT could then only be given in an emergency.

If you are in hospital under a section of the Mental Health Act and are uncertain about your rights, speak to staff and they will give you information or make an appointment for you to see someone with specialist knowledge.

**Following ECT**

After your course of treatment, you will be followed up by your own team.
A member of staff from the ECT Department will offer to visit you at a convenient location about 3 & 6 months after the treatment. This allows the department to monitor the effectiveness of its treatment. You have the opportunity to make suggestions for improving the way we offer treatment.

**Specific instructions for outpatients**

ECT is sometimes given on an outpatient basis. If you are having ECT as an outpatient, please note that your co-ordination and logical thinking may be temporarily affected due to the effects of the anaesthetic and the treatment. During the course of treatment:-

- Do not drive any motor vehicle.
- Do not make important decisions or sign legal documents.
- You must stay with a responsible adult for at least 24 hours after each treatment.
- Do not drink alcohol within 24 hours of treatment.

A friend or relative can drive you to and from the hospital. Please arrive at the time arranged with the department. You must not travel unaccompanied. Ambulance transport can be arranged, but you must have a responsible person in your home to care for you. You must not return to an empty house.

Please do not bring valuable items with you as the Trust cannot accept responsibility for their loss.

You may have a mouthwash or clean your teeth on the morning, but avoid swallowing much water.

If you develop a head cold or chest infection you not be able to have an anaesthetic safely. Please telephone the department to discuss this (01522 573553).

**ANAESTHESIA FOR ECT**

**What does an anaesthetist do?**

An anaesthetist is the doctor who is responsible for putting you to sleep before some medical procedures.

The anaesthetist will find out about your general health, past and present and, knowing what treatment is being planned, decide the best way to look after you. He/ she will see you some time before your treatment and talk to you about what will happen. Before seeing your anaesthetist you will be seen by a psychiatrist or nurse, who will ask about your general health, examine you and perform some investigations. This information will be seen by your anaesthetist, who may ask you for more details.

During the treatment the anaesthetist will stay with you all the time to make sure that you are kept comfortable and safe.

**Do I get any choices or say in what happens to me?**

Generally you do. The doctors who are looking after you will take your wishes into account. Provided that you are well enough to make decisions about your treatment, nothing will happen until you understand and agree to what has been planned for you. There may be important medical reasons why you cannot have all that you want in relation to your treatment. These will be explained to you.

If you are detained under the Mental Health Act, special circumstances apply which will be fully explained to you and, if you wish, to your relatives or advocate. You will have the opportunity to discuss any concerns with the anaesthetist, who will always try to meet any requests you may have regarding your anaesthetic.

**Why does the anaesthetist cancel some treatment?**

Sometimes the anaesthetist may find out something about your general health that has not been noted by other doctors. Using his/ her specialist knowledge, the anaesthetist may decide that it is better to delay your treatment until the problem has, if possible, been treated. Any delays will be explained to you at the time. The anaesthetist’s main concern is your physical wellbeing and to ensure that you are in the best possible state of health before you have any treatment.
When will I meet my anaesthetist?

Usually on the day of treatment, or before that if there are any medical concerns.

Why does the anaesthetist need to ask so many questions?

To make anaesthesia as safe as possible the anaesthetist needs to know a great deal about your previous health, any medicines you take, whether you smoke or drink alcohol, whether you are allergic to any medicines and whether you have had an anaesthetic before and how it affected you.

Why do I have to stop eating and drinking before an anaesthetic?

If you have food or drink in your stomach when you have an anaesthetic you may be sick while you are unconscious. The anaesthetic reduces the body's normal protection defences (like coughing) that prevent this vomit from going into your lungs. If you had been eating or drinking recently, you might choke on the food or 'drown' in the liquid. You should not eat or drink from midnight before each treatment.

Are anaesthetics safe?

Yes they are, but any treatment and anaesthetic carries a slight risk. In a recent survey of operations in the United Kingdom, death due to anaesthesia occurred in about five in every one million anaesthetics given. This is a very low risk.

In those very rare situations where resuscitation is required during ECT, this will always be performed by the ECT Team. Any Advance Decision declining Resuscitation or ‘Do Not Attempt Resuscitation’ Order is not applicable whilst under an anaesthetic.

People who are very ill or with certain medical problems have a higher risk than those who are fit and well. You should ask your anaesthetist if you, or members of your family, are concerned about this.

How do I go to sleep?

You will usually be given an injection in your hand or arm to send you off to a state of carefully controlled unconsciousness. This injection can be a little uncomfortable but any discomfort lasts for only a few seconds. Although additional drugs may be given, there is normally only one injection.

What happens once I am asleep?

You are never left alone during treatment. Your anaesthetist stays with you and keeps you safe, pain free and unaware of what is going on. ECT is a brief procedure and you are not asleep for long.

What does monitoring mean?

There are many different functions of your body that the anaesthetist needs to watch while you are anaesthetised. This process of watching is called ‘monitoring’. The extent of the monitoring depends on your general health. There are machines available that monitor your heartbeat (an ECG) and others that measure your blood pressure. Further machines can measure your pulse and the amount of oxygen in your body from a small peg placed on your finger. Devices like this will be attached to you before you are given any anaesthetic drugs. None of them are painful.

How do I wake up?

The speed at which you wake up after the treatment will depend on many things including the drugs used, the length of the treatment and your state of health. ECT is a brief procedure. Usually you will be asleep for just a few minutes.

Will the anaesthetist be there when I wake up?

You will wake up in a recovery room, where you will be watched over by a specially trained member of staff. Your anaesthetist will stay with you until he/ she is happy that you are waking up normally and will still be nearby if needed.
When can I eat and drink again?

As soon as you are fully awake you will be offered a cup of tea or coffee. You may eat food as soon as you wish.

ADDITIONAL INFORMATION

This Information leaflet was produced by the Lincolnshire Partnership Foundation NHS Trust ECT Department in 2009. Dr Peter Elwood Consultant Psychiatrist and Dr James Craggs Consultant Anaesthetist provided medical opinion regarding the content. The information is based on evidence available at the time of publication, such as that from the Royal College of Psychiatrists and the National Institute for Clinical Evidence. The leaflet will be updated in the light of future research into ECT and anaesthesia.

Further information about ECT can be obtained through the following websites:-

National Institute for Clinical Excellence
www.nice.org.uk

Royal College of Psychiatrists
www.rcpsych.ac.uk

Lincolnshire Partnership NHS Foundation Trust Website
http://www.lpt.nhs.uk/templates/Page____578.aspx
# INITIAL EQUALITY IMPACT ASSESSMENT

## STAGE 1 - Screening to establish if the proposed function has any relevance to any equality issue and/or minority group

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<th>Function to be Assessed:</th>
<th>Existing or New Function:</th>
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| 1. Briefly describe the aims, objectives and purpose of the function: | To provide the county wide treatment of ECT for all service users who have been identified as requiring this treatment |
| 2. Who is intended to benefit from this function, and in what way? | Service users who have been identified by medical staff as being suitable for this treatment, and it has been identified as potentially being a beneficial treatment option: |
| 3. What outcomes are wanted from this function? | To carry out ECT treatment for service users, identified as in need of this particular treatment |
| 4. What factors/forces could/contribute/detract from these outcomes? | None |
| 5. Who are the main stakeholders in relation to the function? | Service Users in all inpatient and community settings |
| 6. Who implements the function, and who is responsible? | ECT nursing Staff, Anaesthetist, ODA, Doctor, Consultant Psychiatrist P Elwood. |

7. Are there concerns that the function has a differential impact on the following groups and what existing evidence (either presumed or otherwise) do you have for this? No

<p>| Race | Y | N | :No |</p>
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If the answer to question 7 is ‘YES’, a partial EIA must be completed.
Should the function proceed to a partial impact assessment?  

If no, please state date of next review: 01/07/2013  
Date on which partial impact assessment to be completed by:

I understand the Impact assessment of this function is a statutory obligation and that, as owners of this function, we take responsibility for the completion and quality of this process.

Signed (Assessor)................................................................................................................. Date........................................

Print Name.................................................................................................................................

Signed (Section Head).................................................................................................................Date........................................

Print Name ....................................................................................................................................