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Swansea Bay University Health Board

MENTAL HEALTH & LEARNING DISABILITIES SERVICES

Policies & Procedures for Electro-Convulsive Therapy (ECT)

Originator:	MH& LD Policies Group
Reviewed by: Date reviewed:	MH & LD Quality & Safety Committee March 2020
Next review:	March 2023
COIN ID:	81

Background

The purpose of this policy is to ensure the safe, appropriate and effective use of electro-convulsive therapy (ECT) within Swansea Bay University Health Board. It should be read in conjunction with: -

- **The ECT Handbook 2005**
  - The third report of the Royal College of Psychiatrists Special Committee on ECT
- **NICE Guidance on the use of Electro-convulsive Therapy** April 2003
- **ECTAS Standards 5th Draft 2007**

It is also supported by the relevant clinical practice guidelines produced for the different professions involved in ECT.

The ECT Suite for Swansea Bay University Health Board is located at Cefn Coed Hospital (CCH), and is registered with the Royal College of Psychiatrists' ECT Accreditation Service (ECTAS). It was first granted accreditation in June 2004 and current accreditation is valid until March 2020. The ECTAS standards and this policy will provide the basis of a programme of audit of local ECT administration and practice. This policy will be reviewed every 2 years (or sooner in light of any new guidance issued by the Royal College of Psychiatrists or National Institute of Clinical Excellence).

Cefn Coed ECT Suite provides electro-convulsive therapy twice weekly: -

- Tuesdays at 9am
- Fridays at 9am

ECT is administered by a consultant psychiatrist, or specialty doctor or trainee doctor (following in-house induction and training).

Rarely, in emergencies, ECT can be arranged additionally on other days of the week by special arrangement with the Nursing Sister responsible for ECT and the Consultant Anaesthetist.

The **Consultant Psychiatrist** responsible for the ECT Suite is [redacted] He can be contacted at Cefn Coed Hospital on [redacted]

The **ECT lead nurse** is [redacted] who is based on Onnen ward, CCH. She can be contacted on 0[redacted]

The **Consultant Anaesthetist** responsible for ECT is [redacted]. She can be contacted in Singleton Hospital Anaesthetic Office via Switchboard Tel [redacted]

Contents

Section A

Who should receive ECT?

The National Institute of Clinical Guidance published Technology Appraisal No 59 in April 2003 entitled "Guidance on the Use of Electroconvulsive Therapy". This guidance stated that: -

- It is recommended that Electroconvulsive therapy (ECT) is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proved ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:
    - Severe depressive illness
    - Catatonia
    - A prolonged or severe manic episode
- The decision as to whether ECT is clinically indicated should be based on a documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anaesthetic; current co-morbidities; anticipated adverse events, particularly cognitive impairment; and the risks of not having treatment.
- The risks associated with ECT may be enhanced during pregnancy, in older people, and in children and younger people, and therefore clinicians should exercise particular caution when using ECT in these groups.
- Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent. Capacity to consent must be assessed and recorded. The decision to use ECT should be made jointly by the individual and the clinician(s) responsible for treatment, on the basis of an informed decision. This discussion should be enabled by the provision of full and appropriate information about the general risks associated with ECT and the risks and potential benefits specific to that individual. The consent process must take into account the Montgomery ruling.
- In all situations where informed discussion and consent is not possible, advance directives should be taken fully into account and the individual's advocate and/or carer should be consulted.
- Clinical status should be assessed following each ECT session and treatment should be stopped when a response has been achieved, or sooner if there is evidence of

adverse effects. Cognitive function should be monitored on an ongoing basis, and at a minimum at the end of each course of treatment.

- It is recommended that a repeat course of ECT should only be considered in those individuals with severe depressive illness, catatonia or mania, who have previously responded well to ECT.

- As the longer term benefits and risks of ECT have not been clearly established, it is not recommended routinely as a maintenance therapy in depressive illness.

- The current state of the evidence does not allow the general use of ECT in the management of schizophrenia to be recommended.

The Royal College of Psychiatrists (RCPsych) have emphasized to the profession that these are guidelines and that there will be a number of clinical situations where it is appropriate to deviate from them for an individual patient. The Third Report of the Royal College of Psychiatrists' Special Committee on ECT was published in 2005 and comprises the latest edition of The ECT Handbook. This provides detailed and comprehensive guidance for the recommended provision of ECT in the UK and prescribers of ECT should refer to this Handbook for advice as required. However, the key recommendations regarding patient selection for ECT are summarised below:

Revised RCPsych Guidance on ECT in the Treatment of Depressive Illness

- ECT May be the treatment of choice for severe depressive illness when the illness is associated with
  - Attempted suicide
  - Strong suicidal ideas or plans
  - Life-threatening illness because of refusal of food or fluids

- ECT may be considered for the treatment of severe depressive illness associated with
  - Stupor
  - Marked psychomotor retardation
  - Depressive delusions or hallucinations

- In the absence of the above, ECT may be considered as a second or third line treatment of depressive illness that has not been adequately treated by antidepressant drug treatment and where social recovery has not been achieved

- The selection of ECT may be affected by
  - Patient preference
  - Previous experience of ineffective and/or intolerable medical treatment
  - Previous recovery with ECT

Suggestions for accommodating prescription practices to the discrepancy between College and NICE Guidance in depressive illness

- Divergence would only occur if ECT were used:
- If the episode was not potentially life-threatening or severe
- If the episode was not demonstrably treatment resistant
- As continuation or maintenance treatment
- Health professionals should make decisions appropriate to the individual patient, in consultation with the patient and/or guardian or carer
- The NICE guidance in itself does not have legal jurisdiction over clinical practice
- Any deviation from the NICE guidelines would require a documented assessment of potential risks and benefits and the patient's true and valid informed consent
- An informal second opinion may be helpful in controversial indications
- Prescribers ought to exercise particular circumspection in depressed patients who have never before been treated with ECT (they have no personal experience to enable them to weigh the benefits and costs of ECT)
- The balance between immediate benefit and long-term risk of distressing retrograde amnesia can be moved in favour of benefit by the use of unilateral ECT
- Valid and informed patient preference may support divergence from the guidance

RCPsych Recommendations regarding the place of ECT in the treatment of mania

- The treatment of choice for mania is a mood-stabilising drug plus and anti-psychotic drug
- ECT may be considered for severe mania associated with:
  - Life-threatening physical exhaustion
  - Treatment resistance, that is, mania that has not responded to the treatment of choice
- The selection of ECT may be affected by:
  - Patient choice
  - Previous experience of ineffective and/or intolerable medical treatment
  - Previous recovery with ECT

RCPsych Recommendations regarding the place of ECT in the treatment of acute schizophrenia

- The treatment of choice for acute schizophrenia is anti-psychotic drug treatment

- ECT may be considered as a fourth-line option, that is, an option for treatment-resistant schizophrenia after treatment with two different anti-psychotic drugs and then with clozapine has already proven ineffective or intolerable

RCPsych Recommendations regarding the place of ECT in the treatment of catatonia

- The treatment of choice is a benzodiazepine drug; most experience is with lorazepam

- ECT may be indicated when treatment with Lorazepam has been ineffective

RCPsych Recommendations for the place of ECT in the treatment of neuro-psychiatric conditions

- ECT is a safe adjunctive treatment for both motor and affective symptoms in people with severe disability due to Parkinson's disease despite medical treatment
- ECT remains an experimental treatment for disorders such as neuroleptic malignant syndrome, Huntington's disease and treatment resistant epilepsy.

Cefn Coed Hospital ECT Suite
Pre-ECT Assessment

ECT is normally prescribed by a Consultant or Senior Trainee, who will explain the procedure to the patient, provide an ECT factsheet, assess capacity and obtain informed consent. The Ward Doctor is involved in the assessment of physical fitness for ECT and may also be involved in discussions with the patient regarding the nature and purpose of the treatment.

When there are major physical problems, but ECT is still considered essential, it will be desirable to discuss this with the anaesthetist ahead of the scheduled ECT session. Dr Shilpa Rawat, Consultant Anaesthetist and Dr Push Mangat, Clinical Director of Anaesthetics responsible for ECT have produced an information sheet detailing those conditions that they would wish to know about in advance. They can be contacted via the Anaesthetic Department in Singleton Hospital. In some instances they may wish to assess the patient on the ward some days prior to ECT treatment. Occasionally ECT will be carried out in Singleton Hospital if physical risk is high.

Prior to administration of ECT all patients require: -

A full physical history and systematic examination taking particular account of: -

- cardiovascular and respiratory problems
- poor dentition – risk of losing teeth
- arthritis in jaw and neck
- gross obesity or hiatus hernia – risk of aspiration
- muscular or neurological conditions
- drug or latex allergies

- previous adverse reactions to anaesthetics

Investigations required: -

- Full blood count
- Urea and electrolytes, glucose and liver function tests
- Lithium level if on lithium medication
- ECG
- Chest X-ray if elderly or any symptoms or signs of cardiac or respiratory disease.
- Dental examination – this can be done by the patient's own dentist, or via the dental service provided to the relevant inpatient unit.
- Assessment of venous thromboembolism risk.
- Pregnancy test.

NBM Procedures: -

- All patients **must** be nil by mouth from midnight of the night prior to ECT. This is to avoid the risk of aspiration whilst under anaesthesia and is of paramount importance. A small amount of clear water (20ml) is allowed until 6am to facilitate any necessary medication (e.g. caffeine).

Medication Review by Senior Psychiatrist or Consultant: -

- A number of medications can affect an individual's seizure threshold and their prescription therefore should be reviewed prior to ECT. These include: -
    - **Benzodiazepines** – are potent anti-convulsants and can adversely affect ECT. Avoid prescription or attempt to withdraw where possible. Withdrawal may result in a lower seizure threshold.
    - **Tricyclic anti-depressants and venlafaxine** – have no clear impact on ECT but be aware of cardiac effects.
    - **SSRIs** – have been associated anecdotally with prolonged seizures; formal research shows little risk except in overdose. Current advice is not to withdraw unless a full washout period is possible. Be aware of the possibility of prolonged seizures.
    - **MAOIs** – raise the seizure threshold and may be relevant if patients have short seizures; the effect of moclobemide on ECT is unknown. MAOIs should not be withdrawn for anaesthetic reasons but the anaesthetist must be informed.
    - **Lithium** – reduces seizure thresholds but its effect on ECT is unclear. There have been reports of increased cognitive side effects when ECT is given whilst patients are taking lithium. A lithium level should **always be checked**

prior to ECT and stimulus dosing should start at a low level (see protocol). Cognitive functioning should be carefully assessed during treatment.

- **Anti-psychotics** – have varying seizure threshold lowering effects but no special precautions are required.

- **Anti-convulsants** – raise seizure thresholds, shorten seizures and may require higher stimulus dosages. The higher doses of ECT that are often required may increase the risk of cognitive side effects. Therefore, cognitive functioning should carefully be assessed during treatment.

Amnesia and Cognitive Impairment Associated with ECT

- **ECT has been associated with risk of cognitive side effects** and this must be made explicit to the patient during the consent procedure

- **Patients should be told** that permanent retrograde amnesia affects at least one third of patients. The amount of life lost to amnesia cannot be predicted – it has been known to extend to 10-20 years.

- Similarly **patients should be told** that ECT may have serious and permanent effects on both memory ability and non-memory cognitive functioning, in other words, 'the ability to organise and get things done'.

- The area of cognitive testing during and after ECT is contentious in the sense that there is no consensus as to which cognitive tests are most sensitive to the sorts of cognitive deficits that result from ECT. Currently the Autobiographical Memory Test (Short Form) is being piloted in some centres in the UK. However, ECTAS is clear that every patient should have both a subjective and objective assessment of cognitive functioning prior to the commencement of ECT, repeated during the course and post ECT. In Swansea Bay University Health Board we use the MOCA test before, during and after treatment.

- **The current requirement of our clinic is that the prescribing team complete either the MOCA or AMTS prior to the start of ECT, repeated at least twice during the course and on its completion.** We would then advise that the responsible team continue to monitor this at 6 weeks then at 3, 6 and 12 months post treatment.

- If it becomes evident that a patient is developing cognitive problems during the course of ECT, then consideration should be given by the prescribing team to switching to unilateral ECT.

- We would also suggest that the prescribing team consider whether more detailed cognitive testing by a Clinical Psychologist is appropriate in individual cases. In these circumstances the current evidence suggests that the following tests may be most appropriate: -

- Benton Visual Retention Test
- Bender Gestalt
- Test of Non-Verbal Intelligence
- Digits Backwards
- Speaking Span Test
- Wisconsin Card Sort
- Halstead Category
- Booklet Category
- Sub-tests of the Wechsler such as Arithmetic and Picture arrangement

Consent Procedures
Informal Status/Mental Capacity Act 2005/Mental Health Act 2007

- **Remember a course of ECT cannot be given to a non-consenting patient whose has capacity.**

- **If the patient is informal and has capacity** then informed written consent must be obtained prior to the administration of ECT. Informed consent requires: -

  - A full explanation of the nature, purpose, likely benefits and potential risks of ECT. This should be provided verbally by the senior psychiatrist or Consultant and supplemented by the ECT Factsheet for Patients and Carers and the Anaesthetic Factsheet.

  - The capacity to understand and retain this information.

  - The ability to weigh this information in the balance to reach a rational decision

- During the discussion the following should be covered and documented: -

  - The purpose of electro-convulsive therapy (ECT)
  - The nature of ECT
  - Why ECT has been recommended
  - The benefits of ECT for that individual
  - The risks of ECT
  - Alternative treatments to ECT for that individual
  - The consequences of not having treatment with ECT

- If an individual is able to give informed consent then they should sign NHS Consent Form 1. The maximum course duration should be recorded on the consent form. The consent form should also include details of whether consent is given for bilateral or unilateral ECT.

- If a patient is informal but lacks the capacity to consent then the Best Interests Procedure of the Mental Capacity Act 2005 can be followed. Practitioners should be aware of Supreme Court ruling (Cheshire West 2014) with respect to Deprivation of Liberty Safeguards and need to consider use of MHA 1983. It will be necessary (to the best of one's abilities) to ensure that there isn't a valid and

applicable Advance Directive refusing ECT – in which case ECT can't be given. It is good practice to involve relatives or carers whenever practical, and in the patient's interest, unless the patient objects. However, a relative cannot consent to ECT on behalf of a patient. If the patient is un-befriended then an Independent Mental Capacity Advocate (IMCA) should be involved. An informal independent second opinion (e.g. from another consultant psychiatrist in the Trust) should be obtained prior to completion of NHS Consent Form 4. The clinical team should consider whether use of the treatment powers available via Section 3 of the Mental Health Act is applicable and whether the statutory criteria for detention are met. If so treatment can be given via Section 3 as described below.

- If a patient is detained under section via the Mental Health Act but has capacity to consent to ECT, the Approved/Responsible Clinician should obtain informed consent in the same manner as for informal patients, culminating in completion of NHS Consent Form 1. The Responsible Clinician should also complete the necessary paperwork under Section 58A MHA 2007.

- If a patient is detained for treatment under the MHA 1983 and lacks the capacity to consent to ECT, the Approved/Responsible Clinician must request the attendance of a Second Opinion Approved Doctor (SOAD) from the Mental Health Act Commission. Under Section 58A it is the responsibility of the SOAD to: -

    - Confirm that the patient is indeed incapable
    - Confirm that ECT is an appropriate treatment modality
    - Confirm that ECT does not conflict with a valid and applicable Advance Directive Refusing Treatment (ADRT) or refusal by a done or deputy under Lasting Power of Attorney, or indeed decision from the Court of Protection

- Provided that the SOAD has confirmed these important tenets, then they will complete the appropriate treatment under Section 68A in order for treatment to proceed.

Emergency Treatment under Section 62(1) MHA 2007 remains an option for those patients detained for treatment as follows: -

- **Can use ECT in emergency (s62 (1A))**
- s62(1)(a) [Where treatment] is immediately necessary to save the patient's life
- s62(1)(b) [Where treatment] which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition.

- **Cannot Use ECT in emergency (s62 (1A))**

- s62(1)(c) [Where treatment] which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient
- s62(1)(d) [Where treatment] which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

- It is possible to override any advance directive refusing ECT, by the use of Section 62 for a limited number of treatments, but it does not enable a course to be administered.

- **Thus a course of ECT cannot be given to a non-consenting patient whose has capacity.**

- For further clarification please see the ECT Consent Algorithm overleaf.

- **ECT and Community Treatment Orders**

  - Part 4A of the MHA 2007 sets out the circumstances in which ECT can be given to patients who are subject to Community Treatment Orders
  - In these circumstances the practical considerations for outpatient ECT need to be taken into account (see later section of Policies and Procedures)

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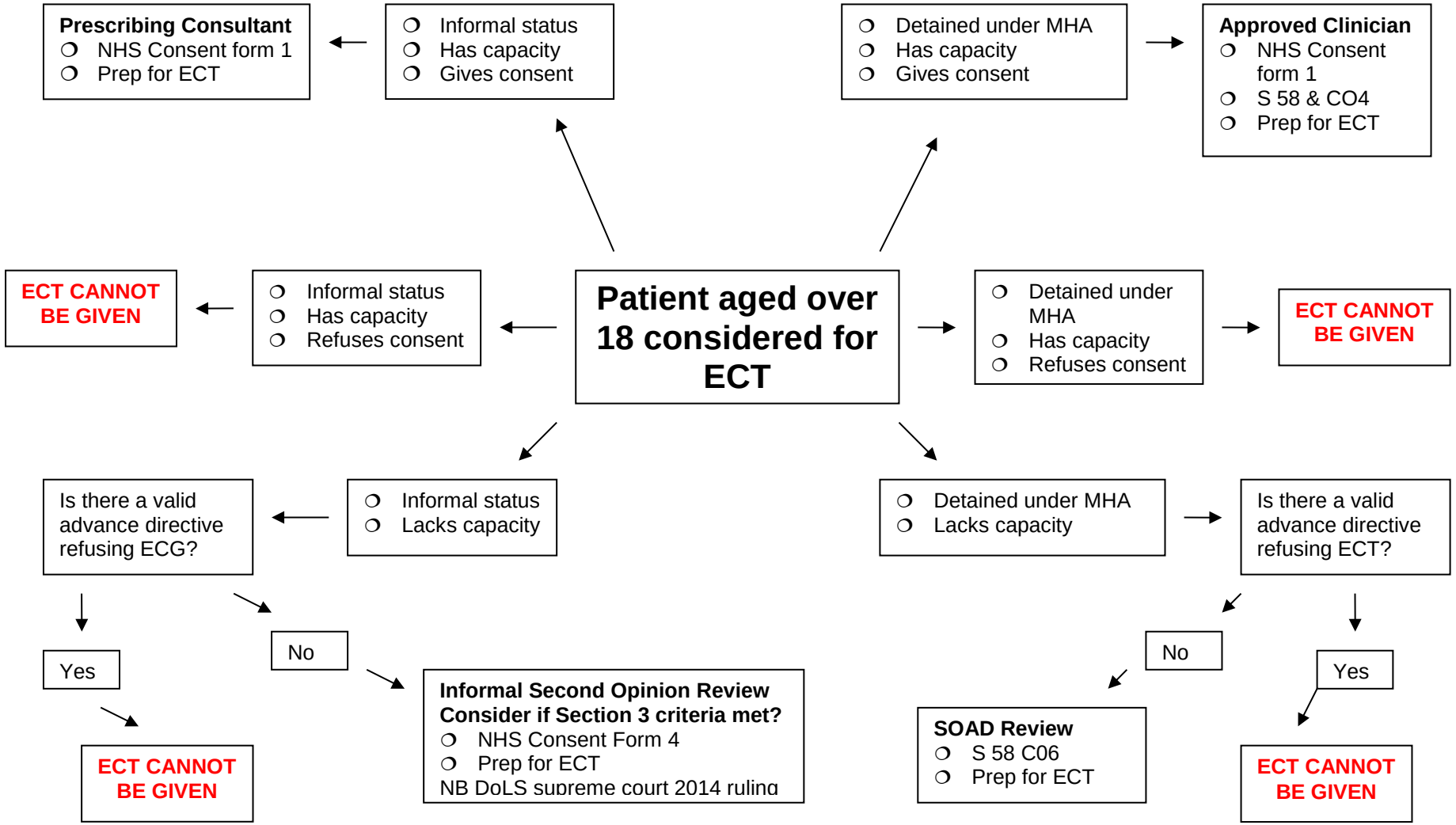
ECT Consent Algorithm for non-urgent treatment compatible with MHA 2007



Prescription of ECT

- An ECT prescription should be completed for the initial treatment and signed again by the prescribing team after each 2 treatments.
- The prescription should indicate whether this is for bilateral or unilateral ECT

Bilateral versus Unilateral

- Neither unilateral or bilateral electrode placement is the treatment of choice for all indications for ECT
- The selection of electrode placement should, where possible, be part of the process of informed consent for ECT

Bilateral placement is preferable when: -

- Rate of clinical improvement and completeness of response have priority
- The index episode of illness or an earlier episode of illness had not been treated adequately by unilateral ECT
- Determining cerebral dominance is difficult
- In the treatment of mania

Unilateral placement is preferable when: -

- Minimising cognitive adverse effects has priority
- The rate of clinical improvement is not critical
- There is a history of recovery with unilateral ECT

- The patient's condition and need for further treatment should be reviewed by the prescribing team before each treatment in the course. Progress should be recorded in the appropriate section of the main ECT Proforma.
- The prescribing team must ensure that all necessary paperwork has been completed prior to ECT being given.

Medication Immediately Prior to ECT

- **Caffeine 250mgs** should be prescribed and given orally one hour prior to each ECT. This acts as a proconvulsant and helps to counter the anti-convulsant activity of the anaesthetic agent used.

- Patients who are prescribed proton pump inhibitors (e.g. omeprazole, lansoprazole, etc) or H2 antagonists (eg ranitidine) for **gastro-oesophageal reflux, hiatus hernia** or other gastric disorder **MUST** be given this medication in the morning prior to ECT.

- Patients with **hypertension MUST** receive their prescribed medication in the morning prior to ECT. Their blood pressure must be recorded prior to leaving the ward to attend the ECT suite and should be clearly documented in the patient case notes.

- Individuals with a history of **asthma**, **chronic obstructive pulmonary disease** or **smoking related airways disease** should receive inhaled ventolin (salbutamol) immediately prior to leaving the ward to come down to ECT.

- Patients with **diabetes mellitus** should **not** receive their usual insulin prior to ECT. The ECT nursing sister should be notified of any diabetic patient due to commence ECT. They will then be placed first on the ECT list. They will be able to have their insulin with their breakfast upon their return to the ward after ECT.

Frequency of ECT

- ECT is administered in Cefn Coed Hospital twice per week – on Tuesday mornings at 9am and on Friday mornings at 9am. A Senior Anaesthetist is always in attendance to provide the anaesthetic.

- In rare circumstances, when emergency ECT is required, ECT may be given on other days of the week by special arrangement.

- Usually patients receiving ECT treatment will be in-patients in ABMU psychiatric wards. However, occasionally patients will receive ECT on an out-patient (day case) basis.

Out-Patient ECT

- Factors to consider before referring patients for outpatient ECT:

    - Suicide risk.
    - Physical fitness to undergo and recover from a general anaesthetic.
    - Ability to retain information about their treatment and fulfil the safety requirements pre- and post-treatment.

- Social support network, i.e. a responsible adult who can remain with them post-treatment, transport to and from sessions.
- Input of care professionals, i.e. CMHT.
- Compliance with the treatment plan, i.e. agreed attendance at the ECT clinic and medical reviews.

- If there are any concerns over any of the above, these should be rectified prior to ECT treatment or consideration given to admitting the patients overnight on the day of the ECT treatment or a brief admission to hospital for the duration of the ECT treatment course.

- This may be arranged at the discretion of the prescribing Consultant. If a team wishes for a particular patient to have out-patient ECT, then this should be discussed with the ECT lead nurse, ECT lead psychiatrist and with the Consultant Anaesthetist, in order to confirm the feasibility and safety of this for that patient. The patients should be prepared for ECT in exactly the same way as an inpatient. In addition to the usual Information leaflets provided, they should also receive the Out-Patient ECT Factsheet. They should also sign the supplementary Out-Patient ECT Consent from (in addition to NHS Consent Form1)

Any patient receiving out-patient ECT should attend the ECT suite at the arranged time. The pre-ECT procedures including investigations, consent, etc should have been completed well in advance of the first treatment. The patient should have remained nil by mouth from midnight. Exceptions to this include the specific medications documented earlier, which should still be given on the morning of ECT with 20mls of clear water.

- Following ECT, the patient should remain in the ECT department until reviewed by a doctor prior to going home – the doctor should confirm that they are fit enough to leave the hospital. The doctor must complete the Out-Patient Discharge Form to confirm that the individual is fit to leave the hospital.

- A patient must not return to an empty house – it must be recommended that a relative or friend remains with them overnight on their return home- this is an ECTAS Type 1 Standard. Due to anaesthetic considerations they should be advised not to drive for 48 hours after each ECT treatment.

- However, the prescribing clinician should also be mindful of the DVLA regulations which state that all patients with psychosis including psychotic depression must not drive until 3 months after recovery. They also state that patients with moderate to severe depression with memory and concentration difficulties should not drive for a suitable period after recovery. This ‘suitable’ period is currently being amended to state 3 months. Therefore most patients receiving ECT (even as an out-patient) are likely to fall into one of these categories – the prescribing clinician needs to consider this when advising on driving for patients receiving out-patient ECT.

ECT in People under 18

- The NICE Technology Appraisal 59 (April 2003) stated 'The risks associated with ECT may be enhanced in children and young people and therefore clinicians should exercise particular caution when considering ECT in this group'.

- The use of ECT in children and adolescents remains controversial and there is little evidence base for its use. Due to the possible increase of cognitive side effects in this age group careful consideration by review of the latest literature would have to be given to the dosing strategy.

- Any use of ECT in persons under 18 would need full consultation between senior ECT staff and prescribers, which would include expert opinion from specialists in adolescent psychiatry.

- A separate treatment session would be arranged for anyone under 18 receiving ECT in line with the Health Boards Safeguarding Children Policy.

- No patient under 18 can be given ECT treatment without a SOAD certificate (even if informal).

ECT in Older Adults

- Age itself does not constitute a contra-indication to ECT

- People should not be denied access to ECT solely on the grounds of age

- All coexisting medical or surgical conditions should be assessed, and where possible, stabilised or treated prior to ECT

- Close attention must be paid to monitoring possible changes in physical state and cognitive functioning during a course of treatment

- Consideration should be given to prescription of unilateral ECT to minimise adverse cognitive effects during ECT

ECT in People with Learning Disability

- There have been no randomised controlled trials specifically in people with learning disability

- It is good practice to use ECT only in carefully selected cases, usually where the psychiatric illness have proved refractory to medical treatment or where there are intolerable adverse effects of medication, or where the clinical condition of the sufferer has severely deteriorated

- There are no absolute contra-indications to the use of ECT in patients with a learning disability

Out-patients

Out-patients who do not return to a ward remain in the ECT suite until reviewed by medical staff after recovery.

They are seen by a doctor who completes the out-patient discharge form, ensuring they will be accompanied by a responsible adult for the next 24 hours.

They are escorted off the premises by the ECT nurse.

Under 50 Treatments

Treatment frequency is monitored and this is not applicable and unlikely to be so. If it becomes applicable then the protocol will be reviewed.

Cefn Coed ECT Suite – Policies and Procedures

Pre – ECT Assessment – Who should the Anaesthetic Team be informed about?

The Consultant Anaesthetists with responsibility for ECT are [redacted] They are both based in Singleton Hospital and can be contacted via the Anaesthetic Office in Singleton ([redacted]

They would like to be informed if ECT is planned for any patient who has one or more of the following conditions. This will enable them to decide if any further investigations are indicated or if certain precautions are required before having anaesthesia for ECT.

- **Any disease severe enough to limit exercise tolerance**
- **A previous history of an anaesthetic problem – e.g. difficult or failed intubation, malignant hyperpyrexia, suxamethonium apnoea**
- **A family history of malignant hyperpyrexia or suxamethonium apnoea**

Respiratory Disease:

- Any upper airway symptoms/signs – eg stridor, postural or nocturnal dyspnoea/choking sensation

- Any severe respiratory disease
- Smokers with more than a normal smoker's cough
- Recent URTI/LRTI
- Previous upper airway surgery
- Previous thoracic surgery
- Previous pneumothorax or chest drain

Cardiovascular Disease:

- Any severe cardiac disease
  - Ischaemic
  - Valvular
  - Cardiomyopathy
- Previous MI
- Pacemaker
- Abnormal ECG
- Hypertension that is difficult to control
- Previous cardiac surgery
- Undiagnosed murmurs
- Syncope
- Chest Pain

Central Nervous System:

- Any severe CNS disease
- Previous craniotomy
- Epilepsy that is difficult to control

Renal System:

- Any severe renal disease
- Any renal failure requiring dialysis

Gastro-intestinal Disease:

- Hiatus hernia
- Liver disease
- Vomiting

Haematological Disease:

- Any haemorrhagic disease

Musculoskeletal System:

- Any severe musculoskeletal disease
- Any severe connective tissue disease
- Previous cervical/thoracic/lumbar spine surgery
- Unstable cervical/thoracic/lumber spine
- Unstable fractures and dislocations

Safe ECT in People with a Physical Illness:

- The balance of risks and benefits to physical and mental health must be considered for each individual
- This will involve discussion with the patient and their families
- If ECT is being considered for patients with significant co-existing physical illness then the prescribing team should discuss this with the ECT Anaesthetic team as well as the lead Consultant for ECT
- Any co-existing medical or surgical condition, should, where possible, be treated or stabilised before ECT is administered
- When a patient is thought to be at greater risk during ECT, consideration should always be given to ways of minimising risk by modifying medical management or ECT technique (or both)
- On the occasions where ECT is prescribed to save life, there may be no absolute contra-indications to it.
- In case of significant physical risk then ECT may be administered in Singleton Hospital theatres following discussion within the ECT team

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ECT PROFORMA

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ECT INPATIENT PROFORMA

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ECT OUTPATIENT PROFORMA

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ECT MAINTENANCE TREATMENT PROFORMA

Integrated Care Pathway for ECT - Treatment

Omit hypnotics and benzodiazepines the night before treatment
Monitor blood glucose levels of closely.
Keep Lithium at lower range/stop 2 days before treatment
No solid food from midnight
Water can be given until 6am

If Patient Asthmatic
Give ventolin prior to ECT

If Patient Diabetic
Insulin/oral hypoglycaemic as per instruction by anaesthetist. Refer to adendum

If Patient Hypertensive
Give prescribed antihypertensives

If patient has GORD/ Hiatus Hernia
Give Proton pump inhibitor or H2 antagonist

Caffeine 250mgs to be given 1hour prior to ECT (unless C/I)
Baseline observations to be performed by ward staff including BP and Nursing check list part A to be completed prior to leaving ward
Patient to be accompanied from other hospitals by two nurses, one being trained.
Patient to be accompanied from ward to ECT clinic by ward nursing staff (and escort staff)
ECT clinic staff to check consent with patient and nurse to sign proforma
Nurse completes section B of Nursing Checklist
Anaesthetic and treatment to be given as per ECT guidelines using stimulus dosing protocol
ECT staff to monitor vital signs during treatment and record on appropriate forms
Anaesthetist and SHO to complete and sign ECT treatment record in proforma
Patient to be transferred to recovery once stabilised

Recovery staff to complete post ECT checklist
If complications ECT clinic staff to discuss with ward team

Out Patient
Nursing staff to complete first part of out-patients ECT discharge form
Nursing staff to accompany patient back to ward
ECT Nurse reviews on ward and entry in notes
Patient reviewed on ward by SHO after 2pm

In Patient
Ward and ECT staff to accompany patient to ward
ECT nurse reviews on ward and entry in notes

In Patient from another hospital
Escort Nurses and ECT staff accompany patient back to designated ward
ECT nurse reviews on ward and entry in notes
Patient reviewed on ward by SHO after 2pm

Is Patient fit to go home

No
SHO to discuss with ward Consultant

Yes
SHO completes final part of outpatient ECT discharge form.Patient and carer to sign form

Responsible medical team to review patient after each treatment
Clinical progress to be noted in case notes and proforma
ECT proforma to be completed by prescribing medical team after every treatment
Congnitive functioning to be monitored (AMTS) after every treatment
ECT to be re-prescribed on ECT proforma after 2 treatments
Decision to stop course of ECT to be taken by prescribing team

Is Patient fit to go back to Hospital

Yes
Transport arranged,patient and escort nurses return to hopital

No
SHO to discuss with ward Consultant

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Integrated Care Pathway
Medication Considerations Prior to ECT

Clozapine
Withhold 12 hours before ECTIf no benefit stop before ECT
During ECT monitor closely, levels and side effects

Moclobemide
Stop at least 2 days before ECT

MAOI
Monitor blood pressure closely and be aware of interactions

Venlafaxine and Tricyclic Antidepressants
Monitor blood pressure, ECG and cerdiac adverse effects

Benzodiazepine
Discontinue before ECT if possible or reduce if possible

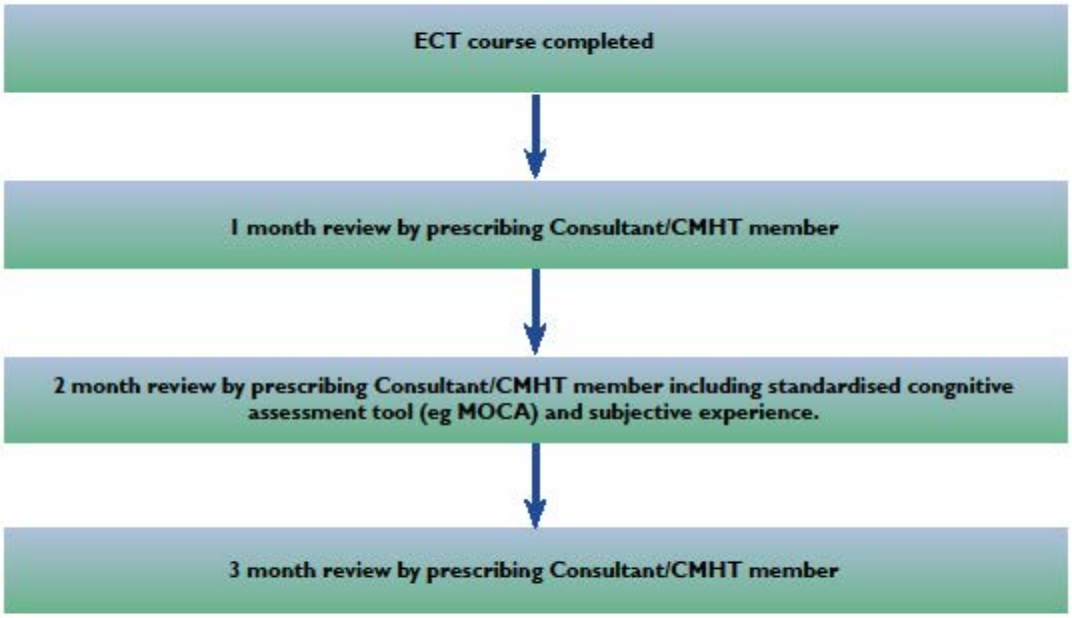
Hypnotic
Avoid if possible, omit night before

Management of Diabetic patient
As per ASGBI guidlines

Lithium
Review effectivenes of Lithium treatment. If not effective stop before ECT.
If effective continue but monitor for adverse effects especialy confusion delirium

Anti Convulsants
If seizure activity poor during ECT then with hold the morning dose
of anticonvulsant before ECT

Integrated Care Pathway
Post ECT Course



ECT Documentation Checklist

The following documentation **must** be completed and readily available in the patient's notes **before** ECT will be given: -

A. For Informal Consenting Patients

- NHS Consent Form 1
- ECT Proforma

B. For Informal Patients who Lack Capacity to Consent

- NHS Consent Form 4 – which must be signed both by the prescribing Consultant and another Consultant acting as an informal second opinion
- ECT Proforma

C. For Detained Consenting Patients

- NHS Consent Form 1
- MHA Section 58A Forms
- ECT Proforma

D. For Detained Non-Consenting Patients

- MHA Section 58A Forms
- ECT Proforma

E. For Out-patient ECT

- NHS Consent Form 1 or appropriate MHA Paperwork e.g. Community Treatment Order
- Supplementary Out-Patient ECT Consent Form
- ECT Proforma

It is the responsibility of the **prescribing Consultant Psychiatrist** and the **Nursing Ward Manager** (or deputy) to ensure that all appropriate documentation has been completed prior to ECT. If this is not available when the patient attends the ECT suite, then ECT **will not** be given on that day.

F. For, informal patients under the age of 18 years old.

- NHS consent form
- SOAD form CO5
- ECT Proforma

G. For detained patients under the age of 18 years old.

- MHS Section S8A Forms
- SOAD Form CO5

- ECT Proforma

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Patient Agreement to Electroconvulsive Therapy

Consent Form 1:
This form is to be used for people aged 16 years and over with mental capacity and people under 16 years of age who are Gillick competent

Patient details (or pre-printed label)

Patient's surname/family name:

Patient's first name……

Date of birth: ……..

☐ Male ☐ Female

NHS Number (or other identifier)……..

Special requirements (eg other language/other communication requirements)

Name of proposed procedure of course of treatment (include brief explanation if medical terms not clear and including laterality and maximum number of treatments)

……
……

Anaesthetic This procedure will involve: ☐general anaesthesia

Any extra procedures which may become necessary during the procedure

☐None expected ☐Blood transfusion……..

☐Other……..

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

People aged 16 years and over (are presumed to have capacity to consent to treatment unless it is established that they lack capacity).

☐An assessment of that patient's mental capacity to consent to treatment has been performed and it has been determined that he/she has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

☐After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient is ***Gillick competent*** to make this decision.

Advance Decisions (for patients aged 18 years and over only)

I am aware of a valid and applicable **advance decision** refusing:

☐ this treatment or procedure (if yes, has the patient now decided to opt for the treatment that is the subject of this advance decision? **Yes/No**)

☐ **A treatment/procedure which may become necessary during the treatment/procedure in question. If there is a valid and applicable advance directive state:**.....
.....
.....
.....

Information about the procedure/treatment;
I have explained the procedure to the patient. In particular, I have explained:
Intended benefits:
.....
.....
.....
.....
.....

Significant, unavoidable or frequently occurring risks including dental risks, memory impairment (short term and retrograde amnesia):
.....
.....
.....
.....
.....

I have also discussed:

☐ **What the procedure is likely to involve** ☐ **Any particular concerns of this patient**

☐ **The benefits and risks of any available alternative treatments (including no treatment)**

Please include details: .....
.....
.....
.....
.....

☐ **I have provided the following leaflet/cd/dvd/web-link (please specify title of the leaflets and date of issue: title of the cd/dvd/and "version" if it has been amended:**
.....
.....
.....
.....
.....

Signed: .....

Date:.....

Name (Print):..... Job Title:.....

GMC no: / NMC pin no: / HPC no: / HPC Pre-registered Group no:
.....

Contact Details (if patient wishes to discuss options later). .....
.....

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

Name (Print)…….....Contact Details:.....

Statement of Signature of patient
You will be offered a copy of this form. If you have any further questions, do ask – we are here to help you. **You have the right to change your mind at any time,** including after you have signed the form.

I understand the information that I have been given about the examination or treatment described on this form.

I agree to the procedure of course of treatment described on this form.

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

I understand That I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedures in addition to those described on this form and which are not the subject of an advance decision 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 which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion, even if not performing such procedures immediately could or would lead to serious permanent injury or death.
……
……
……
……

DECISIONS (*Please delete as appropriate)
I do / do not agree* that students may be present during the procedure
I have / have not* made an advance decision refusing a treatment or procedure which may become necessary in the course of carrying out the treatment or procedure in question (For patients aged 18 years and over).

Patient signature:..... Date…….....

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people / children may also like a parent to sign here (see notes).

Signature ……..... Date…….....

Name (PRINT) ……..... Relationship to patient:.....

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

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

Signed ……..... Date…….

Name (PRINT) ……. Job Title …….....

GMC No: / NMC Pin No: / HPC No: / HPC Pre-Registered Group No: …….

I confirm that I still want the procedure / treatment to go ahead.

Patients signature:……..... Date…….....

Name (PRINT):…….....

Patient has withdrawn consent

Ask patient to sign/date here and write "VOID" across all pages of the form.

Patient's signature:……. Date…….

Name (PRINT):…….....

Top copy of form must be retained in the patient's notes
Copy offered to patient: Welsh copy/ English copy / Declined by patient (please circle)

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Patient Agreement to Electroconvulsive Therapy

Consent form 2: Agreement of person with parental responsibility to examination or treatment for a child under 16 years of age who is not Gillick competent .i.e. does not have sufficient maturity or intelligence to consent for themselves.

Patient details (or pre-printed labels)
Patients surname /family name:.....

Patients first name:.....

Date of birth:.....

☐ **Male** ☐ **Female**

NHS Number (or other identifier).....(please press hard to ensure all 3 copies are legible)

Special Requirements (e.g. other language/other communication method_____
_____
_____

Name of proposed procedure of course of treatment (include brief explanation if medical term(s) not clear and including laterality and maximum number of treatments-
_____
_____

Anaesthetic. This procedure will involve:

☐ **General anaesthesia**

Any extra procedures which may become necessary during the procedure.

☐ **None expected** ☐ **Blood transfusion**

☐ **Other procedure (please specify**_____
_____
_____

Statements of health profession (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy).

People under 16 years of age

☐ **After a full explanation of the procedure and its risks and benefits, i believe that the child does not have sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient is not Gillick competent to make this decision.**

Advance decisions (for patients aged 18 years and over only)
I am aware of a valid and applicable advance decision refusing:

☐ **This treatment or procedure (if yes, has the patient now decided to opt for the treatment that is the subject of this advance decision? YES / NO**

☐ **A treatment / procedure which may become necessary during the treatment / procedure in question.**

If there is a valid and applicable advance decision, state details:_____

_____

_____

Information about the procedure / treatment
I have explained the procedure to the patient. In particular, i have explained:
Intended benefits:_____

Significant, unavoidable or frequently occurring risks including dental risks, memory impairment (short term and retrograde amnesia):_____

I have also discussed:

☐ **What procedure is likely to involve** ☐ **any particular concerns of the patient**

☐ **The benefits and risks of any available alternative treatments (including no treatment). Please include details:**_____

☐ **I have provided the following leaflet/cd/dvd/web-link (please specify title of the leaflet and date of issue, title of the cd/dvd and "version" if it has been amended:**_____

_____

Signed:_____ **Date:**_____

Name (print) :_____ **Job Title:**_____

GMC no. / NMC pin no. / HPC no. / HPC pre-registered group no:_____

Contact details (If patient wishes to discuss options later:_____

_____

Statement of interpreter (where appropriate). I have interpreted the above information to the patient to the best of my ability and in a way in which i believe he/she can understand.

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Signed:_____ **Date:**_____

Name (Print):_____ **Contact Details**_____

Statement and signature of person with parental responsibility.
You will be offered a copy of this form. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed the form. The guidance notes in the inside front cover of the Consent Form Book set out the circumstances in which a person may have parental responsibility for a child.

I confirm that:

I have parental responsibility for this child.

I understand the information that I have been given about the examination or treatment described on this form.

I agree to the procedure of course of treatment described on this form.

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

I understand that the child will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless t he urgency of the situation prevents this. (this only applies to children having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if necessary to save the life of the child or to prevent serious harm to his or her health.

I have been told about the additional procedures which may become necessary during the child's treatment. I have listed below any procedures which I do not wish to be carried out without further discussion:_____

_____

_____

_____

Decision (*please delete as appropriate)

I do / do not agree * that students may be present during the procedure.

Signature:_____ **Date:**_____

Name (print:_____ **Relationship to child:**_____

Child agreement to treatment (if child wishes to sign)
I agree to have the treatment I have been told about:

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Name:_____ **Signature:**_____

Date:_____

Confirmation of consent (to be completed by health professional when the child is admitted for the procedure, if the parent/child has signed the form in advance.
On behalf of the team treating the patient, I have confirmed with the child and those with parental responsibility for him / her that they have no further questions and wish the procedure to go ahead.

Signed:_____ **Date:**_____

Name_____ **Job title:**_____

GMC no. / NMC pin no. / HPC no. / HPC Pre-Registered Group no:_____

I confirm that I still want the procedure / treatment to go ahead.

Parent Signature:_____ **Date:**_____

Name (print):_____ **Signature:**_____

Person with parental responsibility has withdrawn consent
Ask person with parental responsibility to sign/date and write “VOID” across all the pages of the form.

Parents signature:_____ **Date:**_____

Name (print):_____

Top copy of form must be retained in the patients notes.
Copy offered to the patient: Welsh copy / English copy / Declined by patient. (please circle)

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Treatment in best interests (Form 4)
Form for patients aged 16 years and over who lack the capacity to consent to examination or treatment

This form should be completed by the health professional responsible for the proposed procedure or course of treatment. To be retained in patients notes.

This form should be completed by the health professional responsible for the proposed procedure or course of treatment. To be retained in patients notes.

Patient details (or pre-printed label)

Patients surname/family name
_____

Patient's first names:_____

Date of birth:_____ ☐ Male ☐ Female

NHS number (or other identifier:_____

Special requirements (e.g other language/communication method)_____

_____

Decision maker's name.....

GMC no. / NMc Pin No. / HPC No. / HPC Pre-Registered Group No:_____

Details of decision that needs to be made (i.e. Procedure of course of treatment proposed)
(NB: See Section 7 of attached Guidance Notes for details of situations where court approval must first be sought)

Assessment of patient's capacity (in accordance with the Mental Capacity Act 2005) (see Section 1 of the Guidance Notes)

Tick YES or NO as applicable and enter relevant information into each box.

B1. Is there reason to doubt that the person has capacity to make the above decision?

☐ YES – record doubts and go to box B2

☐ NO – presume capacity and end assessment (go to box B9)

B2. Is there an impairment of, or disturbance in, the functioning of the persons mind or brain?

☐ YES – record the nature of the impairment or disturbance and go to box B3

☐ NO – presume capacity and end assessment (go to box B9)

B3. Would the person be able to make the decision at a different time, place or under different circumstances**?**

☐ **YES-** record what would help the patient and reassess capacity at appropriate time and sign Section F:

☐ **NO –** go to box B5

B4. Would the person be able to make the decision with practical help and support ?

☐ **YES –** record support given and presume capacity (go to box B9)

☐ **NO –** go to box B5

If the answer in 'No' to ANY of questions B5-B8, then this person lacks capacity to make this decision.

B5. Does the person understand the nature and consequence of accepting or refusing the proposed treatment, or if not making the decision?

☐ **YES –** go to box B6

☐ **NO –** explain and go to box B9

B.6 Is the person able to retain the information long enough to make the decision?

☐ **YES –** go to box B7

☐ **NO –** explain and go to box B9

B7. Is the person able to use or weigh the information as part of making the decision?

☐ **YES –** go to box B8.

☐ **NO –** explain and go to box B9

B8. Is the person able to communicate their decision in some way?

☐ **YES –** If you have answered 'YES' to questions B5-B8 then this person has capacity to make this decision – go to box B9. Please obtain the patient's consent using the appropriate consent form.

☐ **NO –** explain and go to box B9

B9. Outcome assessment

I have assessed this patient's capacity to make the decision in question and it is my belief, on the balance of probabilities and given the evidence above, that this patient:

☐ has the mental capacity to make the decision about the proposed procedure or course of treatment
(sign Section F0 (obtain the patients consent using the appropriate consent form)

☐ lacks the mental capacity to make the decision about the proposed procedure or course of treatment
(move on to Section C)

Advance Decision, Personnel Welfare Lasting Power of Attorney, Court Appointed Deputy – Complete BOTH sections (C1-C2)

C1. Advance Decision to refuse treatment (see Section 2 of the Guidance Notes)

☐ There is a valid and applicable advance decision which refuses the procedure or course of treatment identified in section A and/or which refuses a procedure which could arise in the course of the respected*) file a copy of the advance decision in the medical record, if it is in writing, or make detailed notes if it was a verbal advance decision).*

☐ I am not aware of a valid and applicable advance decision which refuses the procedure or course of treatment identified in Section A, and or which refuses a procedure which could arise in the course of the proposed procedure or course of treatment.

C2. Personal Welfare Lasting Power of Attorney/Court Appointed Deputy (see Sections 3 & 4 of the Guidance Notes)

Where the patient has authorised an Attorney to make decisions about the procedure in question under a Personal Welfare Lasting Power or Attorney (LPA) or a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the Attorney or Deputy will have the final responsibility for determining whether a procedure is in the patient's bed interests.

Tick one box

☐ I have not been made aware of the existence of a Personal Welfare LPA/Court Appointed Deputy with the necessary authority to me this decision.

☐ I have seen and read the Registered Personal Welfare LPA document and I am satisfied that the Attorney has the authority to take this decision about the proposed treatment (file a copy in the notes).

☐ I have seen and read the Court order appointing the Deputy and I am satisfied that the Deputy has the authority to take this decision about the proposed treatment (file a copy in the notes)

Signature of Attorney / Deputy

I have been authorised to make decisions about the procedure in question under a Personal Welfare Lasting Power of Attorney* / as a Court Appointed Deputy* (*delete as appropriate). I have considered the relevant circumstances relating to the decision in question and believe the procedure described in Section A (tick one box)

☐ is in the patient's best interests and I consent to it being undertaken.

☐ is **not** in the patient's best interests and I do not consent to it.

Any other comments
(including the circumstances considered in working out what is in the patients best interest)

_____
_____
_____
_____

_____
_____
_____
_____

If there is a valid and applicable advance decision refusing the procedure or course of treatment OR a decision of an attorney or deputy you do not need to complete the rest of this form.

Please sign:_____

D. Independent Mental Capacity Advocate (IMCA) (see Section 5 of the Guidance Notes)
For decisions about serious medical treatment, where there is no one appropriate to consult other than paid staff, an independent Mental Capacity Advocate (IMCA) **MUST** be instructed.

Has an IMCA been instructed?
□ **Yes** □ **Not applicable (go to Section E below)**

If yes, the report of the IMCA must be considered in coming to a decision about what is in the patient's best interests (see
Section E). A copy of the report should be filed in the medical record.

If you disagree with the IMCA's recommendations, please state the reasons why:
_____
_____
_____
_____

E. Working out what is in the patient's best interests
(see Section 6 of the Guidance Notes)

The law requires you to do everything you reasonably can to work out what the patient's best interests are **All the boxes below must be completed.**

E1. I s the person likely to have capacity for this decision at some time in the future?

☐ **YES** – record this consideration

☐ **NO**

If 'YES' is it possible to delay the decision?

☐ **YES – do not proceed. Wait until the person regains capacity to consent or refuse.**

☐ **NO** - Capacity unlikely to change or decision cannot be delayed. Record your reasons.

E2. Are there any alternative to this decision that are less restrictive?

☐ **YES –** record considered alternatives and why they are not the best option:

☐ **NO –** There is no satisfactory less restrictive alternatives.

E3. Have you supported the person as much as possible to be involved with this decision (although they don't have the capacity to make the decision)?

☐ **YES –** record support given

☐ **NOT POSSIBLE –** explain reasons:

E4. Have you considered:

(a) any verbal or written wishes and feelings that the person has previously expressed or is currently expressing.
(b) the beliefs and values that would be likely to influence the person's decision if he had capacity, and
(c) Any other factors that the person would have considered if they were able to do so?

☐ **YES** – record considerations

☐ **NO –** There are none available

E5. The following people, if appropriate should be consulted about what they believe are in the patient's best interests, although they do not have the authority to make the decision on behalf of the patient.

Please tick relevant box to identify who of the following has been consulted :

☐ Anyone named in advance by the person as someone to be consulted.

☐ Carers, spouse, partner, civil partner, parents, other family members.

☐ Anyone else interested in the person's welfare e.g. carer/advocate/friend.

☐ An attorney appointed through an LPA or EPA but without authority to make the decision.

☐ A deputy appointed by the Court of Protection but who does not have authority to make this decision.

Give names and relationship of people consulted and details of discussions held: If no-one has been consulted, explain why not *(if the decision is about serious medical treatment, you must instruct an IMCA if there is no-one else available to consult – go back to Section D):*

E6. Were there any disagreements encountered during the assessment of best interests?

☐ **YES –** record what these are, how they are being taken into account and what steps you are taking to resolve them (NB: If the decision is disputed you must seek legal advice) Go to box E7

☐ **No** – go to box E7

E7. Was it necessary to involve the Court of Protection?

☐ **YES** – record decision made by the Court (sign Section F)

☐ **NO** – go to box E8

E8. Best interests decision

You, as the decision-maker, are responsible for the final decision. Record the decision that has been made in the person's best interests in the space below.

☐ I confirm that, in my judgement as the decision maker (insert procedure/course of treatment)

_____
_____
_____
_____
_____

Is in the best interests of this patient because:

_____
_____
_____
_____
_____

(insert summary of reasons for coming to this decision) Sign Section F

_____
_____
_____
_____
_____

F. Signature of health profession completing this form

I confirm that I have (tick all relevant boxes)

☐ Undertaken an assessment of capacity

☐ considered whether or not there is an advance decision/someone with legal authority to make this decision.

☐ consulted with relevant people regarding what is in the patient's best interests

☐ worked out what course of action is in the patient's best interests and made a decision

Signed:_____ Date:_____

Name (PRINT):_____ Job Title:_____

GMC no. / NMC Pin No. / HPC No. / HPC Pre-Registered Group No:_____

G. Related documents copied and filed in medical record

Where applicable, the following documents have been copied and filed in the patient's medical record**:**

☐ Valid and applicable advance decision

☐ Personal Welfare Lasting Power of Attorney documentation

☐ Court order appointing the Deputy

☐ IMCA report

☐ Court order/decision

Guidance Notes for health professionals (to be read in conjunction with Consent Policy)

This form should only be used where it would be usual to seek written consent, but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If a patient of 16 years and over **has** capacity to accept or refuse treatment, you should use Consent Form1 and respect any refusal. In respect of young persons aged 16 or 17 who have capacity but are refusing treatment see the Welsh Government's Reference Guide for Consent to examination or treatment for further guidance. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment, then you must abide by the refusal. For further information on the law on consent, see the Welsh Government's *Reference guide to consent for examination or treatment*
(www.wales.nhs.uk/consent)

Health professionals should only take consent in specific clinical situations where they have undertaken formal training including on consent and mental capacity and have been competency assessed. They should familiarise themselves with any appropriate professional guidance, their organisation's consent policy and Welsh Government's guidance on consent.

1) MENTAL CAPACITY

When treatment can be given to a patient who lacks the capacity to consent
All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005 and its accompanying Code of Practice. Treatment can be given to a patient who is unable to consent, only if:

- The patient lacks the capacity to give or withhold consent to this procedure AND
- The procedure is in the patient's best interests.

Mental Capacity Act 2005 Code of Practice – www.publicguardian.gov.uk/mca/code of practice.htm

Capacity *(MCA Code of Practice, Chapter 4)*

A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

* Understand the information given to them that is relevant to the decision.
* Retain that information long enough to be able to make the decision.
* Use or weigh up the information as part of the decision-making process.

* Communicate their decision – this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be useful to seek advice from a colleague: however, it is the responsibility, as the decision maker, to reach a final decision about the patient's mental capacity.

Capacity is 'decision-specific: a patient may lack capacity to take a particular complex decision, but be able to take other more straight forward decisions or parts of decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity.

2) ADVANCE DECISIONS (*MCA Code of Practice, Chapter 9)*

An advance decision enables a person aged 18 years and over, while still capable, to refuse specified medical treatment at a time in the future when they lack the capacity to consent to or to refuse that treatment. The advance decision must be valid and applicable – if it is, it has the same effect as a decision that is made by a person with a capacity. If the advance decision concerns the refusal of life sustaining treatment, it must be in writing, signed and witnessed and state clearly that the decision applies even if the partner's life is at risk.

3) PERSONAL WELFARE LASTING POWER OF ATTORNEY

(sometimes called a 'Health and Welfare' LPA) (MCA Code of Practice, Chapter 7)
A person of 18 years and over who has capacity, can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Personal Welfare Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the person themselves. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests. An attorney cannot consent to treatment if the patient has made a valid and applicable advance decision to refuse a specific treatment (see chapter 9 of the MCA Code of Practice). But if the patient made a Lasting Power of Attorney after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision. An attorney cannot consent to or refuse most treatment for a mental disorder for a patient detained under the Mental Health Act 1983. An attorney cannot authorise the giving or refusing of consent to the carrying out or continuation of life sustaining treatment, unless the LPA document contains express provision to that effect.

4) COURT APPOINTED DEPUTY (*MCA Code of Practice, Chapter 8)*

The Court of Protection may appoint a person (known as Deputy) to make decisions for people who lack capacity to take particular decisions for themselves, including healthcare. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no other way of settling the matter in the best interests of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity, then it is the deputy rather than the health professional who makes the treatment decision and the deputy must make decisions in the patients best interests. Deputies cannot

make decisions to refuse the provision or continuation of life sustaining treatment. These must be referred to the Court of Protection.

5)INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA*) (MCA Code of Practice, Chapter 10)*

The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are **NOT** decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the *Act*. Paragraph 4.17 of the Welsh Government's Reference Guide for Consent to Examination or Treatment provides guidance on the meaning of "serious medical treatment".

6) BEST INTERESTS (MCA *Code of Practice, Chapter 5)*

The Mental Capacity Act required that a health professional **must** consider all the relevant circumstances relating to the decision in question, including, as far as possible:

- the person's past and present wishes and feelings (in particular if they have been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and
- any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

When determining what is in a person's best interests a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.

If it is practical and appropriate to do so, the Mental Capacity Act requires a health professional to consult other people for their views about the person's best interests and to see if they have information about the person's wishes and feelings, beliefs and values. In particular, a health professional should try and consult: anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues; anyone engaged in caring for the person; close relatives, friends or others who take an interest in the person's welfare; any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person or any deputy appointed by the Court of Protection to make decisions for the person.

7) THE COURT OF PROTECTION *(MCA Code of Practice, Chapter 8)*
Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affection personal welfare matters, including addressing disagreements about healthcare.

Cases involving:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS) or minimally conscious state:
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent;
- cases involving the proposed non therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes); and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests (including cases involving ethical dilemmas in untested areas, where the medical treatment has a fine balance of benefits and risks, where the choice between treatments is finely balanced or there is likely to be a serious consequences to the patient) should be referred to the Court for approval.

The Court can also be asked to make a decision in cases where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

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ECT PROFORMA

Date:

Name: _____ Consultant: _____

Address: _____ Consultant Contact Tel: _____

_____ Inpatient / Outpatient (please circle)

Date of Birth: _____ Ward: _____

Case Record Number: _____ Ethnicity: _____

Right handed / Left handed (please circle) Status: Informal / MHA (please circle)

Indication for ECT (please tick)	**Nature of Indication**
❒ Unipolar depression ❒ Bipolar depression ❒ Mania ❒ Postnatal psychosis ❒ Other, please specify _____ Preferred type of ECT: Bilateral/unilateral (please circle)	❒ Life threatening state (please specify) _____ ❒ Failed adequate trial of pharmacotherapy (give details) _____ _____ ❒ Other (please specify) _____

Please confirm Information Leaflets provided to patient / family

❒ Electro-convulsive Therapy (ECT) – A factsheet for you and your family

❒ About your Anaesthetic for ECT

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PRE-TREATMENT PREPARATION

MEDICAL HISTORY	MEDICATION
	VTE Assessment YES/NO (please circle) **Allergies** Yes / No (please circle) Specify: _____ _____ _____ _____

PREVIOUS ECT?	PREVIOUS ANAESTHETIC PROBLEMS?
Yes / No (please circle) Details:- (e.g. when? response)	Yes / No (please circle) Details:-

CURRENT MENTAL STATE	PRE-TREATMENT COGNITION
Depression Rating Score	Subjective complaints _____ _____ MOCA Score: _____

(Please state scale used) _____	Areas of deficit: _____ _____

PRE TREATMENT EXAMINATION AND INVESTIGATION

Weight (in kg)	<u>Dental</u>
Radial pulse	Dentures
BP	Crowns
Heart sounds	Loose teeth
Chest	Satisfactory?
Abdo	
CNS	
Signed: _____	Signed: _____
Print: _____	Print: _____

INVESTIGATIONS

Please tick if applicable

- **<u>All</u>** Patients — UE, FBC ❒; ECG ❒
- Cardiorespiratory disease — CXR ❒
- Diabetes Glucose
- Thyroid disease — TFTs ❒
- Anticoagulants — INR ❒
- Lithium — Pregnancy Test ❒
- Sickle Test — VTE risk
- Other

RESULTS		
Na	Hb	ECG
K	Wbc	

U	Plts	
CR	Sickle	
Gluc	Li	CXR
TFT		
INR	Other	

Anaesthetic Assessments
(to be completed prior to first treatment by Consultant Anaesthetist)

Previous Anaesthetic Problems	**Past Medical History**
Physical Examination General CVS Resp Abdo CNS	Smoking Y / N No _____ Alcohol Y /N Units/wk _____ Reflux Y / N Allergies? _____ **ASA Grade**

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Airway Assessment	**Pre-ECT Optimisation**
Dental State A/O Extension _____ Mallampati _____ Thyromental distance _____ Jaw thrust _____ Interdental distance _____	• Salbutamol 2.5 mgs Neb Y / N • Omeprazole 20 mgs po Y / N **Hazard Flag**

Completed by:-

Sign: _____

Print: _____

Designation: _____

Date: _____

ECT Documentation

Please tick appropriate box

CONSENTING PATIENTS (INFORMAL OR DETAINED)

NHS Consent Form 1 signed ❒

ECT Prescribed ❒

Consenting patients detained under MHA – Section 58A Form attached ❒

INFORMAL PATIENTS WHO LACK CAPACITY TO CONSENT

NHS Consent Form 4 signed
(by both prescribing Consultant and informal second opinion) ❒

ECT Prescribed ❒

Confirm involvement of family or advocate ❒

NON-CONSENTING PATIENTS DETAILED UNDER MHA

MHA Form via Section S58A completed by SOAD and attached ❒

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ECT Prescribed	❒
If emergency ECT to be given prior to completion of Section 58A, then form 62 to be completed by RMO and attached	❒
Confirm involvement of family or advocate	❒

STATEMENT OF PRESCRIBING CONSULTANT/SPR/SAS doctor

I, Dr _____ of _____
confirm that:-

(1) this ECT Proforma has been appropriately completed

(2) the ECT Documentation is complete and attached

(3) I have fully explained the proposed treatment of ECT

Signed: _____ Position: _____

Print: _____ Date: _____

PATIENTS WITH CAPACITY/COMPETENCE WHO ARE UNDER 18 YEARS OLD

NHS CONSENT FORM ECT PRESCRIBED	☐
CONSENTING OBTAINED PATIENTS SOAD COMPLETED FORM CO5	☐

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Patient Name:_____ Date:_____

Hamilton Rating Scale for Depression (17-items)

Instructions: For each item select the "cue" which best characterizes the patient during the past week.

1. **Depressed Mood**
(sadness, hopeless, helpless, worthless)
0 Absent
1 These feeling states indicated only on questioning
2 These feeling states spontaneously reported verbally
3 Communicates feeling states nonverbally, i.e., through facial expression, posture, voice and tendency to weep
4 Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication

2. **Feelings of Guilt**
0 Absent
1 Self-reproach, feels he has let people down
2 Ideas of guilt or rumination over past errors or sinful deeds
3 Present illness is a punishment. Delusions of guilt
4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. **Suicide**
0 Absent
1 Feels life is not worth living
2 Wishes he were dead or any thoughts of possible death to self
3 Suicide ideas or gesture
4 Attempts at suicide (any serious attempt rates 4)

4. **Insomnia - Early**
0 No difficulty falling asleep
1 Complains of occasional difficulty falling asleep i.e., more than ½ hour
2 Complains of nightly difficulty falling asleep

5. **Insomnia - Middle**
0 No difficulty
1 Patient complains of being restless and disturbed during the night
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

6. **Insomnia - Late**
0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if gets out of bed

7. **Work and Activities**
0 No difficulty
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2 Loss of interest in activity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3 Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities (hospital job or hobbies) exclusive of ward chores.
4 Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted.

8. **Retardation**
(slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 Normal speech and thought
1 Slight retardation at interview
2 Obvious retardation at interview
3 Interview difficult
4 Complete stupor

9. **Agitation**
0 None
1 "Playing with" hand, hair, etc.
2 Hand-wringing, nail-biting, biting of lips

10. **Anxiety - Psychic**
0 No difficulty
1 Subjective tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude apparent in face or speech
4 Fears expressed without questioning

11. **Anxiety - Somatic**
0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating
Physiological concomitants of anxiety such as:
Gastrointestinal - dry mouth, wind, indigestion, diarrhea, cramps, belching
Cardiovascular – palpitations, headaches
Respiratory - hyperventilation, sighing
Urinary frequency
Sweating

12. **Somatic Symptoms - Gastrointestinal**
0 None
1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 Difficulty eating without staff urging. Requests or requires laxatives or medications for bowels or medication for G.I. symptoms.

13. **Somatic Symptoms - General**
0 None
1 Heaviness in limbs, back or head, backaches, headache, muscle aches, loss of energy and fatigability
2 Any clear-cut symptom rates 2

14. **Genital Symptoms**
0 Absent
1 Mild
2 Severe
0 Not ascertained
Symptoms such as: loss of libido, menstrual disturbances

15. **Hypochondriasis**
0 Not present
1 Self-absorption (bodily)
2 Preoccupation with health
3 Frequent complaints, requests for help, etc.
4 Hypochondriacal delusions

16. **Loss of Weight**
A. When Rating by History:
0 No weight loss
1 Probable weight loss associated with present illness
2 Definite (according to patient) weight loss

B. On Weekly Ratings by Ward Psychiatrist, When Actual Changes are Measured:
0 Less than 1 lb. weight loss in week
1 Greater than 1 lb. weight loss in week
2 Greater than 2 lb. weight loss in week

17. **Insight**
0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

Total Score:

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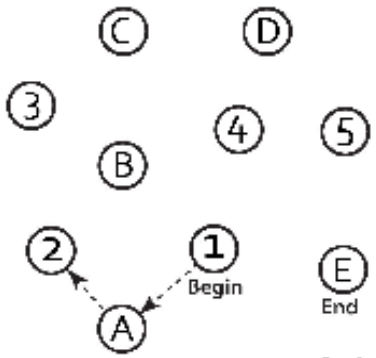
MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.2 Alternative Version

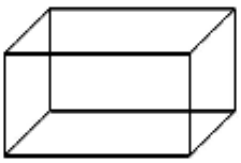
NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



[ ] [ ]

Copy rectangle



Draw CLOCK (Five past four)
(3 points)

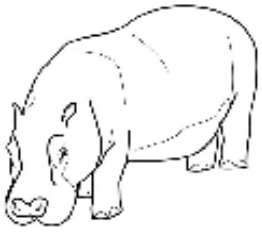
[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING

[ ]

[ ]



[ ]

__/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	TRUCK	BANANA	VIOLIN	DESK	GREEN
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 3 2 9 6 5
Subject has to repeat them in the backward order [ ] 8 5 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 90 [ ] 83 [ ] 76 [ ] 69 [ ] 62 [ ] 55
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

__/3

LANGUAGE Repeat : A lion can fly into closed windows when it's dark and windy. [ ]
The cat dog grandmother sent groceries once a week ago. [ ]

/2

Fluency / Name maximum number of words in one minute that begin with the letter S [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION Similarity between e.g. carrot - potato : vegetable. [ ] diamond - ruby [ ] cannon - rifle

__/2

DELAYED RECALL

	Has to recall words WITH NO CUE	TRUCK [ ]	BANANA [ ]	VIOLIN [ ]	DESK [ ]	GREEN [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

__/5

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

Adapted by : Z. Nasreddine MD, N. Phillips PhD, H. Chertkow MD
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Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yrs edu

Administered by: _____

Nursing Pre-ECT Checklist

Session Number		1	2	3	4	5	6
Date		/ /	/ /	/ /	/ /	/ /	/ /
Item Checklist	Y/N	Initials	Initials	Initials	Initials	Initials	Initials
WARD NURSE↓↓↓↓							
Correct patient?							
Consent Form signed?							
Relatives informed? *(if appropriate)*							
ECT Clinic Nurse informed of any concerns?							
ECT prescription completed?							
ECT Information Record completed?							
Mental Health Act paperwork complete? *(if appropriate)*							
Correct case notes and prescription chart?							
Allergies clearly recorded?							
Fluid Balance chart?							
Relevant investigation results in case notes? *(Blood/CXR/ECG)*							
Blood pressure recorded? *(if known HT)*							
Caffeine given?							
Antihypertensives given? *(if prescribed)*							
Medication for gastric reflux given? *(if prescribed)*							
Ventolin given? *(if indicated)*							
Blood Glucose							
ECT CLINIC NURSE ↓↓↓↓							
Crowns/caps noted?							
Dentures removed?							
Spectacles removed?							
Hearing Aid removed?							
Jewellery removed? *(as appropriate)*							

Artificial eyes/contact lenses removed?							
Wig or hairpiece removed?							
Hair lacquer or gel removed?							
Confirmation by ECT Clinic Nurse that all paperwork is complete?							

Nursing Pre-ECT Checklist

Session Number		7	8	9	10	11	12
Date		/ /	/ /	/ /	/ /	/ /	/ /
Item Checklist	Y/N	Initials	Initials	Initials	Initials	Initials	Initials
WARD NURSE↓↓↓							
Correct patient?							
Consent Form signed?							
Relatives informed? (if appropriate)							
ECT Clinic Nurse informed of any concerns?							
ECT prescription completed?							
ECT Information Record completed?							
Mental Health Act paperwork complete? (if appropriate)							
Correct case notes and prescription chart?							
Allergies clearly recorded?							
Fluid Balance chart?							
Relevant investigation results in case notes? (Blood/CXR/ECG)							
Blood pressure recorded? (if known HT)							
Caffeine given?							
Antihypertensives given? (if prescribed)							
Medication for gastric reflux given? (if prescribed)							
Ventolin given? (if indicated)							
Blood Glucose							
ECT CLINIC NURSE ↓↓↓							
Crowns/caps noted?							
Dentures removed?							
Spectacles removed?							
Hearing Aid removed?							

Jewellery removed? (as appropriate)							
Artificial eyes/contact lenses removed?							
Wig or hairpiece removed?							
Hair lacquer or gel removed?							
Confirmation by ECT Clinic Nurse that all paperwork is complete?							

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TREATMENT NO 1 Date _____

ECT TREATMENT	**TREATMENT DETAILS** (stimulus dose, observed & EEG recorded seizure duration)			Seizure threshold established at
BILAT / UNILAT (please circle)	Stimulus 1	Stimulus 2	Stimulus 3	.....
Prescribed by:- ..... Print:-	Dose ..... Obs ..... EEG ..... Quality	Dose ..... Obs ..... EEG ..... Quality	Dose ..... Obs ..... EEG ..... Quality	Complications Recommendations Signed: ..... Print: .....
ANAESTHETIC DETAILS	**ANAESTHETIC TECHNIQUE**			Anaesthetic Comments
Pre-treatment ASA HR BP O2 sats	Anaesthetic Agent:- Muscle relaxant Intubated Y / N Cricoid pressure Y / N			Signed: ..... Print: .....
POST-ECT TREATMENT	**Orientation check in recovery**			Recovery complications
Pre-discharge HR BP O2 sats	Name ❒ Month ❒ Time to re-orientation ☐ Date of Birth ❒ Year ❒ Age ❒ Prime Minister ❒ Day ❒ Ward ❒			Signed: ..... Print: .....

Signed:-	**Pre treatment CGI score** (circle) **1**=Normal, not al all ill **2**= Borderline mentally ill, **3**=mildly ill, **4**= moderately ill, **5**= severely ill, **6** = Amongst the most severely ill **Signs of Amnesia** immediately before and after treatment Yes/No	Cognition: MOCA /3 0 OR AMTS / 10

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TREATMENT NO 2 Date _____

ECT TREATMENT	**TREATMENT DETAILS** (stimulus dose, observed & EEG recorded seizure duration)		Complications:
BILAT / UNILAT (please circle)	Stimulus 1	Stimulus 2	
Prescribed by:- ..... Print:-	Dose ..... Obs ..... EEG ..... Quality	Dose ..... Obs ..... EEG ..... Quality	Recommendations Signed: ..... Print: .....
ANAESTHETIC DETAILS	**ANAESTHETIC TECHNIQUE**		Anaesthetic Comments
PRE-TREATMENT ASA HR BP O2 sats	Anaesthetic Agent:- Muscle relaxant Intubated Y / N Cricoid pressure Y / N		Signed: ..... Print: .....
POST-ECT TREATMENT	**Orientation check in recovery**		Recovery complications
Pre-discharge HR BP O2 sats	Name ❒ Month ❒ Time to re-orientation ☐ Date of Birth ❒ Year ❒ Age ❒ Prime Minister ❒		Signed: .....

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	Day ❒ Ward ❒	Print: .....
Signed:-	**Between treatment CGI score** (circle) **1** = very much improved, **2** = much improved, **3** = minimally improved, **4** = no change, **5** = minimally worse, **6** = much worse, **7** = very much worse **Signs of Amnesia** immediately before and after treatment Yes/No	Cognition: MOCA / 30 OR AMTS / 10

TREATMENT NO 3 Date _____

ECT TREATMENT	**TREATMENT DETAILS** (stimulus dose, observed & EEG recorded seizure duration)		Complications:
BILAT / UNILAT (please circle)	Stimulus 1	Stimulus 2	
Prescribed by:- ..... Print:-	Dose ..... Obs ..... EEG ..... Quality	Dose ..... Obs ..... EEG ..... Quality	Recommendations Signed: ..... Print: .....
ANAESTHETIC DETAILS	**ANAESTHETIC TECHNIQUE**		Anaesthetic Comments
PRE-TREATMENT ASA HR BP O2 sats	Anaesthetic Agent:- Muscle relaxant Intubated Y / N Cricoid pressure Y / N		Signed: ..... Print: .....
POST-ECT TREATMENT	**Orientation check in recovery**		Recovery complications

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Pre-discharge	Name ❒	Month ❒	Time to re-orientation	
HR	Date of Birth ❒	Year ❒		
BP	Age ❒	Prime Minister ❒		Signed: .....
O2 sats	Day ❒	Ward ❒		Print: .....
Signed:-	**Between treatment CGI score** (circle) **1** = very much improved, **2** = much improved, **3** = minimally improved, **4** = no change, **5** = minimally worse, **6** = much worse, **7** = very much worse **Signs of Amnesia** immediately before and after treatment Yes/No			Cognition: MOCA / 30 OR AMTS / 10

TREATMENT NO 4 Date _____

ECT TREATMENT	**TREATMENT DETAILS** (stimulus dose, observed & EEG recorded seizure duration)		Complications:
BILAT / UNILAT (please circle)	Stimulus 1	Stimulus 2	
Prescribed by:- ..... Print:-	Dose ..... Obs ..... EEG ..... Quality	Dose ..... Obs ..... EEG ..... Quality	Recommendations Signed: ..... Print: .....
ANAESTHETIC DETAILS	**ANAESTHETIC TECHNIQUE**		Anaesthetic Comments
PRE-TREATMENT ASA HR	Anaesthetic Agent:- Muscle relaxant		

BP O2 sats	Intubated Y / N Cricoid pressure Y / N	Signed: ..... Print: .....
POST-ECT TREATMENT	**Orientation check in recovery**	Recovery complications
Pre-discharge HR BP O2 sats	Name ❒ Month ❒ Time to re-orientation ☐ Date of Birth ❒ Year ❒ Age ❒ Prime Minister ❒ Day ❒ Ward ❒	Signed: ..... Print: .....
Signed:-	**Between treatment CGI score** (circle) **1** = very much improved, **2** = much improved, **3** = minimally improved, **4** = no change, **5** = minimally worse, **6** = much worse, **7** = very much worse **Signs of Amnesia** immediately before and after treatment Yes/No	Cognition: MOCA / 30 OR AMTS / 10

Section C

Cefn Coed Hospital
Electroconvulsive Therapy (ECT)
A fact sheet for you and your family

Introduction

This leaflet will try to answer some of the questions that you may have about ECT. You may wish to know, what is ECT? Why is it used? What is it like to have ECT and what are the risks and benefits?

When you are depressed it is often quite difficult to concentrate. Don't be concerned if you can't read through the entire leaflet. Just pick out the sections that seem important at the time, and come back to it later. You may wish to use it to help you ask questions of staff, relatives or other patients. Please remember that your Consultant and other ward staff will be happy to chat through any queries that you may have.

Why is ECT used?

ECT is a treatment that has been used in the treatment of depression, mania, catatonia, and occasionally schizophrenia. Most people who have ECT are suffering from depression. Although we have tablets available to treat depression, some people do not recover completely and others take a long time to recover. ECT is often used for these individuals. In severe cases of depression ECT may be the best treatment and it can be lifesaving.

Why has ECT been recommended for me?

ECT is recommended for many reasons. Some of the commoner ones are listed below. If you are not sure why you are being given ECT, please don't be afraid to ask. It is sometimes difficult to remember things when you are depressed, so you may need to ask several times.

- ECT is most commonly used to treat severe depression
- It may be helpful if you did not recover with antidepressant drugs
- It may help if you can't take antidepressant drugs because of the side-effects
- It may help if you have responded well to ECT in the past
- It may help if you feel so overwhelmed by your depression that it's difficult to function at all

What will happen before I have ECT?

Your Consultant will have discussed the ECT with you and provided you with this information leaflet. A number of tests need to be done before you have the treatment. These include blood tests, a dental check and possibly an ECG (heart tracing) and chest X-ray. ECT treatment involves having an anaesthetic. The tests are performed to make sure that it is safe for you to have an anaesthetic and to have ECT. If you are in agreement to having ECT, your Consultant will then ask for your written consent.

What happens immediately before ECT?

You will need to fast (have nothing to eat or drink) from midnight the night before each treatment. This will involve having no breakfast on the morning that you have ECT. This is very important because if you do eat or drink after midnight, when the anaesthetic is given you could regurgitate stomach contents into your lungs. Important medication can be given to you with a tiny amount of water on the morning of ECT. In particular you will be given a caffeine tablet about 1 hour before treatment. The caffeine helps the ECT result in a seizure.

What will actually happen when I have ECT?

You should wear loose clothes or nightclothes for the treatment. You will be asked to remove any loose jewellery, hair slides or false teeth if you have them. You should not wear make-up, lipstick or nail varnish on the morning of ECT. The reason for this is that the chemicals in these can interact with the electrical current given during ECT.

A nurse will accompany you from the ward to the ECT treatment suite and will remain with you throughout your treatment. In the ECT suite a Senior Anaesthetic Doctor will give you an anaesthetic so that you are unconscious whilst you have the ECT. The anaesthetist will be with you until you are awake again and are ready to return to the ward with the nurse.

The treatment is given in a separate room in the ECT suite and generally only takes 10 to 15 minutes. Other patients will not be able to see you having it. The anaesthetist will give you some oxygen to breathe and will ask you to hold out your hand. They will insert a small needle into the back of your hand, which will feel like a sharp scratch. They will give you an anaesthetic injection through the needle. This will make you become unconscious and will cause your muscles to relax completely. When you are fast asleep, the psychiatric doctor on duty in ECT will pass a small electric current across your head. This causes a mild fit (seizure) of the brain, which lasts about 15 – 20 seconds. There is little movement of your body because of the relaxant injection that the anaesthetist will have given. When you wake up you will be in the recovery area. Once you are wide-awake you will be offered a cup of tea.

How will I feel immediately after ECT?

Some people wake up with no side effects at all or just feel sleepy. Others may feel slightly confused, or may have a headache. There will be a nurse with you when you wake up after the treatment to offer you reassurance and make you feel as comfortable as possible.

How does ECT work?

Although ECT has been used since the 1930s, how it works is still not fully understood. During ECT a small amount of electrical current is sent to the brain. This current produces a seizure, which affects the entire brain, including the centres that control thinking, mood, appetite and sleep. Repeated treatments alter chemical messages in the brain. This should help you to begin to recover from your illness.

How well does ECT work?

Studies have shown that over 8 out of 10 depressed individuals who receive ECT respond well, making ECT the most effective available treatment for severe depression. Those who have responded well to ECT report that it makes them feel “like themselves again” and “as if life was worth living again”. The majority of severely depressed patients who are treated with ECT become more optimistic and less suicidal. Most will make a good recovery from their depressive illness with this treatment.

What is a course of ECT?

ECT is usually given twice a week in Cefn Coed Hospital, on a Tuesday and Friday. It is not possible to say exactly how many treatments you may need. Some people respond to as few as 2 or 3 treatment sessions, others may require as many as 12 and very occasionally more. The treatment does not usually have an instant effect, so do not be alarmed if you do not start to improve immediately after the first few treatments.

What ECT cannot do?

The effects of ECT may relieve the symptoms of your depression but will not help all your problems. An episode of depression may produce problems with your relationships, or problems at home or at work. These problems may still be present after your treatment and you may need further help with these. Hopefully, because the symptoms of your depression are better, you will be able to deal with these other problems more effectively.

What are the side effects of ECT?

About a half of patients complain of a headache following ECT. This is easily treated with a simple painkiller.

Short-term memory impairment around the course of ECT and the few weeks afterwards is common. Past memories can also be affected. It is difficult to know how much of this is caused by ECT and how much by severe depression (memory problems can be linked with severe depression and can be marked even when patients have not had ECT). Memory impairment due to ECT recovers gradually over the six months following treatment, although some patients only very slowly recover past memories and some have permanent gaps in their memory for some past events. The ward doctor will be checking your memory functioning between ECT sessions and your Consultant will be able to discuss any concerns you may have.

ECT does not affect your intelligence. There is no evidence to suggest that ECT causes brain damage.

Are there any serious risks from the treatment?

ECT is among the safest medical treatments given under general anaesthetic. The risk of death or serious injury is slight, only about 1 in 50,000 treatments. This is much lower than the risk reported for childbirth, for example. ECT can affect the heart and blood pressure. Some existing medical conditions do increase the risk associated with ECT and your doctor may ask another specialist to advise before giving ECT if there are any grounds for concern. The ECT anaesthetist has produced an information leaflet about the risks of general anaesthesia. This is also available for you to read if you wish.

What other treatments could I have?

Antidepressant drugs may be suitable to treat your particular condition and it is possible that some of them may work as well as ECT. Psychological therapies are also helpful in the treatment of depression.
Your Consultant will talk to you about the advantages and disadvantages of the different treatment options in your particular circumstances.

Will I have to give my consent? Can I refuse to have ECT?

At some stage before the treatment you will be asked by your Consultant to sign a consent form for ECT. If you sign the form you are agreeing to have up to a certain number of treatments (usually up to 8). Before you sign the form your Consultant and their team will explain what the treatment involves, and why you are having it. They will be available to answer any questions you may have about the treatment. You may also wish to discuss the proposed treatment with your family, close friends and/or advocate.

You can refuse to have ECT and you may withdraw your consent at any time, even before the first treatment has been given. The consent form is not a legally binding document and does not commit you to have the treatment. It is a record that an explanation has been given to you and that you understand to your satisfaction what is going to happen to you. If you withdraw your consent to ECT this will not in any way alter your right to continued treatment with the best alternative treatments available.

If you are deemed not to be mentally capable of making the decision regarding ECT, then your Consultant will take into account any wishes you may have expressed in an advanced directive (living will). They will also encourage involvement of a close family member who you may wish to speak on your behalf. There are certain laws concerning people's consent to have ECT and your Consultant has to adhere to these.

Are there risks in not having ECT as recommended?

If you choose not to accept your doctor's recommendations to have ECT, you may experience a longer and more severe period of illness and disability than might otherwise have been the case. The main alternative is drug therapy, which also has risks and complications, and drug treatment is not necessarily safer than ECT. Whatever your decision regarding ECT, this will not jeopardise the degree of care that you receive. Your Consultant and the ward team will work with you to help you reach a decision that is best for your individual circumstances.

If you would like access to the hospital Advocacy Service, they can be contacted on 01792 516665.

This fact sheet (February 2010) has been compiled from information produced by the Royal College of Psychiatrists' Special Committee on ECT, and from the National Institute for Clinical Excellence (NICE) Guidance on the use of ECT. It is updated locally every year in line with newly available information and evidence.

About Your Anaesthetic for ECT
A Factsheet for you and your family

This factsheet should be read in conjunction with the general factsheet on Electroconvulsive Therapy (ECT).

A Senior Anaesthetist will look after you throughout your ECT treatment until you are awake and able to go back to the ward.

You should not eat anything after 2am although you can drink plain water up to 6 am in the morning, the nursing staff will remind you about this. The reason for this is that any food or drink could make you sick when you are unconscious under the anaesthetic. The sick could then end up in your lungs and make you very ill.

If your chest is prone to get tight we may give you ventolin to inhale before your anaesthetic. This will help you recover better after your anaesthetic. If you suffer with bad indigestion caused by a hiatus hernia, we will give you tablets to help reduce the acid – this will make your anaesthetic safer.

You will only need a very short anaesthetic as the treatment is a quick procedure. The anaesthetic drugs will be given to you through a vein in you arm – the sensation is no worse than having your blood taken. Before you go off to sleep we will give you some oxygen to breathe which makes the procedure safer for you.

When you are asleep we will give you a small dose of a short acting muscle relaxant, which makes your treatment much safer than if we did not use it. The anaesthetist will be breathing for you whilst you are asleep.

Throughout your treatment we will be measuring the amount of oxygen that we are giving you, the amount of carbon dioxide that you are breathing out, the oxygen levels in your blood and your heart rate. We may also measure your blood pressure and heart tracing.

You will wake up in our recovery room breathing oxygen through a mask. We will take this off as soon as the oxygen levels in your blood are OK.

If you suffer from bad indigestion caused by a hiatus hernia, then as you go off to sleep we will put a small amount of pressure just below your voicebox to stop any of the acid coming up and going into your lungs. Whilst you are asleep we will be breathing for you through a tube in the windpipe, which will stop any acid going into your lungs whilst you are asleep. You may feel it there as you are waking up but the anaesthetist will remove it as soon as it is safe to do so.

YOUR ANAESTHETIC – WHAT ARE THE RISKS?

We need to tell you about some of the risks before your anaesthetic. To keep things in proportion with daily life, the risk of dying from a road traffic accident is much higher than dying from your anaesthetic.

We will talk about the risks starting with the common problems and working our way through to the rare problems.

COMMON PROBLEMS: 1 in 10 to 1 in 100 people affected

HEADACHE
The anaesthetic drugs, the treatment, the blood pressure going down or simply being dehydrated can cause a headache. Sometimes due to the ECT the blood pressure can go up and this can also cause a headache. This is only temporary and usually improves with paracetamol.

NAUSEA AND VOMITTING
Again this may be caused by the anaesthetic or being dehydrated. It is only temporary and can be treated with drugs and fluids.

DIZZINESS
The anaesthetic drugs may lower your blood pressure, and being dehydrated will make it worse. We can treat this by giving you fluids and drugs.

MUSCLE PAINS
Don't be alarmed if you get pains across your shoulders or your lower back and hips or even across your chest. This is generally caused by the muscle relaxant that we give to make your treatment safe.

DAMAGE TO LIPS, GUMS, TEETH AND TONGUE
We ask the dentist to see you beforehand and s/he will tell us if you have any dental problems. We always use a tooth guard block when you are asleep to try and prevent any damage during your treatment. If you are very dehydrated or have not been eating nutritional meals for a while then damage can happen more easily. If any teeth do get damaged we will sort it out for you with the dentist after all your treatments are finished.

SORE THROAT
This is temporary and may feel worse if you are dehydrated. It is caused by a tube which we place in your mouth to help us breathe for you whilst you are asleep. It is more common if you have bad indigestion, in which case we have to place a tube in your windpipe when you are asleep.

PAIN OR BRUISING AT THE INJECTION SITE
Some of the anaesthetic drugs may be uncomfortable as they are injected, and the area may be bruised or a bit uncomfortable for a day or two afterwards.

LOSS OF MEMORY AND CONFUSION
This is usually worst when you first wake up from the anaesthetic, but then improves. It may be caused by the ECT treatment, or sometimes by the anaesthetic.

COUGHING

You may find that you are coughing when you wake up. This is caused by your treatment and the anaesthetic, which tends to increase the amount of fluid the breathing tubes produce and can make them tight. This problem is much more common if you smoke.

COMMON PROBLEMS: 1 in 1000 people affected

MEDICAL PROBLEMS BECOMING UNSTABLE
We will not give you an anaesthetic if you are not well enough physically. If necessary we will ask the advice of a senior doctor in another hospital to help get you as well as possible before giving your treatment.

CHEST INFECTION
This is more likely if you smoke, if you have asthma or if you have a cold. We may give you ventolin to breathe beforehand to help stop this happening. If you have a cold then we will delay your treatment until you are better.

SHIVERING
This is caused by the anaesthetic, but is much more common if you have had a long anaesthetic for an operation.

RARE PROBLEMS: 1 in 10,000 to 1 in 100,000 people affected

AWARENESS
This is much less likely during a short anaesthetic for your treatment, than if you were having a long anaesthetic for an operation. We do not let you have your treatment until we know that you are asleep.

ALLERGY TO THE ANAESTHETIC DRUGS
We will check with you beforehand if you have had any previous problems with your anaesthetics, or if you have any allergies. We are able to look after you as safely as possible if this happens.

SUXAMETHONIUM APNOEA
This is a condition that runs in families. It is not an allergy as such, but a low amount of substance in the body that breaks down the muscle relaxant (called suxamethonium) that we give you to make your treatment safe. If this did happen we would keep you asleep and breathe for you until it wore off.

MALIGNANT HYPERPYREXIA
Again this is a condition that usually runs in families. It does not mean that you have cancer. It just means that the body temperature can rise very quickly if you are given certain anaesthetic drugs. If this did happen we would keep you asleep and get your temperature down.

DEATH
As we said earlier, you have more chance of getting killed in a road traffic accident than dying under anaesthetic. In the UK, the chance of you dying during your anaesthetic is about 5 people in every million. This includes everybody having an anaesthetic, no matter how old they are, how ill they are, or how long they are asleep.

If you would like access to the hospital Advocacy Service, they can be contacted on 01792 516665.

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caring for each other working together always improving

Cefn Coed Hospital
Electroconvulsive Therapy (ECT)
A fact sheet for Out-Patient treatment

This fact sheet provides additional information for individuals receiving ECT as an outpatient. It should be read along with the general ECT fact sheet.

If you are having the treatment as an outpatient, there are some rules that **must** be followed. This is because you will have a brief anaesthetic, which will be given by an injection into a vein in your arm.

- You **must not** have anything to eat or drink **after midnight** on the day before your treatment.
- **Do not** wear make-up, jewellery or hair spray on the morning of your treatment.
- You will be able to wash and clean your teeth, but do not swallow any water.
- If you normally take tablets in the morning, **do not** take them yourself on the morning of your treatment. Bring them with you to the hospital and give them to the nurse – they will ask you to take them at the appropriate time.
- You may not be able to have an anaesthetic if you have a severe head cold. Please telephone your ward if you develop a cold during the course of your treatment. They will be able to advise you when you should next come for treatment.
- You **must not** drive a car or any other motor vehicle during your course of ECT, due to your illness. It would be best if a relative or friend could drive you to the hospital and then take you home later. You should not travel unaccompanied. You should **arrive by 8.30am** and you will be ready to go home again by about 2pm. When you arrive in the hospital you should report to your ward. A nurse will then accompany you to the ECT suite.
- You must not sign any legal documents or be in sole charge of children for 24 hours after treatment.
- You must not return to an empty house. Ask your relative or friend to stay with you for 24 hours after returning home. Try to rest or sleep for a few hours.

You may have a slight “muzzy” feeling or headache when you wake up from the anaesthetic. This generally passes off after you have had a cup of tea, which the nurse will bring you.

Your Consultant will review you during the course of your treatment. If, in addition, you wish to discuss your progress with your doctor before any of the treatment sessions, let the ward nurses know when you arrive.

If you would like access to the hospital Advocacy Service, they can be contacted on 01792 516665.

Section D

Administration of ECT

Stimulus Dosing

Over-stimulation with ECT increases the likelihood of cognitive side effects. This results in unnecessary suffering for patients and may reduce the acceptance of ECT as a treatment. Individuals vary widely in their seizure thresholds. This will be affected by a variety of factors including age, sex, medication, previous ECT and fluid balance.

The purpose of stimulus dosing is to minimise this risk by adjusting the ECT dose to the lowest level compatible with effective seizures in individual patients. Stimulus dosing involves increasing the ECT current dose until an effective seizure is induced.

An effective ECT treatment is indicated by: -

- Either a peripheral seizure >15 seconds
- Or an EEG seizure (3Hz spike and wave activity) of >25 seconds

Seizure Monitoring

Therapeutic effect of ECT is linked to seizure quality. It is unacceptable to expose patients to the stress and risk of ECT unless adequate seizures can be ensured. For this reason it is important to note the length and quality of each seizure. This can be done visually, by observing the slight tremor of face and extremities, but more accurate methods are available and should be used as well.

- The **EEG recorder** attached to the Thymatron ECT machine is the preferred method of measuring the seizure activity.

- The Hamilton Cuff technique of measuring seizure length may be of use in some cases of missed seizure, where high doses of muscle relaxant have been used or in certain frail patients. However, it is not without risk and **should not be used** without discussion with the Anaesthetist and the patient's own Consultant Psychiatrist or [redacted]

The sequence and duration of all seizures must be documented in the **ECT Treatment Record** in the patient's case-notes and in the **ECT Suite Logbook**.

Electrode Placement: - Unilateral or Bilateral?

The choice between unilateral and bilateral electrode placement remains controversial. The balance of the evidence points to bilateral electrode placement being preferable in terms of speed of response and overall effectiveness. However, unilateral ECT is thought to result in less cognitive impairment.

The prescribing Consultant Psychiatrist will indicate on the ECT Prescription form their choice of electrode placement for that patient. In practice the majority of patients should be prescribed bilateral ECT. However, unilateral ECT may be considered when: -

- Speed of response is less important
- Where minimising memory impairment is particularly important

Electrode Placement

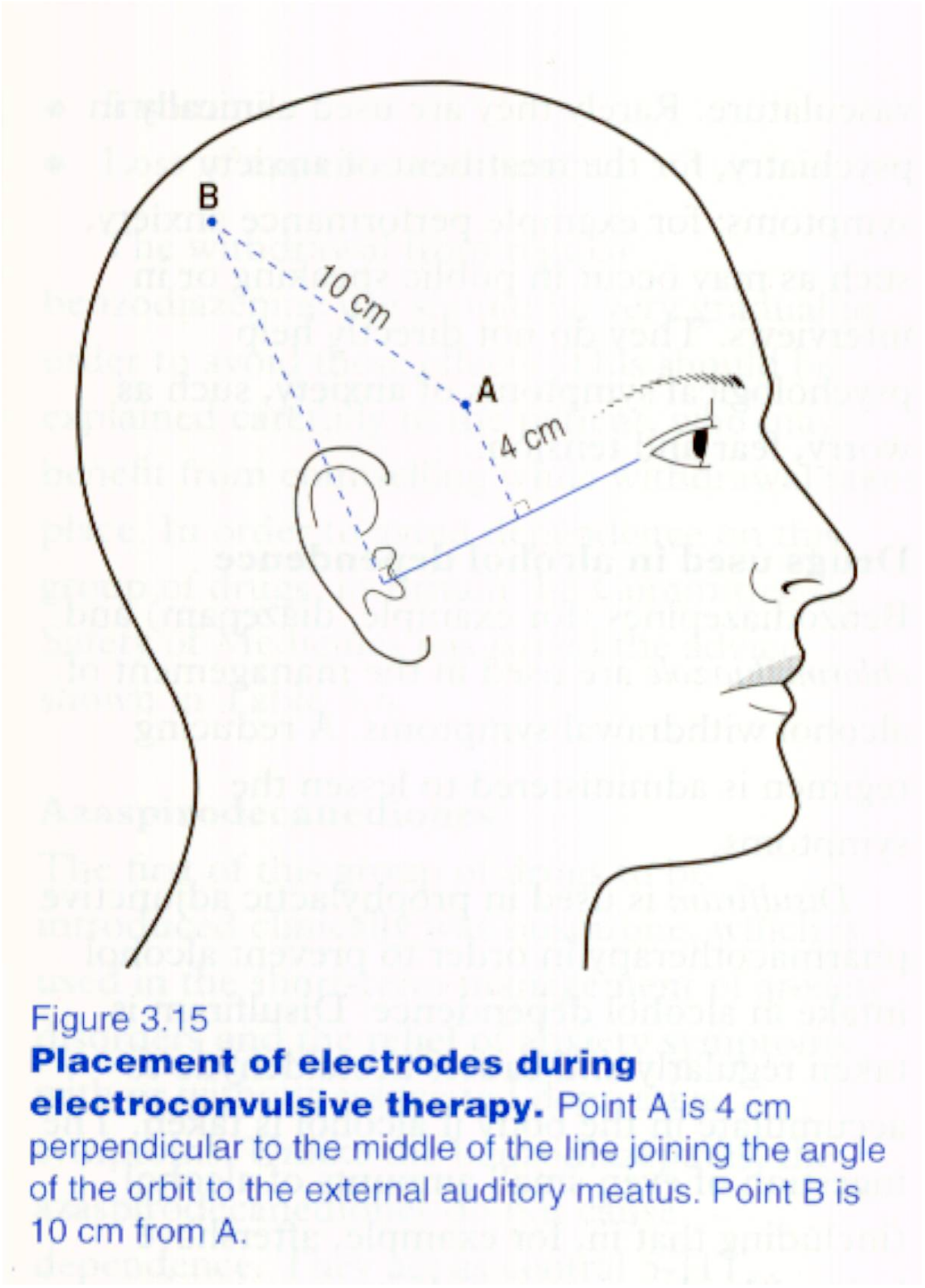

Figure 3.15
Placement of electrodes during electroconvulsive therapy. Point A is 4 cm perpendicular to the middle of the line joining the angle of the orbit to the external auditory meatus. Point B is 10 cm from A.

Bilateral Placement – Electrode at Point A on each side of head
Unilateral Placement – Electrode at Point A and at Point B on same side of head over non-dominant hemisphere

Administration of ECT

- Prior to administration of ECT, the ECT nurse will cleanse the patient's hairline, beyond both ears and right shoulder area with Savlon solution. After drying these areas she will position the EEG monitoring electrodes appropriately.
- The patient will be anaesthetised, relaxed and ventilated, and a rubber gag placed between the teeth.
- Approval to proceed with ECT **must** be given by the anaesthetist.
- Electrode jelly should be applied to the electrode contact areas.
- The treating doctor will then place the electrodes over the stimulation sites, making sure that there is **firm** contact.
- The ECT nurse will then press the impedance button. A reading of around 2000 ohms impedance should be obtained. If a higher reading is obtained this suggests that contact is poor – efforts should then be made to improve contact and lower the impedance.
- The ECT stimulus is administered to the patient by pressing the **TREAT** button on the machine after an impedance reading of about 2000 ohms has been obtained. The ECT nurse holds down the **TREAT** button whilst the doctor continues to maintain electrode contact with the patient's head. They should continue until the buzzing sound stops, which indicates completion of ECT delivery. The EEG analysis, reporting seizure length duration, will proceed automatically.
- A tonic contraction will be seen and then after the passage of current has ceased, clonic contractions should be looked for. These can most easily be seen on the eyelids, fingertips and toes if the patient is very relaxed.
- The nurse will time the duration of clonic contractions.
- The Thymatron System IV ECT machine allows the doctor to monitor any or all of the physiological variables of EEG, ECG and EMG. This is printed out by the machine and generates an end of treatment report. This then studied, recorded in the ECT record and placed in an envelope at the back of the patient's notes.
- At the conclusion of treatment the patient will be placed in the recovery position using the lifting gear provided.
- The patient will be wheeled into the recovery area as soon as the anaesthetist is satisfied. Trained nurses will monitor blood pressure, pulse, respiratory rate and temperature at 10-minute intervals until the patient is fully recovered. Patients will **never** be left unattended in the recovery area and will be accompanied back to the ward by nursing staff.

- An entry should be made on the ECT Treatment record, detailing: -

    - The duration of observed fit
    - The duration of EEG monitored fit
    - The stimulus dose
    - The anaesthetic agents and dose

  Both the treating doctor and the anaesthetist should sign their entries.

- The recovery nurse will complete recovery observations before the patient is accompanied back to the ward by their nurse escort.

What if the patient does not fit?

- If no seizure results or is of inadequate quality, the anaesthetist will further ventilate the patient. The patient may be re-stimulated after the anaesthetist has given approval. Re-stimulation **should only occur** in accordance with the **Stimulus Dosing Protocol**.

- The treating doctor should also check their technique – in particular did they apply the electrodes firmly enough?

- In the event that the patient still does not fit after further stimulation in accordance with the Stimulus Dosing Protocol, then an **entry should be made in the patient's case-notes** to bring the attention to the patient's own psychiatric team.

- The psychiatric team may then wish to consider matters such as doses of drugs with anti-convulsant effects. At the next treatment it will be desirable
  to: -

    - Pay special attention to stimulation technique
    - Adjust the stimulus strength in accordance with the Stimulus Dosing Protocol
    - The anaesthetist may wish to alter the dosages of anaesthetic drugs

What happens if there is a prolonged fit?

- In rare instances a prolonged seizure lasting more than 60-90 seconds may occur. Intravenous diazepam is available in the ECT suite for terminating such a prolonged fit.

Stimulus Dosing Policy for First and Subsequent Treatment Sessions

First Treatment Session

Aims: -

- To determine the seizure threshold, i.e. the lowest stimulus dose which induces an adequate seizure.
- To determine the "treatment dose" to be used at the next treatment session.
- To ensure that the patient has an adequate seizure

Rules: -

- Always check impedance before stimulating the patient.
- **Re-stimulate** if a given stimulation results in: -
    - No detectable seizure
    - Generalised peripheral tonic-clonic activity lasting **<15 seconds**, or EEG polyspike/3Hz spike-and-wave activity lasting **<25 seconds**.
- Always wait a minimum of 30 seconds between stimulations.

First Treatment Session: -

- Start at the dose level for sex and electrode placement on the **Dose Titration Table** (enclosed and also displayed on the wall of the ECT suite), i.e.
    - Female bilateral – Level 2 = Thymatron Setting 10%
    - Male bilateral – Level 3 = Thymatron Setting 15%
- **Start 1 level higher** if: -
    - Patient currently on **benzodiazepines** or **anti-epileptics**
    - The patient is **over the age of 65**
    - Previous **ECT** has been administered **within the last month**
- **Start at Level 2** if: -
    - If patient is on **lithium** therapy
- If the resultant seizure meets criteria for an adequate seizure, then the stimulus dose is considered to be the seizure threshold dose.
- If the outcome of the first stimulation does not meet criteria for an adequate seizure, then wait 30 seconds. Increase the stimulus dose by 1 level and **re-stimulate**. NB You **must not** re-stimulate without the go-ahead from the anaesthetist that it is safe to do so.

- If the resultant seizure meets criteria for an adequate seizure, then the second stimulus dose is considered to be the seizure threshold dose.

- If the outcome of the second stimulation does not meet criteria for an adequate seizure, then wait 30 seconds. Increase the stimulus dose by a further 1 level and **re-stimulate**. NB You **must not** re-stimulate without the go-ahead from the anaesthetist that it is safe to do so.

- If the resultant seizure meets criteria for an adequate seizure, then the third stimulus dose is considered to be the seizure threshold dose.

- **The patient should not receive more than 3 ECT stimuli in this first treatment session.**

Second Treatment Session

- The treatment dose for ECT is considered to be **1 level above** the established seizure threshold dose. Therefore, in the second treatment session, go up 1 level from the seizure threshold dose that was established in the first treatment session, e.g.

    - Session 1 – Seizure threshold dose established as Level 4 = Thymatron Setting of 25%

    - Session 2 – Treatment dose will be 1 level higher i.e. Level 5 = Thymatron Setting of 40%

- If the patient does not have an adequate seizure with the treatment dose then wait 30 seconds. Increase the stimulus dose by a further 1 level and **re-stimulate**. NB You **must not** re-stimulate without the go-ahead from the anaesthetist that it is safe to do so.

- **The patient should not receive more than 2 ECT stimuli in this second and subsequent treatment sessions.**

Third and Subsequent Sessions

- Seizure threshold rises as the course of ECT proceeds, and there is a tendency for seizures to become shorter.

    - Dosage of ECT stimulus should be incrementally adjusted, guided by quality of seizure, clinical response and emergence of cognitive or other side effects

    - Close liaison between the prescribing ward team and ECT clinic is of paramount importance in guiding stimulus dosage

- **The patient should not receive more than 2 ECT stimuli in any treatment session apart from the first when seizure threshold is being established.**

Prolonged seizures

- Seizures lasting 2 minutes or more should be terminated by giving more general anaesthetic or intravenous diazepam. Warn the anaesthetist to prepare to do so after 90 seconds of seizure activity.

- If a patient has a seizure lasting more than 50 seconds during a treatment session, the stimulus dosage should be **reduced by 1 level** at the next treatment session.

Quality of Seizure

- Duration of seizure activity is just one parameter of the quality of the seizure
- The quality of the EEG trace and the nature of the motor activity are also indicators of the quality of the seizure activity and will be taken into account in any decision to move up or down the stimulus dosing levels
- The decision regarding whether to increase or decrease an individual's stimulus dose will also be influenced by feedback from the wards regarding the patient's response to treatment and development of any side effects e.g. cognitive problems – it is therefore imperative that this feedback is recorded on the ECT Proforma between treatments

Monitoring Response between Treatments

- The prescribing ward team **must** monitor and record the patient's clinical response after each treatment session. The use of a suitable rating scale is encouraged eg HAMD-17.
- The patient's cognitive functioning **must** also be monitored using the Abbreviated Mental Test Score (AMTS) after every treatment – if there are concerns regarding cognitive deterioration, then consideration should be given to unilateral ECT
- It is **vital** that this monitoring is fed back to the ECT Clinic team via the **ECT Progress Checklist**, as this will guide the team in providing the appropriate stimulus strength for that individual
- ECT treatment **may not be given** if this feedback is absent
- The ECT must be re-prescribed by the Ward Consultant (or Specialist Registrar/Associate Specialist/Staff Grade Doctor) after every two treatments – this must be specified as bilateral or unilateral
- The ward team should inform the ECT Nursing Sister when the course is considered to have been completed and no more treatment is required (usually after 6 to 12 treatments)

When should ECT be stopped?

The prescribing and discontinuation of ECT are the decision of the patients Consultant/RMO. However, the decision to discontinue ECT may also take place in the context of discussion with the ECT Consultant and/or Anaesthetist in the light of adverse reactions to ECT such as cognitive problems or anaesthetic problems.

Discontinuation may also take place because of poor efficacy or, most importantly, because the patient has withdrawn consent.

The clinical status of a patient should always be assessed between each ECT session and treatment should be stopped when a response has been achieved.

A patient should not receive more treatments than is required to achieve an adequate response, even if more have been prescribed, hence the patient must be reviewed after each treatment during the treatment course.

- ECT should be stopped if at any stage the clinical risks outweigh the benefits
- It is not possible to predict reliably how many treatments will be required in a course of ECT. A set course of treatments should therefore not be prescribed
- The need for further treatment should be assessed after each individual treatment
- If no clinical improvement at all is seen after six properly given bilateral treatments, then the course should be abandoned
- It may be worth continuing up to 12 bilateral treatments before abandoning ECT in patients who have shown definite but slight or temporary improvement with early treatments
- Failure to respond to unilateral ECT does not mean that the individual will not respond to bilateral ECT

Continuing Psychotropic Medication after a course of ECT

- Continuation treatment with doses of medication known to be therapeutic are essential for at least 6 months after successful ECT (or at least 12 months in older adults)
- Many patients will be at high risk of relapse and are therefore candidates for vigorous continuation treatment, often involving augmentation strategies
- Many patients who have suffered from recurrent episodes of illness will be candidates for longer-term prophylactic or maintenance treatment to reduce the likelihood of new episodes of illness

The Role of Continuation ECT

- Continuation ECT is defined as prophylactic treatment over the first 6 months of remission
- Maintenance ECT is reserved for those whose illness recurs after continuation ECT
- The Royal College of Psychiatrists recommend that continuation ECT should be considered for patients who have relapsing or refractory depression which has previously responded well to ECT, but for whom standard pharmacological and psychological continuation treatment is ineffective or inappropriate. Such patients might include: -

  - Those who have early (0-6 months) post ECT relapse not controlled by medication
  - Those with later recurrence (6-12 months) not controlled by medication
  - Those who cannot tolerate prophylactic medication
  - Those who repeatedly relapse because of poor compliance
  - Those who ask for it

- Before commencing continuation ECT, a full review of the case should be undertaken in a similar manner to any case of refractory or relapsing depression
- The RC should record in the patients notes the reasons for proposing maintenance ECT as opposed to alternative treatments.
- The decision should be discussed fully with the patient and their family or carers.
- An informal second opinion should be sought if the patient is not detained under the MHA.
- The decision to recommend maintenance ECT should be discussed with the ECT consultant.
- The risks and benefits of maintenance ECT should be recorded in the patient's notes.
- A statement of capacity should be recorded prior to commencement.
- A consent form stipulating the number of treatments should be completed. The maximum being 12 or the maximum treatments needed over a six month period (whichever is the lower).
- Consent should be renewed after 12 treatments or six months – whichever is sooner. A further statement of capacity and second opinion should also be sought at this time and recorded.
- Patients should undergo the usual clinical investigations before ECT commences.
- Clinical progress, cognitive functioning and side-effects should all be assessed at regular intervals.
- Maintenance ECT should be discontinued at the earliest opportunity when the patient has recovered sufficiently and is stable or when the side-effects of ECT outweigh the benefits.
- Since relapse is most likely within the first 12 months of recovery, it is wise to employ continuation ECT for at least 1 year after recovery.
- For patients detained under a section of the Mental Health Act, a formal second opinion is required and the Section 12 Doctor should be informed that the patient is being consented for maintenance ECT.
- Reduction in the frequency of the ECT from twice weekly should continue until a stable state is achieved, where there is maximum spacing between treatments without return of symptoms. Allowing for individual variation, monthly is an appropriate goal.

- A possible reduction regime could be: -
    - Twice weekly until clinical response (during acute illness)
    - Reduce to weekly
    - Reduce to every 10 days
    - Reduce to every 2 weeks
    - Reduce to every 3 weeks
    - Reduce to monthly

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ECT Stimulus dosing protocol For Thymatron DGX & System IV

Bilateral Treatment

Level Suggested Starting Points	% Energy Setting	Millicoulomb Equivalent
1- Female (young adult)	5	25
2	10	50
3	15	76
4	25	126
5	40	201
6	55	277
7	80	403
8	100	504
9	150	756
10	200	1008

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Start 1 Level higher if: -

- On benzodiazepines or anti-convulsants
- Age over 65
- Male gender

ECT Stimulus Dosing Protocol

For Thymatron DGX & System IV

Unilateral Treatment

Level Suggested Starting Points	% Energy Setting	Millicoulomb Equivalent
1- Female (young adult)	**5**	25
2	**25**	76
3	**40**	126
4	**55**	201
5	**80**	403
6	**150**	756
7	**200(max.)**	1008(Max.)

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Start 1 Level higher if: -

- On benzodiazepines or anti-convulsants
- Age over 65
- Male gender

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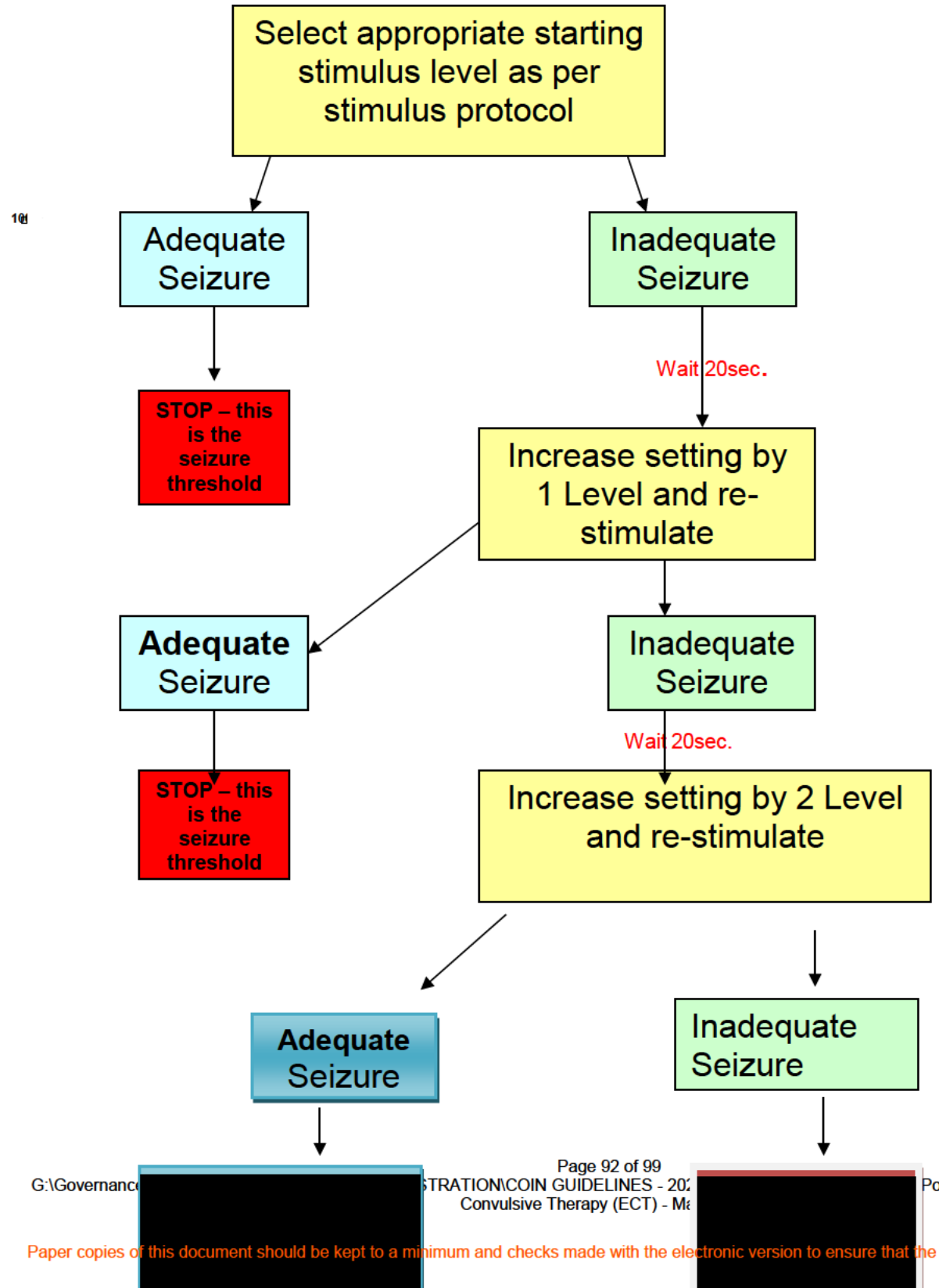
First Treatment Session
Establishing Seizure Threshold



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Second and Subsequent Treatment Sessions

Give treatment dose that is **1 Level** above seizure threshold dose established in first session

Adequate Seizure

STOP

Continue with same dose at next session

NB
If at any stage the seizure duration drops by more than 20% relative to duration at the 2nd session, then the dose should be increased by 1 level at the next session

Inadequate seizure
(If short seizure of 5-10s and no clinical response).

Increase setting by 1 Level and re-stimulate

Adequate Seizure

STOP

Continue with same dose at next session

Inadequate seizure

STOP

Increase dose by 1 Level at next session

Seizure more than 50 secs

Wait 20sec.

STOP

Anaesthetist may need to terminate fit

Reduce stimulus by 1 level at next treatment session

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Definitions and Cautions

Adequate Seizure

Generalised tonic-clonic activity lasting >15 seconds or
EEG polyspike/3Hz spike-and-wave activity lasting > 25 seconds

Inadequate Seizure

Generalised tonic-clonic activity lasting <10 seconds or no clinical response, EEG polyspike/3Hz spike-and-wave activity lasting <25 seconds

Prolonged Seizure

Generalised tonic-clonic activity lasting >50 seconds

Seizures lasting 2 minutes or more should be terminated by giving more general anaesthetic or intravenous diazepam

Maximum ECT Stimulations

An individual should not receive more than a maximum of **3 ECT stimuli** during the **first** treatment session when seizure threshold is being established.
In **second** and **subsequent** ECT sessions an individual should not receive more than a maximum of **2 ECT stimuli.**

NOTE

You **must not** re-stimulate a patient unless the anaesthetist has indicated that it is safe to do so!!

Post ECT monitoring.

After 6 weeks then at 3, 6 and 12 months post ECT MOCA & HAMILTON RATING SCALE should be completed

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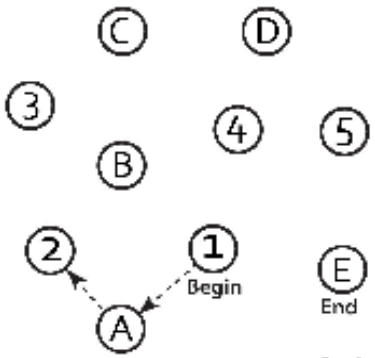
MONTREAL COGNITIVE ASSESSMENT (MOCA)

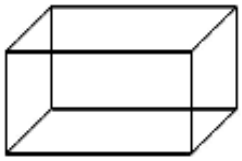
Version 7.2 Alternative Version

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE

Copy rectangle





[ ] [ ]

Draw CLOCK (Five past four) (3 points)

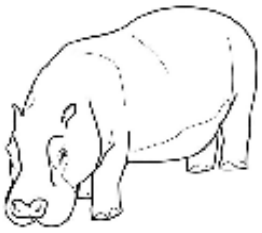
[ ] Contour [ ] Numbers [ ] Hands

POINTS /5

NAMING

[ ]

[ ]



[ ] /3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	TRUCK	BANANA	VIOLIN	DESK	GREEN
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order [ ] 3 2 9 6 5

Subject has to repeat them in the backward order [ ] 8 5 2 /2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B /1

Serial 7 subtraction starting at 90 | | 83 | | 76 | | 69 | | 62 | | 55

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** /3

LANGUAGE

Repeat : A lion can fly into closed windows when it's dark and windy. [ ]

The cat ran quickly under the sofa. [ ] /2

Fluency / Name maximum number of words in one minute that begin with the letter S [ ] _____ (N ≥ 11 words) /1

ABSTRACTION

Similarity between e.g. carrot - potato = vegetable. [ ] diamond - ruby [ ] cannon - rifle /2

DELAYED RECALL

	Has to recall words WITH NO CUE	TRUCK [ ]	BANANA [ ]	VIOLIN [ ]	DESK [ ]	GREEN [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City /6

Adapted by : Z. Nasreddine MD, N. Phillips PhD, H. Chertkow MD

www.mocatest.org

Normal ≥ 26 / 30

TOTAL /30

Add 1 point if ≤ 12 yr edu

Administered by: _____

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Patient Name:_____ **Date:**_____

Hamilton Rating Scale for Depression (17-items)

Instructions: For each item select the "cue" which best characterizes the patient during the past week.

1. **Depressed Mood**
(sadness, hopeless, helpless, worthless)
0 Absent
1 These feeling states indicated only on questioning
2 These feeling states spontaneously reported verbally
3 Communicates feeling states nonverbally, i.e., through facial expression, posture, voice and tendency to weep
4 Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication

2. **Feelings of Guilt**
0 Absent
1 Self-reproach, feels he has let people down
2 Ideas of guilt or rumination over past errors or sinful deeds
3 Present illness is a punishment. Delusions of guilt
4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. **Suicide**
0 Absent
1 Feels life is not worth living
2 Wishes he were dead or any thoughts of possible death to self
3 Suicide ideas or gesture
4 Attempts at suicide (any serious attempt rates 4)

4. **Insomnia - Early**
0 No difficulty falling asleep
1 Complains of occasional difficulty falling asleep i.e., more than ½ hour
2 Complains of nightly difficulty falling asleep

5. **Insomnia - Middle**
0 No difficulty
1 Patient complains of being restless and disturbed during the night
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

6. **Insomnia - Late**
0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if gets out of bed

7. **Work and Activities**
0 No difficulty
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2 Loss of interest in activity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3 Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities (hospital job or hobbies) exclusive of ward chores.
4 Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted.

8. **Retardation**
(slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 Normal speech and thought
1 Slight retardation at interview
2 Obvious retardation at interview
3 Interview difficult
4 Complete stupor

9. **Agitation**
0 None
1 "Playing with" hand, hair, etc.
2 Hand-wringing, nail-biting, biting of lips

10. **Anxiety - Psychic**
0 No difficulty
1 Subjective tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude apparent in face or speech
4 Fears expressed without questioning

11. **Anxiety - Somatic**
0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating
Physiological concomitants of anxiety such as:
Gastrointestinal - dry mouth, wind, indigestion, diarrhea, cramps, belching
Cardiovascular – palpitations, headaches
Respiratory - hyperventilation, sighing
Urinary frequency
Sweating

12. **Somatic Symptoms - Gastrointestinal**
0 None
1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 Difficulty eating without staff urging. Requests or requires laxatives or medications for bowels or medication for G.I. symptoms.

13. **Somatic Symptoms - General**
0 None
1 Heaviness in limbs, back or head, backaches, headache, muscle aches, loss of energy and fatigability
2 Any clear-cut symptom rates 2

14. **Genital Symptoms**
0 Absent
1 Mild
2 Severe
0 Not ascertained
Symptoms such as: loss of libido, menstrual disturbances

15. **Hypochondriasis**
0 Not present
1 Self-absorption (bodily)
2 Preoccupation with health
3 Frequent complaints, requests for help, etc.
4 Hypochondriacal delusions

16. **Loss of Weight**
A. When Rating by History:
0 No weight loss
1 Probable weight loss associated with present illness
2 Definite (according to patient) weight loss

B. On Weekly Ratings by Ward Psychiatrist, When Actual Changes are Measured:
0 Less than 1 lb. weight loss in week
1 Greater than 1 lb. weight loss in week
2 Greater than 2 lb. weight loss in week

17. **Insight**
0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

Total Score:

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(COIN)
Clinical Online Information Network
Authorisation form for items to be published onto COIN

Title of Guideline	Policies and procedures for Electro-convulsive Therapy (ECT)
Name & Signature of Author / Chair of group or Committee *	Author – [redacted] Chair of MH Directorate Policy and procedure Group.
COIN ID: Revision no:	CID 81
Library on which you wish the guideline to be launched	Mental Health
Issue no: Which Version? Supercedes:	2
Published	August 2018
Last Review:	August 2018
Next Review / Guideline Expiry:	August 2020

Name of Group Committee *	Mental health Directorate Health Care Governance Committee.
Name of Signature of lead pharmacist *	N/A
File name: Used to locate where file is stored on the hard drive.	

COIN clinical online information network

Swansea Bay University Health Board

Authorisation Form for Publication onto COIN

PLEASE ENSURE THAT ALL QUESTIONS ARE ANSWERED – IF NOT APPLICABLE PLEASE PUT N/A

COIN ID.	CID81
Title.	Policies and Procedures for Electro-convulsive Therapy (ECT)
Name and Signature of Author/Chair of Group or Committee.	[redacted] Unit Medical Director.
Name and Signature of Lead Pharmacist.	N/A
Please specify whether the document is New, Revised or a Review of a previous version.	Revised
Please specify the section on COIN where you wish the document to be published.	Mental Health
Please sign to confirm that the document has been authorised by an approved governance process in a specialty or delivery unit.	[redacted]
Has NICE guidance been considered/referenced when producing this guidance? If yes, please state the title or reference number.	NICE Guidance on the use of Electro-convulsive Therapy (April 2003)
Is the document relevant to the GP Portal?	N/A
Equality Statement (Mandatory for Policies). (1)	
Please specify keywords to assist with searching. (2)	Electro-Convulsive, Therapy, ECT, ECTAS
Published.	October 2012
Last Review.	March 2020
Next Review/Expiry Date.	March 2023

(1) All policies need to comply with the Policy for the production, consultation, approval, publication and dissemination of strategies, policies, protocols, procedures and guidelines

(2) Relevant keywords will assist COIN users with searching for documents.