Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE ELECTROCONVULSIVE THERAPY (ECT)

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VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*March 2010*	*New SOP.*
2.0	*June 2012*	*Reviewed and amended*
3.0	*December 2014*	*Reviewed and amended*
4.0	*February 2016*	*Reviewed and amended*
5.0	*May 2017*	*Reviewed and amended*
5.1	*May/2017*	*Page numbers corrected*
6.0	*October 2017*	*Reviewed and amended re procedures in treatment room*
6.1	*March 2018*	*Reviewed key points on consent, references up to date*
6.2	*December 2020*	*Addition of SOP20-035 COVID Testing in ECT as Appendix 11*
6.3	*December 2022*	*Reviewed and amended (aneathetics used in ECT and guidelines on BMI and Blood Pressure. RESPECT document. ECTAS recent peer review*
6.4	*February 2023*	*Reviewed. Removal of Methohexidone, Mivacolium and Atenolol from list of medications used in ECT in accordance with national guidelines and availability. See section 26. Introduction of guidelines for both Blood pressure and BMI prior to treatment. See section 8. Introduction of guidelines for Blood Pressure reading during recovery of ECT Treatment. See section 23 Approved by ECT Clinical Team (31/01/2023).*

Contents

This SOP was written and compiled by members of the ECT team. The team consists of:

Current ECT team

Lead Consultant Psychiatrist
Lead consultant anaesthetist
Modern Matron
Lead ECT nurse
ECT Nurse
ECT Healthcare Assistant
ECT Healthcare Assistant
Operating Department Practitioner

ECT Accreditation Service (ECTAS)

The ECT clinic at Miranda House gained accreditation with ECTAS (a branch of the RCPsych). It was awarded an excellence rating in June (2016) against standards set out in Appendix 8. The team continuously works towards maintaining this status for the future. The team are currently awaiting confirmation of the most recent ECTAS accreditation status following peer review in December 2022

1. INTRODUCTION

This SOP has been written to reflect the NICE recommendations for ECT, Oct 2009, NICE Depression guidelines (CG 90) October 2009, RCPsych ECT Handbook 2012, and ECTAS standards April 2016 and aims to provide a framework for giving the highest possible quality of clinical care.

The recommendations in the TA 59 relating to the treatment of depression have been replaced by recommendations in the Depression (update) clinical guideline (CG90) published in October 2009. Please note that the recommendations in this technology appraisal relating to the treatment of catatonia, prolonged or severe manic episodes and schizophrenia have not changed.

The decision as to whether ECT is clinically indicated should be based on a documented assessment of 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 risk of not having treatment.

2. SCOPE

These SOP is intended for use by all clinical staff involved in the referring, prescribing and caring for patients undergoing ECT supported by Trust ECT Policy.

3. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA (Appendix 4). Special precautions are necessary when treating pregnant women or children under the age of 18 with ECT and specific guidance is included in this SOP.

4. OPERATING PROCEDURE/PATHWAY

Referral for ECT

Objective
To ensure ECT is correctly referred, and that the patient is appropriately prepared both emotionally and physically for their treatment.

Principles
All patients to be prescribed ECT must be under the care of a Consultant Psychiatrist. The initial decision to prescribe ECT should be made by the consultant psychiatrist and a clear statement giving reasons for this decision must be documented in the patient's clinical notes.

All ECT treatment packs for starting a course of ECT are available from the ECT department or from the trust's intranet.

Guidelines

- **Ring the ECT department**
  Telephone referrals can be made at any time during the week. If no staff are available then an answer-phone message may be left, and staff will respond to arrange an assessment appointment. It is vital that the department is informed of possible referrals as early as possible to ensure that the offer of an ECT nurse visit to the patient can be facilitated.
- **Obtain ECT Treatment pack**
  This is available on the trust's Patient Electronic Record (Lorenzo) under Clinical Charts-Adult MH Community Clinical Chart-ECT/Clozapine-right click-notes-ECT documents.
- **Discuss with patient and family**
  A discussion with the individual regarding referral, consenting and prescribing's should involve their advocate and/or carer where possible. This discussion should provide full and appropriate information in a suitable format and language to enable an informed decision regarding ECT. An explanation of the general risks of ECT, risks specific to the individual and potential benefits to the individual should be given and the individual should not be pressured or coerced into consent to the treatment. The individual should be reminded that he or she has the right to withdraw consent at any point.
- **Supply patient and family with the ECT information booklet**
  The booklet (Appendix 9) will be offered to all patients and/or carer/s. If this information booklet is required in other languages or format, then this can be made available on request to the ECT department. Arrangements to meet with another patient who has benefited from ECT may also be an additional source of information for the patient/carer and can be organised if requested.
- **Liaison with the ECT Clinic**
  On receiving a referral, the ECT lead nurse will contact the referrer and arrange to visit the patient and/or carer/s prior to commencement of treatment. The patient and carers are also welcome to visit the department prior to the commencement of their proposed treatment. Liaison visits offer an opportunity to review information received from the doctor and answer any questions the patient and/or carer/s may have.
- **Consent**
  All day case and informal patients with capacity must give their written consent to a course of ECT treatment by signing the contract and consent forms in the ECT treatment pack (Appendix 3). The explanation must be carried out by the RC or his deputy who must be conversant with current ECT practice and who must also sign the form. For further information please refer to Appendix 5.

5. PRESCRIBING FOR ECT

Objective
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 proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with: catatonia, a prolonged or severe manic episode or severe depression.

Guidance

- **Prescribing**
  The referring Responsible Clinician and team will follow NICE Guidance on the use of ECT as stated in the Technology Appraisal (TA59) and follow the NICE audit attached in Appendix 2.
- **Other treatment options**
  Ensure that psychological treatments have been trialled or offered in line with NICE guidance before considering ECT.
- **Rating Scales**
  Ensure valid, reliable, symptom and cognitive rating scale assessments are carried out.
- **Arrange Anaesthetic assessment**
  It is a requirement of the Royal College of Anaesthetists and ECTAS (ECT Accreditation Service) that all patients being considered for ECT should have, as part of their preparation, a full assessment as to their suitability and fitness to receive a general anaesthetic using ASA scale 1-6.

1	A normal healthy patient
2	A patient with mild systemic disease
3	A patient with severe systemic disease
4	A patient with severe systemic disease that is a constant threat to life
5	A moribund patient who is not expected to survive without the operation
6	A declared brain-dead patient whose organs are being removed for donor purposes

  This assessment will normally take place in the ECT department on the morning of the first treatment (Tues or Fri) by arrangement with the lead nurse. The patient will need to be escorted by a member of staff (ECTAS standard 3.28) with training in BLS, from their host unit or CPN or a named responsible adult if they are to receive treatment as an outpatient. They will need to bring with them:

  - The relevant volume of the patient's psychiatric notes
  - Completed ECT treatment pack
  - The patient's general medical notes and medication card
  - The results of recent blood tests
  - ECG results (if required)
  - RESPECT document (detailing resuscitation preferences)

  If difficulties are encountered in transporting patients to the department for this assessment then it MAY be possible for this to be carried out on the patient's host unit by special arrangement with the anaesthetist and lead nurse.
  The Anaesthetic assessment should include a discussion on use of medication during ECT treatment.
- **Consenting/Lacking Capacity**
  If the patient is not consenting and/or lacks capacity, the referring team should consider the MCA (Appendix 7) guidance or Treatment under the MHA (Consent under S58 – Appendix 6). DoH guidelines to consent for examination or treatment (2nd ed) Aug 2009 has also been considered.

- **Discuss the procedure**
  The team should discuss the choice of Laterality with the patient and Book treatment

6. THE CHOICE OF LATERALITY

Objective
To administer ECT effectively and safely, whilst minimising cognitive side-effects.

Principles
The choice between unilateral and bilateral electrode placement remains controversial. The results of a systematic review conducted by the UK ECT Review Group are available and largely support bilateral placement when speed and/or remission of symptoms has priority, and that unilateral placement is preferred when minimising cognitive effects has priority.

Guidelines
- Neither unilateral nor bilateral electrode placement is the treatment of choice in all indications for ECT.
- The selection of electrode placement should, where possible, be part of the process of informed consent for ECT. Where possible, patients with the capacity to consent should be involved in discussion regarding choice of laterality.
- Where the rate of clinical improvement and remission of symptoms have priority, bilateral placement is preferable.
- Where minimising the cognitive adverse effects has priority, unilateral placement is preferable. This may be particularly relevant in neuropsychiatric conditions such as Parkinson's disease.
- Bilateral electrode placement will also be preferred where the index episode of illness or an earlier episode of illness had not been treated adequately by unilateral ECT and where determining cerebral dominance is difficult or in the treatment of mania, where the optimal technique for the use of unilateral ECT has not been established.
- Unilateral electrode placement will also be preferred where the rate of clinical improvement is not critical and where there is a history of recovery with unilateral ECT.
- Right unilateral ECT is preferred in people who are consistently right-handed.
- In left-handed people or where cerebral dominance is hard to decide,
  - Bilateral electrode placement may be preferred
  - Alternatively, an empirical trial may be made when the time to recover orientation is compared between right- and left-sided treatment given at consecutive treatment sessions under standard conditions.

7. USE OF MEDICATION DURING AND AFTER THE COURSE ECT TREATMENT

Objective
To achieve maximum benefit, safely and appropriately, of both psychotropic and physical medications whilst the patient is undergoing a course of ECT treatment

Principles
Concurrent therapy can be considered under two headings: general medication and specific psychiatric medication. Both have the potential to modify seizure thresholds. Anticonvulsants, hypnotics and membrane stabilisers tend to raise the seizure threshold, while preparations containing theophyllines can have the opposite effect.

Patient's concurrent medication is usually of a protective nature, such as anti-hypertensives, anti-anginals, anti-dysrhthmics, bronchodilators and/or antacid/anti-reflux therapy.

Guidelines
Patient's concurrent medication should be maintained and can usually be given safely, up to two hours before ECT, with sips of water if necessary. Those receiving long term steroids may need supplementary doses and those on anticholinesterase therapy for glaucoma may require modification of the choice of muscle relaxant. Patients with diabetes who require insulin should attend early and should have medication withheld until after recovery. H^2 receptor antagonists and antacids should be prescribed for those at risk of oesophageal reflux.

Concurrent psychiatric medication can have significant effects upon ECT.

Selective inhibitors of the reuptake of serotonin and noradrenaline can reduce seizure threshold and cause hypertension. Neuroleptics tend to be proconvulsant at low dosage but increase seizure thresholds at higher dosage. Most psychotropics lower seizure threshold except anticonvulsant + benzodiazepines which raise it.

Recommendations for post ECT drug therapy
- Continuation treatment with doses of medication known to be therapeutic is essential for at least six months after successful ECT.
- 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.

8. REQUIREMENTS ON TREATMENT DAYS

Objective
To ensure that the patient is appropriately prepared for ECT and the correct documentation available.

Principles
In order for ECT to be given, certain requirements need to be met, to ensure patient safety and to fulfil all legal requirements.

Guidelines
- **Arrange Transport**
  Patients travelling from in-patient facilities with escort must be transported in a suitable vehicle. This will usually be the unit's own vehicle, but if a suitable driver cannot be made available, then the use of a taxi or ambulance should be considered.
- **Arrange appropriate escort for the patient**
  In accordance with the Royal college of Psychiatrists ECT Handbook, the escort must be a member of staff who has a supportive therapeutic relationship with the patient and who can provide information to the ECT team, as well as giving reassurance to the patient both before and after treatment.
  The escort staff member should have basic life support training and remain with the patient during all stages of treatment. In the case of in-patients the ideal escort is the patient's named nurse, whilst in the case of out-patients the patient's community nurse/key worker should perform this function. If a driver is required this person must be in addition to the escort nurse. The escort nurse is responsible for providing emotional and physical support for the patient as well as responsibility for the patient's possessions and valuables whilst on the ECT unit. The escort nurse must seek advice from the lead ECT nurse before the patient can leave the department. It is the responsibility of the escort nurse to ensure that all relevant documentation is returned with the patient. (ECTAS – if delegated to unqualified nurse then it is the nurse who will be accountable for the consequences of that delegation).
- **Ensure the patient has been fasted**
  The patient must not eat after midnight the day before treatment. One 'non milky' drink i.e. clear fluids may be allowed up to 06.00 hrs, plus essential medication to be taken.

- **Medication**
  Necessary medication i.e. hypotensives, beta-blockers, other cardiac medication and oral antidiabetic medication must be administered with a few sips of water.
  Consider withholding benzodiazepines, hypnotics and antiepileptics as these may reduce the efficacy of the treatment. These can be taken but the escort must inform the ECT team.
- **Ensure correct documentation**
  Psychiatric information is completed on Lorenzo or within the treatment package and general medical case notes are available for review (For anaesthetic assessment on first treatment and brought to subsequent treatments). Current ECT treatment pack fully completed including previous ECT treatment pack where available.
  Mental Health Act documentation where applicable.
  Results of investigations, i.e. blood results and ECG and Medicine card
- **Patient's attire**
  Patients should be requested to wear loose fitting clothing and also to remove make up, nail varnish, contact lenses, body piercings etc. It is also vital to bring a change of clothes for the patient, as there are occasions where incontinence occurs.
- **Patients' Blood pressure**
  Blood pressure should read under 180/100 prior to ECT treatment. This should be done on the ward prior to treatment and staff should call the ward if blood pressure reads higher than this to discuss whether treatment is appropriate.

  Whilst clerking in on morning of treatment, a blood pressure of under 190/100 will allow treatment to go ahead. This allows for a degree of raised blood pressure due to natural anxiety about the procedure
- **Patients BMI**
  A BMI of between 20 and 25 would be ideal for ECT treatment, however a BMI between 25 and 30 will be accepted by the Anaesthetist on most occasions.

  Where a patients BMI is between 30 and 40 a thorough assessment of health and appropriateness of ECT treatment will be undertaken by both the Anaesthetist and the treating Psychiatrist and particular attention will be focused on the benefits of treatment out waying the risks of the treatment on the patient.

  A decision whether to go ahead with treatment will then be made.

  A BMI of over 40 will not be appropriate for ECT treatment

  Similarly, a BMI under 18 would mean that ECT treatment would not go ahead execpt under exceptional circumstances and decided by the ECT medic team.

9. REVIEW AND RE-PRESCRIBING

Objectives
To ensure that all patients receiving ECT are monitored at least weekly and that their clinical status /symptomatic response is assessed and recorded between each treatment session.

Principles
Ensuring compliance with ECTAS standards as well as guidance given in NICE Depression Guidance and NICE Guidance on ECT.

Guidelines
- **Monitor clinical response.** Medical staff to monitor and record evidence of clinical response to ECT using recognised symptom and cognitive rating assessments at MDT meeting weekly.

- **Monitor the patient's subjective and objective response.** Medical staff to monitor and record the patient's subjective experience of treatment side effects and objective side effects following each treatment using the CGI assessment (To be found on each treatment sheet).
- **Recognised and validated symptom rating scale and a cognitive assessment scale (if appropriate) rating assessments.** These assessments are required before starting a course of ECT, every weekly during treatment and about one to two months after the last treatment in line with ECTAS standards (Appendix 8). This assists the treating team in adjusting treatment settings as it offers an indication of any improvement.
- **Treatment to be re-prescribed.** Taking into account all the above, the RC or his deputy may prescribe up to 2 further treatments
- **Section 62.** If still awaiting the opinion of the second opinion doctor (SOAD) the patients RC must also date and sign the section 62 pro-forma indicating the date for the next treatment.

10. DISCONTINUATION OF ECT

Objectives
To achieve the best possible outcome of ECT and to safely end the course, when all are assured that this is the case.

Principles
The prescribing and discontinuation of ECT are the decision of the patient's RC. 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.

Patient's response time to ECT varies, as does the occurrence of side-effects. It is therefore vital that all patients are continuously assessed for signs of improvement and/or side-effects, throughout the course of treatment so discontinuation can occur at the optimal time.

Guidelines
- 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 will be discontinued if the patient withdraws their consent.
- ECT will be discontinued if a serious medical problem arises.
- Some patients will benefit from having an increased interval between treatments when a positive response has been achieved, to ascertain whether the improvement can be maintained whilst undergoing a 'treatment break'.
- Patients will be reviewed at MDT after every second treatment to assess their improvement. This will be documented.
- A recognised symptom scale should be carried out soon after the last treatment and in one to two months post treatment.
- Discontinuation will occur when all (including patient and his/her carer or family) are agreed that the maximum benefit from ECT has been achieved.
- Subsequent medication regime to be agreed, to maintain alleviation of pre-disposing symptoms.

Recommendations (from ECT Handbook, 2013)
A set course of treatments should not be prescribed – the need for further treatments should be assessed after each individual treatment.

Bilateral ECT: **I**f 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.
Unilateral ECT: For patients who do not respond to unilateral ECT, consideration should be given to switching to bilateral treatment. It will be necessary to re-titrate seizure threshold in this case.

11. FOLLOW UP

Objective
That each patient having received ECT is followed up to ensure efficacy of treatment and that no adverse effects have been suffered

Principles
In accordance with ECTAS standards all patients who have received ECT treatment must be followed up at the end of the course by ECT nurses and subsequently by their care team.

Guidelines
- The patient will be seen and assessed by a nursing member of the ECT team or CMHT approximately 1-2 months after the final treatment to obtain an 'Outcome Score' as set out below plus a recognised cognitive and depression assessment.
  1. *No Improvement*
  2. *Minimal improvement- clinically apparent, but patient denies improvement*
  3. *Patient recognises improvement*
  4. *Good, but room for further improvement to be fully recovered*
  5. *Fully Recovered*
- They will be further reviewed by the referring team at least monthly for three months following an acute course of ECT (ECTAS standard 7.16.1).
- All patients and their carers will be offered a feedback form to complete and return to the clinic. All feedback will be appraised by the ECT team.

12. OUTPATIENT ECT

Objective
For patients to receive ECT as an outpatient.

Principles
Prior to a patient being referred for ECT, there are certain criteria to be considered:
1. Has the patient a CPN or other professional carer involved (must be up to date in Basic Life Support Skills). This person will be required to stay with the patient throughout the treatment process to provide both emotional and physical support.
2. Home circumstances. The patient must not return to an empty house and will require the supervision of a responsible adult for 24 hours following treatment under general anaesthetic (Royal College of Anaesthetists-Guidance on Day Case Anaesthesia)
3. Travel arrangements.
   The patient must not drive themselves, and must not drive any motor vehicle throughout the course of ECT.
   They must have a driver AND escort.
   They may not use public transport to travel from the department.
4. Good general medical status (ASA 1-3)

If one or more of above criteria cannot be met, consider the following options:
   a. The ambulance service may be used if the patient has no recognised professional carer who can provide transport (contact ECT department for details).
   b. If there are difficulties in providing 24-hour care post treatment then consider:

Requesting that the patient remain in the ECT department until a carer becomes available no later than 1600hrs.
Or admission to a MHU for the duration of the course of ECT.

Guidelines

- Referring doctor to ring ECT Department (01482 617553) and refer patient (answer-phone available.)
- Complete consent procedure with the patient
- Fully complete all relevant sections of ECT pack, including prescription.
- Ensure blood taken for routine examination.
- Carry out full physical examination, if there are any concerns please report to ECT staff who will inform the anaesthetist.
- Arrange for ECG examination if applicable. If any problems with this then ECT staff may be able to help.
- Give patient information booklet and arrange visit to ECT department if the patient wishes, or for ECT staff to visit the patient.
- Arrange for CPN (or other professional known to the patient) to escort patient to treatment sessions.
- Arrange appropriate transport. Patients must not drive themselves, but a family member may do so. The ambulance service may be used.
- Ensure the patient has a responsible adult present at home for the ensuing 24 hours after treatment.
- Send ECT pack with signed consent form and patients notes to the ECT department.
- Ensure the patient signs the 'Outpatient information and agreement' document.
- Agree date and time for an anaesthetic assessment to be carried out (Please note that the patient's general medical case notes will be required for this assessment to go ahead.
- Inform the patient that the ECT department will ring with the date and time of their 1st appointment and to confirm travel/escort arrangements.

13. DISCHARGE CRITERIA FOLLOWING OUTPATIENT ECT

Objective

To ensure the outpatient having received ECT is well enough to be discharged into the care of their carer.

Principles

The following discharge criteria are in accordance with the guidelines from The British Association of Day Surgery Handbook.
The ECT department recommends that all patients remain at least 1-2 hours in the department following treatment.

Guidelines

The patient will be assessed as to their fitness for discharge from the dept. by one of the ECT lead nurses, using the following criteria:

- Vital signs stable for at least one hour.
- Physical observation checks are consistent with score pre treatment
- Orientation as to 'Time Place and Person' has returned as per pre-treatment.
- Minimal nausea, vomiting, dizziness or headache.
- Has at least taken oral fluids.
- Has a responsible adult to take them home.
- Has agreed to have a carer at home for the next 24 hours.
- Aware of when to attend for further treatment or outpatient review.
- Emergency contact number supplied.

Review/Re-prescribing
All patients **must** be seen by their psychiatric doctor after every two treatments, and will be assessed for evidence of any side effects of ECT as well as an assessment of their cognition and mood. This will usually take place in the outpatient clinic. If the patient is to continue treatment, the ECT prescription will need to be renewed. The patient's professional escort will usually bring their notes and prescription card to the clinic.

14. OUTPATIENT DISCHARGE AWARENESS RE PRECAUTIONS FOR OUTPATIENT

The patient and carer will both need to be aware each time they attend for a treatment that they understand the following information.

During ECT the patient will receive a general anaesthetic and therefore the following standard precautions apply:

The patient and carer acknowledge that the patient will:
- Be in the company of a responsible adult for 24 hours following the treatment.
- Be accompanied home
- Not leave the department if they are feeling unsteady or confused.
- Not operate machinery or appliances for 24 hours.
- Not to drive any motor vehicle. They may wish to take DVLA advice on driving following an episode of mental illness.
- Not be left in sole charge of young children until the following morning.
- Not sign any legal document or make important decisions for 24 hours.
- Not consume alcohol for 24 hours.

Contact details in case of any query:
The ECT department (up to 15.30) Tel 01482 617553

15. ECT OUT OF NORMAL TIMES/EMERGENCY ECT

Objective
To provide ECT out of the usual times when ECT is given, namely a Tuesday and Friday morning. This service can be accessed through the following procedure.

Principles
On occasion it is deemed desirable/necessary to commence a course of treatment for a patient outside of the usual treatment days. This is sometimes necessary when the patient's illness/symptoms are so severe that a delay in starting treatment would be detrimental.

Guidelines
- The referring doctor should contact the Lead Nurse for ECT by telephoning Miranda House switchboard on (01482) 216624. The switchboard will have direct telephone numbers for the ECT staff .The Lead Nurse for ECT will then give an indication of appropriate times ECT can be given.
- The doctor requesting ECT or the lead ECT nurse will then contact the anaesthetic department at HRI and arrange emergency cover by an anaesthetist and ODP. They will liaise with the Lead Nurse for ECT to agree the time for the Anaesthetist, ODP and the doctor administering the ECT to attend. The referring doctor is responsible for giving the ECT treatment or arranging a suitable doctor to do this.

Please note that all the other policies for ECT should be adhered to.

The minimum staffing requirements are slightly changed however in that only one nurse with ECT training needs to be present, due to the fact that only one patient will be receiving ECT. That Nurse will be responsible for participating in the administration of ECT and also in the recovery.

If the Lead Nurse is subsequently informed that not everyone who needs to be present for the ECT treatment session is able to attend then the Lead Nurse will obviously need to contact the referring doctor again.

16. MAINTENANCE ECT

Objective
To administer Maintenance ECT (MECT) in accordance with NICE Guidance[1] and guidance given by the Royal College of Psychiatrists in its ECT Handbook available at: www.rcpsych.ac.uk.

Principles
MECT should be considered for patients who have a 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.

Guidelines

- Locally it has been agreed that if MECT is to be considered then the RC should seek a second opinion from a colleague, and record in the patient's notes the reason for proposing MECT as opposed to alternative treatments.
- Both the patient and RC must complete a Consent/contract every 12 treatments.
- The decision should be fully discussed with the patient, their family/carers and the ECT consultant.
- The risks and benefits of MECT should be recorded in the patient's notes.
- A statement of capacity should be recorded prior to commencement.
- Consent should be renewed after 12 treatments. A further statement of capacity and second opinion should also be sought at this time and recorded.
- All patients receiving MECT must have a full physical examination, including FBC and BCP following a course of 12 treatments.
- Clinical progress, cognitive functioning and side-effects should all be assessed using HDRS and Addenbrooke's ACE3 between each treatment.
- All patients receiving MECT, must be regularly offered psychological interventions or other alternative therapies

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.

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.

[1] Maintenance ECT (MECT): NICE 2003 recommend that ECT should not be used as a long-term treatment to prevent recurrence of depressive illness and that it should not be used in the general management of schizophrenia. However, MECT may be permissible in some circumstances.

17. CONTINUATION ECT (CECT)

Objective
To administer ECT beyond 12 treatments in accordance with NICE Guidance[2] and guidance given by the Royal College of Psychiatrists in its ECT Handbook available at: www.rcpsych.ac.uk.

Principles
On occasion, e.g. when the response has been evident but slow, it is necessary to continue ECT beyond the recommended 12 treatments.

Guidelines
- Locally it has been agreed that if CECT is to be considered then the RC should seek a second opinion from a colleague, and record in the patient's notes the reason for proposing CECT as opposed to alternative treatments.
- All patients receiving CECT must be re-consented after 12 treatments.
- All patients receiving CECT must have a full physical examination, including FBC and BCP following 12 treatments.
- Clinical progress, cognitive functioning and side-effects should all be assessed at regular intervals.
- All patients receiving CECT, must be offered psychological interventions or other alternative therapies

18. ECT AND VULNERABLE ADULTS

Objective
This standard operating procedure demonstrates the department's recognition of its responsibility to prevent the abuse of vulnerable adults and offers some support and direction to staff and managers who come into contact with vulnerable adults.

Principles
The term vulnerable adult refers to anyone over the age of 18 who is, or may be in need of community care services by reason of mental or other disability, age or illness an is, or may be unable to take care of him or herself or is unable to protect him or herself against significant harm or exploitation. The definitions include people who:

- Have a severe physical illness
- Have learning disabilities
- Suffer from a mental illness including dementia
- Are elderly
- Are physically or mentally frail

Guidelines
Action to be taken if someone Reports/Discloses Abuse of a Vulnerable Adult:
- Ensure the persons immediate safety and medical welfare
- Listen, be attentive and sympathetic but do not discourage or press for more detail. Clarify and summarise, remain sensitive – don't make promises that you cannot keep
- Explain that a manager must be informed (unless they are the alleged abuser)
- Make a complete, factual and accurate record of what you have been told, record the date, time and then sign the record. This should be recorded in the person's medical record.

[2] Continuation/Repeat of ECT treatment following a completed course: NICE 2003 recommended that a repeat course of ECT should be considered only for patients who have severe depressive illness, catatonia or mania and who have previously responded well to ECT. In patients experiencing an acute episode but who have not previously responded, a repeat trial of ECT should be undertaken only after all other options have been considered and following discussion of the risks and benefits with the patient and/or where appropriate their carer/advocate.

- The record should immediately be brought to the attention of the appropriate manager (unless they are the alleged abuser – if this is the case then support should be sought directly from the trust Safeguarding Adults Lead). The manager receiving the report will report the alleged abuse to the alleged victims local police or local social services care management team (within 24 hours) or emergency duty team. The manager will also send 'alerter form' to care management and discuss with them the intention to implement the agencies disciplinary process if appropriate.

For the full policy on the safeguarding of vulnerable adults please see the Humber Teaching Foundation Trust's website, Policy and Procedures section.

19. ECT IN THOSE UNDER 18 YEARS OLD

In the case of an under 18 year old patient, the following applies whether the patient is detained under the act or not:

Patient consents	SOAD/Form T5
Patient not competent to consent	Needs to be detained/SOAD/Form T6
Patient refuses	No authority to give treatment – unless sec62 applied.

If ECT treatment is to be given to a patient under 18 years old, then the Lead Consultant for ECT should be involved at the earliest opportunity.

Objective
Although ECT for patients under 18 is extremely rare, there have been occasions when ECT has been given to such patients in this country. The essential indications are the same as for adults.

Principles
There is a general consensus that ECT is an effective treatment for some mental disorders in adolescents and that the indications, response and unwanted side effects are similar to those observed in adults (Rey & Walter, 1997; Walter & Rey, 1997).

Guidelines
- ECT should be used with caution in young people because of the lack of evidence from RCTs.
- First-line use in young people should be very rare.
- Because of reports of increased length of seizures and post-ECT convulsions, clinicians are advised to stop all non-essential medications used by the patient at the time of the course of ECT (Rey & Walter, 1997).
- The first stimulus should be given with the minimum dosage, which should be 5%. The principles in the Stimulus dosing protocol should then be followed. Stimulus dosing should take into account the lower seizure threshold in young people (Cohen et al, 1997; Kellner et al, 1998).

20. ECT AND THE ELDERLY PATIENT

Objective
ECT is a highly effective treatment for depressive illness in the elderly.

Principles
In spite of a higher burden of physical illness, elderly patients with depression are as able as younger, physically healthier patients to complete and benefit from a course of ECT.

Older people tend to have higher seizure thresholds although age alone predicts only a small proportion of the total variance in seizure threshold.

Older patients may be more susceptible to confusion after ECT.

ECT can be given to patients with dementia and depression without ill effect but they may be at increased risk of post-ECT delirium

Guidelines
- Special attention should be given to underlying physical illnesses because of the associated greater risks from anaesthesia.
- Regular assessment of cognitive function at least 24 hours after the administration of ECT is recommended.
- ECT technique may need to be modified, to minimise cognitive adverse effects

21. ECT FOR PATIENTS WHOSE INDICATIONS FOR TREATMENT ARE NOT INCLUDED IN THE NICE GUIDELINES

Objective
On occasion, it may be deemed necessary or appropriate, to treat patients with ECT to alleviate symptoms other than those stated in the NICE Guidelines. It may also be considered at the request of the patient.

Principles
To maintain concordance with Nice Guidelines whilst meeting a clinical need.

Guidelines
- Should ECT outside NICE Guidance be considered for a patient, then the referring RC should consult with the Lead Psychiatrist for ECT, to discuss the rationale for this decision. Therefore gaining a second opinion as indicated by 'Best Practice'. Both should document in the patient's notes the outcome of this discussion.
- The ECT staff should be notified.
- Best Interest meeting should be considered where appropriate.

22. ECT FOR PREGNANT PATIENTS

Objective
For patients with severe psychiatric disorders in the pregnancy period, either medication resistant illness, extremely high suicide risk, psychotic agitation, severe physical decline due to malnutrition or dehydration, electroconvulsive therapy (ECT) still appears as a strong option. ECT is considered to be a relatively safe during pregnancy (American Psychiatric Association 2001).

Guidelines
- In the second trimester, consideration must be given to the risks of aortocaval compression and oesophageal reflux that may require lateral tils while supine and pre-treatment antisecretory drugs, sodium citrate and endotracheal intubation (Miller, 1994).
- Treatment should be planned in consultation with the patient's obstetrician and consideration of methods of fetal monitoring and whether the presence of a midwife would be appropriate.
- Anderson and Reti (2009) have reviewed the use of ECT in pregnancy in 339 published cases. There was a partial response of depressive symptoms in 84% of cases (compared with 61% pregnant women treated for Schizophrenia). The most common adverse effect on the foetus was bradycardia and in 3.5% of cases, uterine contractions and/or premature labour were reported. Positioning the patient with the right hip elevated to minimise aortocaval

compressions should improve placental perfusion and reduce the risk of foetal hypoxia (The ECT Handbook, 3rd Ed, 2013)

23. INFORMATION FOR ECT CLINIC STAFF

ECT staff training, responsibilities and procedures

Objective
That ECT treatment is carried out in accordance with current standards

Principles
Standards regarding ECT staff training, clinic facilities, clinic environment, documentation and procedures have been determined by the following bodies:

- ECTAS
- RCPsych
- Royal College of Anaesthetists
- NICE
- RCN

Guidelines

Medical staff training
Junior doctors specialising in psychiatry may administer ECT only after completing the training package and receiving a certificate of competence signed by the lead consultant for ECT. The training comprises the following elements:

1. Attendance at a lecture and a 'direct observations procedure tutorial' on ECT.
2. To read the current policy and SOP for ECT.
3. To attend a minimum of two practical sessions where the junior doctor will both observe ECT being given and then give ECT under supervision. The practical sessions will take place under the supervision of the lead consultant for ECT until level of competence specified by the RCPsych is achieved.

A list of doctors permitted to give ECT will be available at the ECT suite at Miranda House. This will be updated as needed. A copy of the certificate will be available at Miranda House.

Continuing supervision/training
The Lead Consultant or deputy consultant will attend every week, to provide on-going training for the doctors who have undertaken the initial training as outlined above. Updates for all medical staff will be given annually by the ECT team.

There will always be an ECT consultant available for advice, e.g. in person or by telephone.

Nursing staff training
ECT nurses must hold a nursing qualification entered on either part 1or 3 of the NMC register, and must have attended the ECT nurse course facilitated by the RCPsych and achieved competent status. Training includes all mandatory training.

Competency in ECT is maintained via attendance at national conferences and forums.

Support nurses who work within the ECT department will be given specialist training in ECT to include basic resuscitation skills.

Student nurses are welcome onto the ECT unit, after undergoing a brief induction by the ECT nurse. An appointment for this induction can be made by contacting the department and arranging

a mutually suitable time. This induction usually takes about one hour and will take place in the department. Following this induction, the student will be able to observe an ECT session at a later date.

Under **no circumstances** should students **act as escort nurses** for patients receiving ECT.

Staffing requirements for each treatment session
The minimum staffing requirements, which will allow ECT treatment to proceed, are as follows:
1 Anaesthetist
1 ODP
1 Psychiatrist trained in the administration of ECT
2 Registered nursing staff who have attended the ECT nurse course facilitated by the RCPsych and achieved competent status.
1 ECT support nurse with additional training in ECT
1 Escort nurse for each patient
On no occasion will a patient be left unchaperoned. 2 staff (gender to be considered) will be in attendance at each stage of the treatment.

N.B. Observers
There are often nursing students and medical students who wish to see ECT treatment. Any arrangements made need to ensure that there is only one student in the room where the ECT treatment is given. For training purposes it would seem sensible that half the time is spent in the ECT treatment room and half the time can be spent in the ECT recovery room. This will make it possible that up to two students can attend, one in the treatment room, one in the recovery room, who can then swap halfway through. For the purposes of nursing or medical student training, there is little if any benefit to seeing any more than two ECT treatments being given. The time spent in the recovery room can be used to observe issues relating to recovery, but can also be spent in informal discussion with one of the trained ECT psychiatric nurses. Students are present only to observe and will not participate in any way with the ECT treatment.

Although relatives are permitted to be with a patient receiving ECT up to the point of them receiving their general anaesthetic, they are generally not permitted to watch the ECT treatment being given. If anyone who is not a health professional, or who is not training to be health professional wishes to see the ECT treatment, then this matter should be first referred to both the Lead Manager for ECT and also to the Lead Consultant responsible for ECT. If volunteers are working in the ECT Suite they cannot be involved in direct clinical care of patients and should not be present in the rooms where the ECT treatment is given or in the room where recovery takes place.

Arrival of patient at the ECT clinic
The patient and their escort will be met by ECT nursing staff and shown to the waiting area. An ECT nurse will check all documentation and carry out a capacity assessment. A CGI and patient's subjective and objective review assessment will also be carried out at this time, if this has not been completed by the patient's medical team.

The patient will then wait with their escort in the ECT waiting room.

Procedures in Preparation Room
The patient should be encouraged to pass urine before treatment to avoid incontinence during the procedure and to minimise the likelihood of bladder distension and damage during treatment.

Shortly before the patient is to receive their ECT treatment, the patient and their escort will be taken into the preparation room where the patient will have the opportunity to discuss any concerns they may have with both nursing and medical staff. The following will be carried and recorded out by the attending ECT nurse:

- Affirmation of consent
- BP
- Pulse
- Temperature
- Oxygen saturation
- Allergy status
- ID band placed on patient's wrist (to include patient's name, forename, date of birth and NHS number). If the patient has any allergies a red ID wristband will be used)
- Confirmation of fasting status
- Removal of dentures, glasses, jewellery and shoes (all are labelled and handed to the escort nurse for safe keeping)
- ECG monitoring stickers applied
- BP cuff applied
- Orientation assessment
- Signing of day patient agreement

The patient's notes and ECT pack will be handed to the treatment room nurse for further checks and for the pre-treatment nursing checks to be signed prior to the patient being moved into the treatment room.

Procedures in Treatment room
When the patient is taken into the treatment room, the following will be carried out:

- The patient introduced to each member of the team and given a brief explanation of the member's role in the ECT procedure.
- A BP (Hamilton) cuff is applied to the left leg (just above the knee)
- The ECT nurse will attach EEG and EMG monitoring equipment.
- The ODP will connect ECG, BP and pulse oximetry monitoring
- The anaesthetist will gain IV access assisted by the ODP
- The anaesthetist or ODP will pre-oxygenate the patient prior to, and following the administration of the anaesthetic
- The anaesthetist will administer the anaesthetic agents and then flush after each with saline solution. (Patient safety alert NHS/PSA/D/2017/006)
- The ECT nurse will inflate the Hamilton cuff prior to the administration of the muscle relaxant
- The ODP will insert a bite block once anaesthesia is established and fasciculation has occurred
- The ECT nurse will apply either saline gel or ordinary saline to the patient's temples
- The ECT nurse will set the EEG baseline on the Thymatron machine
- The ECT doctor will check the patient's ECT record and the previous treatment settings. Treatment settings for this treatment determined and set into the Thymatron
- The ECT doctor will apply saline gel to the Thymatron paddles and will administer ECT
- The motor seizure activity is observed by the ECT doctor and the EEG trace discontinued when a five-second break in the ictal line is established
- The ECT nurse will deflate the Hamilton cuff and remove EEG and EMG monitoring
- Both the anaesthetist and the ECT doctor must complete the relevant sections of the ECT treatment record
- The ECT nurse or the ODP will print the record from the capnograph and place in the ECT record with the EEG trace

The anaesthetist and ODP will continue to monitor vital signs while patient recovers and regains control of their airway.

Procedures in the Recovery Room
Once the patient has regained control of his airway and is breathing unaided then the anaesthetist will give the go ahead for the patient to be moved in to the recovery room.

Here the recovery nurse will:

- Attach blood pressure monitoring and record readings at least every minute for five minutes, if the BP remains within limits for the patient, the interval can be reduced to every five minutes. Any concerns must be reported to the anaesthetist.
- Attach pulse oximetry equipment and record readings.
- Apply oxygen mask as necessary and administer oxygen at 4 litres per minute until satisfactory oxygen levels are achieved, i.e. 95-100%.
- Remove airway adjuncts when appropriate. NB Aspirate as necessary.
- Apply ECG monitoring if necessary.
- Take and record the patient's temperature.
- Ensure the IV venflon is in situ and adequately secured.
- Continue to monitor intravenous infusion if in situ.
- Enter time of entry into recovery and all other details in ECT log.
- Observe and act on any sign of post anaesthetic complications as below:
    - Vomiting/nausea
    - Breathing difficulties
    - Headache
    - Post Ictal seizures
    - Incontinence
- Complete and record all other post ECT physical observations.
- When the patient is fully aware, check and record the patient's orientation.
- When the patient is stable, i.e. observations have returned to pre-treatment levels and just before they are ready to return to the waiting/coffee lounge, remove the Venflon/cannula and all other monitoring and ensure record of site area is made in the notes.
- Ensures that the patient is given assistance in walking to the coffee lounge.
- Should BP be 200/100 or over during recovery room observations, the Anaesthetist or treating Psychiatrist should be informed immediately

Recovery Room 2

When the patient is seated in the lounge area they will be offered a drink and something to eat. It is important to note that hot drinks must be allowed to cool, and given under supervision, which will normally be by the patient's escort.

Prior to leaving the department discharge observations will be completed. A record is also made of any pain/nausea experienced, orientation and whether food and fluids have been taken.

It is a requirement that the patient does not leave the department until discharge is approved by the lead nurse.

All documentation and personal belongings need to be taken on discharge.

24. MEDICAL ADMINISTRATION OF ECT

Bilateral or Unilateral and Frequency

All the advice here is taken directly from the Royal College of Psychiatrists ECT Handbook, third edition 2013. It is recommended that ECT is administered by a constant current, brief-pulse ECT machine with a wide output range and a facility for electroencephalography.

The optimal frequency is said to be twice a week. Studies have shown no advantage with treatment given three times a week. There is no evidence that daily ECT leads to a more rapid response and memory impairment is severe.

Bilateral ECT (BECT) is thought overall to be better.

Unilateral ECT (UECT) should be considered when:

- Speed of response is less important.
- There has been a previous good response to UECT.
- Minimising memory impairment is particularly important e.g.: outpatient ECT.

Bilateral ECT should be used when:

- Speed and remission of symptoms have a priority.
- Unilateral ECT has failed.
- Previous Bilateral ECT has produced a good response without undue short-term memory impairment.

Giving of the electrical stimulus

Before patients are given ECT they are given a general anaesthetic and muscle relaxant. This is clearly the responsibility of the anaesthetist. The attending ECT nurse is required to attach ECG monitoring equipment and pulse oximeter and BP cuff as well as EEG monitoring, setting the baseline. Once the patient has been fully anaesthetised and the muscle relaxant has taken effect, the anaesthetist will indicate that treatment can be given. The Anaesthetist or ODP may then hold the head in position – this will be more necessary for unilateral ECT treatment. The treating doctor will then apply the electrodes; the attending nurse will then check the impedance. The treating doctor will then say “READY”. The ECT Nurse will confirm this by saying “OK” and confirm the dose to be administered. The treating doctor will then say “YES” at which point the ECT Nurse will press the button on the ECT machine, which will cause the electrical stimulus to be given.

Electrode Positioning

For bilateral ECT the position of electrodes is shown in diagram (a). Draw an imaginary line from the external auditory meatus to the lateral angle at the eye. Measuring 4cm above the midpoint of this line will give you the electrode positioning point.

For unilateral ECT one of the electrodes is positioned as per bilateral and another in an arc 18cm behind the first electrode as shown in diagram (b).

Please note that electrode placements are often inaccurate. Placements tend to drift too far anterior or posterior. A too low placement is also a common mistake which would not give a passage of current across the brain. A conscious effort must be made on each occasion to ensure accurate electrode placement.

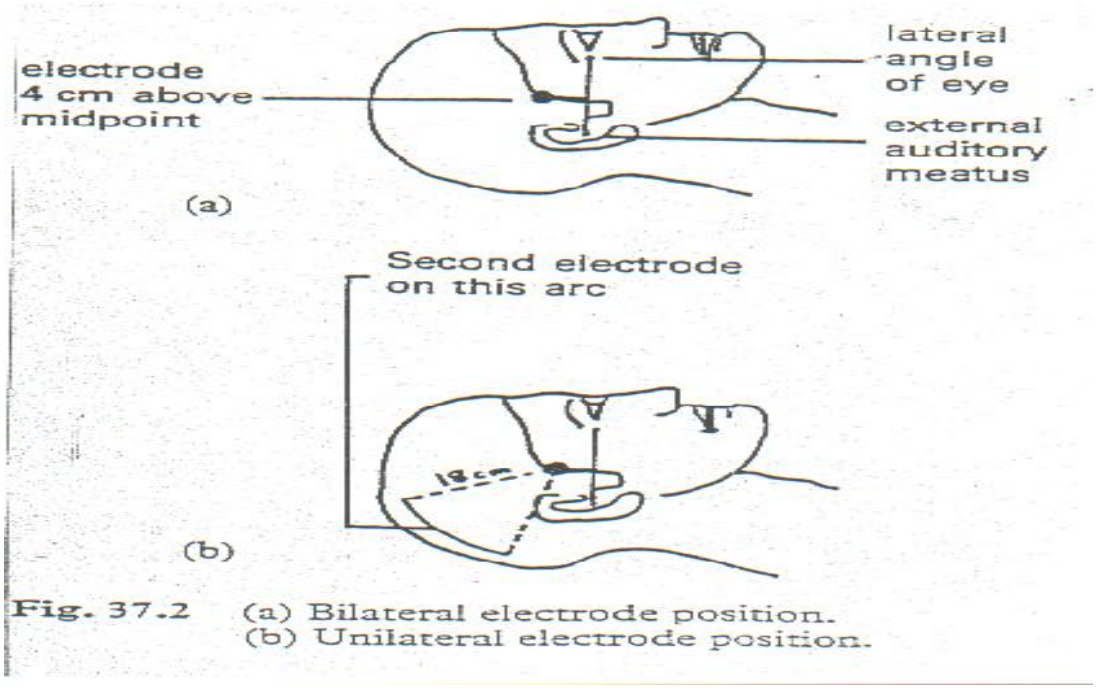


Fig. 37.2 (a) Bilateral electrode position.
(b) Unilateral electrode position.

Prolonged Seizures
This is classed as a seizure lasting more than two minutes. The seizure should be terminated by either intravenous benzodiazepine or more anaesthetic agent. The anaesthetist will administer these drugs if so required.

Seizure Monitoring
Seizures should be monitored by external observation from the treating doctor. Evidence of bilateral clonus should be elicited and the Anaesthetist normally assists in letting the treating doctor know of any clonus that is occurring on any parts of the body. In terms of monitoring seizure lengths, the start time is the time when the electrical stimulus comes to an end. The end time is when all visible bodily movements, secondary to seizure activity is finished.

EEG activity is recorded simultaneously. The paper tracing of this should not be stopped before there is a clear five-second break in the 'Ictal Line' to ensure an 'endpoint' is achieved.

Stimulus Dosing Protocol

General Aims
- An operational definition of the seizure threshold is 'the minimum amount of electrical charge (as a %) that will induce a classical generalised tonic-clonic convulsion at the first or second treatment in a course of ECT.
- The aim is for the dose of electrical charge in subsequent treatments to be clearly supra-threshold.
- The only exception to these general aims is where treatment is started to save life. It is recommended that, in these cases, the seizure threshold be estimated and treat with a supra-threshold dose for maximum effect. If possible discuss with Lead ECT Consultant.

Titration of seizure threshold
See dosing titrations bi- and uni-lateral

Patients not taking anti-epileptic drugs
See dosing titrations bi- and uni-lateral

Patients taking anti-epileptic drugs
See dosing titrations bi- and uni-lateral

Calculation of the seizure threshold
Ideally, the dose that did not induce the necessary convulsion will be only 5% less than the dose that did. Although the actual seizure threshold will lie between these two values, it is sufficient to take the upper value as the seizure threshold (see note 1 below).

Dosing strategy
Once the seizure threshold has been established at the first or second treatment, then the dose must be increased at the next treatment session to exceed the threshold as follows:
- For bilateral ECT, the dose should exceed the seizure threshold by 1.5 times the seizure threshold.
- For unilateral ECT, the dose should be 4 times the seizure threshold.
- The only exception to these general rules is the patient who displayed the necessary convulsion with only 10%, and is to be treated by unilateral ECT. It will be sufficient to increase the dose by only three times.

Adjusting the dose throughout a course of treatment.
This may be indicated for the following reasons:
- Repeated ECT can lead to a rise in the seizure threshold, and a dose that initially induced the necessary seizure may fail to do so later in the course. A higher dose will therefore be required. It is sometimes said that a progressive shortening in convulsion length means that

the seizure threshold is rising; this is not invariable. In such circumstances it is vital that the ECT team finds out from the referring team how well the patient is progressing; if improvement is absent or slight, then it may be entirely reasonable to increase the dose.

- The initial dosing strategy brings about only slight or no clinical improvement. Doses of up to 2.5 times the seizure threshold may be indicated in bilateral ECT and doses up to 6 times seizure threshold in unilateral ECT.
- Significant treatment emergent cognitive side-effects may be an indication to reduce the electrical dose. Please discuss with ECT Lead Psychiatrist (see note 2 below).

Failure to induce a convulsion
During a course of treatment, stimulation may fail to induce a convulsion if there has been a marked rise in the seizure threshold (see above) or because of a change in a variable that independently alters the seizure threshold (e.g. use of anti-epileptics or change in anaesthetic technique). It is essential to repeat stimulation with a higher dose. If it is desirable to establish the new, higher, seizure threshold, then a small increase in dose is appropriate i.e. 5 or 10 % (Thymatron doses).

But if the patient is severely ill, it is not desirable to treat with a dose close to threshold; it is better to estimate that the new seizure threshold is 5 or 10% higher (Thymatron doses) dose that did not lead to a convulsion, and then use this estimate to calculate the dose for restimulation as per the dosing strategy above.

Note 1
Before deciding how to dose the patient, you must ask yourself what you believe the patient's seizure threshold to be on that day and before you stimulate the patient. It may be helpful to record the seizure threshold on the treatment record (e.g. ST =20%).

Note 2
Both inadequate clinical improvement and treatment-emergent cognitive side effects may affect the choice of electrode placement. Patients who do not recover from depressive illness with high dose unilateral ECT may subsequently recover with moderate-dose bilateral ECT. Prolonged disorientation is much less of a risk in unilateral ECT.

EEG Monitoring

Objectives
All patients receiving ECT will have concurrent EEG monitoring during the treatment session.

Principles
Compliance with ECTAS standards.

Guidelines

- The patient's skin on temples, forehead and behind the ears to be thoroughly cleaned with chloroprep prior to treatment.
- EEG stickers to be adhered to the following areas: one above each eye, one on each mastoid process and one on the patient's chest/shoulder immediately before treatment
- Channel 1(one) leads to be attached to the stickers on the patient's right side (red above the eye, black on the mastoid process)
- Channel 2 (two) leads to be attached to the stickers on the patient's left side (red above the eye, black on the mastoid process)
- The earth lead (green) to be attached to the chest/shoulder sticker.
- EEG activity is then recorded during the seizure. The paper tracing of this should not be stopped before there is a clear five-second break in the 'Ictal Line' to ensure an 'endpoint' is achieved.

25. EQUIPMENT IN THE ECT DEPARTMENT AT MIRANDA HOUSE

The following equipment is used to enable ECT to be given safely. It must be regularly serviced and maintained by a recognised authority, namely the Clinical engineering department of Hull Royal Infirmary. The following is a list of equipment after each piece of equipment the minimum frequency between services is indicated as well as who is responsible for servicing and their contact phone number.

Ante Room
Datascope Monitor (serial no. CM22106-C4)
Minimum service interval – six months
Responsible authority for servicing – Med Physics. Tel (01482) 608965

Nesco chair scales (serial no. 8945520)
Minimum service interval – six months
Responsible authority for servicing – Nesco 346865 Contract no HU4/018

Covidien Genius 2 tympanic thermometer and base (Serial no. N12570052)
Minimum service interval – yearly
Responsible authority for servicing – Med Physics.Tel 608965

Dell Monitor (Serial no. C/N-082K5X-72872-591-A5VB-A02)
Minimum service interval – yearly

Treatment Room
Datex-Ohmeda Aespire View (Serial no. APHV00703)
Minimum service interval – six months
Responsible authority for servicing – Med Physics. Tel 608965

GE Healthcare Carescape Monitor B650 (Serial no. SK415361140HA)
Minimum service – six-monthly
Responsible authority for servicing – Med Physics. Tel 608965

OKI Printer (Serial no. AK 57058181)
Minimum service – six-monthly
Responsible authority for servicing – Med Physics. Tel 608965

Dell Laptop (A/N. 2743445)
Minimum service – six monthly
Responsible authority for servicing – Dantec

Eschman Suction machine (Serial no. V2AC-3B-1745)
Minimum service interval – six months
Responsible authority for servicing Med Physics. Tel 608965

Thymatron System IV ECT machines x 2 (Serial nos. 43313 and 43314)
Minimum service interval – yearly
Responsible authority for servicing – Dantec/Thymatron

Fridge (Meds) Airco
Minimum service interval – six months
Responsible authority for servicing Med Physics. Tel 608965

Lifepak defibrillator (Asset code HFT 0114640)
Minimum service interval – yearly
Responsible authority for servicing – Med Physics. Tel 608965

Recovery Room 1

Datascope monitors x 2 (serial nos. CM22095-C4, CM22118-C4)
Minimum service interval – six months
Responsible authority for servicing – Med Physics. Tel 608965

Cavendish 460M anaesthetic machine (Serial no. 671799)
Minimum service interval – six months
Responsible authority for servicing MIE Tel no 01392 431831

Eschman Suction machine (Serial no. V2AD-6I-1337)
Minimum service interval – six months
Responsible authority for servicing MPD tel. 461346

Kings fund patient trolleys x 6 (serial no. 464398-403)
Serviced annually
In case of problems – estates maintenance – 886644

Covidien Genius 2 tympanic thermometer and base (Serial no. N12569781)
Minimum service interval – yearly
Responsible authority for servicing – Med Physics. Tel 608965

Mortara Dolby Eli 250c – 12 lead interpretive ECG machine (s/n 115110248210)
Minimum service interval – yearly
Responsible authority for servicing – Med Physics. Tel. 608965

Oxygen:
9 x size HX
3 x size E
1 x size CD

Medical Air:
2 x size E

Recovery Room 2
Greenlight manual Sphygmomanometer

26. DRUG REQUIREMENTS

Drugs used on the ECT Unit are requested by the Consultant Anaesthetist and monitored by the operating department assistants. The Nurse in charge of the ECT Suite is responsible for ordering and safe and appropriate storage of the drugs.

The drugs used in the ECT Suite at Miranda House (MH) are obtained from Lloyds Pharmacy. The medicine box is collected from Miranda House every week day morning and returned in the afternoon with any ordered stock.

Nursing staff must not be involved in the preparation of anaesthetic drugs.

Intravenous anaesthetics	Thiopentone
	Propofol
	Midazolam
Muscle relaxants	Suxamethonium
Anti-cholinergic	Atropine

	Glycopyrrolate
	Ondansetron
Vasoconstrictors	Ephedrine pre-filled Syr 3mg/mL 10ml
Bronchodilators	Aminophylline
	Salbutamol (IV and Nebuliser)
Intravenous Hydrocortisone	Solucortef
Beta Blockers	Metoprolol
	Labetalol
Anti-hypertensive	Nifedipine sublingual
Anti-anginal	GTN Spray
Inatrope	Adrenaline (1:1000)
Local Anaesthetic	Lidocaine
Sedatives/Anti-epileptic	IV Midazolam
Analgesia	Paracetamol
Intravenous Infusions	Hartmanns
	Na Cl 0.9%
	Glucose
IV Fluids in emergency trolley	Na. Cl.
	Volplex
	Glucose
Malignant Hypothermia	Dantrolene
12 x bottles of Dantrolene are kept in the medicine cupboard at all times, with bottles of sterile water for its reconstitution. Instructions on how obtain further supplies are attached to the front of the same cupboard, i.e. via operating theatres at Hull Royal Infirmary.	

27. TRAINING SESSIONS AND COMPETENCIES FOR QUALIFIED NURSES

Name…….

Competency Obs/Instr.

Date How evidenced Achieved (Date)

Signature

Knowledge of Royal College, NICE and ECTAS Guidelines.		Verbally		
Knowledge of local guidelines and policy, with special ref. to: a. Escort nurses b. Referral process c. Prescription d. Review process		Verbally		
Demonstrate a knowledge of the Consent to treatment requirements, including MCA and MHA documentation/ requirements (p20 NICE)		Verbally		
Knowledge of the indications for ECT (NICE)		Verbally		
Able to describe the contra-indications for ECT.		Verbally		

Able to describe the possible side effects, risks and benefits of ECT.		Verbally		
Able to describe the pre-treatment preparations required to be undertaken by referring doctor.		Verbally		
Able to describe the pre-treatment preparations required to be undertaken in the ECT department.		Verbally		
Able to describe the procedure for the administration of ECT.		Verbally		
Able to describe the observations and procedures necessary in the recovery room.		Verbally		
Able to demonstrate knowledge of the drugs used in the ECT department and ordering/storing of these.		Verbally		
Able to describe the procedure for the referral of an outpatient for ECT.		Verbally		
Able to describe the theories as to how ECT works, with ref. to the NICE Guidelines.		Verbally		
Able to describe the procedure for performing emergency (out of hours) ECT		Verbally		
Demonstrate a basic knowledge of anaesthetic techniques		Verbally		
Able to describe procedures for the management of emergencies, e.g. Suxamethonium apnoea, malignant hyperthermia.				
Demonstrate a knowledge of NICE Guidance on: a. Continuance ECT b. When ECT should be discontinued c. Unilateral or bilateral treatment		Verbally		
Correctly and sensitively informs the patient and their carers of the procedures involved in ECT		Observed		
Able to set up and organise the department in preparation for a treatment session. Including emergency trolley checks		Observed		
Able to demonstrate use and maintenance of equipment in the department, especially: a. Vital signs monitors in all three areas b. All oxygen flow meters (changing of empty cylinders and re-ordering system) c. Thymatron and Ectron machines		Observed		
Able to correctly and efficiently prepare the patient for their treatment: a. Checks all documentation		Observed		

b. Correctly records observations and checks i.e. blood pressure, pulse and temperature c. Correctly applies monitoring equipment d. Gives reassurance at all times				

Practical Aspects

Able to assist competently in the treatment room: a. Reassures the patient. b. Correctly applies monitoring equipment. c. Correctly applies EEG monitoring equipment. d. Assists the doctor in administering ECT. e. Aids in putting the patient in the recovery position when appropriate.		Observed		
Able to demonstrate competency in airway management, the use of suction and the care of intravenous infusions		Observed		
Able to demonstrate competency in caring for the patient whilst in the recovery area, i.e.: a. Monitor and record accurately BP, pulse and O2 levels until patient is conscious b. Removal of intravenous cannula when the patient is fully conscious and before they leave the recovery area c. Accurate recording of treatment in the ECT log. d. Complete cognitive assessment.		Observed		
Demonstrates a knowledge of, and acts in accordance with, the local discharge criteria		Observed and verbally		

Other areas

Awareness of advance directives				
Working with carers				
Evidence and audit				
Undertakes appropriate continuing professional development				
Has regular clinical practice				
Completes and keeps updated all mandatory training				

N.B. Obs. = Observed Instr. = Instructed

Appendix 1: Advance statement

Advance Statement/Decision Guidelines G372

This is the Advance Statement/Decision of:
Name: _____

Date of Birth: _____ **(essential to be able to confirm identity on electronic record)**

Address: _____

If at any time in the future I experience a mental health crisis, I would want the following instructions to be followed (Advance Decision) and guide my care and treatment with the Advance Statements below

Signed: _____

Date: _____

Witnessed by:

Signature: _____

I have provided a copy of this document to the following people:

GP: _____

Partner/spouse/supporter: _____

Family members: _____

My care co-ordinator: _____

Humber Teaching NHS Foundation Trust Mental Health Legislation Dept. _____

Appendix 2: Measures that can be used as a basis for audit as per NICE Guidance

The measures that can be used in an audit on ECT are as follows:

Criterion	Standard	Exception	Definition of terms
1. The individual receiving ECT has one of the following: a. severe depressive illness b. catatonia c. a prolonged or severe manic episode	100% of individuals receiving ECT	None	Local clinicians will have to agree on how and where the indications for ECT are documented for audit purposes.
2. ECT is used to achieve rapid and short-term improvement of severe symptoms when an adequate trial of other treatment options has proven ineffective, and/or the individual has a potentially life-threatening condition	100% of individuals receiving ECT	None	Local clinicians will have to agree on how severe symptoms and response to other treatment options and potentially life-threatening conditions are documented for audit purposes.
3. An assessment of the risks and potential benefits of ECT for the individual is documented	100% of individuals receiving ECT	None	The documented assessment before treatment should note: risks associated with the anaesthetic; current comorbidities; anticipated adverse events, including cognitive impairment; and the risks of no treatment.
4. The individual provides consent for each course of ECT treatment	100% of individuals receiving ECT	a. The individual does not have the ability to grant or refuse consent, in which case advance directives are fully taken into account and the individual's advocate and/or carer are consulted. b. The individual is detained under the Mental Health Act	Local clinicians should agree on how consent to ECT is documented for audit purposes. A course of ECT is usually 6 to 12 sessions, usually given at the rate of two a week. The individual who has had/is having ECT should be asked for his/her views as to whether or not this criterion is being met.
5. The consent process provides that the clinician(s) responsible for treatment carries out all of the following:	100% of individuals receiving ECT	a. The individual is detained under the Mental Health Act b. The individual does not have the	Local clinicians should agree on how the format and language used to communicate the information

a. involves the individual's advocate and/or carer where possible b. provides full and appropriate information in a suitable format and language to enable an informed discussion c. explains and discusses the general risks of ECT, risks specific to the individual, enhanced risks for individuals in specific groups and potential benefits to the individual d. does not pressure or coerce the individual into consent to the ECT treatment e. reminds the individual that he/she has the right to withdraw consent at any point		ability to grant or refuse consent but is compliant with treatment and 5 a-e is carried out with an advocate and/or carer	provided and the involvement of advocates or carers prior to consent to ECT are documented for audit purposes. See 3 above for a list of general risks to be discussed. Groups of people for whom there may be enhanced risks to be discussed include individuals who are pregnant, older or a child or young person. The individual who has had/is having ECT should be asked for his/her views as to whether or not this criterion is being met.
6. The individual's clinical status is assessed after each ECT session	100% of individuals receiving ECT	None	Local clinicians should agree on what constitutes an assessment of clinical status following an ECT session.
7. The individual's cognitive function is monitored: a. on an ongoing basis and b. at a minimum at the end of each course of treatment	100% of individuals receiving ECT	None	Local clinicians should agree on what constitutes monitoring of cognitive function and how monitoring is documented for audit purposes. The individual who has had/is having ECT should be asked for his/her views as to whether or not this criterion is being met.
8. ECT is stopped if one of the following occurs: a. a response is achieved b. there is evidence of adverse effects c. the individual withdraws consent	100% of individuals receiving ECT	None	Local clinicians will have to agree on what constitutes a desired response and evidence of adverse effects for audit purposes. The individuals who have had/is having

			ECT should be asked for his/her views as to whether or not this criterion is being met.
9. A repeat course of ECT is provided only for an individual in either one of the following circumstances: a. the individual meets criteria 1 and 2 above and has previously responded well to ECT or b. the individual has not responded previously but is experiencing an acute episode and all other options have been considered and following discussion with the individual and/or where appropriate the carer or advocate of the risks and benefits of such a course of action	100% of individuals receiving a repeat course of ECT	None	Local clinicians will have to agree on what constitutes a good response to ECT for audit purposes. See 4 above for definition of course of treatment. See 3 and 5 above for reference to risks.
10. ECT is used as a maintenance therapy in depressive illness	0% of individuals receiving ECT	None	
11. ECT is used for the management of schizophrenia	0% of individuals receiving ECT		

Appendix 3: ECT Treatment pack (version Oct 2017)

Give ECT and advocacy information booklets

Contact ECT dept, 01482 617553 to refer and request staff to visit patient

May arrange visit to ECT Dept. for anaesthetic assessment

Detained under MHA

Patient consents

Form T4
All sections of the ECT pack completed and signed, this includes consent form & ECT prescription.
If under 18 SOAD and T5 required (even if informal)

Patient incapable

Form T6
All sections of the ECT pack completed and signed.

Patient refuses

No authority to treat except in MHA emergency powers

Emergency

Patient detained under MHA and SOAD applied for. Section 62 document completed.

Refusal in these circumstances includes refusal by advance directive, or conflict with a decision by a deputy, donee or the Court of Protection.

Out of Hours

Contact Miranda House, tel. 01482 216624 and ask for Jon Spence or Grace Gava

Informal/Outpatient/Day cases

All sections of the ECT pack (or version on Lorenzo) completed and signed and dated, this includes consent form and ECT prescription

Necessary Investigations

Medical and physical history
Full Bloods – FBC, BCP, glucose
ECG for all patients
Physical Exam as per ECT Pack including VTE assessment
CXR only if unstable or cardiac disease or at anaesthetist request
Pregnancy test for fertile women

All sections of ECT Pack completed

Review and prescribe after maximum every two treatments.

Day of Treatment

1 Nothing to eat or drink after midnight.
2 May have **sips of water and necessary meds** up to 06.00.
3 Dress in light clothing to enable easier positioning of monitoring equipment.
4 Consider bringing a change of clothes.
5 No make-up, nail varnish, jewellery.
6 ECT Staff will phone units between 07.30 and 08.30 to confirm appointments.
7 OK to have medication and inhalers and acid blockers including benzodiazepines, hypnotics, anti-epileptics with sips of water pre-treatment.

REMEMBER to bring

Psychiatric notes
Medication chart
MHA Documentation
General medical Notes
Results of Investigations
One escort nurse per patient (CPR trained)
Separate driver
ECT pack with signed prescription or Lorenzo documentation completed

Has the patient a CPN or other professional carer involved (must be up to date in Basic Life Support Skills). This person will be required to stay with the patient throughout the treatment process to provide both emotional and physical support.

Home circumstances
The patient must not return to an empty house and will require the supervision of a responsible adult for 24 hours following treatment.

Travel arrangements:
- The patient must not drive themselves
- They must have a driver AND escort
- They may not use public transport

Good general medical status (ASA 1-3)
If one or more of above criteria cannot be met, consider the following options:
a. The ambulance service may be used if the patient has no recognised professional carer who can provide transport (contact ECT department for details).
b. If there are difficulties in providing 24-hour care post treatment then consider:
    i. Requesting that the patient remain in the ECT department until a carer becomes available to return them home, but no later than 1600hrs.
    ii. Admission to a MHU for the duration of the course of ECT.

Referral

- Referring doctor to ring ECT Department (01482 617553) and refer patient-answer phone available.
- Complete consent procedure with the patient.
- Fully complete all relevant sections of ECT pack, including prescription.
- Ensure blood taken for routine examination.
- Carry out full physical examination, if there are any concerns please report to ECT staff who will inform the anaesthetist.
- Arrange for ECG examination if applicable. If any problems with this then ECT staff may be able to help.
- Arrange for the anaesthetic assessment to be carried out. Obtain General Medical notes
- Give patient information booklet and arrange visit to ECT department if the patient wishes, or for ECT staff to visit the patient.
- For patients receiving acute course of ECT arrange for CPN (or other professional known to the patient with CPR) to escort patient to and from treatment sessions.
- For patients receiving maintenance ECT, they may convey themselves to the ECT department but MUST be escorted from the clinic by a named responsible adult.
- Arrange appropriate transport. Patients must not drive themselves, but a family member may do so. The ambulance service may be used.
- Ensure the patient has a responsible adult present at home for the ensuing 24 hours after treatment.
- Send/bring completed ECT pack and patients notes to the ECT department.
- (Please include patient's contact phone number).

Discharge Criteria
The following discharge criteria are in accordance with the guidelines from The British Association of Day Surgery Handbook.
The ECT department recommends that all patients remain at least 1-2 hours in the department following treatment.
The patient will be assessed as to their fitness for discharge from the dept. by one of the ECT lead nurses, using the following criteria:

- Vital signs stable for at least one hour
- Correct orientation as to Time Place and Person
- Minimal nausea, vomiting, dizziness or headache
- Has at least taken oral fluids
- Has a responsible adult to take them home
- Has agreed to have a carer at home for the next 24 hours
- Aware of when to attend for further treatment or outpatient review
- Emergency contact number supplied

Review/Re-prescribing

All patients **must** be seen by their psychiatric doctor after every two treatments, this will usually take place in the outpatient clinic. If the patient is to continue treatment, the ECT prescription will need to be renewed. The patient's professional escort will usually bring their notes and prescription card to the clinic. However, in exceptional circumstances when a CMHT are unable to provide a professional escort, then a review form will be provided by the dept. for the patient to take to the clinic.

Contract for Day Case/Informal Patient for ECT

Patient's name:_____**Date of birth:**_____
Contact phone number:_____**NHS number:**_____

If you are receiving ECT as an outpatient/informal your doctor will have explained the procedure to you to ensure that you meet the requirements needed so that you have safe and effective ECT treatments.

You and your carer will both need to sign the form below to confirm that you have read and understood the following information and you will then be asked to sign to confirm you consent to this contract each time you come for treatment.

You can withdraw your consent by informing your care coordinator, doctor or ECT staff.

During ECT you will receive a general anaesthetic and therefore the following standard precautions apply:

You must:

- Be in the company of a responsible adult for 24 hours following the treatment.
- Be accompanied home
- Not leave the hospital if you are feeling unsteady or confused.
- Not operate machinery or appliances for 24 hours.
- Do not drive any motor vehicle in accordance with DVLA guidelines (to contact DVLA for full criteria). This is the advice from the DVLA and ECTAS standards.
- For patients receiving maintenance ECT, they are not advised to drive for 48 hours following treatment.
- Not be left in sole charge of young children until the following morning.
- Not sign any legal document or make important decisions for 24 hours.
- Not consume alcohol for 24 hours.
- You must not have anything to eat or drink after midnight on the day of your treatment. You may have one non-milky drink at 06:00.
- If you are taking tablets in the morning, don't take them on the morning of your treatment; bring them with you and give them to the nurse who will give them to you after your treatment.
- It is recommended that you wear light clothing and remove nail varnish and excessive jewellery

Once you have returned home if you begin to feel unwell please contact either:
The ECT department (up to 15:30), tel: 01482 617553 or your care coordinator.

If you are unable to attend for an ECT treatment please contact the ECT department or your CPN/Care Coordinator.

Patient signature…….……Date……

Carer signature……..……..Date……..

Patient Consent for Electro Convulsive Therapy (ECT)

Affix patient's ID label if available	
Patient surname	
Patient first names	
Unit No.	NHS No.
Date of birth	
Male ϒ Female ϒ	Ethnicity
Special requirements (other language/communication method)	
Consultant Psychiatrist	

Statement of medical staff

I have assessed the above named patient for the purpose of assessing whether he/she has capacity to understand the proposed treatment/care plan based on the Mental Capacity Act criteria.
I have explained the procedure to the patient. In particular I have explained:
The intended benefits are an alleviation of symptoms which may be more rapid than medication.
The serious or frequently occurring risks including the possibility of:

Please tick when discussed

- Temporary memory disturbances ☐
- Memory loss (possibly permanent) ☐
- Headache, muscle aches, nausea, fatigue, "muzzy headedness" ☐
- Temporary confusion ☐
- Possible dental damage ☐

Any additional procedures, which may become necessary during the procedure (e.g. rarely an intravenous infusion of fluids/drip may be needed after ECT to prevent dehydration)
The procedure will involve general anaesthetic with a muscle relaxant and the patient has been provided with relevant information.
I have provided the patient with the ECT and anaesthetic information booklet, the CQC your rights about consent to treatment and the IMHA advocacy leaflet Yes ☐ No ☐
If no, please state reason: ……
I have told the patient that there are risks with any general anaesthetic and risks associated with the muscle relaxant used and referred the patient to the section in the booklet that describes these risks.
I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- Has the patient the **capacity to give consent** for ECT? Yes ☐ No ☐

If 'No' has 'Best Interest' meeting documentation been completed? Yes ☐ No ☐
Please attach copy.

- Was an IMHA required? Yes ☐ No ☐

Signed	Date
Name (PRINT)	Job Title

Contact details (if patient wishes to discuss options later)
Ward/CMHT ……
Tel no ……..

Name…… NHS/unit number ……

CAPACITOUS Patient Consent for electro convulsive therapy (ECT)

Statement of Capacitous Consenting Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you.

You have a right to change your mind at any time, including after you have signed this form and anytime during the course of treatment.

I agree to a course of Bi/Uni* lateral ECT.
(* Please delete that which does not apply. You may wish to discuss this with your doctor)

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.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures that may become necessary during my treatment. I have listed below any procedures that I do not wish to be carried out without further discussion or any other concerns I have re the treatment.

I understand that I can withdraw my consent at any point.
……..……..……

Patient's signature…….Date……..….

Name (Print) …… Unit No. ……

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signature…….Date……

Name (PRINT)…….

Is an interpreter required? Yes ☐ No ☐

Statement of interpreter (where appropriate)

I have interpreted the information above 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) Job Title

Approved by HMHTT – December 2005 Important note: (tick if applicable)

See also advance statement/directive/living will (e.g. Jehovah's Witness form)

Photocopy of consent forms accepted by the PATIENT: **YES ☐ NO ☐**

If NO please state reason why:…….

Name……..NHS/Unit No……

Indication for ECT (completed by referring RC)

Severe Depressive Illness	☐
If severe depression:	
1. Failure of response to at least two adequate courses of antidepressants and been offered psychological therapy	☐
Life threatening depression e.g. suicidal, severe self-neglect.	☐
Other – please specify	☐
(Please specify treatments considered/tried prior to ECT if applicable.)	
Catatonia	☐
A prolonged or severe manic episode	☐
Other – please specify	

PRE ECT PREPARATION (completed by referring doctor)

Please enclose copies of ALL relevant investigations, whether the results are normal or abnormal, for the first ECT treatment in a course. After this the results can be filed. If changes occur during the course of ECT treatment in physical health or investigations the anaesthetist must be informed.

1 **Baseline scores** (please indicate which test) Cognitive…….. Symptom……..

Physical Examination Normal ☐ Abnormal ☐

2 **BP**…… **Pulse**…….. **Resp**……

FBC Normal ☐ Abnormal ☐ **BCP** Normal ☐ Abnormal ☐

ECG Normal ☐ Abnormal ☐ **CXR** Not indicated ☐ Normal ☐ Abnormal ☐

PREGNANCY N/A ☐ -VE ☐ +VE ☐ **VTE assessment** Normal ☐ Abnormal ☐

VTE prophylaxis indicated ☐ not indicated ☐

Other tests – Specify which tests were done and give results

……..……
……..……
……..

3 **Significant past or present physical health problems.**

No ☐ Yes ☐

……..……
……..
……

Name……..NHS/Unit No……

4 **Current drug treatment**…

Drug	Dose	Frequency

5 **Allergies:** No Yes please specify…….…….

6 **Dental state** (please specify if loose crown)

Own teeth and good condition ☐ Other ☐ Details below:
…….
…….

7 **Previous ECT** No ☐ Yes ☐
a) When……..
b) Initial determined moderately suprathreshold dose (MTSD) leave blank if not known……
c) Any problems No ☐ Yes ☐

Previous general anaesthetic adverse effects No ☐ Yes ☐ Not known ☐

Please specify…….

Signed……Name…….Date…….
(referring doctor)

Additional information provided by nursing staff or doctors

PRE-ECT ANAESTHETIC ASSESSMENT (completed by anaesthetist)

Name……..Unit/NHS number……..…….

Date……Time……..

Temp…… Weight……kg Height……cm. Age…… ASA….

Na…….K……..Urea……..Creat…….Hb…….Platelets……....

Past Medical History/Anaesthesia.

Cardiovascular
Pulse…….BP……..ECG……SATS…….

Respiratory CXR Airway Assessment Smoker? Yes…… No…….	Dental indications ie caps, palates, dentures

Current Medication	Allergies

Statement of Anaesthetist

I have discussed the anaesthetic part of the procedure with the patient.
I have provided information if appropriate that is not included within the anaesthetic information leaflet and have answered any questions that the patient has asked.
I have seen the medical notes ☐ psychiatric notes ☐ medication chart ☐

Signed……Date……..

Name (print) …….Job Title (print)…….

Name……..NHS/Unit No……

Prescription and Treatment Record

To be completed by the patients RC or his deputy on reviewing this patient between ECT Treatments, please make special reference to the patient's subjective experience of ECT and evidence of cognitive and non-cognitive side effects as well as completing a CGI assessment

Severity				**Improvement**			
1=Normal, not ill at all		5=Markedly ill		1=Very much improved		5=Minimally worse	
2=Borderline mentally ill		6=Severely ill		2=Much improved		6=Much worse	
3=Mildly ill		7=Extremely ill		3=Minimally improved		7=Very much worse	
4=Moderately ill		**Please tick**		4=No change		**Please tick**	

ECT Prescription

Another treatment prescription may be completed on next page, but please do NOT prescribe more than 2 treatments at once.

Treatment no.	Date to be given	Bi or Uni lateral	Symptom Score	Cognitive Score	Signature	Date
1						

Capacity assessment must be carried out in the 24 hours before the next prescribed treatment.
(ECTAS standards Dec. 2014)

Criteria	**Yes**	**No**
a) Is the patient able to understand the information given re. ECT?		
b) Is the patient able to retain this information?		
c) Is the patient able to weigh-up the information given re. ECT with its risks and benefits?		
d) Is the patient able to communicate his decision?		

If you answered 'yes' to questions a-d it confirms the patient has capacity to give their consent to ECT.
If you answered 'no' to **any one** of the questions the patient lacks capacity to give their consent to ECT, proceed as below:

Informal	Previously yes, now no	Do not proceed with ECT. Suggest 'Best Interest meeting'
Informal	Previously no, now yes	Do not proceed with ECT. Consent must be obtained
Sec 3 (T6)	Previously no, now yes	Consent and T4 documentation required before further ECT
Sec 3 (T4)	Previously yes, now no	SOAD and T6 documentation required before further ECT

Signature		**Designation**	
Date		**Time**	

Pre-treatment nursing checks

Weight		ID confirmed and band applied		Make-up/hair lacquer or cream to forehead removed.			
Pulse		Nil by mouth		Voided urine			
Oxygen sats		Dentures removed		Orientation	Time	Place	Person
BM (if diabetic)		BP cuff in situ					
Temperature		Glasses, contact lens, hearing aids removed and jewellery checked		Informal Patient signature agreeing to ECT + relevant contract			
BP							
Allergies		ECG pads applied		T4 T6 Sec 62			
Date		**Time**		**Nurse Signature**			

Name……..NHS/Unit No……

Pre-Treatment and Anaesthetic Record *(Observations print–out attached)*

Treatment number …1…

Date			**Time**		
Anaesthetic machine checked			**Induction agent**	Thiopentone/Propofol/ Methahexitone	Dose
Difficult airway /aspiration risk * Relevant equipment available.	Yes*	No	**Muscle relaxant**	Suxamethonium/ …… ……	Dose
Team members introduced			**Other drugs used and/or iv fluids**		
ASA confirmed					
Patient ID confirmed			**Comments**		
Signature			**Designation**		

Treatment Record

	1st Treatment			**2nd Treatment**			**3rd Treatment**			**Comments**
Bi/Unilateral										
Dose setting										
Seizure length (seconds)	EEG	EMG	Obs	EEG	EMG	Obs	EEG	EMG	Obs	
Seizure description										
Signature							**Designation**			

Recovery Area Observations

Key concerns for recovery and management of this patient. *(Anaesthetist or Psychiatrist to identify)*

……

……

…..

Time In and Out			Pain-head or muscular			
BP			IV Fluids			
Pulse			Other drugs given			
Oxygen saturation			Venflon removed	Where site: Site OK : Yes No		
Temperature			Orientation	Time	Place	Person
Nausea/ Vomiting			Confusion			
Incontinence			**Signature**			

Pre-Discharge Observations

Blood Pressure		Food taken			
Pulse		Fluids taken			
Pain/Headache (medication given)		Orientation	Time	Place	Person
Nausea/Vomiting		**Signature & time of discharge**			

Name……NHS No…….

Prescription and Treatment Record

To be completed by the patients RC or his deputy on reviewing this patient between ECT Treatments, please make special reference to the patient's subjective experience of ECT and evidence of cognitive and non-cognitive side effects as well as completing a CGI assessment

Severity				**Improvement**			
1=Normal, not ill at all		5=Markedly ill		1=Very much improved		5=Minimally worse	
2=Borderline mentally ill		6=Severely ill		2=Much improved		6=Much worse	
3=Mildly ill		7=Extremely ill		3=Minimally improved		7=Very much worse	
4=Moderately ill		**Please tick**		4=No change		**Please tick**	

ECT Prescription

Another treatment prescription may be completed on next page, but please do NOT prescribe more than 2 treatments at once.

Treatment no.	Date to be given	Bi or Uni lateral	Symptom Score	Cognitive Score	Signature	Date
2						

Capacity assessment must be carried out in the 24 hours before the next prescribed treatment.
(ECTAS standards Dec. 2014)

Criteria	**Yes**	**No**
a) Is the patient able to understand the information given re. ECT?		
b) Is the patient able to retain this information?		
c) Is the patient able to weigh-up the information given re. ECT with regard to its risks and benefits?		
d) Is the patient able to communicate his decision?		

If you answered 'yes' to questions a-d it confirms the patient has capacity to give their consent to ECT.
If you answered 'no' to **any one** of the questions the patient lacks capacity to give their consent to ECT, proceed as below:

Informal	Previously yes, now no	Do not proceed with ECT. Suggest 'Best Interest meeting'
Informal	Previously no, now yes	Do not proceed with ECT. Consent must be obtained
Sec 3 (T6)	Previously no, now yes	Consent and T4 documentation required before further ECT
Sec 3 (T4)	Previously yes, now no	SOAD and T6 documentation required before further ECT

Signature		**Designation**	
Date		**Time**	

Pre- treatment nursing checks

		ID confirmed and band applied		Make-up/hair lacquer or cream to forehead removed.			
Pulse		Nil by mouth		Voided urine			
Oxygen saturation		Dentures removed		Orientation	Time	Place	Person
BM (if diabetic)		BP cuff in situ					
Temperature		Glasses, contact lens, hearing aids removed and jewellery checked		Informal Patient signature agreeing to ECT + relevant contract			
BP							
Allergies		ECG pads applied		T4 T6 Sec 62			
Date		**Time**		**Nurse Signature**			

Name……..NHS/Unit No……

Pre-Treatment and Anaesthetic Record *(Observations print–out attached)*

Treatment number …2…

Date			**Time**		
Anaesthetic machine checked			**Induction agent**	Thiopentone/Propofol/ Methahexitone	Dose
Difficult airway /aspiration risk * Relevant equipment available.	Yes*	No	**Muscle relaxant**	Suxamethonium/ …… ……	Dose
Team members introduced			**Other drugs used and/or iv fluids**		
ASA confirmed					
Patient ID confirmed			**Comments**		
Signature			**Designation**		

Treatment Record

	1st Treatment			**2nd Treatment**			**3rd Treatment**			**Comments**
Bi/Unilateral										
Dose setting										
Seizure length (seconds)	EEG	EMG	Obs	EEG	EMG	Obs	EEG	EMG	Obs	
Seizure description										
Signature							**Designation**			

Recovery Area Observations

Key concerns for recovery and management of this patient. *(Anaesthetist or Psychiatrist to identify)*

……

……

…..

Time In and Out			Pain-head or muscular			
BP			IV Fluids			
Pulse			Other drugs given			
Oxygen saturation			Venflon removed	Where site: Site OK : Yes No		
Temperature			Orientation	Time	Place	Person
Nausea/ Vomiting			Confusion			
Incontinence			**Signature**			

Pre-Discharge Observations

Blood Pressure		Food taken			
Pulse		Fluids taken			
Pain/Headache (medication given)		Orientation	Time	Place	Person
Nausea/Vomiting		**Signature & time of discharge**			

Appendix 4: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** ECT SOP
2. **EIA Reviewer (name, job title, base and contact details):** Dr Richard Ward
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** SOP

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	ECT is not a recognised treatment for younger children.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	RCPsych and ECTAS Guidelines and handbook
Sex	Men/Male Women/Female	Low	ECT is a recognised treatment for both genders
Marriage/Civil Partnership		Low	
Pregnancy/ Maternity		Low	RCPsych Handbook and Guidelines
Race	Colour Nationality Ethnic/national origins	Low	Information available in most languages. Interpreter available if necessary.
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	
Sexual Orientation	Lesbian Gay Men Bisexual	Low	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision above:	
AGE – ECT has to be used with caution when treating under 18's. Guidelines are to be followed. (From RCPSYCH Handbook). Always require a SOAD and T5. Pregnancy – ECT must be used with caution and special consideration implemented when treating pregnant women (RCPSYCH Handbook).	
EIA Reviewer –Dr Richard Ward	
Date completed: January 2023	Signature: R Ward

Appendix 5: Consent to Treatment

Guidance to health professionals (to be read in conjunction with consent policy and DH guidelines for examination or treatment 2nd edition, Aug 2009)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult has capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. 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 treatment is being provided under the authority of Part IV of the Mental Health Act 1983, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health and Social Care's reference guide to consent for examination or treatment (https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition).

Valid consent should be obtained in all cases where the individual has the ability to grant or refuse consent. The decision to use ECT should be made jointly by the individual and clinicians responsible for treatment on the basis of an informed discussion (NICE 2012).

It is important that when patients are giving consent for ECT that the prescribing doctor ensures that the consent is valid and that the consent form is completed and signed as far as the confirmation of consent which will be completed by the ECT staff when the patient attends for treatment for the first time.

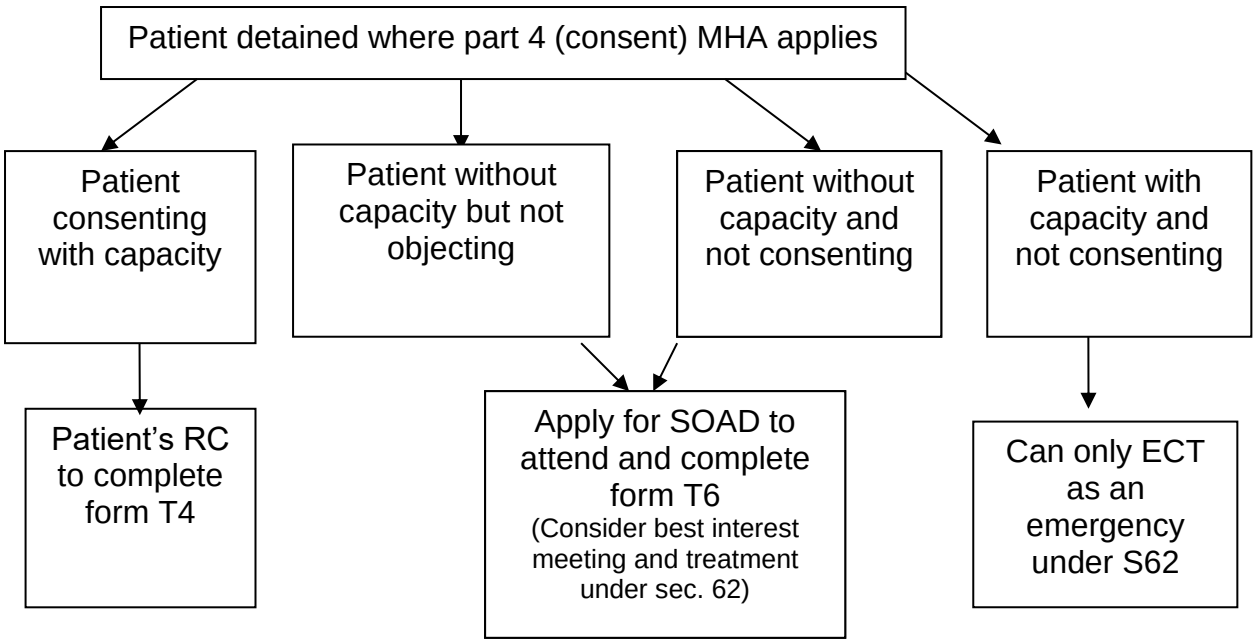
The doctor should ensure that all necessary and appropriate information is given to the patient in order for him or her to make an informed choice. This discussion must include information about the general risks associated with ECT and the risks and potential benefits specific to that individual (NICE 2012).

The involvement of patient advocates and/or carers to facilitate informed discussion is strongly encouraged (NICE 2012).

The consent process provides that the clinician(s) responsible for treatment:

- involves the individual's advocate and/or carer where possible
- provides full and appropriate information in a suitable format and language to enable an informed discussion
- explains and discusses the general risks of ECT, risks specific to the individual and potential benefits to the individual
- does not pressure or coerce the individual into consent to the treatment
- reminds the individual that he or she has the right to withdraw consent at any point

Consent and the detained patient: The following flowchart may be used for guidance:



When treatment can be given to a patient who is unable to consent
For treatment to be given to a patient who is unable to consent, the following must apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND the procedure must be in the patient's best interests

Capacity
A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). 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 or supporters. Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests
A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the patient when competent; their current wishes; their general well-being; their spiritual and religious welfare

Two incapacitated patients, whose physical condition is identical, may therefore, have different best interests. Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide

particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

12 KEY POINTS ON CONSENT: THE LAW IN ENGLAND

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: "can this patient understand and weigh up the information needed to make this decision?" Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some-one with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent cannot over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient's consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.
8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusal of treatment

10. Competent adult patients are entitled to refuse treatment at any point during their treatment, even when it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult save the two exceptions under the Mental Capacity Act 2005. However, you may still treat such a patient if the treatment would

be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general wellbeing and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available from the NHS Response Line 08701 555 455 and at https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

Reference guide to consent for examination or treatment (second edition)
Guide to the legal framework that health professionals need to take account of in obtaining valid consent to examination, treatment or care.

Published 4 August 2009
From: Department of Health and Social Care
Applies to: England

Documents
Reference guide to consent for examination or treatment (second edition)

Information to assist in amending consent forms

Details

This document updates that issued in 2001 and provides a guide to the legal framework that all health professionals need to take account of in obtaining valid consent for any examination, treatment or care that they propose to undertake.

Since 2001, the Department of Health guidance on consent has required NHS Trusts to adopt a model consent policy, model forms and information leaflets with the aim of ensuring that good practice in seeking consent was put in place throughout the NHS. The department has been considering the future role of its guidance and has been undertaking a review of consent in the NHS which will not only identify and evaluate the NHS approach to, and practice on, gaining consent but which will also evaluate the impact on practice of existing Department of Health guidance and forms.

We are aware of the importance to trusts of having up to date guidance available to them to ensure they continue to have in place effective and legal consent processes. This is especially so at a time when the Care Quality Commission is developing its regulatory framework (and associated guidance) and that there is a continuing need for Trusts to meet the risk management standards required by the NHS Litigation Authority.

Thus, as an interim measure whilst we carry out our review, we have updated the Reference Guide to Consent for Examination or Treatment, to reflect legal developments since the guide was issued, including the Human Tissue Act 2004, the Mental Capacity Act 2005 and relevant judgements made in the High Court of Justice.

As part of our review, we will evaluate the impact on practice of the Department of Health consent forms and consider the best approach to promoting quality consent processes (including

documentation) in the future. In the interim, trusts are free to develop their own documentation, including their consent forms (using the DH model form if they so wish), to reflect the current legal position and reflect local practice as appropriate. These documents include some advice on how legal terminology has evolved since the forms were produced, which may help in this regard.

Although the revised reference guide reflects the current legal position trusts are advised to ensure that ALL relevant information and guidance is taken account of when establishing, reviewing or putting into practice consent policy and processes. Where trust staff have any doubts about how the law applies to an individual case, they should seek appropriate legal advice.

Published 4 August 2009

Appendix 6: ECT under Section 58A (used to authorise treatment)

Where ECT treatment is given to a patient who has not consented, the prescribing doctor should ensure that Sections 58A and/or 62 of the Mental Health Act 1983 are complied with. Particular attention should be made to ensuring that either a Form T4 (T5 for under 18's even having capacity and consenting) or Form T6 is attached to the ECT card for patients detained under the Mental Health Act. Further information can be obtained from either the Mental Health Act itself or the most current version of the code of practice.

Section 58A applies to ECT and to medication administered as part of ECT. It applies to detained patients and to all patients aged under 18 (whether or not they are detained).

The key differences from section 58 are that:

- Patients who have the capacity to consent may not be given treatment under section 58A unless they do in fact consent
- No patient aged under 18 can be given treatment under section 58A unless a SOAD has certified that the treatment is appropriate; and there is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT)

A patient who has capacity to consent may not be given treatment under section 58A unless the clinician in charge, or a SOAD, has certified that the patient has the capacity to consent and has done so. If the patient is under 18, only a SOAD may give the certificate, and the SOAD must also certify that the treatment is appropriate.

A patient who lacks the capacity to consent may not be given treatment under section 58A unless a SOAD certifies that the patient lacks capacity to consent and that:

- The treatment is appropriate
- No valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 (MCA) refusing the treatment
- No suitably authorised attorney or deputy objects to the treatment on the patient's behalf; and the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given

In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.

For children and young people under 18, a SOAD certificate by itself is not sufficient to authorise the treatment, unless they are detained. Clinicians must also have the patient's own consent or some other legal authority, just as they would if section 58A did not exist (see chapter 36 Mental Health Act Code of Practice).

Whether or not section 58A applies, patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

Summary

- NICE guidelines April 2003 recommend that the consent process provide that the clinicians responsible for treatment carry out all the following:
- Involves the individuals advocate and/or carer where possible.
- Provides full and appropriate information in a suitable format and language to enable an informed discussion.
- Explains and discusses the general risks of ECT, risks specific to the individual, enhanced risks for individuals in specific groups and potential benefits to the individual.
- Does not pressure or coerce the individual into consent to the ECT treatment.
- Reminds the individual that he/she has the right to withdraw consent at any time.

In all situations where informed discussion and consent is not possible advance directives should be taken fully into account and the individuals advocate and or carer should be consulted.

Appendix 7: Mental Capacity Act (used as a principle to assess capacity)

The Principles of the 2007 Act:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- The right for individuals to be supported to make their own decisions-people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests-anything done for or on behalf of people without capacity must be in their best interest.
- Least restrictive intervention-anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedom.

Relationship between the Mental Capacity Act and the Mental Health Act 1983

- Advance decisions can refuse any kind of treatment, whether for a physical or mental disorder.
- Advance decisions to refuse treatment for other illnesses or conditions are not affected by the fact that the person is detained in hospital under the Mental Health Act.

Advance Decisions

- An advance decision to refuse treatment enables an adult to make treatment decisions in the event of their losing their capacity at some time in the future.
- Such a decision properly made is as valid as a contemporaneous decision (made at the time) and so it must be followed, even if it results in the person's death.
- If an advance decision involves refusing life-sustaining treatment, it has to be put in writing, signed and witnessed but, otherwise, advance decisions can be verbal.
- Since 2009 detained patients with capacity can refuse ECT, advanced refusal for ECT remains valid even if detained except in an emergency to prevent death or deterioration and such stated under section 62 will apply.

Advance Decisions to Refuse Treatment

- Allows you to refuse specified medical treatment in advance. Were legally binding previously, the MCA gives greater safeguards.
- Must be made when you have capacity and comes into effect if you lack capacity. Also previously called 'living wills' or 'advance directives'.
- Must be clear about which treatment it applies to and when and must be in writing and witnessed if it applies to life-sustaining treatment.
- Doctors can provide treatment if they have any doubt as to the validity of the advance decision.

IMHAs
Independent Mental Health Advocates have a role to support people detained under the Mental Health Act 1983.

Where incapacitous are detained under the mental health act they will be referred to an IMHA where necessary.

IMCAs
The Mental Capacity Act (MCA) 2005 came into force in 2007 and introduced the new statutory role of the Independent Mental Capacity Advocate (IMCA) to support people who lack capacity to make certain decisions.

From 2 April 2007, Local Authorities and NHS bodies have a duty to instruct an IMCA to support an individual if they meet the criteria as laid out in the Act.

An IMCA must be instructed where:

- There is a decision to be made regarding either serious medical treatment
- (SMT) or change of accommodation.

AND the person has no close family or friends to represent their views
AND the person has been deemed by the Decision Maker not to have capacity to make that decision in accordance with the assessment of capacity as defined in the Act.

This can include people with dementia or mental ill health; people with learning disabilities; people with physical disabilities; people who have had a stroke; people with acquired brain injuries and people who are unconscious or in a coma.

Valid advanced refusal for ECT remains valid under MHA except in an emergency when ECT can be given under section 62 MHA 1983. Locally, Cloverleaf advocacy is the Independent Mental Health Advocacy Service, and can be contacted on: Tel. 0300 012 0512 or email IMHA@cloverleaf-advocacy.co.uk

Advance statement (see Appendix 1)

- Allows you to specify which treatment you would prefer in advance should you recognise a deterioration in your mental health.
- Recorded on Lorenzo and a flag is attached to the EPR.
- Must be clear under which circumstances treatment will be reviewed/considered.
- This is not legally binding.

Appendix 8: ECTAS 13th Edition Standards

ECT Accreditation Service (ECTAS) – Standards for the administration of ECT

https://www.rcpsych.ac.uk/pdf/ECTAS%2013th%20Edition%20Standards.pdf

Humber NHS
NHS Foundation Trust

Information on ECT
(Electro-Convulsive Therapy)

This leaflet tells you about ECT and anaesthesia.

For patients, their families, carers, and

healthcare practitioners.

What is ECT and what does it involve?

ECT is used primarily in the treatment of depressive illness, mania and catatonia.

ECT is given under general anaesthesia. A muscle relaxant is also given to prevent excessive body spasms.

During ECT, electrodes are put to the head and an electric current is passed through the electrodes to the brain, which causes a seizure (a ‘fit’).

The treatment only takes a few minutes and you will not be aware of anything; you will certainly not feel anything.

The treatment is usually given twice a week for 3-6 weeks, depending on your response. You will be seen at least weekly by your psychiatrist to assess your progress/improvement, as well as reviews after each treatment to hear how YOU feel the treatment is going and any problems you may be experiencing.

Why has ECT been recommended for me?

ECT is most commonly used to treat severe depression, and may have been recommended for you because you did not get better with anti-depressant drugs alone. It may be that you don’t tolerate anti-depressant drugs because of their side effects, or that you have responded well to ECT in the past

What are the benefits, risks, side effects and alternatives?

Benefits

The main benefit of ECT is the speed of recovery from a depressive episode when compared to drug treatment alone. Although you may not feel any improvement straight away, you may notice an improvement in your mood after 3-4 treatments. This varies enormously and you will be given only as much treatment as you need to get better.

Risks

ECT is one of the safest procedures performed under general anaesthesia; the risk of death or serious injury with ECT is slight, about 1 in 50,000. Complications rarely occur because of heart problems, and you may still receive ECT safely if you have heart disease, as all patients have heart monitoring throughout the procedure. Your doctor will ask another specialist to advise if there are grounds for concern.

Side effects

- Some patients may be confused just after waking from the treatment but this generally clears up within an hour or so.

- Your memory of recent events may be upset and dates, names of friends, public events, addresses and telephone numbers may be temporarily forgotten. In most cases this memory loss goes away within a few days or weeks, although some patients continue to experience memory problems for several months. ECT has not been proven to have long-term effects on your memory or your intelligence.

- Some people have a headache or feel sick when they wake, but we can alleviate these symptoms with medication should this happen

Alternatives

- Depression may be managed with anti-depressants, counselling and psychotherapy either alone or in combination.

- Catatonia can be treated with benzodiazepines or barbiturates.

- Acute manic episodes may be treated with Lithium, anti-psychotics or anti-convulsants.

Will I have to sign a consent form?

At some stage before the treatment you will be asked by your doctor to sign a consent form for ECT. If you sign the form, you are agreeing to have a course of treatment under general anaesthetic, but you are free to withdraw this consent at any time. Before you sign the form your doctor will explain what the treatment involves and why you are having it. The doctor will be able to answer any questions you may have. Your consent to the treatment will be sought verbally each time you attend for treatment.

It is possible for ECT to be given without your consent, but for this to happen you must be detained in hospital under the Mental Health Act, and your doctor must assess your capacity to give consent as well as an independent doctor's second opinion before this can go ahead.

Where will I have the treatment?

ECT is given in a purpose-built department on the second floor of Miranda House, near Hull Royal Infirmary. If you wish, you can visit the department before your course if treatment, and meet and talk to the staff. They will be glad to answer any further questions and show you round. Staff on your ward or your care-coordinator will arrange transport, and someone will escort you to the department and stay with you throughout the treatment and make sure you get back safely.

What preparation will I need?

You will need to have a full medical examination by your doctor and a blood sample will be taken to make sure you are in reasonably good general health. If you are a man aged over 45 or a woman aged over 55 you will need an electrocardiogram (ECG). Sometimes this will need to be carried out if you have other physical health problems.
You must also be assessed by one of the ECT anaesthetists; this will normally take place in the ECT department immediately prior to your treatment.
Because you will be having a general anaesthetic you must not have anything to eat after midnight on the day of treatment, but you may have a non-milky drink, ie black tea or coffee, fruit juice or water at 06.00 on the day of treatment (no later).
You will be able to wear your ordinary day clothes throughout the procedure; although we would like these to be loose so we can access your chest for the placement of heart monitoring equipment. Please keep facial make-up to a minimum (if at all) and remove any nail polish.

What will happen when I arrive in the ECT department?

When you arrive in the ECT department you will be greeted by one of the ECT nurses. These are experienced nurses who have received extra training in ECT and work solely in the department. You will be asked to wait for a short while in the waiting area until the doctors are ready for you. There may be other patients and their escorts also waiting in this room. You will then be shown through to the pre-treatment room where an ECT support nurse will help you get ready for your treatment. She will amongst other things take your blood pressure and temperature as well as placing sticky patches on your chest.

How is the treatment given?

ECT is always given under a general anaesthetic in the treatment room, using a very short acting drug which is always administered by a consultant anaesthetist.
To monitor you during your treatment, your anaesthetist (or his assistant) will attach you to machines to watch:

- Your heart-ECG
- Your blood pressure- a blood pressure cuff will be placed on your upper arm.
- The oxygen level in your blood-a clip will be placed on your finger.

To give your anaesthetic, your anaesthetist needs to give you drugs into a vein. A needle will be used to put a thin plastic tube (a cannula) into a vein in the back of your hand or in your arm. This is taped down to stop it slipping out. Sometimes it can take more than one attempt to insert the

cannula. You may be able to choose where your cannula is placed.
If you are worried about the use of a needle, you can ask to have a local anaesthetic cream put on your hand or arm to numb the skin before you go into the treatment room. The nurse in reception should be able to do this for you.
Once the cannula is in place, the anaesthetist will give you some oxygen to breathe for a few moments before giving you the anaesthetic drugs. If you experience any pain when the drugs are given through your cannula, it is important that you tell the anaesthetist.
While the anaesthetist is doing this, the nurse will attach sticky patches to one of your legs and to your head. These are solely for monitoring purposes and will not cause you any discomfort.
Once you are asleep, the anaesthetist will give you a muscle relaxing drug to temporarily paralyse the muscles of your body. He will choose a way of making sure you can breathe easily by either tilting your head back and lifting your chin or inserting a short tube called an airway.
When the ECT trained psychiatric doctor has given the ECT, the anaesthetist will give you oxygen through a mask until you are breathing on your own again. Once he is satisfied that you are recovering normally you will be turned onto your side and taken to the recovery room.
This whole process usually takes approximately 10 minutes.

What happens in the recovery room?

While you are in the recovery room a trained nurse will be with you at all times. The nurse will continue to monitor your blood pressure, oxygen levels and pulse rate.

Oxygen will be given through a lightweight clear plastic mask, which covers your mouth and nose. Breathing oxygen keeps up its level in your blood while the anaesthetic wears off. The staff will remove your mask as soon as these levels are maintained without it.
If you feel sick you may be given drugs that will help this.
When you are fully alert, the cannula in your hand or arm will be removed and a dressing applied. Dentures, hearing aids and glasses will also be returned to you. You will be also asked a set of simple question to ensure that you are fully orientated.

How long will I have to stay in the department?

How you will feel afterwards depends on how much anaesthetic was used and on your general health. Most people feel fine after treatment; some people may suffer from minor side effects, such as feeling sick, dizzy or shivery, or have general aches and pains.
Some people have blurred vision, drowsiness, headache or a sore throat.
Once you have completely recovered from your anaesthetic, you will be helped into the waiting room again where you will be offered a drink and some breakfast. Here the staff will continue to monitor you and once it is thought that you are completely well, you may return to your unit, ward or home. We like you to stay in the department between 1 and 2 hours before returning. Please note that smoking is NOT allowed anywhere in the department.
Once you are back on your unit or ward, the staff there will take over your care. If you experience any problems they will be able to help you.

How will my progress be assessed?

Your doctor will want to speak to you and the nursing staff on the ward at least once a week. He will want know how you are feeling and how you think the treatment is going.

May I drive my car whilst receiving ECT?

Following recent guidance from the DVLA and the Royal College of Psychiatrists, we advise that you do NOT drive any motor vehicle whilst receiving a course of ECT. This is because your reactions and concentration may be impaired during this time.
If you chose to drive during this time, you must be aware that your motor insurance may be invalidated.

Who may I talk to for further advice?

If you don't have, or don't wish to talk to family or close friends about whether to consent to a course of ECT then you may wish to speak to an independent mental health advocate who will be able to speak for you and help you decide.
The same applies if you are detained under the Mental Health Act and you are unsure of your rights with regard to ECT.
Locally a group called 'Speaking Up' provide this service and may be contacted on: - 07920774548.
Staff on the ward will be able to help you contact them.

What happens at the end of my course of treatment?

Once it has been decided by your medical team and yourself that you are better and that no further treatments are necessary, then the treatment course will be stopped.
A week or so after your last treatment a nurse from the ECT department will visit you to see how you are and to carry out an assessment of your mood and of your memory.
We will then invite you to attend a follow-up clinic in the department after 3 and 6 months.

I am having my treatment as an outpatient, what else do I need to know?

Outpatients are required to sign a contract agreeing to the following:

- To be in the company of a responsible adult for 24 hours after treatment
- To be accompanied home
- Not leave the hospital if you are feeling unsteady or confused.
- Not operate machinery or appliances for 24 hours.
- Not be left in sole charge of young children until the following morning.
- Not sign any legal document or make important decisions for 24 hours.
- Not consume alcohol for 24 hours.

Other than this, your treatment will be given as previously described.

Sources of reference for this leaflet:

- ‘The use of Electroconvulsive Therapy’
  The National Institute for Health and Clinical Excellence (NICE) - April 2003

- ‘The Treatment and management of depression in Adults’
  The National Institute for Health and Clinical Excellence (NICE) – October 2009

- ‘The Handbook of ECT’
  The Royal College of Psychiatrists – 2005

- ‘Anaesthesia Explained’
  The Royal College of Anaesthetists – October 2002

Who can I contact for more information?

The Lead ECT Nurse
ECT Department.
Miranda House.
Gladstone St.
Hull
HU3 2RT

Telephone:

01482 617553 or
01482 216624

Useful Websites and telephone numbers:

National Institute for Health and Clinical Excellence
www.nice.org.uk
0845 003 7780

MIND
www.mind.org/information/booklets
01482 240200

NHS Direct was dissolved in March 2014 but for health enquiries
www.nhsdirect.nhs.uk
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This document is available in other formats (other languages, large print, audio and Braille as appropriate. Please telephone communications:
01482 389200

Date of publication
January 2016

Appendix 10: References

This procedure is a local implementation of the Royal College of Psychiatrists ECT handbook published in January 2004. The handbook has a full list of references.

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NICE: https://www.nice.org.uk/
Department of Health: https://www.gov.uk/government/organisations/department-of-health-and-social-care

Glossary of Abbreviations

ECT	Electroconvulsive Treatment
ECTAS	ECT Accreditation Service
BP	Blood Pressure
IV	Intravenous
TPR	Temperature Pulse and Respiration
ODP	Operating Department Practitioner

ECG	Electrocardiogram
MSTD	Moderately Suprathreshold Dose
CPN	Community Psychiatric Nurse
CED	Clinical Engineering Department

Other Trust policies of particular relevance to ECT

Infection Control
COSHH
Health and Safety
Manual handling
Serious Incidents
Complaints
Mental Health Act 1983 forms T4 and T6
Section 62

Appendix 11: COVID-19 Testing in ECT SOP

Humber Teaching NHS Foundation Trust

COVID-19 TESTING IN ELECTROCONVULSIVE THERAPY (ECT) STANDARD OPERATING PROCEDURE

Document Reference	SOP20-035
Version Number	1
Author/Lead **Job Title**	Andrea Copeland Team Leader and Clinical Development Lead, ECT and Clozaril
Instigated by: **General Manager/Clinical Lead /Committee** **Date Instigated:**	
Date Last Reviewed:	14 December 2020
Date of Next Review:	-
Consultation:	
Ratified and Quality Checked by: **General Manager/Clinical Lead/Committee** **Date Ratified:**	
Name of Trust Strategy/Policy/Guidelines this SOP refers to:	ECT SOP Infection Prevention and Control Arrangements Policy

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1	14/12/20	New SOP

28. INTRODUCTION

ECT is an established, evidence-based treatment and HTEFTLYPFT offers ECT to patients from a wide range of clinical settings and the community. The ECT Service is committed to maintaining the highest possible standards of patient safety.

It is recognised that testing for COVID19 is not a panacea. It is unable to delineate between active virus and non-active virus particles, and current evidence is limited to reviews of upper respiratory tract samples (significant for ECT as this is classed as an aerosol generating procedure in accordance with PHE guidance). Testing however enables a further level of assurance for patients, the service and staff.

The contents of this document should be read in conjunction with the national IPC guidance COVID-19 infection prevention and contro guidance 2020 and with the Trust's relevant Infection Prevention and Control policies which are at https://intranet.humber.nhs.uk/document-library/infection-prevention-and-control-policies.htm

29. CONSENT FOR TESTING

All patients referred and accepted in principle for ECT will be provided with a patient information leaflet outlining the nature, frequency and timing of screening tests and how they will be informed of the results so as to support informed consent for the process (Refer to Appendix 1). The leaflet will also include background information including the rationale for testing, the importance of reducing COVID 19 exposure risk between treatments and the use of PPE in the ECT suite, together with an explanation as to the possible scenarios should the patient refuse testing.

The patient's capacity (or otherwise) to consent to testing will be assessed (and documented) by the ECT team prior to each test being carried out.

For capacitous patients who refuse testing the referring team would be informed and will be required to look at alternative treatments. If no suitable alternatives are identified then discussions will be had between the treating team and the ECT team (in conjunction with HUTH anaesthetists as/when appropriate) on a case by case basis to explore possible options to facilitate the patient's safe access to treatment (noting that this may include managing the patient as per the 'COVID positive pathway' below).

For patients receiving ECT treatment under MHA or MCA it is recognised that patients who are demonstrated to lack capacity in relation to the decision to have ECT may or may not have capacity to give permission for testing. As the primary purpose of the test is to keep patients safe, and medical advice is that the testing regime is primarily aimed at keeping the patient safe, then testing is in the patient's best interest and will be performed under the authority of the Mental Capacity Act should the patient be assessed as not possessing capacity to make informed decisions on this matter. In such cases a documented consultation with a suitable informant will be undertaken to demonstrate that the best interest requirement is met.

30. MANAGEMENT OF COVID-19 TEST RESULTS

The ECT department will inform the patients who have been swabbed of their results. This will be accessed through the HUTH Lorenzo system and documented within the patient's clinical care record both electronically and a paper copy. The patient will also be informed of their results verbally by the ECT if an outpatient. if an inpatient the ward will be responsible for informing the patient.

31. COVID-19 TESTING REGIME

Pre-ECT

Patients from inpatient environments within the mental health setting

- All inpatients accepted for ECT will be tested for COVID 19 not more than 72 hours before their first ECT treatment.
- The patient should be treated in accordance with the medium care pathway unless the patient has been nursed in isolation between the swab being taken and receiving treatment.
- This will be undertaken by the ward staff.
- In the event that patients take leave from the ward during the course of their treatment, they will be informed of the isolating advice as for patients from outpatient environments (see 4.1.3 below)

Patients from inpatient environments within HUTH

- All inpatients accepted for ECT will be tested for COVID 19 not more than 72 hours before their first ECT treatment by the ward staff.
- The patient should be nursed within a side room they may be classed as low risk pending the results. If this is not possible/ the patient is being cared for in a bay with other patients the medium care pathway should be followed.
- In the event the patients are discharged from the ward during the course of their treatment, they will be informed of the isolating advice as for patients from outpatient environments (see 4.1.3 below)
-

Patients from outpatient environments

- All outpatients accepted for ECT will be tested for COVID19 not more than 72 hours before their first ECT treatment.
- This will be undertaken by the Community Mental Health Team or alternatively the ETC team if the patient is well enough to attend.
- A telephone call will be made to the patient by the ECT team prior to their appointment to ensure they are aware of the arrangements.
-

Additional advice for isolating for patients from outpatient environments

- Outpatients will be advised to observe social distancing for 14 days prior to attending for their first ECT appointment and for the duration of their course of ECT.
- They will also be advised to self-isolate from the day of the pre-treatment test (4.1.2) until the day of the treatment
- Where this is not possible (e.g. for 'maintenance' patients who may be receiving prolonged periods of treatment over months/years, or for those for whom isolation would risk a significant detrimental impact on the patient's mental health) then the patient should discuss this with the ECT department and decisions will be made as to whether or not to proceed with treatment on

a case by case basis following a risk assessment and swabbing to be considered as outlined above.

- Members of the patient's household will be asked to observe social distancing for the duration of the patient's treatment wherever possible. Where this is not possible household members will be asked to alert the ECT department to this and decisions will be made whether or not to proceed with the patient's treatment on a case by case basis

During ECT (COVID-19 Negative Patients)

Patients from inpatient environments

- The ECT will check the patient's clinical condition before the patient leave the ward to confirm the patient's absence of possible COVID 19 symptoms.
- Patients will have a documented temperature check by ECT staff on arrival in the department and will complete the COVID check list. Any abnormalities will be escalated for review by the ECT lead/ Consultant Psychiatrist

Patients from outpatient environments

- All outpatients will be telephoned the day before the treatment to check that isolation advice has been adhered to by the patient and their household and to confirm the absence of any possible COVID 19 symptoms.
- Patients and carer will be asked to comply with current Trust guidance for visitors to Trust sites (including being provided with a mask and asked to sanitise their hands at their point of entry to the building)

Patients from any environment attending once or twice weekly

- Patients will be tested twice-weekly.
- This will be done by trained ECT staff before or during the anaesthetic procedure

Patients from outpatient environments receiving ECT less frequently than once weekly (maintenance patients)

- Patients will be tested prior 72 hours prior to each attendance at ECT since it is not possible to guarantee that these patients have not been exposed to COVID19 between treatments. This will be done by the trained ECT staff.

During ECT (COVID-19 Positive Patients)

- Patients who test positive at any point during the course of their treatment will be reviewed on a case by case basis with the ECT team, the referring clinician and (if appropriate) the HUTH anaesthetists and/Infectious Disease Consultants.
- If clinically appropriate ECT will be suspended for 14 days (day 1 being the day the positive swab was taken), following which the requirement for reinstatement of ECT will first be assessed by the patient's referring team.
- In the unlikely event that ECT is critically required to be administered to a patient who has active symptoms of ongoing infection the need for treatment should be urgently reviewed and if deemed to be essential the patient placed last on the list with minimal personnel present. Recovery of the patient to take place.
- Patients who require ECT to be reinstated after 14 days (day 1 being the day the positive swab was taken) will be checked to ensure that they have been

fever-free for 48 hours and have improving respiratory symptoms. Once this has been confirmed they will be treated as per the COVID negative pathway (4.2 above). They will not however need a pre-treatment swab.

- The only exception to this are patients who have significant immunosuppression who will require a specimen after 14 days (day 1 being the day the positive swab was taken) i) confirmation of full resolution of all symptoms and ii) a further swab. Patients for whom a negative repeat swab is returned will then be managed as per the COVID19 negative pathway (4.2 above). Patients for whom a positive repeat swab is returned will then be managed as per the COVID19 negative pathway (4.2 above) with the following adjustments: i) the patient will receive treatment as the last patient on the list for that day ii) they will only be invited into the department when the other patients have left the department iii) they will be recovered from their anaesthetic in the treatment room iv) full infection control precautions will be strictly adhered to.

32. REVIEW

The above arrangements will be reviewed by the ECT team on a bimonthy basis

Print names: Andrea Copeland
Deborah Davies

Date: 19th January 2021

Appendix 1: Having ECT during the COVID-19 Pandemic

We know that the COVID-19 pandemic has caused difficulties for many of our service users, and their families, friends and carers. We have all had to make changes to the way we live and work and we appreciate your understanding and support in helping us protect you, other service users and our staff.

What is COVID-19?

COVID-19 is the infectious disease caused by a newly discovered coronavirus (SARS-CoV-2). The main symptoms of a COVID-19 infection are fever, cough, and a loss or change to your sense of taste or smell. Most people who become infected experience mild symptoms and recover, but for some it can be more severe.

How does it spread?

The COVID-19 virus spreads mainly through droplets from the nose and/or mouth when an infected person speaks, coughs or sneezes, and usually happens over a short distance.

The virus can also be spread when a person touches an object that is contaminated and transfers the virus to another person. Examples of potential surfaces are telephones and frequent touch points such as door handles.

Why have I been given this leaflet?

You are scheduled to have your ECT treatment soon.

As part of our response to the COVID-19 pandemic to keep patients and staff safe we have had to make some changes to our procedures which you need to be aware of before attending your appointment. This leaflet will give an outline of what to expect.

What changes will I see?

There are social distancing rules in place in all areas of the department including the ECT department. We ask that you maintain a 2 metre distance from anyone else. We also ask that you wear a face mask on entering the hospital building and this will be provided for you by a member of the ECT staff.

The ECT staff will be wearing personal protective equipment (PPE) to minimize the risk of spreading the virus. This could include gloves, face mask, eye goggles, face shield, apron and/or a long-sleeved gown.

What if I am coming for ECT from my home?

If you are coming for ECT from where you live you will be asked to have a COVID-19 swab 72 hours before your first ECT treatment. The ECT staff will telephone you in advance of this appointment to remind you and your care provider.

You will be informed of the swab test result by the ECT staff once it is available.

Social distancing and self-isolating before and after treatments

If you are coming from home for your treatment you are asked to observe social distancing for 14 days before your first ECT appointment and for the duration of your course of ECT. We ask that members of your household do the same. We recognise that this may be difficult for some people and, if this is the case for you or the members of your household, please talk about this with the ECT team.

You are also be asked to self-isolate from the day of your pre-treatment test until the day of your first treatment. If this is something which you would find difficult to do please let the ECT team know.

You will be telephoned before your treatment by the ECT team to check whether you and your household members have been able to adhere to the isolation advice and to check if you have had any COVID-19 symptoms.

What if I am already in hospital?
If you are an inpatient in hospital you will be tested on the ward for COVID-19 by a swab test of your mouth and/or nose by ward staff not more than 72 hours before your first ECT treatment.

You will be informed of the swab test result by the staff once it is available.

The ECT team will telephone your ward before your treatment to check if you have had any COVID-19 symptoms.

What happens on the day of my treatement?

On the day of your treatment please report to reception. Reception will let the ECT staff know that you are here.

On the day of your treatment, if you are coming from a ward, a member of the ward staff will escort you to the ECT department and provide you with a mask to wear.

You will have your temperature checked on arrival in the ECT department by ECT staff and, assuming it is within the normal range, your treatment will proceed

Will the COVID-19 test be repeated at any stage?

If you are receiving ECT once or twice weekly you will be tested twice weekly. These tests will be performed by the trained ECT staff before or during the anaesthetic procedure that you will normally be having as part of your ECT.

If you are receiving ECT less frequently than once weekly, you will be tested on your first attendance at ECT and at every attendance thereafter. These tests will be performed by the trained ECT staff before or during the anaesthetic procedure.

What will happen to my treatment if I test positive for COVID-19?

If you test positive at any point during the course of your treatment you will be reviewed by a multidisciplinary team including the ECT team, your referring clinician and (if appropriate) the HUTH anaesthetists.

If clinically appropriate ECT will be suspended for two weeks from the date of the positive test was taken and the requirement for ECT will be reviewed.

The results may be discussed with a virologist to help decide about ECT treatment. You might need to have your ECT treatment paused or receive your treatment in an area specified for people who are COVID-19 positive if it is deemed necessary.

Any questions?

If you have any questions about ECT please feel free to contac the department to discuss with staff 01482 617553

Appendix 2: Care Pathways for the ECT Department

Low Risk	Medium Risk	High Risk
Patients in the community Patients in the community who have no symptoms or known recent COVID-19 contact AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of the treatment and have self-isolated from the test date	**Patients in the community** Any patient who has been clinically assessed but are awaiting a SARS-CoV-2 (COVID-19) test result with no known recent COVID-19 contact OR declines testing Any patient whose behaviours suggest that social distancing/contact with other potential high risk individuals cannot be ruled out	**Patients in the community** Any patient who presents for assessment OR treatment with symptoms. OR a confirmed SARS-CoV-2 (COVID-19) positive OR symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case OR are symptomatic and awaiting test results OR symptomatic individuals who decline testing
Inpatients from the mental health units Patients who have no symptoms or known recent COVID-19 contact AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of the treatment and have self-isolated from the test date/in a unit in the low risk pathway	**Inpatients from the mental health units** Patients who have no symptoms or known recent COVID-19 contact AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of the treatment but have not self-isolated from the test date/and are being cared for in a unit in the medium risk pathway.	**Inpatients from the mental health units** Patients who are displaying or recent potential/actual contact with a COVID-19 individual. From a unit experiencing a covid related outbreak.
Inpatients from secondary care Patients who have no symptoms or known recent COVID-19 contact AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of the treatment and have been cared for in a single room or in a bay/ward which is deemed to be COVID-free Individuals who have recovered from COVID-19 and have had at least 3 consecutive days without fever or respiratory symptoms and a negative COVID-19 test	**Inpatients from secondary care** Patients who have been triaged that have no reported symptoms or known recent COVID-19 contact AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of the treatment but have not been cared for in a single room or in a ward bay deemed to be COVID free	**Inpatients from secondary care** Patients triaged that have been in an area where COVID positive cases have been identified/an outbreak has occurred

PPE Requirements for Aerosol Generating Procedures

PATHWAY				
LOW	Single use if contact with blood and/or body fluids is anticipated	Single use apron (gown required if risk of spraying/ splashing)	Surgical mask Type I, II or IIR for extended use1 FRSM Type IIR for direct care	Risk assess and use if required for care procedure/ task where anticipated blood/body fluids spraying/ splashes
MEDIUM	Single use	Single use Disposable gown	FFP3 mask or hood for AGPs	Single use or reusable visor /goggles
HIGH	Single use	Single use Disposable Gown	FFP3 mask or hood for AGPs	Single use or reusable visor/goggles

PPE Requirements for Non-Aerosol Generating Procedures

PATHWAY				
LOW	Single use if contact with blood and/or body fluids is anticipated	Single use apron (gown required if risk of spraying/ splashing)	Surgical mask Type I, II or IIR for extended use1 FRSM Type IIR for direct care	Risk assess and use if required for care procedure/ task where anticipated blood/body fluids spraying/ splashes
MEDIUM	Single use	Single use apron (gown required if risk of spraying/ splashing	FRSM Type IIR for direct patient care	Single use or reusable
HIGH	Single use	Single use apron (gown required if risk of spraying/ splashing)	FRSM Type IIR for direct patient care	Single use or reusable