Black Country Partnership
NHS Foundation Trust

Electroconvulsive Therapy (ECT)

Target Audience				
Who Should Read This Policy	Mental Health	Learning Disabilities	Children, Young People & Families	Corporate
All Clinical Staffs	✓	✓	✓	✗

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Appendices

Explanation of terms used in this policy

ECT - is the induction of a generalized, bilateral tonic/clonic seizure by passing an electric current through the brain after the patient has received a general anaesthetic and muscle relaxant. A muscle relaxant is administered to reduce the intensity of jerky motor movements during the clonic phase of the seizure.

Although ECT has been used since the 1930s, there is still a lack of widespread consensus regarding its mechanism of action. The most prevalent hypotheses are that it causes an alteration in the post-synaptic response to central nervous system (CNS) neurotransmitters and/or proliferation of a specific type of neurone (nerve cell).

In contrast to the United States, where ECT prescribing is on the increase, there has been a steady decline in the use of ECT in the UK since 1985. This may be due to improvement in other treatments for depressive illness, negative experience and feedback from patients in the past, concerns around long term outcomes and stigma associated with ECT.

BECT - Bilateral ECT

UECT - Unilateral ECT

ECT - Electroconvulsive therapy

ECG - Electrocardiogram – a recording of the electrical changes in the heart muscle during the cardiac cycle

EEG - Electroencephalogram – a recording of electric changes produced by activity in the brain Maintenance ECT - May be indicated in patients where the index episode of depressive illness responded well to ECT and there is early relapse despite adequate continuation of drug treatment or an inability to tolerate continuation drug treatment. It would be desirable to use a less frequent schedule – every 2-4 weeks.

ODP - Operating Department Practitioner

RC - Responsible Clinician-consultant psychiatrist

Stimulus dosing Protocol - An explicit set of user guidelines which take into account a number of individual patient parameters when calculating the initial dosing regimen.

SOAD - Second Opinion Approved Doctor

DVLA -Driver and Vehicle Licensing Agency

1.0 Introduction

This policy outlines the principles and procedures for delivery of electro convulsive therapy (ECT) service at Black Country Partnership (BCP) NHS Foundation Trust. ECT is a safe and effective treatment used to treat patients with specific types of serious mental illness. It can be lifesaving when other treatment options have proved ineffective or are contraindicated.

The service is provided twice weekly on Monday and Thursday morning at Edward Street Hospital ECT Suite by a team of dedicated, well-trained and experienced medical and nursing staff.

There is a named Consultant psychiatrist in charge of the suite and a named RMN qualified nurse who takes overall responsibility for the management and running of the service.

Administration of ECT requires appropriate consent and consent to treatment issues must be addressed prior to initiation of treatment. The consent process is facilitated by patients receiving appropriate verbal and written information in a format which is easily understood.

The use of ECT within the Trust follows the recommendations set out by the Royal College of Psychiatrists (2013) and takes into consideration the Guidance on the Use of ECT by the National Institute for Clinical Excellence (NICE) (2009).

2.0 Purpose

The policy sets out standards for delivery of a high quality, safe and effective ECT service in line with recommendations from NICE Guidance on the use of ECT, (CG 90, NICE, 2009). When ECT is considered for use outside NICE guidance, the treatment rationale must be documented in the patient's case notes and their ECT Care Pathway by the Consultant Psychiatrist/ RMO. This should be discussed with the patient as part of the consent process for ECT.

This policy also takes into consideration best practice guidelines set out in 'The ECT Handbook' (Royal College of Psychiatrists, 2012 3rd Edition), the Mental Capacity Act (2005), the Trust's Consent to Treatment policy (2006) and the ECT Accreditation Service (ECTAS, 2013). It provides assurance that the service meets legal requirements in relation to capacity and consent and the use of the Mental Health Act (MHA) and Mental Capacity Act (MCA).

Anaesthetic and recovery section incorporate recommendations from the Royal College of Anaesthetists' Guidance on the provision of anaesthetic care in the non-theatre environment (GPAS 2018). Consideration is given to safeguarding patient's privacy and dignity during treatment.

3.0 Objectives

It applies to all patients referred for ECT services provided by the Black Country Partnership NHS Foundation Trust. It sets standards in relation to the ECT Clinic facilities, referral pathway, indications, the assessment and preparation of patients, the administration of ECT, anaesthetic practice, monitoring, recovery and special precautions in particular patient groups. It provides guidance on the use of the Care Pathway (2016) by the clinical staff (medical, nursing and others).

4.0 Process

4.1 Indications for ECT

It is recommended that ECT is used to treat:

- Severe mental illness which may be life-threatening or resistant to other types of treatment.
- Less severe mental illness where the person has responded well to ECT in the past, has requested ECT again or where availability of other treatment options is reduced e.g. due to a co-existing medical condition.

ECT is most frequently used to treat severe depressive illness and severe mania; although its use is not limited to these conditions, e.g. ECT is effective in treating the motor and non-motor symptoms of Parkinson's disease.

Selection of ECT may be affected by:

- patient choice;
- previous experience of ineffective/intolerable medical treatment;
- Previous recovery with ECT;
- Suitability of alternative treatment options.

4.2 Resources and Equipment

Premises

The ECT suite is situated on the first floor at Edward Street Hospital, Edward Street, West Bromwich. The service operates from 08.00 on Monday and Thursday.

The standards set out in the Royal College of Psychiatrists guidance state that the minimum requirement is five rooms:-

- A quiet waiting room separate from other waiting areas and clinical activities;
- A treatment room with direct communication to an adjacent recovery room;
- A recovery room of sufficient size to accommodate rate and number of patients treated per session;
- An office for use by the ECT team, for administration, telephone liaison and meetings;
- A post-ECT waiting area.

Monitoring and Resuscitation Equipment

ECT is administered using a machine recommended by Royal College of Psychiatrists, a MECTA 5000M, which allows EEG monitoring.

Anaesthesia is administered on a tipping trolley and these are sufficient for the rate and number of patients treated. Minimum monitoring standards as set out by AAGBI Recommendations for standards of monitoring during anaesthesia and recovery', Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2015) are followed.

The following equipment is in, or immediately adjacent to, the ECT treatment room:

- An oxygen cylinder, mask and bag and at least one full spare cylinder;

- Airway equipment including Laryngoscopes (different sizes), Oro-pharyngeal airway (different sizes), and Endo-tracheal tubes(different sizes)
- Difficult airway trolley as recommended by DAS (See appendix 3)
- A fully equipped emergency drugs tray (See appendix 1)
- Resuscitation drugs (See appendix 2)
- A fully equipped emergency trolley
- Monitoring facilities including: ECG machine, capnography, Pulse oximeter, BP monitor
- A defibrillator
- A suction machine in each of the treatment and recovery rooms;
- Blood pressure monitor and pulse oximeter in the recovery room.

Maintenance and Checking of equipment

- The output and electrical safety of the ECT machine is checked and recorded annually by contracted manufacturers;
- The ECT electrodes are visually checked weekly for integrity of their insulation and wiring by Lead ECT Nurse;
- Emergency resuscitation equipment is tested and checked at least weekly;
- The emergency drugs tray is checked monthly for out-of-date drugs and missing items.
- The anaesthetist and the ODP must check the anaesthetic, monitoring and suction equipment prior to every session.
- The defibrillator must be checked in the morning by the ODP prior to each session.

4.3 Preparation for ECT

The ECT Care Pathway and ECT Anaesthetic care pathway outline the journey before, during and after treatment for patients and healthcare professionals involved in ECT.

When ECT is being considered as part of a treatment plan, an ECT Care Pathway Pack is available from Medical secretaries located at Penn, Hallam and Edward Street. This can also be requested from the ECT Department (ext. 8242). It contains all the relevant ECT paperwork and guidance on how and by whom this should be completed. It is colour-coded to facilitate use.

The ECT Care Pathway pack contains documentation relating to ECT prescribing, consent to treatment, ECT administration, monitoring and follow-up care. It is used alongside the ECT Patient Information Booklet. Specified documents are completed by the referring psychiatrist, ward clinical team, patients, and ECT team. Written guidance is provided in the ECT pack and additional support is provided by telephone advice from the ECT team and ward visits. It is the referring team's responsibility to ensure that all documentation is completed in accordance with the policy.

All patients are offered an opportunity to visit the ECT suite and to speak to ECT staff regarding their treatment.

ECT may be deferred if the appropriate preparations have not been made. Depending on the reason, this can be the decision of the ECT Lead Consultant or

Anaesthetist and/or ECT Charge Nurse. Reasons for deferring treatment must be documented in the patients' notes.

4.3.1 Consent to treatment

Assessment of Capacity for Consent to ECT
As part of the ECT Care Pathway, the referring Consultant Psychiatrist or their nominee completes a Capacity Assessment for Consent to ECT for every patient referred for ECT. The completed assessment form is stored in the ECT Care pathway pack.

The capacity assessment for consent to ECT identifies if a patient:

- Understand the information relevant to the decision;
- Retains that information long enough to make a decision;
- weigh up the pros and cons of the information to come to a decision;
- communicate their decision;

(Trust Consent to Treatment Policy & Mental Capacity Act Protocol).

The referring psychiatrist records whether the patient has or lacks capacity to consent to ECT. For those lacking capacity to consent to ECT, a SOAD (second opinion medical opinion) must be requested. The date of SOAD request is recorded.

As part of the ECT Care Pathway, a Statement of Health professional document is completed by the referring psychiatrist. It confirms that the patient has been provided with verbal and written information about the treatment, its likely benefits and risks and possible side effects. It is recorded that the patient is informed about alternative treatments, including no treatment, and DVLA guidance on the effect of ECT on fitness to drive. The referring psychiatrist records that the patient has been informed of their right to refuse ECT and the means by which ECT can be given without consent if authorized by a SOAD. Further information is provided in the ECT Patient Information Booklet including information relating to unilateral and bilateral ECT, type of treatment being prescribed and the reasons for this.

Additional information may be provided by the referring Consultant Psychiatrist at their discretion and in response to issues raised by the patient and/or their carers. Efforts to involve carers in discussions around consent to ECT are recorded by the referring psychiatrist. The Lead ECT Consultant Psychiatrist is available to support the referring psychiatrist in responding to queries raised by patients and carers. The referring psychiatrist must also ensures that the patient: is aware that they have the right to withdraw consent at any time; does not feel pressurised into giving consent to treatment; has full and appropriate information in format that they can understand;

As part of the consent to treatment process, individuals referred for ECT are advised that follow up assessments are carried out at 3 and 6 months post-treatment, to check for any long-term adverse effects arising from treatment. These assessments are arranged by the ECT Team.

Relevant advance statements are considered during the consent to treatment process, as per section (4.3.2): Advance Statements.

Patients consent to treatment is confirmed prior to each treatment session by the ECT Nurse/Team, who documents it in the Care pathway under ECT Consent to Treatment.

Consent to ECT for Informal Patients
Informal patients having capacity may agree or refuse to consent to ECT.
Where, as a result of a capacity assessment, an informal patient is deemed to lack capacity to consent to ECT, consideration must be given as to whether treatment is most appropriately given under Part IV of the Mental Health Act 1983. If so, this authorises the administration of ECT without the patient's consent.

When it is not appropriate that an incapacitated service user receives ECT under Part IV of the Mental Health Act 1983, then the Mental Capacity Act 2005 applies. A Best Interest Checklist tool should be utilised to determine whether or not ECT is in the best interest of the individual concerned. (See Appendix 4 for Mental Capacity Act Flowchart)

Consent to ECT for Detained Patients
Detained patients with capacity to do so should sign an ECT consent form, should they agree to receive ECT. A Form T4 should be completed by the Responsible Clinician (Consultant Psychiatrist) or Consultant recognised as providing locum RC cover, confirming that the patient has capacity to consent to ECT. ECT is then given under section 58a.

Patients detained under Part IV of the Mental Health Act (1983) who lack the capacity to consent may receive ECT without their consent.
In non-emergency cases, a recommendation from an independent Second Opinion Doctor (SOAD) supporting/authorising the use of ECT is obtained. A SOAD is an independent medical practitioner appointed by the Mental Health Act Commission. He/she is required to interview the patient, complete the relevant documentation and stipulate the number of treatments the patient would receive in one course. He/she consults with the patient's Doctor and two other professionals concerned with their care.

The patient is deemed to be 'not capable of understanding the nature, purpose and likely effects of the treatment or has not consented to it but that, having regard to the likelihood of its alleviating or preventing a deterioration of his condition, the treatment should be given'. Form T6 is completed.
It is good practice to involve relatives/carers, but no relative/carer may consent on behalf of an adult.

ECT under Section 62 Mental Health Act
In Emergency cases, detained patients may receive a limited number of treatments under section 62 of the Mental Health Act, if they require emergency, life-saving treatment before it is possible to arrange a SOAD assessment.
A section 62 Form is completed by the Responsible Clinician (Consultant Psychiatrist) or the Consultant Psychiatrist recognised as providing locum RC cover. A separate form must be completed for each treatment unless exceptional circumstances apply.

The Role of IMCA and Consent to ECT
In line with the IMCA Engagement Protocol, an unfriended incapacitated patient should have access to Independent Mental Capacity Advocacy services, which will represent the patient during completion of the Best Interest Checklist. This reflects the Trust's view of ECT as a serious medical treatment.

Legal Status	Capacity to Consent	Agreeing or Refusing	Recommendations
Informal	Yes	Agreeing	Treat under normal rules of written consent (Consent Form 1, Appendix D)
	Yes	Refusing	Cannot treat with ECT
	No	Agreeing	It may be possible to treat under Section 5 of the Mental Capacity Act. Independent opinion (informal) advised, or the second option would be use Mental Health Act + SOAD
	No	Refusing	Not appropriate to use the Mental Capacity Act. If ECT is to proceed, the patient may need to be detained under the Mental Health Act + SOAD
Detained (where Part IV of the Mental Health Act applies)	Yes	Agreeing	Treat with written consent that must be certified on (form T4)
	Yes	Refusing	Cannot treat with ECT, request urgent SOAD
	No	N/A	Treat if approved by SOAD from CQC on (Form T6)

4.3.2 Advance Statements

Advance Statements and ECT
Where valid advance statements relating to ECT exist, these apply for all capacitated individuals, and are to be taken into account by the referring clinical team.

Advance Statements concerning Resuscitation and ECT
In the event of acute cardiac/pulmonary arrest or difficulty, efforts are always made to resuscitate individuals receiving treatment within the ECT department, regardless of whether a previous 'Do Not Resuscitate' decision exists. This is in line with guidance from the Royal College of Anaesthetists, and reflects the iatrogenic nature of adverse outcomes resulting from a medical procedure such as ECT.

4.3.3 Physical Assessment
The patient's fitness for general anaesthetic must be assessed. A full medical history is obtained and a physical examination with the assessment of oral health i.e. Dentition, prior to receiving ECT by the referring team. The risks of dental damage

should be explained to the patient by the referring team. ECT Anaesthetic Care Pathway.

It is recommended that any significant physical illness is fully investigated and treated as far as possible prior to treatment. Examination and investigations must be carried out in a timely manner, generally within 72 hours of the first treatment. However, the prescribing doctor should use his/ her clinical judgement to determine the timing of these investigations.

- ECG, FBC, U&E, LFTs & random glucose are essential for all patients.
- Chest x-ray should be performed when clinically indicated.
- Lithium Levels & Sickle cell tests are performed when indicated.
- Venous Thrombo Embolism (VTE) Screen should be carried as per trust's protocol.

Patients are graded by ASA Grade (American Society of Anaesthesiologists classification). ASA categories 1 and 2 need not be reported to the Anaesthetist before the patient presents for treatment, subject to the results of other investigations being in place. Patients with ASA classification 3, 4, or 5, or with a significant concurrent medical disorder, will always require notification to the Lead Anaesthetist before the treatment session. As a guide the following patients are always discussed with the anaesthetic Lead

- ASA 3 or 4 patient, especially all patients with major cardio-respiratory issues
- Pregnant patients
- Patients with Body Mass Index (BMI) >= 40
- Patients with insulin dependent diabetes
- Patients with pacemakers
- History of airway problems/ difficulty with intubation
- Personal or family history of Suxamethonium apnoea
- History of allergy to neuromuscular blockers
- History of Malignant Hyperthermia

The ECT Anaesthetic Link nurse liaises with the patient, referring team and the Lead ECT Anaesthetist in relation to physical health and anaesthetic issues as per the ECT Anaesthetic Care Pathway.

4.3.4 Pregnancy testing prior to ECT:

Pharmacologic therapies can pose risks to the foetus in pregnant patients. In a crisis situation in which the risks of untreated symptoms are extreme, the patient is known to be refractory to medications, or the medication represents a substantial risk to the foetus, ECT represents a valuable alternative in the pregnant patient. When administered by trained staff, and when precautions germane to pregnancy are considered, ECT is a relatively safe and effective treatment during pregnancy.

Pregnancy test should be considered in all pre-menopausal women and women of childbearing age, although ECT is not generally of increased risk in pregnant women. Although no data exist on the optimal interval in time between the pre-ECT evaluation and the first treatment, the evaluation should be performed as close as possible to the initiation of treatment, keeping in mind that it often must be spread over a number of days, due to need for specialty consultations, waiting- for laboratory results, meetings with patient and significant others, and other factors. The treatment

team should be aware of pertinent changes in the patient's condition over this time interval and should initiate further evaluation as indicated.

4.3.5 Medication

During treatment, a patient's seizure threshold is affected by a number of medications e.g. antipsychotics, antidepressants, benzodiazepines and anti-convulsants. Individuals receiving such medications have been reported to have good clinical response to ECT in the majority of cases. Where this is so, it is unnecessary to omit the medication prior to treatment. For others however, such medication negatively impacts on the potential response to ECT by interfering with seizure threshold. It may be recommended that these individuals have their medication reviewed and, if appropriate, that the relevant medication is omitted prior to ECT. The ECT department will advise the referring team if this latter applies.

- Anticonvulsants raise seizure threshold and may shorten seizure duration. They should not be stopped prior to treatment – whether being used as an anticonvulsant or mood stabiliser. A higher stimulus dose may be required.
- Long established benzodiazepines should not be stopped suddenly before ECT. There is a risk of a dramatic lowering the seizure threshold.
- Lithium may result in long seizures. Lithium should be continued but consider a lower stimulus at the first treatment. Pre-treatment screening must include a lithium level.
- No special precautions are required for antipsychotics, except Clozapine which may lower the seizure threshold markedly. A lower stimulus is advisable, and clozapine withheld for 12 hours prior to each ECT session.
- A number of reports suggest that SSRIs may be related to prolonged seizure activity. Stopping the drug immediately prior to ECT is of no benefit because the drugs have a long half-life. Consider a lower stimulus at the first treatment.
- Monoamine Oxidase Inhibitors and Tricyclic Antidepressants do not need to be discontinued prior to ECT. L-Tryptophan may shorten seizures. The anaesthetist should be informed in advance that the patient is taking one of these medications.

In general, most medication prescribed for a general medical condition is continued during a course of ECT unless the anaesthetist requests that it is omitted. The decision on whether to continue medication is based on a risk benefit analysis for each individual.

- Patients who are prescribed proton pump inhibitors (e.g. omeprazole, lansoprazole, etc.) or H2 antagonists (e.g. ranitidine) for gastro-oesophageal reflux, hiatus hernia or other gastric disorder MUST be given this medication in the morning prior to ECT.
- Patients with hypertension MUST receive their prescribed medication in the morning prior to ECT. Their blood pressure must be recorded prior to leaving the ward to attend the ECT suite and should be documented in the patient notes.
- Individuals with a history of asthma, chronic obstructive pulmonary disease or smoking related airways disease should receive routinely prescribed inhalers prior to leaving the ward.
- Medicines which are not normally given on an empty stomach (e.g. non-steroidal anti-inflammatory drugs) are omitted on the morning of ECT.

- Peri-procedure management if diabetes is complex and guidelines recommended by AAGBI - Peri-operative management of the surgical patient with diabetes 2015 must be followed. All Patients with diabetes mellitus should be discussed with the anaesthetist prior to ECT. An individual treatment plan must be in place. Patients should have their blood glucose concentration measured prior to leaving the ward or upon arrival to the ECT suite. They will usually be placed first on the ECT list. Diabetics should bring their insulin and administering pen with them to the ECT suite.

Medication is administered in line with the Trust ECT Nursing Care Plan, which states that regular medications should be administered at 07.00 hours on the morning of ECT with a few sips of water. This instruction should be written on the medication sheet by the referring medical team, and the administering nurse should enter the time at which the medication was given on the morning of ECT. Clinicians involved in prescribing ECT are required to remain updated on ECT and appropriate prescribing practices.

4.3.6 SMART teams and WHO check list for ECT:
The World Health Organization Surgical safety checklist was developed after extensive consultation aiming to decrease errors and adverse events and increase teamwork and communication within interventional teams.

The “five steps to safer surgery” as proposed by NPSA’s Patient safety first campaign has been modified to account for the difference in processes within ECT suite. All clinical staff participating in ECT will use the ‘modified three steps to safer ECT’. The “three steps to safer ECT” are described as follows:

1. Team Brief
2. WHO Checklist Sign In + Time Out
3. Debrief

Step 1: Team Briefing
1.1 All team members must introduce themselves by name and role.

1.2 Each patient will be discussed in list order and where relevant the following will be discussed:

Issues during previous ECT session
- Allergies
- Comorbidities and complications
- Need for fluids
- Any modification to ECT treatment and dose
- change is dose of anaesthetic drugs

1.3 SMART team: Complications are extremely rare during ECT but in case of an emergency, in order to achieve the best outcome for the patient it is vital that each member of the team understands their roles and responsibilities. The allocation of the roles and responsibilities are discussed as part of team brief;

- Anaesthetist (ALS Trained) – Leads during an emergency and manages airway

- ODP (ILS Trained) – Supports the anaesthetist and Provides chest compressions
- ECT nurse (ILS Trained) – Provides chest compressions
- Psychiatrist (ILS Trained) –
- Runner (ELS Trained) –
- Recovery staff (ILS Trained) -

Step 2: Sign In
2.1 The first stage of check list is performed in the Pre-ECT Treatment room. It is the responsibility of the nurse to ensure that the patient is wearing an appropriate wrist band and a red allergy band.

2.2 Sign in is then performed in the ECT suite by the anesthetist and anesthetic practitioner and Nurse. It is good practice to involve the patient in these checks. Sign In must include checking the patient's identity using positive patient identification, consent, both verbally and against available documentation. Also, any other risks particularly allergies must be identified at this time. Sign in must be completed in the patient's folder both by the anesthetist and the psychiatrist.

2.3 Post ECT it is important that all lines and cannulas are flushed, and this must be clearly documented in patients notes by the anesthetist.

Step 3: Debrief
3.1 This will take place at the end of a list and will involve the key team members from Psychiatrist, anesthetists and nursing staff. This is an opportunity for the team to highlight issues that have arisen during the list. Debrief is also an opportunity for promoting good practice, and team members that have contributed to safety or efficiency during the list or session should be recognized. The Lead nurse will be responsible for feeding information into the local governance process.

3.2 These issues should be documented in the debrief section of the form so that they can be addressed and avoided during subsequent sessions.

3.3 Any incident that has occurred must discussed in the de-briefing to keep everyone in the team informed. All incidents or errors must be reported using the trusts incident reporting systems and escalated using the appropriate local governance processes.

4.3.7 ECT and DRIVING
The 2010 DVLA guidance for individuals with severe or psychotic depressive illness, with significant memory or concentration problems, is that driving should cease for up to 3 months after recovery. This information should be provided by the Referring Consultant Psychiatrist as part of the consent to treatment process and is included in the ECT Treatment Proposal form in the ECT Care Pathway.

4.4 ECT Prescribing: Bilateral ECT and Unilateral ECT
A patient is prescribed ECT by their Consultant Psychiatrist. The Consultant prescribes either bilateral (BECT) or unilateral (UECT) treatment, based on clinical presentation, previous response to ECT, history or development of any adverse effects, e.g. cognitive impairment and where appropriate, patient choice.

Bilateral ECT involves bi-temporal electrode placement. Unilateral ECT involves placing electrodes on the non-dominant hemisphere in a temporo-parietal position. The decision to prescribe bilateral or unilateral ECT is made in line with the Protocol for Choice of Laterality in ECT Prescribing.

During a course of treatment, it may become necessary to switch from UECT to BECT (e.g. if there is no clinical response despite adequate seizure response), or from BECT to UECT (e.g. due to the development of significant cognitive side effects). A reason for switching between treatments is documented in the ECT Care Pathway and stimulus dose is re-calibrated as appropriate. The change in prescribing must also be discussed with the patient as part of the re-consent process.

Both unilateral and bilateral ECT is given twice weekly on a Monday and Thursday morning. Increasing the frequency of treatment may increase the risk of cognitive impairment and does not increase the speed of clinical response.
A set number of treatments should not be prescribed at the start of a course of ECT. It is common practice to obtain consent for ‘up to 12 treatments.

ECT Monitoring
The patient is reviewed after each treatment by the clinical team and a further 1 or 2 treatments prescribed, if necessary. This also allows relevant clinical information to be picked up and communicated to the ECT team (ECT consultant or ECT charge nurse).

Monitoring of cognitive status is undertaken by the ECT Lead Nurse baseline and following treatment 4, 8 and 12, using the MMSE. Clinical progress is monitored weekly using validated assessment tools, e.g. Clinical Global Inventory (CGI). The patient is invited to keep an ECT diary during the course of ECT, to log their experience of treatment.

Discontinuing ECT
If no clinical improvement is seen at all after 6 applications of the appropriate stimulus dose (excluding seizure threshold calibration), then it may be necessary to consider discontinuing ECT. Some patients do not respond to unilateral ECT but subsequently respond to bilateral treatment, so a change in prescribing may be appropriate. Patients having capacity must consent to this change in their treatment and a new consent form must be signed. Alternatively, some patients’ clinical response only becomes evident late in a course of treatment. In these cases, it is appropriate to persist with ECT up to an agreed number of treatments. Standard practice is to provide up to 12 treatments for patients who have shown definite but slight improvement, although 12 treatments may not be required for everyone if recovery occurs earlier.

ECT may also be discontinued for other reasons e.g. factors relating to anaesthesia and recovery. These must be documented in the ECT Care Pathway.

4.5 Administration of ECT

Referral to ECT
A referral form is obtained from the intranet for both inpatient and outpatient. This is completed and sent to the ECT department via Ectteam mailbox and is followed up by a telephone call to acknowledge receipt of the referral. Each referral is discussed

with the ECT Lead Consultant Psychiatrist. Patients with comorbidities are discussed with the Lead consultant anaesthetist. If patient is deemed suitable for ECT a date and time will be given regarding the start of treatment.

Visit to the department
Patients and their carer will be given the opportunity to visit the department prior to treatment and to discuss any queries with the team.

Commencement of treatment
Before a treatment session can take place, there must be an anaesthetist, ODP, psychiatrist and ECT trained nursing staff present. Team brief takes place in the morning in the ECT suite where all the members of the team must be in attendance. All patients on the list are discussed as per section 4.3.6.

The ODP is responsible for checking the defibrillator and the monitoring equipment in the morning. They also ensure that there is adequate supply of oxygen cylinders and that necessary equipment and drugs are available for the smooth running of the session. The anaesthetist is responsible for checking the airway equipment and preparing the drugs. The psychiatrist and the lead nurse are responsible for checking the ECT machine prior to the start of the session.

All patients are fasted for solids for at least six hours prior to treatment. Fluids are allowed up to 2 hours prior to treatment. On arrival at the ECT department, an identity bracelet is placed on the patient's wrist by the ECT staff (Charge Nurse or Healthcare Support Worker). This remains in place until the patient is ready for discharge from the recovery area following their treatment. Patient with any allergies must have a Red allergy bracelet with appropriate allergies recorded on the bracelet. Nil by mouth status is confirmed. When the patient is coming from their own environment, extra care must be taken to ensure that the patient has been nil by mouth. Depending on patient's choice, dentures could be removed in the ward or immediately before treatment. Dentures removed in the treatment room, should be placed in a marked container clearly identifying the patient. Head and neck jewellery including studs and hair clips must not be worn and all rings should be secured with adhesive tape. The nurse also ensures that patient has taken or omitted their routine medication as per the protocol and any deviation is communicated to the anaesthetist.

Up-on arrival into the treatment area, The ECT team should introduce themselves to the patient and sign-in must be completed by the anaesthetist. Monitoring equipment is attached by the OPD. In uncooperative patients it is acceptable to attach the necessary monitoring post induction. Patient is cannulated and following a period of pre-oxygenation, anaesthesia is usually induced by intravenous drugs. Propofol is the preferred induction agent at a dose from 1.5-2.5mg/kg and Suxamethonium is the preferred muscle relaxant at a dose from 0.5mg/kg. The anticholinergic of choice to protect against bradycardia and limit secretions is Glycopyrronium bromide 0.2 mg IV. Atropine as this is a potent cause of confusion especially in the elderly. It is vital that there is consistent use of anaesthetic agents and dosing. Any reason for a change in anaesthetic induction agent is discussed with the ECT team and documented. Ventilation with oxygen will reduce adverse effects. Hyperventilation is a useful technique which can augment seizure activity. If the patient has their own teeth, a bite block is placed in the mouth to protect them from biting their tongue and

also causing damage to gum or dentition. IV fluids, antiemetic drugs are administered as required.

The psychiatrist applies EEG monitoring leads to monitor cerebral seizure activity. Two leads are applied to each side of the head using a frontal-mastoid montage, to record seizure activity from each cerebral hemisphere. A fifth lead is applied to the mid forehead, which functions as 'earth', and has no recording function. When anaesthesia has been induced, two electrodes are applied to the patient's head (non-dominant temporo-parietal areas for unilateral ECT and both temporal areas for bilateral ECT). The ECT machine measures potential impedance to the electric stimulus about to be delivered. Once this is within the appropriate range and the psychiatrist is satisfied with the electrode placement, the electric stimulus is delivered once the ECT Charge Nurse presses the stimulus button on the ECT machine. ECT is administered using Accredited Treatment Protocols.

The electrical stimulus is delivered through the scalp and cranium and is expected to result in a modified bilateral generalized seizure. This is evidenced by muscle stiffening during the tonic phase and rhythmic limb jerking or twitching during the clonic phase. Seizures are monitored by observing and timing the motor ictal response and monitoring ictal electroencephalogram (EEG) activity. Adequate cerebral seizure activity is indicated by the presence of bilateral 3-per-second, spike and slow wave activity on the EEG.

After the administration of a successful stimulus, the anaesthetist administers oxygen and observes the patient until the effects of the anaesthetic and muscle relaxant have worn off. The patient remains in the treatment room until he/she begins breathing independently.
Anaesthetic administration record and any anaesthetic problems and complications are documented on the ECT Treatment Record sheet of the ECT Care pathway. Any residual Suxamethonium in the cannula can lead to late respiratory depression. Post procedure it is important that the cannula is flushed, and this must be recorded in the care plan.

4.6 ECT Parameters and Seizures

Clinical response to ECT is influenced by a number of factors: the relationship between seizure threshold and stimulus dose, electrode placement, age, gender, physical health, and medication.

Seizure threshold is determined by a process of dose titration at the first or second treatment session (Protocol for Measuring Seizure Threshold). Up to three applications are administered per treatment session until seizure threshold is established. There is a 30-60 seconds observation period between applications.

Once seizure threshold has been established, an individual's course of treatment is managed using Protocols Measuring Seizure Adequacy and Managing a Course of ECT. The dose is reviewed on the basis of seizure adequacy, adverse effects and clinical response. A dose increase is indicated if there is either an inadequate seizure or poor clinical response. A decrease in stimulus dose is indicated if the patient is experiencing unacceptable side-effects, e.g. cognitive impairment.

It may be necessary to increase the dose during a course of ECT, because of a rise in seizure threshold. Seizure duration is no longer used as the important treatment

outcome measure. Qualitative measures now considered important include bilateral motor response, symmetrical ictal response, wave formation and amplitude as observed by EEG. Clinical response is also taken into account when considering stimulus dosing.

Use of the Hamilton cuff on a limb can assist in determining whether a seizure has occurred. This method is carried out by applying a blood pressure cuff to the ipsilateral limb and inflating the cuff to well above systolic blood pressure before the muscle relaxant is injected. A seizure is more accurately timed in this limb. Re-stimulation is prescribed as per Protocol for Measuring Seizure Adequacy there is an appropriate 30-60 second delay between doses, so as to minimize the risk of a prolonged seizure.

Prolonged Seizures
A seizure of 120 seconds or longer is considered a prolonged seizure for which intervention is required Managing a Prolonged Seizure. Specific intravenous anaesthetic agents e.g. Propofol, or benzodiazepines are used to terminate the seizure. The frequency of prolonged seizures is extremely rare, but patients are advised of this risk as part of the consent to ECT process.

Tardive Seizures
A tardive seizure is a late return of seizure activity, most likely to occur in recovery. It is managed as per Protocol Managing a Tardive Seizure, i.e. by maintaining oxygenation, monitoring EEG and intervention by the anaesthetist to terminate the seizure using specific intravenous anaesthetic agents or benzodiazepines as in the case of prolonged seizures. Monitoring continues until the seizure terminates and the patient recovers fully. Likely causes of tardive seizures are investigated. The patient is discharged from the department as per the usual Discharge Protocol. Stimulus dose, anaesthetic agent and prescribed psychotropic medication are reviewed at the following treatment session.

4.7 Recovery
While the patient is recovering from the anaesthetic, the recovery nurse ensures that an adequate airway is maintained. The patient's pulse and blood pressure is monitored until stable. There is one-to-one monitoring by a nurse until the patient is fully conscious and communicating and can respond to commands and move. He/she is moved to a quiet area to recover fully and given a drink of their choice. Levels and length of post treatment confusion and disorientation are monitored, documented and treatment reassessed if cognitive impairment is significant. Discharge from the recovery room is at the discretion of the anaesthetist /recovery nurse.

Discharge from ECT Department following ECT Treatment and transfer back to the ward is under the observation of an accompanying nurse.
Outpatients will need a responsible adult escort to take responsibility for them once they leave the ECT department.

Observation is continued on the ward and ward staff bring to the attention of the psychiatric team any complaint the patient may have following treatment and report any cognitive or non-cognitive effects. The Anaesthetist, ODP and Psychiatrist should remain in the ECT suite until all patients have fully recovered consciousness and are stable. At the end of the session debrief is completed as per section

4.8 Side Effects Following ECT

In the past, memory loss and cognitive impairment were associated with sine wave electrical stimuli from older ECT machines and the lack of an individualised stimulus dosing protocol. Modern machines deliver brief-pulse stimulation and allow lower doses of electricity to be delivered in relation to the patient's seizure threshold.

Cognitive side effects

It has been reported that up to 60% of patients undergoing ECT may experience temporary memory impairment for events immediately before, during or after a course of ECT. Depressive illness can adversely affect cognition and it may be difficult to distinguish the effects of ECT on cognition from the effects of the illness itself. In most cases, this memory loss is temporary and fades within days to weeks following treatment. However, recent research has identified individuals who have reported permanent autobiographical memory impairment following ECT. In such cases, individuals reported memory loss for a specific event or time period in their lives. It has proven difficult to identify in advance of treatment, individuals at such risk.

Reports that ECT causes structural brain damage or affects intelligence are not supported by evidence.

Cognitive assessments are undertaken at regular intervals (at baseline, after 4th 8th and 12th Treatments) during a course of ECT so as to identify problems early, and allow review of the treatment plan.

Other risks/side effects

Risks/side effects relating to anaesthetic are outlined in the patient information booklet. There may be loss or damage to the patient's dentition dependent on their oral health, hygiene and dentistry. This may delay treatment and all necessary precautions taken for teeth.

During recovery or immediately after treatment patients may experience headaches, muscular pains, and nausea or breathing difficulties. These are usually mild and respond well to symptomatic treatments.

Risks and benefits of treatment are assessed for each individual, bearing in mind the severity of the mental illness and the nature of the physical illness that may prevent ECT being given.

Absolute contra-indications to ECT are extremely rare, e.g. certain types of cardiac pacemakers. ECT may destroy the cochlear implant and hence ECT should not be given to these patients unless cleared by an otolaryngologist. Patients with Brain Implants must be discussed with the Consultant Psychiatrist & Consultant Anaesthetist prior to ECT. Caution is required in patients with a history of recent myocardial infarction, angina, congestive heart failure, hypertension or airway problems. It may be necessary to arrange that ECT is administered at the Sandwell hospital if there are particular risks that require liaison with other professionals.

Anaesthesia is usually deferred in cases where the patient presents with a current symptomatic upper respiratory tract infection or where they have suffered a cerebrovascular event (CVA) or untreated Intra-cranial aneurysm or myocardial infarction within the last three months. ECT is not contraindicated in pregnancy but its

use requires careful monitoring and it is advisable to carry out the procedure in theatre.

Discussion will occur between the anaesthetist and psychiatrist as to the most appropriate course of action on a given day. Liaison between psychiatric and anaesthetic staff is critical and it may be necessary to arrange further investigations before treatment.

4.9 Emergency ECT

It is difficult to find a consensus definition of what constitutes Emergency ECT among different localities and clinicians. A practical working definition is important so as to provide a common understanding amongst the clinicians involved in delivering ECT within the Trust.

As an emergency treatment, ECT is mainly used for patients with a severe depressive episode and severe psychomotor retardation with associated problems of eating and drinking or physical deterioration. Its use is also considered when a depressed patient is actively suicidal.

In this context, Emergency ECT is defined here as that necessary to treat an illness of such severity as to be life threatening and where any delay in receiving ECT will significantly impair the patient.

Medical fitness to undergo a general anaesthetic, and therefore to receive routinely scheduled ECT on a Monday or Thursday. Emergency ECT may be prescribed under section 62 of the Mental Health Act for incapacitated detained patients if SOAD is awaited.

It has been found to be extremely rare in The Black Country Partnership NHS Foundation Trust that ECT has been required outside the regular Monday and Thursday sessions, when the necessary preparations have been completed. In view of this, additional Emergency ECT sessions are not currently provided by the Trust outside of the regular Monday and Thursday service.

Inclusive of urgent referrals, an appropriate preparatory period is required during which to undertake ECT workup (physical examination, blood and other investigations and obtaining consent) and if appropriate, to consider a trial of alternative treatment. Emergency ECT is administered.

4.10 Continuation & Maintenance ECT

Developments in pharmacotherapy have reduced the use of continuation and maintenance ECT, but it is recognised that some patients respond only to ECT and in these cases, continuation or maintenance ECT may be the treatment of choice. Some patients request maintenance ECT as their treatment of choice because of good clinical response or reduction in length of hospital stay.
Since 2009, NICE supports the use of continuation and maintenance ECT in certain circumstances.

Continuation ECT

Continuation ECT is delivered as per Protocol for Continuation ECT. Continuation ECT is defined as prophylactic treatment aimed at preventing early relapse during the 6-12 months following an acute depressive episode. If continuation ECT is being

prescribed, this decision and the reason for it must be documented by the Consultant Psychiatrist following discussion with the patient. There should be a properly documented risk/benefit assessment for that patient, and separate signed consent form is required.
It is recommended that a patient receiving continuation ECT is reviewed after each treatment. The frequency of treatment is a judgment for each referring Consultant Psychiatrist in discussion with the ECT Department and should be titrated to the needs of individual patient.
The use of continuation ECT within the Trust is monitored through audit.

Maintenance ECT
Maintenance ECT is delivered in line with Protocol for maintenance ECT. It refers to prophylactic ECT administered so as to prevent illness recurrence, and usually follows on from a course of continuation ECT.

Where maintenance ECT is being prescribed, this decision and the reason for it must be documented by the Consultant Psychiatrist following discussion with the patient. There should be a properly documented risk/benefit assessment for that patient, and separate signed consent form is required.

It is recommended that a patient receiving maintenance ECT is reviewed after each treatment. The frequency of treatment is a judgment for each referring Consultant Psychiatrist in discussion with the ECT Department and should be titrated to the needs of individual patient. There is no lifetime maximum number of maintenance ECTs which may be given and individual factors are considered in the risk/benefit assessment. The use of maintenance ECT within the Trust is monitored through audit.

4.11 Outpatient ECT
Individuals referred to the ECT department as outpatients receive their treatment in line with the same policies governing inpatient ECT.

Outpatient ECT is prescribed by a patient's Consultant Psychiatrist. It is recommended that outpatients are reviewed by their doctor after each treatment, and that any relevant clinical issues are communicated in a timely manner to the ECT Department, e.g. emailing or scanning copies of review letters. Such communication is especially important when it concerns issues that may impact on risk assessment. Prior to their discharge from the department, outpatients are provided with an information sheet describing a number of important issues for patients who have undergone general anaesthetic. Patient Information Sheet following Outpatient ECT. Outpatients are discharged from the ECT department. It is recommended that they are accompanied by another adult for the next 24 hours.

4.12 ECT Aftercare
Every individual who has received ECT in The Trust receives a 3-6 month follow-up appointment. This facilitates monitoring of their cognitive status and current symptoms and to offers the opportunity to feedback to the Department regarding their ECT experience and their views some months following completion of treatment. This information is forwarded to the individual's referring Consultant Psychiatrist and copied to their GP.

5.0 Procedures connected to this Policy

There are currently no procedures linked to this policy

6.0 Links to Relevant Legislation

Mental Health Act 1983 (Amended 2007) & Code of Practice (2015)

The Code provides guidance on how professionals can ensure that their roles and responsibilities under the Mental Health Act 1983 are carried out in a manner that ensures the delivery of safe and high quality care to patients.

The Code has a wide-ranging application; it applies to the care and treatment of all patients in England, who are subject to the exercise of powers and duties under the Act. The Code notes that the 1983 Act, “affects the lives and liberty of many people, impacting upon them, their families and community. In 2013-14, there were more than 53,000 detentions in England under the Act.”

Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. It aims to ensure that people are given the opportunity to participate in decisions about their care and treatment to the best of their capacity. It covers all aspects of health and social care. The Act creates a new statutory service, the Independent Mental Capacity Advocate (IMCA) Service. Its purpose is to help vulnerable people who lack mental capacity who are facing important decisions about serious medical treatment and changes of residence.

The Act also created a new criminal offence of Ill treatment or neglect of a vulnerable adult.

1 April 2009 saw the implementation of the Deprivation of Liberty Safeguards under the Mental Capacity Act. These safeguards were created to create legal protection for adults who lack capacity to consent to care or treatment in a hospital or care home and that care or treatment constitutes a deprivation of their liberty. These safeguards are not an alternative to the Mental Health Act but instead provide a legal framework for people who cannot legally be made subject to the Mental Health Act (i.e. they are not eligible for some reason).

6.1 Links to Relevant National Standards

- Care Quality Commission(CQC)
- NHS Litigation Authority (NHSLA)
- National Institute for Health & Clinical Excellence (NICE)
- ECTAS standards 14th Edition revised January 2019
- Office of the Public Guardian

6.2 Links to other Key Policies

Infection Prevention and Control Assurance Policy

The purpose of this document is to set out the system for the prevention and control of infection in the Black Country Partnership NHS Foundation Trust, which is a key priority within the Trusts strategic objective of patient safety. The Trust has a continued commitment to an approach whereby prevention & control of infection is viewed as integral to service delivery and development.

Mental Health Act 1983 (amended in 2007) Policy
The aim of the policy is for staff to understand and comply with the legal framework on how they should proceed when undertaking duties under The Mental Health Act 1983 (amended in 2007) and it's associated 2015 Code of Practice.

Mental Capacity Act Policy
The purpose of this policy is to underpin the implementation of the MCA within the Trust by outlining the procedures to assess mental capacity, make decisions in the best interests of patients including patients who appear to have no family or friends to consult, use restraint, and follow valid and applicable advanced decisions. The Trust takes its responsibility for the care and treatment of patients seriously and aims to ensure compliance with legislation, statutory instruments and guidance.

Medical Devices Policy
This policy covers the provision for systems and process to ensure that whenever / wherever a device is used it is:

- Suitable for its intended purpose
- Properly understood by the professional and end user
- Maintained in a safe and reliable condition

This policy and the related standard operating procedures include reference to three factors, which have a significant impact on device safety:

- Training of staff and end users including parents/carers of children or adults with complex health care needs who have a medical device(s) for use at home
- Maintenance of the medical device
- Decontamination of the medical device

6.3 References

- Royal College of Anaesthesia – Good Practice Guidelines
- ECTAS Standards 14th Edition
- Sandwell & West Birmingham Policy & Protocols
- NICE Guidance 2010
- ECT Handbook 3rd Edition

7.0 Roles and Responsibilities for this Policy

Title	Role	Key Responsibilities
Chief Executive	Accountable	- The Chief Executive is responsible for assuring that this policy is implemented within the Trust. Operational responsibility has been delegated.
Executive Director of Nursing, AHPs and Governance	Executive Lead	Responsibility for this policy has been delegated by the Chief Executive to the Executive Director of Nursing, AHPs and Governance who:- - is responsible for ensuring the Trust's Electroconvulsive Therapy (ECT) is discharged appropriately and has lead responsibility for the implementation of this policy - Identifying and implementing strategies to minimise any risks in relation to the standards for Electroconvulsive Therapy (ECT) - and that any serious concerns regarding the implementation of this policy are brought to the attention of the Board
Psychiatric Staff	Advisory	- Trust has a named Lead ECT Consultant who along with the Lead ECT nurse and the Lead Consultant Anaesthetist advises on appropriate treatment facilities, is responsible for development and update of ECT policy and training and supervision of medical staff. - They will advise on appropriate treatment protocols for individual patients based on established ECTAS Guidelines. - The Lead Consultant also advises nursing staff on the suitability of referrals to the service. Lead Consultant is supported by a Speciality Associate Specialist Doctor (SAS) experienced in ECT. - ECT is administered by the ECT Lead Consultant and the Speciality doctors working at Edward Street Hospital. Training and supervision is provided in accordance with the guidance set out by Royal College of psychiatry for doctors involved in the administration of ECT. - It is recommended that the SAS doctor's Rota is organised to facilitate continuity of care. - Competency to perform ECT is determined by the ECT Lead Consultant. - The lead is responsible for ensuring that staff having regular ECT sessions maintains appropriate CPD activity and adhere to Competencies set for Medical Staff by Royal college of Psychiatrists 2013.
Anaesthetic Staff	Support and Administration	- A named Lead Consultant Anaesthetist and group of appropriately trained and experienced Anaesthetists (both consultants and SAS doctor) are responsible for the administration of anaesthesia for ECT. - The anaesthetists are provided by the department of anaesthesia at Sandwell and West Birmingham Hospitals NHS trust that has an SLA agreement with Black Country Partnership NHS Foundation Trust. - The Lead Consultant Anaesthetist along with the Lead ECT Consultant and Lead ECT nurse is responsible for development and update of ECT policy. - The lead anaesthetist must do a minimum of 2 ECT sessions per month. The Lead Anaesthetist assesses patients for anaesthetic risk and will discuss in detail those patients who need further assessment or investigation with the referring teams. Lead anaesthetist is responsible for ensuring that anaesthetic staff having regular ECT sessions, maintain appropriate CPD activity, are up-to-date with their knowledge and competencies in provision of anaesthesia for ECT.

		- An Operating Department Practitioner (ODP) is employed to assist the Anaesthetist, as required by the Royal College of Anaesthetists. - The ODP is currently provided by Sandwell and West Birmingham hospitals NHS trust which has an SLA agreement with the Black Country Partnership NHS Foundation Trust. - There might be occasions where an ODP cannot be provided by SWBH NHS trust. Every effort must be made to have an ODP and alternative options to source an agency ODP must be made. - Cancelling an ECT list can have serious and detrimental impact on patient's progress. In such instances it is important to consider alternatives like having an additional anaesthetist/anaesthetic trainee or an additional senior recovery nurse who is trained in airway skills to support the anaesthetic team. It is acceptable that the list is slowed down to enable full recovery of patients prior to starting the next case.
Nursing Staff	Adherence	- There is a named Lead psychiatric nurse (RMN) who is in charge of ECT and takes overall responsibility for the clinic. - The lead nurse manages the ECT service as a whole, ensuring the environment and equipment are suitable and systems and process are in place to maintain safety. - The lead also manages the team of ECT nurses, ensuring their training needs are met and process are in place to meet, share practice and review progress. - There is an ECT Anaesthetic Link Nurse (RGN) and Healthcare Support Worker (HCSW) who are the core team of nurses who work in the clinic every week for the purpose of continuity. - During treatment, there is a qualified nurse present in the treatment room and one in the recovery room. - An RMN qualified nurse who is known to the patient should accompany the patient from the ward to the ECT suite. - The nurse will remain with the patient in the waiting area, during treatment in the recovery room and following recovery. - The nurse accompanying the inpatient to ECT must be familiar with the legal status and the physical and mental state of the patient. - If there are two or more patients from the same ward, it is acceptable that one of the staffs is a qualified nurse and the other a senior healthcare support worker with the above knowledge. - Outpatients do not need to be escorted by a registered nurse but must be accompanied by a named responsible adult in all cases. - Each new patient, or patient who is detained under the Mental Health Act, must be accompanied by a qualified member of staff.

8.0 Training

All Anaesthetists

All medical staff involved in the administration of ECT is required to attend training and to maintain their skills and knowledge of ECT. They are also required to keep up to date with their Immediate Life Support training, in accordance with the requirement outlined in the Trust's mandatory and risk management training needs analysis.
Nursing staff qualified in ECT are also required to keep their Immediate Life Support Training up to date, and complete an Anaesthetic and Recovery course that includes practical experience at a general hospital.

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory & Specialist Mandatory Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training?
Immediate Life Support (ILS)	All staff groups within BCPFT	Yearly Trust - In house	-	Resus Counsel	Yearly	L & D Lead ECT Nurse Medical Staff Anaesthetist
Post Perioperative Recovery module	Recovery Nurse	Specialist - one off	-	SWBNHT	One off qualification	Lead ECT Nurse
Mental Health Act Level 1 & 3	All Staff	In house – Mandatory	-	BCPFT Trust	3 years	Lead ECT Nurse Medics L & D
Mental Capacity Act	All staff	One off	-	BCPFT Trust	One off	Lead ECT Nurse Medics L & D

Equipment – all necessary equipment outlined in the policy	Anaesthetist ODP Medics Nursing Staff	Internal & External Training	-	Sandwell & West Birmingham NHS Trust BCPFT Trust	1 or 3 years according to medical devices policy	L & D Medical Devices Trainer Lead ECT Nurse Lead Consultant
Prescribers Update	ECT Lead Consultant Other medics	Specialist Mandatory Training		Royal College of Psychiatrist	Yearly	Clinical Director
ECTAS Training Days Peer Reviews NALECT	ECT Lead Nurse	Specialist Mandatory Training		Royal College of Psychiatrist	Yearly 3 Monthly Yearly	Service Manager
ECT Training Days	All ECT Staff	Specialist Mandatory Training		In house / Royal College of Psychiatrist	Yearly	ECT Lead Nurse

9.0 Equality Impact Assessment

Black Country Partnership NHS Foundation Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Equality & Diversity Team on Ext. 8067 or email bcpft.equalityimpactassessment@nhs.net

10.0 Data Protection and Freedom of Information

Data Protection Act provides controls for the way information is handled and to gives legal rights to individuals in relation to the use of their data. It sets out strict rules for people who use or store data about individuals and gives rights to those people whose data has been collected. The law applies to all personal data held including electronic and manual records. The Information Commissioner's Office has powers to enforce the Data Protection Act and can do this through the use of compulsory audits, warrants, notices and monetary penalties which can be up to €20million or 4% of the Trusts annual turnover for serious breaches of the Data Protection Act. In addition to this the Information Commissioner can limit or stop data processing activities where there has been a serious breach of the Act and there remains a risk to the data.

The Freedom of Information Act provides public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities; unless there is a good reason for them not to. The Freedom of Information Act applies to corporate data and personal data generally cannot be released under this Act.

All staffs have a responsibility to ensure that they do not disclose information about the Trust's activities; this includes information about service users in its care, staff members and corporate documentation to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies. The Information Governance Team provides a central point for release of information under Data Protection and Freedom of Information following formal requests for information; any queries about the disclosure of information can be forwarded to the Information Governance Team.

11.0 Monitoring this Policy is Working in Practice

This is undertaken by ECTAS through its annual self-review audits and 3 yearly peer review visits. The trust undertakes annual audit of service delivery against NICE guidance. Clinical supervision is provided by ECT Consultant Psychiatrist, Lead ECT Anaesthetist, and Lead ECT nurse.

What key elements will be monitored? (measurable policy objectives)	Where described in policy?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently?	Group/Committee that will receive and review results	Group/Committee to ensure actions are completed	Evidence this has happened
Training & research	8.0	Audits Training Records ECTAS Standards	Lead ECT Nurse RCpsy	Yearly Every 3 years	ECTAS BCPFT		
Monitoring and follow up	8.0	Audits Training Records ECTAS Standards	Lead ECT Nurse RCpsy	Yearly Every 3 years	ECTAS BCPFT		

Appendix 1

Suggested Pharmacy Stock for Provision of ECT Anaesthesia

Emergency (Cardiac Arrest) Box containing:

- Adrenaline minijets 1 in 10,000 (1mg in 10ml) x 6
- Atropine prefilled syringe 3mg in 10ml x 1
- Calcium Chloride minijet 1g in 10ml x 1
- Amiodarone prefilled syringe 300mg in 10ml x 2
- Sodium Bicarbonate minijet 8.4% x 1
- Magnesium Sulfate 5 g in 10ml x 1

Emergency Drugs

- Adenosine inj 6mg/2ml
- Atropine inj 600mcg/ml
- Digoxin inj 500mcg/2ml
- Dextrose 25 g/50ml
- Diazepam inj 5 mg rectal
- Doxopram inj 100 mg/5 ml
- Ephedrine inj 30 mg/ml
- Furosemide inj 20 mg/2 ml
- Flumazenil inj 0.5 mg/5mls
- Glycopyrronium inj 200mcg/ml
- Lorazepam tab 1mg
- Metaraminol 10 mg/ml
- Neostigmine/glycopyrrolate 0.5mg/2.5mg/ml
- Salbutamol inj 50mcg/5ml

For use in Malignant Hyperpyrexia

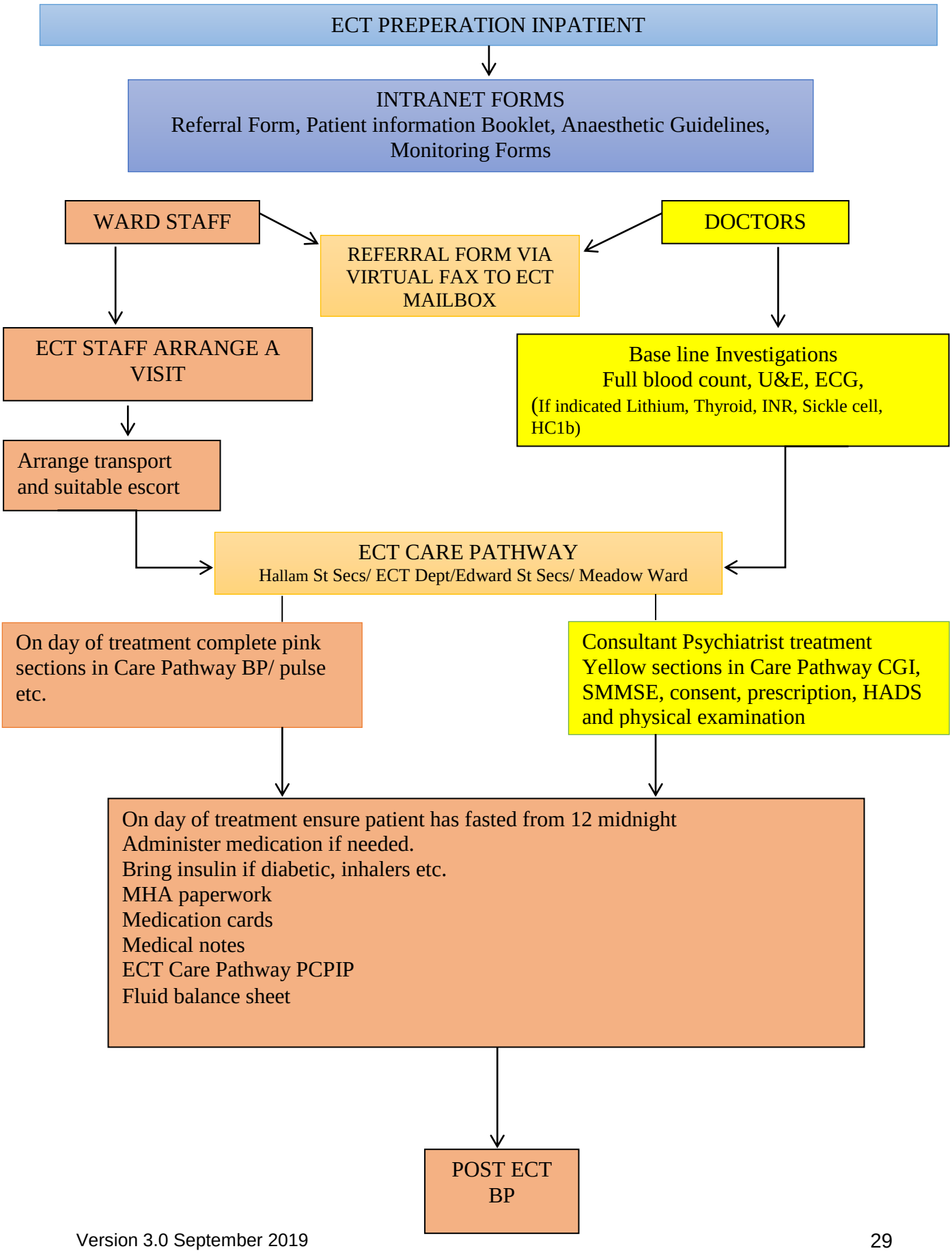
- Dantrolene inj 20mg
- Water1 x 50ml 10ml vial

For use in Anaphylaxis

- Adrenaline inj 1mg/ml
- Chlorpheniramine inj 10mg/ml
- Hydrocortisone inj 100mg/ml

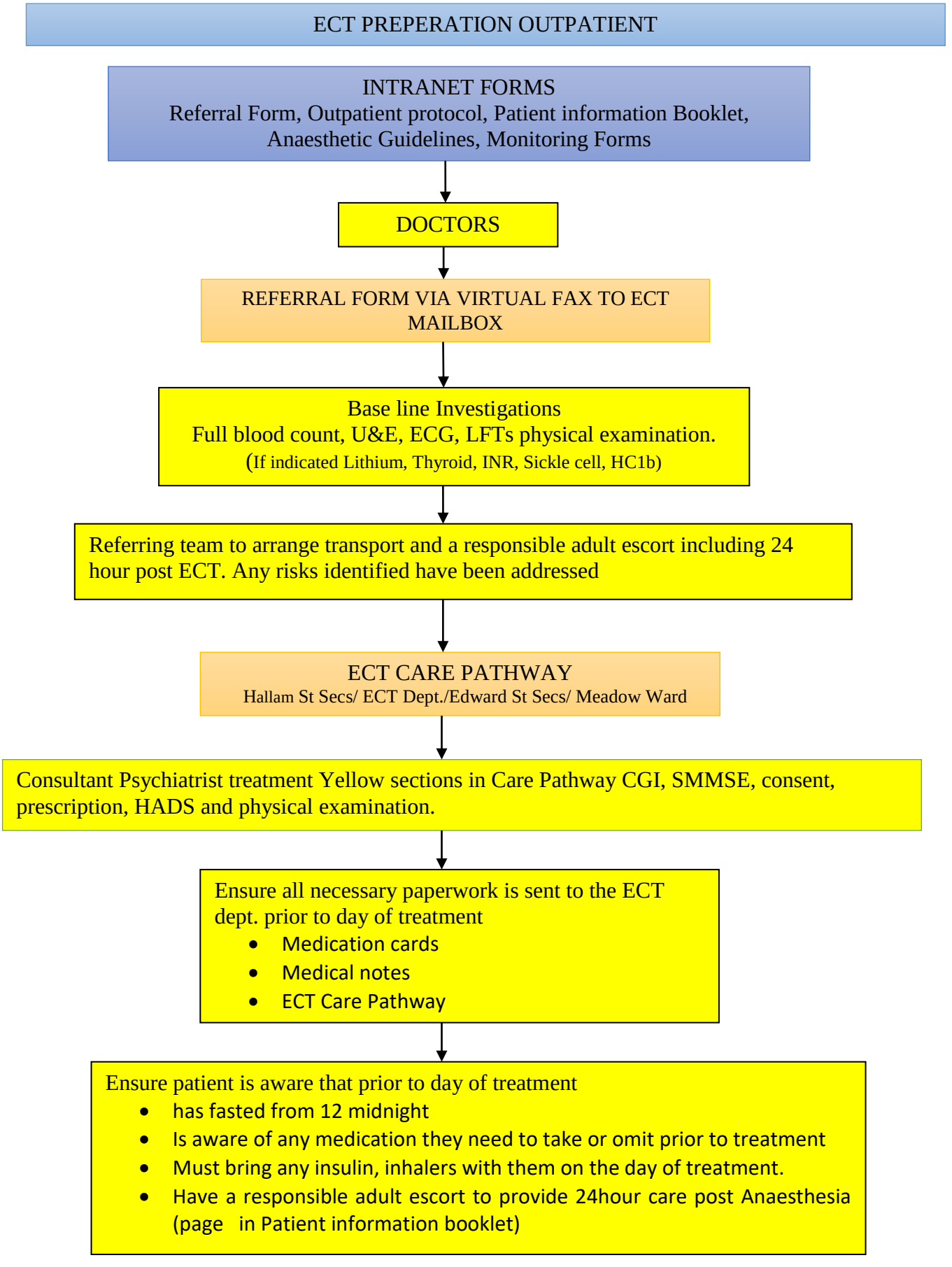
Appendix 2

Inpatients Referral Flowchart



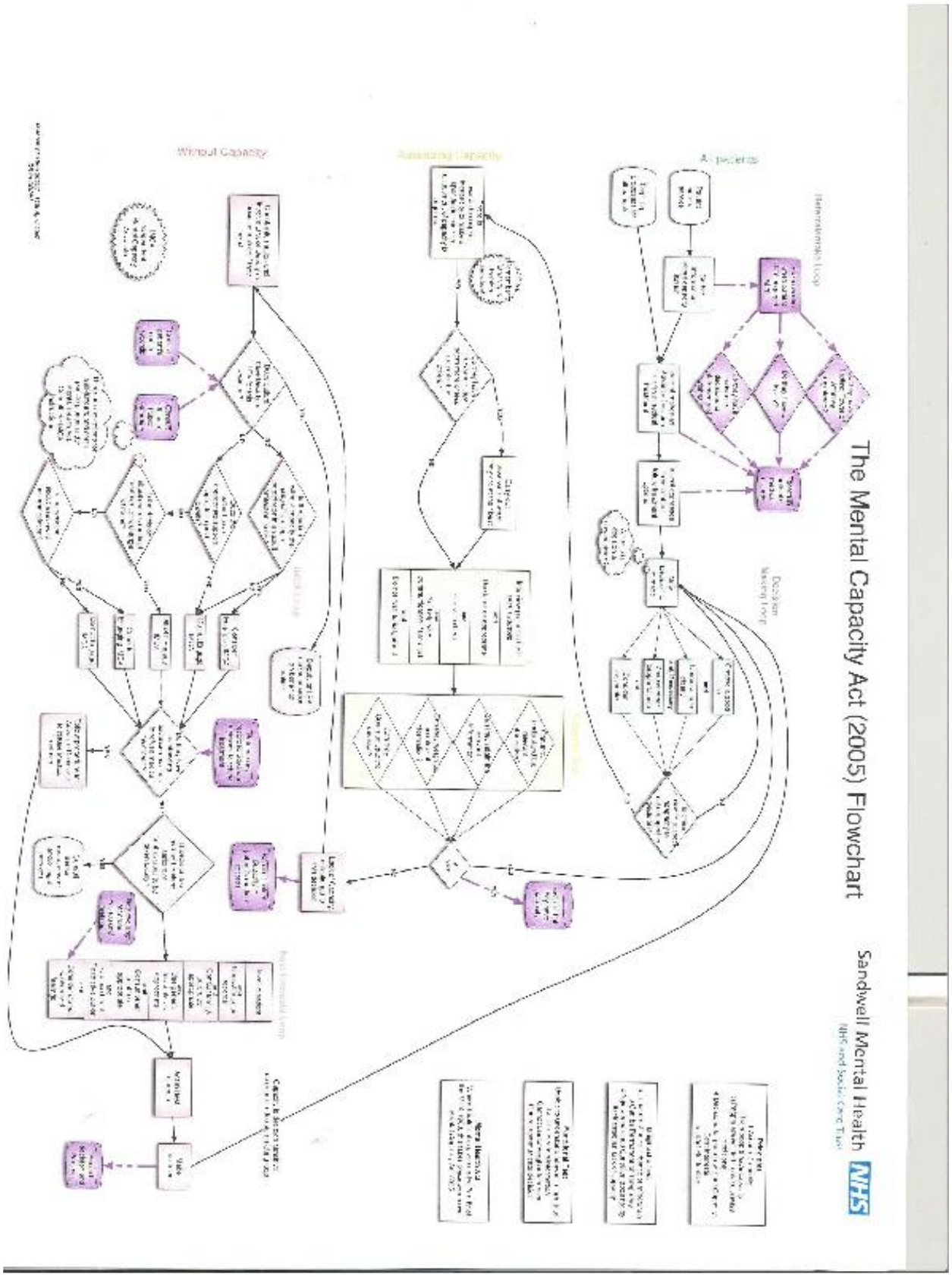
Appendix 3

Outpatients Referral Flowchart



Appendix 4

Mental Capacity Act Flowchart (can also be found on BCPFT Intranet)



Policy Details

Title of Policy	Electroconvulsive Therapy (ECT)
Unique Identifier for this policy	BCPFT-CLIN-POL-22
State if policy is **New** or **Revised**	Revised
Previous Policy Title where applicable	Policy and Procedure for Electroconvulsive Therapy (ECT)
Policy Category Clinical, HR, H&S, Infection Control etc.	Clinical General
Executive Director whose portfolio this policy comes under	Executive Director of Nursing, AHPs and Governance
Policy Lead/Author Job titles only	Lead ECT Consultant Psychiatrist
Committee/Group responsible for the approval of this policy	Nursing Board
Month/year consultation process completed *	December 2019
Month/year policy approved	January 2020
Month/year policy ratified and issued	January 2020
Next review date	January 2023
Implementation Plan completed *	Yes
Equality Impact Assessment completed *	Yes
Previous version(s) archived *	Yes
Disclosure status	'B' can be disclosed to patients and the public
Key Words for this policy	

* For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Governance

Review and Amendment History

Version	Date	Details of Change
3.0	Sept 2019	Policy fully reviewed in new template, amendments made to in line with new relevant standards and legislation changes.
2.0	Sept 2014	Amendments to the whole document due to New ECTAS standards
1.0	Mar 2013	New Policy for BCPFT