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Charity reg no:
228636



The Royal College of
Psychiatrists' Research
Unit
4th Floor
Standon House
21 Mansell Street
London
E1 8AA
www.rcpsych.ac.uk/cru
[www.rcpsych.ac.uk/cru/
ECTAS.htm](http://www.rcpsych.ac.uk/cru/ECTAS.htm)

Edited by Lauren Rayner

ECTAS Newsletter

Hello and welcome to the third edition of the ECTAS Accreditation Service newsletter. This is your newsletter, so please let us know what you think about it. We would also like to hear about your experience with ECTAS and about any improvements you have made to your clinic as a result of participation. Please write, phone or email us and we will include your contribution in the next edition.

MEMBERSHIP UPDATE

ECTAS has reached its target for 2005 and now has 81 member clinics. Of those, 38 have completed accreditation, three with excellence (members are listed at the end of the newsletter). Research is currently being undertaken to ascertain the exact number of ECT clinics in England, Northern Ireland, The Republic of Ireland and Wales. Once this is established we aim to undertake a comprehensive recruitment drive in April.

THE SELF REVIEW PROCESS

At the ECTAS reference group meeting in October it was suggested that a single self-review at 18 months should replace the two annual self-reviews clinics currently undertake. At present it is difficult for clinics to fit two annual self-reviews into the 3-

year cycle. Thus, it was agreed that one midway self-audit, along with brief annual questionnaires to affirm accreditation would help ease clinics' workload. The new self-review process will apply to those clinics joining ECTAS in the New Year. Clinics that have already joined will begin the revised process in their second cycle.

ACCREDITATION LEVELS

The issue of accreditation levels was also raised at the reference group meeting. It was suggested that the accreditation criteria be revised so that smaller clinics that are not attached to a large teaching hospital have a better chance of attaining excellence. Previously, clinics awarded excellence have been expected to excel in research, audit and teaching as well as clinical practice. This has limited small, 'clinically' excellent units without teaching and research resources to Category 2 Accreditation. It was agreed that quality of the patient experience is paramount and that the research, audit and teaching aspect should be relaxed in order to enable smaller clinics to achieve excellence. Already accredited clinics that met all other standards may be resubmitted to the Accreditation Advisory Committee for reappraisal.

SERVICE USER / LAY PERSON REPRESENTATION

ECTAS invited the discussion group to comment on its plans to involve service users/ laypersons in peer reviews. Responses were mostly positive and there was general agreement that service user/ layperson representation would add value to the review process. However, there was concern that those chosen should be subject to selection criteria to ensure their input is as balanced and objective as possible. The issue was taken to the ECTAS Reference Group on 17th October. It was agreed that service users/ laypersons should have a specific set of standards to check in order to avoid them becoming 'token' reviewers in situations requiring clinical knowledge. The problem of recruitment was addressed and it was suggested that non-executive trust directors and those involved in lay advocacy at the clinic should be approached.

REVISED STANDARDS

The reference group have again revised the ECTAS standards. The new edition is attached along with the newsletter.

THE FIRST NATIONAL REPORT

The first edition of the ECTAS National Report is due out at the end of December. This biannual publication will be

sent to all member clinics and all Trusts in England, Wales and Ireland. We welcome any feedback on its contents.

A CALL FOR REVIEWERS

Once again, many thanks to all those who have been carrying out peer reviews on behalf of ECTAS. The reviews are an opportunity to visit other clinics and share ideas and experience. We hope that they are interesting and helpful for both the reviewers and the clinic teams visited. If you are interested in becoming a reviewer, please contact ECTAS for more information.

THE EMAIL DISCUSSION GROUP

Once again, the email discussion group has proved a useful forum for debating contentious issues, discussing queries and exchanging current ideas in ECT. We also welcome comments and questions about the ECTAS standards and all aspects of the accreditation process.

RECENT QUERIES AND DEBATE

Prolonged Asystole

A query regarding a patient who experienced a 60 second asystole during ECT prompted a good deal of discussion. Bradycardia and brief asystole appear to be fairly common in connection with ECT, though no one had experience of such a prolonged asystole. Pre-treatment with an anti-

cholinergic to block transmission at the vagus/ heart interface was repeatedly suggested as a means of prevention. Glycopyrrolate was the most popular choice, as it avoids the disorientation and tachycardic effects associated with atropine. Opinion differed as to whether all patients should be premedicated or only those known to be susceptible. There was general consensus that for those patients' susceptible to asystole, treatment should only continue if performed in a clinic with access to critical care facilities.

Relatives Viewing Treatment

Advice was sought regarding whether or not patient's relatives should be permitted to view ECT. On balance, most people felt it was inappropriate for relatives to view the procedure on the basis that their presence could be off-putting to staff and put patients at risk. Common practice seems to be for relatives to accompany the patient until they are anaesthetised and then rejoin them in post-recovery. The point was raised that if a patient does not trust the clinical team to look after them, the issue of consent should be re-examined. Others commented that they had no problem with relatives viewing the procedure, provided clinic staff clearly explain what will happen beforehand so that the observer is not shocked by the convulsion. Dr Ross Clark

advised that relatives should be accompanied by a trained member of staff able to answer any questions they may have. It was suggested that allowing next of kin to observe ECT might have positive implications by helping dispel fear and stigma surrounding the treatment.

Dementia Query

We received a query regarding a patient who was experiencing cognitive deficits following a course of treatment and was concerned that ECT could increase the risk of dementia. Dr Easton replied that there is no evidence of a relationship between ECT and dementia because the pathophysiological processes behind the two are unrelated. He noted however, that post treatment confusion may worsen behavioural problems, and that the memory deficits related to ECT can complicate a dementing illness (though that risk is often outweighed by the benefits of treating the depressive disorder). There is, therefore, a strong argument for using unilateral ECT for patients with an underlying dementing illness.

NATIONAL ECT NURSE TRAINING CONFERENCE

NALNECT (the National Association of Lead Nurses in ECT) is now taking bookings for the first National ECT Nurse Training Conference. The event will take place in Hull on Wednesday 6th September 2006. The day will

provide a forum for discussing current issues in ECT and sharing information on nursing care. Please see the documents attached with the newsletter for further details and a booking form.

REASONS FOR DEFERRAL

ECTAS has found that there are several mandatory Type 1 standards that clinics persistently fail to meet, resulting in those clinics' accreditation being deferred. The most common reason for deferral is poor documentation – most frequently, failure to record the ASA grade. The other common reasons are absence of an anaesthetic assistant (ODA/ODP), lack of a capnograph and the lead consultant psychiatrist not having dedicated sessional time.

INTRODUCING KERRY KERSHAW...

My name is Kerry Kershaw and I have just embarked on a 3-year ESRC- funded PhD at Goldsmith's college in collaboration with the Royal College of Psychiatrists.

When ECTAS was first being established it soon became clear to the team that there was a large gap in theoretical knowledge about the effects of ECT on Retrograde Amnesia (RA). It also became apparent that there was no available measure of RA suitable for use in the clinical setting. The ESRC project will try to address these issues, and will,

accordingly, involve the investigation of Retrograde Amnesia (RA) following ECT, and the development of a measure of retrograde memory that can be easily administered by clinicians. I will also be looking at individual differences in susceptibility to RA, using both objective and subjective memory measures, and how these memory measures relate to self-reported quality of life.

My ultimate aim is to help improve clinical outcomes and the patient experience of ECT, as well as contributing to a greater knowledge in the field. I will keep you all informed of my progress and from time to time would appreciate any help you could give me via the ECTAS e-mail discussion group. If you are interested in this work or have any questions/suggestions, please do not hesitate to contact me by e-mail; kerrykershaw@yahoo.co.uk.

AND FINALLY...

Wishing all our members a Merry Christmas and a Happy New Year!



Member Clinics

Member clinics that have not yet been accredited and are currently in the self- and peer-review stages of the process

Ablett Unit, Denbighshire
Addenbrookes Hospital, Cambridge
Addington Ward, Kettering General
Airedale Hospital, West Yorkshire
Barnes Hospital, Barnes
Barnsley District General Hospital
Barrow Hospital, Bristol
Becklin Centre, Leeds
Blackberry Hill Clinic, Bristol
Broadoak Unit, Merseycare
Cefn Coed ECT Suite, Garngoch Hospital, Swansea
Clatterbridge Hospital, The Wirral
Coity Clinic, Bridgend
County Hospital, Durham
ECT Clinic, Barnet Enfield and Haringey
Fairfield General Hospital, Bury
Farnham Road Hospital
Forston Clinic, Dorset
Fountain Way ECT Department, Salisbury
Green Lane Hospital, Devizes
John Conolly Wing, Southall
John Elliot Unit Birch Hill Hospital Rochdale

Ladywell Mental Health Unit, University Hospital, Lewisham
Melbury Lodge, Royal Hampshire County Hospital
Millbrook Clinic, Nottingham
Montpellier Unit, Gloucestershire
Newsam Centre, Leeds
Parkhouse Hospital, Manchester
Priority House, Maidstone
Royal Oldham Hospital
Somerset Partnership NHS Trust, Taunton
Springfield Hospital, London
Stepping Hill Hospital, Stockport
St George's Hospital, Stafford
Sutton Clinic, Sutton
Tameside Hospital, Ashton-under-Lyne
The Mount, Leeds
Prospect Park Hospital, Reading
West Cumberland Hospital, Cumbria
Weston General, Weston Super Mare
West Park Hospital, Darlington
Wolverhampton City PCT, Wolverhampton
Wootton Lawn ECT, Stroud

Accredited Clinics

Bethlem Royal Hospital
Bodmin Hospital, Cornwall
Bushey Fields Hospital, Dudley
Cheadle Royal Hospital
Cherry Knowle Hospital, Tyne and Wear
Clos Bran, Llangadog, Carmarthenshire
Clonskeagh Hospital, Dublin
Derby City General
Dorothy Pattison Hospital, West Midlands
ECT Clinic for South and West locality, Newton Abbot
Edward Street Hospital, West Bromwich
Glenbourne Clinic, Derriford Hospital, Plymouth
Hadrian Clinic, Newcastle General Hospital
Hartington ECT Department, Derby
Ladywell Mental Health Unit, Lewisham
Lakeview Clinic, Caludon Centre, Coventry
Littlemore Clinic, Oxford
Maudsley Hospital*
Mount Gould Hospital, Plymouth

Needham Suite, Bootham Park Hospital, York
Parkwood ECT Suite, Blackpool
Princess Marina Hospital, Northampton
Priory Hospital Roehampton*
The Priory, North London
Purbeck Suite, St Ann's Hospital, Poole
Queens Medical Centre, Nottingham
Sevenacres, St Mary's, Isle of Wight
Shelton Hospital, Shrewsbury
St Georges Hospital, Morpeth, Northumberland
St Patrick's Hospital, Dublin*
The Riverside Clinic, Hillingdon Hospital, Uxbridge
University College Hospital, Galway
Warneford Clinic, Oxford
Warrington (Bronte Unit, Hollins Park Hospital)
Waterford Regional Hospital
Whiston Hospital, Prescot
Whitchurch Hospital
Wigan and Leigh

* Accredited with excellence

Joanne Cresswell
Email: jcresswell@cru.rcpsych.ac.uk
Phone: 020 7977 6694

Lauren Rayner
Email: lrayner@cru.rcpsych.ac.uk
Phone: 020 7977 6696

Chloë Hood
Email: ChloeH@cru.rcpsych.ac.uk
Phone: 020 7977 6695

ECTAS@cru.rcpsych.ac.uk
www.rcpsych.ac.uk/cru/ECTAS.htm