

Quality Standards for ECT Clinics

Sixteenth edition

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Correspondence:

ECT Accreditation Service (ECTAS)
Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescott Street
London E1 8BB

Tel: 020 8618 4030

Email: ectas@rcpsych.ac.uk

Web: www.rcpsych.ac.uk/ectas

This publication is available at www.rcpsych.ac.uk/ectas.

Any enquiries relating to the publication should be directed to: ectas@rcpsych.ac.uk.

Introduction

The ECT Accreditation Scheme (ECTAS) was established in 2003 to support the quality improvement of ECT clinics in the UK and Ireland and is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

These standards have been developed from key documents and expert consensus and have been subject to extensive consultation with professional groups involved in the provision of ECT services, and with people who have received ECT.

The standards have been developed from references in key literature, consultation with a range of stakeholders including those from the devolved nations; Wales and Ireland. These standards have been reviewed by college officers, ECT and related treatments committee, ECTAS staff members, and members of the ECTAS Accreditation Committee and Advisory Group.

Terms

Please note that throughout this document, people who are receiving ECT are referred to as 'patient' and 'carer' refers to the individual supporting the patient and if possible, accompanying them to appointments. A carer can be a friend or relative.

Categorisation of standards

To support their use in the accreditation process, each standard has been categorised as follows:

Type 1: failure to meet these standards would result in a significant threat to patient safety, rights, or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: standards that an accredited team would be expected to meet;

Type 3: standards that are aspirational, or standards that are not the direct responsibility of the team.

The full set of standards is aspirational, and it is unlikely that any team would meet them all. To achieve accreditation, a team must meet 100% of type 1 standards, 80% of type 2 standards and 60% of type 3 standards.

Commendation awards

If an ECT clinic meets all the standards in a particular domain for commendation, they will be eligible for a commendation award in addition to their accreditation. A clinic may only receive a commendation award if they are accredited, but the achievement or otherwise of commendation awards does not affect accreditation status.

The Standards

Section 1: The ECT Clinic

Std No	Type	Standard	Ref
1	3	Everyone can access the service using public transport or transport provided by the service.	1
2	2	The ECT clinic consists of a minimum of four rooms: a waiting room, treatment room, recovery area and post-ECT waiting area.	2
3	3	The clinic has an office for ECT staff which is private, i.e., it is not part of another room.	2, 3
4	2	The clinic is clean, comfortable, and welcoming.	1
5	1	The clinic audits its adherence to infection control.	3
6	1	The environment complies with current legislation on accessible environments. <i>Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.</i>	1
7	1	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	1

The Waiting Room

8	1	There is access to toilet facilities from the waiting area.	2
9	1	The waiting area is large enough to accommodate the throughput of patients and those accompanying them.	2
10	1	Patients waiting for ECT are not able to see into the treatment area while the treatment is taking place.	2
11	2	Patients waiting for ECT are not waiting in the same room as patients in the post-recovery area.	2
12	2	The waiting area is quiet and has a range of distractions. <i>Guidance: Distractions could include a radio, TV, artwork or magazines in line with Trust infection control policy.</i>	3
13	1	Steps are taken to avoid speech being heard between different rooms/areas of the clinic. <i>Guidance: This could include thick doors, the consideration of the location of the rooms and the use of noise such as music.</i>	3

The Treatment Room			
14	1	The treatment room is of an adequate size for its purpose. <i>Guidance: The room can accommodate a minimum of five people comfortably for the safe administration of ECT.</i>	3
15	1	There is a telephone in the treatment room.	2
16	1	If nitrous oxide and/or anaesthetic inhalation agents are ever used, then the treatment room is equipped with scavenging equipment and agent monitoring.	
17	1	The treatment room has a work surface and sink with hot and cold water.	
18	1	The treatment room has a clock with a second hand, or similar to enable anaesthetists to time the doses of anaesthetic being administered.	3
19	1	There is secure storage for drugs, including a fridge with temperature control.	3
20	1	There is a fully equipped emergency trolley with adequate resuscitation equipment and a defibrillator. This is tested and checked before each ECT clinic session. <i>Guidance: As per locally agreed protocol in consultation with Resuscitation Department.</i>	4
21	1	There is equipment available for establishing an emergency surgical airway.	4
The Recovery Area			
22	1	The recovery area is large enough to accommodate the throughput of patients lying on trolleys with additional space to manoeuvre. <i>Guidance: This includes the recovery area doorway being large enough to admit a trolley from the treatment room.</i>	2
The Post-ECT Waiting Area			
23	2	The post-ECT waiting area has provision for refreshments for patients and the patient is offered something to eat and drink before they are discharged from the ECT suite.	2
24	1	There is one trolley or bed per patient which can comfortably accommodate a reclining adult, has braked wheels, and can rapidly be tipped into a head-down position.	3, 4
25	2	There is moving and handling equipment available.	2
The ECT Machine and Clinic Equipment			

26	1	A registered and appropriately trained professional ensures that the machine function and maintenance is checked and recorded at least every year or according to machine guidance.	2
27	1	A registered and appropriately trained professional ensures that the equipment in the clinic is well-maintained and that up-to-date instructions are available.	
28	1	A back-up ECT machine can be accessed by the clinic within one hour, and staff are competent in its use.	2
29	1	If the machine does not self-check, a registered and appropriately trained professional ensures that the output and electrical safety of the ECT machine is checked and recorded prior to each ECT session, including the testing of delivery dose.	
30	1	There is a nerve stimulator and a thermometer.	5
31	1	An oxygen cylinder, facemask and self-inflating bag and at least one full spare cylinder are available in both the treatment and recovery areas to provide positive pressure ventilation.	3,4
32	1	There is one suction machine for each unconscious patient and one spare. <i>Guidance: There is a suction machine in the treatment room and recovery room that is not part of the resuscitation equipment.</i>	4
33	1	There is a local protocol for maintaining anaesthesia, ventilation and monitoring in the event that safe and effective transfer to an ambulance or Critical Care Area is needed, including access to an infusion pump.	
34	1	There is a blood glucose monitor.	6, 3

Section 2: ECT Procedures and Systems

35	3	If activity falls below 50 individual treatments a year and/or there is more than a three-month gap between treatment sessions, there is a CPD process in place to ensure adequate practice is undertaken in a neighbouring facility.	
36	1	Every effort is made to ensure that patients are able to receive ECT twice weekly where clinically indicated. The clinic collects data on the number of treatments cancelled and action is taken to address any issues identified. <i>Guidance: Treatments may be cancelled for a number of reasons including administrative, clinical and non-clinical matters.</i>	7
37	1	There is a malignant hyperthermia protocol which identifies how much Dantrolene is required to treat cases of malignant hyperthermia, and where and how the Dantrolene is stored and accessed. Initial doses (2.5mg/kg) of Dantrolene are stored in the clinic and subsequent doses (3mg/kg) are available within 20 minutes.	4
38	2	The clinic has up-to-date treatment protocols in place. These include maintenance/continuation ECT which incorporates provision for regular reviews of the patient's clinical status, the frequency of which depend on the frequency of treatment.	
39	2	There is a protocol on the choice of laterality of treatment.	8
40	2	The clinic has a protocol or checklist for monitoring patients immediately after ECT.	
41	1	The clinic has a protocol relating to the treatment of young people under 18. This includes reference to cognitive side effects and seizure thresholds.	
42	1	There is a protocol about when to discontinue treatment when no clinical response is seen.	
43	1	There is a local protocol about the quality and timing of an adequate seizure.	
44	1	There is a local protocol about the management of a prolonged or tardive seizure.	3
45	1	There is a local protocol about when to re-stimulate a patient after a brief or missing seizure.	
46	1	There is a stimulus dosing protocol that is in accordance with the latest ECT Handbook.	3
47	1	The latest protocols for management of cardiac arrest and anaphylaxis and an up-to-date protocol for malignant hyperthermia are readily available and accessible to staff.	9
48	1	There is a protocol for consultation between the ECT consultant and the referring clinician in situations where ECT is prescribed outside of NICE guidelines.	

Section 3: Consent and Capacity

Consent

49	1	The process of obtaining consent to ECT treatment includes discussion of the following: • The nature of the treatment and a description of the process; • Indication, intended benefits and likelihood of success of ECT (dictated by current evidence base); • Risks, including common and rare physical and cognitive adverse effects; • General anaesthetic risks; • Likely consequences of not having ECT; • Treatment alternatives and confirmation that these will be available if the patient decides not to have ECT; • How to access independent advocacy and obtain additional information; • Post-anaesthetic risks; • Dental and oral soft tissue trauma. <i>Guidance: This is documented on the consent form.</i>	8,3
50	1	Consent is only obtained by a psychiatrist who has adequate knowledge of the nature and effects of ECT and patient rights.	
51	1	The referring psychiatrist is responsible for ensuring the patient completes a consent form, or an appropriate alternative process is undertaken, if consent cannot be given.	1
52	1	Patients are informed by both the referring psychiatrist and the ECT team that their consent can be withdrawn at any time. Consent will then be required before any further ECT treatments can take place.	8
53	1	Patients' consent is never obtained through any form of coercion.	10
54	1	Original and valid on-going consent is checked and recorded by the ECT team before each ECT treatment.	8
55	1	For every new course of ECT, except in an emergency, patients are given the option of a period of at least 24 hours to reflect on information about ECT and discuss this with relatives, friends, or advisers before making an informed decision regarding consent.	
56	2	The ECT clinic's consent policy, and all consent forms used, are fully compliant with guidelines from Department of Health and Social Care England, Public Health Wales, Department of Health Northern Ireland, Department of Health Republic of Ireland or equivalent.	

Capacity

57	1	The ECT team confirms that the patient's capacity is in line with the consent and legal framework that is in place for the patient to receive ECT treatment. If this has changed, the ECT team will alert the referring team as soon as possible. Treatment may need to be delayed or cancelled to allow the appropriate time for any consent process or legal documentation to be put in place. The capacity assessment should be formally recorded in the patient's notes. <i>Guidance: The formal assessment should be carried out by a competent practitioner such as the ECT nurse or administering practitioner. The assessor should seek senior advice from the clinician leading the ECT session if there are concerns about the outcome of a capacity assessment.</i>	
58	1	If a patient is assessed as lacking capacity to consent to ECT treatment, it is only ever administered under an appropriate legal framework such as the Mental Capacity Act (England and Wales), Mental Health Order (Northern Ireland), Mental Health Act (England and Wales) or Mental Health Act (Ireland).	8
59	1	For all patients detained under the Mental Health Act, or Mental Capacity Act (NI), who are unable to consent to treatment, a certificate of second opinion (T6 Form or relevant certificate) or legal authority for emergency treatment (Section 62 form or equivalent) is present in the clinic for every treatment.	
60	1	For all patients detained under the Mental Health Act, Mental Health Act Ireland or Mental Capacity Act Northern Ireland, who are able to consent to treatment, the T4 (or equivalent) Form is present in the clinic for every treatment.	
61	1	For all young people under 18 years of age, a Second Opinion Appointed Doctor (SOAD) is consulted for ECT, regardless of the young person's capacity to consent (England and Wales only). For the Republic of Ireland, approval of the District Court is required.	11

Section 4: Referring and Assessment

62	1	The team provides information about how to make a referral and waiting times for assessment and treatment.	1
63	1	For non-emergency assessments, the team writes in advance to patients including the following information as appropriate: • The name and title of the professional they will see; • An explanation of the assessment process; • Directions to the clinic base; • Information on parking arrangements; • Information on who can accompany them; • Information about the safekeeping of valuables; • The location of toilets; • Arrangements for further appointments; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	1
64	1	All patients referred to the service are assessed for ECT within a locally specified timeframe. Action is taken where issues and delays are identified.	1
65	1	The ECT assessment includes a detailed medical history.	
66	1	An anaesthetic assessment is carried out, including an assessment of the patient's ASA grade.	12
67	1	The assessment includes a physical examination which includes: • the cardiovascular, respiratory and neurological systems; • a VTE assessment; • a basic dental/oral cavity assessment; • and a pregnancy test where applicable.	13, 3
68	1	As part of the assessment, current medication and drug allergies are recorded as well as any noted problems with illicit drugs.	6,3
69	1	The patient's Mental Health Act status is recorded.	
70	1	An assessment of the risk/benefit balance of having ECT is considered and recorded. <i>Guidance: The risks associated with ECT may be greater in older people; caution is given when considering ECT treatment in this group.</i>	8
71	1	A mental state examination is recorded.	
72	1	Prior to treatment commencing, an assessment of the patient's memory is recorded using a standardised cognitive assessment tool and subjective questioning. <i>Guidance: If a patient refuses or there are mitigating circumstances, this is then recorded.</i>	8

73	1	An assessment of orientation is recorded.	3
74	1	The patient's weight is recorded.	
75	1	The patient's routine drug regime is reviewed prior to treatment, and an individualised medication plan for treatment days agreed upon. This is reviewed during the course of ECT, and any necessary adjustments made.	3
76	1	There is a local policy, agreed with the anaesthetic department/consultant anaesthetist, detailing which investigations are needed before the start of a course.	
77	1	Before the decision to opt for ECT treatment is finalised, the patient's capacity to consent to ECT is assessed and recorded by the referring clinician using the appropriate consent form.	1
78	2	ECT clinics detail whether someone has had (or been offered) psychological treatment. If this has not happened, the clinic should clearly detail the justification behind this decision. <i>Guidance: This could be included on the referral form such as: During this episode of illness has the patient been offered any psychological therapy Y/ N</i> <i>If no, why not:</i> • <i>Therapy not available (provision issue);</i> • <i>Not previously responded to this treatment approach and not clinically indicated;</i> • <i>Too clinically unwell to engage/benefit;</i> • <i>Patient declined/not their preference.</i>	8
79	2	Prior to ECT commencing, the patient and carer, with patient consent, identify what recovery with ECT may look like for them with a member of staff from the ECT team. This includes formulating an ECT care and treatment plan that will include short- and longer-term goals for ECT treatment and the support they would like to receive during the ECT journey. This should be reviewed during the acute course, at the end, and at the two month follow up point. For patients on continuation and maintenance this should be reviewed at regular intervals as agreed with the patient and their carer.	1

Section 5: The ECT Administration Process

80	1	Day patients receiving an acute course of ECT are accompanied both to and from the ECT clinic by a named responsible adult.	3, 2
81	1	Day patients receiving maintenance and continuation ECT may convey themselves to the ECT clinic if this is deemed clinically appropriate but are accompanied from the clinic by a named responsible adult.	3
82	1	Inpatients are accompanied to and from the ward by a clinical member of staff. Guidance: This may include healthcare assistants and support workers.	3
83	1	The person accompanying the patient is known to the patient, is aware of the patient's legal and consent status and has an understanding of the ECT process.	2
84	2	The arrival of patients at the ECT clinic is managed to minimise waiting time.	2
85	2	The clinic has a planned and regular starting time; pre-anaesthetic fasting time is adjusted to this.	
86	1	Before each ECT treatment, the patient is given any further information they may need, introduced to the clinical team administering the treatment and asked if they agree to the presence of anyone attending in a learning capacity.	3
87	1	Patients are supported from the waiting room through treatment and recovery by members of the ECT team.	
88	1	The patient's identity is checked, and the patient wears an identity wristband whilst in the ECT clinic.	6
89	2	A pre-procedure checklist is run through for each patient before the treatment commences. This includes: • Introducing members of the team • Patient identity • Laterality and dose • Mental Health Act status • Consent and capacity status • Any changes to the anaesthetic • Any changes to the ASA grade • Asking patients when they last ate and drank.	6
90	1	Prior to the administration of anaesthesia, the patient is asked to remove hearing aids and glasses/contact lenses.	3
91	1	The patient's record is checked to confirm that they are not allergic to anything affecting the treatment or anaesthetic. The patient is asked if they have any allergies.	6, 3

92	1	Patients and/or their carers sign a form which confirms: • They will not drive during a course of acute ECT, or for at least 48 hours after a general anaesthetic during a course of maintenance ECT; • They will not drink alcohol for 24 hours after each treatment or until advised by their consultant psychiatrist; • They will be accompanied home following each ECT treatment; • They will have appropriate direct supervision (this includes not being left alone in a room for significant periods of time) by a responsible adult for the 24 hours following each ECT treatment; • They will not sign any legal documents for at least 24 hours following each ECT treatment or until advised by their consultant psychiatrist.	3
93	1	The team ensures that the patient's blood pressure, pulse, and temperature are recorded, and the patient is encouraged to empty their bladder.	2, 5
94	1	The ECT clinic staffing means there is an ECT practitioner in the treatment room, at least one registered nurse in the treatment room, one recovery-trained practitioner in the recovery area, and one experienced anaesthetist present during treatment and recovery. <i>Guidance: The recovery practitioner should be present as the patient recovers consciousness.</i>	3
95	1	The number of staff in the recovery area exceeds the number of unconscious patients by one.	3
96	1	There is a trained professional such as an Anaesthetic Nurse or Operating Department Practitioner (ODP) who meets the competencies set out in Appendix A or the HCPC ODP portfolio, present during treatment and recovery whose sole responsibility is to assist the anaesthetist during the procedure.	5, 4
97	1	There is at least one supervising practitioner (who meets the RCPsych ECT Capabilities for a GA/OA higher trainee) present within the clinic during treatment who is part of the WHO briefing for the patient being treated.	
98	1	Anaesthesia is administered by a consultant anaesthetist, or by a non-consultant career grade doctor or trainee under the supervision of a named lead consultant anaesthetist.	5, 4
99	1	The clinic stocks at least two different anaesthetic induction agents. The stock is regularly checked and re-supplied.	4
100	1	The clinic stocks at least two different muscle relaxants such as Suxamethonium and an alternative. The stock is regularly checked and re-supplied.	
101	1	The clinic includes emergency drugs and equipment as agreed with the Lead Anaesthetist, pharmacy team and resus committee. These are checked before each ECT clinic session for out-of-date drugs and missing items.	4

102	1	The clinic stocks a supply of drugs needed to treat other unwanted autonomic, cardiovascular, respiratory or neurological effects. These may include Atropine, Glycopyrrolate, Midazolam and Dantrolene as agreed with the ECT anaesthetist.	4
103	1	The anaesthetist checks that there have been no problems with previous anaesthetics at each treatment.	
104	1	Recommendations for standards of monitoring during anaesthesia and recovery from the Association of Anaesthetists are followed.	4
105	1	The anaesthetist or ODP checks the anaesthetic and suction equipment and prepares the anaesthetic agents.	4
106	1	The clinic is consistent in the use of anaesthetic agents and dosing.	4
107	2	Any reason for a change in anaesthetic induction agent is discussed with the ECT team and documented.	
108	1	Oxygen is always administered before ECT.	4
109	1	Before induction, the anaesthetist or anaesthetic nurse/ODP checks that any dentures have been removed or are secure.	5
110	1	Once anaesthesia has been induced, the anaesthetist or anaesthetic nurse/ODP inserts a bite block to prevent injury to the tongue and dental damage.	
111	1	The following are always used during anaesthesia: • a pulse oximeter; • an NIBP monitor; • an ECG monitor; • and a capnograph.	3, 5, 4
112	1	The administering practitioner ensures the seizure is tonic-clonic and of adequate duration, by monitoring the motor effects and EEG.	3
113	1	Except in exceptional circumstances, the patient is treated on the same make of ECT machine throughout the course of treatment.	
114	1	There is a section of the ECT record which includes: The pre-procedure checklist, the anaesthetic induction agent dose; muscle relaxant dose; any ancillary medication; nature of ventilation; cardiorespiratory changes; seizure quality and duration; time to orientation and post-procedural problems; charge delivered; bilateral/unilateral seizure and immediate side effects.	3
115	1	Pulse, blood pressure and pulse oximetry readings are documented by the recovery practitioner.	
116	1	The anaesthetist is immediately contactable until all patients recover full consciousness and are physiologically stable.	2
117	1	Patients are not discharged from the clinic until assessed as fully recovered by the recovery practitioner and/or the ECT nurse.	3, 4

118	1	Patients in recovery are asked about any side effects such as headaches and nausea. This is recorded and the necessary prophylactic is given in subsequent treatments.	3
119	1	Any cannulas in situ are flushed after the last intravenous drug has been administered.	
120	2	There is a clear rationale for whether inpatients are admitted to a ward on the same site as, or a different site from, the ECT suite and this is documented. <i>Guidance: A note should be made showing that the following risks and benefits have been considered and balanced: continuity of care with an established inpatient care team but disruption and distress due to travelling time and distance, versus the disruption of a new inpatient care team but quick and easy access to the ECT suite.</i>	14
121	1	Patients assessed as high-risk by anaesthetists are reviewed for treatment in an environment allowing rapid intervention should complications occur, for example, a theatre suite or its recovery area.	3, 4
122	1	People receiving ECT who are under the age of 18 do not come into contact with adult patients whilst in the ECT clinic.	
123	1	Discharge criteria for patients leaving the clinic following treatment, which include assessment before discharge are agreed with the local anaesthetic department.	4

Section 6: Monitoring and Follow-up

124	1	During acute courses of ECT, treatment outcome is monitored and recorded at least weekly between treatment sessions and treatment appropriately adjusted by the ECT team in light of this. <i>Guidance: Validated rating scales include the MADRS, HDRS, BDI, PANSSs, HAM-D.</i>	8
125	1	The patient's clinical status/symptomatic response is assessed and recorded at baseline, between each treatment session, and at the end of the treatment course using the Clinical Global Impression (CGI) scale.	8
126	1	A subjective test of memory is recorded before every ECT treatment using item 17 of the Comprehensive Psychopathological Rating Scale (CPRS) and in a clinical interview after two months.	
127	1	The patient's memory and cognition are reviewed and assessed throughout the course of ECT treatment. This includes assessing the patient's memory before the first treatment, after every four treatments and after the last session using a standardised cognitive assessment tool. Cognitive side effects are assessed using a standardised cognitive assessment tool in a clinical interview after two months.	
128	1	The patient's time to re-orientation is recorded after each ECT treatment. If the patient's time to re-orientation is prolonged, this is reported to the prescribing clinician and treatment reviewed.	3
129	2	Non-cognitive side effects are assessed and recorded between treatment sessions.	
130	2	Patients who experience memory problems have access to a specialist assessment by a neuropsychologist or memory assessment service if clinically indicated.	2
131	1	The number of treatments in a course is determined solely by clinical parameters (e.g. the patient's response to treatment, any side effects experienced). <i>Guidance notes: rationale for continuing or stopping treatment (e.g. consideration of CGI-I score, SMQ score) should be documented. There should be no documentation presupposing a maximum number of treatments.</i>	7
132	1	No more than two treatments are prescribed at a time before reviewing and renewing the prescription.	3
133	1	The team follows up patients who have not attended an appointment/assessment. If a patient cannot be contacted, a plan is made by the team, based on patient need and risk, regarding further contact with the patient or any onward referral. <i>Guidance: Where patients consent, the carer is contacted.</i>	1

134	1	If a patient does not attend for an assessment/appointment, the assessor contacts the referrer. <i>Guidance: If the patient is likely to be a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.</i>	1
135	3	The patient is reviewed by the appropriate team at least once a month for the three months following an acute course of ECT.	2

Section 7: Staffing and Training

Staff Support			
136	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	1
137	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	1
138	1	In clinics that deliver nurse-administered ECT, there is a named lead consultant psychiatrist who has been in post for at least six months.	2
139	1	Where a nurse is administering ECT, there are sufficient other staff in the ECT suite to ensure the administering nurse is not responsible for other tasks in the treatment room.	3
140	1	The clinic provides training for core trainees (CT) and opportunities for senior trainees (ST) to develop higher levels of ECT-related competencies and ensures that all core trainees on the training scheme have an opportunity to achieve the Royal College of Psychiatrists' ECT capabilities or College of Psychiatrists of Ireland learning outcomes. Trainees attend the clinic regularly.	
141	1	All anaesthetists meet current Royal College of Anaesthetists Certificate of Completion of Training (CCT) in Anaesthetics competencies for non-theatre settings.	3, 4
142	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	1
143	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover.	1
144	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. <i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications</i>	1
145	2	All staff members receive line management supervision at least monthly.	1
146	1	For clinics practising nurse-administered ECT, the administering nurse receives monthly clinical supervision with the lead consultant psychiatrist.	

147	1	The service actively supports staff health and well-being. <i>Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i>	1
148	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. <i>Guidance: They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i>	1
Lead Psychiatrist			
149	1	There is a named ECT lead consultant psychiatrist who meets the competencies set out in the Royal College of Psychiatrists' competency document at appointment, demonstrates ongoing CPD in their annual appraisal and maintains their clinical skills.	15
150	1	The named lead consultant psychiatrist has dedicated sessional time for ECT, and this is included in a job plan.	2
151	1	The named lead consultant psychiatrist is covered during absence by a named psychiatrist who meets the competencies set out in the Royal College of Psychiatrists' competency document.	2
Lead Nurse			
152	1	There is a named lead ECT nurse who: • Has dedicated sessional time for ECT; • Attends at least 50% of clinics; • Takes overall responsibility for management of the clinic; • Has dedicated hours for administrative work relating to ECT; • And has been assessed as competent to carry out the role.	2, 3
153	2	The named lead nurse is of at least Band 7 (CNM2 in the Republic of Ireland).	3
154	2	The named lead nurse has appropriate ECT and clinical experience. <i>Guidance: This includes meeting the minimum competencies from the ECT foundation training course within a year of appointment to the role.</i>	3

Lead Anaesthetist			
155	1	There is a named lead consultant anaesthetist who attends the clinic regularly. <i>Guidance: This involves attending at least one clinic per month.</i>	
156	1	The Royal College of Anaesthetists' current guidelines on supervision of those working in remote sites are followed, including a clear pathway to gain advice from a readily contactable consultant.	4
157	1	Anaesthetists on the rota do not include unsupervised doctors in junior training grades (including CT1 & 2).	4
158	1	The named lead anaesthetist is involved in: • Developing the service; • Helping with training and revalidation of staff; • Ensuring safety standards are met; • And that appropriate audits on anaesthetic care are performed.	4
159	2	The named lead consultant anaesthetist has dedicated sessional time on a weekly basis, devoted to direct clinical care in the provision of anaesthesia for ECT.	4
The ECT Staff Team			
160	2	The roles and responsibilities of clinic staff are clearly defined, e.g. included in up-to-date job descriptions, including the appropriate grade for the position. This includes a line management structure with clear lines of accountability within the clinic.	
161	2	There are operational multi-disciplinary team meetings to discuss clinical matters, policy and administration at least every two months.	
162	2	The core team works in the clinic every week for the purposes of continuity.	
163	2	The team takes an active role in audit, academic teaching and development of evidence-based best practice for ECT.	
164	1	The clinic submits outcome data to the ECTAS dataset.	
165	2	The team is actively involved in QI activity.	1
166	2	The team actively encourages patients and carers to be involved in QI initiatives.	1
167	3	The team is actively involved in and has sessions to discuss the appraisal of papers on ECT. <i>Guidance: This is to keep up-to-date with the latest developments in the ECT field and gain and develop basic skills, such as reading and appraising scientific papers.</i>	

Training

168	1	Staff receive training on the use of legal frameworks, such as the Mental Health Act, Mental Health Act Ireland, the Mental Capacity Act Mental Capacity Act (Northern Ireland).	1
169	1	Staff receive training on safeguarding vulnerable adults and children. <i>Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.</i>	1
170	1	Staff receive training on risk assessment and risk management. <i>Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.</i>	1
171	1	Staff receive training on recognising and communicating with patients with cognitive impairment or learning disabilities.	1
172	1	Staff receive training in inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	1
173	2	Staff receive training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	1
174	3	Patient and carer representatives are involved in delivering and developing staff training.	1
175	2	The ECT team has development meetings, including liaison with a member of the Senior Management Team, or a Deputy at least every six months.	
176	1	All clinical staff receive an induction that includes: • An introduction to the theoretical basis of effective treatment with ECT; • Familiarity with local ECT protocol and clinic layout; • Observation of the administration of ECT prior to their first administration of ECT; • ECT policies and procedures.	
177	1	Staff who administer ECT review their competencies with the lead consultant psychiatrist on an annual basis.	
178	1	Practitioners administering ECT are trained to at least meet the RCPsych ECT Capabilities for a GA/OA higher trainee if they are doing so independently; otherwise, they are supervised whilst administering ECT by an ECT practitioner meeting those capabilities.	3
179	2	ECT anaesthetists receive a verbal and written induction from the lead anaesthetist.	4

180	1	ECT anaesthetists have read guidelines on the administration of anaesthesia for ECT, e.g. the relevant chapter of the ECT Handbook, or other current reviews	4
181	2	ECT clinic staff attend appropriate training or CPD events at least once every two years. This could include a training event or conference.	
182	2	The training needs of ECT clinic staff are formally assessed, for example in staff appraisals.	
183	2	Practitioners working in recovery should have completed recovery training and the recovery competencies in line with the clinic's protocol/agreement. <i>Guidance: The recovery practitioner is competent in caring for the unconscious patient as agreed with local anaesthetic protocols. They are fully conversant with aspiration/suction techniques and resuscitation procedures including Immediate Life Support, and informs the anaesthetist of any cause for concern.</i>	3
184	1	All registered clinical staff present during a treatment session are trained in Immediate Life Support on a Resus UK approved course, or a course of demonstrably equivalent standard.	3, 7

Section 8: Patient and Carer Experience

185	1	Staff members treat patients and carers with compassion, dignity and respect.	1
186	1	Patients feel listened to and understood by staff members.	1
187	1	Patients feel welcomed by staff members when attending their appointments. <i>Guidance: Staff members introduce themselves to patients, and address patients using their preferred name and correct pronouns.</i>	1
188	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	1
189	3	Administering practitioners meet regularly with patients and carers to provide an update on the patient's progress throughout treatment and answer any questions they may have.	16
190	2	The team asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. <i>Guidance: This feedback is documented, displayed in the ECT clinics and regularly appraised by the ECT Team.</i>	1
191	2	Feedback received from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics.	1
Information			
192	1	Patients are given accessible written information, as relevant, which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	1
193	1	Patients detained under mental health legislation are provided with the Care Quality Commission Your rights about consent to treatment leaflet (England), or equivalent, and this is verbally explained and documented.	
194	2	Information for patients and carers is written simply and clearly and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	17

195	2	The team works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	1
196	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	1
197	1	The team knows how to respond to carers when the patient does not consent to their involvement. <i>Guidance: The team may receive information from the carer in confidence.</i>	1
198	1	Before each treatment, the core ECT team explains the procedure to the patient, gives reassurance and spends time with relatives answering questions.	

Section 9: ECT Clinic Provision and Development

199	2	There is a dedicated budget for ECT. <i>Guidance: The budget supports the provision for the clinic.</i>	2
200	3	The ECT clinic present on their work externally, such as at conferences. This could include poster presentations.	18
201	2	The service reviews data at least annually about the people who use it. Data is compared with local population statistics and actions taken to address any inequalities of access that are identified.	1
202	1	All patient information is kept in accordance with current legislation. <i>Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.</i>	1
203	2	Patient or carer representatives are involved in the interview process for recruiting potential staff members. <i>Guidance: These representatives should have experience of the relevant service.</i>	1
204	1	Staff members, patients and carers who are affected by a serious incident are offered post-incident support. <i>Guidance: This includes attention to physical and emotional well-being of the people involved and post-incident reflection and learning review.</i>	1
205	2	The service's clinical outcome data are reviewed at least annually. The data are shared with the Trust/organisation, the team, patients and carers, and used to make improvements to the service.	1
206	1	A clinical member of staff is available to discuss emergency referrals during operating hours.	1
207	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this	1
208	1	When serious mistakes are made in care, this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	1
209	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	1

210	3	The service is developed in partnership with appropriately experienced patient and carers, who have an active role in decision making.	1
211	3	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/minimising waste and low carbon interventions). <i>Guidance: Progress against this improvement plan is reviewed at least quarterly with the team.</i>	1

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Glossary

Anaesthetic agent	A drug used to induce anaesthesia.
Advocacy services	Advocacy services are when a trained individual is provided to help you understand your rights, express your views, and wishes, and help ensure your voice is heard. An advocate is from an independent not for profit organisation who'll support you in making the right decisions in relation to your treatment.
Agent monitoring	Technology that measures the concentration of any inhalational anaesthetic agent. This allows quantification of the amount of anaesthetic that is being given to the patient.
ASA grade	ASA grades are a simple scale describing a person's fitness to be given an anaesthetic for a procedure.
Capacity assessment	Capacity means the ability to use and understand information to make a decision, and communicate any decision made. A capacity assessment is undertaken by a health professional.
Carer awareness	Training for ECT staff to understand the role of a carer, how to ensure the carer is involved in decision-making where possible and that their role is valued.
Clinical Global Impression Scale	The CGI is a 3-item observer-rated scale that measures illness severity (CGI-S), global improvement or change (CGI-I/CGI-C) and therapeutic response.
Comprehensive Psychopathological Rating Scale	This refers to a subjective test of memory using simple questions and a rating scale performed prior to each ECT treatment session.
Continuation ECT	Continuation ECT is a term for when treatments are intended to be given at a lower frequency than twice a week, following a successful acute course of treatment, for the purpose of prevention of early relapse of illness.
CPD	CPD stands for Continuing Professional Development and is the term used to describe the learning activities professionals engage in to develop and enhance their abilities. CPD is a holistic approach towards the enhancement of personal skills and proficiency throughout a professional's career.
Day patients	Patients who are admitted electively during the course of a day for treatment or

	care, which will not require an overnight stay in hospital and return home as scheduled.
District Court	In the Republic of Ireland, the District Court is a court of local and summary jurisdiction. The business of the District Court can be divided into four categories: - criminal, civil, family law and licensing.
Duty of Candour	The duty of candour requires providers to be open with the people who use their service. When a specified safety incident has occurred in respect of care provided, the regulation sets out a clear set of legal duties on registered providers about how and when to notify people using their service (or their relevant representatives) about those safety incidents. The regulation also describes when a notification about a safety incident needs to be made to CQC.
EEG	An electroencephalogram (EEG) is a recording of brain activity. During this painless test, small sensors are attached to the scalp to pick up the electrical signals produced by the brain. These signals are recorded by a machine and are looked at by a doctor.
Family inclusive practice	Family inclusive practice supports patients to include and consider their family context and members in care assessments, planning and treatment when accessing mental health support.
Laterality	Laterality refers to the placement of the electrodes on the patient, this can either be bilateral or unilateral.
Maintenance ECT	Maintenance ECT means treatments given intermittently in the longer term to prevent recurrence of illness. It typically follows six months of continuation ECT.
Mental Capacity Act (2005)	The Mental Capacity Act 2005 is the law that tells you what you can do to plan ahead in case you can't make decisions for yourself, how you can ask someone else to make decisions for you and who can make decisions for you if you haven't planned ahead.
Mental Health Act (1983)	This is a law that applies to England and Wales which allows people to be detained in hospital (sectioned) if they have a mental health disorder and need treatment. You can only be kept in hospital if certain conditions are met.
Mental Health Order	Legal framework in Northern Ireland for a patient that is assessed as lacking capacity to consent.

Nerve stimulator	A device that is used in patients who have been given muscle relaxant drugs, to determine the degree of paralysis. It uses electrodes to stimulate peripheral nerves.
Orientation	Orientation is awareness of time, place, person and the situation. The patient knows what time it is, what day it is and the date. They know where they are. They know who they are and recognise others. Finally, they know what is happening to them. Disorientation is said to occur when the person is unaware of one or more of these things.
Prescribing clinician	The consultant psychiatrist in charge of the patient's care who makes the initial decision to give a patient ECT.
Referring clinician	A clinician who makes the decision after summing up the risks and benefits of treatment to opt for ECT. The referring clinician must complete all the appropriate referring forms.
Reflective practice	Reflective practices are methods and techniques that help individuals or groups to reflect on their experiences and actions to engage in a process of continuous learning.
Safeguarding	Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults on independence and choice.
Scavenging equipment	Essential equipment used to collect and remove vented anaesthetic gases from the treatment room.
Second Opinion Appointed Doctor (SOAD)	This is an independent doctor appointed by the Care Quality Commission in England or by the Healthcare Inspectorate Wales. You need his or her approval to be given or continue to be given certain forms of medical treatment under the Mental Health Act 1983.
Seizure threshold	The likelihood that a patient will have a seizure. In ECT, it means the minimal electrical dose that induces a generalised tonic-clonic seizure. The seizure threshold can be altered by various factors. e.g. taking benzodiazepine drugs raises the seizure threshold, making a seizure less likely.
Social systems	Social systems are the interrelationships existing between individuals, groups, and institutions which can affect patients'

	health, values, occupational attainment, and sense of belonging in society.
Standardised cognitive assessment tool	A standardised cognitive assessment tool is a verified test for cognitive impairment—a deficiency in knowledge, thought process, or judgment. Examples are the Addenbrookes Cognitive Examination III or the Montreal Cognitive Assessment.
Suction machine	A suction machine is a type of medical device that is primarily used for removing obstructions — like mucus, saliva, blood, or secretions — from a person's airway.
Tardive seizure	Seizures that occur spontaneously after termination of an electroconvulsive therapy (ECT) seizure are termed tardive seizures.
Vulnerable adults	A person is considered a 'vulnerable adult' if they: • are aged 18 or over; • need community care services because of a disability, age or illness, and • are unable to take care of themselves or protect themselves against significant harm or exploitation.

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Appendix A

The following competencies have been adapted from the 'NHS Education for Scotland Core Competencies for Anaesthetic Assistants' document to ensure they are appropriate for use in ECT.

Number	Competency
1.1	Understands the assessment, significance, and limitations of the ASA score.
1.2	Aware of anaesthetic factors in the pre-operative clinical assessment of patients.
1.3	Aware of principles involved in assessing airway for potential difficulty with intubation and/or ventilation.
1.4	Can state fasting guidelines and clinical aspects of these.
1.5	Understands the anaesthetic consequences of obesity.
1.6	Understands the significance of pre-operative investigations and can demonstrate a basic level of interpretation.
1.7	Understands principles involved in pre-medication and pre-operative therapy.
1.8	Aware of roles and responsibilities of ECT personnel.
2.1	Able to complete routine pre-operative checklist.
2.2	Understands legal issues surrounding informed consent for anaesthesia and ECT.
2.3	Assesses, plans, implements and evaluates peri-operative care.
2.4	Able to maintain patient's comfort and dignity throughout the perioperative period.
2.5	Recognises signs of anxiety, their effects on anaesthesia and offers reassurance.
2.6	Demonstrates personal and professional accountability in relation to the role of an AA.
2.7	Aware of management of confused patients or patients with incapacity.
2.8	Able to assess and manage patients with learning disabilities.
2.9	Knows standard precautions for known or suspected infection risks (e.g. HIV/Hep B/ serious or resistant organism infection).
2.10	Able to assess and manage elderly patients or children under 16 (as relevant to scope of normal practice).
3.1	Can assist anaesthetist during establishment of peripheral IV access.
3.2	Able to secure an IV cannula or local anaesthetic catheter.
3.4	Can assist the anaesthetist during establishment of invasive monitoring.
3.5	Understands the principles and hazards of IV sedation.
3.6	Can assist in the care of a patient during a procedure under sedation.
4.1	Recognises the complementary role of the AA in airway establishment.
4.2	Knows the anatomy of the upper airway.
4.3	Can clear the airway where upper airway obstruction is present.
4.4	Can set up for, and assist the anaesthetist with, routine intubation of the trachea.
4.5	Understands features of oxygen delivery equipment.
4.6	Detailed knowledge of airway equipment, features, role and mode of use.
4.7	Can calculate endotracheal tube sizes and lengths.
4.8	Can describe features of self-inflating bags and can set up and use these.
4.9	Can set up difficult intubation equipment.
4.10	Knows protocol for unexpected difficult intubation / failed intubation drill.
4.11	Participates in Rapid Sequence Induction, including effective cricoid pressure.

4.12	Demonstrates ability to perform either role in two-person bag-mask ventilation.
4.14	Can assist with inhalation induction if applicable.
4.15	Demonstrates ability to place a laryngeal mask airway (LMA) in an adult patient.
4.16	Can assist during cricothyroidotomy.
4.17	Can assist in management of patient with unstable cervical spine.
5.1	Able to set up an anaesthetic machine, check it, pass it as safe to use and record this information appropriately. Includes routine between case-checks.
5.2	Knows safety features of the anaesthetic machine.
5.3	Can identify common breathing systems, state their Mapleson classification and their functional characteristics, check them and pass them as safe to use.
5.4	Understands purpose and features of an Anaesthetic Machine Ventilator.
5.5	Can identify gas cylinders. Knows how to safely handle and store gas cylinders.
5.6	Can safely connect and disconnect gas supplies. Can operate emergency shut-off valves.
5.7	Can identify and correct anaesthetic machine problems which may occur during use.
5.8	Demonstrates ability to correctly establish routine monitoring.
5.9	Able to understand anaesthetic charting and trends, perform charting of physiological data and describe monitoring status appropriately to the anaesthetist.
5.10	Can describe principles of monitoring depth of anaesthesia, including clinical aspects of prevention awareness.
5.12	Knowledge of electrical safety (see 6.13).
6.1	Knows how to manage the systematic introduction and care of new anaesthetic equipment.
6.2	Can implement standard precautions for infection control during the handling of anaesthesia equipment.
6.3	Understands factors to be considered when arranging routine maintenance of equipment.
6.4	Can identify and manage faulty or broken equipment.
6.5	Knows features and management of syringes, needles and other sharps.
6.6	Can set up IV infusion equipment.
6.9	Can describe the principle associated with train-of-four NMJ assessment.
6.10	Is able to set up and apply a train-of-four stimulator.
6.12	Can measure blood glucose and describe risks associated with abnormal values.
6.14	Can describe anaesthetic aspects of pacemakers and implantable cardiac defibrillators (ICD).
7.1	Knows principles of, and participates in, maintaining normothermia in intraoperative patient.
7.2	Understands principles of, and participates in, maintaining fluid balance in intra-operative patient.
7.3	Can use the operating table or patient trolley and its attachments.
7.4	Knows anatomy relevant to, and shares knowledges of, the risks of patient positioning.
7.5	Can position patients safely for treatment, including transfer using appropriate equipment.
7.7	Understands the risks of deep vein thrombosis, the principles of prophylaxis and the equipment involved.

7.8	Able to quantify tissue viability and can implement appropriate strategies to reduce risk.
8.1	Adheres to approved policies for the secure storage and management of medicines, including controlled drugs.
8.2	Understands principles of rotating drug stocks to minimise waste.
8.3	Knows the hazards of anaesthetic agent pollution.
8.4	Understands the clinical differences between crystalloids and colloids.
8.6	Can maintain clear, accurate and complete records of drug use.
8.7	Can calculate dosages and concentrations appropriate for clinical use.
8.8	Understands basic pharmacological principles.
8.9	Understands the clinical indications, storage requirements, clinical preparation, labelling and disposable requirements of drugs relevant to anaesthetic practice.
8.11	Able to set up and prepare equipment for target-controlled infusion equipment.
8.14	Can set up equipment to deliver nebulised drugs.
9.1	Can handover a patient in recovery, summarising relevant clinical features of the patient's pre- and intra-operative care.
9.2	Can systematically assess a patient in recovery using the ABC headings and appropriate monitoring.
9.3	Can assess post-operative pain.
9.4	Can assess post-operative nausea and vomiting.
9.5	Understands the important conditions which must be met before a patient can be discharged on the day of anaesthesia.
9.6	Can insert an oropharyngeal airway when indicated and confirm its effectiveness.
9.7	Can remove laryngeal mask airway.
9.8	Can assist in removal of endotracheal tube.
17.1	Can describe the problems associated with anaesthesia in an isolated site.
17.4	Aware of increased risk to patient in remote areas with regard to oxygen supply.
17.6	Is aware of current Mental Health Act legislation.
17.7	Understands the physical risks for a patient receiving ECT.
20.1	Can describe principles of adult preparation and stabilisation prior to transfer.
20.2	Can describe principles and difficulties of monitoring the critically ill adult patient during inter-hospital and intra-hospital transfer.
20.3	Can describe anaesthetic principles of patient transfer by road.
20.5	Understands importance of communication associated with inter-hospital patient transfer.