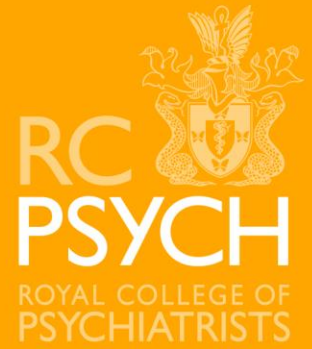


**ECTAS**  
ECT ACCREDITATION  
SERVICE



## **ECT Accreditation Service (ECTAS)**

Standards for the administration of ECT

15<sup>th</sup> Edition

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## **Contents**

<b>Foreword</b> .....	<b>4</b>
<b>Introduction</b> .....	<b>5</b>
<b>Section 1: The ECT Clinic and Facilities</b> .....	<b>6</b>
<b>Section 2: Staff and Training</b> .....	<b>13</b>
<b>Section 3: Assessment and Preparation</b> .....	<b>21</b>
<b>Section 4: Consent and information giving</b> .....	<b>26</b>
<b>Section 5: Anaesthetic Practice</b> .....	<b>32</b>
<b>Section 6: The administration of ECT</b> .....	<b>33</b>
<b>Section 7: Recovery, monitoring and follow-up</b> .....	<b>35</b>
<b>Section 8: Special precautions</b> .....	<b>39</b>
<b>Section 9: Protocols</b> .....	<b>41</b>
<b>Section 10: Nurse administered ECT</b> .....	<b>43</b>
<b>Appendix A</b> .....	<b>45</b>
<b>Appendix B</b> .....	<b>48</b>
<b>Acknowledgements</b> .....	<b>49</b>

## **Foreword**

I am delighted to introduce this latest edition of the ECTAS standards, which represents a major revision of this document. Since the formation of ECTAS in 2003, standards have been developed and reviewed regularly, and, as a result, have grown in number and complexity and with some repetition. The standards have also had to evolve to reflect developments in practice, particularly in relation to nurse-administered ECT, and changes in legislation and practice across all the territories covered by ECTAS.

The Advisory Group, with input from staff from ECTAS member clinics, has worked hard to produce a revamped and slimmed-down set of standards which are easier to navigate and avoid duplication. Following the demarcation of standards which pertain to particular commendation domains in the last edition, guidance notes have been added in this edition to give clarity to clinics as to what is required to meet certain standards. This will help all current member clinics, as well as potential new ones, be more confident that they are meeting the standards for accreditation and, in many cases, commendations for high-quality care.

The development of these standards has harnessed the expertise of many psychiatrists, nurses, anaesthetists and ODPs. I would like to thank all members of the Advisory Group for their endeavours and for the free and frank discussions which have shaped this document. I would particularly like to thank the ECTAS team, without whose support and expertise these standards could not have been published. I am confident that these standards will continue to make a major contribution to the provision of high-quality ECT services.

**Dr Vimal Sivasanker**  
**Chair, ECTAS Advisory Group**

## 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 for the purposes of review and accreditation as part of the ECT Accreditation Scheme, however, they can also be used as a guide for new or developing services.

## Terms

Please note that throughout this document, people who are receiving ECT are referred to as 'patient'.

## 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. Standards included in each domain for commendation are marked with letters noted in the key below.

## Key

*	Standard <b>modified</b> since last edition
†	<b>New</b> standard since last edition
M	Monitoring
T	Training and Research
D	Documentation
P	Patient Experience

## Section 1: The ECT Clinic and Facilities

No.	Type	Standard	CD	Guidance Notes
1.	2	The ECT clinic consists of a minimum of four rooms: a waiting room, treatment room, recovery area and post-ECT waiting area		
2.	2	The clinic is clean, comfortable and provides a welcoming atmosphere	<b>P</b>	
3.	1	The clinic adheres to the Trust's infection control policy		
4.	1	The clinic has access and facilities for disabled people		
5.	3	The clinic has an office for ECT staff which is private, i.e., it is not part of another room		
<b>Waiting area</b>				
6.	1	There is access to toilet facilities from the waiting area		
7.	1	The waiting area is large enough to accommodate the throughput of patients and escorts		
8. *	1	Patients waiting for ECT are not able to see into the treatment area while the treatment is taking place	<b>P</b>	
9.	2	Patients waiting for ECT are not waiting in the same room as patients in post-recovery		

No.	Type	Standard	CD	Guidance Notes
10.	2	The waiting area is comfortable and quiet and has a range of distractions		E.g. an outside window, pictures or magazines
<b>Treatment room</b>				
11.	1	The treatment room is of an adequate size for its purpose		
12.	1	The treatment room has easy access to a telephone		
13. *	1	Up to date protocols for the management of critical incidents such as cardiac arrest, anaphylaxis and malignant hyperthermia are readily available and accessible to staff		E.g. The current edition of the Association of Anaesthetists (AAGBI) Quick Reference Handbook <a href="https://anaesthetists.org/Home/Resources-publications/Safety-alerts/Anaesthesia-emergencies/Quick-Reference-Handbook">https://anaesthetists.org/Home/Resources-publications/Safety-alerts/Anaesthesia-emergencies/Quick-Reference-Handbook</a>
14.	1	If nitrous oxide and/or anaesthetic inhalation agents are used, then the treatment room is equipped with scavenging equipment and agent monitoring		

No.	Type	Standard	CD	Guidance Notes
15.	1	The treatment room has a work surface and sink with hot and cold water		
16.	2	The treatment room has a clock with a second hand, or similar		
17.	1	The treatment room has a secure drug storage cupboard		
18.	1	The treatment room has a secure drug fridge with temperature control		
19.	1	Steps are taken to avoid speech being heard between different rooms/areas of the clinic (waiting area, treatment room, recovery area and post-ECT waiting area)		E.g. use of thick doors, consideration of location, use of music to mask sound, etc.
20.	1	Clinic staff in the treatment room are able to speak directly with staff in the recovery area		E.g. rooms are adjacent, or there is an intercom system
<b>Recovery area</b>				
21.	2	The recovery area is large enough to accommodate the throughput of patients lying on trolleys with additional space to manoeuvre		
22.	2	The recovery area has a doorway large enough to admit a trolley from the treatment room		
<b>Post ECT waiting area</b>				



No.	Type	Standard	CD	Guidance Notes
23.	2	The post-ECT waiting area provides a friendly, relaxed environment		
24.	2	The post-ECT waiting area has provision for refreshments for patients		
<b>Equipment</b>				
25.	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		
26.	1	There is a fully equipped emergency trolley with adequate resuscitation equipment and a defibrillator		A manual defibrillator with pacing facility
27.	1	There is a means of establishing an emergency surgical airway		E.g. an emergency cricothyroidotomy kit (and the anaesthetist is familiar with the use of the kit stored in the clinic)
28.*	1	There is a neuromuscular monitor and a means of measuring temperature		
29.	1	Provision is made for positive pressure respiration: oxygen cylinder, mask and self-inflating bag and at least one full spare cylinder in both the treatment and recovery areas		

No.	Type	Standard	CD	Guidance Notes
30.	1	There are at least two suction machines; one in the treatment room and one in the recovery room. Treatment of a patient does not start until the previously treated patient is conscious, as assessed by the recovery practitioner or anaesthetist		
31. *	1	There is a pulse oximeter, which is always used during anaesthesia		
32. *	1	There is an NIBP monitor which is always used during anaesthesia		
33. *	1	There is a capnograph, which is always used during anaesthesia		
34. *	1	There is an ECG monitor, which is always used during anaesthesia		
35.	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		
36.	2	There is a means of measuring blood glucose concentration		
37.	2	There is moving and handling equipment		E.g. a sheet to help turn the patient
38.	2	There is a dedicated budget for ECT		

**The following drugs are stocked in the clinic:**

No.	Type	Standard	CD	Guidance Notes
39.	1	At least two different anaesthetic induction agents		E.g. Thiopental, Propofol or alternatives
40.	1	At least two different muscle relaxants		E.g. Suxamethonium and an alternative
41.	1	Oxygen		
42.	1	Emergency drugs and equipment as agreed with the local pharmacy or resuscitation committee		
43. *	1	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		
<b>ECT machine and equipment</b>				
44. *	1	The ECT machine can provide brief pulse stimuli according to current guidelines set out in the ECT Handbook, and has two-channel EEG monitoring		
45.	1	The ECT nurse ensures that the machine function and maintenance is checked and recorded at least every year or according to machine guidance		

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
46.	2	The ECT nurse ensures that the clinic is properly prepared, organised and maintained		
47. *	1	The ECT nurse ensures that the equipment in the clinic is well-maintained and that up to date instructions are available		Equipment instructions may be available online
48. *	2	The ECT nurse is responsible for ensuring that systems are in place for the ordering and stocking of drugs		
49.	2	The ECT nurse is responsible for ordering and stocking disposable equipment		
50. *	1	A back-up ECT machine can be accessed by the clinic within 2 hours, and staff are competent in its use		

## Section 2: Staff and Training

No.	Type	Standard	CD	Guidance Notes
51.	1	There is at least one trained nurse in the treatment room	T	
52. *	1	There is at least one recovery-trained practitioner in the recovery area	T	Training standards/ core competencies should be agreed with the Lead ECT Consultant & ECT Manager. If only one patient is treated in a session, the same practitioner may attend both treatment and recovery, if competent.
53. †	2	Practitioners working in recovery should have completed recovery training and the recovery competencies as per their Trusts' training requirements		
54.	1	There is at least one experienced anaesthetist present during treatment and recovery	T	

No.	Type	Standard	CD	Guidance Notes
55. *	1	There is an Operating Department Practitioner (ODP), an Anaesthetic Assistant, or a Nurse with anaesthetic training present during treatment and recovery whose sole responsibility is to assist the anaesthetist during the procedure. They will have achieved the competencies set out in the NHS Scotland Core Competencies for Anaesthetic Assistants (see appendix A).	T	NMBI-approved courses for nurses in Ireland meet some of the competencies set out in Appendix A. Evidence will need to be provided that the remaining competencies (Appendix B) have also been met. Medical staff (including trainee or career grade anaesthetists) will not routinely meet the competencies in Appendix A and should not be performing this role.
56. *	1	There is at least one suitably trained psychiatrist present during treatment, as defined by the Royal College of Psychiatrists' competency document	T	
57.	1	The number of staff in the recovery area exceeds the number of unconscious patients by one		
58.	1	All clinical staff present during a treatment session are trained in Basic Life Support	T	

No.	Type	Standard	CD	Guidance Notes
59.	1	In addition to the anaesthetist, there is one member of staff trained to at least Immediate Life Support level on a Resuscitation Council (UK) approved course, or a course of demonstrably equivalent standard, present during the treatment session	T	
60.	2	There are back-up staff easily available to assist in an emergency situation		
61.	1	There are systems to ensure that staffing of the clinic is sufficient when members of the team are absent for planned or unplanned periods	T	
62. *	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this		
63. †	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement		
64. †	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 lessons		
<b>Lead Psychiatrist</b>				
65.	1	There is a named ECT lead consultant psychiatrist		
66. *	1	The named lead consultant psychiatrist has dedicated sessional time for ECT and this is included in a job plan, where such exists		

No.	Type	Standard	CD	Guidance Notes
67.	2	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	T	
68.	1	The named lead consultant psychiatrist 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		
69.	2	The named lead consultant psychiatrist is involved in developing protocols for the prescription of ECT by his or her peers in order to update their prescribing practice	T	
<b>Lead nurse</b>				
70.	1	There is a named lead ECT nurse who: <ul style="list-style-type: none"> <li>• has dedicated sessional time for the administration of ECT;</li> <li>• attends at least 50% of clinics;</li> <li>• takes overall responsibility for management of the clinic;</li> <li>• has dedicated hours for administrative work relating to ECT</li> </ul>		
71. *	1	The named lead nurse is of at least Band 6 (CNM2 Republic of Ireland) and has been assessed as competent to carry out the required role		
72.	3	The named lead nurse is trained in Immediate Life Support		
73.	2	The named lead nurse has appropriate ECT and clinical experience		



No.	Type	Standard	CD	Guidance Notes
<b>Lead anaesthetist</b>				
74. *	1	Anaesthesia is administered by a consultant anaesthetist, or by a non-consultant career grade or trainee under the supervision of a named lead anaesthetist. The named lead anaesthetist attends the clinic regularly. All anaesthetists meet current Royal College of Anaesthetists <i>CCT in Anaesthetics</i> competencies for non-theatre settings	T	See Royal College of Anaesthetists (RCoA) 'Guidelines for the Provision of Anaesthetic Services in the Non-Theatre Environment' points 3.27-3.33 <a href="https://www.rcoa.ac.uk/gpas/chapter-7">https://www.rcoa.ac.uk/gpas/chapter-7</a>  See RCoA competencies relevant to ECT (p0-20) <a href="https://www.rcoa.ac.uk/sites/default/files/documents/2019-08/TRG-CCT-ANNEXD.pdf">https://www.rcoa.ac.uk/sites/default/files/documents/2019-08/TRG-CCT-ANNEXD.pdf</a>
75.	1	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		
76.	1	Anaesthetists on the rota do not include unsupervised doctors in junior training grades (including CT1 & 2)		
77. *	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 are performed	T	

No.	Type	Standard	CD	Guidance Notes
78. *	2	The named lead anaesthetist has dedicated sessional time devoted to direct clinical care in the provision of anaesthesia for ECT		
<b>ECT Team</b>				
79.	2	There is a line management structure with clear lines of accountability within the clinic		
80.	2	There are regular operational multi-disciplinary team meetings for clinical matters, policy and administration		
81.	2	The roles and responsibilities of clinic staff are clearly defined, e.g. in up to date job descriptions, including the appropriate grade for the position		
82.	2	The core team works in the clinic every week for the purposes of continuity		
83.	2	The team takes an active role in audit, academic teaching and development of evidence-based best practice for ECT	<b>T</b>	
84. †	2	Clinics submit outcome data to the ECTAS minimum dataset	<b>D</b>	
85. †	2	The clinic team use quality improvement methods to implement service improvements		
86. †	2	The clinic team actively encourage patients and carers to be involved in QI initiatives		
<b>The core team has responsibility for:</b>				

No.	Type	Standard	CD	Guidance Notes
87.	1	The development of local treatment protocols	T	
88.	1	The supervision of clinical staff	T	
89.	1	Liaising with, and advising, other professionals	T	
<b>Training – all staff</b>				
All clinic staff have received appropriate training and education. This includes training on:				
90.	1	Legal frameworks, e.g. Mental Capacity Act and Mental Health Act Code of Practice	T	
91.	2	The ECT Team has regular development meetings, including liaison with a member of the Senior Management Team, or a Deputy	T	
<b>Training – administering doctors and nurses</b>				
92.*	1	ECT is only administered by: <ul style="list-style-type: none"> <li>• Psychiatrists who meet the RCPsych Competencies for Doctors;</li> <li>• Doctors and nurses under the supervision of the named lead consultant psychiatrist or an appropriately trained deputy;</li> <li>• Nurses who meet all requirements in section 10: Clinics practising nurse-administered ECT</li> </ul>	T	
<b>Administering professionals receive induction training, including the following:</b>				

No.	Type	Standard	CD	Guidance Notes
93.	1	An introduction to the theoretical basis of effective treatment with ECT	T	
94.	1	Familiarity with local ECT protocol and clinic layout	T	
95.	1	Observation of the administration of ECT prior to their first administration of ECT	T	
96.	3	The appraisal of papers on ECT	T	
<b>Training – other staff</b>				
97.	1	Other staff involved in the administration of ECT have appropriate induction and ongoing training	T	
98.	1	ECT nurses undergo an induction programme covering ECT policies and procedures, medical equipment safety and clinic management	T	
99.	2	The ECT lead nurse attends the Royal College of Psychiatrists'/ NALNECT course for nurses in ECT, or the HSC Clinical Education Centre Electroconvulsive Therapy 2-day training course	T	
100.	2	ECT anaesthetists receive a verbal and written induction from a consultant anaesthetist with an interest in ECT	T	
101.	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		

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
102.	2	ECT clinic staff attend appropriate training or CPD events at least once every 2 years. This could include a training or conference event, ECT Special Interest Group, or an ECTAS peer review visit	<b>T</b>	
103.	2	The training needs of ECT clinic staff are formally assessed, for example in staff appraisals	<b>T</b>	
104.	2	There is provision in the departmental budget for necessary training relating to ECT		
105.	3	Other nurses in the clinic attend the Royal College of Psychiatrists' / NALNECT course for nurses in ECT, the HSC Clinical Education Centre Electroconvulsive Therapy 2-day training course, or equivalent	<b>T</b>	
106.	2	Lead ECT nurses, or their delegate, attend their regional ECT practitioners' special interest group	<b>T</b>	

### **Section 3: Assessment and Preparation**

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
107.	1	All prospective ECT patients have a formal, documented assessment and are prepared for ECT	<b>D</b>	
108.	1	A detailed medical history is recorded	<b>D</b>	

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
109.	1	An anaesthetic assessment is carried out, including assessment of ASA grade	<b>D</b>	The ASA grade should be confirmed by an anaesthetist
110.	1	Any variation in the ASA grade of the patient is recorded and communicated to the ECT team before the treatment session	<b>D</b>	
111.	1	A physical examination is recorded which includes the cardiovascular, respiratory and neurological systems, a VTE assessment and a pregnancy test where applicable	<b>D</b>	
112.	1	Current medication and drug allergies are recorded as well as any noted drug problems	<b>D</b>	
113.	2	The patient's ethnicity is recorded	<b>D</b>	
114.	1	The patient's Mental Health Act status is recorded	<b>D</b>	
115.	1	An assessment of the risk/benefit balance of having ECT is considered and recorded	<b>D</b>	
116.	2	A mental state examination is recorded	<b>D</b>	
117.	2	An assessment of memory is recorded using a standardised cognitive assessment tool and subjective questioning	<b>D</b>	E.g. Montreal Cognitive Assessment (MoCA) or Mini-Mental State Examination (MMSE)

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
118.	2	An assessment of orientation is recorded	<b>D</b>	
119.	2	The patient's weight is recorded	<b>D</b>	
120.	2	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	<b>D</b>	
121.	1	There is a local policy, agreed with the anaesthetic department/consultant anaesthetist, detailing which investigations are needed before the start of a course	<b>D</b>	
122.	1	The ECT nurse is responsible for ensuring that emergency resuscitation equipment is tested and checked before each ECT clinic session		
123.	1	The ECT nurse is responsible for ensuring that emergency drugs and equipment are checked before each ECT clinic session for out of date drugs and missing items		
124.	1	The ECT nurse is responsible for ensuring that the ECT electrodes are checked visually before each ECT clinic session		
125.	1	If the machine does not self-check, an ECT nurse 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		
126.	1	Day patients receiving an acute course of ECT are escorted both to and from the ECT clinic by a named responsible adult	<b>P</b>	

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
127.	1	Day patients receiving maintenance ECT may convey themselves to the ECT clinic if this is deemed clinically appropriate, but are escorted from the clinic by a named responsible adult	<b>P</b>	
128.	1	Patients are supported and supervised from the waiting room through treatment and recovery by members of the ECT team	<b>P</b>	
129.	1	Inpatients are escorted to and from the ward by a member of staff	<b>P</b>	When selecting an escort, the nurse-in-charge of the ward considers risk to the patient, discussion with the ECT team, and is accountable for any consequences of that selection
130.	2	The escort is known to the patient, is aware of the patient's legal and consent status and has an awareness of the ECT process	<b>P</b>	
131.	2	The arrival of patients at the ECT clinic is managed to minimise waiting time	<b>P</b>	
132.	2	The clinic has a planned and regular starting time; pre-anaesthetic fasting time is adjusted to this	<b>P</b>	
133.	* 2	The ECT nurse plans the arrival times of patients by liaising with the wards, outpatient department, day hospitals and with day patients and families".	<b>P</b>	



<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
134.	2	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	<b>P</b>	E.g. students, visiting trainees or clinicians
135.	2	Before each treatment, the core ECT team explains the procedure to the patient, gives reassurance and spends time with relatives answering questions	<b>P</b>	
136.	2	The core ECT team provides information about the safekeeping of valuables, location of toilets and arrangements for further appointments		
137.	1	The following documentation is available for clinic staff's reference: <ul style="list-style-type: none"> <li>• The patient's consent form, Mental Health Act documentation and a copy of any other supporting documentation relating to consent</li> <li>• The patient's pre-ECT assessment including medical examination, drug history and other investigations</li> </ul>	<b>D</b>	
138.	1	The patient is asked when he or she last ate and last drank and this concurs with the length of time required for 'fasting' agreed with the local anaesthetic department	<b>P</b>	
139.	1	The patient's identity is checked, and the patient wears an identity wristband whilst in the ECT department		In exceptional circumstances, an identity wristband may not be worn, for example if there is a risk of self-harm

No.	Type	Standard	CD	Guidance Notes
140.	2	All metal objects are removed from the patient's hair and the patient is asked if he/she is wearing any make up or nail polish, or whether he/she has lacquer or cream in his/her hair		
141.	2	The patient is asked to remove hearing aids and glasses/contact lenses		
142.	1	The patient's record is checked to confirm that he/she is not allergic to anything affecting the treatment or anaesthetic. The patient wears an allergy wrist band whilst in the ECT department, if appropriate		
143.	1	The ECT nurse ensures that the patient's blood pressure, pulse, and temperature are recorded, and the patient is encouraged to empty their bladder	<b>D</b>	
144.	1	The anaesthetist checks that there have been no problems with previous anaesthetics at each treatment		

## Section 4: Consent and information giving

No.	Type	Standard	CD	Guidance Notes
145. *	1	All patients (and their relatives if applicable), regardless of their capacity to consent to ECT, are provided with an ECT patient information leaflet and/or a local ECT patient information leaflet, and this is verbally explained and documented	P, D	
146.	1	All patients are provided with the Care Quality Commission <i>Your rights about consent to treatment</i> leaflet (England), or equivalent, and this is verbally explained and documented	D	
147.	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	D	
148.	2	The service uses 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	D	Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice
<b>Assessing capacity</b>				

No.	Type	Standard	CD	Guidance Notes
149.	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	<b>D</b>	The consent form is appropriate to the patient's capacity to consent to ECT and Mental Health Act 1983 (Amended 2007) Status or equivalent
150.	* 2	Patients are informed by both the referring clinician 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		
151.	1	If a patient is assessed as lacking capacity to consent to ECT treatment, the provisions stipulated under the Mental Health Act 1983 (Amended 2007) code of practice and the Mental Capacity Act (2005) or equivalent are followed in order to validate the legal authority under which ECT treatment is delivered	<b>D</b>	
<b>Obtaining consent</b>				
152.	* 1	Consent is only obtained by a psychiatrist who has adequate knowledge of the nature and effects of ECT and patient rights		
153.	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)		

No.	Type	Standard	CD	Guidance Notes
154.	1	Patients' consent is never obtained through any form of coercion		E.g. implying the use of the Mental Health Act 1983 (Amended 2007) or equivalent if the patient refuses
155.	2	For every new course of ECT, except in an emergency, patients are given 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	<b>P</b>	
<b>During the consent process, the following areas are discussed by the referring clinician and the patient:</b>				
156.	1	The nature of the treatment and a description of the process	<b>P, D</b>	
157.	1	Indication, intended benefits and likelihood of success of ECT (dictated by current evidence base)	<b>P, D</b>	
158.	1	Risks, including common and rare physical and cognitive adverse effects	<b>P, D</b>	
159.	1	General anaesthetic risks	<b>P, D</b>	
160.	1	Likely consequences of not having ECT	<b>P, D</b>	
161.	1	Treatment alternatives and confirmation that these will be available if the patient decides not to have ECT	<b>P, D</b>	
162.	1	How to access independent advocacy and obtain additional information	<b>P, D</b>	

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
163.	2	Post-anaesthetic risks	<b>D</b>	I.e. driving, operating machinery, alcohol use, signing documents and the need for supervision
164.	2	The referring clinician advises patients not to drive whilst undergoing an acute treatment course of ECT. Maintenance patients are advised not to drive for at least 48 hours after a general anaesthetic	<b>D</b>	
165.	1	The referring clinician asks the patient to complete a consent form or there is an equivalent process, if consent cannot be given	<b>D</b>	
166.	1	All information collected by the referring clinician is shared with the ECT team		
167.	2	The ECT clinic's consent policy, the referring Trust's consent policy, and all consent forms used are fully compliant with Department of Health Guidelines or equivalent	<b>D</b>	
<b>The ECT team</b>				
168.	1	The ECT team confirms that the patient's capacity to consent to ECT agrees with the referring clinician's capacity assessment. Any changes are communicated to the referring clinician in a timely manner	<b>D</b>	
169.	1	Original and valid on-going consent is checked and recorded by the ECT team before each ECT treatment	<b>D</b>	

No.	Type	Standard	CD	Guidance Notes
170.	2	The patient's relatives are kept informed about the patient's ECT treatment unless issues surrounding patient confidentiality preclude this		
171.	1	For all patients detained under the Mental Health Act 1983 (amended 2007), or equivalent, who are unable to consent to treatment, a certificate of second opinion (T6 Form or equivalent) or legal authority for emergency treatment (Section 62 form or equivalent) is present in the clinic for every treatment	<b>D</b>	This may be available in either paper or electronic format
172.	1	For all patients detained under the Mental Health Act 1983 (amended 2007) or equivalent who are able to consent to treatment, the T4 (or equivalent) Form is present in the clinic for every treatment	<b>D</b>	

## Section 5: Anaesthetic Practice

No.	Type	Standard	CD	Guidance Notes
173.	1	<i>Recommendations for standards of monitoring during anaesthesia and recovery, Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2015) are followed</i>		
174.	1	The anaesthetist checks the anaesthetic and suction equipment and prepares the anaesthetic agents		
175.	1	There is consistent use of anaesthetic agents and dosing		
176.	2	Any reason for a change in anaesthetic induction agent is discussed with the ECT team and documented	<b>D</b>	
177.	1	Oxygen is normally administered before ECT		
178.	1	Before induction, the anaesthetist or assistant checks that any dentures have been removed or are secure		
179.	1	Once anaesthesia has been induced, the anaesthetist or assistant inserts a bite block		



## Section 6: The administration of ECT

No.	Type	Standard	CD	Guidance Notes
180.	1	The clinic has the capability to give both unilateral and bilateral ECT		
181. *	1	<p>A pre-procedure checklist is run through for each patient before the treatment commences. This includes:</p> <ul style="list-style-type: none"> <li>• Introducing members of the team</li> <li>• Patient identity</li> <li>• Laterality and dose</li> <li>• Mental Health Act status</li> <li>• Consent and capacity status</li> <li>• Any changes to the anaesthetic</li> <li>• Any changes to the ASA grade</li> </ul>	<b>D</b>	
182.	1	The administering professional ensures the seizure is tonic-clonic and of adequate duration, by monitoring the motor effects and EEG		
183.	2	Except in exceptional circumstances, the patient is treated on the same make of ECT machine throughout the course of treatment	<b>D</b>	
184.	2	Adequate records are kept of treatment and incidents		

No.	Type	Standard	CD	Guidance Notes
185. * 1		<p>There is a section of the ECT record which includes:</p> <ul style="list-style-type: none"> <li>• The pre-procedure checklist</li> <li>• the anaesthetic induction agent dose;</li> <li>• muscle relaxant dose;</li> <li>• any ancillary medication;</li> <li>• nature of ventilation;</li> <li>• cardiorespiratory changes;</li> <li>• seizure quality and duration;</li> <li>• time to orientation and post-procedural problems;</li> <li>• charge delivered;</li> <li>• bilateral/unilateral seizure;</li> <li>• and immediate side effects</li> </ul>	<b>D</b>	
186.	2	The psychiatrist prescribes no more than two treatments at a time before reviewing and renewing the prescription	<b>D</b>	

## Section 7: Recovery, monitoring and follow-up

No.	Type	Standard	CD	Guidance Notes
187.	1	The recovery practitioner is present as the patient recovers consciousness		
188.	1	The recovery practitioner is competent in caring for the unconscious patient, is fully conversant with aspiration/suction techniques and resuscitation procedures including basic life support, and informs the anaesthetist of any cause for concern		
189.	1	Pulse, blood pressure and pulse oximetry readings are documented by the recovery practitioner	<b>D</b>	
190.	1	As the patient recovers consciousness, the recovery practitioner reassures gently and repeatedly and cares for the patient until they are fully awake	<b>P</b>	
191.	1	The anaesthetist is immediately contactable until all patients recover full consciousness and are physiologically stable		
192.	1	The ECT nurse ensures that patients are not discharged from the clinic until fully recovered		
193.	2	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	<b>D</b>	
194.	† 1	Any cannulas in situ are flushed after the last intravenous drug has been administered		

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
195.	3	The psychiatrist remains in the building and contactable until all patients recover full consciousness and are physiologically stable		This refers to the psychiatrist in charge of the session
196.	2	The patient is offered something to eat and drink before they are discharged from the ECT suite	<b>P</b>	
<b>Monitoring</b>				
197.	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	<b>D, M</b>	
198.	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	<b>D, M</b>	
199.	3	Clinical response is monitored and recorded using a validated depression rating scale at least weekly between treatment sessions for patients receiving an acute course of ECT, or between each session for patients receiving maintenance ECT	<b>D, M</b>	E.g. Montgomery-Åsberg Depression Rating Scale (MADRS) or Hamilton Rating Scale for Depression)

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
200.	† 1	Subjective test of memory before every ECT using the Comprehensive Psychopathological Rating Scale (CPRS)	<b>D, M</b>	Item 17: 0: Memory as usual 2: Occasional increased lapses of memory 4: Reports of socially inconvenient or disturbing loss of memory 6: Complaints of complete inability to remember
201.	* 1	The patient memory is assessed before the first and after every four treatments using a standardised cognitive assessment tool	<b>D, M</b>	E.g. Montreal Cognitive Assessment (MoCA) or Mini-Mental State Examination (MMSE)
202.	† 1	The patient's time to re-orientation is recorded after each ECT treatment	<b>D, M</b>	
203.	† 1	If the patient's time to re-orientation is prolonged, this is reported to the prescribing clinician		
204.	† 2	The patient's orientation and memory are assessed after the last session using a standardised cognitive assessment tool	<b>D, M</b>	E.g. Montreal Cognitive Assessment (MoCA) or Mini-Mental State Examination (MMSE)
205.	* 2	The patient's cognitive side effects are assessed using a standardised cognitive assessment tool in a clinical interview after 2 months	<b>D, M</b>	E.g. Montreal Cognitive Assessment (MoCA) or Mini-Mental State Examination (MMSE)

No.	Type	Standard	CD	Guidance Notes
206.	* 2	The patient's memory is assessed using a subjective questioning in a clinical interview after 2 months	<b>D, M</b>	
207.	† 3	Patients who experience memory problems have access to a specialist assessment by a neuropsychologist or memory assessment service if clinically indicated		To comply with this standard, clinics will need to evidence that they can refer to a neuropsychologist or memory assessment service if clinically indicated
208.	2	Non-cognitive side effects are assessed and recorded between treatment sessions	<b>D, M</b>	
209.	3	Issues of non-compliance with assessments and monitoring are addressed with the referring team on each occasion. Sustained non-compliance issues are addressed through established risk-reporting systems	<b>D, M</b>	
<b>Follow-up</b>				
210.	3	The patient is reviewed by the appropriate team at least once a month for the 3 months following an acute course of ECT	<b>M</b>	
211.	* 3	Patients and their carers are offered the opportunity to formally feedback on their experiences of care and treatment. This feedback is documented, displayed in the ECT clinics and regularly appraised by the ECT Team	<b>P</b>	
212.	3	The clinic can evidence carer involvement		

## Section 8: Special precautions

No.	Type	Standard	CD	Guidance Notes
213.	1	High-risk patients are considered for treatment in an environment allowing rapid intervention should complications occur		E.g. a theatre suite or its recovery area
214.	2	ECT sessions for people under 18 are held separately from sessions involving adults		Under 18- year olds should have no contact with adult patients. Sessions could be held at the beginning or end of clinic sessions to accommodate this
215.	2	Special arrangements are made when patients are given ECT in a clinic on a different site from their base hospital. Commuting patients are treated at the beginning of the session to allow maximum time for recovery		
<b>Day patients</b>				
216.	1	Before treatment commences, day patients are advised and/or given specific guidelines relating to driving, drinking alcohol and being accompanied home after each treatment	<b>P</b>	
217.	1	Discharge criteria which include assessment before discharge are agreed with the local anaesthetic department		

No.	Type	Standard	CD	Guidance Notes
218.	1	<p>Day patients and/or their carers sign a form which confirms:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• They will not drink alcohol for 24 hours after each treatment or until advised by their consultant psychiatrist;</li> <li>• They will be accompanied home following each ECT treatment;</li> <li>• They will have appropriate direct supervision by a responsible adult for the 24 hours following each ECT treatment;</li> <li>• They will not sign any legal documents for at least 24 hours following each ECT treatment or until advised by their consultant psychiatrist</li> </ul>	<b>P, D</b>	
<b>Clinic activity</b>				
219.	3	<p>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 to ensure adequate practice is undertaken in an adjacent or neighbouring facility</p>	<b>T</b>	
220.	2	<p>Every effort is made to ensure that patients receive ECT twice weekly if required. ECT clinics are only cancelled in exceptional circumstances</p>		



## Section 9: Protocols

No.	Type	Standard	CD	Guidance Notes	
221.	*	1	Policies relating to ECT are reviewed at least once every three years	<b>D</b>	
222.		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	<b>D</b>	See UKMH Registry Dantrolene stock levels guidance <a href="http://www.ukmhr.ac.uk/pharmacists/dantrolene-stock-levels/">http://www.ukmhr.ac.uk/pharmacists/dantrolene-stock-levels/</a>
223.		1	There is a protocol for the management of cardiac arrest	<b>D</b>	
224.		1	There is a protocol for the management of anaphylaxis	<b>D</b>	
225.		1	There is a protocol that addresses the needs of day patients, including preparation for leaving hospital	<b>D</b>	
226.		2	There is a protocol on 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	<b>D</b>	
227.		2	There is a protocol on the choice of laterality of treatment	<b>D</b>	
228.		2	The clinic has a protocol or checklist for monitoring patients immediately after ECT	<b>D</b>	

<b>No.</b>	<b>Type</b>	<b>Standard</b>	<b>CD</b>	<b>Guidance Notes</b>
229.	2	There is an up to date protocol relating to the patient's medication during and after treatment	<b>D</b>	
230.	2	The clinic has a protocol relating to the treatment of young people under 18. This includes reference to cognitive side effects, and seizure thresholds	<b>D</b>	
231.	2	There is a protocol about when to discontinue treatment when no clinical response is seen	<b>D</b>	
232.	1	There is a local protocol about the quality and timing of an adequate seizure	<b>D</b>	
233.	1	There is a local protocol about the management of a prolonged or tardive seizure	<b>D</b>	
234.	1	There is a local protocol about when to re-stimulate a patient after a brief or missing seizure	<b>D</b>	
235.	1	There is a stimulus dosing protocol that is in accordance with the ECT Handbook	<b>D</b>	
236.	3	There is a protocol for consultation between the ECT consultant and the referring clinician in situations where ECT is prescribed outside of NICE guidelines	<b>D</b>	

## Section 10: Nurse administered ECT

NOTE: Whether or not a clinic undertakes nurse-administered ECT is the decision of the individual clinic/Trust. These standards apply only to those clinics that practise nurse-administered ECT.

No.	Type	Standard	CD	Guidance Notes
237.	1	<p>The administering nurse can evidence:</p> <ul style="list-style-type: none"> <li>• They have completed and updated the ECT nurse training course;</li> <li>• They have attended an ECT training day in the last 3 years;</li> <li>• They attend and contribute to a regional special interest group</li> </ul>		
238.	1	The administering nurse has completed the current Royal College of Psychiatrists' competencies for junior doctors and the ECT nurse competencies, and this is reassessed regularly in supervision		
239.	1	The administering nurse has an up-to-date appraisal		
240.	* 1	The administering nurse receives monthly medical supervision with the lead psychiatrist, both clinical and managerial		
241.	1	The administering nurse completes at least 20 treatments a year to retain competency, with at least 10 treatments supervised by the department's medical lead		

No.	Type	Standard	CD	Guidance Notes
242.	1	<p>In clinics that deliver nurse-administered ECT, there is a named lead consultant psychiatrist who:</p> <ul style="list-style-type: none"> <li>• has been in post for at least 6 months;</li> <li>• has dedicated sessional time in the clinic;</li> <li>• meets the competencies set out in the Royal College of Psychiatrists' competency document at appointment;</li> <li>• demonstrates ongoing CPD in their annual appraisal and maintains their clinical skills</li> </ul>		
243.	1	There are sufficient other staff in the ECT suite during nurse-administered treatment		The nurse should not be distracted by other nursing/management tasks or responsibilities during nurse-administered treatment
244.	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 competencies or College of Psychiatrists of Ireland learning outcomes. Trainees attend the clinic regularly	<b>T</b>	

## Appendix A

The following competencies from the 'NHS Education for Scotland Core Competencies for Anaesthetic Assistants' document are required for Standard 55. Please see the document for a list of the skills and knowledge expected for each standard. The required competencies are also highlighted.

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 theatre personnel.
2.1	Able to complete routine pre-operative checklist.
2.2	Understands legal issues surrounding informed consent for anaesthesia and surgery.
2.3	Assesses, plans, implements and evaluates peri-operative care.
2.4	Able to maintain patient's comfort and dignity throughout the peri-operative 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 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.
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 the 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 of awareness.
5.11	Can describe principles of calculating intra-operative blood loss.
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.
6.7	Knowledge of the equipment associated with blood and blood product transfusion.
6.9	Can describe the principles 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).
6.15	Can assist with the positioning of nasogastric tubes.
7.1	Knows principles of, and participates in, maintaining normothermia in intra-operative patient.

7.2	Understands principles of, and participates in, maintaining fluid balance in intra-operative patient.
7.3	Can use the operating table and its attachments.
7.4	Knows anatomy relevant to, and shares knowledge of, the risks of patient positioning.
7.5	Can position patients safely for surgery, including transfer to the operating table using appropriate equipment.
7.6	As part of the peri-operative team, can safely return patient to supine or lateral decubitus position.
7.7	Understands the risks of deep venous 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 difference between crystalloids and colloids.
8.5	Understands the principles involved in the safe administration of blood and blood products
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 disposal requirements of drugs relevant to anaesthetic practice.
8.11	Able to set up and prepare equipment for target controlled infusion equipment.
8.12	Understands the principles of patient controlled analgesia.
8.13	Can set up patient controlled analgesia equipment.
8.14	Can set up equipment to deliver nebulised drugs.
8.15	Can set up equipment for epidural infusion.
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 the Mental Health (Care and Treatment) (Scotland) Act (2003)
17.7	Understands the physical risks for a patient receiving ECT
20.1	Can describe principles of adult patient 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.

## Appendix B

The following competencies from the 'NHS Education for Scotland Core Competencies for Anaesthetic Assistants' [document](#) are required for Standard 55. Please note the NMBI-approved courses for nurses in Ireland does not meet some of the competencies set out in 'Appendix A'. See the document for a list of the skills and knowledge that will need to be evidenced for the remaining competencies. Medical staff (including trainee or career grade anaesthetists) will not routinely meet the competencies in Appendix A and should not be performing this role.

Number	Competency
2.10	Able to assess and manage elderly patients or children under 16 (as relevant to scope of normal practice).
4.10	Knows protocol for unexpected difficult intubation / failed intubation drill.
4.14	Can assist with inhalation induction.
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 the 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.
5.7	Can identify and correct anaesthetic machine problems which may occur during use.
5.11	Can describe principles of calculating intra-operative blood loss.
6.7	Knowledge of the equipment associated with blood and blood product transfusion.
6.9	Can describe the principles associated with train-of-four NMJ assessment.
6.10	Is able to set up and apply a train-of-four stimulator.
6.14	Can describe anaesthetic aspects of pacemakers and implantable cardiac defibrillators (ICD).
6.15	Can assist with the positioning of nasogastric tubes.
8.3	Knows the hazards of anaesthetic agent pollution.
8.4	Understands the clinical difference between crystalloids and colloids.
8.5	Understands the principles involved in the safe administration of blood and blood products
8.11	Able to set up and prepare equipment for target controlled infusion equipment.
8.13	Can set up patient controlled analgesia equipment.
8.15	Can set up equipment for epidural infusion.
20.3	Can describe anaesthetic principles of patient transfer by road.
20.5	Understands importance of communication associated with inter-hospital patient transfer.



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Maureen Longstaff, ECT Lead Nurse, Tees Esk and Wear Valleys NHS Trust

Shilpa Rawat, Consultant Anaesthetist, Swansea Bay University Health Board

Tania Gergel, Patient Representative

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