ECT Accreditation Service (ECTAS)

Standards for the administration of ECT

Thirteenth Edition: April 2016

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The standards are also available on our website at: www.ectas.org.uk

Standards and criteria have been categorised as follows:

Type 1: Essential standards. Failure to meet these 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: expected standards that all services should meet;

Type 3: desirable standards that high performing services should meet.

These standards relate to the process of administration of ECT and in this regard are consistent with NICE guidance. They do not relate to clinical decisions about which patients should be given ECT.

Key: **M** Standard **modified** since last edition
N **New** Standard since last edition

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Foreword

We are pleased to introduce the thirteenth edition of the ECTAS standards and appreciate the continuing collaborative effort to improve the quality of the administration of ECT.

These standards have been developed from a literature review and in consultation with stakeholder groups. These standards also cover NICE Guidance. Attempts have been made to include information from a wide range of sources and to take into account the views of both clinic staff and service users.

The standards are intended to provide staff with a clear and comprehensive description of best practice in the administration of ECT. They are reviewed on a regular basis, so please give the project team any comments, using the form provided at the back of this booklet.

These standards will be applied each year in self- and external peer-review by ECTAS member clinics. If you work in an ECT clinic, we hope you will continue to support the network and join in the review cycle.

The ECTAS Team

Contents

Introduction

The accreditation standards have been drawn from key documents including the ECT Handbook (Royal College of Psychiatrists, 2013), the NICE Appraisal of ECT (National Institute for Clinical Excellence, 2003) and the Scottish National Audit of ECT (CRAG Working Group on Mental Illness, 2000). They have been subject to extensive consultation with all professional groups involved in ECT and with service users and their representative organisations.

The standards cover the following topics:

- The ECT Clinic and Facilities
- Staff and Training
- Assessment and Preparation
- Consent
- Anaesthetic Practice
- The Administration of ECT
- Recovery, Monitoring and Follow up
- Special Precautions
- Protocols
- Clinics Practising Nurse Administered ECT

These standards relate to the process of administration of ECT and in this regard are consistent with NICE guidance. All standards relate to the treatment of both inpatients and day patients unless otherwise stated. They do not relate to clinical decisions about which patients should be given ECT.

The full set of standards is aspirational and it is unlikely that any clinic would meet all of them. To support their use in the accreditation process, each standard has been categorised as follows:

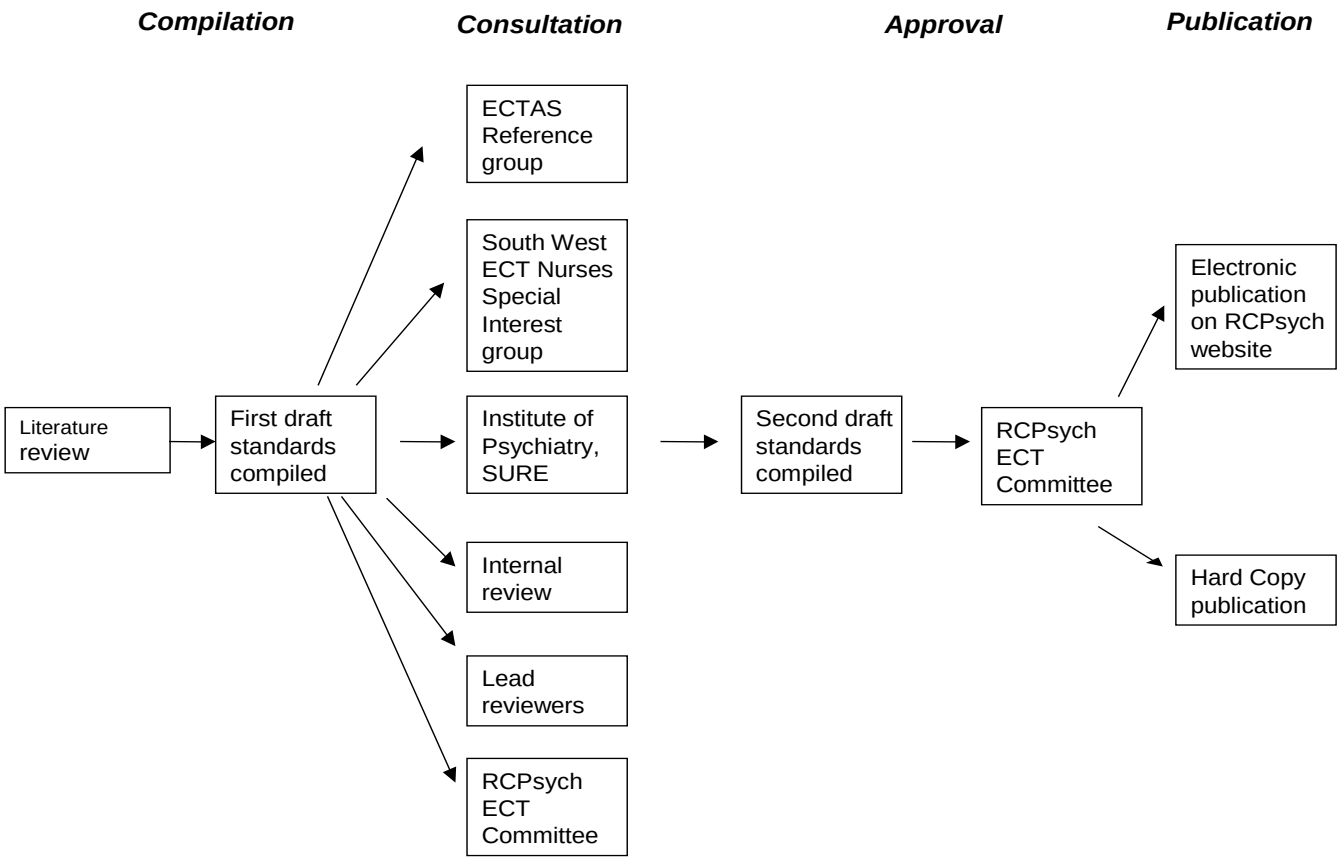
Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.

Type 2: expected standards that all services should meet;

Type 3: desirable standards that high performing services should meet.

Method

Figure 1: Compilation to publication of the first edition ECTAS standards



2nd Edition of the ECTAS Standards:

Revisions suggested by the email discussion group, lead reviewers and the ECTAS Accreditation Advisory Committee. These were discussed and ratified by the ECTAS Reference Group.

3rd Edition onwards of the ECTAS Standards:

Revisions suggested by ECTAS members via the email discussion group, Service Users forum, lead reviewers and other ECT clinicians, and the ECTAS Accreditation Committee. These were discussed and ratified by the ECTAS Reference Group.

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The ECTAS Reference Group:

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ECT service users

ECTAS member clinics

The National Association of Lead Nurses in ECT

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Section 1

The ECT Clinic and Facilities

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Number	Type	Standard
Section 1: The ECT clinic and facilities		
M1.1	**2**	The ECT clinic consists of a minimum of four rooms: a waiting room, treatment room, recovery area and post-ECT waiting area
1.2	**2**	The clinic is clean, comfortable and provides a welcoming atmosphere
1.2.1	**1**	The clinic is able to demonstrate that it adheres to the Trust's infection control policy
1.3	**1**	The clinic has access and facilities for disabled people
M1.4.1	**3**	The clinic has an office for ECT staff which is private, i.e., it is not part of another room
Waiting Area		
1.5	**1**	There is access to toilet facilities from the waiting area
1.6	**1**	The waiting area is large enough to accommodate the throughput of patients and escorts
1.7	**2**	Patients waiting for ECT are not able to see into the treatment area while the treatment is taking place
1.7.1	**2**	Patients waiting for ECT are not waiting in the same room as patients in post-recovery
1.8	**2**	The waiting area is comfortable and quiet and has a range of distractions, for example, an outside window, pictures or magazines
Treatment Room		
1.9	**1**	The treatment room is of an adequate size for its purpose
1.10	**1**	The treatment room has easy access to a telephone
1.11	**1**	Up to date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia are prominently displayed in the treatment room

Number	Type	Standard
1.12	**1**	If nitrous oxide and/or anaesthetic inhalation agents are ever used, then the treatment room is equipped with scavenging equipment and agent monitoring
1.13	**1**	The treatment room has a work surface and sink with hot and cold water
M1.14	**2**	The treatment room has a clock with a second hand, or similar
1.15	**1**	The treatment room has a secure drug storage cupboard
1.16	**1**	The treatment room has a secure drug fridge with temperature control
1.17	**1**	Speech from the treatment room cannot be heard in the waiting area, e.g. staff keep their voices low, or music is played in the waiting area to mask sound
1.18	**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
Recovery Area		
1.20	**2**	The recovery area is large enough to accommodate the throughput of patients lying on trolleys with additional space to manoeuvre
1.21	**2**	The recovery area has a doorway large enough to admit a trolley from the treatment room
Post-ECT Waiting Area		
1.23	**2**	The post-ECT waiting area provides a friendly, relaxed environment
1.24	**2**	The post-ECT waiting area has provision for refreshments for patients
Office		
1.25	**2**	Staff conversations and telephone calls cannot be overheard outside the office
1.26	**2**	The office has a telephone

Number	Type	Standard
1.27	**2**	The office has a computer provided
Equipment		
1.28	**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
1.29	**1**	There is a fully equipped emergency trolley with adequate resuscitation equipment and a defibrillator
1.29.1	**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 particular kit stored in the clinic)*
1.30	**1**	There is an NIBP monitor and a means of measuring temperature
1.32	**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
1.33	**1**	There is at least one suction machine, preferably one in treatment room, one in recovery room. If only one is available, treatment of a patient does not start until the previously treated patient is conscious, as assessed by the recovery practitioner or anaesthetist
1.34	**1**	There is a pulse oximeter, which is routinely used during anaesthesia
1.35	**1**	There is a capnograph, which is routinely used during anaesthesia
1.36	**1**	There is an ECG monitor, which is routinely used during anaesthesia
M1.37	**1**	Provision is made for maintaining anaesthesia, ventilation and monitoring in the event that safe and efficient transfer to an ambulance or Critical Care Area is needed
1.38	**2**	There is a means of measuring blood glucose concentration
1.39	**2**	There is moving and handling equipment, e.g. a sheet to help turn the patient

Number	Type	Standard
1.40	**2**	There is a dedicated budget for ECT
The following drugs are stocked in the clinic:		
1.41	**1**	At least two different anaesthetic induction agents, for example, Thiopental, Propofol or alternatives
1.42	**1**	At least two different muscle relaxants: Suxamethonium and an alternative
1.43	**1**	Oxygen
1.45	**1**	Emergency drugs and equipment as agreed with the local pharmacy or resuscitation committee
1.46	**1**	An initial dose of Dantrolene, plus sterile water, available immediately in the clinic
1.48	**1**	A supply of drugs needed to treat other unwanted autonomic, cardiovascular, respiratory or neurological effects are available. These may include: Atropine, Glycopyrrolate, Midazolam as agreed with ECT anaesthetist
ECT Machine and equipment		
M1.49	**1**	The ECT machine is capable of providing stimuli according to current guidelines set out in The ECT Handbook (3rd edition)
N1.49.1	**1**	The ECT machine delivers a brief pulse stimulus
1.52	**1**	Two-channel EEG monitoring facilities are available
1.53	**1**	The ECT nurse ensures that the machine function and maintenance is checked and recorded at least every year or according to machine guidance
1.54	**2**	The ECT nurse ensures that the clinic is properly prepared, organised and maintained
1.55	**1**	The ECT nurse ensures that the equipment in the clinic is well maintained
1.56	**2**	The ECT nurse is responsible for ordering and stocking drugs

Number	Type	Standard
1.57	**2**	The ECT nurse is responsible for ordering and stocking disposable equipment
M1.58	**1**	There is a suitable back-up ECT machine, or arrangements are in place to obtain a machine from another clinic, and staff are competent in its use

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Section 2

Staff and Training

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Number	Type	Standard
Section 2: Staff and Training		
2.2	**1**	There is at least one trained nurse in the treatment room
2.3	**1**	There is at least one trained nurse in the recovery area
2.4	**1**	There is at least one experienced anaesthetist present during treatment and recovery
M2.5	**1**	There is an anaesthetic assistant present during treatment and recovery whose sole responsibility is to assist the anaesthetist during the procedure, i.e. an Operating Department Practitioner (ODP, in the UK) or a suitably trained anaesthetic assistant (in the Republic of Ireland) who has achieved the competencies set out in the *NHS Scotland Core Competencies for Anaesthetic Assistants*
2.6	**1**	There is at least one suitably trained psychiatrist present during treatment, as defined by the Royal College of Psychiatrists' competency document
2.7	**1**	The number of staff in the recovery area exceeds the number of unconscious patients by one
2.8	**1**	All clinical staff present during a treatment session are trained in Basic Life Support
2.9	**2**	There is one person competent in cardiopulmonary resuscitation for every unconscious patient
2.10	**1**	In addition to the anaesthetist, there is one member of staff trained in at least Immediate Life Support present during the treatment session
2.11	**2**	There are back-up staff easily available to assist in an emergency situation
2.12	**2**	If only one patient is treated in a session, the same nurse may attend both treatment and recovery
2.12.1	**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

Number	Type	Standard
Lead psychiatrist		
2.14	**1**	There is a named consultant psychiatrist who leads ECT
2.15	**1**	The lead consultant psychiatrist has dedicated sessional time for ECT and this should be included in a job plan, where such exists
2.15.1	**2**	The lead consultant psychiatrist is covered during absence by a suitably competent psychiatrist
M2.15.2	**1**	The 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
2.20.1	**2**	The lead consultant psychiatrist is responsible for developing protocols for the prescription of ECT by his or her peers in order to update their prescribing practice
2.21	**2**	ECT is administered by a small cohort of experienced psychiatrists who regularly attend the ECT clinic
N10.10	**1**	Junior doctors attend ECT clinic sessions on a regular basis
Lead Nurse		
M2.22	**1**	There is a named ECT nurse who has dedicated sessional time for the administration of ECT, and attends at least 50% of clinics
2.23	**1**	The lead nurse of at least Band 6 (CNM2 Republic of Ireland)
2.23.1	**2**	The lead nurse has been assessed as competent to carry out the required role
2.23.2	**3**	The lead nurse is trained in Immediate Life Support
2.24	**2**	The lead nurse has appropriate ECT and clinical experience
M2.25	**1**	The lead nurse takes overall responsibility for the management of the clinic and care of the patient

*http://www.rcpsych.ac.uk/pdf/ECTcompetenciesJan2013.pdf

Number	Type	Standard
Lead Anaesthetist		
2.26	**1**	Anaesthesia is administered either by a consultant anaesthetist, or by a non-consultant career grade or trainee under the supervision of a named consultant anaesthetist. The supervising consultant anaesthetist attends the clinic regularly
2.27	**1**	Royal College of Anaesthetists' 2014 guidelines on supervision of those working in remote sites is followed, including a clear pathway to gain advice from a readily contactable consultant
2.28	**1**	Anaesthetists on the rota do not include unsupervised doctors in junior training grades (including CT1 & 2)
2.29	**1**	There is a named consultant anaesthetist who is involved in: developing the service; helping with training and revalidation of staff; ensuring safety standards are met; and ensuring that appropriate audits are performed
2.30	**2**	There is a named consultant anaesthetist who has dedicated sessional time devoted to direct clinical care in the provision of anaesthesia for ECT
ECT Team		
2.31	**2**	Clinic staff work effectively as a multi-disciplinary team
2.32	**2**	There is a line management structure with clear lines of accountability within the clinic
2.33	**2**	There are regular multi-disciplinary team meetings for clinical matters, and policy and administration
2.34	**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
2.35	**2**	The same team works in the clinic every week for the purposes of continuity
2.36	**3**	The team takes an active role in audit, academic teaching and development of evidence-based best practice of ECT

Number	Type	Standard
The clinic has a system for:		
2.16	**1**	The development of treatment protocols
2.17	**1**	The training and supervision of clinical staff
2.18	**1**	Liaising with, and advising, other professionals
2.19	**1**	Audit and quality assurance
2.20	**1**	Continuing professional development
Training – All staff		
2.37	**1**	All clinic staff have received appropriate training and education This includes training on:
2.37.1	**2**	The Mental Capacity Act
2.39	**2**	Policy and procedures
2.40	**2**	Legal frameworks, e.g. the Mental Health Act Code of Practice
2.40.1	**3**	The team has regular development meetings, attended by a member of the Senior Management Team, or a Deputy
Training – Administering doctors & nurses		
M2.41	**1**	ECT is only administered by doctors with formal training, or nurses who meet all of the requirements in section 10: clinics practising nurse-administered ECT
Administering professionals receive induction training, including the following:		
2.42	**1**	An introduction to the theoretical basis of effective treatment with ECT
2.43	**1**	Familiarity with local ECT protocol and clinic layout

Number	Type	Standard
2.44	**1**	Observation of the administration of ECT prior to their first administration of ECT
2.45	**1**	Direct supervision by the ECT consultant or appropriately trained deputy until they are assessed as competent to administer ECT unsupervised, e.g. using RCPsych ECT Competencies for Doctors*
2.46	**2**	Direct supervision or thorough examination of treatment charts at least once a week whilst administering ECT
2.47	**3**	The opportunity to appraise papers on ECT
Training – Other staff		
2.48	**1**	Other staff involved in the administration of ECT have appropriate induction and ongoing training
2.49	**1**	ECT nurses undergo an induction programme covering ECT policies and procedures, medical equipment safety and clinic management
M2.49.1	**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
2.50	**2**	ECT anaesthetists receive a verbal and written induction from a consultant anaesthetist with an interest in ECT
2.51	**1**	ECT anaesthetists have read departmental guidelines on the administration of anaesthesia for ECT
2.52	**2**	ECT clinic staff attend appropriate training and conference events, e.g. Royal College of Psychiatrists' ECT training course, at least once every three years
2.55	**2**	The training needs of ECT clinic staff are formally assessed, for example in staff appraisals
M2.56	**2**	There is provision in the departmental budget for necessary training relating to ECT

*http://www.rcpsych.ac.uk/pdf/ECTcompetenciesJan2013.pdf

Number	Type	Standard
2.57	**2**	There is evidence that staff keep up to date with best practice and latest information
M2.58	**3**	Other nurses within the clinic attend the Royal College of Psychiatrists' / NALNECT course for nurses in ECT, or the HSC Clinical Education Centre Electroconvulsive Therapy 2 day training course
M2.59	**2**	Lead ECT nurses, or their delegate, attend a regional ECT nurse special interest group at least once a year

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Section 3

Assessment and Preparation

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Number	Type	Standard
Section 3: Assessment and preparation		
General		
3.0	**1**	The clinic has a protocol in place for ensuring there is someone responsible for assessing and preparing the patient for ECT
3.1	**1**	All prospective ECT patients receive a formal documented assessment
3.2	**1**	A detailed medical history is recorded
3.3	**1**	The anaesthetic risk is identified, assessment made on the basis of this and this is recorded. This includes the ASA grade of the patient
3.4	**1**	Any variation in the ASA grade of the patient is recorded before the treatment session
3.5	**1**	A physical examination is recorded which includes the cardiovascular, respiratory and neurological systems, a VTE assessment and a pregnancy test where applicable
3.6	**1**	Current medication and drug allergies are recorded as well as any noted drug problems
3.7	**2**	The patient's ethnicity is recorded
3.8	**1**	The patient's Mental Health Act status is recorded
3.9	**1**	An assessment of the risk/benefit balance of having ECT is considered and recorded
3.10	**2**	A mental state examination is recorded
3.11	**2**	An assessment of memory is recorded using a standardised cognitive assessment tool and subjective questioning
3.12	**2**	An assessment of orientation is recorded
3.12.1	**2**	The patient's weight is recorded
3.13	**1**	A clear statement is included on why ECT has been prescribed

Number	Type	Standard
3.13.1	**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
Anaesthesia		
3.14	**1**	There is a local policy, agreed with the anaesthetic department/consultant anaesthetist, detailing which investigations are needed before the start of a course
The Clinic Session		
3.22	**1**	The ECT nurse is responsible for ensuring that emergency resuscitation equipment is tested and checked before each ECT clinic session
3.23	**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
3.24	**1**	The ECT nurse is responsible for ensuring that the ECT electrodes are checked visually before each ECT clinic session
3.25	**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
M3.26.1	**1**	Day patients receiving an acute course of ECT are escorted both to and from the ECT clinic by a named responsible adult
N3.26.4	**1**	Day patients receiving maintenance ECT may convey themselves to the ECT clinic if this is deemed clinically appropriate, but must be escorted from the clinic by a named responsible adult
M3.26.3	**1**	Patients are escorted from the waiting room, through ECT and recovery by a member of the ECT team
3.28	**1**	Inpatients are escorted to and from the ward by a member of staff
3.29	**2**	The escort is known to the patient, is aware of the patient's legal and consent status and has an understanding of ECT

Number	Type	Standard
3.30	**2**	The escort acts as an advocate, assessing concerns and feeding these back to the members of the team
3.31	**2**	The arrival of patients at the ECT clinic is managed to minimise waiting time
3.31.1	**2**	The clinic has a planned and regular starting time; pre-anaesthetic fasting time is adjusted to this
3.32	**2**	The ECT nurse plans the arrival times of patients by liaising with the wards, outpatient department and day hospitals
3.33	**2**	Measures are put in place to avoid unreasonable delays, and if these do occur, the circumstances are reviewed and action taken to prevent a recurrence
3.34	**2**	Before ECT is administered, the patient is given any further information they may need and is introduced to the clinical team administering the treatment
3.35	**2**	The patient agrees to the presence of anyone attending in an observing capacity (e.g. students, visiting trainees or clinicians)
3.36	**2**	The psychiatrist explains what he/she is going to do and why
3.37	**2**	The ECT nurse explains the procedure to the patient again, gives reassurance and spends time with relatives answering questions
3.38	**2**	The ECT nurse provides information about the safekeeping of valuables, location of toilets and arrangements for further appointments
3.39	**2**	The patient is asked if he/she has all the information they need and whether they have any more questions or queries at each treatment
3.40	**2**	The clinic has a protocol for dealing with patient valuables and property
The following documentation is available for clinic staff's reference:		
3.41	**1**	The patient's consent form, Mental Health Act documentation and a copy of any other supporting documentation relating to consent

Number	Type	Standard
3.42	**1**	The patient's pre ECT assessment including medical examination, drug history and other investigations
Before each treatment, the following checks are carried out and recorded:		
3.43	**1**	The patient is asked when he or she last ate and last drank and this concords with the length of time required for 'fasting' agreed with the local anaesthetic department
3.44	**1**	The patient's identity is checked and the patient wears an identity bracelet. In exceptional circumstances, an identity bracelet may not be worn, for example if there is a risk of self harm
3.45	**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
3.46.1	**2**	The patient is asked to remove hearing aids and glasses/contact lenses
3.47	**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 bracelet if appropriate
3.48	**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
3.49	**1**	The anaesthetist checks that there have been no problems with previous anaesthetics at each treatment

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Section 4

Consent and Information Giving

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Number	Type	Standard
Section 4: Consent and information giving		
4.1	**1**	Patients are provided with appropriate information to allow them to give consent This covers:
4.2	**1**	The nature of the treatment and a description of the process
4.3	**1**	The purpose and benefits of treatment, including likelihood of success
4.4	**1**	The risks and likelihood of adverse effects
4.4.1	**1**	The relative risks of the possible impact of ECT on cognition
4.5	**1**	The likely consequences of not having ECT
4.6	**1**	Treatment alternatives and confirmation that these will be available if the patient decides not to have ECT
4.7	**1**	The patient's rights in relation to ECT
Information		
4.8	**1**	A fact sheet is given to all patients, including patients unable to consent, that explains key information about ECT
4.9	**1**	The Care Quality Commission "ECT rights about consent to treatment" leaflet is provided to all detained patients (England only) in addition to local ECT information
4.10	**1**	The patient is informed about how to obtain additional information and access to independent advocacy
4.11	**2**	Information is provided to patients verbally and in written formats
4.13	**2**	Information, when necessary, is available in languages other than English and in a format which people with sight, learning and other disabilities can use

Number	Type	Standard
4.14	**2**	If a person has difficulty communicating in English, information is provided through an interpreter and this is recorded in the patient's notes
4.15	**2**	The doctor obtaining consent asks patients what additional information they might need
4.16	**2**	The fact sheet is clearly and simply written, explains key information, is up to date and was developed with service user consultation
4.17	**2**	Fact sheets with key information are on clear display and are readily available
4.17.1	**2**	Information about post anaesthetic risks (driving, operating machinery, need for supervision, alcohol, signing documents) is provided to all patients
4.17.2	**2**	The referring consultant advises the patient that they should not drive during the acute course of ECT, and should not resume driving until advised that they are able to do so
M4.17.3	**2**	Patients receiving maintenance ECT are advised not to drive for 48 hours following treatment, and receive individualised advice about driving whilst they are undergoing maintenance treatment
4.18	**1**	The patient completes a consent form or there is an equivalent process, if consent cannot be given
M4.20	**1**	For adults who are unable to consent to treatment, the relevant Mental Health Act documents are viewed (England and Wales only)
M4.20.1	**1**	For adults being treated under the Mental Capacity Act the appropriate documentation/consent form is viewed (England and Wales only)
M4.20.2	**1**	The Mental Health Act Guidance 2007 must be followed in all instances when prescribing ECT for a young person under 18 years of age, and a SOAD consulted (England and Wales only)

Number	Type	Standard
4.20.4	**1**	The ECT team confirms that the patient's presentation concurs with the findings of any capacity assessment, including those patients who have received a formal second opinion under the relevant Mental Health Act, before each treatment. If the patient's presentation does not concur with these findings, this is escalated to the referring team
4.20.5	**1**	For informal patients, capacity assessments are documented by the referring team and this information is available in the ECT clinic
4.21	**1**	Consent is obtained by a psychiatrist with adequate knowledge of the nature and effects of ECT and patients' rights
M4.22	**1**	Before commencing ECT, the referring consultant assesses the patient to determine whether he/she can give valid consent and this is documented
4.23	**1**	The patient's consent is never obtained through any form of coercion, e.g. implying the Mental Health Act will be applied if the patient refuses
4.24	**1**	In detained patients not able to give valid consent, a second opinion is obtained within the appropriate legislative framework
4.25	**1**	Where ECT is administered under the Mental Health Act, clinicians comply with the Code of Practice and the relevant documentation is completed
4.27	**2**	The professional administering the treatment, the anaesthetist and the ECT nurse check the consent form or other relevant documentation at each treatment

Number	Type	Standard
The consent form contains:		
M4.29	**1**	Confirmation that the consultant psychiatrist, or another competent doctor designated by the consultant, has explained the procedure to the patient and the intended benefits, and discussed: • any serious/frequent occurring risks; • any transient side-effects; • the benefits and risks of any alternative available treatments (including no treatment); • any particular concerns of the patient; • dental risks
4.30	**2**	A statement from an interpreter when appropriate
4.45	**2**	What written information has been provided to the patient
4.46	**2**	What procedures the treatment will involve, including anaesthesia
Consent process		
4.32	**2**	The clinic's consent policy, and all consent forms used, comply with Department of Health guidelines for design and use
M4.33	**2**	An ongoing record is kept of the assessment of competence and details of the process of consent, if there are changes
4.34	**2**	The decision to prescribe ECT is based on a documented assessment of the risks and potential benefits to the individual
4.35	**2**	For a new course of ECT, except in an emergency, the patient is given at least 24 hours to reflect on information about ECT and discuss with relatives, friends or advisers before making a decision regarding consent
4.36	**2**	The referring psychiatrist informs the patient that consent can be withdrawn at any time, and that fresh consent is then required before further treatment can be given
4.37	**2**	The patient is asked by the referring psychiatrist to give consent at the beginning of each course of ECT

Number	Type	Standard
4.39	**2**	In situations where valid consent is difficult, the individual's advocate and/or carer is consulted and lasting power of attorney and MCA advance directives are taken into account
4.40	**2**	The patient's relatives are informed about the treatment unless issues of patient confidentiality preclude this
4.41	**1**	Clinic staff check for original and valid on-going consent before each treatment and this is documented
4.43	**1**	For patients detained under the Mental Health Act and unable to consent to treatment, a certificate of second opinion (form T6 or local equivalent) is present in the clinic at each treatment
4.44	**1**	For patients detained under the Mental Health Act who are able to consent to treatment form T4 (or local equivalent) is present in the clinic at each treatment

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Section 5

Anaesthetic Practice

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Number	Type	Standard
Section 5: Anaesthetic Practice		
M5.1	**1**	*Recommendations for standards of monitoring during anaesthesia and recovery*, Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2015) are followed
5.2	**1**	The anaesthetist checks the anaesthetic and suction equipment and prepares the anaesthetic agents
5.2.1	**1**	There is consistent use of anaesthetic agents and dosing
5.2.2	**2**	Any reason for a change in anaesthetic induction agent is discussed with the ECT team and documented
5.3	**1**	Oxygen is normally administered before ECT
5.5	**1**	Before induction, the anaesthetist or assistant checks that any dentures have been removed or are secure
5.7	**2**	The anaesthetist explains what he/she is doing and why
5.9	**1**	Once anaesthesia has been induced, the anaesthetist or assistant inserts a bite block

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Section 6

The Administration of ECT

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Number	Type	Standard
Section 6: The administration of ECT		
6.1.1	**1**	The clinic has the capability to give both unilateral and bilateral ECT
6.1.2	**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
M6.2	**1**	The seizure is tonic-clonic, of adequate duration, and the duration is monitored by the direct observation of the resulting motor effects and two-channel EEG monitoring
6.3	**2**	Except in an emergency, patients are given ECT twice a week at most
M6.4	**2**	The ECT team assesses the patient before each treatment, with attention to possible adverse side effects, in order to advise the referring team on further treatment
6.6	**2**	The administering professional ensures that an appropriate seizure is induced
6.10.1	**2**	Except in exceptional circumstances, the patient is treated on the same make of ECT machine throughout the course of treatment
6.11	**2**	Adequate records are kept of treatment and incidents

Number	Type	Standard
M6.12	**1**	There is a section of the ECT record which includes: • 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
6.13	**2**	Adverse incidents and near misses are recorded, reported and investigated
6.14	**2**	The referring psychiatrist prescribes no more than two treatments at a time before reviewing and renewing the prescription

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Section 7

Recovery, monitoring and follow-up

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Number	Type	Standard
Section 7: Recovery, monitoring and follow-up		
7.1	**1**	The recovery practitioner is present as the patient recovers consciousness
7.3	**1**	The recovery practitioner is competent in caring for the unconscious patient, and is fully conversant with aspiration/suction techniques, resuscitation procedures, including basic life support, and informs the anaesthetist of any cause for concern
7.4	**1**	Pulse, blood pressure and pulse oximetry readings are documented by the recovery practitioner
7.5	**1**	As the patient recovers consciousness the recovery practitioner reassures gently and repeatedly and cares for the patient until they are fully awake
7.6	**1**	The anaesthetist is immediately contactable until all patients recover full consciousness and are physiologically stable
7.7	**1**	The ECT nurse ensures that patients are not discharged from the clinic until fully recovered
7.7.1	**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
7.8	**3**	The psychiatrist remains in the building and contactable until all patients recover full consciousness and are physiologically stable
M7.9	**2**	The patient is offered something to eat and drink before they are discharged from the ECT suite
Monitoring		
7.10	**1**	During acute courses of ECT, treatment outcome is monitored and recorded at least weekly between treatment sessions and treatment appropriately adjusted in light of this

Number	Type	Standard
7.11	**1**	The patient's clinical status/symptomatic response is assessed and recorded at baseline, between each treatment session, and following the course of ECT using the Clinical Global Impression (CGI) scale
7.11.1	**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
7.12	**2**	The patient's orientation and memory is assessed before and after the first ECT, and re-assessed at intervals throughout the treatment course, using a standardised cognitive assessment tool
7.12.1	**2**	The patient's cognitive side effects/memory are assessed using a standardised cognitive assessment tool and subjective questioning in a clinical interview at 1 or 2 months follow up
7.14	**2**	Non-cognitive side effects are assessed and recorded between treatment sessions
7.15	**2**	The patient's subjective experience of treatment side effects and objective cognitive side effects are recorded between treatment sessions, for example, using a memory log
7.15.1	**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
Follow-up		
7.16	**2**	Treatment outcome is adequately monitored and recorded after the course of ECT
7.16.1	**3**	The patient is reviewed by the referring person/team at least once a month for the 3 months following an acute course of ECT
7.17	**3**	There are evidence-based care pathways for both pre-ECT treatment and post-ECT treatment

Number	Type	Standard
7.21	**3**	Patients and their carers are offered the opportunity to formally feedback on their experiences of care and treatment. This feedback is documented and regularly appraised by the ECT Team
N7.21.1	**3**	Clinics are able to evidence carer involvement

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Section 8

Special precautions

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Number	Type	Standard
Section 8: Special Precautions (also see PROTOCOLS)		
8.1	**1**	High risk patients are considered for treatment in an environment allowing rapid intervention should complications occur, for example, a theatre suite or its recovery area
8.2	**1**	The ECT machine used is able to give flexible doses, including very low stimuli
8.4	**2**	For bilateral ECT, the initial stimulus given to adolescents and children is at the bottom end of the range
8.5	**2**	ECT sessions for people under 18 are held separately from sessions involving adults
8.6	**2**	Special arrangements are made when patients are given ECT in a clinic on a different site from their base hospital: they have an individual trained nurse escort and commuting patients are treated at the beginning of the session to allow maximum time for recovery
Day patients		
4.12	**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
8.7	**1**	Discharge criteria which include assessment before discharge are agreed with the local anaesthetic department
M8.8	**1**	Capacitous patients and/or their carers sign a form which confirms: • They will not drive in accordance with DVLA guidelines • 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 by a responsible adult for the 24 hours following each ECT treatment • They will not sign any legal documents for at least the 24 hours following each ECT treatment or until advised by their consultant psychiatrist

Number	Type	Standard
Clinic activity		
8.9	**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 to ensure adequate practice is undertaken in an adjacent or neighbouring facility
8.10	**2**	Every effort is made to ensure that patients receive ECT twice weekly if required. ECT clinics are only cancelled in exceptional circumstances

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Section 9

Protocols

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Number	Type	Standard
Section 9 - PROTOCOLS		
9.1.1	**1**	Policies relating to ECT are reviewed at least once every two years
9.1	**1**	There is a protocol for how and where the initial and subsequent doses of Dantrolene are stored. If subsequent doses are not stored in the clinic, they are accessible within 5 minutes
9.2	**1**	There is a protocol for the management of cardiac arrest
9.3	**1**	There is a protocol for the management of anaphylaxis
9.4	**1**	There is a protocol for the management of malignant hyperthermia
9.5	**1**	There is a protocol that addresses the needs of day patients including preparation for leaving hospital
9.6	**1**	There is a protocol addressing what information staff should give to day patients before they are discharged
9.7	**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
9.8	**2**	There is a protocol on the choice of laterality of treatment
9.9	**2**	There is a protocol relating to preparing patients for ECT
9.10	**2**	There is a protocol relating to who may obtain consent in the clinical team who refer to the clinic
9.11	**2**	The clinic has a protocol or checklist for monitoring patients immediately after ECT
9.12	**2**	There is an up to date protocol relating to the patient's medication during and after treatment
9.13	**2**	The clinic has a protocol relating to the treatment of elderly people. This includes reference to cognitive side effects, seizure threshold and choice of anaesthetic induction agent

Number	Type	Standard
9.14	**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
9.15	**2**	There is a protocol about when to discontinue treatment when no clinical response is seen
M9.16	**1**	There is a local protocol about the quality and timing of an adequate seizure
M9.17	**1**	There is a local protocol about the management of a prolonged or tardive seizure
M9.18	**1**	There is a local protocol about when to restimulate a patient after a brief or missing seizure
M9.19	**1**	There is a stimulus dosing protocol that is in accordance with the ECT Handbook (3rd Edition)
9.20	**2**	There is a protocol on the use of EEG monitoring
9.21	**3**	There is a protocol for consultation between the ECT consultant and the referring psychiatrist in situations where ECT is prescribed outside of NICE guidelines

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Section 10

Clinics practising nurse-administered ECT

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Number	Type	Standard
Section 10 – CLINICS PRACTISING 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.		
N10.1	**1**	Any nurse who administers ECT is of at least Band 7, with a minimum of 3 years' senior nurse experience
N10.2	**1**	The administering nurse can evidence: • They have completed and updated the ECT nurse training course • They have attended an ECT training day in the last 3 years • They attend and contribute to a regional special interest group
N10.3	**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
N10.4	**1**	The administering nurse has an up-to-date appraisal
N10.5	**1**	The administering nurse receives monthly 'medical' supervision, both clinical and managerial
N10.6	**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
N10.7	**1**	The department consultant has been in post for at least 6 months, demonstrates ongoing CPD in their annual appraisal and maintains their clinical skills
N10.8	**1**	Specialist medical advice is available during nurse-administered treatment
N10.9	**1**	There are sufficient other staff in the ECT suite during nurse-administered treatment

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