Sheffield Health and Social Care NHS Foundation Trust

Policy:

MD 008 ECT (Electroconvulsive Therapy)

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Policy Owner	ECT Consultants, Specialist Nurse ECT
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Document type	Policy
Document version number	Version 6
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Summary of policy

This policy replaces version 4 and takes into account changes in practice recommended by the ECTAS standards issued by the Royal College of psychiatrists in 2018.

Target audience	Services using ECT as part of treatment plans (to include SHSC, STH, and out of area services referring in to SHSC)

Keywords	ECT – Electroconvulsive therapy

Storage

Version 6 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V4 15.11.2016). Any copies of the previous policy held separately should be destroyed and replaced with this version.

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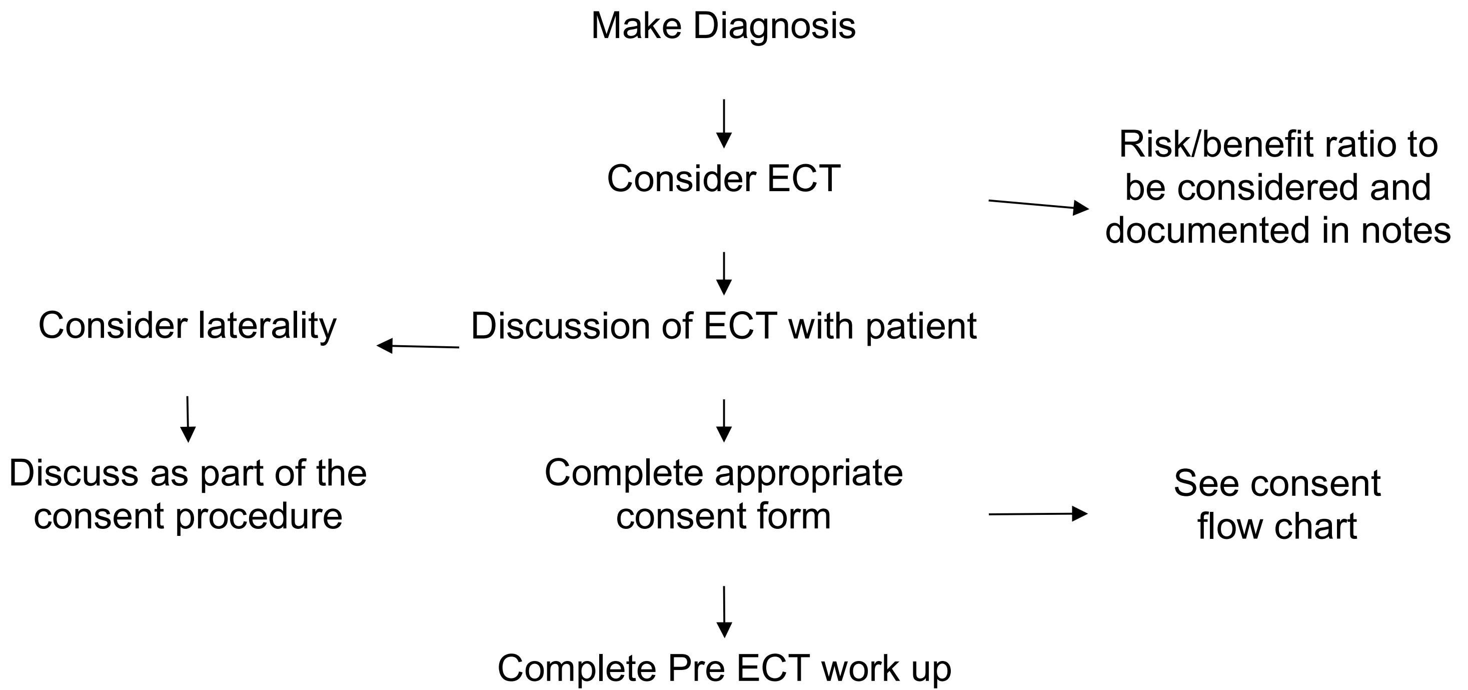
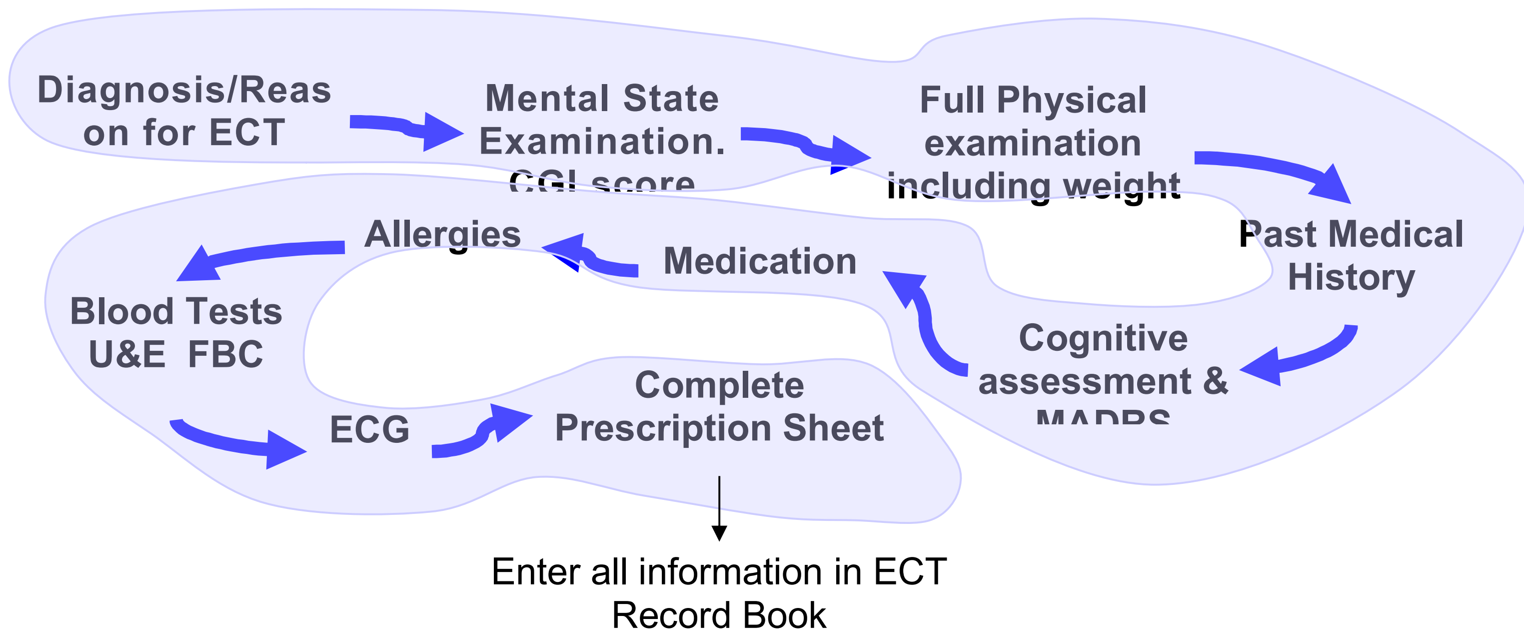
Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	MM/YYYY	New policy commissioned by EDG on approval of a Case for Need.
1.0	Approval and issue	MM/YYYY	Amendments made during consultation, prior to ratification.
2.0	Review / approve / issue	MM/YYYY	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
2.1	Review on expiry of policy	MM/YYYY	Committee structure updated
3.0	Review / approval / issue	MM/YYYY	Full review completed as per schedule
6.0	Review	24.05.2021	Early review in order to comply with new regulatory requirements. Review of medications made after discussion with anaesthetic team to keep our advice in line with standard practice.

Flowchart

ECT Preparation





Enter all information in ECT Record Book

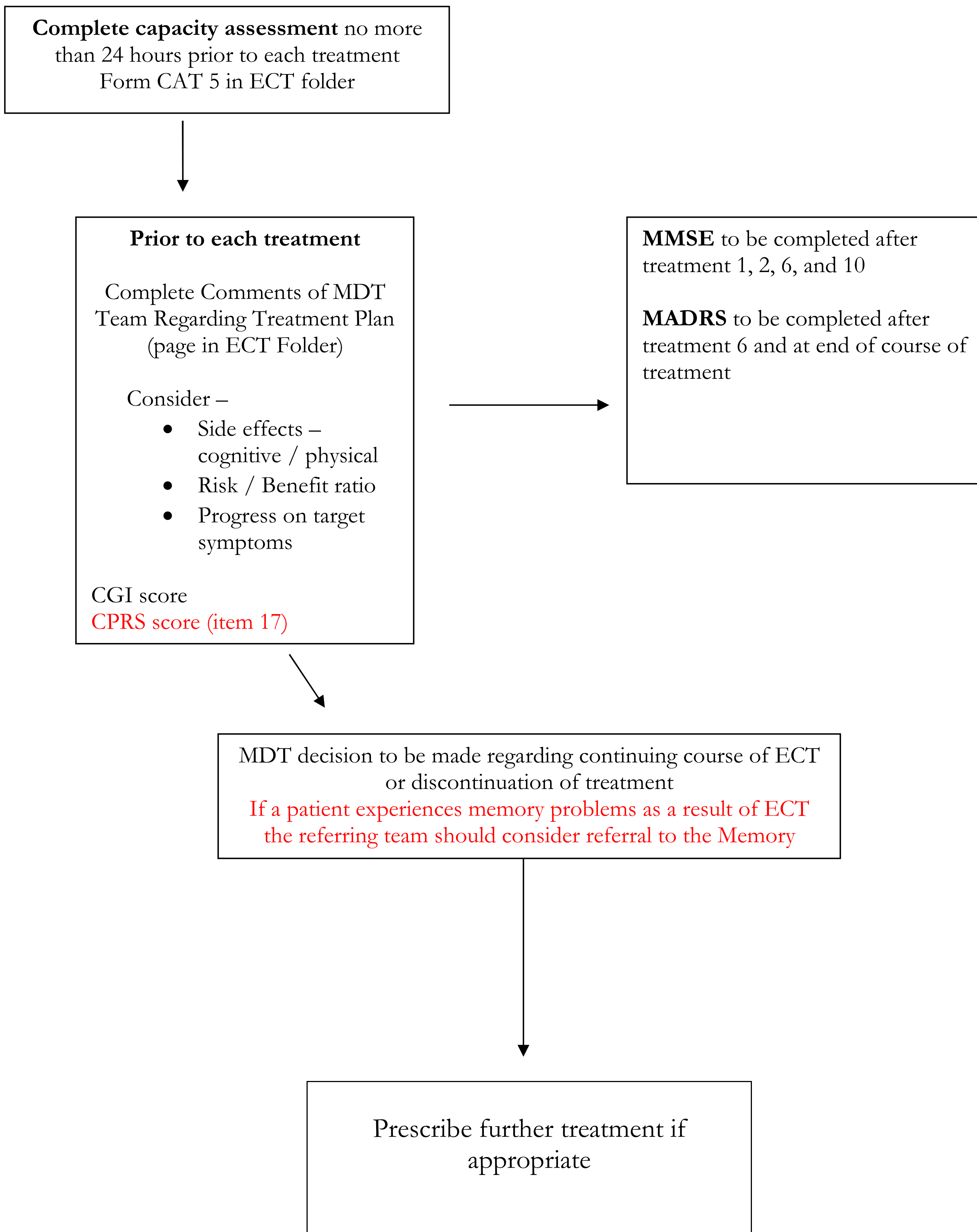
Contact Treatment Suite EXT 61678 to arrange a start date

All ECT work up Documentation has to be available in the treatment suite on the ECT Session prior to intended treatment commencement date

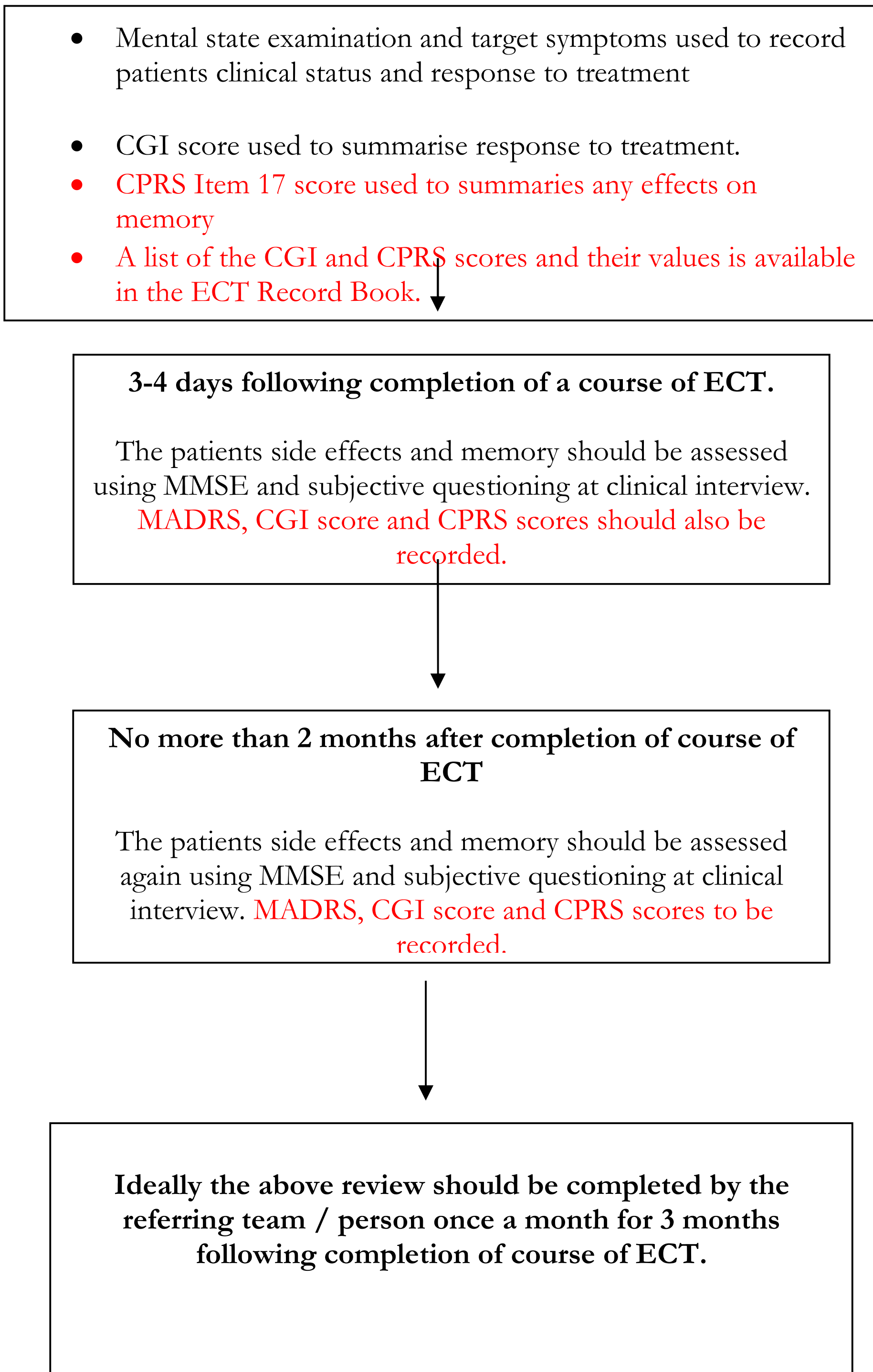
Consent Flow Diagram for ECT

IT IS IMPORTANT TO UNDERSTAND THAT ANY PATIENT, DEEMED TO HAVE CAPACITY, WHO WITHDRAWS CONSENT TO TREATMENT AT ANY STAGE CANNOT RECEIVE ECT UNTIL THEY HAVE BEEN RE-CONSENTED

Review of patient during course of ECT



Review and monitoring of patients following completion of a course of ECT



1 Introduction

The aim of this policy is to provide a safe, ethical and legal process to the therapeutic intervention of Electro Convulsive Therapy (ECT) and is a partnership between Ward & Treatment Suite staff. Included within the policy are the procedures and local protocols required by various services, the accompanying documentation and patient information leaflets.

2 Scope

This policy is Trust wide and also relevant to out of city services referring service users for ECT treatment.

3 Purpose

This policy sets out the roles and responsibilities of referring clinicians with regard to the preparation, review and follow-up care when referring service users for ECT. It also sets out the roles and responsibilities of the ECT team in providing safe delivery of ECT treatment to service users referred into this service.

The aim of this policy is to provide a safe, ethical and legal process to the therapeutic intervention of Electro Convulsive Therapy (ECT) and is a partnership between Ward & Treatment Suite staff. Included within the policy are the procedures and local protocols required by various services, the accompanying documentation and patient information leaflets.

4 Definitions

Term	Definition
The Act	Unless otherwise stated, the Mental Health Act 1983 (as amended by the Mental Health Act 2007).
Advanced decision to refuse treatment	A decision, under the **Mental Capacity Act**, to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse the specified treatment.
Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also **Independent mental health advocate**.
Appropriate medical treatment	**Medical treatment for mental disorder** which is appropriate taking into account the nature and degree of the person's **mental disorder** and all the other circumstances of their case.
Approved clinician	A mental health professional approved by the **Secretary of State** (or the **Welsh Ministers**) to act as an approved clinician for the purposes of **the Act**. Some decisions under the Act can only be taken by people who are approved clinicians. All **responsible clinicians** must be approved clinicians.
Approved mental health professional (AMHP)	A social worker or other professional approved by a **local social services authority (LSSA)** to carry out a variety of functions under **the Act.**
Attorney	Someone appointed under the **Mental Capacity Act** who has the legal right to make decisions (e.g. decisions about treatment) within the scope

	of their authority on behalf of the person (the donor) who made the power of attorney. Also known as a “donee of lasting power of attorney”.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (e.g. to **consent** to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the **Mental Capacity Act** 2005. See also **competence to consent.**
CGI	Clinical Global Impression scale
Community treatment order (CTO)	Written authorisation on a statutory form for **the discharge** of a **patient** from **detention** in hospital onto **supervised community treatment.**
Competence to consent	Similar to **capacity** to **consent,** but specifically about children. As well as covering a child’s inability to make particular decisions because of their mental condition, it also covers children who do not have the maturity to take the particular decision in question.
Compulsory treatment	**Medical treatment for mental disorder** given under **the Act** against the wishes of the **patient.**
Term	**Definition**
Consent	Agreeing to allow someone else to do something to or for you. Particularly consent to treatment. Valid consent requires that the person has the **capacity** to make the decision (or the **competence to consent**, if a child), and they are given the information they need to make the decision, and that they are not under any duress or inappropriate pressure.
CO_2	Carbon Dioxide
Court of Protection	The specialist court set up under the **Mental Capacity Act** to deal with all issues relating to people who lack **capacity** to take decisions for themselves.
CPRS	Comprehensive Psychopathological Rating Scale
CQC	Care Quality Commission
Deputy (or Court-appointed deputy)	A person appointed by the **Court of Protection** under section 16 of the **Mental Capacity Act** to take specified decisions on behalf of someone who lacks **capacity** to take those decisions themselves. This is not the same thing as the **nominated deputy** sometimes appointed by the **doctor** or **approved clinician** in charge of a patient’s treatment.
Detained patient	Unless otherwise stated, a patient who is **detained** in hospital under patient **the Act**, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention (and detained)	Unless otherwise stated, being held compulsorily in hospital under **the Act** for a period of **assessment** or **medical treatment.** Sometimes referred to colloquially as “sectioning”.
Detention for medical treatment (and detained for medical treatment)	The **detention** of a person in order to give them the **medical treatment for mental disorder** they need. There are various types of detention for medical treatment in **the Act.** It most often means detention as a result of an **application for detention** under section 3 of the Act. But it also includes several types of detention under **Part 3** of the Act, including **hospital directions, hospital orders** and **interim hospital orders.**
Doctor	A registered medical practitioner.
ECG	Electro Cardiogram

EEG	Electro Encephalogram
Electro-convulsive therapy (ECT)	A form of **medical treatment for mental disorder** in which seizures are induced by passing electricity through the brain of an anaesthetised **patient;** generally used as treatment for severe depression.
Independent hospital	A hospital which is not managed by the NHS.
Informal patient	Someone who is being treated for a **mental disorder** and who is not **detained** under **the Act**. Also sometimes known as a "voluntary patient".
Medical treatment for mental disorder	**Medical treatment** which is for the purpose of alleviating, or preventing a worsening of, the **mental disorder,** or one or more of its symptoms or manifestations.
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people who lack **capacity**, both where they lose capacity at some point in their lives, e.g. as a result of dementia or brain injury, and where the incapacitating condition has been present since birth.
MADRS	Montgomery and Asberg Depression Rating Scale
NHS Commissioners	**Primary care trusts (PCTs)** and other bodies responsible for commissioning NHS services.
NHS trust / NHS foundation Trust	Types of NHS body responsible for providing NHS services in a local area.

Nominated Deputy	A **doctor** or **approved clinician** who may make a report detaining a **patient** under the **holding powers** in section 5 in the absence of the doctor or approved clinician who is in charge of the patient's treatment.
ODP	Operating Department Practitioner
Part 2	The part of **the Act** which deals with **detention, guardianship** and **supervised community treatment** for civil (i.e. non-offender) patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the **Secretary of State for Justice** under **Part 3** of **the Act**.
Part 2 patient	A civil patient – i.e. a patient who became subject to **compulsory measures** under **the Act** as a result of an **application for detention** or a **guardianship application** by a **nearest relative** or an **approved mental health professional** under **Part 2** of the Act.
Part 3	The part of **the Act** which deals with **mentally disordered offenders** and defendants in criminal proceedings. Among other things, it allows courts to **detain** people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the **Secretary of State for Justice** to transfer people from prison to detention in hospital for treatment.
Part 3 patient	A patient made subject to **compulsory measures** under **the Act** by the courts or by being transferred to detention in hospital from prison under **Part 3** of the Act. Part 3 patients can be either "restricted" (i.e. subject to special restrictions on when they can be **discharged**, given **leave of absence**, and various other matters) or "unrestricted" (i.e. treated for the most part like a **Part 2 patient**).

Part 4	The part of **the Act** which deals mainly with the **medical treatment for mental disorder** of **detained patients** (including **CTO patients** who have been **recalled** to hospital). In particular, it sets out when they can and cannot be treated for their mental disorder without their **consent.**
Part 4A	The Part of the Act which deals with the **medical treatment for mental disorder** of CTO **patients** when they have not been **recalled** to hospital.
Part 4A certificate	A **SOAD or an RC certificate** approving particular forms of **medical treatment for mental disorder** for a **CTO patient**.
Part 4A patient	In **chapters 23** and **24** means an **CTO patient** who has not been **recalled** to hospital.
Patient	People who are, or appear to be, suffering from a **mental disorder.** This use of the term is not a recommendation that the term "patient" should be used in practice in preference to other terms such as "service users", "clients" or similar terms. It is simply a reflection of the terminology used in **the Act** itself.
Recall (and recalled)	A requirement that a **patient** who is subject to **the Act** return to hospital. It can apply to patients who are on **leave of absence**, who are on **supervised community treatment**, or who have been given a **conditional discharge** from hospital.
Responsible clinician	The **approved clinician** with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's **detention** or placing a patient on **supervised community treatment**) can only be taken by the responsible clinician.
Revocation (and revoke)	Term used in **the Act** to describe the rescinding of a **community treatment order (CTO)** when a **CTO patient** needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is **detained** under the powers of the Act in the same way as before the CTO was made.
SCT patient	A patient who is on **supervised community treatment.**

Second opinion appointed doctor (SOAD)	An independent **doctor** appointed by the **Commission** who gives a second opinion on whether certain types of **medical treatment for mental** disorder should be given without the patient's **consent.**
Section 58 treatment	A form of **medical treatment for mental disorder** to which the special rules in section 58 of the Act apply, which means medication for **mental disorder** for detained patients after an initial three-month period.
Section 58A treatment	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply especially electro-convulsive therapy.
SOAD certificate	A certificate issued by a **second opinion appointed doctor (SOAD)** approving particular forms of medical treatment for a patient.
Supervised community treatment (SCT)	Arrangements, under which patients can be discharged from detention in hospital under the Act, but remain subject to the Act in the community rather than in hospital. Patients on CTO are expected to comply with conditions set out in the community treatment order and can be recalled to hospital if treatment in hospital is necessary again.
Voluntary patient	See informal patient.
WHO	World Health organisation

5 Detail of the policy (title needs to be changed as appropriate)

This policy outlines the roles and responsibilities of the ECT team and referring teams to ensure that ECT treatment is delivered in a safe and patient centred manner
The development of this updated policy is in line with the most recent ECTAS standards that were issued in 2018.

6 Duties

All Staff:
All staff involved in the provision of ECT treatment and in the care of service users receiving it are responsible for:

- Ensuring that they comply with this policy and procedure, in collaboration with their colleagues;
- Providing safe, high quality care (within their remit) in line with the Mental Health Act 1983 (as revised), the Mental Capacity Act 2005, Mental Health Act 1983 Code of Practice 2015 and associated policy documents;
- Ensuring that their practise is up to date and that they undertake any required training updates; and
- Reporting any concerns regarding this policy or its implementation and application via line management and the Trust's incident reporting process.

Referring Consultant

- Ensure that the service user's mental capacity for treatment and their physical health and suitability for treatment is fully assessed and recorded prior to treatment;
- Ensure that the service user consents to treatment and is fully aware (including written information) of the benefits and risks of receiving ECT treatment;
- Ensure that where the service user lacks capacity all relevant Mental Health Act documentation is available and appropriate to the treatment.
- Monitor the service user's condition throughout the treatment;
- Ensure that all relevant documentation (as per remit) is kept up to date.

ECT Consultant

- Ensure that the service user's mental capacity for treatment and their physical health and suitability for treatment is fully assessed and recorded prior to treatment;
- Ensure that the service user consents to treatment and is fully aware (including written information) of the benefits and risks of receiving ECT treatment;
- Check that where the service user lacks capacity all relevant Mental Health Act documentation is present and completed correctly.
- Monitor the service user's condition throughout the treatment;
- Ensure that all relevant documentation (as per remit) is kept up to date.
- Provide training for the CT and ST trainees

Anaesthetist and Operating Department Practitioner

- This service is purchased from Sheffield Teaching Hospitals NHS Foundation Trust (STH NHS FT) and these staff work within STH NHS FT policies and guidelines.

Clinical Specialist ECT:

- Manage the ECT service as a whole; ensuring that the environment and equipment are fit for purpose and that systems are in place to deliver safe, high quality care and treatment;
- Ensure that the training needs of staff are addressed and identified in their appraisals and that learning and quality improvement mechanisms are in place;
- Ensure that staff working within the ECT service adhere to this policy and procedure.

Staff Nurse – ECT

- Ensure the safe recovery of service users following ECT treatment
- Assist with the training of staff working in the ECT Suite
- Assist the Lead Nurse in the operation of the department.

Escort Nurse

- To accompany the service user throughout the process. The escort nurse should be known to the patient, be aware of their legal and consent status and have an understanding of ECT.
- Act as an advocate, assessing concerns and feeding these back to the members of the team. This is to give support and reassurance, as well as to assist the service user through recovery.
- To assist with the recovery of the patient by following the pre and post ECT orientation checklist and staying with the patient until a member of the ECT team indicates they are now ready to be escorted to the refreshment area.
- If in any doubt, to check with the consultant psychiatrist, anaesthetist or Treatment Suite staff if concerned about any aspect of the service user's recovery.

7 Procedure

Please refer to sections 7.1 – 7.13

7.1 Preparation of patient for ECT by referring team

- **When considering a patient for ECT a full assessment of the potential risks and intended benefits should be discussed in the MDT, with the patient and relevant family members (if appropriate). This discussion should be recorded in the notes.**

- **A full Mental State Examination should be recorded with particular emphasis on target symptoms which it is expected will be improved by ECT.**

- ECT information leaflets should be offered to every patient as part of the consent procedure. These include – the "ECT Information leaflet", "You and your anaesthetic" and the CQC leaflet "ECT your rights about consent and treatment"

- All consent forms are available via SHSC intranet on the risk website. The form, appropriate to the patient's circumstances should be printed and completed. It is the responsibility of the prescribing consultant to ensure that the correct consent form is completed by a competent medical practitioner of appropriate grade in line with the Trust Consent policy.

- 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 advisors before making a decision regarding consent. The Information leaflets included in the ECT Record Book should be given to ALL patients and relatives if appropriate prior to ECT and used as part of the consent procedure.

- Prior to ECT all patient will have a full physical examination including Venous Thromboembolism screen and blood tests to assess their suitability for anaesthetic. Patients must also have their weight recorded.

- Investigations: All patients must have a Full Blood Count (including sickle cell status in all at risk groups) and Urea and Electrolytes.
-
- ECG is required for those with cardiovascular disease
  Respiratory disease
  Renal disease
  Irregular pulse
  Heart murmur
  Hypertension
  Diabetes over the age of 40
  Over 50 years of age

- Chest X ray if clinically indicated

It is the responsibility of the prescribing Consultant to ensure that these investigations are completed within 4 days of ECT treatment or 24 hours if at risk of becoming dehydrated – This should be documented on the Physical Health Screen on Insight and also on the ECT Pre- Treatment Medical Screen page in the ECT Record Book.

- All patients should have a Mini Mental State Examination completed before a course of treatment begins, after the 1st and 2nd treatments and then after treatment 6 and 10. MMSE should also be recorded 3 – 4 days after completing a course of ECT and again at 1 – 2-month follow-up – this is the responsibility of the referring team.

- All patients should have a MADRS completed prior to starting a course of ECT; this should be repeated after treatment 6 and at the end of the course of ECT.

- All Patients should have a Clinical Global Impression score recorded prior to commencing ECT, between each treatment, and again on completion of a course of ECT

- All patients should have a CPRS score Item 17 (Comprehensive Psychopathological Rating Scale Item 17) recorded prior to commencing ECT, between each treatment, and again on completion of a course of ECT.

- All patients should have a CAT 5 capacity assessment for ECT form completed in line with Mental Health Act requirements and the Trust policy. no more than 24 hours prior to each treatment. For detained patients, the CAT 5 should be completed by the Responsible Clinician (as stated on the CAT 5 form).

- Wards must contact Treatment Suite staff to arrange for a patient to attend for ECT and complete the ECT referral available on Insight and in the ECT Record folder giving the following information:
- Name, date of birth, if attending as in/outpatient.
- Legal status, relevant medical problems or anticipated management problems.
- Any relevant medical problems must be notified to the ECT team as soon as possible. The anaesthetist can be contacted to discuss any problems.

- To enable Anaesthetic assessment and checking of documentation, all pre ECT documentation must be available in the Treatment Suite at least 1 session prior to the expected start date of treatment. Referring teams will then be informed of any further investigations or specific pre ECT preparation that may be necessary for that patient.

Treatment Suite staff can be contacted on Ext 61678 Tuesday and Friday between 7am and 3pm and Thursday afternoon between 1pm and 4pm.

- Treatment Suite staff will ring the ward areas on the morning of treatment to confirm the names of patients attending and to arrange arrival times for treatment.

- Transport, if needed, must be arranged by the Service/Department from which the patient comes.

- The named nurse and/or responsible consultant will be responsible for formulating a care plan, which identifies the specific needs for ECT. This will take into account the physical and psychological effects of the treatment, and the preparation that is needed. In the absence of the named nurse, the nurse in charge will delegate this responsibility to another registered nurse.

- Ward based staff escort patients to ECT and assist with them during their treatment. Escort staff should include a qualified nurse who is knowledgeable of the patient and able to stay with the patient in the Treatment Suite until the patient is medically well enough to travel back to the ward.

People attending as outpatients are given a detailed information sheet regarding any medication that needs to be taken prior to attending and instructed not to travel unaccompanied and not to return to an empty house, (there should be a responsible person at home to take care of them for 24 hours following ECT treatment). The responsible consultant should also give patients attending as out-patients information regarding driving whilst undergoing their course of ECT treatment.

For further information regarding outpatient ECT please see section 7.13 “Notes for Medical Staff Arranging Outpatient ECT”.

7.2 PREPARATION OF PATIENT ON MORNING OF ECT

- Patients must starve (both food and fluids) from 12 midnight the night prior to ECT, other than a small amount of water to take with medication, if general medication is needed, prior to treatment. Breakfast is given in the ECT Suite after recovery from anaesthesia.

- All information relating to the ECT treatment is recorded in the ECT Record Book which remains with the patient.

- Temperature, pulse, respirations and blood pressure, BM stick (if appropriate) and the Nursing Orientation Questionnaire and Pre ECT Check List will be completed by the ward based staff prior to each treatment. Any changes in medication, ill health or problems/concerns requiring previous treatment should be documented on that day's Treatment sheet.

- All forms must be signed and dated by a qualified nurse or countersigned if completed by non-qualified staff.

- All patients should have their capacity assessed no more than 24 hours prior to ECT, this should be documented on the Capacity Assessment Form in the ECT Record Book, (or documented on Insight CAT 5 form)

- All patients should have a review completed following each treatment, their response to treatment and any adverse effects monitored and documented in the ECT Record book along with a CG1 score, CPRS score item 17 and prescription for continuation of treatment. This should be documented on the page "Comments of Multidisciplinary Team Regarding Treatment Plan" and on Insight. MMSE and MADRS should be completed as required.

Medication

PSYCHIATRIC MEDICATION, BENZODIAZEPINES IN PARTICULAR, MUST NOT BE GIVEN ON THE MORNING OF TREATMENT.

ALL MEDICATION SHOULD BE WITHHELD PRIOR TO ECT WITH THE EXCEPTION OF:

BETA BLOCKERS e.g. Atenolol, Propranolol, Acebutolol, Betaxolol Hydrochloride.

ANTACIDS e.g. Ranitidine, Omeprazole, Lansoprazole.

ACE INHIBITORS, DRUGS ENDING…. **PRIL** e.g. Captopril, Cilazapril, Lisinopril, Enalapril Meleate, Ramipril.

CALCIUM CHANNEL BLOCKERS DRUGS ENDING …….DIPINE e.g. Amlodipine, Nifedipine, Felodipine, also Diltiazem, Verapamil.

DIURETICS e.g Bendroflumethiazide, Furosemide, Spironolactone

It is also important that any inhalers or nebulisers are given prior to ECT if prescribed and also to bring any inhalers to the ECT session with the patient.
THE FOLLOWING MEDICATION SHOULD BE OMITTED 24 HOURS PRIOR TO ECT:

DRUGS ENDING…ARTAN e.g. Losartan, Eprosartan, Candesartan Cilexitil, and **IRBESARTAN**

Note:

- Medication for diabetes and anticonvulsants will be administered by nursing staff on the patient's return to the ward following ECT treatment.

- Patients coming from off site and on anticonvulsants or diabetic medication should bring their medication with them. It will be given in the treatment suite after the patient has recovered.

7.3 PREPARATION OF THE ECT TEAM ON THE MORNING OF ECT

Prior to the arrival of patients the team including any visiting staff will meet to complete the team brief – staff introduce themselves to other members of the team, any staffing or equipment issues are addressed and the team discuss any pertinent issues reported on Insight or handed over by ward staff regarding the patients that are scheduled to attend that days treatment session.

7.4 PROCEDURE ON ARRIVAL AT THE ECT SUITE

1. Patients are received into the Treatment Suite and wait in the waiting area for a short while. Insight notes and ECT record are checked to ensure that all necessary documentation is present and correct.

i. ECT Record Book including the ECT Prescription and Legal Status.
ii. Consent Form where applicable.
iii. Capacity Assessment
iv. Mental Health Act documentation relating to ECT.
v. Details of physical examination, blood results, ECG and chest x-ray reports if appropriate, available for the anaesthetist.
vi. Medication Record – check that appropriate medication has been given.

Any problems relating to the legal documentation should be reported to the psychiatrist responsible for administering the ECT as soon as possible.

2. Prior to treatment the clinician responsible for administering the ECT will reconfirm capacity and record this on the capacity Assessment Form in the ECT Record Book. He / she will also reconfirm that ECT is indicated and is an appropriate treatment and sign the appropriate section in the ECT Record Book. In line with SHSC Consent Policy, ECT suite staff will confirm and sign that informal consent remains valid prior to each treatment. Any concerns regarding capacity will be brought to the attention of the referring team. Any Mental Health Act documentation is checked to ensure it is in date and relevant to the treatment.

3. When the patient last had anything to eat or drink and any concerns regarding physical health are checked and reported to the anaesthetist. Temperature, pulse and blood pressure are checked if ward readings are outside normal limits or unusual for the patient.

4. It should be confirmed with the JAC drug record and the escort nurse (drug card) that relevant medication has been given.

5. The patient is escorted to a trolley in an adjacent room and assisted to lie down on the trolley. Any hair grips, loose fitting false teeth (well fitting dentures will be left in situ), spectacles or contact lenses, false eyes should be removed. Tight clothing is loosened (belts, shirt or blouse collars), bulky jumpers/cardigans are removed. Shoes or slippers are removed. Property is stored in the tray

beneath the trolley so it can remain with the patient. Hearing aids are removed prior to treatment.

6. **The patient is transferred to the treatment room where the ECT is administered by the consultant psychiatrist in charge of the treatment or by a designated Deputy.**

7.5 PROCEDURE IN THE TREATMENT ROOM

1. All medical equipment and oxygen required for ECT must be checked prior to each ECT session.

2. The WHO Surgical Safety Checklist (modified for ECT) is completed for each patient.

3. The patient is introduced to members of the ECT team.

4. The consultant psychiatrist adjusts the ECT machine to the required setting for that treatment. This is done following the unit's dosing policy and with regard to the patient's response at any previous treatments. It is the responsibility of the doctor administering the treatment to ensure that the setting is checked by a second member of the team.

5. The skin of the forehead and over the mastoid processes is cleaned and dried. The EEG electrodes are then applied and the impedance button depressed to establish an EEG baseline. The display shows READY when this is achieved.

6. A cannula is inserted into the back of the hand.

7. A blood pressure cuff is applied to the patient's other arm.

8. The consultant psychiatrist should proceed to apply the disposable treatment electrodes. Pretac solution should be applied to the skin before the treatment electrodes. When the electrodes are in position the impedance button should be depressed to show the impedance. Less than 3000 ohms is adequate for treatment. In the event that this is not possible with the disposable electrodes the paddles can be used with electrode gel. Impedance should be checked when the paddles are in treatment position.

9. The anaesthetic is administered. Propofol or Etomidate are currently used. Etomidate may be preferred where it is difficult to achieve a therapeutic fit.

10. The blood pressure cuff is inflated to 280 mmHg as the patient drifts off to sleep. This is in order to isolate that forearm from the effect of the muscle relaxant Suxamethonium.

11. The patient's head is slowly lowered and a muscle relaxant is administered.

12. Oxygen therapy is given. The patient's pulse and oxygen saturation ECG and expired CO_2 are monitored throughout the procedure.

13. When asleep and relaxed a mouth gag is inserted to protect the teeth and tongue from damage.

14. If the disposable electrodes are in use the psychiatrist operates the ECT machine. If the paddles are used the ECT machine is operated by a second member of staff. EEG monitoring begins automatically after administration of the stimulus and the psychiatrist is required to stop the trace only when the seizure is deemed to be finished.

15. During the treatment the patient is held gently in order to minimize the risk of injury from any involuntary movement.

16. The length of the fit is timed by stopwatch from the end of the stimulus to the end of the twitching in the right forearm. The end of the seizure on the EEG recording is judged on the last spike and wave complex and the appearance of post ictal suppression of EEG activity.

17. The settings on the ECT machine, the length and nature of fit are recorded on the ECT Record Sheet and recommendations made for the next treatment.

18. EEG tracings are labelled with the patients details and retained in the Treatment Suite.

19. The ECT Register is completed and retained in the Treatment Suite.

20. Oxygen is administered. The mouth gag is removed at the end of the convulsion. An airway inserted if necessary.

21. When the muscle relaxant has worn off and the patient breathing unaided he/she is turned into the recovery position.

22. When the anaesthetist is happy with the patient's condition they are transferred to the recovery area.

23. The anaesthetist records details of the dose of anaesthetic and muscle relaxant used and any recommendations for next treatment on the ECT record sheet.

7.6 ROLE OF THE ESCORT NURSE DURING ECT

The nurse will accompany the patient throughout the process. They should be known to the patient, be aware of their legal and consent status and have an understanding of ECT. The escort nurse acts as an advocate, assessing concerns and feeding these back to the members of the team. This is to give support and reassurance, as well as to assist the patient through recovery.

The nurse will be required to assist with the recovery of the patient by following the pre and post ECT orientation checklist and staying with the patient until a member of the ECT team indicates they are now ready to be escorted to the refreshment area.

If in any doubt, always check with the consultant psychiatrist, anaesthetist or Treatment Suite staff if concerned about any aspect of the patients' recovery.

There should be no urgency about returning to the ward, the patient should be allowed time to recover. Nurse and patient will not leave the suite until the Discharge Criteria (in the ECT Record Book) is completed and their departure is approved by a member of the Treatment Suite team.

7.7 PROCEDURE IN THE RECOVERY AREA

During this period patients are supervised by qualified nursing staff at all times.

1. Oxygen therapy continues to be administered at 5 litres per minute through a medium concentration oxygen mask and oxygen saturation monitored until the patient is awake and able to maintain his/her own airway.

2. Colour and respiration are monitored. The level of consciousness is monitored by response to stimulus, i.e. able to respond to command or normal speech.

3. Pulse, oxygen saturation and blood pressure are monitored and recorded including ongoing ECG if appropriate.

4. The nursing Orientation questions are completed during the recovery phase.

5. Patient is allowed to rest on the trolley until he/she feels ready to get up.

6. When ready, spectacles, teeth, etc, are replaced and the patient escorted to refreshment area for breakfast.

7. Discharge Criteria Record is completed by Treatment Suite staff.

8. When suitably recovered, arrangements are made for the patient to return to the ward area or home.

9. Any problems/concerns are to be referred to anaesthetist and/or psychiatrist.

7.8 RETURN TO THE WARD

1. Using the post ECT checklist the escorting nurse will observe the patient and report immediately any concerns to the nurse in charge upon returning to the ward.

2. Ensure all records and the patient is returned to the ward.

3. Continue to observe the patient during the journey back to the ward.

4. The patient will be given the opportunity to rest following treatment and observations should continue for a minimum of 3 hours once they have returned to the ward.

7.9 MONITORING OF ECT AND FOLLOW-UP CARE

PRIOR TO STARTING A COURSE OF ECT

- The patients clinical status including a full mental state examination should be documented prior to starting a course of ECT (baseline)
- MMSE to be recorded at baseline
- MADRS to be completed at baseline
- CPRS Item 17 score to be recorded at baseline (Comprehensive Psychopathological Rating Scale Item 17)
- CGI score to be recorded at baseline.
- Capacity to be assessed and documented in the ECT Record Book

BETWEEN EACH TREATMENT

The outcome of treatment should be monitored to allow the ECT treatment to be adjusted accordingly

- Clinical status and response with particular regard to baseline target symptoms should be assessed and documented between each treatment including a full mental state examination and the Clinical Global Impression scale (CGI). The CPRS Item 17 score (Comprehensive Psychopathological Rating Scale Item 17) should be recorded between each treatment.
- If a patient experiences memory problems as a result of ECT the referring team should consider referring them to the Memory Service or a Neuropsychologist if clinically indicated.
- The patients subjective experience of side effects and objective side effects should be recorded between treatments.
- MMSE should be recorded after the 1st and 2nd treatments and then after treatments 6 and 10.
- MADRS to be completed after treatment 6 and at completion of the course of treatment.
- Non cognitive side effects should be assessed and documented in the ECT Record Book and Insight between each treatment This record should include the patients subjective experience of side effects and any objective cognitive side effects.
- Orientation questions should be asked prior to each treatment and repeated following treatment. This is repeated at each ECT treatment.
- Capacity should be assessed by the ward team a maximum of 24 hours prior to treatment and documented in the ECT Record Book, this should be done in line with the MHAct and Trust policy . This capacity assessment will then be confirmed by the ECT team immediately before treatment, any discrepancy / concern will be brought to the attention of the referring team.
- A record should be made of the risks and benefits of continuing with ECT and a decision made regarding continuation of the treatment.
- The next treatment should be prescribed by the referring Consultant.

FOLLOW-UP CARE

- Mental state examination and target symptoms will be used to record the patient's clinical status and response to treatment. CGI should be used to summarise response to treatment. The patient's side effects and memory should be assessed using the CPRS Item 17 score (comprehensive Psychopathological rating scale item 17), MMSE and subjective questioning in a clinical interview 3 – 4 working days after completing their course of ECT and again at follow-up no more than 2 months following completion of ECT. Ideally, the patient is reviewed by the referring person / team at least once a month for the 3 months following an acute course of ECT.
- The outcome of the treatment continues to be monitored and recorded after the course of ECT.

7.10 PROCEDURE FOR EMERGENCY ECT (i.e. Outside normal ECT List times)

Emergency ECT is when a treatment is deemed to be essential outside the regular list times i.e. Tuesday 9.00 am and Friday 9.00 am. It is the responsibility of the

consultant team responsible for the patient to make arrangements with the Treatment Suite Manager and the anaesthetic department at the Northern General Hospital. The consultant team is also responsible for providing the psychiatrist to administer the ECT.

1. The usual ECT medical work up is required. See Preparation of a Patient for ECT by Referring Team. Where appropriate, the patient's written consent should be obtained on the standard form (available under the ECT Policy on the Trust Intranet). Consent should be obtained following the Trust Consent Policy or the appropriate Mental Health Act documentation completed.

2. The Treatment Suite Manager (Ext 61678) should be contacted directly in the first instance to notify her that emergency ECT is to be arranged. If you are unable to contact the Treatment Suite Manager contact ECT Consultant Dr Sivakumar Tel:- 2263965 or Dr Edward Dimelow Tel 3050300 alternatively, both can be contacted via the Trust switchboard. The Treatment Suite Manager may not always be able to attend the session but can give advice.

3. The secretary in the anaesthetic department at the Northern General (Ext 14818) should be contacted and she will put you in contact with the on call anaesthetist and ODP. A convenient time will need to be negotiated between the psychiatrist, anaesthetist and The Treatment Suite Manager.

4. **The patient's ward doctor must contact the Sister on duty for emergency theatres at the Northern General Hospital in order that the patient can be put on the list for emergency theatres Sister on duty for emergency theatres can be contacted via the Northern General Switchboard, 15800 Bleep 2192**

7.11 PREPARING FOR EMERGENCY ECT

Regular members of the ECT Team may not always be available to run these sessions.

Staff Present
Psychiatrist
Anaesthetist
Operating Department Practitioner (ODP)
Qualified Nurse Trained in ECT
Qualified Nurse from Ward
Other Nursing Staff as necessary
Students/Trainees

Anaesthetic Cover
This is usually provided by the 'emergency list Anaesthetist. The Ward Doctor should contact the Anaesthetics Secretary, on Ext 14818, who will inform him/her of which Anaesthetist should be contacted. A mutually convenient time can then be arranged for the session. The sister in Emergency theatres (bleep 2192 NGH switchboard) should be contacted to log the case on the emergency list.

Psychiatric Cover

The Approved Clinician in charge of the treatment who is arranging the session should ensure that a psychiatrist trained in ECT is available to administer the treatment.

Nursing Cover

It is necessary that at least one qualified member of the nursing team escort the patient for treatment. If the patient is to be treated in the Treatment Suite the qualified nurse trained in ECT/Recovery will be responsible for the safe recovery of the patient, and will also need to sign the ECT Register and complete other documents at the end of the session. Contact the Treatment Suite Manager (Ext 61678) for names of trained staff who can be approached.

ODP Cover

This can be organized by either the medical or nursing staff. The ODPs can be contacted through Northern General Hospital Switchboard via Bleep 2266, let them know the date and time of the session. It is important to remember to arrange ODP cover, as it is Northern General Hospital Trust policy to only anaesthetise patients with an ODP present.

7.12 NON-NHS PATIENT PROTOCOL - REFERRED FOR ECT AT THE LONGLEY CENTRE

Please refer to section Legal Issues re: Capacity, Consent and Emergency ECT.

1. Consultants referring patients for ECT should initially contact the Treatment Suite Manager in the ECT Suite (2261678); she will forward to the consultant an ECT Package. This consists of an “ECT Information Booklet for Patients”, “You and Your Anaesthetic” leaflet and “CQC ECT Your rights about consent to treatment” (which should be given to the patient), an ECT record book, the ECT policy and the consent form. The patient’s written consent, (where applicable) witnessed by the consultant, who has knowledge of consent process and procedures, should be obtained.

2. The Treatment Suite Manager will alert the Contracting Department regarding the proposed referral. The Contracting Department will liaise with the referring organisation in order to set up a contract.

3. All patients should be escorted by a qualified nurse who knows them and is trained in Basic Life Support.

4. Each patient should have a named consultant and approved clinician who has clinical responsibility for them during the course of ECT. That consultant is responsible for prescribing the treatment, monitoring response to treatment and completing the reviews in the ECT Record Book. The name of this consultant must be notified to the Treatment Suite Manager before the patient attends for the first treatment.

5. Patients should be informed that ECT is not given by one particular doctor and may be given by psychiatric trainees under supervision.

6. Preparation of patients for ECT should be as documented in the Trust ECT Policy documentation.

NB If a patient has an out of town GP staff in the Treatment Suite need to confirm with the Contracts Department that Sheffield Health and Social Care hold a contract with that area.

7.13 NOTES FOR MEDICAL STAFF ARRANGING OUTPATIENT ECT

Please refer to section Legal Issues re: Capacity, Consent and Emergency ECT

1. It is essential to give the patient a copy of the ECT information leaflet along with a copy of You and Your Anaesthetic as a basis for discussing the proposed ECT treatment. It is the approved clinicians' responsibility to ensure that the appropriate consent be obtained where necessary (see Legal Issues: Capacity, Consent and Emergency ECT). The patient and their carer should also sign the form to confirm that they have read and understand the instructions for receiving ECT as an outpatient treatment and this will be repeated at each treatment.

2. The Preparation of the patient for outpatient ECT is as described above in Preparation of the Patient for ECT

3. Arrangements must be made with the Treatment Suite Manager, (Ext 61678) regarding a suitable starting date for the patient. No patient will be accepted for ECT unless the documentation is completed and the results of the investigations have been recorded on the Record Sheet.

4. An ECT Package is available from the Treatment Suite Manager, (Ext 61678) if necessary.

5. Any concerns about the patient's physical condition must be discussed with the anaesthetist well before the treatment's starting date. If a patient has a significant medical problem which could make out patient ECT hazardous he/she should not be having ECT as an outpatient.

6. Patients must be responsible and understand the importance of "Nil by Mouth from Midnight" except for the need to take morning tablets with a small amount of water. The patient should be advised what medication to take on the morning of treatment and advised to take it at 7.00am to 7.30am with plain water.

Medication

PSYCHIATRIC MEDICATION, BENZODIAZEPINES IN PARTICULAR, MUST NOT BE GIVEN ON THE MORNING OF TREATMENT.

ALL MEDICATION SHOULD BE WITHHELD PRIOR TO ECT WITH THE EXCEPTION OF:

BETA BLOCKERS e.g. Atenolol, Propranolol, Acebutolol, Betaxolol.

ACE INHIBITORS, DRUGS ENDING …. PRIL e.g Captopril, Cilazapril, Lisinopril, Enalapril, Meleate, Ramipril.

CALCIUM CHANNEL BLOCKERS, DRUGS ENDING ….DIPINE, e.g. Amlodipine, Nifedipine, Felodipine, also Diltiazem, Verapamil.

DIURETICS e.g. Bendroflumethiazide, Furosemide, Spironolactone.

ANTACIDS e.g. Ranitidine, Omeprazole, Lansoprazole.

It is also important that any inhalers or nebulisers are given prior to ECT if prescribed and also to bring any inhalers to the ECT session with the patient.

THE FOLLOWING MEDICATION SHOULD BE OMITTED 24 HOURS PRIOR TO ECT:

DRUGS ENDING…ARTAN e.g. Losartan, Eprosartan, Candesartan Cilexitil, and Irbesartan.

Note: Patients coming from off site and on anticonvulsants or diabetic medication should bring their medication with them. It will be given in the treatment suite after the patient has recovered.

7. Transport to and from the Treatment Suite at the Longley Centre needs to be arranged by the referring doctor. It is essential that the patient has a named, responsible escort to and from the Treatment Suite. Patients should not return home to an empty house. Arrangements should be made for them to have company for the remainder of the day.

8. Patients will not be allowed to leave the Treatment Suite until they are felt to have recovered from their treatment. It is essential that there is a responsible adult at home to keep an eye on the patient for 24 hours following treatment. This is to ensure that the patient does not attempt to undertake any potentially hazardous activities whilst still recovering.

9. The Treatment Suite staff will refuse to give ECT if there is evidence that the transport/home situation is not safe.

10. The referring team must arrange for the patient to be reviewed after each treatment, the review sheet completed (as detailed above in Monitoring of ECT and Follow Up Care) and subsequent treatments prescribed.

11. The patient will be referred back to the prescribing doctor/approved clinician if he/she has any questions or concerns that cannot be answered by the ECT staff.

PATIENTS FROM MEDICAL WARDS/OTHER TRUSTS ATTENDING THE LONGLEY CENTRE FOR ECT

Please refer to section Legal Issues re: Capacity, Consent and Emergency ECT

Occasionally patients with severe depression are nursed on general medical wards and need to attend the Longley Centre for ECT. ECT is undertaken routinely on Tuesday mornings and Friday mornings and can be arranged on other days in emergency situations. The following information may be useful for non-psychiatric staff caring for patients who are going to attend for ECT.

1. The Preparation of the Patient for ECT (as detailed in the main body of the policy) should be a joint process by those responsible for the patient's physical care and psychiatric care. Information regarding past medical history, current physical status and physical investigations will usually be the responsibility of the medical team.

2. Explanation of the procedure, providing the Information Sheets obtaining consent and ensuring the correct Mental Health Act Documentation is completed and available is the responsibility of the referring Psychiatric Consultant.

3. The patient should have been given a copy of the leaflets "ECT Fact Sheet for Patients", "You and Your Anaesthetic" and the "CQC ECT Your Rights and Consent to Treatment". This is the psychiatrist's/ approved clinicians' responsibility.

4. On the treatment day the patient should have "Nil by Mouth from Midnight". The only exception being a small amount of water in order to take his or her morning tablets, as below.

Medication

PSYCHIATRIC MEDICATION, BENZODIAZEPINES IN PARTICULAR, MUST NOT BE GIVEN ON THE MORNING OF TREATMENT.

ALL MEDICATION SHOULD BE WITHHELD PRIOR TO ECT WITH THE EXCEPTION OF:

BETA BLOCKERS e.g. Atenolol, Propranolol, Acebutolol, Betaxolol

ACE INHIBITORS DRUGS ENDING ….PRIL e.g. Captopril, Cilazapril, Lisinopril, Enalapril, Meleate, Ramipril.

CALCIUM CHANNEL BLOCKERS Drugs ending …….DIPINE e.g. Amlodipine, Nifedipine, Felodipine, also Diltiazem, Verapamil.

DIURETICS e.g. Bendroflumethiazide, Furosemide, Spironolactone

ANTACIDS e.g. Ranitidine, Omeprazole, Lansoprazole.

It is also important that any inhalers or nebulisers are given prior to ECT if prescribed and also to bring any inhalers to the ECT session with the patient.

THE FOLLOWING MEDICATION SHOULD BE OMITTED 24 HOURS PRIOR TO ECT:
DRUGS ENDING…ARTAN e.g. Losartan, Eprosartan, Candesartan Cilexitil, and **IRBESARTAN**

Note:

i. Medication for diabetes and anticonvulsants will be administered by nursing staff on the patient's return to the ward following ECT treatment.
ii. Patients coming from off site and on anticonvulsants or diabetic medication should bring their medication with them. It will be given in the treatment suite after the patient has recovered.

5. The inside of the ECT Record book comprises a page for each treatment. Ward based nursing staff need to complete the "ward observations" section on each occasion the patient attends for ECT. Ward based nursing staff also need to complete Pre-Treatment Checklist and Orientation Questionnaire. The ECT team should be informed of any concerns identified since the patient last attended for ECT.

6. Transport needs to be arranged by ward nursing staff to enable the patient to be at the Treatment Suite to arrive at the Treatment Suite at the time agreed with the Treatment Suite staff.

7. If there are any problems contact the Treatment Suite Manager on 61678.

7.15 Legal issues

The Mental Health Act (2007) and the Mental Capacity Act (2005) have resulted in different categories of patient for whom different rules apply with regard to consent or the authority to treat with ECT in the absence of consent. A variety of documentation related to consent and Mental Capacity Assessment/best interest decisions are located in the relevant trust consent policy and Mental Capacity Act guidelines on the Trusts intranet.

- **Informal Patients**

Informal patients who have attained the age of 18 years and have capacity / competence.
Proceed with ECT with consent.
The "Patient Agreement to Electroconvulsive Therapy" consent form should be completed along with a CAT 5 "Capacity to Consent to ECT" capacity assessment form; this should be completed no more than 24 hours before each treatment.

Informal patients, who have NOT attained the age of 18 years, but have capacity/competence to give consent. These individuals may not be given ECT unless they consent and a SOAD certifies the consent and that the treatment is appropriate

Informal patients who have attained the age of 16 years and lack capacity.
Informal patients who lack capacity will not be given ECT by Sheffield Health and Social Care Trust under the Mental Capacity Act and Best Interests Decisions. For

those who are deemed to lack capacity and ECT is a treatment option, consideration should be given to the use of the Mental Health Act.

NB. ECT must not be given if an incapacitated informal patient has a valid and applicable advance decision under the MCA refusing the treatment (a patient must have attained the age of 18 years to make such an advance decision); if a suitably authorised attorney or deputy object to the treatment on the patient's behalf; or if the treatment would conflict with a decision of the Court of Protection to prevent the treatment being given.

- **Patients Detained under the Mental Health Act – Part 4 MHA, s 58A**

Detained patients who have attained the age of 16 years and lack capacity.

These individuals may not be given ECT unless a SOAD certifies the lack of capacity and that the treatment is appropriate, except in an emergency (see below).

The SOAD cannot certify the treatment if a suitably authorised attorney or deputy object to the treatment on the patient's behalf; or if the treatment would conflict with a decision of the Court of Protection to prevent the treatment being given.

Treatment certified by the SOAD must stop if any of the reasons listed above preventing the certificate come to light after it has begun.
Section 58A 5

Capacity to make decisions regarding treatment must be reviewed before each treatment – this is the responsibility of the prescribing team. If the patient regains capacity and then refuses further ECT the treatment cannot proceed.

Detained Patients who have attained the age of 18 years and have capacity.

These individuals may not be given ECT unless they consent to it and the approved clinician in charge of the treatment or a SOAD certifies that the patient has the capacity to consent and has done so (2015 Code of Practice Ch 25.21), except in an emergency, see below.
Section 58A 3

Detained Patients who have NOT attained the age of 18 years but who have capacity or are competent to give consent.

These individuals may not be given ECT unless they consent, and a SOAD certifies the consent and that the treatment is appropriate and if the patient is 16 or 17 years old giving the treatment would not conflict with decision made by a deputy or by the Court of Protection in accordance with the MCA, except in an emergency, see below.
Section 58A 4

NB. **non-urgent** ECT (i.e. that which is not administered pursuant to MHA s62(1)(a-b), see below) must not be given if a detained patient has a valid and applicable advance decision under the MCA refusing the treatment (a patient must have attained the age of 18 years to make such an advance decision); if a suitably authorised attorney or deputy object to the treatment on the patient's behalf; or if the treatment would conflict with a decision of the Court of Protection to prevent the treatment being given.
Patients under Compulsion in the Community – Community Treatment Order – Part 4A MHA.

Patients who have attained the age of 18 years and have capacity to consent to ECT and have done so may have their consent recorded by the RC on the appropriate form.

Patients who have NOT attained the age of 18 years but have capacity/competence to consent to ECT and have done so must have their consent recorded by a SOAD on the appropriate form.

Those who have attained the age of 16 years and lack capacity may not be given ECT unless a SOAD records that the treatment is appropriate on the appropriate form.

If an RC is considering ECT as a treatment under a CTO there should be a full discussion with the ECT team and the Mental Health Act Officer.

NB – Check that lawful authority is in place before administering ECT to a recalled CTO patient, or in the event that the CTO has been revoked.

- **Emergency Treatment – section 62(1)(a)-(b)**

The MHA Code of Practice 2015 (Ch 25.38) defines what constitutes an emergency which would warrant the use of ECT as follows:

- It is immediately necessary to save the patient's life.
- It is immediately necessary to prevent a serious deterioration of the patient's condition and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.

Section 58A does not apply in urgent cases where treatment is immediately necessary. If it is no longer 'immediately necessary' the normal rules for certificates apply. Please refer to the MHA Code of Practice, 2015 Code of Practice Ch 25 paragraphs 37 – 42.

Dissemination, storage and archiving (Control)

The issue of this policy will be communicated to all staff via the Communications Digest. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced with this version.

8 Development, Consultation and Approval

This section should include details of:

- *Who was involved in developing the policy and any guidance followed?*
- *Groups and individuals consulted (including staff side groups and service user carer involvement including link back to the Equality Impact Assessment).*
- *Any changes made as a result of the consultation process.*
- *Which governance group reviewed the document*
- *Dates for consultation and review.*

This policy was written by members of the ECT Multidisciplinary team in line with the current ECTAS Standards issued by the Royal College of Psychiatrists and in line with Royal College of Anaesthetist Guidelines.

9 Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
National Standards for the administration of ECT in an Accredited Clinic	18 monthly review	ECT clinical team in partnership with ECT Accreditation Service (ECTAS)	18 monthly	ECT Suite Governance Team	ECT Suite Governance Team	ECT Suite Governance team and Quality Assurance Team
National Standards for the administration of ECT in an Accredited Clinic	3 yearly audit	ECT clinical team in partnership with ECT Accreditation Service (ECTAS)	3 yearly	ECTAS Accreditation Committee	ECT Suite Governance Team	ECT Governance Team and ECTAS Accreditation Team

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change.
This policy will be reviewed by April 2022

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of finalisation	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	
Make team aware of new policy	Team manager		On agenda for team meeting

Policy Template

11 Dissemination, storage and archiving (Control)

The issue of this policy will be communicated to all staff via the Communications Digest. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and PDF copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced with this version.

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	July 2007	July 2007	
2.0	January 2009	January 2009	
3.2	April 2013	April 2013	Launch through Policy Governance Group - May 2013
4.0	Aug 2016	Aug 2016	Re-launch of Policy Governance Group
5.0	March 2019	March 2019	
6.0	July 2021	July 2021	

12 Training and other resource implications

The policy must include a consideration of any training and development requirements for its effective implementation. Where training needs are identified, these must be discussed with the Education, Training and Development Team and reflected in the Trust's Training Needs Analysis.

Other resource implications to consider include the cost of dissemination and any new job roles or functions which are not in current job descriptions or work plans.
Any anticipated savings and efficiencies as a result of implementing the policy should also be considered.

Substantive ECT suite staff will be supported and have access to the appropriate external, accredited training as required

Consent training around process and procedures in line with national guidelines should be available to staff

ECT support staff will be provided training by the ECT suite staff on an annual basis following a formal programme. This is proving more difficult to facilitate due to pressures on in-patient wards and difficulty releasing staff.

13 Links to other policies, standards (associated documents)

- Consent policy
- MHA Policy
- MCA Policy
- Advanced decisions

14 Contact details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Consultant Psychiatrist	Velusamy Sivakumar		Velusamy.sivakumar@shsc.nhs.uk
Consultant Psychiatrist	Ed Dimelow		Ed.dimelow@shsc.nhs.uk
Clinical Nurse Specialist ECT	Ann Blackburn	2261678	Ann.blackburn@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - **I**s the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Ann Blackburn 07.05.2021	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**		
Disability	**No**		
Gender Reassignment	**No**		
Pregnancy and Maternity	**No**		

Race	**No**		
Religion or Belief	**No**		
Sex	**No**		
Sexual Orientation	**No**		
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended

Impact Assessment Completed by:
Name /Date

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Y
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Y
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y