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HPFT

Electroconvulsive Therapy (ECT) Suite at Kingfisher Court, Kingsley Green & ECT Services provided by HPFT

HPFT Operational Policy

Version	4.1
Executive Lead	Executive Director of Quality and Safety
Lead Author	ECT Lead Nurse
Approved Date	18th March 2020
Approved By	West SBU Quality and Risk Meeting
Ratified Date	18th March 2020
Ratified By	West SBU Quality and Risk Committee
Issue Date	04/09/2020
Expiry Date	18th March 2022
Target Audience	This Policy must be understood by anyone: • Working in the ECT Suite at Kingfisher Court • All other staff as they need to be aware of how the ECT Suite at Kingfisher Court is operationally managed.

Document on a Page

Title of document	Electroconvulsive Therapy (ECT) Suite at Kingfisher Court, Kingsley Green & ECT Services provided by HPFT		
Document Type	Operational Policy		
Ratifying Committee	West SBU Quality and Risk Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
4.1	4th September 2020	18th March 2022	ECT Management team
Staff need to know about this policy because (complete in 50 words)	Staff need to read this Policy to be informed about the ECT Service and understand the processes from referral to treatment, to review and to discharge.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	ECT is an evidence-based form of treatment for certain psychiatric disorders, whereby 2 electrodes are used to pass a brief electrical current, supplied by a specialist machine, through the brain with the intention of inducing an epileptic type seizure. Current practice requires ECT to be given under a general anaesthetic and using a muscle relaxant drug. Patients receiving ECT Treatment will have the treatment under anaesthetic. ECT is administered on 2 sites based on the anaesthetic assessment and grading. HPFT Kingfisher Court ECT Services is an accredited Service meeting ECTAS Standards. These Standards describe the process of administration of ECT and are consistent with NICE guidance.		
Summary of significant changes from previous version are:	- Removed reference to District General Hospital (DGH) – outdated term and changed to Watford General Hospital (WGH) for the purpose of this policy. Updated to reflect impact of Covid-19 pandemic - NHS England Updated titles of management meeting Updated Supporting references Updated typographical errors eg Appendices		

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PART 1 – Preliminary Issues:

1. ECT Flowchart

Referral made to ECT Team to book ECT:

Owing to COVID19 restrictions, currently only inpatient treatment is available.
Inpatients referrers are provided with the document, which is returned to the ECT service
referral form and patient is formally assessed at ECTSuite for treatment.

Referring team to ensure:

1. appropriate escorts and transport are in place to facilitate safe transfer from ward to ECT Clinic and back.
2. appropriate support for the patient on the ward for 24 hours after ECT.
3. arrangements to monitor and assess the patient between treatments. See Appendix 7

SCREENING:

Non–urgent patients will be screened prior to ECT day by the Anaesthetist

The Psychiatric/ nursing team will screen the documents and the patient to ensure that the complete referral information is present. (Appendix on referral pack)

Anaesthetic assessment / screening using ASA scoring system:

- ASA1 - fit and well
- ASA2 - documented medical condition(s) not affecting everyday lifestyle
- ASA3 - medical condition(s) that do affect lifestyle (e.g. reduced exercise tolerance)
- ASA4 - serious medical condition(s) causes constant threat to life
- ASA5 - moribund (anaesthesia / surgery only contemplated to save life)

ASA1 & ASA2 - Fit for ECT at Kingfisher court

ASA3 may have ECT at Kingfisher court or DGH depending on level risk (only Only WGH inpatients can receive ECT in Theatres during COVID 19 pandemic

ASA4, ASA5, pregnancy ECT (if justified) at WGH Only

(ECT treatment at WGH is only available to WGH inpatients)

Patient booked for ECT

ECT treatment starts

After each treatment inpatient referring team re-assesses and prescribed and for the outpatient the ECT Team re-assesses and re-prescribes

When the decision is made to discontinue treatment the patient is reviewed ater 3-4 days and monthly for 3 months

Emergency Transfer to DGH:

1. Most sudden deteriorations can be managed by the anaesthetist & ODP, which is part of the SLA.
2. Rarely, a patient may require emergency transfer - '999' and a 'blue light' ambulance - to Watford General Hospital, supported by anaesthetist.

PART 1 – Preliminary Issues:

2. Definitions & Abbreviations

2.1 Description of Electroconvulsive Therapy (ECT)

ECT is an evidence-based form of treatment for certain psychiatric disorders, whereby 2 electrodes are used to pass a brief electrical current, supplied by a specialist machine, through the brain with the intention of inducing an epileptic type seizure. Current practice requires ECT to be given under a general anaesthetic and using a muscle relaxant drug.

2.2 ECTAS – The Royal College of Psychiatrists' ECT Accreditation Service

The ECTAS Standards have been developed from all available literature (including NICE guidance and the ECT Handbook) and expert consensus of a high skilled and experienced reference group, which includes both clinical and patient representatives.

These Standards describe the process of administration of ECT and 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.

They are used as the basis for accreditation review by ECTAS and the standards are reviewed every 18 months – 2 years.

The standards cover the following topics:

- The ECT Clinic and Facilities
- Staff and Training
- Assessment and Preparation
- Consent and information giving
- Anaesthetic Practice
- The Administration of ECT
- Recovery, Monitoring and follow-up
- Special Precautions
- Protocols
- Clinics practising nurse-administered ECT

2.3 Abbreviations used in this Policy

ASA	American Society of Anaesthesiologists
CATT	Crisis Assessment & Treatment Team
CGI	Clinical Global Impression scale
ECT	Electroconvulsive Therapy
EPR	Electronic Patient Record
HPFT	Hertfordshire Partnership University NHS Foundation Trust
IPC	Infection, Prevention and Control
KG	Kingsley Green
MADRS	Montgomery-Asberg Depression Rating Scale
MCA	Mental Capacity Act
MHA	Mental Health Act
MMSE	Mini-Mental State Examination
NBM	Nil By Mouth
NICE	National Institute for clinical Excellence
ODP	Operating Department Practitioner
MHLT	Mental Health Liaison Team

SLA	Service Level Agreement
SOAD	Second Opinion Appointed Doctor
WGH	Watford General Hospital
WHHT	West Herts Hospitals NHS Trust
WHO	World Health Organisation
PPE	Personal protective equipment

3. Purpose of the Policy

3.1 This Operational Policy describes the Electroconvulsive Therapy (ECT) service provided by Hertfordshire Partnership University NHS Foundation Trust (The Trust). It offers guidance for staff and others working in the ECT Suite at Kingfisher Court, Kingsley Green on its design and operation, as well as guidance for referrers and others.

3.2 It is intended to provide a safe, ethical and legal framework to govern the approach adopted by the Trust as a whole and its individual staff to all patients being considered for or treated with ECT, and their carers.

3.3 It sets out the core principles and operational procedures relating to the provision of a safe and effective ECT service by the Trust.

3.4 Other Trust Policies which are relevant to the safe and effective provision of ECT are listed in Part 3 of this Policy and should be consulted when further guidance on specific issues is required.

3.5 This Policy refers to service users as 'patients', owing to the prescribed service provision.

3.6 This policy is impacted (including its appendices) by the major incident management of Covid-19. Trust guidance is updated on an ongoing basis in line with government guidance and should be read on the HPFT Hive communication website The Hive

4. Purpose and Aims of the Trust

4.1 The Trust aims to provide an ECT service that complies with the legislation and meets the standards set out above. In particular, the Trust aims to provide a service that meets Level 3 for quality outlined in the ECTAS standards.

4.2 The ECT service also aims to:

- Respect the individual's human rights at all times, including dignity, comfort and privacy;
- Provide a core team of suitably trained and experienced staff to support safe and effective care delivery at each ECT clinic session;
- Provide appropriate training for doctors in training as required by the Royal College of Psychiatrists (as detailed in the core curriculum); and
- Provide appropriate training for qualified Nurses and other health care professionals who may need to access the ECT service for a patient.

5. Responsibilities and Assurance

As a provider of ECT, The Trust has an obligation to provide an effective ECT service with appropriate training to their staff and a suitable infrastructure to establish and continue support for this treatment.

It is the responsibility of the ECT Lead Psychiatrist and ECT Nurse Lead, reporting to the ECT Sub-committee, to ensure implementation of and compliance with the operational Policy within the organisation.The ECTAS standards assure patients, referrers, staff, commissioners and regulators of the quality of the service being provided.

Part 2 – What needs to be done and who by

6. The ECT Service at Kingfisher Court

6.1 The ECT Suite – Rooms and Equipment

The ECT suite at Kingfisher Court was purpose built and incorporates the requirements as set out in the ECTAS s.

It is located on the ground floor in the link corridor in Kingfisher Court and comprises:

- Reception
- Pre-treatment waiting area
- Office/clinical room for anaesthetic assessment and pre-treatment checks Treatment room and Primary recovery area
- Post-recovery waiting area (restricted use owing to COVID19 IPC requirements
- There are also an accessible lavatory (reachable from both the pre-treatment and post-recovery waiting areas), linen store, cleaner's cupboard, dirty utility and, adjacent to the Suite, PPE donning & doffing area and other store rooms.

There is access for emergency services through the service yard at the rear of the suite. This entrance may also be utilised, with prior notice, for patients arriving by ambulance and unable to walk to the suite.

Access into the suite is restricted and controlled by staff electronic passes, although egress to the main corridor is by wall mounted buttons.

In the event of an emergency, for example fire, egress can also be via the storage/plant area at the rear of the suite, controlled by staff electronic passes.

6.2 Treatment Days

The Trustwide ECT service will provide ECT on Kingfisher Court site on Tuesday and Fridays and owing to COVID19 IPC restrictions, ECT can only currently be provided at WGH for patients admitted to WGH wards, this occurs on Monday and Thursdays.

7. Management

The ECT Service is part of the Trust's West Strategic Business Unit.

There is an ECT Management Sub-comittee, which is a sub-committee of the Physical Health Committee.

8. Staffing & Roles

The core ECT Team comprises the following:

- ECT Lead Consultant Psychiatrist
- ECT Lead Nurse
- ECT Nurses
- Consultant Anaesthetist
- Operating Department Practitioner

The ECT Service has a dedicated nursing team employed by the Trust who ensures that it meets quality and safety s of the service, in accordance with national and local

guidelines. This includes working in partnership with all disciplines involved with ECT across the Trust and other external organisations.

The Trust has a Service Specification (SLA) with West Herts Hospitals Trust (WHHT), who provide a named Consultant Anaesthetist Lead for ECT. This Anaesthetist or another Consultant from a small pool of Anaesthetists staff the ECT clinic on treatment days, together with Operating Department Professional/s (ODP)). The Anaesthetist and ODP are present during the patients' treatment and recovery.

9. Patient Age Profile

9.1 ECT in Children & Adolescents

ECT can be prescribed for all age groups, although it is rarely used in children. The use of ECT in children and adolescents is controversial, although it can be used, subject to certain safeguards. In children the indications for, response to and side effects of ECT are similar to those that apply to adults.

The Royal College of Psychiatrists (2012) recommends the following:

- ECT should be used with caution due to the lack of evidence from randomised controlled trials
- ECT as a first line treatment in young people should be very rare
- For a patient under 16, two independent opinions from Child & Adolescent Psychiatrists should be obtained
- Younger people have a lower seizure threshold so are likely to need a lower dose of electricity
- Parent and child should be involved in the consent process. Where it is not possible to obtain consent, ECT should only be given when the patient's life is at risk from suicide or physical debilitation due to depression
- Whether the patient is informal or detained s58A(4) of the MHA applies and a SOAD will need to certify the consent and that ECT is appropriate, using a T5 form
- If a patient is under 18 and lacks capacity to consent, the other requirements that apply to adults also apply
- Younger patients receiving ECT should have separate sessions from sessions for adults

If a patient under 18 was referred for ECT in the Trust, the ECT Team would have a detailed discussion with the referrer, and ensure that the recommendations set out above were followed.

Special provisions apply to the consent procedure for ECT in children, this information can be found in the Consent to Examination, Care and Treatment Policy.

9.2 ECT in Older Patients including cognitive side effects, seizure threshold and choice of anaesthetic agents

Age should not preclude safe and effective treatment with ECT if the usual referral criteria are followed. Research studies report response rates of at least 70% with 92% showing improvement, the overall response increasing with increasing age. Also, some forms of pharmacotherapy in the elderly may be associated with a higher incidence or severity of adverse effects than ECT.

As older people are more likely to have physical health problems, special attention must be paid to their physical health when both weighing up the risks/benefits of ECT and in optimising their physical health prior to and during ECT. If the patient's physical health warrants it, the anaesthetist can recommend that the treatment takes place at WGH however this is not currently available unless the patient is admitted/inpatient at WGH owing to COVID19 Pandemic IPC restrictions. The anaesthetist will also advise about any adjustments that should be made to the patient's medication prior to ECT.

9.3 Protocol for Assessing Laterality

Deciding on laterality of treatment is important to ensure the correct balance between speed of response and memory side effects is achieved for every patient.

For a capacitous patient, if speed of response is the priority over lowering the risk of memory side effects, they should be given bilateral ECT (administered bitemporally). If the converse if true, they should be given unilateral ECT.

If the decision is made to treat unilaterally, the stimulus is administered to the non-dominant cerebral hemisphere. As detailed dominance testing is time-consuming and the majority of the population is left-dominant, unilateral ECT is administered to the right side of the head.

If there is post-treatment confusion or delayed time to reorientation beyond what might be expected for that patient, the ward or ECT team may reassess the patient's cerebral dominance and give a trial of left unilateral treatment if warranted.

10. Access to healthcare for people with a learning disability

HPFT have a responsibility to ensure that all people with a learning disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that:

- Reasonable adjustments are made to ensure that each person has the same opportunity for health, whether they have a learning disability or not. (Equality Act 2010)
- Assume that each person presented to the service has capacity. If assessment shows they don't, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)

Adjustments will include:

- spending time with the individual to gain an understanding of their preferences for treatment
- To ask them where they would prefer to be treated,
- To provide additional support to assist with communication, this support will be available via easy read material. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
- If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support

- All people with a learning disability may have a Health Action Plan or Purple Folder and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
- To value and welcome the contribution of the relative/carer/advocate

11. Clinical Indications for ECT

ECT is clinically indicated for the following:

- Treatment-resistant or severe, life-threatening unipolar or bipolar depression
- Resistant mania
- Catatonia of any origin
- Affective psychoses
- Non-affective psychotic illness (e.g. schizophrenia) where
    - The patient has repeatedly developed neuroleptic malignant syndrome in response to antipsychotics and symptomatic treatment is urgently required
    - The patient has clozapine-resistant schizophrenia (i.e. there are residual symptoms despite confirmed compliance with clozapine and a therapeutic serum level)
- Previous response to ECT
- An appropriate request by the patient for ECT

A number of guidelines and research studies have looked at this issue; they are summarised in the Royal College of Psychiatrists' latest position statement on ECT.

12. Contraindications, Risks and Side Effects of ECT

Psychiatric disorders can be life threatening, so all contraindications to ECT are relative, given the balance of risks and benefits of the various treatment options, including of providing no treatment.

In patients with concomitant physical health problems, the role of the anaesthetist is central. This is discussed further below.

Conditions associated with high anaesthetic risk include:

- myocardial infarction in the previous 3 months
- cerebro-vascular accident in the previous 3 months
- cardiac failure
- valvular heart disease
- aneurysm or other vascular malformation
- unstable cervical spine
- other conditions leading to an ASA rating of 3 or above

Some medical conditions require special provisions or cautions and if these are followed, ECT can be administered safely. These include certain allergies, diabetes, cardiac conditions, epilepsy, pregnancy.

13. Capacity and Consent

If ECT is felt to be the most appropriate treatment, either alone, or in conjunction with other treatments, the referring consultant should assess the patient's capacity to consent to ECT and document this in the EPR. Full details can be found in the Consent

to Examination, Care and Treatment including Electro-compulsive Therapy (ECT) Policy.

Change of Capacity/Consent during a course of ECT

Each time a patient attends for treatment, the ECT nurse will assess their capacity and consent status. If a previously consenting patient has capacity and declines treatment, ECT cannot go ahead on that day and the referring team must be notified of this and the reason. If a previous capacious patient loses the capacity, the referring team must be contacted and a decision needs to made regarding treatment on that day.

A detained patient who was previously having ECT under either s62 or SOAD T6 authorisation might improve over the course of ECT so that they regain capacity to consent. If this occurs, the referring team should update the capacity to consent status and obtain consent. In a patient who has regained capacity to consent to ECT and then refuses, ECT must cease.

14. Referral Process & Documentation

If ECT is being considered for a patient, the referring psychiatric team should contact the ECT team either by email or telephone 01923 633766

The ECT Team will guide the referring team about what assessments and documents are required and agree when the patient should attend for anaesthetic assessment, meet the ECT team and be shown around the ECT suite and, pending completion of all pre-treatment procedures, when the treatment will be able to start. At this point the COVID19 precautions are discussed.

The referring team should complete the ECT referral form which includes the indication for ECT, medical and psychiatric histories, medication, allergies, current physical state, capacity and consent status.

15. Referral Screening

The ECT Team will screen the referral documentation. The ECT Team will consider the appropriateness of the referral and if there are doubts, the ECT Consultant will discuss the patient with the referrer.

16. Assessment Procedures

The referring team will undertake a physical examination of the patient, and appropriate investigations. The referring team will also assess the patient's general functioning and symptoms prior to the course of ECT starting. In complex cases, this may be further informed by discussion with the Anaesthetist at any stage.

16.1 Anaesthetic Assessment

Once the completed referral documentation is received, an anaesthetic assessment is arranged with a Consultant Anaesthetist. If the patient is admitted within the Trust then assessments are performed at Kingfisher court. If the patient is inpatient at Watford General Hospital then the assessment will take place on the ward.

The anaesthetist will review the referral information, interview the patient and/or carer, undertake a physical examination, recommend any further investigations, give specific advice about medication on the treatment day and determine the patient's ASA rating A decision will also be made as to whether the patient can have ECT safely at the Kingfisher Court ECT suite. This is recorded on the anaesthetic assessment sheet. COVID19 swab result is required to be arranged by referring team and result to be available on planned day of treatment in order for treatment to go ahead.

17. ECT for Outpatients / Day Cases including accessibility

ECT for outpatients is suspected at present owing to COVID19 IPC restrictions.

18. ECT for Inpatients including accessibility

Treatment is prescribed by the Inpatient Consultant Psychiatrist and dates for treatment are agreed in advance with the ECT Team.

The ECT Team will advise the ward what time the patient should attend the ECT suite.

Inpatients at Kingfisher Court will be escorted from the ward to the suite by a member of the ward staff. Escorting ward staff will remain with the patient through pre-treatment assessment and until the patient has moved into the treatment room if this is required.

Each patient will be assessed on a case by case basis, which then determines if the escorting ward staff will be required to remain with the patient throughout their treatment or for a part of it or may return to the ward.

Inpatients at other units will be escorted from their ward to the suite by a member of the ward staff. If arriving by ambulance, the ambulance staff will ring for access to the service yard and be guided by staff to the rear of the suite, where ECT staff will allow access. Escorting ward staff will remain with the patient through pre-treatment assessment and until the patient has moved into the treatment room if this is required.

Appropriate PPE is worn by all staff and service users in keeping with latest guidance.(Guide to the latest PPE requirements.)

Following treatment, the patient will be transferred into the primary recovery area where they will remain until fully awake, orientated and able to resume their usual level of mobility. A separate section, below, deals with wheelchair users.

When sufficiently recovered, they will then be escorted to theward. .

19. Procedures on a Treatment Day

19.1 Preparation

On a treatment mornings all environmental and safety checks are carried out by ECT Team. Pre-checks are performed by the host ward nurses commencing from the night before treatment and confirmed by the ECT nurses pre-treatment.

If the patient is usually on cardiovascular or anti-ulcer medication in the morning, this should be taken with a small amount of water, at approximately 6.00am, but no later than 7.30am. Patients who are very agitated may be given an anxiolytic on the morning of treatment. Diabetic medication is usually withheld.

19.2 Team briefing

The ECT Team meet for a briefing for each patient, prior to treatment commenced. This includes discussion on capacity and consent status, medical history, dose and laterality of treatment, and any particular concerns.

19.3 Pre-treatment checks

The ECT nurse will meet the patient and escort them into the pre-treatment clinical room where the nurse undertakes a series of checks. If a student or other observer has requested to observe the procedure, the patient, if deemed to have capacity is asked permission for this.

19.4 Treatment

In line with COVID19 IPC guidance, each service user is treated and the area cleaned prior to next patient being brought forward for treatment. ECT treatment is an Aerosol Generating Procedure (AGP) and staff will follow IPC guidance in line with this – Guide to the latest PPE Requirements

The allocated ECT nurse will ensure that the modified WHO surgical checklist is completed including all present in the treatment room introducing themselves.

Some patients can be agitated, distressed or confused and every effort should be made to reassure them and reduce their distress.

Once the WHO checklist has been completed, items such as hearing aids or spectacles are removed from the patient.

The anaesthetist, with assistance from the ODP, inserts a cannula into the patient's vein, usually on the arm or hand. If the patient is highly distressed, making cannulation difficult, the anaesthetist may administer an anaesthetic gas such as sevoflurane to induce drowsiness and allow cannulation.

Monitoring leads (ECG, pulse oximeter, EEG) and a blood pressure cuff are placed on the patient.

When everything is ready, the anaesthetist or ODP administers oxygen via a face mask. The anaesthetist then injects the induction agent and then the muscle relaxant.

Once the patient is asleep, the team looks for fasciculation to determine if the patient's muscles have been paralysed. Once the team is satisfied that this is the case, the ECT psychiatrist and assistant, whether another doctor on the ECT rota, or the ECT nurse will administer the electricity to the patient. The amount of electricity is determined by the patient's previous response to treatment.
The patient and the EEG tracing are observed for evidence of a seizure and the duration of both the visual seizure and EEG seizure are noted.

The patient can be administered up to three stimuli, at increasing doses, in one treatment session, until a satisfactory seizure is observed. It may be necessary for further oxygen, induction agent or muscle relaxant to be administered to allow this.

During the procedure, the anaesthetist and ODP will monitor the patient's physiological state including level of oxygen saturation, ECG and BP. If these cause concern, the

anaesthetist can intervene as appropriate, even if this means not proceeding with the ECT.

19.5 Documentation of the treatment

The anaesthetist must complete the anaesthetic record including the names and doses of drugs administered, relevant vital signs before and after the treatment and any observations, comments or recommendations for immediate management or on future treatment days.

The psychiatrists must record the patient's consent and legal status, names of the doctors present, names and doses of anaesthetic drugs, dose of electricity, duration of seizure (observed and EEG) and any comments or recommendations. This will be recorded both in the patient's ECT records and in the ECT log.

19.6 Recovery

When the patient is breathing spontaneously, the oxygen from the anaesthetic machine is replaced by oxygen from the cylinder on the trolley, monitoring leads are disconnected and the trolley is wheeled into the recovery room. The nurse will monitor the patient’s airway, breathing and vital signs and remove the cannula.

When the patient is more alert, the nurse will offer them a drink, assess their orientation, and ask about any discomfort or other symptoms they may have.

All monitoring is recorded on MEWS(Modified Early Warning Score) chart, post treatment checklist and orientation forms.
If necessary, the nurse will ask the anaesthetist to review the patient.

19.7 Post recovery

Once the patient is fully alert and able to resume their usual mobility, they are supported off the trolley and transferred into the post-recovery lounge or back to their host ward with escorting nurse..

19.8 Transport

When the patient is fully recovered from the anaesthetic and ECT, a nurse from their ward accompanies them back .

19.9 Supervision of a Patient, driving, signing legal documents after ECT

Patients should not be alone for 24 hours after ECT in case they become confused or otherwise physically unwell.

Patients receiving an acute course of ECT should also not drive at all during the course of ECT. Patients receiving maintenance ECT should not drive for 48 hours after ECT. Patients are also routinely advised not to sign legal documents in the 24 hours after ECT. Patients having ECT should not be in the sole company of children for 24 hours post treatment.

19.10 Pathway for Using Host Families Service for Outpatients

ECT treatment for Outpatients is currently suspended owing to COVID19 IPC restrictions.

20. Monitoring and recording the patient's response to ECT and re-prescribing ECT

It is essential that the patient's clinical response to ECT is assessed so appropriate decisions can be made about ongoing treatment.

After every treatment of an inpatient, the prescribing team should assess the clinical response and overall functioning using the CGI (Cognitive Global Impression) and document cognitive and non-cognitive side effects of ECT. After every two treatments the prescribing Team should complete the Montgomery-Asberg Depression Rating Scale (MADRS) or similar for depressed patients and Cognitive functioning should also be monitored using the Mini Mental State Examination (MMSE) or similar. The results should be compared with the previous results.

Any changes in the plan should be discussed with the ECT Team, including a decision to suspend, stop or change frequency or change laterality of treatment.
Maintenance ECT is currently suspending owing to COVID19 IPC restrictions.

21.1 Guidelines for Continuation & Maintenance ECT

Continuation ECT (cECT) and **Maintenance ECT (mECT)** are currently suspended owing to COVID19 IPC restrictions.

References

NICE (2009) CG90: *Depression: The Treatment and Management of Depression in Adults* (updated April 2016)
Waite J & Easton A (eds) (2012) *The ECT Handbook 3rd Edition*. London: Royal College of Psychiatrists

21. Change of prescriber during a course of ECT

Occasionally, a patient has a change of prescriber during a course of ECT. This might happen because they move between, medical and psychiatric wards or between different psychiatric wards. There is no need for the new prescriber to complete any new documents eg. capacity statement,S62 and T4 form and they must be satisfied that the other existing documents remain accurate and valid.

22. Ending a Course of ECT

A course of ECT may be ended for a variety of reasons including:

- Sufficient response
- Lack of efficacy
- Intolerable side effects / risks outweighing benefits
- The capacious patient withdrawing consent

After a course has ended, regardless of the timing and the reason for ending, the prescribing team should assess the patient 3-4 days after the final and every month for 3 months thereafter following an acute course. They should complete the post-ECT course documentation.

22.1 Discontinuation of ECT

The prescribing and discontinuation of ECT are the decision of the Prescribing Psychiatrist. However, the decision to discontinue ECT may also take place in the context of discussion with the ECT Consultant and/or Anaesthetist in the light of adverse reactions to ECT such as cognitive problems or anaesthetic problems.

Discontinuation may also take place because of poor efficacy or, most importantly, because the patient has withdrawn consent. The clinical status of a patient should always be assessed between each ECT session to ensure that the treatment is producing the desired therapeutic response.

The Royal College of Psychiatrists recommend that a set number of treatments should not be pre-determined. The need for further treatments should be assessed after each individual treatment.

23. Communication Between the Referring/Prescribing Team and ECT Team

The safe provision of ECT requires effective communication between the referring/ prescribing team and the ECT Team and vice versa.

The ECT Team is responsible for screening the completed documents received from the referring team.

Any changes in the patient's health during a course of ECT should be reported to the ECT Team, including any adverse reactions during or after administration of ECT, and any change in transport or escort needs.

The prescribing team is encouraged to contact the ECT Team via email or telephone, as appropriate, over any concerns or queries.

The patients EPR should be updated, including uploading relevant documents, in a timely way.

It may be necessary for the ECT Team to communicate directly with the patient's GP or specialist over physical health concerns and inform the referring team and this usually done by email.

24. Provision of ECT to 'High Risk' Patients

In the majority of cases, ECT is no riskier than minor day-case surgery which involves general anaesthetic, which is regularly practiced at remote sites.

All patients who are considered for ECT are screened by a Consultant Psychiatrist and Consultant Anaesthetist prior to their first ECT. This will allow the identification of any particular risks and will inform the decision about where ECT should take place.

The assessment process uses the American Society of Anesthesiologists (ASA) grading system. The majority of patients considered for ECT are graded ASA 1& 2, which indicates that they are suitable for treatment in the Kingfisher Court ECT suite.

ECT in pregnancy can be associated with additional risks:

- The seizure generated by ECT can trigger premature labour.
- Lying supine can be uncomfortable and cause pressure on maternal abdominal blood vessels, potentially compromising the fetal blood supply and increasing the risk of venous thrombo-embolism.
- The pregnancy can cause or worsen reflux of the stomach contents into the oesophagus, with an associated risk of inhalation.
- The anaesthetic drugs may cross the placenta and affect the fetus.

These risks can be managed in the following way:-

- Risks to the fetus should be considered in the treatment decision, as well as the potential risks of not giving ECT.
- Pregnant women must only have ECT in a hospital with maternity facilities.
- A midwife must check on fetal wellbeing both before and after the ECT is administered.
- The use of thrombo-embolism stockings.
- Ensuring the usual pre-treatment nil by mouth procedure is followed.
- Having the patient only partially recline during the preparation for ECT and the treatment itself.
- The administration of a drug to reduce gastric secretions and prevent reflux.
- Using an endotracheal tube to prevent inhalation of oesophageal contents.
- Being vigilant for signs of reflux and applying suction as necessary.

If a patient seen for pre-treatment assessment, or at a later stage of the on-going assessment process, has a score of ASA3 or above, consideration should be given to the patient receiving their ECT in Main Theatres at WGH. This may include patients with significant medical problems or patients who have had a serious adverse reaction during previous ECT. At present, ECT treatment at WGH is only available to patients who are admitted to WGH wards.

On the morning of ECT, if a patient is considered unfit for the procedure, they will not receive the treatment at Kingfisher Court. The Consultant Psychiatrist and Consultant Anaesthetist will discuss the best way forward, including rescheduling or suspending treatment. This may require a discussion with the prescribing team and the patient and carer will also be involved as far as possible.

24.1 Patients in a medical ward

Occasionally a patient in a medical ward in the general hospital may need ECT. A typical scenario is an elderly patient with several medical problems and depression, where the medical problems exacerbate the depression and vice versa, for example not eating or drinking. The more frail the patient, the more urgent it is to lift their mood, but also the greater the risks associated with ECT.

Sometimes the decision is as stark as “without ECT the patient will die, but with ECT, and in spite of the associated risks, there is some chance the patient will recover”.

Patients with psychiatric disorder in medical wards are usually assessed by the MHLT and one of their consultants will decide whether ECT is appropriate. This will be subject to the usual safeguards including weighing the benefits and risks, capacity, consent and views of the family.

If ECT is to be administered, it will be in the Main Theatres of Watford General Hospital, as agreed with WGH. The patient will return to the medical ward once they have recovered from the procedure, and MHLT will monitor the patient's progress.

If a patient is in a medical ward at a hospital where ECT is not available, efforts should be made to transfer them to WGH which provides ECT.

If the patient's physical state improves sufficiently, it may be possible for them to transfer to a psychiatric ward. In this scenario, if they need further ECT, this can continue at the at Kingfisher Court if the anaesthetist considers it safe.

24.2 Anaphylaxis

Anaphylactic reactions to the agents commonly used in ECT anaesthesia are rare but not unknown. They can also occur in response to other substances after the patient has been sensitised.

Procedures are in place for checking known allergies, including in the referral process, existing prescription chart, pre-treatment assessment, and as part of the modified WHO surgical checklist immediately prior to a treatment.

Severe anaphylaxis is potentially life threatening and the patient may need the administration of oxygen, with or without an endotracheal tube, antihistamines, adrenaline and steroids.

The anaesthetist and ODP will be the practitioners most skilled in managing an anaphylactic reaction that might occur in the ECT Suite. It may be necessary for the patient to be transferred to the general hospital.

If it is decided that the patient needs to continue with ECT, this can only be provided at Kingfisher Court as only inpatients at WGH can receive ECT treatment at WGH.

If it is suspected that one of the anaesthetic agents is responsible for an anaphylactic reaction, this will be documented in the patient record and on their medication chart and the referring team and GP will be informed. Alternative agents will be used in future ECTs. The patient may be referred to an immunologist or similar for further investigation/confirmation of the allergy.

24.3 Malignant hyperthermia/hyperpyrexia

This is a rare, life-threatening condition that can be triggered by certain drugs used in anaesthesia, including Suxamethonium and Sevoflurane but not Propofol, and which is manifest by high temperature, rapid heart rate and rapid respiration.

The ECT Team have access to protocols for the management of malignant hyperthermia and these are displayed on the wall of the treatment room and in the anaesthetic information folder. The treatment is the administration of Dantrolene, which is available in the ECT suite.

In the event of a patient developing this condition, the decision about any future ECT will need to take this into account. Future treatment would need to take place at WGH and different anaesthetic drugs would be used. However this is not currently an option unless the patient is admitted to a WGH ward owing to the COVID10 pandemic.

25. Urgent/Emergency Transfer from Kingfisher Court

If a patient receiving ECT will has an adverse reaction to the treatment or their physical health deteriorates suddenly and severely, it may be necessary to transfer the patient to WGH site and the Consultant Anaesthetist will need to accompany the patient in the ambulance.

Any situations warranting an ECT patient being transferred to WGH is likely to justify calling '999' and a 'blue light' ambulance. The alarm pagers must also be activated to alert the 'response team' for assistance (please see Stanley Security Systems Operational Policy/Kingfisher Court Policy).

A member of the ECT nursing team will inform Kingfisher Court reception that an ambulance is on its way and to ensure it is directed straight to the suite via the rear entrance of the ECT suite.

26. Records Management, Confidentiality and Access to Records

Paris is the electronic patient record (EPR) used by HPFT. Staff are required to record all contacts with the patient on Paris. If difficulty arises, such as there is no access to a computer, a written note can be made in the paper light record and subsequently added to the EPR.

Requests for access to records whether by the patient or a third party, including where legal access is requested, should be handled in keeping with the Trust's policy.

27. Medicines Management

The handling of all medicines and related items are subject to the Trust's relevant policies.

Medical gas stocks are controlled by the Pharmacy Department and stored, along with the empty bottles, within the service yard. The stock of gases are managed by the nursing team, and cylinders are changed as required.

All medicines, including medical gases for use in the suite are securely stored within the Treatment Room and Primary Recovery Area.

There are two fully equipped emergency crash trolleys in the suite which are checked by the nursing team on treatment days and replenished by the Pharmacy Department and the ECT nurses..

28. Health & Safety

Every employee and those persons working on behalf of the Trust has a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. They must also cooperate with the Trust so far as it is necessary to enable management to carry out its legal duties

relating to health and safety matters for example follow instructions and training, use equipment provided for their protection, and report defects, damage or health and safety concerns.

HPFT staff have a duty to remedy and/or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor. Please see the Trust Policy for further details.

29. Safekeeping of Property

During ECT at Kingfisher Court and Watford General Hospital

- Patients for ECT are advised to keep jewellery and other valuables to a minimum which supports safekeeping and IPC precautions.
- If the patient attends ECT from a ward, the escorting nurse or HCA keep the property safe until the patient has completed their treatment.
- Various items of property are kept safely at the various stages of treatment (see table below).

TYPE OF PROPERTY	METHOD OF SAFEKEEPING
Valuables including jewellery (except wedding band and ear/nose studs)	If accompanied by a friend/carer, they should keep items safe, otherwise kept safe by staff and returned once patient has recovered. Ideally safekeeping of property should be done at pre-ECT assessment and documented, otherwise removed in treatment room.
Limb prostheses, dentures, hearing aids, spectacles, etc.	Will be removed immediately prior to treatment in the treatment room and returned in the primary recovery area.
Coats, scarves, gloves, handbags, umbrella, mobile phone, keys, accessories, etc.	Will be kept in the patient lockers located at the ECT reception. These items of property will be recorded in the property record and stored in the patient lockers and the key for the locker will be kept in a drawer at the ECT reception.
Mobility aids such as wheelchair, Zimmer frame, walking sticks etc.	Will be kept in the post-recovery lounge and returned to the patient in the primary recovery area.
Other clothing e.g. cardigan, socks, shoes	Will remain with the patient, until they are escorted into the treatment room. These items will then be, put at the bottom of the patient trolley and returned in the primary recovery area.
Finger rings or ear/nose studs	Will be taped in the treatment room before treatment and tape removed after treatment.

30. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care and support of patients, carers and staff.

RESPECT means ensuring that the particular needs of ‘protected groups’ are upheld at all times and individually assessed on entry to the service. This includes the needs

of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where patients can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for patients, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where patients and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Patient, carer and/or staff access needs (including disability)	The ECT Service is compliant with statutory requirements as set out in Equality Act 2010. The suite is on the ground floor with full accessibility for wheelchair users, including toilet facilities. Provision of disabled parking bays and reasonable adjustments in place for patients and staff working within Kingfisher Court. The treatment provided by ECT services meet the patient's needs taking into consideration: ◦ Age ◦ Culture & Ethnicity ◦ Spirituality
Involvement	The ECT service will involve all patients and carers in the planning and delivery of their care and treatment. The ECT Steering group includes a patient representative.
Relationships & Sexual Orientation	No adjustments are required in the ECT Service to meet the needs of these various groups
Culture & Ethnicity	The patient's culture and ethnicity will be carefully considered in terms of the referral process and planning of care and treatment with regards to the identified needs e.g. ◦ Language ◦ Diet ◦ Personal care ◦ Preliminary physical investigations - Sickle cell test for African, Caribbean, Middle Eastern, Mediterranean or Asian ethnic origin
Spirituality	The ECT service encompasses the 'model of HOPE' H – Sources of Hope O – Needs re: organised religion P – Personal belief structure (including non-faith) E – Effects on care of practicing spiritual beliefs (positive and negative)
Age	The service is primarily targeted at adults over 18. In extraordinary circumstances, and paying careful attention to the specific legal requirements that apply to younger people, ECT may be provided to people under 18.

	The needs of older people will be determined and addressed with reference to their needs and not according to their age.
Gender & Gender Reassignment	No adjustments are required in the ECT Service to meet the needs of this group.
Advancing equality of opportunity	The ECT Steering group includes a patient representative. The ECT service will reflect on information from patient and carer feedback, within the unit team and practice governance meetings to inform the continuous improvement of services.

31. Communication and accessibility of information

Patient information leaflets are available and the information patients are given should meet the individual's communication needs especially where there are specific language and sensory communication requirements. Patient information sheets are available in several languages. The HPFT guidance on Communicating with Patients from Diverse Communities provides further information and the procedure for use of the interpreting service.

An easy read information sheet about ECT is available for people with a learning disability.

Where there are specific cultural/religious practices which affect the provision of treatment, the patient should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

32. Process for monitoring compliance with this document

Key process for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed
Review of compliance with ECTAS Standards	Review Policy against ECTAS Standards	ECT Medical Lead and Nurse Lead	During Self review every 18 months	ECT Management Sub-Committee	ECT Management Sub-Committee - Physical Health Committee

33. Induction, Staff Support, Training, Supervision, Refreshing & Appraisal

It is essential that all staff involved in ECT are familiar with the suite, procedures and relevant Trust Policies. This Policy must be read by all ECT staff.

Staff of all disciplines receive an induction appropriate to their role, as well as training, supervision and appraisal.

All staff are expected to adhere to the Trust's Dress Code Policy. Nursing staff are required to wear the Trust's uniforms whilst on duty and to comply with latest guidance and follow the guide on PPE requirements – (Guide to the latest PPE requirements., Uniform, workwear and dress code – essential guidelines)

34. Comments, Complaints and Compliments

All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure.

The Policy requires all oral or written complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager at Trust Head Office. Comments and Compliments, once responded to, should be sent for information to the Complaints Team at Trust Head Office. Leaflets outlining the procedure are available in the suite.

Part 3 – Document Control & Standards Information

35. Version Control

Version control for the Procedural Document Management System

Version	Date of Issue	Author	Status	Comment
V1	**17th June 2014**	**Clinical Services Manager**	**Superseded**	**Guidance as part of the Kingfisher Court Policy**
V2	**September 2016**	**Consultant Psychiatrist / Medical Lead for ECT**	**Superseded**	**Current Policy**
V3	**November 2018**	**ECT Lead Nurse**	**Superseded**	**Policy updated to meet ECTAS Standards 2018**
V4	**18TH March 2019**	**ECT Lead Nurse**	**Superseded**	**Full review**
V4.1	**04th September 2020**	**ECT management team**	**Current**	- Removed reference to District General Hospital (DGH) – outdated term and changed to Watford General Hospital (WGH) for the purpose of this policy. Updated to reflect impact of Covid-19 pandemic - NHS England Updated titles of management meeting Updated Supporting references Updated typographical errors eg Appendices

36. Relevant Standards

ECT Accreditation Service (ECTAS)
Standards for the administration of ECT

These standards describe the process of administration of ECT and 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.

Relevant standards might be external and those upon which the procedural document is based or guided by.

37. Associated Documents

Care Records Management
Clinical Information Filing
Consent
Corporate Records Management Policy
Dress Code
Fire
Formal Access to Patient Records
Health & Safety
Host Families
Incident Reporting
Infection Control
Kingfisher Court Operational
Medical Electronics
Medicines Management
Moving & Handling
Observation
Oxygen
Physical health
Protection and Use of Patient Information
Resuscitation and DNR
Sharps Safety
Stanley Security Systems Operational
Transport
Venepuncture
VTE
Written and Electronic Communications

Other documents

Freedom of Information Act
Mental Capacity Act & Code of Practice
Mental Health Act & Code of Practice

38. Supporting References

38. Supporting References

Department of Health and Social Care: Reference Guide to Consent for Examination or Treatment (2nd Ed.), 2009

ECT Accreditation Service (ECTAS): Standards for the administration of ECT (15th Ed.), 2020

Mental Capacity Act 2005

Mental Health Act 1983 (amended 2007)

National Institute for Health and Care Excellence: Clinical Guideline (CG90): Depression in Adults, 2009

National Institute for Health and Care Excellence: Clinical Guideline (CG185): Bipolar Disorder, 2014 (updated 2020)

National Institute for Health and Care Excellence: Technology Appraisal (TA59): Electroconvulsive therapy, 2003 (updated 2009)

Royal College of Anaesthetists: Guidelines for the Provision of Anaesthesia Services in the Non-theatre Environment (Chapter 7, Guidelines for the Provision of Anaesthetic Services), 2020

Royal College of Psychiatrists: ECT Handbook (4th Ed.), 2019

39. Consultation

In the case of the Procedural Document Management System, the following have been consulted so far.

Job Title of person consulted:
ECT Lead Nurse
Practice Governance

Part 4 Appendices

List of Appendices including forms and checklists

Appendix 1

Hertfordshire Partnership NHS
University NHS Foundation Trust

ECT REFERRAL

PATIENT DETAILS:

Name: _____ Known as: _____

DOB: _____ NHS no.: _____

Address: _____

Contact details (landline/mobile/email): _____ Marital status: _____

Ethnicity: _____ Religion: _____

CURRENT LOCATION / TEAM:

Outpatient / ADTU / inpatient (specify ward): _____

Current consultant: _____

If inpatient, leave allowed: _____ Care level: Standard / CPA

Care Coordinator: _____ Community team base: _____

PAST PSYCHIATRIC HISTORY: *(Diagnoses, treatments. If previous ECT, please give year, location, response, adverse reactions)*

CURRENT PSYCHIATRIC SYMPTOMS AND MENTAL STATE
(Include mental act status i.e. section 2,3 and expiry date)

CURRENT PHYSICAL HEALTH: (including **recent** physical examination findings and date)

Does the patient have:	**Yes**	**No**	**Comments**
Shortness of breath			
Asthma or bronchitis			
High blood pressure			
Heart attack or other heart trouble			
Chest pain on exercise or at night			
Hiatus hernia or frequent heartburn			
Diabetes			
Fits (epilepsy)			
Kidney or urinary trouble			
Jaundice or liver disease			
Anaemia or other blood disease			
Arthritis			
Muscle disease			
Cochlear implant			
Pacemaker			
Cigarettes			Consumption per day:
Alcohol			Units per week:
Illicit drugs			Details:
Pregnant			Unknown: (do pregnancy test)

PAST MEDICAL HISTORY: (Attach GP summary)

IS THE PATIENT LEFT OR RIGHT HANDED: (*Please circle)*

Left / Right / Unknown

PHYSICAL INVESTIGATIONS

	N/A	Date performed	Results		N/A	Date performed	Results
FBC				Lithium			
Sickle cell				Hep B & C			
U & Es				INR			
LFTs				ECG			
Calcium				CXR			
TFTs				Pregnancy			
Random glucose							

PHYSICAL EXAMINATION FINDINGS:

CVS:

Respiratory:

Abdomen:

CNS:

Other:

CURRENT MEDICATION: *(Please list regular, prn, over the counter, herbal etc*)

ALLERGIES / SENSITIVITIES: (medication, latex etc. - not foods - and type of reaction)

Patient able to give reliable account of history, allergies & physical symptoms to anaesthetist?

YES ☐ NO ☐ UNCERTAIN ☐ CARER ABLE TO GIVE FULL ACCOUNT ☐

MOVING & HANDLING REQUIREMENTS: *(Fully ambulant, stick/s, Zimmer, wheelchair, trolley, limb prostheses, other including physically resistant)*

COMMUNICATION / SENSORY IMPAIRMENT:

Language spoken: _____ Hearing problems: _____

Visual impairment: _____ Other: _____

TRANSPORT & ESCORT REQUIREMENTS: (for outpatient or patient coming from other units)

N.B. Referring team responsible to arrangements – liaise with ECT Team for guidance

Private car / taxi / hospital transport / ambulance / other (specify) _____

Escort name/designation: _____

Escort contact details: _____

***Outpatients only**:
Adult who will supervise patient for 24 hours after ECT (if different from escort)

Supervisor name/designation: _____

Supervisor contact details: _____

DIETARY REQUIREMENTS:

Allergies / sensitivities: _____

Preferences: _____

Intake: good / poor / nil

DENTAL RISK QUESTIONS	Y	N	COMMENTS
Has the patient had any previous head, neck or jaw surgery or suffer from any jaw joint problems, such as arthritis? If YES, obtain full details metal plates, if present, may reduce impedance and influence electrode placement			
Is the patient edentulous?			

If the patient has any dentures, are there any 'retention pins' present in the jaws?			
Does the patient have any teeth that are loose, painful to bite on, or is afraid to bite on (for any reason)?			
Does the patient ONLY have anterior teeth (canines and incisors)?			
Does the patient have any crowns, bridges or implants on the premolars and molars?			
Are there gaps, to suggest extractions? Are there more than 4 gaps present?			
Are there any crowns, bridges or implants on the anterior teeth (canines or incisors)?			
Are there any ornamental studs present in the lips or tongue? If YES, can they be removed before treatment?			
VTE RISK QUESTIONS	**Y**	**N**	**NA**
Active cancer or cancer treatment			
Age >60			
Dehydration			
Significantly reduced mobility for >3 days			
Obesity (BMI >30)			
Known thrombophilia			
One or more significant medical problems			
Personal history or 1st degree relative with history of VTE			
On HRT			
On oestrogen containing contraception			
Varicose veins with phlebitis			
Pregnant or within 6 weeks post-partum			
Other risks			

<u>INDICATION FOR ECT</u>:

- Depression, meets NICE criteria (excludes maintenance ECT)
- Catatonia, meets NICE criteria
- Prolonged mania, meets NICE criteria
- Other (specify)

_____

N.B. If indication does not meet NICE criteria, referrer MUST discuss with ECT Consultant

RISK-BENEFIT BALANCE:
(Reasons why ECT is the most appropriate current treatment and, if patient is depressed, why treatment-resistant depression protocol is not applicable)

RISKS/ CONCERNS RELEVANT TO ATTENDING FOR ECT NOT ALREADY MENTIONED:
(e.g. aggression, absconding, etc.)

GOAL OF ECT:

- To improve appetite and sleep pattern
- To reduce anxiety or agitation
- To improve mood, level of concentration and motivation
- ……..
- ……..
- ……..
- ……..

ADDITIONAL INFORMATION:

COMPLETED BY:	SIGNATURE:
DESIGNATION:	DATE:

ECT PRESCRIPTION (CONSULTANT OR SAS DOCTOR ONLY):

Bilateral / Unilateral

Twice weekly / weekly / 10 days / fortnightly / other (specify) _____

Proposed number (subject to weekly review): _____

Other details: _____

- **Prescribing team MUST review after each treatment & send the Review & Re-prescription Form to the ECT Team**

PRESCRIBER'S NAME:	PRESCRIBER'S SIGNATURE:
DESIGNATION:	DATE:

PLAN:

- The patient will be welcomed into the ECT waiting area and supported throughout the assessment, treatment and recovery.
- ECT nurse will ensure any belongings will be kept safely.
- ECT nurse will perform pre-ECT check and assess for any change in the patient's physical/ mental/social wellbeing and will report any concerns to Anaesthetist/ Psychiatrist.
- ECT nurse will assess the patient's orientation and memory.
- The patient will have blood sugar level and temperature checked in recovery room.

Notes

Please contact the ECT department if you have any queries or concerns.

Please note: the ECT team may recommend some medication should ideally be witheld or discontinued prior to treatment. If the patient is on morning medication, the referring team will also be advised whether it should be witheld, taken early e.g. at 0600 hrs with sips of water, taken after the patient has recovered from ECT etc. Patients with diabetes also need their medication regime modifying as they will be starved on a treatment day.

A patient coming from the community must be advised by the referring team that for the first 24 hours after ECT they must

- be escorted home and be supervised by a responsible adult (so also not to be in sole charge of a young child)
- not sign any legal documents
- not drink alcohol
- not operate machinery, including kitchen appliances
- not drive a motor vehicle or ride a bicycle on the road (DVLA). The Royal College of Psychiatrists advise that a patient should not drive for the entirety of an acute ECT course.

If there is no adult who can supervise a community patient for the first 24 hours after ECT, consideration shoulf be given to delaying the treatment (if clinically possible), admitting the patient to hospital overnight, or having them stay with a host family for 24 hours. The referring team is responsible for making those arrangements, but the ECT Team will also liaise to ensure things go smoothly.

During a course of ECT the prescribing team remains clinically responsible and must feedback to the ECT Team and re-prescribe the ECT at least once a week (after each treatment in maintenance ECT).

After a course of ECT has ended, there are strict requirements on follow-up assessments at 3-4 days, 1-2 months, 3 months and 6 months which must also be fed back to the ECT Team.

Contact details for the ECT Team

ECT Suite Kingfisher Court Kingsley Green Harper Lane Radlett WD7 9FB	Tel. 01923 633 766 Email hpft.ect.kfc@nhs.net	You can also see the Trust ECT policy and download forms on the Intranet

Appendix 2

Hertfordshire Partnership NHS
University NHS Foundation Trust

ECT DAY PATIENT REFERRAL FORM

NAME	
DOB	
NHS NUMBER	
MALE/FEMALE	
ADDRESS	
TELEPHONE NUMBERS	
DIAGNOSIS	
ICD-10 CODE	
OUTPATIENT BASE	
CONSULTANT	
CURRENT MEDICATION	

RECENT BLOOD TESTS (IF APPLICABLE): done on……..at……
(date) ***(location)***

ECT DETAILS
CAPACITY TO CONSENT TO ECT: Yes/No *(delete as applicable)*
TARGET SYMPTOMS:

Signed…… Name……..……

Position…… Date……...……
Please return this form to the ECT Department (e-mail hpft.ect.kfc@nhs.net).

Appendix 3

Montgomery and Asberg Depression Rating Scale (MADRS)

The scale may be used for any time interval between ratings, be it weekly or otherwise but this must be recorded. The rating should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. The rater must decide whether the rating lies on the defined scale steps (0, 2, 4, 6) or between them (1,3,5). It is important to remember that it is only on rare occasions that a depressed patient is encountered who cannot be rated on the items in the scale. If definite answers cannot be elicited from the patient all relevant clues as well as information from other sources should be used as a basis for the rating in line with customary clinical practice. **DATE**	Name: DOB: NHS no.:					
1. Apparent Sadness - Representing despondency, gloom and despair, (more than just ordinary transient low spirits) reflected in speech, facial expression, and posture. *Rate by depth and inability to brighten up.* 0 No sadness. 1 2 Looks dispirited but does brighten up without difficulty. 3 4 Appears sad and unhappy most of the time. 5 6 Looks miserable all the time. Extremely despondent.						
2. Reported Sadness - Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or the feeling of being beyond help and without hope. *Rate according to intensity, duration and the extent to which the mood is reported to be influenced by events.* 0 Occasional sadness in keeping with the circumstances. 1 2 Sad or low but brightens up without difficulty. 3 4 Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances. 5 6 Continuous or unvarying sadness, misery or despondency.						
3. Inner Tension - Representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread or anguish. *Rate according to intensity, frequency, duration and the extent of reassurance called for.* 0 Placid. Only fleeting inner tension. 1 2 Occasional feelings of edginess and ill-defined discomfort. 3 4 Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty. 5 6 Unrelenting dread or anguish. Overwhelming panic.						
4. Reduced Sleep - Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well. 0 Sleeps as usual. 1 2 Slight difficulty dropping off to sleep or slightly reduced, light or fitful sleep. 3 4 Sleep reduced or broken by at least two hours. 5 6 Less than two or three hours sleep.						
5. Reduced appetite - Representing the feeling of a loss of appetite compared with when well. *Rate by loss of desire for food or the need to force oneself to eat.*						

0 1 2 3 4 5 6	Normal or increased appetite. Slightly reduced appetite. No appetite. Food is tasteless. Needs persuasion to eat at all.						

	DATE						
6.	**Concentration Difficulties -** Representing difficulties in collecting one's thoughts mounting to incapacitating lack of concentration. *Rate according to intensity, frequency, and degree of incapacity produced.* 0 No difficulties in concentrating. 1 2 Occasional difficulties in collecting one's thoughts. 3 4 Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation. 5 6 Unable to read or converse without great difficulty.						
7.	**Lassitude -** Representing a difficulty getting started or slowness initiating and performing everyday activities. 0 Hardly any difficulty in getting started. No sluggishness. 1 2 Difficulties in starting activities. 3 4 Difficulties in starting simple routine activities which are carried out with effort. 5 6 Complete lassitude. Unable to do anything without help.						
8.	**Inability to feel -** Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced. 0 Normal interest in the surroundings and in other people. 1 2 Reduced ability to enjoy usual interests. 3 4 Loss of interest in the surroundings. Loss of feelings or friends and acquaintances. 5 6 The experience of being emotionally paralysed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.						
9.	**Pessimistic thoughts -** Representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin. 0 No pessimistic thoughts. 1 2 Fluctuating ideas of failure, self-reproach or self-depreciation. 3 4 Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future. 5 6 Delusions of ruin, remorse or unredeemable sin. Self-accusations which are absurd and unshakable.						

10. Suicidal thoughts - Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and preparations for suicide. Suicidal attempts should not in themselves influence the rating. 0 Enjoys life or takes it as it comes. 1 2 Weary of life. Only fleeting suicidal thoughts. 3 4 Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention. 5 6 Explicit plans for suicide when there is an opportunity. Active preparation for suicide.						
SCORE						

*
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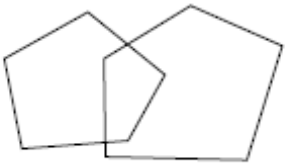
Marie Asberg, M.D. Karolinska Institute, Stockholm, Sweden **** Correspondence.*** *(Received 24 April; revised 30 August 1978)*

SMART!

MINI MENTAL STATE EXAMINATION (MMSE)

Patient's name:

Hospital number:

	DATE			
ONE POINT FOR EACH ANSWER				
ORIENTATION				
Year Month Day Date Time	____/5	____/5	____/5	____/5
Country Town District Hospital Ward	____/5	____/5	____/5	____/5
REGISTRATION				
Examiner names 3 objects (eg apple, table, penny) Patient asked to repeat (1 point for each correct). THEN patient to learn the 3 names repeating until correct.	____/3	____/3	____/3	____/3
ATTENTION AND CALCULATION				
Subtract 7 from 100, then repeat from result. Continue 5 times: 100 93 86 79 65 Alternative: spell "WORLD" backwards - dlrow.	____/5	____/5	____/5	____/5
RECALL				
Ask for names of 3 objects learned earlier.	____/3	____/3	____/3	____/3
LANGUAGE				
Name a pencil and watch.	____/2	____/2	____/2	____/2
Repeat "No ifs, ands, or buts".	____/1	____/1	____/1	____/1
Give a 3 stage command. Score 1 for each stage. Eg. "Place index finger of right hand on your nose and then on your left ear".	____/3	____/3	____/3	____/3
Ask patient to read and obey a written command on a piece of paper stating "Close your eyes".	____/1	____/1	____/1	____/1
Ask the patient to write a sentence. Score if it is sensible and has a subject and a verb.	____/1	____/1	____/1	____/1
COPYING				
Ask the patient to copy a pair of intersecting pentagons: 	____/1	____/1	____/1	____/1
TOTAL	____/30	____/30	____/30	____/30

Appendix 5

Clinical Global Impression Scale

Improved response format for the Clinical Global Impression severity scale in depression.

Normal, not at all ill
The patient has no symptoms to suggest depression

Borderline mentally ill
The patient complains of periodic tiredness, unhappiness or loss of optimism, but this does not affect his/her relationships or job.
Working life and family life are a little less pleasant for the patient. He/she describes moments of sadness and internal tension.

Mildly ill
The patient is tired, has difficulty taking initiatives or making an effort. Labile mood. At times, deterioration of professional performance.
The patient is tense and irritable. He/she has difficulty concentrating on daily tasks, although he/she mostly gets them done.

Moderately ill
The patient is sad and talks about waves of anxiety. His/her nights are restless. His/her professional life is taking the toll despite efforts to face up to it.
The patient has to fight against moments of despair. He/she is exhausted. His/her relationships are affected.

Markedly ill
The patient is listless, says he/she cries easily. He/she is eating irregularly, the face is thin. He/she complains of an impoverished emotional life, he/she can see no future.

The patient is no longer able to struggle against his/her sad mood. He/she describes a permanent state of internal tension. Everything is difficult to bear.
Severely ill
The patient is without reaction, permanently overwhelmed with his/her sad and painful mood. He/she is not eating.
The patient's face and utterance are devoid of affects. He/she has no plans, and says he/she is waiting to die.

Among the most extremely ill patients
The patient is cachectic, utterances are incoherent and centred on morbid themes. Distress is extreme.
The patient is prostrate, eyes averted. The face expresses painful tension. The interview is virtually impossible because of a refusal to communicate. The few utterances are delirious.

Kadouri et al. BMC Psychiatry 2007 7:7

Appendix 6

Hertfordshire Partnership NHS
University NHS Foundation Trust

STATEMENT OF CAPACITY AND CONSENT TO ECT
(MODIFIED FOR ECT FROM TRUST STANDARD FORM)

Patients Name: ……..Date of Birth: ……..

Unit/Ward: …….. Date of Admission: …….

Clinician: Dr …….

I have assessed the above named patient and am satisfied that, at this time, he/she has the capacity/does not have the capacity* to consent to treatment (Code of Practice 23.37).

I have explained to him/her the nature of the proposed treatment plan, likely effects and possible risks of that treatment, including the likelihood of its success and any alternatives to it. (Code of Practice 15.15).

- Information has been given in a language/way that he/she can understand
- He/she is able to retain this information
- Has used this information as part of their decision making process
- Has communicated their decision to me.

Signature:…….. Date:……

**delete the phrase which does not apply*

Patient:

Dr. ……has explained my proposed treatment plan and has given me all the information stated above.

I have consented to that treatment plan at this time.

I understand that I have the right to withdraw my consent at any time.

Signature:…… Date:……

Appendix 7

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 1	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
mMSE or other cognitive scale: (total score and relevant detail)	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 2	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR <u>ACUTE TREATMENT</u>

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 3	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 4	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 5	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 6	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
mMSE or other cognitive scale: (total score and relevant detail)	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR <u>ACUTE TREATMENT</u>

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 7	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR <u>ACUTE TREATMENT</u>

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 8	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 9	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR <u>ACUTE TREATMENT</u>

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 10	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR <u>ACUTE TREATMENT</u>

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 11	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…….…… Stop* *Other comments:*	
Consultant:	Signature:

ECT TREATMENT REVIEW AND PRESCRIPTION FORM FOR ACUTE TREATMENT

NAME: DOB: NHS No.

REVIEW AFTER TREATMENT NUMBER 12	
DATE ASSESSED:	
Clinical Global Impression-Improvement scale (CGI-I) (circle as appropriate) 0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally Improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	
MADRS score: (Depressed patients only, for other conditions use appropriate scale)	
Mental State Examination:	
Complaints of cognitive side effects:	
Objective evidence of cognitive side effects:	
mMSE or other cognitive scale: (total score and relevant detail)	
Complaints about physical side effects:	
Other change in physical health (include recent investigation results with dates):	
Other comments or changes: (e.g. MHA status, consent, capacity, medication, etc.)	
Name of assessor:	Signature:
PLAN REGARDING FURTHER ECT: *Twice weekly Weekly Other (specify)…… Stop* *Other comments:*	
Consultant:	Signature:

Appendix 8

Covid 19 Guidance Links

Link	Title	Link
1	**HPFT Hive – Covid-19**	**The Hive**
2	**NHS England**	NHS England
3	**Public Health England (PHE) latest guidance and information Coronavirus (Covid-19)**	**Public Health England (PHE) Latest guidance and information on Coronavirus (Covid 19)**
4	**Stay at Home Guidance**	**Stay at Home Guidance**
5	**Guide to the latest PPE Requirements**	**Guide to the latest PPE Requirements**
6	**Donning and doffing PPE**	**https://hertfordshirenhs.interactgo.com/Interact/Pages/Content/Document.aspx?id=6087**
7	Management of a suspected case of Covid 19 flow chart	**Management of a suspected case of Covid-19 flow chart**
8	Masks, comms and Posters	**Masks, Comms and Posters**


Our Values
Welcoming Kind Positive Respectful Professional