

Mental Health Commission

Code of Practice

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients

Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001.

VISION

Working Together for Quality Mental
Health Services

Preamble

Section 33(3)(e) of the Mental Health Act 2001 (the “2001 Act”) obliges the Mental Health Commission to: *“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”*.

Section 59(2) of the 2001 Act obliges the Mental Health Commission to make rules providing for the use of electro-convulsive (ECT) therapy on patients. These rules came into force on 1st November 2006 and have recently been updated following an independent review. This review was carried out between September and December 2008 and involved an extensive stakeholder consultation. A patient under the 2001 Act is construed in Section 14 and refers to a person to whom an admission (or renewal) order relates. The rules therefore apply to the use of ECT on a person involuntarily admitted to an approved centre only.

As a consequence, in accordance with section 33(3) of the 2001 Act, the Commission published a *Code of Practice Governing the Use of Electro-Convulsive Therapy for Voluntary Patients* in approved centres in 2008. An approved centre is a centre that is registered pursuant to the 2001 Act.

The Code has now also been updated following the review of the rules as the Code in many respects, mirrors the provisions set out under the Section 59(2) rules. The main amendments to the Code are indicated in the *Memorandum on Key Revisions Contained in the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, Version 2*. A copy of the Memorandum is available on our website at www.mhcirl.ie.

The preamble to Version 1 of the Code of Practice indicated that the Commission would consider including a provision relating to having an anaesthetic assistant present during ECT treatment and recovery. Following on from a recommendation of the review, this provision has not been included.

The date of commencement of this Code is 1st January 2010. Therefore, the Inspector of Mental Health Services will begin assessing compliance with the revised Code from this date.

In line with its commitment to keep existing rules and Codes of Practice under review, the Commission intends to review this Code no later than five years from its date of commencement.

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients

This Code of Practice has been prepared by the Mental Health Commission, in accordance with Section 33(3)(e) of the Mental Health Act 2001, for the guidance of persons working in the mental health services.

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Glossary

Approved Centre

A “centre” means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the 2001 Act. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the 2001 Act.

ASA Grade

Assessment of fitness for anaesthesia.

Cerebral

Pertaining to the cerebrum of the brain.

Child

A person under the age of 18 years other than a person who is or has been married.

Clinical file

A record of the voluntary patient’s referral, assessment, care and treatment while in receipt of mental health services. This documentation should be stored in the one file. If all relevant information is not stored in the one file, the file should record where the other information is held.

Cognitive impairment

Impairment of mental abilities, skills or knowledge, involving receptive functions (abilities to select, acquire, classify and integrate information), memory and learning (information storage and retrieval), thinking (mental organization and reorganisation of information) and expressive functions.

Consent

Consent refers to an individual’s agreement or not to a certain specified action or actions e.g. treatment, care, transfer of personal information. Consent is comprised of three key elements:

- It must be given or withheld voluntarily;
- It must be given or withheld by someone with capacity to do so, in terms of age and mental competence; and
- It must be based on sufficient relevant information.

Consultant psychiatrist

A consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.

ECG

A recording of the electrical activity of the heart.

EEG

A method of monitoring electrical (or seizure) activity of the brain using high sensitive recording equipment attached to the scalp by fine electrodes.

End tidal carbon dioxide

The amount of carbon dioxide at the end of exhalation.

Foetal gestation

The period commencing the end of month two post-fertilisation to week thirty-eight.

Intellectual disability

A condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities, as measured by currently recognised criteria.

Muscle relaxant

An agent used to ameliorate the convulsive muscle activity during stimulation and the subsequent seizure, and to reduce the risk of injury.

Neonatal

Pertaining to the first four weeks after birth.

Obstetrician

A physician specialist expert in the delivery of total obstetrical care and the diagnosis and treatment of gynaecological disease whose name is entered on the Register of Medical Specialists maintained by the Medical Council.

Patient

A person to whom an admission or renewal order relates. The term patient is to be construed in accordance with Section 14 of the 2001 Act. Section 14(1)(a) states, *inter alia*, that “*a person to whom an admission order relates is referred to in this Act as a patient*”.

Representative

A person of the voluntary patient’s choosing or a legal professional or Guardian ad Litem appointed by the voluntary patient, statutory organisation or court to represent the best interests of the voluntary patient.

Scavenging equipment

Equipment used to reduce the effects of anaesthetic gases in the environment in which ECT is being administered.

Stimulus dosing

The selection of the electrical dose for the individual voluntary patient.

The 2001 Act

Refers to the Mental Health Act 2001.

Trimester

A period of three months; one-third of the length of a pregnancy.

Voluntary patient

A person receiving care and treatment in an Approved Centre who is not the subject of an admission order or a renewal order.

Urea

A substance that is formed in the liver when the body breaks down protein.

Part 1: Introduction

1. Purpose of the Code

- 1.1** Section 33(3)(e) of the 2001 Act requires the Commission to: *“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”*.
- 1.2** The 2001 Act does not impose a legal duty on persons working in mental health services to comply with Codes of Practice, but best practice requires that they be followed to ensure the 2001 Act is implemented consistently by persons working in mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.
- 1.3** As required by Section 33(3)(e) of the 2001 Act, the Commission shall review Codes of Practice periodically, after consultation with appropriate bodies. This Code shall be reviewed no later than five years from the date of commencement.

2. Scope of the Code

- 2.1** The scope of the Code is prescribed for in the 2001 Act by the provisions of Section 33(3)(e). The Code is intended as guidance for persons working in approved centres, and in particular for staff involved in the delivery of electro-convulsive therapy to voluntary patients in approved centres. The Code is intended to be complementary to the 2001 Act, which should always be referred to for its precise terms.
- 2.2** The Code does not purport to be all encompassing. Its intention is to provide practical guidance on the delivery of electro-convulsive therapy (ECT) to voluntary patients on such areas as consent, information provision, administration of ECT and staffing, to facilitate mental health professionals to work together effectively.

3. Definition of Electro-Convulsive Therapy

- 3.1** Electro-convulsive therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

- 3.2** A programme of ECT refers to no more than 12 treatments, prescribed by a consultant psychiatrist, following a psychiatric examination of the voluntary patient.

Part 2: Consent and Information

4. Consent

- 4.1** ECT should only be administered to a voluntary patient following his/her consent.
- 4.2** A voluntary patient should be considered capable of giving informed consent for ECT, including anaesthesia, unless there is evidence to the contrary.
- 4.3** The consultant psychiatrist responsible for the care and treatment of the voluntary patient should be satisfied that the voluntary patient has capacity to provide consent before he or she obtains consent for a programme of ECT, including anaesthesia, from the voluntary patient.
- 4.4** Capacity to consent should ensure that the voluntary patient can:
- a) Understand the nature of ECT;
 - b) Understand why ECT is being proposed;
 - c) Understand the benefits, risks and alternatives to receiving ECT;
 - d) Understand and believe the broad consequences of not receiving ECT;
 - e) Retain the information long enough to make a decision to receive or not receive ECT;
 - f) Make a free choice to receive or refuse ECT; and
 - g) Communicate the decision to consent to ECT.
- 4.5** A written record of assessments of capacity to consent to ECT should be kept in the voluntary patient's clinical file.
- 4.6** Consent should be voluntary. Therefore, a voluntary patient should be aware that he/she can refuse to give consent or withdraw consent for ECT at any time.
- 4.7** No relative, carer or guardian should give consent for ECT on behalf of the voluntary patient.

- 4.8** Consent should not be obtained through coercion or threats.
- 4.9** Consent for each programme of ECT, including anaesthesia, should be obtained in written form. Consent should also be obtained in writing for each ECT treatment session, including anaesthesia. It should be obtained by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care of the voluntary patient prior to each ECT treatment session. It should be recorded in the voluntary patient's clinical file.
- 4.10** The consent form for ECT should include, as a minimum, all the particulars included in the accompanying "*Consent Form for ECT Programme*" associated with this Code.
- 4.11** Specific consent for maintenance/continuation ECT should be obtained and renewed after 6 months.

5. Information

- 5.1** Appropriate information about ECT should be given to the voluntary patient by the consultant psychiatrist responsible for the care and treatment of the voluntary patient to enable him/her to give informed consent. Information should include the following:
- a) The nature of the treatment of ECT;
 - b) Description of process of ECT;
 - c) Purpose of treatment with ECT;
 - d) Intended benefits of treatment with ECT;
 - e) Possible consequences of not having ECT;
 - f) Treatment alternatives to ECT; and
 - g) Confirmation that the voluntary patient will be offered alternative treatment to ECT if he/she decides to withhold consent.

- 5.2** Information should also be provided on the likely adverse effects of ECT, including the risk of cognitive impairment and the risk of amnesia and other potential side effects.
- 5.3** Information should be provided in both oral and written forms.
- 5.4** Information should be clearly and simply written.
- 5.5** Information should be available in languages other than English if necessary and/or an interpreter provided including Irish sign language interpreters for any voluntary patient who is deaf.
- 5.6** Subject to the urgency of the clinical circumstances, the voluntary patient should be given at least 24 hours to reflect on the information, should he or she wish.
- 5.7** The voluntary patient should be informed that he/she may have access to an advocate of his/her choosing at any stage.
- 5.8** The voluntary patient should be given an opportunity to raise questions and these questions should be answered. A record of these discussions should be maintained in the voluntary patient's clinical file.



Part 3: Administration of ECT

6. Prescription of ECT

- 6.1** A programme of ECT should only be prescribed by the consultant psychiatrist responsible for the care and the treatment of the voluntary patient.
- 6.2** The consultant psychiatrist responsible for the care and the treatment of the voluntary patient should record the decision to prescribe ECT in the voluntary patient's clinical file. The record should include:
- a) The reason for the decision to use ECT;
 - b) Alternative therapies that have been considered or proved ineffective;
 - c) Documentation of the discussion with the voluntary patient, and, where appropriate, the voluntary patient's next of kin or representative; and
 - d) Current mental state examination.
- 6.3** The initial stimulus dose of electricity to be delivered to each voluntary patient should be discussed and considered by the treating consultant psychiatrist and the consultant psychiatrist responsible for the administration of ECT in advance of ECT and prescribed accordingly.

7. Assessment of Voluntary Patient

- 7.1** A cognitive assessment should be completed for the voluntary patient before each programme of ECT.
- 7.2** The voluntary patient's clinical status should be assessed before and following each ECT treatment session.
- 7.3** The voluntary patient's cognitive functioning should be monitored on an ongoing basis throughout the programme of ECT.
- 7.4** A cognitive assessment should be completed for the voluntary patient after each programme of ECT.

7.5 The consultant psychiatrist in consultation with the voluntary patient should review the voluntary patient's progress and the need for continuation of the programme of ECT. In the event of a programme of ECT being terminated, reasons for this termination should be documented in the voluntary patient's clinical file.

8. Anaesthesia

8.1 Anaesthesia for ECT should be given by an anaesthetist who has experience in providing anaesthesia for ECT. Where the anaesthetist is not a consultant anaesthetist, he or she should be under the supervision of a consultant anaesthetist.

8.2 Formal identification of the voluntary patient should be confirmed to the anaesthetist.

8.3 The anaesthetist should ensure that a pre-anaesthetic assessment has been carried out and recorded in the voluntary patient's clinical file. The assessment should include the following:

- a) A detailed medical history and a full physical examination should be performed before ECT and recorded.
- b) Any physical problem should be recorded and the anaesthetist notified.
- c) A detailed medication history, including allergies or previous anaesthetic difficulties, should be taken and recorded.
- d) The presence or absence of dental problems and/or dentures should be noted.
- e) The length of time the voluntary patient has been fasting should be recorded.
- f) Investigations such as full blood count, urea and electrolytes, urine testing for blood glucose and protein should be performed. Voluntary patients at risk for sickle-cell anaemia should have blood tests for this condition.
- g) An ECG for voluntary patients with cardiovascular disease or who have risk factors for cardiovascular disease should be performed.

h) A chest X-Ray is required if the voluntary patient has cardio-respiratory problems.

i) Any other relevant information.

8.4 The anaesthetic risk of the voluntary patient should be assessed by the anaesthetist and recorded in the voluntary patient's clinical file. Any variation in the ASA grade of the voluntary patient should be recorded before the ECT treatment session.

8.5 The designated ECT nurse should be responsible for checking that the pre-anaesthetic assessment is completed and made available to the anaesthetist.

8.6 The voluntary patient's consent form, clinical file, medication prescription chart and record of administered drugs should be made available to the anaesthetist.

8.7 The anaesthetic induction agent used for the voluntary patient should remain consistent throughout the duration of his/her programme of ECT unless such an approach is contraindicated.

8.8 The doses of all anaesthetic agents used, the voluntary patient's response and the monitor recordings before and immediately after treatment and recovery should be recorded, dated and the record signed by the anaesthetist.

9. Administration of ECT

9.1 ECT should be administered by a constant current, brief pulse ECT machine capable of delivering a wide range of electrical dose, from 25 millicoulombs to 1000 millicoulombs or more.

9.2 ECT should be administered to a voluntary patient using the same ECT machine throughout his/her programme of ECT, unless in exceptional circumstances. Where the same machine is not used, the rationale for this should be clearly documented in the voluntary patient's clinical file.

9.3 There should be a facility for EEG monitoring on two channels.

- 9.4** All machines should have a regular programme of maintenance and service. Records of maintenance should be kept safe by the approved centre and confirmation of the service should be identifiable from the machine, as is appropriate.
- 9.5** Stimulus dosing or using recommended starting dose regimes (per age/sex) as per the Royal College of Psychiatrists' Guidelines should be used and recorded in the ECT record.

10. ECT Suite

- 10.1** ECT should only be carried out in a dedicated ECT suite in an approved centre or where deemed appropriate, in a specified location in a critical care area in a general hospital or maternity hospital.
- 10.2** An ECT suite should have a private waiting area, an adequately equipped treatment room and an adequately equipped recovery room.
- 10.3** High risk voluntary patients should be treated in an environment allowing rapid intervention should complications occur, for example, a theatre suite or its recovery area.
- 10.4** The recovery room should be of sufficient size to accommodate the number of people receiving ECT at each treatment session.

11. Materials and Equipment

- 11.1** Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia should be prominently displayed.
- 11.2** If nitrous oxide is ever used, then the treatment room should be equipped with scavenging equipment.
- 11.3** There should be one tipping trolley or bed, with cot sides, per voluntary patient which can comfortably accommodate a reclining adult, with braked wheels and which can rapidly be tipped into a head down position.

- 11.4** There should be a fully equipped emergency trolley with adequate resuscitation equipment including a defibrillator.
- 11.5** There should be means of measuring temperature, blood pressure, oxygen saturation, ECG and end-tidal carbon dioxide.
- 11.6** Provision should be made for positive pressure respiration: oxygen cylinder, mask and self-inflating bag and at least one full spare cylinder in both the treatment and recovery areas.
- 11.7** There should be two suction machines, one in the treatment room and one in the recovery room.
- 11.8** The following drugs should be available in the ECT suite:
- a) An anaesthetic induction agent;
 - b) A neuro-muscular blocking agent; and
 - c) Oxygen.
- 11.9** There should be a standard tray of drugs for use in the event of cardiac arrest. The emergency tray should contain drugs and equipment agreed with the local pharmacy or resuscitation committee.
- 11.10** Dantrolene and sterile water should be available. These should be stored under the direction of the anaesthetist and there should be a protocol in the ECT suite for where they are stored.

12. Staffing

- 12.1** There should be a named consultant psychiatrist with overall responsibility for the management of ECT.
- 12.2** ECT should only be administered by a registered medical practitioner. Where the

registered medical practitioner is not a consultant psychiatrist, he or she should be under the supervision of a consultant psychiatrist.

- 12.3** There should be a named consultant anaesthetist with overall responsibility for anaesthesia.
- 12.4** An anaesthetic should only be administered by an anaesthetist. Where the anaesthetist is not a consultant anaesthetist, he or she should be under the supervision of a consultant anaesthetist.
- 12.5** The anaesthetist has responsibility for anaesthesia and recovery of the voluntary patient. He or she should be satisfied that the voluntary patient is fully recovered prior to leaving the ECT suite.
- 12.6** There should be a minimum number of two registered nursing staff in the ECT suite at all times to safely meet the needs of voluntary patients, one of whom should be trained in ECT and should be known as “a designated ECT nurse”.
- 12.7** All registered nurses involved in the administration of ECT treatment should be trained in Professional Cardio-Pulmonary Resuscitation.
- 12.8** The designated ECT nurse is responsible for ensuring that before each ECT treatment session, emergency resuscitation equipment is tested and checked in the ECT suite, and the emergency drugs tray has been recently checked and stocked. All such checks should be recorded.
- 12.9** The designated ECT nurse should be in the treatment room while ECT is being administered.

13. Documentation

- 13.1** The ECT Register should be completed for the voluntary patient on conclusion of a programme of ECT and a copy filed in the voluntary patient’s clinical file. A copy of the form should be made accessible to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

- 13.2** Pre-ECT assessments (capacity to consent, consent, pre-anaesthetic assessment, anaesthetic risk, mental state) should be completed and filed in the voluntary patient's clinical file.
- 13.3** A record of ECT should be completed after each ECT treatment session and filed in the voluntary patient's clinical file. The record should include:
- a) Session number;
 - b) Laterality;
 - c) Dose (set and received);
 - d) Duration and quality of seizure;
 - e) Any/all complications experienced; and
 - f) Signature of registered medical practitioner(s) administering ECT.
- 13.4** A record of anaesthesia should be completed after each ECT session and filed in the voluntary patient's clinical file.
- 13.5** Post-ECT assessments (clinical status, voluntary patient progress) should be recorded after each ECT treatment session in the voluntary patient's clinical file. Reasons for continuing or discontinuing further ECT should be outlined. Any adverse events during or following ECT should be addressed in full and recorded.
- 13.6** A copy of all cognitive assessments that are completed should be filed in the voluntary patient's clinical file.

14. ECT During Pregnancy

- 14.1** All pregnant voluntary patients should be assessed by an obstetrician prior to receiving ECT.

- 14.2** Facilities administering ECT to pregnant voluntary patients should have resources for managing obstetric and neonatal emergencies.

- 14.3** If foetal gestation age is past first trimester, foetal monitoring is required.

Appendices

Appendix 1 Consent Form for ECT Programme

Appendix 2 ECT Register

Appendix 1: Consent Form for ECT Programme

To be completed by the Voluntary Patient, the Consultant Psychiatrist responsible for the care and treatment of the voluntary patient and the Anaesthetist responsible for administering anaesthetic for ECT.

Please use BLOCK CAPITALS

1 – 11 TO BE COMPLETED BY THE VOLUNTARY PATIENT

1. TITLE:	2. FIRST NAME:	3. SURNAME:
4. DOB: □ □ / □ □ / □ □ □ □	5. HOSPITAL:	
<p>6. I agree to undergo a programme of ECT treatment and I have discussed the following with my consultant psychiatrist <input type="checkbox"/></p> <p>(a) The nature of ECT treatment and description of the process of ECT treatment and why it has been proposed (including anaesthesia and muscle relaxation)</p> <p>(b) The risks, benefit and side effects of treatment</p> <p>(c) The availability of other treatments and the risk and benefits of those treatments</p> <p>(d) I have had an opportunity to ask questions about the treatment and these have been answered</p>		
<p>7. I confirm that</p> <p>(a) I have read the ECT INFORMATION SHEET and understand the risks involved in having ECT treatment <input type="checkbox"/></p> <p>(b) I have been offered at least 24 hours, subject to the urgency of the clinical circumstances, to make a decision regarding treatment and to discuss treatment with family and/or a representative should I so wish <input type="checkbox"/></p>		
<p>8. I understand that I may withdraw my consent at any time during the treatment duration <input type="checkbox"/></p>		
<p>9. I understand that the maximum number of treatments in this programme of ECT will be 12 and that my consent will be obtained for each treatment <input type="checkbox"/></p>		
<p>10. I have discussed whether the treatment will be unilateral or bilateral with my consultant psychiatrist and the treatment will be:</p> <p style="text-align: right;">Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/></p>		
11(a). VOLUNTARY PATIENT'S SIGNATURE:	11(b). DATE: □ □ / □ □ / □ □ □ □	

12 – 14 TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST RESPONSIBLE FOR CARE AND TREATMENT OF THE VOLUNTARY PATIENT:

<p>12. I have examined this voluntary patient and established that he/she is competent to give consent for ECT <input type="checkbox"/></p>	
<p>13 CONSULTANT PSYCHIATRIST NAME (please print):</p>	
<p>14(a). CONSULTANT PSYCHIATRIST SIGNATURE:</p>	<p>14(b). DATE: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

15 – 17 CONSENT TO ANAESTHESIA FOR ECT – TO BE COMPLETED BY THE VOLUNTARY PATIENT

<p>15. I have read the fact sheet for ECT anaesthesia and understand the procedure, relevant risks and complications. I have discussed these with the anaesthetist. <input type="checkbox"/></p>	
<p>16. I hereby consent to having general anaesthesia for ECT <input type="checkbox"/></p>	
<p>17(a). VOLUNARY PATIENT’S SIGNATURE:</p>	<p>17(b). DATE: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

18 – 20 ASSESSMENT OF FITNESS FOR ANAESTHESIA FOR ECT – TO BE COMPLETED BY THE ANAESTHETIST RESPONSIBLE FOR ADMINISTERING ANAESTHETIC FOR ECT

<p>18. I have reviewed the medical history, relevant investigations and physical condition of this voluntary patient and I consider that he/she is fit for general anaesthesia for ECT. I have explained the relevant risks and complications for general anaesthesia and the particular risks for ECT anaesthesia. This information has also been presented to the voluntary patient in the form of a fact sheet.</p>	
<p>19. ANAESTHETIST NAME (please print):</p>	
<p>20(a). ANAESTHETIST SIGNATURE:</p>	<p>20(b). DATE: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Appendix 2: ECT Register

To be completed by the consultant psychiatrist responsible for the care and treatment of the resident.

Please use BLOCK CAPITALS

1. TITLE:	2. RESIDENT'S FIRST NAME:	3. SURNAME:
4. DOB: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	5. GENDER: M <input type="checkbox"/> F <input type="checkbox"/>	
6. LEGAL STATUS: Involuntary <input type="checkbox"/> Ward of Court <input type="checkbox"/> Voluntary <input type="checkbox"/>		
7. Was this patient (please select response a or b) a) A patient of this Approved Centre who was administered ECT in this Approved Centre? Or b) A patient of another Approved Centre who was referred here for ECT treatment? (if yes please specify name of other Approved Centre)		
8. Did the patient's legal status change during the programme of ECT? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please give details:		
9. HSE AREA:	10. APPROVED CENTRE:	
11. PRIMARY DIAGNOSIS (ICD 10):		
12. INDICATIONS FOR ECT:		
Rapid Response Required	<input type="checkbox"/>	
Acute Suicidality	<input type="checkbox"/>	
Physical Deterioration	<input type="checkbox"/>	
Refractory to Medication	<input type="checkbox"/>	
Maintenance ECT	<input type="checkbox"/>	
Other (please specify)	<input type="checkbox"/> _____	
13. DATE OF FIRST TREATMENT:	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
14. OTHER DATES OF TREATMENT:	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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15. TOTAL NO. OF TREATMENTS ADMINISTERED:	<input type="checkbox"/> <input type="checkbox"/>	

16. NO. OF TREATMENTS ADMINISTERED WITH CONSENT:	<input type="checkbox"/> <input type="checkbox"/>
17. NO. OF TREATMENTS ADMINISTERED WITHOUT CONSENT:	<input type="checkbox"/> <input type="checkbox"/>
18. TREATMENT TYPE:	Unilateral <input type="checkbox"/> Bi-lateral <input type="checkbox"/>
19. STIMULUS DOSING:	Yes <input type="checkbox"/> No <input type="checkbox"/>
20. REASON FOR TERMINATION OF TREATMENT:	
Improvement	<input type="checkbox"/>
No Improvement	<input type="checkbox"/>
Resident Withdrew Consent	<input type="checkbox"/>
Complications (please specify)	<input type="checkbox"/> _____
Other (please specify)	<input type="checkbox"/> _____
21. OUTCOME AT TERMINATION OF ECT	
Complete Recovery	<input type="checkbox"/>
Significant Improvement	<input type="checkbox"/>
Moderate Improvement	<input type="checkbox"/>
Some Improvement	<input type="checkbox"/>
No Change	<input type="checkbox"/>
Deterioration	<input type="checkbox"/>

SIGNATURE:

22. CONSULTANT NAME (please print):	
23(a). CONSULTANT SIGNATURE:	23(b). DATE: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



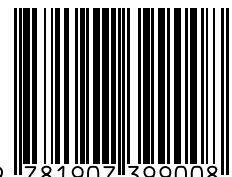


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