Mental Health Commission

Code of Practice

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

Mental Health Commission
Coimisiún Meabhair-Shláinte

St. Martin's House,
Waterloo Road, Dublin 4

Telephone: **01 636 2400** Fax: **01 636 2440**
Email: **info@mhcirl.ie** Web: **www.mhcirl.ie**

ISBN 978-1-907399-21-3

COP – S33(3)/01/2016
Version 3

Version 3
February 2016

Preamble[1]

Section 33(3)(e) of the Mental Health Act 2001 (the "2001 Act"), as amended by the Mental Health (Amendment) Act 2015 (the "2015 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 (as amended) obliges the Mental Health Commission to make rules providing for the use of electro-convulsive therapy (ECT) on a patient. A patient under the 2001 Act (as amended) 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 on 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 (as amended).

The Code, in many respects, mirrors the provisions set out under the Section 59(2) Rules and was updated in 2010 following an independent review of the Rules and Code.

The Rules have now been revised to take into account the 2015 Act. The Code has been updated accordingly. The date of commencement of the Code is 15th February 2016.

[1]The preamble provides an explanation and context to the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients. It is not part of the Code.

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 (as amended), for the guidance of persons working in the mental health services.

Table of Contents

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 (as amended). The Mental Health Commission establishes and maintains the register of approved centres pursuant to the 2001 Act (as amended).

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

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 organisation and reorganisation of information) and expressive functions.

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.

Designated ECT nurse

The named ECT nurse who has overall responsibility for nursing care for voluntary patients receiving ECT.

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.

Muscle relaxant

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

Patient

A person to whom an involuntary admission or renewal order relates. The term patient is to be construed in accordance with Section 14 of the 2001 Act (as amended).

Policy

Written statement that clearly indicates the position of the organisation on a given subject.

Stimulus dosing

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

The 2001 Act

Refers to the Mental Health Act 2001, which includes all legislative amendments, from 2001 to date.

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.

Part 1: Introduction

1. Purpose of the Code

1.1 Section 33(3)(e) of the 2001 Act (as amended) 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 (as amended) 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 (as amended) 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.

2. Scope of the Code

2.1 The scope of the Code is prescribed for in the 2001 Act (as amended) 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 (ECT) to voluntary patients in approved centres. The Code is intended to be complementary to the 2001 Act (as amended), 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 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 (ECT)

3.1 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: Information and Consent

4. Information

4.1 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 the voluntary patient to make a decision on 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.

4.2 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.

4.3 Information should be provided both orally and in writing, or in any other form that is in clear and simple language that the voluntary patient can understand.

4.4 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.

4.5 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.

4.6 The voluntary patient should be informed that he/she may have access to an advocate of his/her choosing at any stage.

4.7 The voluntary patient should be given an opportunity to raise questions at any time before, during or after a programme of ECT and these questions should be answered. A record of these discussions should be maintained in the voluntary patient's clinical file.

5. Consent

5.1 ECT should only be administered to a voluntary patient following his/her consent.

5.2 A voluntary patient should be considered capable of giving informed consent for ECT, including anaesthesia, unless there is evidence to the contrary.

5.3 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.

5.4 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.

5.5 A written record of assessments of capacity to consent to ECT should be kept in the voluntary patient's clinical file.

5.6 Consent for each programme of ECT, including anaesthesia, should be obtained in written form. The form should contain, but is not limited to, the following:

a) Confirmation that all the points at 4.1 have been discussed with the voluntary patient;

b) Confirmation that the voluntary patient has been provided with all relevant information; and

c) Confirmation that the voluntary patient understands that they may withdraw their consent at any time during the treatment session.

5.7 Consent should also be obtained in writing for each ECT treatment session, including anaesthesia.

5.8 All consent should be obtained by the consultant psychiatrist responsible for the care of the voluntary patient, or by a registered medical practitioner under the supervision of the responsible consultant psychiatrist, prior to each ECT treatment session. It should be recorded in the voluntary patient's clinical file.

5.9 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.

5.10 No relative, carer or guardian should give consent for ECT on behalf of the voluntary patient.

5.11 Consent should not be obtained through coercion or threats.

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;

d) Current mental state examination; and

e) The assessments referred to at 7.1 to 7.5 of this Code of Practice.

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 patent'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, in line with best international practice, 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) Relevant haematology and biochemistry investigations that are needed before the start of an ECT programme;

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; and

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 anaesthetic risk 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 and dated. The record should be signed by the anaesthetist and filed on the voluntary patient's clinical file.

8.9 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.

9. Administration of ECT

9.1 The voluntary patient's clinical file and the forms that are required by this Code of Practice should be made available to all involved in the administration of ECT.

9.2 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.

9.3 ECT should be administered by a constant current, brief pulse ECT machine capable of delivering a wide range of electrical dose, in line with best international practice.

9.4 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.

9.5 Stimulus dosing or using recommended starting dose regimes (per age/sex) in line with best international practice, 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, in line with best international practice.

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.

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

10.6 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.

10.7 All materials and equipment in the ECT suite, including emergency drugs, should be in line with best international practice.

10.8 Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia should be prominently displayed.

11. Staffing

11.1 There should be a named consultant psychiatrist with overall responsibility for the management of ECT.

11.2 There should be a named consultant anaesthetist with overall responsibility for anaesthesia.

11.3 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 designated as having overall responsibility for nursing care for voluntary patients receiving ECT.

11.4 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.

11.5 The designated ECT nurse should be in the treatment room while ECT is being administered.

11.6 All staff involved in ECT should be trained commensurate with their role, in line with best international practice.

11.7 All staff involved in ECT should have appropriate training and education in basic life support techniques.

12. Documentation

12.1 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.

12.2 The Register should be made accessible to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

12.3 Pre-ECT assessments (capacity to consent, pre-anaesthetic assessment, anaesthetic risk, mental state) should be completed and filed in the voluntary patient's clinical file.

12.4 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 (prescribed and administered);

d) Duration and quality of seizure;

e) Any/all complications experienced; and

f) Signature of registered medical practitioner(s) administering ECT.

12.5 A record of anaesthesia should be completed after each ECT session and filed in the voluntary patient's clinical file.

12.6 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.

12.7 A copy of all cognitive assessments that are completed should be filed in the voluntary patient's clinical file.

13. Clinical Governance

13.1 An approved centre where ECT is administered to voluntary patients should have written operational policies and procedures concerning ECT and should ensure that such procedures comply with this Code of Practice.

13.2 Written operational policies and procedures concerning ECT should be reviewed annually, in line with best international practice.

13.3 Specific protocols should be developed in line with best international practice including, but not limited to:

a) How and where the initial and subsequent doses of Dantrolene are stored;

b) The management of cardiac arrest;

c) The management of anaphylaxis;

d) The management of malignant hyperthermia; and

e) Obtaining consent for maintenance/continuation ECT.

Resources

- ECT Accreditation Service (ECTAS), Royal College of Psychiatrists, UK
- ECT Handbook, Royal College of Psychiatrists, UK
- National Institute for Health and Care Excellence (NICE), UK