Electroconvulsive Therapy: compliance with national guidelines and practice standards

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Introduction

In 1996, an audit of the standards of practice of Electroconvulsive Therapy (ECT) in Bedfordshire & Luton Community NHS Trust (BLCT) was conducted. The catchment area of BLCT is approximately 570,000 people. Whilst subsequent audits were carried out, these were not documented or recorded.

Following a review of the National Institute of Clinical Excellence (NICE) Health Technology Appraisal (NICE 2003), an audit of ECT was identified as a priority in the corporate plan for the year April 2004 - March 2005. This audit was planned as the first part of a programme of regular audits. The criteria for the audit would be based on the national audit tool (NICE 2003). Other relevant protocols and guidance documents were also considered in developing the audit criteria (BLCT Policy GC17, RCP 1994, ECTAS 2004).

Aims & Objectives

Aims and objectives were agreed for the audit, as follows:

Aim:
To evaluate whether ECT procedures and record keeping in BLCT are in accordance with NICE Guidance on ECT.

Objectives:
To assess the compliance of current ECT procedures and record keeping arrangements for patients who received ECT between January 2004 and June 2004 with the NICE Guidelines.
To identify any training needs that are required to meet national ECT standards.

Methodology

The Consultant Psychiatrists responsible for ECT in the north and south of the county approved the audit tool as based on the NICE Technology Appraisal (NICE 2003): this incorporated 11 quality standards. The ECT Services Manager and the nurse in charge assisted with data collection.
All patients receiving ECT from January 2004 to June 2004 from the working age mental health and mental health for older peoples services were included in the audit.

As ECT services are provided at two centres over the county, for practical purposes these centres were considered as two units.

A consent form approved by the Department of Health (reference guide to consent for examination or treatment: HSC 2001/023) was used during data collection for Unit 1.

Summary of Audit Results

A total of 35 service-users were receiving ECT and were included in this audit (21 for Unit 1 & 14 for Unit 2). Of these, documentation for 5% in Unit 1 and 29% in Unit 2 could not be retrieved for audit purposes.

The ratio of males to females was 11:24 and the mean age of service-user was 65 years old. One service-user died during the period, although this was not due to the treatment.

A summary of the audit results for both units is shown in Table 1. As shown, 90% of Unit 1 service-users and 64% of Unit 2 service-users were suffering with a severe depressive illness. 81% in Unit 1 and 57% in Unit 2 had received treatment with a view to gaining rapid and short term improvement. The risks and potential benefits were documented for 95% of Unit 1 service-users and for 29% of Unit 2 service-users. 95% of service-users in Unit 1 and 60% of service-users in Unit 2 had given consent for each session of the treatment. There was good compliance with the standards on involving the service-user’s advocate and carer and for providing information for Unit 1 service-users, although this was generally poor for Unit 2 service-users. Only one service-user had their condition assessed after each ECT session and none had their cognitive functioning formally monitored. Treatment was stopped in the majority of cases when a response had been achieved and a repeat course of ECT was only offered in a small number of cases, and only if the first two standards were met or the service-user had previously shown a good response to treatment. Only 4/35 service-users were receiving maintenance treatment and none were diagnosed with schizophrenia.

Psychiatric and vocational General Practice trainees are involved in the provision of services under the supervision of a Consultant Psychiatrist in charge for ECT. The ECT treatment unit in Luton is the responsible training unit for the trainees in this area and regular Induction programmes are conducted for them. Anaesthetist services are provided by qualified Specialist Registrar Anaesthetists from the local general hospital.

ECTAS recommendations of designated, trained nursing staff members are implemented (ECTAS 2004).

The equipment used for administering ECT is the latest model MECTAS SR2 which has the advantage of simultaneous recording of electro-encephalogram (EEG) during treatment. The Royal College of Psychiatrists recommended protocol for dose titration is followed in both units and a seizure period of 15 seconds duration is considered to be of therapeutic value (MacEwan 2002).

Both units are well-equipped with the latest anaesthetic monitoring and emergency resuscitatory equipment. The units have the recommended patient waiting room, treatment room, recovery room, and post recovery rooms.
### Table 1: audit of ECT records

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criterion</th>
<th>% Compliance Rates</th>
<th>Unit 1</th>
<th>Unit 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Indication for ECT is for one of the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Severe depressive illness</td>
<td>90.5%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Catatonia</td>
<td>5%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Prolonged / severe mania</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ECT is used to achieve rapid and short term improvement</td>
<td></td>
<td>81%</td>
<td>57%</td>
</tr>
<tr>
<td>3</td>
<td>The risks and potential benefits of ECT have been documented</td>
<td></td>
<td>95%</td>
<td>29%</td>
</tr>
<tr>
<td>4</td>
<td>The individual provides consent for each course of ECT</td>
<td></td>
<td>95%</td>
<td>64%</td>
</tr>
<tr>
<td>5</td>
<td>The clinician responsible for treatment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ involves the person’s advocate / carer</td>
<td>95%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ provides full information in a suitable format and language</td>
<td>95%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ explains / discusses the general risks and potential benefits</td>
<td>95%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ does not pressure or coerce</td>
<td>95%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ reminds that s/he has the right to withdraw consent</td>
<td>95%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>The patient’s clinical status is assessed after each ECT session</td>
<td></td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>7</td>
<td>The patient’s cognitive functioning is monitored</td>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>8</td>
<td>ECT stopped if one of the following occurs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ response is achieved</td>
<td>90.5%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ evidence of adverse effect</td>
<td>5%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ withdraws consent</td>
<td>0%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Repeat course of ECT is only given if:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ criteria 1 &amp; 2 are met / previous good response to ECT</td>
<td>14%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ not responded previously but no other effective treatment options</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>ECT used as maintenance therapy</td>
<td></td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>11</td>
<td>ECT used in management of schizophrenia</td>
<td></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Lack of documentary evidence</td>
<td></td>
<td>5%</td>
<td>29%</td>
</tr>
</tbody>
</table>
Conclusions

Three key conclusions can be drawn from this audit:
1. The documentation of ECT prescription, and the involvement of individuals and carers within decision making needs to be improved.
2. Formal monitoring of the service-user's clinical status and cognitive functioning after each ECT session needs to be implemented.
3. There is a need to ensure that the training needs of staff members and junior doctors are met.

Recommendations

☐ The prescription of ECT will include the NICE Guidance criteria and in situations otherwise, the reasons for the prescription of ECT should be documented. In a nation-wide audit of the prescription habits of psychiatrists, the following observations have been made: 'Changing clinicians prescribing practice of ECT is difficult' (Nandhra et al 2004). In the light of such peer review, the practice of ECT prescription in BLCT will be monitored rigorously.

☐ 'In the UK, only one-third of clinics are rated as meeting College standards. Twenty years of activity by the Royal College of Psychiatrists and three large-scale (nation-wide) audits have been associated with only modest improvement in local practice' (Duffett et al 1998). This peer review highlights that practice standards need to be audited regularly and thus a re-audit should be completed after 6 months (August 2005) in order to check if the recommendations have been implemented.

☐ The ECT documents should be placed in a separate folder for easy maintenance and reference. This can be facilitated via the provision of colour-coded documents. The current documents need to be reviewed as they are not up-to-date. A set of new recording forms has now been prepared by the authors.

☐ The service-user's clinical status and cognitive functioning need to be monitored after each ECT session and a provision for the same has been made in the proposed new recording forms.

☐ Trust policy regarding the prescription of maintenance ECT needs to be developed.

☐ Inadequacies in informed consent have been highlighted in a nationwide study (Rose et al 2005) - this needs to be considered for further study in the light of the findings.

Ethical Obligations

'All doctors have an ethical obligation to keep up to date throughout their careers, and this includes a requirement to be aware of the latest guidelines. Guidelines are just that - they provide guidance. They do not and should not imply that doctors must suspend their clinical judgement in order to follow the letter that has been written down. Because no two clinical situations are exactly the same, it is important for doctors to maintain their freedom to decide on the most appropriate treatment strategy for their patient.' (Colbrook 2005).

References

Appraisal No. 59.
Royal College of Psychiatrists (1994) Electroconvulsive Therapy: the official video teaching pack of The Royal College of Psychiatrists Special Committee on ECT. London:

Royal College of Psychiatrists.

Acknowledgements
Dr John Rao, Consultant Psychiatrist
Mandy Quarmby, Clinical Audit Manager
Jackie Brennan, Staff Nurse - ECT Service
Patricia Whinett, Staff Nurse - ECT Service
Dr Srinivas Gopi, Locum Senior House Officer
Dr Alex Smallwood, GP VTS Trainee