Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Electro-Convulsive Therapy Policy**
Version:	**4**
Reference Number:	**CL081**
Scope:	
This policy applies to all Adult Inpatient and Day Patient Mental Health Services staff within Pennine Care NHS Foundation Trust	
Purpose:	
The purpose of this document is to describe the management of ECT for both inpatients and day patients and to set out the roles and responsibilities, care and after care of those individuals receiving ECT.	
Requirement for Policy	
Mental Health Legislation Mental Health Act Code of Practice (2015)	
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Clarification on ECT for informal patients Clarification on ECT for patients subject to the MHA or the DoLS Clarification on the consent process Updated ECT Form and Care Pathway Maintenance ECT pathway added	
Owner:	
Mental Health Law Manager ECT Lead	
Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Dr Hayden • Mia Majid	

Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Mental Health Law Scrutiny Group • ECT Forum • Acute Care Forum	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL002	Consent To Examination or Treatment
CL058	Treatment of Patients subject to the Mental Health Act 1983
Policy Associated Documents:	
TAD_CL081_01	Electroconvulsive Therapy Consent Form & Care Pathway
TAD_CL081_02	ECT Rules and Procedures
TAD_CL002_05	Consent Form 4

TAD_CL002_07	Consent Forms – Guidance to Health Professionals
TAD_CL002_14	Mental Capacity Assessment Form
TAD_CL002_15	Best Interest Checklist for Decision Makers
TAD_CL002_10	Guidance Note for Staff and Patients Advance Decisions
TAD_CL002_11	Advance Decision Template
Other external documentation/resources to which this policy relates:	
	Mental Capacity Act (MCA) 2005
	National Institute for Health and Care Excellence. 2003 (updated 2009) Guidance on the use of electroconvulsive therapy (TA59). Available from: https://www.nice.org.uk/guidance/ta59/resources/guidance-on-the-use-of-electroconvulsive-therapy-pdf-2294645984197
	National Institute for Health and Care Excellence. 2009 (updated 2018) Depression in adults: recognition and management (CG90). Available from: https://www.nice.org.uk/guidance/cg90
	National Institute for Health and Care Excellence. 2005 (updated 2017) Depression in children and young people: identification and management (CG28). Available from https://www.nice.org.uk/guidance/cg28/resources/depression-in-children-and-young-people-identification-and-management-pdf-975332810437
	National Institute for Health and Care Excellence. 2014 (updated 2018) Antenatal and postnatal mental health: clinical management and service guidance (CG192) available from : https://www.nice.org.uk/guidance/cg192
CQC Regulations **This guideline supports the following CQC regulations:**	

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1. INTRODUCTION

Electro Convulsive Therapy (ECT) is one of the therapeutic treatment options available to Inpatients and day patients within Pennine Care NHS Foundation Trust. ECT is considered to be safe, effective and essential in the treatment of mental disorders. There are ECT clinics in Stockport, Tameside, Oldham, Rochdale and Bury.

Pennine Care NHS Foundation Trust is dedicated to providing a high quality service which all patients rightly expect. All patients who have been prescribed ECT as a treatment option can be assured that:

- Their illness has been properly assessed
- Other treatment options have been considered and discussed with them
- They are properly advised about the process of ECT and its possible side effects
- The consent policy and process is fully explained
- The treatment is delivered by practitioners from Pennine Care and corresponding Acute providers in cooperation. Staff are trained to the competency levels stipulated by ECT Accreditation Services (ECTAS). Staffing numbers are maintained in accordance with ECTAS standards.
- There is full electroencephalogram (EEG) recording of the process for each client
- There is regular review of the treatment via the audit process
- The patient will have access to high quality ECT services across Pennine Care NHS Foundation Trust which has been accredited by ECTAS.

This policy reflects current standards in the practice of ECT, and is liable to be updated as standards and practice change.

This policy must be read in conjunction with the CL002 Consent to Examination or Treatment Policy and where applicable the CL058 Treatment of Patients Subject to the Mental Health Act 1983 - Part 4 & Part 4A.

2. PURPOSE

The purpose of this document is to ensure clear, accessible information and a consistent, high quality approach to the delivery of ECT within Pennine Care NHS Foundation Trust (the Trust), which meets national standards and to provide guidance, support and standard documentation to referring teams to ensure safe and legal delivery of ECT within the Trust.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

These are defined within the policy and associated documents.

4. INDICATIONS FOR ECT

ECT may be administered for the relief of conditions contained in (please always check for the latest updates):

- The NICE Guidelines TA59, Guidance on the Use of Electro Convulsive Therapy published April 2003 or
- The ECT Handbook Council Report CR176 published by the Royal College of Psychiatrists 3rd Edition published by the Royal College of Psychiatrists 2013 and
- The NICE Guidelines for Depression CG90 2009 (last updated April 2016).

Clinicians who wish to prescribe ECT for conditions not included in the latest NICE Guidelines or the latest version of the ECT Handbook from the Royal College of Psychiatrists must obtain a second consultant opinion which must confirm that the proposed treatment is in the best interest of the patient, notwithstanding any consent the patient may give. Such cases will also be discussed with the Lead Borough ECT Consultant.

5. INFORMATION ABOUT CONSENT TO ECT

Please refer to the Trust policy on Consent to Examination and Treatment for information on the consent process and the application the of the Mental capacity Act (MCA) 2005 framework in the absence of capacitated consent (CL002) and the Policy on Treatment of patients subject to the Mental Health Act (MHA) 1983 – Part 4 and Part 4A (CL058).

The principles of self-determination and patient autonomy are well established in English law. The provision of information and the dialogue between the health care professional proposing the treatment and patient is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it (including the risks/benefits of doing nothing). Discussions should focus on the patient's 'individual situation and risk to them'. The law now demands a standard of consent broadly similar to that required by the professional guidance of the General Medical Council (GMC). For example doctors must now ensure that patients are aware of any "material risks" involved in a proposed treatment, and of reasonable alternatives.

Capacitated adults have a right to give or withhold consent to treatment at any time. Any attempt to treat or even touch a patient without consent (that falls outside of the legal framework and provisions available under the MHA where this applies or the MCA in the absence of capacity) may amount to civil and or criminal offence and may breach a person's rights under the European Convention of Human Rights.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.

- Voluntary consent: This means that the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.
- Informed consent: This means that the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment does not go ahead (NHS Choices, 2015).

Patients who are subject to the MHA must be told what the MHA says about treatment for their mental disorder. In particular they must be told:

- The circumstances (if any) in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment
- The role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved;
- The rules around ECT and the medication administered as part of ECT (see MHA Code of Practice (2015) paragraphs 25.19 – 25.25) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

In addition to the above patients should also be provided with the most up to date version of the patient information leaflets from the Royal College of Psychiatrists (Information about ECT (Electro-convulsive therapy)
available: http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/ect.aspx and;

The Care Quality Commission patient leaflet on Electro-convulsive therapy (ECT) – Your rights about consent to treatment
(http://www.cqc.org.uk/sites/default/files/documents/20120821_mha_ect_booklet_final.pdf

Information must be given to all patients in an appropriate manner for their needs. Where English is not the patients first language translation services must be used in accordance with Trust policy.

Clinic staff will check for original and valid on going informed consent before each application/administration of ECT. Any concerns will be communicated to the referring team but if the clinic staff do not believe there is valid and informed consent and or the relevant legal authority/documentation under the MHA is in place then ECT will not take place.

6. SIDE EFFECTS

All patients for whom ECT is considered must be informed of the benefits and adverse effects of ECT both in the short term and potentially long term, and this must be done within the consenting process incorporated in the ECT Pathway document and the Trust policy CL2. All patients will be offered both written and verbal information. Please refer to the Pennine Care NHS Foundation Trust ECT Pathway (see TAD_CL081_01).

Patients must also be informed of the possible consequences and outcomes of not having ECT which may include but isn't limited to:

- Longer recovery time
- Deterioration of mental and/or physical health
- Increased risk of completed suicide.

7. CONSENT TO TREATMENT AND PROVISIONS UNDER THE MENTAL HEALTH ACT (MHA) PLEASE REFER TO TAD_CL081_02 & 03

7.1 Adult inpatients and day patients with capacity

Voluntary inpatients and day patients must give capacitated and informed consent to treatment and this must only be done on the current consenting documentation within the ECT Care Pathway, (see Pathway Document (TAD_CL081_01)). Consent shall be given without duress and the patient shall be advised that consent can be withdrawn by them at any time. Although documentation will be used to initiate the consent process prior to commencing ECT the patient will be asked to confirm consent at the time of each application.

Voluntary inpatients and day patients may make an Advance Decision refusing treatment. It is the responsibility of the patient or their representative to notify the clinician of this. However, the referring Clinician should ask the patient whether or not they have made an advance decision regarding ECT.

7.2 Adult inpatients and day patients who lack capacity to consent

Inpatients and day patients who do not have capacity and for whom ECT is recommended are unable, by definition, to give consent. ECT may be given if the provisions of the Mental Capacity Act (MCA) are followed. A test of capacity and best interest's decision under the MCA could provide authority to give treatment as long as it does not conflict with an advance decision made by the patient or the views of an attorney, deputy or the court of protection and there is no reason to believe that the patient would object to the proposed treatment or that the administration of ECT would amount to a deprivation of their liberty. Otherwise consideration should be given to such patients being assessed under the Mental Health Act (MHA), and if detained, treated under the safeguards provided under s58(A).

It is worth noting that ECT is considered under the MCA to be 'serious medical treatment' and that as such, if appropriate, an independent mental capacity advocate (IMCA) may need to be appointed. If ECT is to be given to an individual who lacks capacity and is under a granted DoLS authorisation or Court of Protection order, consideration should be given to seeking an independent second medical opinion before treatment which could, in principle, be given under the MCA (remembering that a DoLS authorisation only authorises the deprivation of liberty, not the treatment itself).

7.3 Adult patients detained in Hospital under the MHA 1983 who are subject to Part 4 treatment rules under sections 2, 3, 36, 37, 38, 47 and 48 without restrictions

ECT is covered under section 58A of the MHA 1983 (as amended). See also Chapter 24 (Medical Treatment) and Chapter 25 (Treatments subject to special rules and procedures) of the MHA Code of Practice 2015 (CoP).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA Code_of_Practice.PDF

Detained adult patients with capacity to consent

Patients who have the capacity to consent may not be given ECT unless they consent to it (except in urgent cases subject to the legal provisions under s62 of the MHA see paragraphs under the heading 5.7 below).

Before ECT is given to a capacious patient (except in an urgent case) the Approved Clinician (AC) / Responsible Clinician (RC) in charge of the patients' treatment **or** a Second Opinion Appointed Doctor (SOAD) must provide a certificate under Part 4 of the Act (Form T4) confirming:

- That the patient is capable of understanding the nature, purpose and likely effects of the treatment
- That the patient has given their informed consent

Please note that a s58A certificate is required for ECT at any time - even in the first three months of detention and will also include medication administered as part of ECT.

7.4 Adult detained patients lacking the capacity to consent

In order that an incapacitated patient may be legally given ECT, (except in an urgent case subject to the legal criteria under s62), a SOAD must, after appropriate consultation, provide a certificate under Part 4 of the Act (Form T6) confirming that:

- They are not capable of understanding the nature, purpose and likely effects of the treatment **but**
- it is appropriate for the treatment to be given **and**
- giving them treatment would not conflict with an advance decision which is valid and applicable, or a decision made by the lasting power of attorney or deputy or by the Court of Protection.

An attorney or deputy may not give consent on the patient's behalf if that patient is detained under the MHA.

If ECT is to be given to an individual who lacks capacity and is under a DoLS authorisation or Court of Protection order, consideration should be given to seeking an independent second medical opinion before treatment which could, in principle, be given under the MCA (remembering that a DoLS authorisation only authorises the deprivation of liberty, not the treatment).

As stated earlier ECT is considered under the MCA to be 'serious medical treatment' and that as such, if appropriate, an independent mental capacity advocate (IMCA) may need to be appointed.

7.5 Patients on Community Treatment Orders (CTOs) who have not been recalled to hospital and consent to ECT

For CTO patients who are aged 18 years or over, Form CTO12 can be used to certify informed consent to ECT treatment in the rare circumstances where this might be considered

by the AC/RC.
ECT treatment cannot be given to any patient who is not yet 18 (regardless of whether or not the patient is detained or subject to a CTO and regardless of their capacity to consent to ECT), ECT can only be authorised if a second opinion appointed doctor has certified such treatment on a Part 4A certificate that the patient consents to ECT and that the treatment is appropriate.

Further information regarding emergency treatment under section 64G for CTO patients not recalled to hospital (part 4A patients) is available in paragraphs 24.24 – 24.28 of the MHA Code of Practice, 2015.

7.6 CTO Patients who have been recalled to Hospital and or have had their CTO revoked

ECT may be given to a patient who has been recalled to hospital and or who have had their CTO revoked when:

- A Part 4A Certificate (Form CTO11) explicitly approves continued ECT treatment in the circumstances, or;
- Treatment already being given on the basis of a Part 4A Certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing such treatment would cause the patient serious suffering. Treatment may however only be administered pending a new certificate being provided by a SOAD.

7.7 Urgent cases where Certificates are not required (S62 Treatment)

Section 58A does not apply in urgent cases where treatment is immediately necessary. Similarly a Part 4A certificate is not required in cases where treatment is immediately necessary. However Approved and/or Responsible Clinicians authorising treatment under S62 must be aware that the circumstances under which S62 treatment can be given are different from the circumstances allowing medical treatment under S62, and are given in the para. below:

ECT under S62 may only be given if the treatment is immediately necessary to:

- Save the patient's life, or;
- Prevent a serious deterioration of the patient's condition and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.

If the clinician is unsure if criteria for urgent treatment are met he/she should obtain advice from the MHL Manager.

Treatment may only be given for as long as it is immediately necessary. When treatment ceases to be immediately necessary, the usual requirements for certificates apply.

7.8 Circumstances where a Certificate ceases to authorise treatment

A certificate provided under Part 4 or Part 4A will cease to authorise treatment when:

- The clinician who provided the certificate stops being the approved clinician in charge of the patient's treatment
- The patient stops being detained in hospital or liable to a CTO (even if only temporarily) (except for patients under the age of 18 (please refer to heading 5.9))
- The patient regains capacity where they previously lacked capacity or the patient loses capacity.
- The patient consented to treatment but is now refusing.
- A clinician treating the patient becomes aware that treatment would conflict with an advance decision to refuse treatment.
- A clinician treating the patient becomes aware that the Court of Protection or an attorney or deputy makes (or has previously made) a decision that treatment should not be given.
- The SOAD has specified a time limit and that time expires, or limits the number of treatments and the number is reached.
- Change of laterality of ECT administration

Unless in an urgent case (see section 7.7 above) treatment may not be continued whilst a new certificate is obtained.

All expired or ended certificates must be clearly marked as expired and copies kept with the ECT Pathway with the patient's health records.

7.9 Special provisions applicable to young persons under the age of 18

The principles and key considerations for providing ECT to patients under the age of 18 are set out in chapters 19 and 25 of the MHA Code of Practice 2015. Because providing ECT to under 18s is done so rarely it is not covered in detail in this policy. If you or a colleague are considering providing ECT to a patient under 18 you should first discuss this with the Lead Consultant for ECT within the Trust and the MHL Manager to ensure the necessary clinical and legal measures are in place before the treatment proceeds.

8. PRE–TREATMENT PROTOCOL

All patients must enter the ECT treatment process via the current Pennine Care ECT Pathway which is in use at all Trust sites delivering ECT. The Pathway includes a mandatory physical examination and other investigations determined by age and physical health together with a baseline mental state examination.

The Pathway includes an anaesthetic assessment which documents the anaesthetic risk and quantifies the risk using the American Society of Anaesthesiologists classification (ASA). This assessment is completed by the Anaesthetist prior to treatment. Once the

Anaesthetist has decided on the correct ASA category for each patient a decision will be made about the location of treatment. Patients who are ASA Grade 3 or above may not be suitable for ECT treatment at remote locations and treatment may be given in the main theatre. Patients will not be treated in remote sites without prior discussion with the Anaesthetist.

Any variation in the ASA grade of the patient is recorded before the treatment session.

A Physical examination is recorded which includes the cardiovascular, respiratory and neurological systems, a VTE assessment and a pregnancy test where applicable.

The patients legal status is recorded including detention/treatment status under the MHA or whether subject to DoLS. All copies of the treatment and consent forms (i.e. T4, T6 or s62 must be appended to the ECT Care Pathway).

An assessment of risk/benefit balance of having ECT is considered and recorded.

A clear statement is included on why ECT has been prescribed.

9. PRESCRIPTION OF ECT

ECT will be prescribed on a weekly basis by the consultant in charge of the patients care or their nominated deputy. A maximum of two applications may be prescribed at any one time. The total number of treatments in any one course would not normally be expected to exceed twelve applications. Should it be considered necessary to give more than twelve applications, then a second opinion from a Consultant colleague is advised. The patient's Consultant is responsible for the prescription of ECT.

Electrode placement should be decided by the prescribing clinician after discussion between the referring Consultant, the ECT Consultant and, where capacious, the consenting patient. In making that decision the prescribing clinician will be aware of the urgency to achieve a therapeutic result, the potential for adverse effects and any previous history.

If a patient requires more than 12 treatments a new care pathway and consent form should be completed.

10 ADMINISTRATION OF ECT

ECT will be administered in clinical areas suitable for the purpose. All sites will match standards of the Electro Convulsive Therapy Accreditation Service (ECTAS) of The Royal College of Psychiatrists. High risk patients (ASA 3 or greater or pregnant or with significant concurrent medical disorders) will not be treated in remote sites without prior discussion with the Anaesthetist and a risk analysis being done. Inpatients attending for ECT should be accompanied throughout the treatment process by a Nurse escort who is familiar with the patient. The escorting Nurse should always be a registered nurse. If the escort role is delegated to an unqualified member of staff/care assistant, then it is the delegating nurse who will be accountable for the consequences of that delegation.

The number of escorts and grade of staff accompanying patients shall be decided according to individual patient need and consideration of their physical and mental health risks. Individual needs shall be determined by the multidisciplinary team before a course of ECT starts and be reviewed prior to each session by the Nurse in charge of the Ward. The escorting Nurse will know the patient and have knowledge of the ECT procedure and suite layout so that they are able to provide informed support for the patient. Escorts should be available to respond to patients' needs during the journey so should not be driving and fulfilling the role of escort at the same time. Outpatients receiving ECT as day cases will need to be collected from the ECT suite following their treatment by an informed responsible adult who is aware of the requirements of the Guidance for Day Patients Receiving ECT.

Both first and second stage recovery will be monitored using the paperwork of the current Care Pathway document.

Post Anaesthetic Management: Patients recovering from anaesthesia for ECT will be supervised by a Recovery Nurse where regular and appropriate observations will be made in both first stage and second stage recovery. The Anaesthetist must satisfy himself that patients are fully recovered before the Anaesthetist leaves the Department. After anaesthetic recovery patients should have a supervised sitting area where appropriate refreshments can be obtained.

Following treatment and recovery the patient will be discharged from the ECT Treatment Suite. Patients must fulfil the criteria on the Recovery Record Sheet (Discharge) within the Care Pathway. Responsibility for discharge will rest with the ECT team. Different criteria apply to the discharge of inpatients returning to the Ward and outpatients returning to their own home.

11. EQUIPMENT

The ECT machine will be of sufficient standard to meet the current requirements of The Royal College of Psychiatrists' recommendations.

Machines will be replaced in a planned schedule at regular intervals by the Trust. The estimated lifetime of the Thymatron ECT machine is 10 years on average.

Thymatron IV machines will be used conforming to ECTAS standards.

Each machine should have an annual service by an approved engineer

Anaesthetic standards when ECT is performed on "remote sites" will always conform to the standard set in the Interim Statement from The Royal College of Anaesthetists on "Electro Convulsive Therapy provided in Remote Sites".

12. STIMULUS DOSING AND ELECTRODE PLACEMENT

The threshold of convulsive stimulation will be determined by stimulus dosing agreed by this Trust. This should be routinely measured by an empirical titration method and this should ideally be determined at the first or second treatment in a course of ECT. The purpose of stimulus dosing is two-fold, first, to achieve sufficient electrical discharge to cause a therapeutic fit and second, to avoid excessive dosage which has a proportionate

impact on the side-effects experienced. In certain cases where there is a need for a rapid response, i.e. in a life threatening situation it may not be appropriate to perform Stimulus Dosing. Stimulus Dosing can be completed for such a patient at a later application and once the situation is less urgent.

Electrode placement is a clinical decision made by the prescribing consultant, the patient and following discussion with the ECT consultant. The one foreseen exception to this procedure will be those clients for whom ECT is viewed as an emergency or life-saving situation in which case, bilateral ECT without the full regime of stimulus dosing may be employed to achieve a therapeutic fit at first application. It is not expected that all patients treated under Section 62 would necessarily or routinely fall into this category.

13. CONTINUATION AND MAINTENANCE ECT

The NICE Guidelines for Depression 2009 support the use of Maintenance ECT in specific clinical circumstances. Pennine Care NHS Foundation Trust recognise that it is likely that all Consultant Psychiatrists will have experience of patients whose illnesses relapse, who are not controlled by medication or cannot tolerate medication or are poorly compliant with medication. Some of these patients will benefit from maintenance ECT treatment.

A protocol for maintenance ECT is appended at the end of this Policy at Appendix 9.

14. TRAINING

All personnel in the ECT Treatment Team must have received appropriate training which ensures they are competent to carry out their particular role within the procedure. Patients will only be taken through the consent process by Doctors who have been specifically trained and are competent to fully answer questions posed by patients. The Doctor delivering the treatment will have received both theoretical and practical training and be supervised when he or she first begins to administer ECT. Only when the Consultant Psychiatrist responsible for the Department is satisfied in the competence of the Doctor will they be allowed to administer the treatment unsupervised. All junior doctors will be expected to attend Core Skills Group and Medical Device training as well as training and observation by local ECT Lead.

Nursing members of the ECT Team will receive specialist training before being given responsibility for a treatment session. All ECT staff will have specialist training in appropriate procedures which will be evidenced at appraisal. This may include Consenting the patient, Stimulus Dosing, the physical monitoring requirements in anaesthesia and recovery and medical device training.

It is recommended that the Lead Nurse attends the North West ECT Forum Special Interest Group for ECT and The Royal College of Psychiatrists ECT training events on a regular basis.

15. INFORMATION TO PATIENTS

Information must be given to all patients in an appropriate manner for their needs. Where English is not the patients first language translation services must be used in accordance with Trust policy.

16. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

17. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

18. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

19. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

20. MONITORING

The standards determined by the Trust for record keeping should be regarded as a minimum when prescribing and administering ECT. The process of consent must fall within the Trust's Consent to Examination or Treatment Policy, and take into account the provisions of the Mental Capacity Act (2005) where these apply. For patients subject to the provisions of the MHA staff must also refer to CL58 Treatment of patients Subject to the Mental Health Act 1983 - Part 4 & Part 4A V2. Information must be recorded in an accessible and auditable manner.

The Trust ECT Forum will regularly monitor its service to ensure that Clinical Governance and standards are maintained. It will publish its findings and recommendations to the Trust Medical Director. The forum will review and monitor ECT incidents quarterly. ECT activity across the Trust will be monitored and collated annually.

It is recommended that the patient's mental state be monitored and documented at a minimum between every two ECT applications by the prescribing team. It is expected that the prescribing Psychiatrist or a nominated deputy shall review the patient on a weekly basis. The patient's mental state must be evaluated at the end of a course of treatment in accordance with the standards determined by the Care Pathway.

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

21. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

22. REFERENCES

- National Institute for Clinical Excellence, Guidance on the use of Electro Convulsive Therapy. Technology Appraisal 59 April 2003 (updated 2009).
- National Institute for Clinical Excellence, CG90, 2009 (updated 2016): Depression
- The ECT Handbook, Third Edition, 2013 - The Royal College of Psychiatrists Council Report CR128 2005. Electro Convulsive Therapy (ECT) for Depressive Illness, Schizophrenia, Catatonia and Mania, The School of Health & Related Research (ScHARR)
- Mental Health Act 1983 (as amended)
- Mental Capacity Act 2005