




Electro Convulsive Treatment (ECT) Care Pathway (2G-E5-09)

| | |
|---------------|-------|
| Surname | Title |
| First names | |
| NHS No. | |
| Trust No. | |
| Date of Birth | |

| | |
|---|---|
|  | Allergies / Warnings (see inside cover) Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | Consultant |
| Named Nurse/ Care coordinator | |
| Special Requirements E.g. language/ communication/ mobility needs | |
| Circle as required Gender Male/ Female | |
| Ethnicity <i>White British (A) Irish (B) White Other (C) White & Black Caribbean (D) White & Black African (E) White & Asian (F) Any other mixed background (G) Indian (H) Pakistani (J) Bangladeshi (K) Any other Asian Background (L) Caribbean (M) African (N) Any other Black Background (P) Chinese (Q) (Nationality if non UK resident)</i> | |

All professionals recording information in this pathway must complete their full name, designation, full signature and initials below before they write in this pathway

To be retained in the patients notes

Allergies/ Warning

To be completed and kept by the persons named/ associate nurse or care coordinator. If they are not available to complete this section it should be kept updated by another member of the team.

5 For detained patients: CQC leaflet given

2 Has the day patient pathway been completed

| | | |
|--------------------------------|-------------------------------|---|
| Yes (Initial & Date) | No (Initial & Date) | Variance/ Comments/ Action taken/ or additional details |
| | | If yes, complete questions immediately below. If no, go onto question 1.3 |
| | | |
| | | |
| | | |
| | | |
| Yes (Initial & Date) | No (Initial & Date) | |
| | | If YES continue with this section, If NO go to section 3. |
| | | |

Tick the appropriate statement & complete any missing details (no recordable variances this section)

Does the Patient have Capacity to Consent to ECT treatment
Yes ☐ No ☐

Informal & Consenting, consent form signed

Detained under section ____, & giving valid consent form T4 signed

Detained under section ____, not/ unable to consent, second opinion, form T6 signed

Detained under section ____, emergency treatment, & not consenting (section 62) form 2G-P16-MHA-08 signed

Completed by: _____ Date: _____

This section must be completed if there is a change in the person's legal status or consent

| | |
|---|-----------------------------|
| Does the Patient have Capacity to Consent to ECT treatment | |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Informal & consenting- consent form signed | |
| Detained under section ____, and giving valid consent form T4 signed | |
| Detained under section ____, not/ unable to consent, second opinion, form T6 signed | |
| Detained under section ____, emergency treatment, & not consenting (section 62) form 2G-P16-MHA-08 signed | |
| Completed by: | Date: |

Name

NHS
Number

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Consent

Medical Consent to treatment- (Consent Form 1)

Name of proposed procedure or course of treatment - **Electro Convulsive Treatment**
(include brief explanation if medical term not clear)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy i.e. Consultant Psychiatrist or Doctor)

I have explained the procedure to the patient. In particular, I have explained:

B - Electrode placement i.e. Bilateral vs Unilateral, likely number of treatments and monitoring frequency. q

.....

This procedure will involve general anaesthesia and a muscle relaxant.

.....

C - A - The intended benefits and likelihood of success of ECT and likely consequences of not having ECT

.....

D - Serious or frequently occurring risks and side effects – (Including memory and cognitive disturbance, risks to dental tissues, including crowns, implants, bridges and loose teeth AND general anaesthetic risk AND post anaesthetic risk

.....

Any extra procedures which may become necessary during the procedure

☐ other procedure (specify) i.e. Airway maintenance, Heart Monitoring, Treatment of any drug reactions, Intravenous Fluids

.....

Name

NHS
Number

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I have also discussed what the procedure is likely to involve, the benefits and the risks of any available alternative treatments (*including no treatment*) and any particular concerns of this patient. I have also explained to them the need to fast for 6 hours prior to treatment.

☐ The following leaflet/ tape has been provided: RCPsych ECT leaflet

Would you, or your carers, like to have copies of correspondence about your health and treatment? Y/N

Would you like to see the ECT department and meet the team prior to ECT if requested Y / N
If yes for the referring doctor to contact the ECT department.

Information on how to access independent advocacy given Y / N

Consultant/ Doctor Signed: Job Title

Date... ..

Contact details (*if patient wishes to discuss options later*)

Statement of Interpreter (*where appropriate*)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Copy of this page given to patient ☐ yes ☐ declined

Name

NHS
Number

| | | | | | | | | | |
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Statement of Patient*Please read this form carefully.*

If your treatment has been planned in advance, you should already have your own copy of page 3, which describes the benefits, and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the course of electroconvulsive treatment described on this form and consent to receiving - *(delete as appropriate)*

- Either Bilateral or Unilateral treatment
- Only Bilateral Treatment
- Only Unilateral Treatment

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that students may be present to observe treatment as part of their training.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I acknowledged the risks as described by the prescribing consultant/ doctor.

I understand that if I receive any part of this treatment whilst as an outpatient or if I go on leave from hospital after treatment that I must not

- drink alcohol for 24 hours,
- take non-prescribed drugs except simple pain killing medication,
- be on my own for 48 hours afterwards,
- be in sole charge of children.

I also understand that I should seek medical advice before driving, operating machinery or signing legal documents. I also understand that I must fast for 6 hours before receiving any treatment.

Patient's signature Date.....

please print your name

To be used if the patient wishes to withdraw or change consent after completing section above

Patients Statement *-(delete as appropriate)*

A) I wish to withdraw consent from having ECT

Or

B) I wish to change consent from..... to..... *(i.e. Unilateral to Bilateral)*

Patient's signature Date.....

print name

Name

NHS
Number

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Indication for ECT. (Consider 2nd opinion if indication is outside NICE guidelines)

| | | |
|---|---|--|
| NICE guidance | Severe or life threatening depressive illness | |
| | Catatonia | |
| | Prolonged or severe manic episode | |
| RCPsych ECT Consensus group, additional indications | Non severe depression, inadequate drug response | |
| | Acute schizophrenia, 4 th line treatment after Clozapine | |
| Other (please specify) | | |

Assessment

RATING SCALE:

Score

Date

CGI (Clinical Global Impressions Scale)**Item 1. Severity of illness-** Rate the severity of the patient's illness at the time of assessment

- | | |
|----------------------------|-------------------|
| 1. Normal (not at all ill) | 4. Moderately ill |
| 2. Borderline mentally ill | 5. Markedly ill |
| 3. Mildly ill | 6. Severely ill |
| | 7. Extremely ill |

CPRS (Comprehensive Psychopathological Rating Scale)

- | | |
|--|---|
| Memory as usual | 0 |
| Occasional increases lapses of memory | 2 |
| Report of socially inconvenient or disturbing loss of memory | 4 |
| Complaints of complete inability to remember | 6 |

MOCA Score (for **all** patients receiving ECT and to be repeated every 4 sessions)

Please tick the scoring used:

HDRS Score (when ECT is being given for depression) ☐Bush Francis (when ECT is being given for catatonia) ☐Young Mania Rating Scale (YMRS) (when ECT is been given for mania) ☐BBRS (when ECT is been given for schizophrenia) ☐

Pre-treatment Mental State Examination summary including statement of orientation and memory status:

Name

NHS
Number

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Assessment

Previous Episodes of ECT

Has the patient received ECT before **Yes/No**. If yes, state the date and centre where ECT was given and any known clinical response.

Psychological interventions used and if not used reasons why this was not considered:

Seizure Threshold Risk Factors (tick)

| | |
|-------------------|--------------------------|
| Over 65 | <input type="checkbox"/> |
| Male | <input type="checkbox"/> |
| Baldness | <input type="checkbox"/> |
| ECT in last month | <input type="checkbox"/> |

Benzodiazepines (now or in last month)

Carbamazepine (now or in last month)

Other anticonvulsants

L-tryptophan

Beta blockers

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

ASSESSMENT Complete all parts. This part is intended to act as the assessment for suitability for anaesthetic, Physical and to provide a baseline to monitor the physical effects of ECT treatment

Medical History/ Operations:

VTE Risk and anticoagulation used if applicable:

Could the patient be pregnant? Yes/No

If Yes- results of pregnancy test:

Illicit drugs and Alcohol (include drug and alcohol history and date of last use if known):

Smoker (pack years/average number a day):

Name

NHS
Number

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|--------|--|--------|--|------|--|
| BP | | Pulse | | Temp | |
| Weight | | Height | | BMI | |

| | | | | | | | | | | | | | |
|----------|--------------------------|--------------|--------------------------|----------------|--------------------------|------------|--------------------------|-------------|--------------------------|------------------|--------------------------|-----------|--------------------------|
| Dentures | <input type="checkbox"/> | Capped Teeth | <input type="checkbox"/> | Contact lenses | <input type="checkbox"/> | Spectacles | <input type="checkbox"/> | Hearing Aid | <input type="checkbox"/> | Artificial Limbs | <input type="checkbox"/> | Allergies | <input type="checkbox"/> |
|----------|--------------------------|--------------|--------------------------|----------------|--------------------------|------------|--------------------------|-------------|--------------------------|------------------|--------------------------|-----------|--------------------------|

Any oral/nasal piercings? ☐

General Appearance

Specific Features

State Of Nutrition

Bruises & Scars

| | | |
|-------|-----------------------------|--|
| Skin: | Mouth & Throat; Thyroid; | Description of any crowns/bridges/ implants & loose teeth |
|-------|-----------------------------|--|

Mouth opening/neck movement

CVS

| | | |
|-----|---------------|------------------|
| JVP | Heart Sounds; | Cardiac Impulse; |
|-----|---------------|------------------|

Any Other Features

RS:

| | | |
|-------------------|----------|--------|
| Respiratory Rate: | Trachea: | Nodes: |
|-------------------|----------|--------|

| | | |
|------------|------------------|-------------|
| Air Entry: | Chest Expansion: | Percussion: |
|------------|------------------|-------------|

Breath Sounds:

Any Other Features:

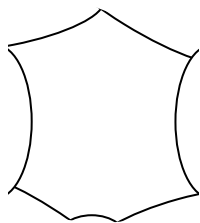
Assessment

Name

NHS
Number

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GIT:



Liver:

Spleen:

Kidneys:

Masses:

Bowel Sounds:

*Any Other
Features:*

CNS:

Gait:

Tremor:

Speech:

Fundi:

Cranial Nerve:

Motor Power:

Sensations

Tone:

Reflexes:

***Any Other
Features:***

INVESTIGATIONS (DETAILS OF BLOOD RESULTS/INVESTIGATIONS TO BE NOTATED**)**

Name

NHS
Number

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ACTIVE PROBLEMS

INACTIVE PROBLEMS

| | | Yes (Initial & Date) | No (Initial & Date) | Comments/ Action taken |
|---|--|----------------------------|---------------------------|------------------------|
| 1 | Any Abnormalities Noted | | | |
| 2 | If yes, Anesthetist informed of abnormalities | | | |

[illegible]

| |
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Assessment

Date Commenced

[illegible]

Date Stopped

| Item | Cost | Quantity | Vendor/Shipping | Date Shipped |
|------|------|----------|-----------------|--------------|
| | | | | |
| | | | | |
| | | | | |
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Signature Date

[illegible]

Pre Treatment Check List/WHO

[illegible]

Name

NHS
Number

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To be completed by ECT Doctor

WHO Check List

| Session no | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|--|---|---|---|---|---|---|---|---|---|----|----|----|
| Date | | | | | | | | | | | | |
| Uni-lateral or Bi-lateral | | | | | | | | | | | | |
| MHA status Capacity (Y/N) Legal framework for ECT treatment | | | | | | | | | | | | |
| Dose Plan % | | | | | | | | | | | | |
| Time to re-orientate | | | | | | | | | | | | |
| Comprehensive Psychopathological Rating Scale (CPRS) | | | | | | | | | | | | |
| Clinical Global Improvement Rate (CGI) | | | | | | | | | | | | |
| Clinical Rating Scale Score Circle appropriate scale: HDRS, Bush Francis, YMRS | | | | | | | | | | | | |
| Any medication given prior to ECT? | | | | | | | | | | | | |
| If a student if attending has the patient agreed to this? Y/N | | | | | | | | | | | | |
| Signature of ECT Doctor | | | | | | | | | | | | |

Name

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| This section is to be completed by Anaesthetist | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|
| Medical notes reviewed? | | | | | | | | | | | | |
| Dental risks considered? | | | | | | | | | | | | |
| ASA grade | | | | | | | | | | | | |
| Any need to change the induction agent? | | | | | | | | | | | | |
| Signature of Anesthetist | | | | | | | | | | | | |

Name

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Treatment

ECT PRESCRIPTION

| | | | | |
|---|--|---|---|---|
| Treatment | Session 1 | | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: ----- 8. Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: ----- Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time | |
| | Date Prescribed | | | |
| | Type R, L, Bi | | | |
| | Prescribed By | | | |
| | Prescriber Signature | | | |
| | Anaesthetic agent, dose: Muscle relaxant, dose: | | | |
| | Cannula size & location | | | |
| | ASA Grade | | | |
| | Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | | |
| | Comments/ Complications | | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | | |
| Anaesthetist Signature | | | | |
| Stimulation #1 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">1</td> <td style="width: 33%; text-align: center;">2</td> <td style="width: 33%; text-align: center;">3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #2 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">1</td> <td style="width: 33%; text-align: center;">2</td> <td style="width: 33%; text-align: center;">3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #3 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">1</td> <td style="width: 33%; text-align: center;">2</td> <td style="width: 33%; text-align: center;">3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | | |
| Plan For Next Session/ Post ECT side effects | | | | |
| Administering Doctor Signature | | | | |
| Date scoring completed: | | | | |

Name

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Number

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Treatment

ECT PRESCRIPTION

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| Treatment | Date Prescribed | Session 2 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: ----- 8. Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: ----- Rating Scale score (circle appropriate scale used): HDRS / Bush francis / YMRS Score: ----- Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time Date scoring completed: ----- |
| | Type R, L, Bi | | |
| | Prescribed By | | |
| | Prescriber Signature | | |
| | Anaesthetic agent, dose: | | |
| | Muscle relaxant, dose: | | |
| | Cannula size & location | | |
| | ASA Grade | | |
| | Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | |
| | Comments/Complications | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | |
| Anaesthetist Signature | | | |
| Stimulation #1 | | | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| Stimulation #2 | | | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| Stimulation #3 | | | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | |
| Plan For Next Session/ Post ECT side effects | | | |
| Administering Doctor Signature | | | |

Name

NHS
Number

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Treatment

ECT PRESCRIPTION

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| | Session 3 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: ----- 9. Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: ----- Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) Worse, No change, Bit better, Much better, 100% well What is your memory like now compared with before ECT? (<i>circle</i>) Much worse, Bit worse, No change, Better ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time | | |
| Date Prescribed | | | | |
| Type R, L, Bi | | | | |
| Prescribed By | | | | |
| Prescriber Signature | | | | |
| Anaesthetic agent, dose: Muscle relaxant, dose: | | | | |
| Cannula size & location | | | | |
| | ASA Grade Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | | |
| Comments/ Complications | | | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | | |
| Anaesthetist Signature | | | | |
| Stimulation #1 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td>1</td><td>2</td><td>3</td></tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #2 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td>1</td><td>2</td><td>3</td></tr> </table> | 1 | 2 | 3 |
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| 1 | 2 | 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | | |
| Plan For Next Session/ Post ECT side effects | | | | |
| Administering Doctor Signature | | | | |
| | Date scoring completed: | | | |

Name

NHS
Number

| | | | | | | | | | |
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Treatment

ECT PRESCRIPTION

| | | | | |
|---|--|--|---|---|
| Date Prescribed Type R, L, Bi Prescribed By Prescriber Signature | Session 4 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: <hr/> Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: <hr/> Rating Scale score (circle appropriate scale used): HDRS / Bush francis / YMRS Score: <hr/> Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> <hr/> Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time Date scoring completed: | | |
| | Anaesthetic agent, dose: Muscle relaxant, dose: | | | |
| | Cannula size & location | | | |
| | ASA Grade Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | | |
| | Comments/ Complications | | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | | |
| Anaesthetist Signature | | | | |
| Stimulation #1 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #2 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #3 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | | |
| Plan For Next Session/ Post ECT side effects | | | | |
| Administering Doctor Signature | | | | |

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Post 4th ECT session:

MOCA score:

Date:

Completed by:

ECT Doctor's review of current progress and dosing used:

Name

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| Date Prescribed | Session 5 | Item 2. Clinical Global Improvement Rate: 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: |
| Type R, L, Bi | | |
| Prescribed By | | |
| Prescriber Signature | | |
| Anaesthetic agent, dose: | | Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time |
| Muscle relaxant, dose: | | |
| Cannula size & location | ASA Grade Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | |
| Comments/Complications | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | |
| Anaesthetist Signature | | |
| Stimulation #1 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| Stimulation #2 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| Stimulation #3 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | |
| Plan For Next Session/Post ECT side effects | | |
| Administering Doctor Signature | | |
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Treatment

ECT PRESCRIPTION

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| | Session 6 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: _____ 8. Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: _____ Rating Scale score (circle appropriate scale used): HDRS / Bush francis / YMRS Score: _____ Patients self report: How do you feel compared with how you felt before ECT? (circle) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (circle) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time Date scoring completed: _____ | | |
| Date Prescribed | | | | |
| Type R, L, Bi | | | | |
| Prescribed By | | | | |
| Prescriber Signature | | | | |
| Anaesthetic agent, dose: | | | | |
| Muscle relaxant, dose: | | | | |
| Cannula size & location | ASA Grade Guedel 6 <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | | |
| Comments/Complications | | | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | | |
| Anaesthetist Signature | | | | |
| Stimulation #1 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (see key below) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #2 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (see key below) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| Stimulation #3 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (see key below) | <table border="1"> <tr> <td>1</td> <td>2</td> <td>3</td> </tr> </table> | 1 | 2 | 3 |
| 1 | 2 | 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | | |
| Plan For Next Session/Post ECT side effects | | | | |
| Administering Doctor Signature | | | | |

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Treatment

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| <div> <div>Date Prescribed</div> <div>Type R, L, Bi</div> <div>Prescribed By</div> <div>Prescriber Signature</div> <div>Anaesthetic agent, dose:</div> <div>Muscle relaxant, dose:</div> <div>Cannula size & location</div> <div>Comments/ Complications</div> <div>Post Treatment Oxygen Prescriptions</div> <div>Anaesthetist Signature</div> <div>Stimulation #1</div> <div>Electrode Placement</div> <div>Dose setting</div> <div>Impedance test</div> <div>Seizure pattern</div> <div>Seizure duration</div> <div>EEG Seizure duration</div> <div>EEG pattern (see key below)</div> </div> | Session 7 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: _____ Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: _____ Patients self report: How do you feel compared with how you felt before ECT? (circle) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (circle) <i>Much worse, Bit worse, No change, Better</i> _____ Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time |
| | ASA Grade | |
| | Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | |
| | Give oxygen at rate of 5-7lts/per minute during recovery as required | |
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| <div> <div>Stimulation #2</div> <div>Electrode Placement</div> <div>Dose setting</div> <div>Impedance test</div> <div>Seizure pattern</div> <div>Seizure duration</div> <div>EEG Seizure duration</div> <div>EEG pattern (see key below)</div> </div> | <div>123</div> | |
| <div> <div>Stimulation #3</div> <div>Electrode Placement</div> <div>Dose setting</div> <div>Impedance test</div> <div>Seizure pattern</div> <div>Seizure duration</div> <div>EEG Seizure duration</div> <div>EEG pattern (see key below)</div> </div> | <div>123</div> | |
| <div> <div>EEG KEY</div> <div>Plan For Next Session/ Post ECT side effects</div> <div>Administering Doctor Signature</div> </div> | <div> <div>1= Recruitment</div> <div>2= Delta waves</div> <div>3= Post ictal suppression</div> </div> | |
| Date scoring completed: | | |

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Treatment

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| | Session 8 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: Rating Scale score (circle appropriate scale used): HDRS / Bush francis / YMRS Score: Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time Date scoring completed: | | | | | |
| Date Prescribed | | | | | | | |
| Type R, L, Bi | | | | | | | |
| Prescribed By | | | | | | | |
| Prescriber Signature | | | | | | | |
| Anaesthetic agent, dose: Muscle relaxant, dose: | | | | | | | |
| Cannula size & location | | | | | | | |
| Comments/ Complications | ASA Grade Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | | | | | |
| | | | | | | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | | | | | |
| Anaesthetist Signature | | | | | | | |
| Stimulation #1 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td></td><td></td><td></td></tr> <tr> <td>1</td><td>2</td><td>3</td></tr> </table> | | | | 1 | 2 | 3 |
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| 1 | 2 | 3 | | | | | |
| Stimulation #2 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td></td><td></td><td></td></tr> <tr> <td>1</td><td>2</td><td>3</td></tr> </table> | | | | 1 | 2 | 3 |
| | | | | | | | |
| 1 | 2 | 3 | | | | | |
| Stimulation #3 Electrode Placement Dose setting Impedance test Seizure pattern Seizure duration EEG Seizure duration EEG pattern (<i>see key below</i>) | <table border="1"> <tr> <td></td><td></td><td></td></tr> <tr> <td>1</td><td>2</td><td>3</td></tr> </table> | | | | 1 | 2 | 3 |
| | | | | | | | |
| 1 | 2 | 3 | | | | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | | | | | |
| Plan For Next Session/ Post ECT side effects | | | | | | | |
| Administering Doctor Signature | | | | | | | |

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Post 8th ECT session:

MOCA score:

Date:

Completed by:

ECT Doctor's review of current progress and dosing used:

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Treatment

ECT PRESCRIPTION

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|---|--|---|--|
| Treatment | Session 9 | | Item 2. Clinical Global Improvement Rate: 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time |
| | Date Prescribed | | |
| | Type R, L, Bi | | |
| | Prescribed By | | |
| | Prescriber Signature | | |
| | Anaesthetic agent, dose: | | |
| | Muscle relaxant, dose: | | |
| | Cannula size & location | | |
| | ASA Grade | | |
| | Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | | |
| Comments/ Complications | | Score: Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | | |
| Anaesthetist Signature | | | |
| Stimulation #1 | | | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| Stimulation #2 | | Score: Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| Stimulation #3 | | | |
| Electrode Placement | | | |
| Dose setting | | | |
| Impedance test | | | |
| Seizure pattern | | | |
| Seizure duration | | | |
| EEG Seizure duration | | | |
| EEG pattern (<i>see key below</i>) | | | |
| | 1 2 3 | | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | | |
| Plan For Next Session/ Post ECT side effects | | Date scoring completed: | |
| Administering Doctor Signature | | | |

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Treatment

ECT PRESCRIPTION

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| | Session 11 | Item 2. Clinical Global Improvement Rate: How much the patient's illness has improved or worsened relative to a baseline state. 1. Very much improved 2. Much improved 3. Minimally improved 4. No change 5. Minimally worse 6. Much worse 7. Very much worse Score: _____ Comprehensive Psychopathological Rating Scale: 0 – Memory as usual 2 – Occasional Lapses of Memory 4- Report of socially inconvenient or disturbing loss of memory 6- Complaints of complete inability to remember Score: _____ Patients self report: How do you feel compared with how you felt before ECT? (<i>circle</i>) <i>Worse, No change, Bit better, Much better, 100% well</i> What is your memory like now compared with before ECT? (<i>circle</i>) <i>Much worse, Bit worse, No change, Better</i> ----- Any reported/observable side effects (headaches, muscle soreness etc) Any changes in patients physical health: Are you happy to continue with ECT Treatment? YES / NO Does patient have capacity to consent to ECT? YES / NP Plan to continue with ECT: YES / NO If yes please prescribe further dose of ECT- No more than two ECT's to prescribed at one time |
| Date Prescribed | | |
| Type R, L, Bi | | |
| Prescribed By | | |
| Prescriber Signature | | |
| Anaesthetic agent, dose: | | |
| Muscle relaxant, dose: | | |
| Cannula size & location | | |
| | ASA Grade | |
| | Guedel <input type="checkbox"/> Mouthguard <input type="checkbox"/> | |
| Comments/ Complications | | |
| Post Treatment Oxygen Prescriptions | Give oxygen at rate of 5-7lts/per minute during recovery as required | |
| Anaesthetist Signature | | |
| Stimulation #1 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| Stimulation #2 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| Stimulation #3 | | |
| Electrode Placement | | |
| Dose setting | | |
| Impedance test | | |
| Seizure pattern | | |
| Seizure duration | | |
| EEG Seizure duration | | |
| EEG pattern (<i>see key below</i>) | | |
| | 1 2 3 | |
| EEG KEY | 1= Recruitment 2= Delta waves 3= Post ictal suppression | |
| Plan For Next Session/ Post ECT side effects | | |
| Administering Doctor Signature | | |
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Name

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Post 12th ECT session:

MOCA score:

Date:

Completed by:

ECT Doctor's review of current progress and dosing used:

Name

NHS
Number

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See guidance note 2 p. 29

Reassessment 1

See guidance note 3

Anaesthetic Recovery Observation - Treatments 1 & 2

Session no 1 Treatment Date:

Treatment Time:

Recovery

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

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|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 2 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Name

NHS
Number

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
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Anaesthetic Recovery Observation - Treatments 3 & 4

See guidance note 3

Session no 3 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ₂ | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Have they vomited? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 4 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ₂ | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Name

NHS
Number

| | | | | | | | | | |
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Anaesthetic Recovery Observation - Treatments 5 & 6

See guidance note 3

Session no 5 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|--|------------|-------|------------|------------|------------|------------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|---|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 6 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|--|------------|-------|------------|------------|------------|------------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|---|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Name

NHS
Number

| | | | | | | | | | |
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Anaesthetic Recovery Observation - *Treatments 7 & 8*

See guidance note 3

Session no 7 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 8 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Name

NHS
Number

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Anaesthetic Recovery Observation - Treatments 9 & 10

See guidance note 3

Session no 9 Treatment Date:

Treatment Time:

Recovery

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 10 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Name

NHS
Number

| | | | | | | | | | |
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| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Anaesthetic Recovery Observation - Treatments 11 & 12

See guidance note 3

Session no 11 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

Session no 12 Treatment Date:

Treatment Time:

| Interval | Pre ECT | 5 min | 10 mins | 15 mins | 20 mins | 30 mins | 1 hr | 3 hr | 6 hr |
|---|---------|-------|---------|---------|---------|---------|------|------|------|
| Time Due | | | | | | | | | |
| Time Completed | | | | | | | | | |
| BP | / | / | / | / | / | / | / | / | / |
| Pulse | | | | | | | | | |
| Respiration | | | | | | | | | |
| SAO ² | % | % | % | % | % | % | % | % | % |
| State of Consciousness | | | | | | | | | |
| Airway | | | | | | | | | |
| O ² | lts | lts | lts | lts | lts | lts | lts | lts | lts |
| Temperature | | | | | | | | | |
| Nausea /Vomiting | | | | | | | | | |
| Orientation In Time | | | | | | | | | |
| Orientation In Person | | | | | | | | | |
| Orientation In Place | | | | | | | | | |
| Do they have a headache? | | | | | | | | | |
| Is the patient agitated? | | | | | | | | | |
| Abnormalities reported to anaesthetist / duty doctor? | | | | | | | | | |
| Cannula Removed | | | | | | | | | |
| Signed | | | | | | | | | |

| | | | | |
|--|--------------|-------------|---|--------------|
| Patient meets criteria for discharge from the ECT Clinic - see discharge criteria at back of booklet | Time | NEWS Score: | Person receiving the patient from the clinic and taking responsibility for ongoing observation, | Time |
| | Signed | | | Signed |

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Guidance notes

Note 1 ECT PRESCRIPTION

No more than two ECTs to be prescribed at one time. Treatment to be reviewed and documented after every treatment session, including an assessment of orientation and memory. Prior to prescribing the first ECT, assessment including a **Clinical Global Impressions Scale (CGI)** item 1, a **Comprehensive Psychopathological Rating Scale (CPRS)**, **MOCA** and **HDRS** (if depressed) or other relevant rating scale for condition must be completed.

Note 2 Post-treatment Reassessment

After each 1 prescriptions/ treatments the **CGI item 2** (improvement measure) and CPRS must be completed. After every 2 sessions a HDRS (if depressed) or the relevant rating scale must be completed before further treatments may be given. After every 4 sessions a MOCA must be completed.

Note 3 Anaesthetic Recovery Observation

Post ECT observations should be completed to assess the physical recovery of the patient post anaesthetic and to provide information to assist with prescribing of anaesthetic and a Stimulation dose for future treatments. The person receiving the patient from the ECT suite should sign to indicate that they have received the patient and will continue to observe, or remain with the patient until they have fully recovered. If a prescribed set of observations is either completed at a different time from identified or missed for any reason this should be noted in the comments box.

Note 4 On Completion of ECT Treatment Plan

MOCA to be completed after the final ECT session and then again 2 months post-ECT & uploaded onto RiO.

ECT Clinic Discharge Criteria

Discharge Check List

| | Met | Not Met | Comment/Variance |
|--|-----|---------|------------------|
| Vital signs; blood pressure, pulse & respirations within his/her normal limits | | | |
| Tolerating fluids; can tolerate at least 150ml fluid (e.g: cup of hot drink or glass of water) | | | |
| Post treatment nausea or vomiting; minimal nausea & any vomiting ceased | | | |
| Pain; (e.g: headache) controlled by oral analgesia | | | |
| Orientation; co-ordination, mobility – returned to normal level | | | |
| Patient property returned; shoes, bags, false teeth, etc. | | | |
| In-patient: accompanying nurse to return patient back to ward & monitor | | | |
| Day Patients: relative/appropriate adult to take person home | | | |
| Day Patients: relative/appropriate adult signed the discharge form | | | |

Note 4 Orientation Checklist Assessment

- 1) What is your name?
- 2) What is the date (*day/month/year*)?
- 3) What is the name of your ward/hospital?
- 4) What town/county/country are we in?

Name

NHS
Number

| | | | | | | | | | |
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