CARE RECORD: FOR PATIENTS RECEIVING ELECTROCONVULSIVE THERAPY

This care record is to be used with all patients who are receiving electroconvulsive therapy (ECT) within RDASH Mental Health Services. The care record starts once the decision to prescribe ECT has been made and ends once treatment has been discontinued. Any reasons for treatment being refused or withheld should be recorded on the discontinuation sheet.

Instructions for use:

Before writing in this care record please ensure you have signed the signature sheet. The care record documentation allows for up to 12 sessions of ECT to be administered. If more sessions are required this should be documented on 'Supplementary Sheet One'.

Overall care objectives:

- To perform the ECT procedure in a safe manner which produces minimum stress to the patient's physical and mental health.
- To initiate change in mental function to enable other interventions (nursing/medical/therapy etc) to be implemented.
- For patient to be made fully aware of procedures and understands possible benefits and side effects.
- Consult widely with patient/carer prior to administering ECT to ensure the patient/carer fully understands the process.
- To adhere to NICE Guidance on ECT (Technology Appraisal 59, April 2003).

The pre-commencement section of this care record (including physical examination) is to be completed by the patient's consultant or their deputy.

Abbreviations: ECT – Electroconvulsive Therapy
SOAD – Second Opinion Approved Doctor

Patient name: DOB: Maracis No.:

Rotherham Doncaster and NHS
South Humber Mental Health
NHS Foundation Trust

Care Record for:
Patients receiving Electroconvulsive therapy

SIGNATURE SHEET
All disciplines writing in this care record must sign below prior to writing in it.

Full Name (print)	Designation	Signature	Initials	Date of Entry

Patient name: DOB: Maracis No.:

Care Record for: Patients receiving Electroconvulsive therapy

PRIOR TO COMMENCING COURSE OF ECT (CONSENT)

CONSULTANT PSYCHIATRIST TO COMPLETE:

Mental Health Act Status: Informal ☐ Detained ☐ (specify section) ☐

Informal Patient with capacity and consent form signed ☐

Treatment under best interests form 4 completed ☐

Consenting detained patient with capacity form T4 completed ☐ (Mental Health Act Commission leaflet No. 3 given)

Non consenting detained patient, without capacity, SOAD completed form T6 ☐ (Mental Health Act Commission leaflet No. 3 given)

Emergency treatment Section 62 completed ☐

Patients under 18 who have consented, SOAD completed form T5 ☐

If other treatments have been considered, indicate which treatments.

____

____

Please indicate why ECT has been prescribed.

____

____

The ECT prescription falls within NICE (2003;2009) Guidelines ☐ Yes
(If no is indicated the reasons **must** be stated in the notes) ☐ No

I recommend ECT for the above named Patient.

Unilateral ☐ Bilateral ☐

Right ☐ Left ☐

Date ________ Time ________ Dr Signature ______________ Dr Name ______________

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

1. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

2. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to ECT treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

3. **Efficacy index:** Rate this item on the basis of ECT only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as ‘Moderate’ and side effects are judged ‘Do not significantly interfere with the patient’s functioning’.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient’s functioning*	*Significantly interferes with patient’s functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn’t alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

CAPACITY ASSESSMENT (must include detailed documentation in the notes)

Capacity must be assessed within the 24 hours prior to treatment. It must not be assessed in the 24 hours following treatment/any anaesthetic procedure.

If an advanced directive is known to exist, has it been taken into consideration?
Yes ☐ No ☐
If no specify why ______________________________

Does the patient have capacity to give valid consent for ECT? Yes ☐ No ☐

Consent: Unless it is an emergency, prior undergoing ECT, the patient must either give valid consent to their Consultant Psychiatrist, or in the event of the patient lacking capacity to give consent, treatment must be authorised by a second opinion approved doctor from the Mental Health Act Commission using a form T6.

Patient name: DOB: Maracis No.:

CONSENT FORM

Consultant Psychiatrist or nominated deputy to complete:

Doctor's Explanation

I confirm that I have explained to the patient the nature, purpose, and likely benefits of ECT and also the possible adverse effects/risks of this treatment, including temporary memory disturbances, memory loss (possibly permanent), headache, dental risk (identifying caps/crowns/bridges/dentures), muscle ache, nausea, fatigue, 'muzzy headedness' and temporary confusion. A test of capacity has taken place and the patient is able to give valid consent. I have also given the patient an information leaflet about ECT. I have discussed available alternative treatments (including no treatment) with the patient (documentation of the details of this is in the notes).

Date ____________ Time ____________ Signed: ____________________

Patient's Consent

I ______________ of ____

Hereby consent to undergo to administration of

Bilateral ☐ Unilateral ☐

ECT (electroconvulsive therapy), the nature, purpose and likely effects of which have been explained to me by Dr _____________________________________ . Any concerns have been discussed. The maximum number of treatments I have consented to is 12.

I also consent to the administration of general anaesthetic and muscle relaxant. I confirm that I have been given written information re ECT and I understand that an assurance has not been given that the treatment will be administered by a specific practitioner and understand that I may withdraw my consent at any time.

Date ____________ Time ____________ Signed: ____________________

Record of Discussion with Relative where appropriate

I ___________________________ of _________________________________ and being the _______________________________ (State nature of relationship), confirm that an explanation of the nature, purpose and the likely effects of ECT (electroconvulsive therapy) were given to me by Dr _________________ I have been given an information leaflet about ECT.

Signed : ____ Date: ______ Time: _____________

By relative

Patient name: DOB: Maracis No.:

Care Record for Patients receiving Electroconvulsive therapy

PRIOR TO COMMENCING COURSE OF ECT (PHYSICAL AND MENTAL STATE ASSESSMENT)

Consultant Psychiatrist / Nominated Deputy to complete:

Medical History include: existing health issues: heart disease (ischemic heart disease or hypertension, valvular heart disease or CHF, recent MI), chest diseases, diabetes, stroke, aneurysm, head injury, cerebral tumour, fracture, severe osteoporosis/rheumatoid arthritis, retinal detachment/glaucoma.

____

____

____

____

Physical Examination: ____________________________

CVS: ____________________________

Respiratory: ____________________________

CNS: ____________________________

Abdomen: ____________________________

VTE ____________________________

Investigation	Result	Date
FBC:		
U&E and other biochemistry:		
Other: e.g. sickle cell, Hep B, LFT.		
ECG		
Chest X-ray (if indicated):		

Diagnosis: Severe depressive illness ☐ Catatonia ☐ Mania ☐ Other (specify)………………

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Patient name: DOB: Maracis No.:

PRIOR TO COMMENCING COURSE OF ECT
(PHYSICAL AND MENTAL STATE ASSESSMENT CONT.)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced	Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Recently discontinued medication/illicit substances: (specify drug, frequency, dose when discontinued)

Name	Dose	Frequency	Date Discontinued	Name	Dose	Frequency	Date Discontinued

Allergies: ☐ Present, indicate: ________________

☐ Not known

ECT HISTORY:

Previous ECT: Yes ☐ No ☐

If yes, unilateral ☐ bilateral ☐

How many previous courses: ____________

Response to previous ECT: ________________________________

____

Date: ______ Time: __________ Signature: Dr ____________ Name: ____________

ANAETHESTIST'S COMMENTS: (if required)

____

____

____

____

____

Date: ______ Time: __________ Signature: Dr ____________ Name: ____________

Patient name: DOB: Maracis No.:

Care Record for:
Patients receiving Electroconvulsive therapy

THEATRE CHECKLIST – TO BE COMPLETED BY WARD STAFF

Ethnicity: ……………………..

Weight: __________________ Kgs Urine test abnormalities: ______________________

Could patient by pregnant? n/a ☐ yes ☐ no ☐

Does patient have/wear: ☐ dentures ☐ capped teeth ☐ hearing aid.
☐ Spectacles ☐ Oral piercings

Ward: __________________ **or** ☐ **outpatient**

(If patient requires more than 12 sessions of ECT, please use a supplementary theatre checklist).

Session	1	2	3	4	5	6	7	8	9	10	11	12
Date												
Time												
1. Correct patient (ID band/label) Allergies written in red on wristband (see guidelines)												
2. Correct case notes/prescription/ ECT record												
3. Medication given Pre-ECT <u>**only**</u> as requested.												
4. ECT nurse informed of any abnormalities												
5. Consent form signed, or, MHA documentation in case notes												
6. Investigation results in case notes												
7. Physical observations recorded on treatment page.												
8. When did patient last pass urine (date/time)												
9. When did patient last eat/drink (date/time) <u>*Must be nil by mouth from 3am*</u>												
10. Make up/nail varnish removed												
11. Hair washed night before, not wearing gel etc												
12. Jewellery and hair pins removed												
12. Encouraged to empty bladder/bowels												
14. Completed Manual Handling Assessment available in notes.												
Staff Initials:												

Patient name: DOB: Maracis No.:

THEATRE CHECKLIST TO BE COMPLETED BY PRE-TREATMENT ECT STAFF

Session	1	2	3	4	5	6	7	8	9	10	11	12
Date												
Time												
16.Oral body piercings removed												
17. Artificial eyes/contact lenses removed.												
18. Anaesthetist informed of any abnormalities												
19.Hearing aids/ spectacles removed												
20.Dentures removed												
21 Electrode sites prepared												
22. Diabetics only: blood glucose level.												
23. Patient's consent or appropriate forms checked.												
Staff Initials.												

Patient name: DOB: Maracis No.:

DATE **TREATMENT 1**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

1. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

2. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

3. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

Patient name: DOB: Maracis No.:

CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature _______________________

Print name ___________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 2**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**		**Airway**	
BP		Thiopentone				Guedel	
ECG		Propofol				Bite Block	
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit		LMA	
ETCO2		Other				ETT	
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

1. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

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3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

2. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
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3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

3. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
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Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

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CAPACITY ASSESSMENT

Must be completed by the <u>Consultant Psychiatrist or Section 12 Approved doctor</u>

Has capacity changed since the last review? Yes ☐ No ☐

Patient name: DOB: Maracis No.:

Does the patient have capacity to consent to ECT? Yes ☐ No ☐
Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature ______________________

Print name __________________

DATE: INTERIM REVIEW

Consultant Psychiatrists/ Nominated deputy to complete

INTERIM REVIEW – To be completed by Consultant Psychiatrist/Nominated Deputy

Physical Examination: ______________________________

CVS: ______________________________

Respiratory: ______________________________

CNS: ______________________________

Abdomen: ______________________________

VTE ______________________________

Investigation	**Result**	**Date**
FBC:		
U&E and other biochemistry:		
Other:LFT,sickle cell, Hep B.		
ECG (if indicated		
Chest X-ray (if indicated)		
Pregnancy test (if indicated)		

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced

Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Date: ______ Time: ____________ Signature: Dr ______________ Name: ______________

NB If treatment is to continue please complete next pre-treatment prescription, or record reason for discontinuation on variance sheet

Patient name: DOB: Maracis No.:

DATE **TREATMENT 3**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ………………………

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

4. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill
1 = Normal, not at all ill 5 = Markedly ill
2 = Borderline mentally ill 6 = Severely ill
3 = Mildly ill 7 = Among the most extremely ill patients

5. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change
1 = Very much improved 5 = Minimally worse
2 = Much improved 6 = Much worse
3 = Minimally improved 7 = Very much worse

6. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as ‘Moderate’ and side effects are judged ‘Do not significantly interfere with the patient’s functioning’.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient’s functioning*	*Significantly interferes with patient’s functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn’t alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

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Patient name: DOB: Maracis No.:

CAPACITY ASSESSMENT

Must be completed by the <u>Consultant Psychiatrist or Section 12 Approved doctor</u>

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date__________ Time________ Signature _________________________

Print name _____________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 4**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

4. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

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1 = Normal, not at all ill | 5 = Markedly ill
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3 = Mildly ill | 7 = Among the most extremely ill patients

5. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed | 4 = No change
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2 = Much improved | 6 = Much worse
3 = Minimally improved | 7 = Very much worse

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Unchanged or worse		13	14	15	16
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CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Patient name: DOB: Maracis No.:

Does the patient have capacity to consent to ECT? Yes ☐ No ☐
Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature _______________________

Print name ___________________

DATE: **INTERIM REVIEW**

Consultant Psychiatrists/ Nominated deputy to complete

INTERIM REVIEW – To be completed by Consultant Psychiatrist/Nominated Deputy

Physical Examination: ____________________________

CVS: ____________________________

Respiratory: ____________________________

CNS: ____________________________

Abdomen: ____________________________

VTE ____________________________

Investigation	Result	Date
FBC:		
U&E and other biochemistry:		
Other:LFT,sickle cell, Hep B.		
ECG (if indicated		
Chest X-ray (if indicated)		
Pregnancy test (if indicated)		

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced

Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Date: ______ Time: ____________ Signature: Dr ______________ Name: ______________

NB If treatment is to continue please complete next pre-treatment prescription, or record reason for discontinuation on variance sheet

Patient name: DOB: Maracis No.:

DATE **TREATMENT 5**

WARD NURSING STAFF RESPONSIBILITIES:
Important – specify medication changes
Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ………………………
Consent Informed consent (Consent form and/or T4 completed) ☐
Second Opinion (T5/T6 completed) ☐
Best Interest (DoH form 4 completed) ☐
Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐
Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

7. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

8. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

9. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

Patient name: DOB: Maracis No.:

CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date__________ Time________ Signature ________________________

Print name ____________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 6**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD						
ASA Grade		Comments:				
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**	
BP		Thiopentone			Guedel	
ECG		Propofol			Bite Block	
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA	
ETCO2		Other			ETT	
Date and Time:			**Anaesthetists Signature:**			

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

7. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

8. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

9. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

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CAPACITY ASSESSMENT

Must be completed by the <u>Consultant Psychiatrist or Section 12 Approved doctor</u>

Has capacity changed since the last review? Yes ☐ No ☐

Patient name: DOB: Maracis No.:

Does the patient have capacity to consent to ECT? Yes ☐ No ☐
Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature _______________________

Print name ___________________

DATE:	**INTERIM REVIEW**
Consultant Psychiatrists/ Nominated deputy to complete	

INTERIM REVIEW – To be completed by Consultant Psychiatrist/Nominated Deputy

Physical Examination: ______________________________

CVS: ______________________________

Respiratory: ______________________________

CNS: ______________________________

Abdomen: ______________________________

VTE ______________________________

Investigation	**Result**	**Date**
FBC:		
U&E and other biochemistry:		
Other:LFT,sickle cell, Hep B.		
ECG (if indicated		
Chest X-ray (if indicated)		
Pregnancy test (if indicated)		

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced

Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Date: ______ Time: ____________ Signature: Dr ______________ Name: ______________

NB If treatment is to continue please complete next pre-treatment prescription, or record reason for discontinuation on variance sheet

Patient name: DOB: Maracis No.:

DATE **TREATMENT 7**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD						
ASA Grade		Comments:				
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**	
BP		Thiopentone			Guedel	
ECG		Propofol			Bite Block	
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA	
ETCO2		Other			ETT	
Date and Time:			**Anaesthetists Signature:**			

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

10. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

11. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

12. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature _______________________

Print name ___________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 8**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

10. Severity of Illness: Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

11. Global improvement: Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

12. Efficacy index: Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

CAPACITY ASSESSMENT

Must be completed by the <u>Consultant Psychiatrist or Section 12 Approved doctor</u>

Has capacity changed since the last review? Yes ☐ No ☐

Patient name: DOB: Maracis No.:

Does the patient have capacity to consent to ECT? Yes ☐ No ☐
Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature ______________________

Print name ___________________

DATE:	**INTERIM REVIEW**
Consultant Psychiatrists/ Nominated deputy to complete	

INTERIM REVIEW – To be completed by Consultant Psychiatrist/Nominated Deputy

Physical Examination: ____________________

CVS: ____________________

Respiratory: ____________________

CNS: ____________________

Abdomen: ____________________

VTE ____________________

Investigation	Result	Date
FBC:		
U&E and other biochemistry:		
Other:LFT,sickle cell, Hep B.		
ECG (if indicated		
Chest X-ray (if indicated)		
Pregnancy test (if indicated)		

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced

Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Date: ______ Time: ____________ Signature: Dr ______________ Name: ______________

NB If treatment is to continue please complete next pre-treatment prescription, or record reason for discontinuation on variance sheet

Patient name: DOB: Maracis No.:

DATE **TREATMENT 9**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**		**Airway**	
BP		Thiopentone				Guedel	
ECG		Propofol				Bite Block	
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit		LMA	
ETCO2		Other				ETT	
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

13. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

14. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

15. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

Patient name: DOB: Maracis No.:

CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date__________ Time________ Signature _________________________

Print name ____________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 10**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

13. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed
1 = Normal, not at all ill
2 = Borderline mentally ill
3 = Mildly ill
4 = Moderately ill
5 = Markedly ill
6 = Severely ill
7 = Among the most extremely ill patients

14. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed
1 = Very much improved
2 = Much improved
3 = Minimally improved
4 = No change
5 = Minimally worse
6 = Much worse
7 = Very much worse

15. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

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CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Patient name: DOB: Maracis No.:

Does the patient have capacity to consent to ECT? Yes ☐ No ☐
Additional documentation should be completed in the notes to support the above assessment.

Date_________ Time_______ Signature ______________________

Print name __________________

DATE:	**INTERIM REVIEW**
Consultant Psychiatrists/ Nominated deputy to complete	

INTERIM REVIEW – To be completed by Consultant Psychiatrist/Nominated Deputy

Physical Examination: ______________________________

CVS: ______________________________

Respiratory: ______________________________

CNS: ______________________________

Abdomen: ______________________________

VTE ______________________________

Investigation	**Result**	**Date**
FBC:		
U&E and other biochemistry:		
Other:LFT,sickle cell, Hep B.		
ECG (if indicated		
Chest X-ray (if indicated)		
Pregnancy test (if indicated)		

Mental State Assessment:

Cognitive Assessment (MMSE, retrograde amnesia and assessment of subjective memory impairment)

Current Medication: (specify drug, frequency, dose, when commenced)

Name	Dose	Frequency	Date Commenced

Name	Dose	Frequency	Date Commenced

Please discontinue Benzodiazepines and anticonvulsants if possible

Date: ______ Time: ____________ Signature: Dr______________ Name: ______________

NB If treatment is to continue please complete next pre-treatment prescription, or record reason for discontinuation on variance sheet

Patient name: DOB: Maracis No.:

DATE **TREATMENT 11**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

TO BE COMPLETED BY THE CONSULTANT PSYCHIATRIST (or Section 12 approved doctor) PRIOR TO EACH TREATMENT SESSION – CLINICAL GLOBAL IMPRESSION SCALE (CGI) AND CAPACITY ASSESSMENT (WITHIN 24 HOURS PRIOR TO TREATMENT).

CLINICAL GLOBAL IMPRESSION (CGI)

16. **Severity of Illness:** Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

0 = Not assessed 4 = Moderately ill
1 = Normal, not at all ill 5 = Markedly ill
2 = Borderline mentally ill 6 = Severely ill
3 = Mildly ill 7 = Among the most extremely ill patients

17. **Global improvement:** Rate total improvement whether or not, in your judgement, it is due entirely to drug treatment. Compared to hid/her condition at admission to the project, how much has he/she changed?

0 = Not assessed 4 = No change
1 = Very much improved 5 = Minimally worse
2 = Much improved 6 = Much worse
3 = Minimally improved 7 = Very much worse

18. **Efficacy index:** Rate this item on the basis of drug effect only. Select the terms which best describe the degrees of therapeutic effect and side effects and record the number in the box where the two items intersect.

EXAMPLE: Therapeutic effect is rated as 'Moderate' and side effects are judged 'Do not significantly interfere with the patient's functioning'.

Therapeutic effect		**Side effects**			
		None	*Do not significantly interfere with patient's functioning*	*Significantly interferes with patient's functioning*	*Outweighs therapeutic effect*
Marked	Vast improvement. Complete or nearly complete remission of all symptoms.	01	02	03	04
Moderate	Decided improvement. Partial remission of symptoms.	05	06	07	08
Minimal	Slight improvement which doesn't alter status of care of patient.	09	10	11	12
Unchanged or worse		13	14	15	16
Not assessed = 00					

Reproduced from Guy W, editor. ECDEU Assessment Manuals for Psychopharmacology. 1976. Rockville, MD, U.S. Department of Health.

CAPACITY ASSESSMENT

Must be completed by the Consultant Psychiatrist or Section 12 Approved doctor

Has capacity changed since the last review? Yes ☐ No ☐

Does the patient have capacity to consent to ECT? Yes ☐ No ☐

Additional documentation should be completed in the notes to support the above assessment.

Date__________ Time________ Signature _________________________

Print name _____________________

Patient name: DOB: Maracis No.:

DATE **TREATMENT 12**

WARD NURSING STAFF RESPONSIBILITIES:

Important – specify medication changes

Temperature: Pulse: BP: Oxygen Saturation:

WARD MEDICAL STAFF RESPONISBILITIES: Pre treatment prescription tick boxes as appropriate

Mental Health Act Status Informal ☐ Section ☐ Please specify ……………………..

Consent Informed consent (Consent form and/or T4 completed) ☐

Second Opinion (T5/T6 completed) ☐

Best Interest (DoH form 4 completed) ☐

Emergency Treatment (Section 62 completed) ☐

ECT Prescription Weekly ☐ Twice Weekly ☐

Bilateral ☐ Unilateral ☐ Right ☐ Left ☐

Date	**Consultant Psychiatrist/Nominated Deputy's Signature**

ECT TEAM TREATMENT RECORD

PSYCHIATRISTS RECORD	1st Stimulation	2nd Stimulation	3rd Stimulation
Dose in millicoulombs			
Setting (%)			
Seizure Duration observed			
Seizure Duration EEG			
Comments (including description of seizure)			
Date and Time:	**Psychiatrists signature:**		

ANAESTHETIC RECORD							
ASA Grade		Comments:					
Monitoring (tick)		**Drugs Given**		**IV Access**	**Airway**		
BP		Thiopentone			Guedel		
ECG		Propofol			Bite Block		
SaO2		Suxamethonium		**Gas Delivery** 100% Oxygen by Waters' circuit	LMA		
ETCO2		Other			ETT		
Date and Time:			**Anaesthetists Signature:**				

Observations	**Pre Treatment**	**Post Treatment**	**Recovery Room**	**Recovery Nurse Comments (Including time to recover)**
Oxygen Saturation				
Pulse				
BP				
Respiration				
Temperature				**Date and time:** **Recovery Nurse Signature:**

Patient name: DOB: Maracis No.:

DISCONTINUATION DECISION

Consultant Psychiatrist Responsibilities

Once the decision is made to discontinue treatment please complete the following:

Number of sessions of ECT administered: ☐

Reasons for discontinuation: Desired clinical response achieved ☐

Poor clinical response: ☐ Physical Health problem ☐ Adverse event ☐ Consent withdrawn ☐

Comments

Date: ________ Time: ________ Signed: ________