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COMPLIANCE WITH ECT NICE GUIDANCE BY THE JOHN CONNOLLY ECT CLINIC: JANUARY 2010 - JULY 2010

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SUMMARY

Objectives: *To review current practice at the John Connolly Wing ECT clinic and to explore compliance with NICE ECT guidance. Standards used included the ECT TA59 guidelines of 2003 with the updated depression guidance CG90 of 2009. To recommend a programme of action to the Trust which would ensure that clinical practice and service delivery within the Trust complies with NICE guidance.*

Method: *A retrospective baseline Trust wide audit was conducted between the period of January 2010 to July 2010 inclusive. Cases were identified using ECT clinic record then computer Rio notes explored for evidence of compliance with NICE guidelines as set out in the audit standards. All data was extracted from the case notes on the Rio system. An audit tool was completed for each case. The data recorded on the audit tool was explored and entered onto an Excel spreadsheet for analysis.*

Results: *A total of 14 patients were identified. Of these, 6 were male and 8 were female. They comprised of 8 inpatients and 6 outpatients. The majority of patients had a diagnosis a severe depressive episode.*

13 patients received bilateral ECT. In 1 case the first 3 sessions were unilateral and the rest were bilateral due to patient choice. 9 patients consented to ECT; 5 lacked capacity to consent and 1 of those was treated under Section 62 of the Mental Health Act. The number of treatments ranged from 0-15 with an average number of 7. This included 1 patient who did not receive ECT at all due to concerns raised by anaesthetist once at the ECT clinic. Reasons for stopping ECT included a response being achieved in 5 patients; anaesthetic risk in 3; withdrawal of consent in 2; T6 no longer valid in 1; no reason documented in 3 patients.

Compliance with NICE guidelines was particularly good regarding the indications for ECT. An adequate trial of treatment was evidenced prior to consideration of ECT. Documentation of the exploration of the risk to benefit ratio both amongst the team and with the patient was poor. Assessment of the patient after each ECT and on-going cognitive assessment was poor.

Conclusion: *This audit highlights the need for sound documentation of our practice. It also stresses the need for further clarity regarding the roles and responsibilities of the RMO and their team and the ECT team.*

Recommendations: *An ECT Care Pathway document has been produced to improve compliance with NICE guidance and improve documentation of practice. This document has been introduced for use in the Trust. We plan to re-audit for improvement in compliance.*

Key words: *ECT – audit - depression*

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INTRODUCTION

A retrospective baseline audit was conducted to assess compliance of practice at the ECT clinic with NICE guidance. This included the ECT TA59 guidelines of 2003 with the updated depression guidance CG90 of 2009. All patients that underwent ECT from January 2010 to July 2010 inclusive were included and data was collected from the Rio notes.

Table 1. People involved with the audit

Name	Job Title	Service Delivery Unit
Dr Ian Nnatu	ECT Lead Consultant Psychiatrist	Ealing Service Delivery Unit
Dr Sophia Ulhaq	CTI Psychiatry	Ealing Service Delivery Unit
Raj Sooky	Ward Manager	Ealing Service Delivery Unit
Sara Kerry	Clinical Effectiveness & Audit Co-ordinator	Trust-wide

Standards

NICE ECT Guidance 2003. See Appendix C.

OBJECTIVES

To recommend a programme of action to the Trust which would ensure that clinical practice and service delivery within the Trust complies with the NICE guidance.

METHODOLOGY

A retrospective audit was conducted. All patients that underwent ECT during the audit period of January 2010 to July 2010 inclusive were included. The case notes for these patients were identified on the Rio system. Each set of case notes was explored for evidence of compliance with NICE guidelines as set out in the audit standards.

Data collection

All data was extracted from the case notes on the Rio system. The audit tool was completed for each case and was stored both on paper files and on computer files.

Data analysis

The data recorded on the audit tool was explored and entered onto an Excel spreadsheet for analysis.

Table 2. Findings - the heading itself

Criterion	Standard	Compliance
1	The individual receiving ECT has one of the following: a. Severe depressive illness b. Catatonia c. A prolonged or severe manic episode d. Not stated e. Other	100 % (14/14)
2	ECT is used to achieve rapid and short-term improvement of severe symptoms	100% (14/14)
3	An adequate trial of treatment options has proven ineffective	100% (14/14)
4	The individual has a potentially life threatening condition	79% (11/14)
5	An assessment of the risks and potential benefits of the ECT for the individual has been made: Risk associated with anaesthetic	64% (9/14)
6	Current comorbidities	64% (9/14)
7	Anticipated adverse events including cognitive impairment,	57% (8/14)
8	The individual provides consent for each course of treatment	100% (9/9)
9	If lacks capacity advance directives, individuals carer or advocate consulted	60% (3/5)
10a	Consent process: Involved the individuals advocate and/or care where possible	43% (6/14)
10b	Provided full and appropriate information in a suitable format and language to enable an informed discussion	43% (6/14)
10c	Explained and discussed the general risks of ECT, risks specific to the individual, enhanced risks for individuals in specific groups and potential benefits to the individual	50% (7/14)
10d	Not pressured or coerced the individual into consenting to ECT	100% (14/14)
10e	Reminded the individual that he/she has the right to withdraw consent at any point	44% (4/9)
11	The individuals clinical status was assessed after each ECT session	29%(4/14)
12	The individuals cognitive function was monitored on an ongoing basis	7% (1/14)
13	The individuals cognitive function was monitored at the end of the course of treatment	29% (4/14)
14	Was ECT stopped?	100% (14/14)
15	ECT was stopped when: a. A response was achieved b. Ther was evidence of adverse events c. The individual withdrew consent d. No response was achieved	79% (11/14)
16	Repeat course of ECT	nil

RESULTS

A total of 14 patients were identified for the audit period from January to July 2010 inclusive and included in the audit. Of these, 6 were male and 8 were female. They comprised of 8 inpatients and 6 outpatients.

Diagnoses included 12 patients with a severe depressive episode, 1 with paranoid schizophrenia and 1 with recurrent depressive disorder with comorbid emotionally unstable personality disorder.

ECT was prescribed to improve severe symptoms in all 14 cases and evidence of an adequate trial of treatment was found in all 14. In 11 cases it was clearly documented that the patient was in a potentially life threatening condition.

Regarding exploration of the risk to benefit ratio, this was documented in 9 cases but not documented in 5. There was documentation that the risks and benefits were discussed with the patient in 7 cases. However this was not documented in 7 cases.

Consent to treatment with ECT was given in 9 cases. In 4 cases a T6 was implemented and in 1 case ECT was given under section 62 of the Mental Health Act. There was no evidence of undue coercion in any case. Of the 9 cases that consented, 1 patient consented for the first 2 treatments. This patient was then treated for further

ECT under a T6. Another patient gave consent for treatment at the first 6 ECT sessions. The next session was administered under a T2, then all further sessions administered with the patient giving consent.

It was documented in 6 cases that there had been discussion with the patient's carer or advocate when reaching a decision on prescribing ECT.

There was documented evidence that full information was provided in 6 cases. However this was not documented in 8 cases.

The right to withdraw consent was explained to 4 cases but not documented in 5. In 5 cases this was not applicable.

The assessment of clinical status after each ECT was documented in 4 cases but not documented in 10 cases. On-going monitoring of cognitive function was documented in 1 case but not documented in 13 cases. Assessment of cognitive function at the end of course of ECT was documented in 4 cases but not in 10 cases.

13 patients received bilateral ECT. In 1 case the first 3 sessions were unilateral and the rest were bilateral due to patient choice.

The number of treatments received by each patient ranged from 0-16. The average number of treatment received by each patient was 7. This included 1 patient who did not receive ECT at all, initially due to incomplete medical workup. When he did undergo full medical investigation it was found he was at a high anaesthetic risk, so ECT was not administered. This patient was included in the audit as he did attend the ECT clinic despite ECT not being administered.

The reasons for discontinuing ECT were varied. In 5 cases, a response was achieved. In 3 cases ECT was stopped due to anaesthetic risk. In 2 cases consent was withdrawn. In 1 case it was documented that the T6 was no longer valid. In 3 cases the reasons for discontinuing ECT were not documented.

Of note, the ECT clinicians assessed potential risks and benefits of ECT and the consent process in 9 out of 14 patients.

DISCUSSION

Methodological issues

Due to time constraints, data was collected from Rio system only. We plan to explore in addition to this, the medical files also when conducting any future audit.

Compliance with the standards

Overall compliance with the standards was fair. Compliance was particularly good in regard to the indications for ECT, namely severe mental illness with potentially life threatening conditions. In all cases an adequate trial of alternative treatment has been explored prior to the consideration of ECT.

However this audit highlighted a number of issues. Documentation of the exploration of risks and benefits of ECT amongst the medical team and discussion with the patient was poor. Similarly the provision of full information including the right to withdraw consent was not evidenced in the majority of cases. The assessment of the patients after each ECT session and on-going monitoring of cognitive function was also poor.

These difficulties may arise as a result of inadequate clarity regarding who is responsible to complete the work up prior to ECT administration and who is to monitor the patient during and after treatment. It is, of course the responsibility of the RMO's team to explore the suitability of ECT and have discussions with the patient regarding risk and benefits. Similarly it is the same team's responsibility to assess the patient after each ECT session and continually monitor cognitive function.

CONCLUSION

The aim of this audit was to review current practice at the John Connolly Wing ECT clinic and to explore compliance with the NICE ECT guidance 2003. Data was collected retrospectively for all patients that were to have ECT during the period January to July 2010 inclusive. 14 patients were identified and the Rio case notes explored for evidence of compliance with NICE guidelines for each patient. All data was recorded on the audit tool electronically and on paper files. The compliance with NICE guideline was particularly good regarding the indications for ECT, with all the majority of patients having a severe depressive episode with potentially life threatening features. An adequate trial of treatment was evidenced prior to consideration if ECT. Documentation of the exploration of the risk to benefit ratio both amongst the team and with the patient was poor. Assessment of the patient after each ECT and on-going cognitive assessment was poor. This audit highlights the need for further clarity regarding the roles and responsibilities of the RMO and their team and the ECT team. It has shown that documentation needs to be improved and therefore highlights the need for sound documentation of our practice.

RECOMMENDATIONS

We recommend a future audit of compliance with NICE guidelines to be undertaken.

We recommend for any future audit the exploration of evidence of compliance in the medical files in addition to the Rio system notes.

An ECT Care Pathway document has been produced to improve compliance with NICE guidance and improve documentation of practice. This document has been introduced for use in the Trust. We plan to re-audit for improvement in compliance.

ACTION PLAN

This audit report will be disseminated following completion of the documentation audit.

Appendix A. Audit Tool

The following information is clearly documented in the patients records:

The individual receiving ECT has one of the following

❑ *Severe Depressive Illness*
❑ *Catatonia*
❑ *Prolonged Severe Manic Episode*
❑ *Not stated*
❑ *Other*
If other, please state

ECT is being used to achieve rapid and short term improvement of severe symptoms?

❑ *Yes* ❑ *No*

An adequate trial of treatment options has proven ineffective?

❑ *Yes* ❑ *No*

The individual has a potentially life threatening condition

❑ *Yes* ❑ *No*

An assessment of the risks and potential benefits of the ECT for the individual has been made

Risk associated with the anaesthetic

❑ *Yes* ❑ *No*

Current co-morbidities

❑ *Yes* ❑ *No*

Anticipated adverse event, including the risk of cognitive impairment

❑ *Yes* ❑ *No*

The individual provides consent for each course of treatment

❑ *Yes* ❑ *No*
❑ *Detained MHA* ❑ *Lacks capacity*

If lacks capacity advance directives, individuals carer or advocate consulted

❑ *Yes* ❑ *No*

The consent process provides that the clinician(s) responsible for treatment has:

Involved the individuals advocate and/or care where possible

	Yes	*No*
Involved the individuals advocate and/or care where possible	❑	❑
Provided full and appropriate information in a suitable format and language to enable an informed discussion	❑	❑
Explained and discussed the general risks of ECT, risks specific to the individual, enhanced risks for individuals in specific groups and potential benefits to the individual	❑	❑
Not pressured or coerced the individual into consenting to ECT	❑	❑
Reminded the individual that he/she has the right to withdraw consent at any point	❑	❑

The individuals clinical status was assessed after each ECT session

❑ *Yes* ❑ *No*

The individuals cognitive function was monitored on an ongoing basis

❑ *Yes* ❑ *No*

The individuals cognitive function was monitored at the end of the course of treatment

❑ *Yes* ❑ *No*

Was ECT stopped?

❑ *Yes* ❑ *No*

ECT was stopped when:

	Yes	*No*
A response was achieved	❑	❑
There was evidence of adverse events	❑	❑
The individual withdrew consent	❑	❑
No response was achieved	❑	❑

A repeat course of ECT is provided only for an individual in either one of the following circumstances:

The individual meets criteria as set out in Q3 to Q6 and has previously responded well to ECT	❑
The individual has not responded previously but is experiencing an acute episode and all other options have been considered and following discussion with the individual and /or where appropriate, the carer or advocate of the risks and benefits of such a course of action	❑

Appendix B. Post-Audit IMPLEMENTATION PLAN

West London Mental Health NHS Trust
Many viewpoints. One vision.

Appendix B Post-Audit IMPLEMENTATION PLAN

To be completed upon receipt of an audit report and at least every 6 months thereafter until all action has been taken.

Audit:
Team/Service:
Directorate:
Division:
Plan signed off by:
Date:

Plan copied to: *please delete those not applicable*

-Clinical Effectiveness & Audit Forum
-Divisional Clinical & Research Governance Group
-Directorate Clinical & Research Governance Group
-Directorate Audit Group - *for information*
-Clinical Effectiveness & Audit Team - *for information*
-Other:

Area identified for action *Identify all areas within the audit report that require action*	**Changes to be implemented** *Describe the necessary changes to be made to practice*	**By Whom** *Person responsible for making the changes*	**By When** *When this will be completed*	**Review date** *Date when you will review progress.*	**Current Progress** *Describe what has been achieved. Add new actions in rows below as required.*
Audit of documentation	Audit of documentation will ratify the RiO audit and further identify our compliance with the guidance. Recommendations will be made following this audit.	CT 1-3	March 2011	March 2011	

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