The Regulation and Quality Improvement Authority

Electroconvulsive Therapy (ECT) Suite

Altnagelvin Area Hospital

Western Health and Social Care Trust

Date of Inspection 4 July 2016

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1.0 Summary of this Inspection

This report provides information on the findings of RQIA following the inspection of Electroconvulsive Therapy (ECT) in Altnagelvin Area Hospital on 4 July 2016. Altnagelvin was selected as it is not ECT Accreditation Service (ECTAS) accredited.

For patients who reside in the Northern Sector of the Western Trust, ECT is carried out in the Day Procedures Unit, Altnagelvin Area Hospital. The ECT suite was last inspected on 25 November 2013. The review was based on ECTAS standards which are recognised and endorsed by the Royal College of Psychiatrists. The purpose of ECTAS standards is to assure and improve the quality of the administration of ECT.

Prior to the inspection ECTAS standards were cross referenced to the four domains used by RQIA in inspections in 2016-17 and this report highlights the levels of compliance in relation to safe, effective, compassionate and well led care. RQIA noted a high level of conformity with the ECTAS standards. Improvement is required in relation to dedicated sessional time for ECT lead nurse.

Given that the trust has achieved a high level of compliance in relation to ECTAS standards it is encouraged to apply for ECTAS accreditation.

The views of service users who have experienced ECT are obtained separately. At the time of inspection no service user was available for interview.

We would like to thank all staff involved in returning information on ECT to RQIA and those who participated in the inspection process.

This inspection focused on the theme of **Person Centred Care.**
This means that patients are treated as individuals, and the care and treatment provided to them is based around their specific needs and choices.

2.0 Inspection Methodology

RQIA agreed a number of Inspection standards based on ECT Accreditation Service (ECTAS) standards.

The standards selected were as follows:

- Policies and Procedures
- Staff induction, training records and rotas
- Review of patient notes and ECT records
- ECT pathway
- Maintenance of equipment records
- Incident records
- Patient experience/ feedback
- Environmental assessment
- Quality of environment
- Patient experience questionnaire

On 10 May 2016 RQIA informed the Western Trust of the inspection date of 4 July 2016 and forwarded the associated inspection documentation, to enable the trust to complete a self-assessment against the agreed standards. Return of this self-assessment questionnaire to RQIA was requested by 7 June 2016.

The Inspection process included an analysis of the trust's self-assessment documentation, other associated information, and discussions with key staff. These staff included lead consultant, lead consultant anaesthetist, the administering doctor and nurses involved in the administration of ECT. A range of multi-disciplinary records were also examined as part of the Inspection process.

The individual's right to privacy, dignity and autonomy, and the patient experience, is central to the work of the MHLD Directorate.
Although patients were not interviewed as part of this review, RQIA sought the views of patients by using an amended ECTAS patient questionnaire which was distributed by the trust to patients following their course of ECT. A separate batch of 40 questionnaires was given to WHSCT for onward distribution to all patients post ECT treatment from April 2016. There was no requirement by RQIA to observe ECT being carried out in each suite.

What the inspectors did:

- Reviewed self assessment documentation sent to RQIA prior to the inspection
- Talked to staff
- Reviewed other documentation on the days of the inspection
- Reviewed the progress made in the administration of ECT since the last inspection

3.0 ECT Introduction

ECT is a medical procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalised seizure activity. The person receiving the treatment is placed under general anaesthetic and muscle relaxants are given to prevent muscle spasms. Repeated treatments induce several molecular and cellular changes in the brain that are believed to stimulate antidepressant mechanisms. Normally ECT is given twice a week up to a maximum of 12 treatments per course of ECT.

ECT is usually provided to patients who have not responded to other treatments and for whom there are no other effective treatments. It is often a life-saving treatment for those who are actively suicidal or refusing food and fluids or who are physically debilitated by depression. Guidelines produced by NICE advises that ECT should be used when other treatments have failed, or in emergency situations.

Depressive disorders continue to be indicated as the diagnostic group who require the majority of ECT courses: treatment resistant mania and, in some circumstances, schizophrenia are occasional indications for treatment with ECT.

There is robust scientific evidence that ECT is medically safe and effective. It is most commonly prescribed for severe depression. Many patients receiving ECT do so voluntarily and provide fully informed consent, based on an understanding of the treatment, the reasons why it is being offered and possible risks and side effects.
In cases where this is not possible, a second opinion of a Part IV doctor is sought from RQIA.

4.0 Follow up on Previous Recommendations

Ten key areas required improvement by WHSCT following inspection on 25 November 2013 these are set out below;

- a designated budget for ECT including training
- a lead ECT Nurse should be identified
- the lead consultant should have protected time specified in their job plan
- multidisciplinary team working requires to be developed to improve communication between general hospital and mental health/older peoples directorates as there was little opportunity for joint working between directorates
- dedicated sessional time should be agreed for all staff involved in the management and administration of ECT
- an ECT Care Pathway requires to be developed further and implemented
- training and development plans for all ECT staff should be developed
- the methodology for data collection requires to be reviewed in relation to the compilation of ECT statistics for RQIA accurately every quarter
- the trust should review post treatment availability of refreshments for patients
- the trust should strive to achieve ECTAS accreditation

Action taken by the trust since 25 November 2013

A designated budget for ECT including training

There is currently no defined ECT training budget and inspectors were advised that training is fully funded and as there is a generous allocation of training a defined budget is not required.

A lead ECT Nurse should be identified

A lead ECT nurse has now been identified and the role has been developed for the Northern sector of WHSCT. While there is no dedicated sessional time for the clinical duty a band 6 has been given the nominal title of ECT Lead Nurse.

The lead consultant should have protected time specified in their job plan

The lead consultant has protected time and has a dedicated session for ECT in her job plan and time for CPD related to ECT.
She is assessed as competent to carry out the role and has completed the competencies from the RCPsych document.
She has participated in the NI training day to ensure others had the competencies completed.
She is a member of the RCPsych in NI ECT Consultants' group and regional ECT forum.
She has contributed to the development the WHSCT ECT care pathway and policy including protocols, and is present for at least 25% of ECT sessions

The multidisciplinary team working requires to be developed to improve communication between general hospital and mental health/older peoples directorates as there was little opportunity for joint working between directorates.

There was evidence of excellent multidisciplinary working between mental health and general hospital staff. Joint induction sessions have been organised and roles and responsibilities have been clearly defined. There was evidence of joint protocols and training initiatives have been developed.

Dedicated sessional time should be agreed for all staff involved in the management and administration of ECT

There is dedicated sessional time for staff involved in the management and administration of ECT and this is agreed and clearly defined. Although there is no dedicated sessional time for the clinical duty a band 6 has been given the nominal title of ECT lead nurse. There is time allocated to induction and the team meet on a regular basis.

The ECT Care Pathway requires to be developed further and implemented

The ECT Care Pathway has been developed for the WHSCT and is fully implemented. There is an ECT Policy which details and outlines individual roles and responsibilities for each member of the MDT involved in the administration of ECT.

Training and development plans for all ECT staff should be developed

Training and development plans have been developed and training competencies are defined e.g. all medical and nursing staff must be trained to ILS minimum.

The methodology for data collection requires to be reviewed in relation to the compilation of ECT statistics for RQIA accurately every quarter

This has been completed and is evidenced by the timely statistical returns which are forwarded to RQIA. The methodology for data collection has been reviewed and ECT statistics are sent to RQIA on a quarterly basis.

The trust should review post treatment availability of refreshments for patients

This was in place and all patients receive tea/coffee/ toast following their procedure. The post ECT waiting area has provisions for refreshments for patients and provides a relaxed environment and the patient is offered something to drink and eat before they are discharged from the ECT suite. Water is available from the kitchen and tea and toast is provided at the bedside.

The trust should strive to achieve ECTAS accreditation

Inspectors agreed that the trust should achieve ECTAS accreditation as the policies, procedures and the standards are in place and the trust has demonstrated readiness for ECTAS requirements.

5.0 The Four Stakeholder Outcomes, and What We Found

5.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Examples of Evidence:

- ✓ The ECT treatment area is of an adequate size for its purpose has easy access to a telephone and speech from the treatment area cannot be heard in the waiting area.
- ✓ All clinic staff involved in the administration of ECT have appropriate induction and training including basic life support techniques.
- ✓ Up to date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia are prominently displayed.
- ✓ There is a fully equipped emergency trolley with resuscitation equipment, drugs as agreed with the ECT anaesthetist or pharmacy and a defibrillator.
- ✓ The treatment area is located a reasonable distance from the waiting area and therefore speech cannot be overheard.
- ✓ Clinic staff can communicate with the recovery area by internal phone or by leaving the treatment area and walking to the recovery area; this is adjacent or a few doors down, depending on the treatment day.
- ✓ There is a named consultant anaesthetist with dedicated sessional time devoted to direct clinical care in the provision of anaesthesia for ECT.
- ✓ Up to date protocols are available but are not prominently displayed.
- ✓ The treatment room is equipped with scavenging equipment and agent monitoring.
- ✓ Anaesthesia is administered by either a consultant anaesthetist or non-consultant career grade.
- ✓ A small number of anaesthetic speciality/consultant doctors manage the large majority of the ECT treatment sessions.
- ✓ The rota does not include unsupervised doctors in junior training grades.

- ✓ All clinical staff are trained in basic life skills (BLS).
- ✓ All the medical staff and ECT nursing staff are trained to at least intermediate life skills (ILS) standard.
- ✓ There is one person competent in CPR for every unconscious patient. The number of staff in the recovery area exceeds the number of patients by one.
- ✓ Day procedure staff are trained in relation to life support, and are aware of legislation around capacity, involuntary treatment etc.
- ✓ Medical staff are fully conversant with the MHO issues, and capacity, the legal frameworks which apply and the policies which govern ECT.
- ✓ Mental health nursing staff receive training around the MHO, capacity, legal issues etc.
- ✓ ECT nurses receive training via the CEC.
- ✓ The lead nurse attends the relevant courses, or are enabled to do so by the Trust as part of their role.
- ✓ The service leads are involved in the regional ECT forum.
- ✓ Valid consent is documented in the care pathway along with consideration of capacity.
- ✓ There is a ECT Care pathway which is used for the administration and monitoring. A record is kept of treatment doses, seizure quality and duration and whether bilateral or unilateral has been administered. A record is kept of the patients physiological parameters. A record is kept of the anaesthetic induction agent dose, muscle relaxant dose and any other ancillary medication used.
- ✓ The clinical notes are conveyed along with the ECT care pathway including consent documentation and any relevant MHO documentation to the treatment area.

- ✓ A fully trained theatre nurse from day procedure is responsible for the unconscious patient and is able to spot signs of deterioration and use aspiration/suction equipment, inform the anaesthetist and perform BLS. They ensure the patient awakes appropriately and meets the discharge criteria to exit stage one recovery and move to second stage recovery.
- ✓ The escort nurse follows the patient through this to have a familiar face/voice on awakening.

- ✓ There were no adverse incidents reported since the last inspection in 2013.

Area(s) for Improvement: None identified

5.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Examples of Evidence:

- ✓ The lead psychiatrist has a dedicated session for ECT in her job plan, and time for CPD related to ECT.
- ✓ She is assessed as competent to carry out the role and has completed the competencies from the RCPsych document.
- ✓ She has participated in the NI training day to ensure others had the competencies completed.
- ✓ She is a member of the RCPsych in NI ECT Consultants' group and regional ECT forum.
- ✓ She has contributed to the development the WHSCT ECT care pathway and policy including protocols, and is present for at least 25% of ECT sessions.
- ✓ An ECT nurse is responsible for ensuring that the machine function and maintenance is undertaken and recorded at least annually (or according to manufacturer's guidance); ensuring that the clinic is properly prepared.
- ✓ The ECT nurse who is leading that day checks the function of the machine using a variable dose prior to beginning any ECT treatment. This is recorded in a log book which is kept with the primary ECT machine. Drugs are re-ordered through the theatres restocking process as per their standard procedures. The disposable equipment relevant to the ECT machine such as EEG electrode pads, gel, and paste are ordered and stocked by the nurse leading each treatment.
- ✓ The ECT machine and back up machine are delivered by the theatre porters prior to each session.
- ✓ ECT is delivered by a small cohort of band 5 nurses who have completed a training course in anaesthetic recovery nursing in ECT. Training regarding the delivery of ECT and function of the machine has been peer led.
- ✓ There is no dedicated sessional time for the clinical duty. A band 6 has been given the nominal title of ECT lead nurse.

- ✓ The ECT machine is capable of providing stimuli according to the current guidelines and has stimulus settings that may be altered easily and quickly. There are two channel EEG monitoring facilities available.
- ✓ The consultant psychiatrist who leads ECT has dedicated sessional time specified in their job plan and completes annual appraisal and have been assessed as competent to carry out the required role and has completed the RCP competency course to the required level.
- ✓ The lead psychiatrist is covered in their absence by a suitably competent psychiatrist. ECT is administered by a small cohort of experienced psychiatrists who regularly attend the ECT clinic.
- ✓ There is a line management structure with clear lines of accountability within the clinic and definition of roles and responsibilities.
- ✓ The same team work in the ECT clinic every week for the purposes of continuity.
- ✓ ECT is only administered by a psychiatrist with formal training. There is direct supervision and thorough examination of treatment charts at least once per week whilst administering ECT.
- ✓ The deputy has had ECT training in November 2015.
- ✓ Trainee psychiatrists may only administer ECT once they have completed appropriate competencies, this is under full observation and guidance by the lead Psychiatrist/ speciality doctors.
- ✓ There is a line management structure for each discipline of the multidisciplinary team involved in ECT.
- ✓ Members of the team have clear roles and responsibilities within the clinic.
- ✓ There is a small cohort of nurses, psychiatrists and anaesthetists involved in the ECT clinics. Often each week it is the same team administering the treatment.
- ✓ The patient's orientation and memory is assessed before, after the first ECT treatment and re-assessed at intervals throughout the course of ECT using a standardised cognitive assessment tool.
- ✓ Cognition is assessed prior to ECT and during the course of treatment as well as after, any issues noted or patient complaints are recorded and followed up appropriately.

- ✓ The lead nurse will be taking forward a piece of work to arrange Outpatient review at 1, 2 and 3 months post-ECT to include cognitive assessment.
- ✓ A letter to prompt community teams is being included in the up-date of the ECT policy.

Area(s) for Improvement:

- X There should be dedicated sessional time for ECT lead nurse.

5.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Examples of Evidence:

- ✓ Patients waiting for treatment are not in the same area as patients in post recovery.
- ✓ The waiting area is located a suitable distance from the treatment room and the treatment room is not visible from the waiting area.
- ✓ It has access to toilet facilities and patients waiting for ECT cannot see into the treatment area whilst treatment is taking place.
- ✓ Patients who have received ECT and have recovered can use the same waiting area as those still awaiting treatment, but this is unlikely to be the case given timing and preferred no more than 3 patients/session.
- ✓ There is no contact with those awaiting ECT and those receiving treatment.
- ✓ The area is easily accessed by a either a bed lift or standard lift therefore is fully accessible to all.
- ✓ The post ECT waiting area has provisions for refreshments for patients and provides a relaxed environment and the patient is offered something to drink and eat before they are discharged from the ECT suite.
- ✓ Water available from kitchen and tea and toast provided at the bedside.

Area(s) for Improvement: None identified

5.4 Is The Service Well Led?

Effective leadership, management and governance which create a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care.

Examples of Evidence:

- ✓ The training needs of ECT clinic staff are formally assessed and there is a budget for training related to ECT. There is evidence that staff keep up to date with best practice and latest information, and ECT staff attend appropriate training and conference events. There is evidence that such training is incorporated into their continuing professional development plans.
- ✓ There is regular training for nurses in ECT arranged by the CEC, as well as this medical staff attend ECT training, and are engaged in the local ECT Forum, and also are involved in developing training. This training is in their PDPs.
- ✓ The lead psychiatrist was facilitated to attend the RCPsych 2 day training in November 2015.
- ✓ The ECT consultant/ ECT lead nurse ensures that patients receive the Patient Experience Questionnaire following their course of ECT and requests that the patient returns it to RQIA
- ✓ The ECT consultant has a standard procedure for accurately recording information on the administration of ECT for prompt onward transmission to RQIA on a quarterly basis.
- ✓ Policies relating to ECT are reviewed at least once every two years.
- ✓ There are regular meetings between the lead consultant, lead nurse and lead anaesthetist to discuss the ECT service.
- ✓ There are regular meetings between the ECT Team and senior management within the Trust to address the budget issues, training needs, development of the service, quality improvement, safety issues and adverse incidents/near misses.
- ✓ Academic teaching and training sessions are held regularly for all ECT clinical staff and the referring clinical teams to attend.
- ✓ Regular audits are carried out to inform service improvement.

- ✓ This information is captured in the ECT care pathway, which has a specific sheet for RQIA monitoring information.
- ✓ The speciality doctor (NC) collects these sheets at the end of the treatment and keeps them in a central point to facilitate returns.
- ✓ Patient experience questionnaires and Guidance are distributed via the speciality doctor.
- ✓ The ECT lead nurse will ensure all wards have a stock of questionnaires and Guidance and that they are provided to the patients following their treatment. There were 40 supplied during the inspection.
- ✓ There is a trust-wide ECT group which meets, and the local group meets regularly, as well as attending the regional forum.
- ✓ The Northern Sector ECT staff meet regularly informally.
- ✓ Formal meetings have occurred, usually in response to issues arising.
- ✓ It is anticipated these will be introduced on a regular basis to monitor the smooth running of the service.
- ✓ ECT- specific meetings occurred frequently during the service improvement project, ECT is a part of other meetings within the trust where these issues are discussed. Subsequent regular meetings occurred around the two-site/one-site model, and looking at how to facilitate patients in Omagh with anaesthetic risk factors necessitating transfer to Altnagelvin.
- ✓ ECT monitoring figures are fed back to RQIA for collection of data on an annual basis. Local ECT audit is one of the standard audits the audit department recommends, one will be undertaken this year.
- ✓ Teaching programmes within Psychiatry and Anaesthetics which teams attend, and ECT is discussed at these.
- ✓ It is hoped to share the re-developed Policy it is finalised as an educational session for all relevant staff.

Area(s) for Improvement: None identified

6.0 Conclusion and Next Steps

This is a report on the findings of RQIA following an inspection of ECT suite, Day Procedures unit Altnagelvin Hospital on 4 July 2016. The following area of improvement was identified;

- It is recommended that there should be dedicated sessional time for ECT lead nurse.

This report is sent to the trust for factual accuracy and the trust is requested to return this within 28 days. The report will be published on RQIA website.

RQIA will:

- provide the trust with the individual inspection report
- include the findings of this inspection report on the RQIA website
- encourage the trust to sign up to ECTAS
- continue to gather the return of information quarterly on the administration of ECT from the trusts in order to monitor trends and any emerging issues or themes
- facilitate patients with a copy of the RQIA patient experience questionnaire and accompanying guidance to complete and return to RQIA in the SAE following their period of treatment so that RQIA can monitor the quality of the patient experience
- provide a separate report of findings of patient experience from analysis of questionnaires