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Good practice in ECT

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At the Department of Psychiatry, Royal South Hants Hospital, an Audit Committee of two consultant psychiatrists and the three senior registrars working in the department meet every two to three weeks to plan and execute audit projects.

Electroconvulsive therapy (ECT) was felt to be an area of practice worth evaluating. It is frequently used and is one of our more potent and invasive treatments. It had been noted that the rationale for giving ECT and the response and reason for stopping a course had, on some occasions, not been clearly documented.

The study

A two page questionnaire was compiled, the first part dealing with demographic, illness and treatment details and the second part examining specific aspects of documentation of practice. A multiple choice format was used. The questionnaire was piloted on the case-notes of six patients to eliminate any ambiguities or difficulties.

The names of the 72 patients who began a course of ECT during the six months ending on 30 September 1990 were extracted from the ECT register. A covering letter with the names of four patients and four questionnaires to be completed were circulated to all the available consultants, senior registrars and registrars who were working in the department (four patients were chosen at random not to be audited). Each doctor was asked to find the medical notes and complete the questionnaire for the course of treatment beginning on a specified date. As virtually all the medical staff were actively involved with data collection this, in itself, served to increase awareness of the inadequacies of our documented management of ECT.

Findings

Fifty completed questionnaires were returned; 18 sets of notes were not available. The results were analysed on a pocket calculator. As feedback is essential to improve practice, the senior registrar presented the results for discussion to the medical staff at the audit meeting.

Patient and treatment details

There were 19 men and 31 women in the sample. The mean age was 46.3 years with a range of 19–70 (the psychogeriatric service is situated at another hospital). Thirty-seven patients were in-patients during the course of treatment, 12 were out-patients and one patient started treatment as an in-patient and completed the course as an out-patient. The spread of diagnoses included: depression 34 (68%), mania 5 (10%), schizophrenia 3 (6%), schizophrenia with depression 5 (10%), neurosis 2 (4%), and paranoid disorder 1 (2%).

The legal status of the patients was: 44 patients voluntary, 2 patients on a section 2 or 3 (Mental Health Act, 1983) and 4 patients on a section 2 or 3 with second opinion (section 58).

The mean number of ECT treatments given in a course was 6.15; when those who withdrew consent or stopped due to side-effects the mean was 6.5. The maximum number given in one course was 17 treatments. Separate courses of ECT were not added together. Forty-five patients had bilateral ECT, 2 unilateral and 3 both.

Audit results

Was the reason for giving ECT clearly documented? If so what was the reason?

Forty-one of the 50 patients had one or more reasons given. In nine no reason was specified; "give ECT a try" was not felt to be an adequate reason.

Reason for prescribing ECT	*Number of patients*
Poor response to current medication	27
Previous good response to ECT	13
Suicide risk	11
Depression with delusions or hallucinations	11
Excitement or disturbed behaviour	9
Stupor or retardation	8
Not eating or drinking	8
Poor response to medication (previous episode)	5
	92

Was the ECT prescription form completed with details of medication, physical examination and handedness (if unilateral ECT was given)?

Five ECT prescription forms had no note of current medication; ten had no mention of physical

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examination and none of the five given unilateral ECT had any mention of handedness. Of particular concern was a patient who had mitral stenosis, where no mention was made of any physical findings beyond "mitral stenosis".

Was the patient reviewed weekly during a course of ECT?

Ten patients were not reviewed weekly; six of these were receiving out-patient ECT.

Was the response to ECT documented in the notes?

In ten casenotes no mention was made of response to ECT. Of the 40 who did have a mention, 19 showed a good response, 14 some improvement, five no change and two became manic.

Was the reason for stopping the course documented?

Eighteen notes gave no reason for stopping ECT. In some cases more than one reason for stopping ECT was given. Six patients withdrew consent, two stopped due to becoming manic, one because of a non-fatal cardiac arrest (the patient with mitral stenosis) and one because of prolonged confusion. Six patients stopped due to side-effects of ECT.

Comment

In a report to the Royal College of Psychiatrists, Pippard & Ellam (1980) gave details of their prospective study in the use of ECT. There appeared to be few significant differences in demographic, illness and treatment details between this study and theirs apart from significantly fewer unilateral courses given in this study.

Although examination of medical notes is a somewhat crude measure of patient care, good documentation tends to reflect that thought has gone into treatment decisions. It was felt by all the medical staff who attended the audit presentation that there was considerable room for improvement in the documented management of ECT.

All aspects of the care of patients should be carefully considered and documented. The rationale for giving ECT, the response and reason for stopping are all important aspects of the total care of the patient. Special attention should be paid to those having out-patient ECT and arrangements should be made to have these patients regularly reviewed. The ECT prescription form should always be completed, and particular attention should be paid to patients who are physically unwell. Handedness should be specified in patients who have unilateral ECT.

The audit project allowed other issues concerning the administration of ECT to be reviewed. As part of a future study it was decided to time all fits as this has not been regularly done in the past. To complete the audit cycle a repeat audit is planned for six months time to see whether any improvements in practice have occurred.

Reference

PIPPARD, J. & ELLAM, L. (1981) *Electroconvulsive Treatment in Great Britain, 1980*. London: Gaskell (Royal College of Psychiatrists.

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Medical audit among Scottish child psychiatrists

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Working for Patients (DOH, 1989) has provided considerable impetus to the development of medical audit. The Royal College of Psychiatrists (1989) Preliminary Report on Medical Audit defined and distinguished between clinical audit, peer review and performance indicators, and referred to some of the particular problems affecting the development of audit in psychiatric practice. There are special concerns for child and adolescent psychiatrists developing medical audit programmes because of the wide diversity of child and adolescent practice and the considerable variability of resources in the subspecialty. Nicol (1989) has described the initial concern of the National Child Psychiatry Section's

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