ECT ACCREDITATION SERVICE (ECTAS)

Prof. Chris Freeman
Chair Accreditation Committee and
Chair Reference Standards Group

ECTAS
ECT ACCREDITATION SERVICE

ECT ACCREDITATION SERVICE 10TH BIRTHDAY PARTY

ECTAS is pleased to announce we will be celebrating our 10th BIRTHDAY in 2013! We will be holding an anniversary event including presentations on best practice and a celebratory lunch, and we hope that our members will be able to join us!

Details

Date: Wednesday 22 May 2013

Place: Birmingham (venue will be confirmed with attendees)

Cost: FREE OF CHARGE

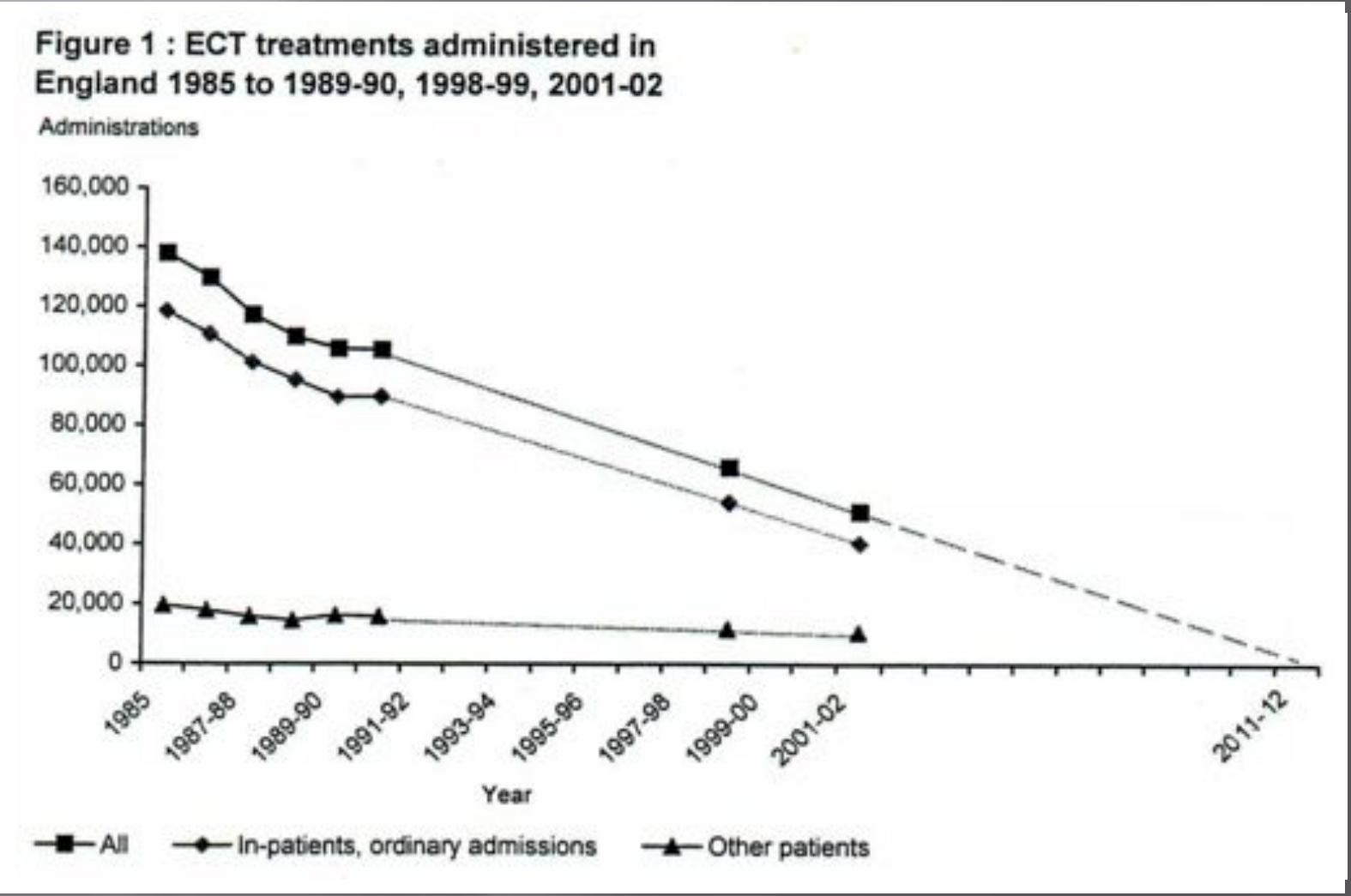
Politics : How not to offend the Scots and Irish

- **SEAN Scottish ECT Accreditation Service**
- **ECTAS ECT Accreditation Service (England, Wales, Northern Ireland, Eire)**
- **Great Britain = England, Wales, Scotland**
- **UK = GB plus Northern Ireland**
- **British Isles = UK plus Channel Islands and Isle of Man**

Issues for discussion?

- Are we the ECT police?
- Is it aversive to ECT teams?
- Does accreditation reduce rate of giving ECT ?
- Does it really improve standards ?
- Are there ethical issues which may effect patient care ?
- Is the worst still to come?
- What to do when everyone has won and all have got prizes?

ECT use- the future?



Department of Health Statistical Bulletin 2003/08

What is ECTAS

- Collaboration between Royal College of Psychiatrists, Royal College of Nursing and Royal College of Anaesthetists
- Run by R.C.Psych Centre for Quality Improvement
- First of now 22 national accreditation programmes, eg Liaison Psychiatry, Therapeutic Communities, Acute inpatient care, eating disorder units.

Guidelines and Audits UK

- Pippard and Ellam 1981
- Pippard 1992
- ECT Handbook first edition 1995
- Duffett and Elliot 1998
- APA Task force 2001
- CRAG 2002
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- ECTAS 2004
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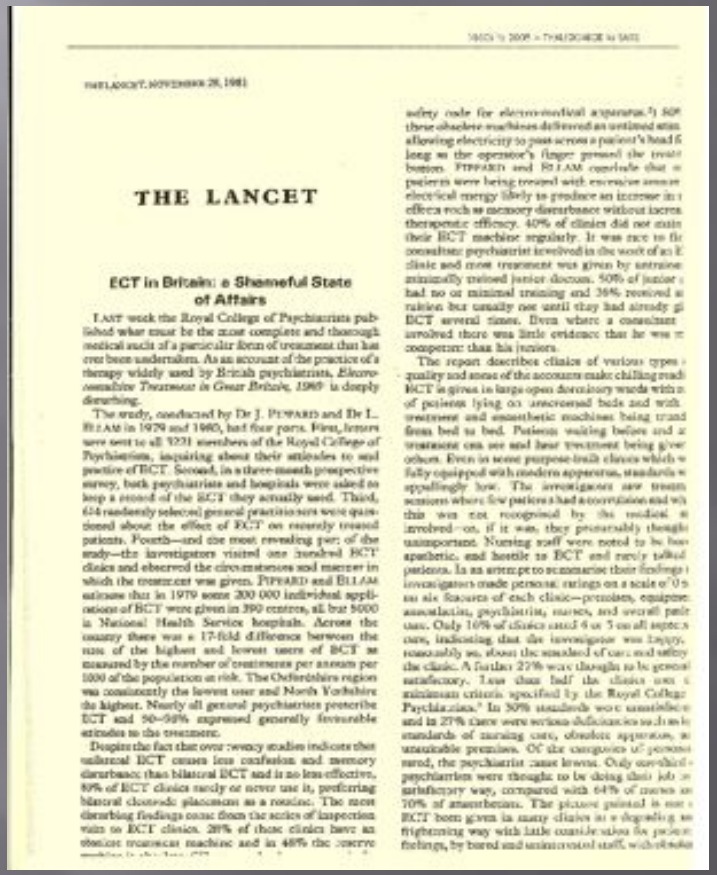
1981



THE LANCET, NOVEMBER 28, 1981

THE LANCET

ECT in Britain: a Shameful State of Affairs

LAST week the Royal College of Psychiatrists published what must be the most complete and thorough critical audit of a particular form of treatment that has ever been undertaken. As an account of the practice of a therapy widely used by British psychiatrists, *Electroconvulsive Treatment in Great Britain, 1980* is deeply disturbing.

The study, conducted by Dr J. PIPPARD and Dr L. BELLAM in 1979 and 1980, had four parts. First, letters were sent to all 3231 members of the Royal College of Psychiatrists, inquiring about their attitudes to and practice of ECT. Second, in a three-month prospective survey, both psychiatrists and hospitals were asked to keep a record of the ECT they actually used. Third, 654 randomly selected general practitioners were questioned about the effect of ECT on recently treated patients. Fourth—and the most revealing part of the study—the investigators visited one hundred ECT clinics and observed the circumstances and manner in which the treatment was given. PIPPARD and BELLAM estimate that in 1979 some 200 000 individual applications of ECT were given in 390 centres, all but 9000 in National Health Service hospitals. Across the country there was a 17-fold difference between the rate of the highest and lowest users of ECT as measured by the number of treatments per annum per 1000 of the population at risk. The Oxfordshire region was consistently the lowest user and North Yorkshire the highest. Nearly all general psychiatrists prescribe ECT and 90–98% expressed generally favourable attitudes to the treatment.

Despite the fact that over twenty studies indicate that unilateral ECT causes less confusion and memory disturbance than bilateral ECT and is no less effective, 89% of ECT clinics rarely or never use it, preferring bilateral electrode placement as a routine. The most disturbing findings came from the series of inspection visits to ECT clinics. 20% of these clinics have an obsolete transducer machine and in 46% the reserve [illegible] safety code for electromedical apparatus.[1] Such these obsolete machines delivered an untimed stim allowing electricity to pass across a patient's head f long as the operator's finger pressed the trans button. PIPPARD and BELLAM conclude that m patients were being treated with excessive amount electrical energy likely to produce an increase in t effects such as memory disturbance without increa therapeutic efficacy. 40% of clinics did not main their ECT machine regularly. It was rare to fi consultant psychiatrist involved in the work of an E clinic and most treatment was given by untrained minimally trained junior doctors. 50% of junior had no or minimal training and 36% received n tuition but usually not until they had already gi ECT several times. Even where a consultant involved there was little evidence that he was m competent than his juniors.

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Do guidelines change practice

- Probably not
- Far too much time and effort put into producing guidelines which have no statutory or legal status
- Guidelines are good for suing doctors
- Those who practice well anyway pay attention to guidelines and update their practice

The ECTAS Team

Project Manager : Joanne Cresswell

Deputy Project Manager : Emily Doncaster

Project Worker: Geraldine Murphy

Chair of AAC and Reference group : C.Freeman

Key points

- Running for 9 years, some clinics inspected 4 times
- Standards high but continuing to improve
- Raised status of ECT and working in ECT clinics particularly for anaesthetists and nurses who are some of most active members
- We have a parallel but different system in Scotland (SEAN)

England

- ECTAS members 96 of 114 clinics (74%)
- 38 accredited
- 35 accredited excellent
- 2 dormant
- 21 in process

Wales

- ECTAS members 4 of 8 clinics (50%)
- 2 accredited
- 2 accredited excellent

Northern Ireland

- ECTAS members 3 of 10 clinics (30%)
- 1 accredited
- 0 accredited excellent
- 1 dormant

Eire

- ECTAS members 7 of 23 clinics (29%)
- 3 accredited
- 2 accredited excellent
- 2 in process

ECTAS

- 60 million population
- 136 clinics
- Used to be over 200

Aims and Objectives

- Accredit ECT Clinics
- Maintain National Network to support staff through:

- A database of standards in the administration of ECT
- ECTAS peer-review process
- An email discussion group and Quarterly Newsletter
- An Annual Members' Forum

- Self-regulating and self-funding network
- To provide training and continuing professional development to all staff and referring psychiatrists

How do we set standards?

- All statements from NICE, Royal College APA that can be operationalised
- We exclude all standards that are already being checked, e.g. infection control etc.
- We review every year in a Reference Group that includes patients and carers

Standards

- ECT Clinic and Facilities
- Staff and Training
- Assessment and Preparation
- Consent
- Anaesthetic Practice
- Administration of ECT
- Recovery, Monitoring and Follow up
- Special Precautions

Standard Classifications

- **Type 1**: Failure to meet these standards would result in a significant threat to patient safety or dignity and/ or would breach the law

- **Type 2**: Standards that an accredited clinic would be expected to meet

- **Type 3**: Standards that it would be desirable for a clinic to meet

Standards

- 60 type 1 standards
- 93 Type 2 standards
- 40 Type 3 standards

Example Type 1 Standard

- **Written evidence that the anaesthetic risk was assessed (eg ASA grade recorded and assessment based on this)**

- **There is a capnograph and it is used at every treatment session**

Example Type 2 standard

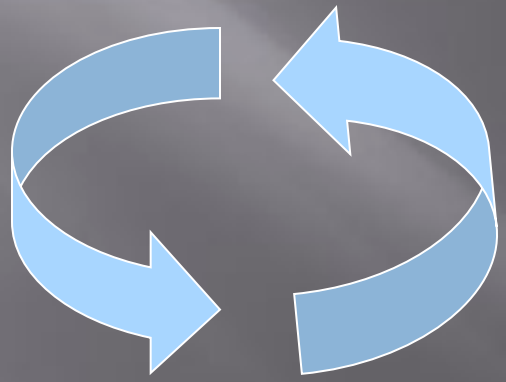
- **Written confirmation that the health professional discussed with the patient alternative treatments (including no treatment)**
- **The timing of seizure is recorded**

Examples Type 3 standards

- **The training needs of all clinic staff are formally appraised**
- **The extent of retrograde and anterograde amnesia is measured**

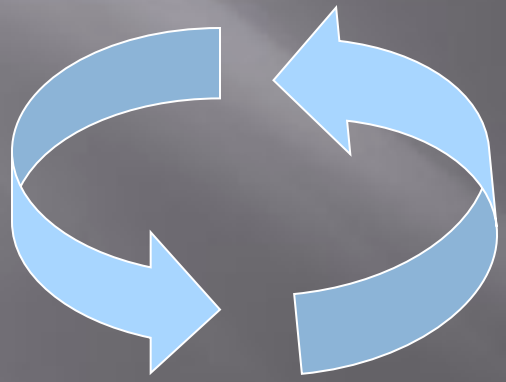
The Accreditation Process

First contact with ECTAS



The Accreditation Process

Self – review



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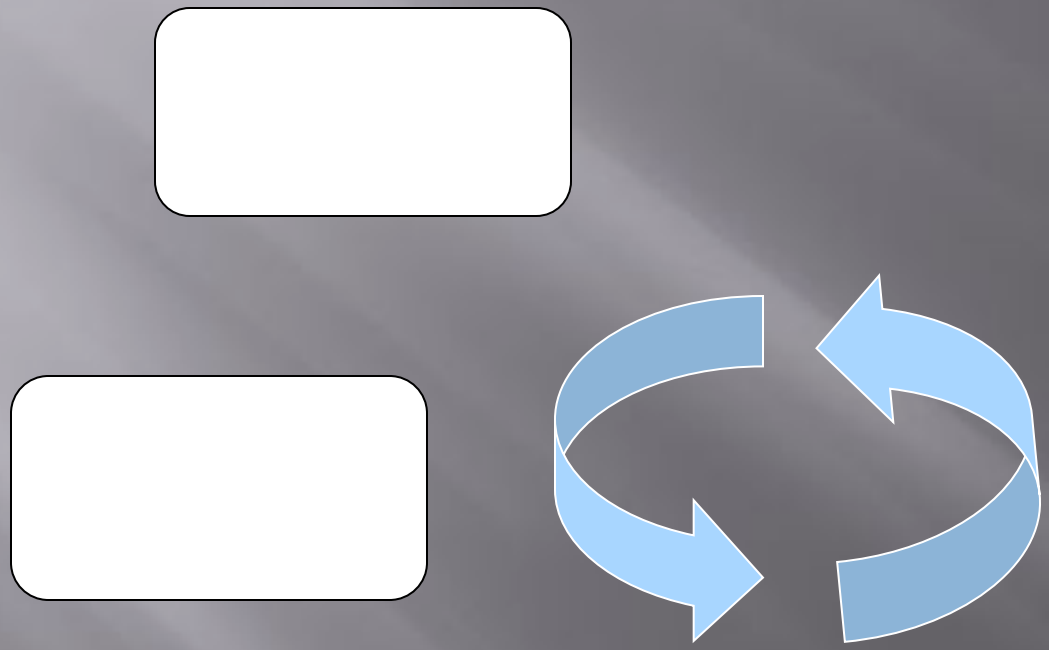
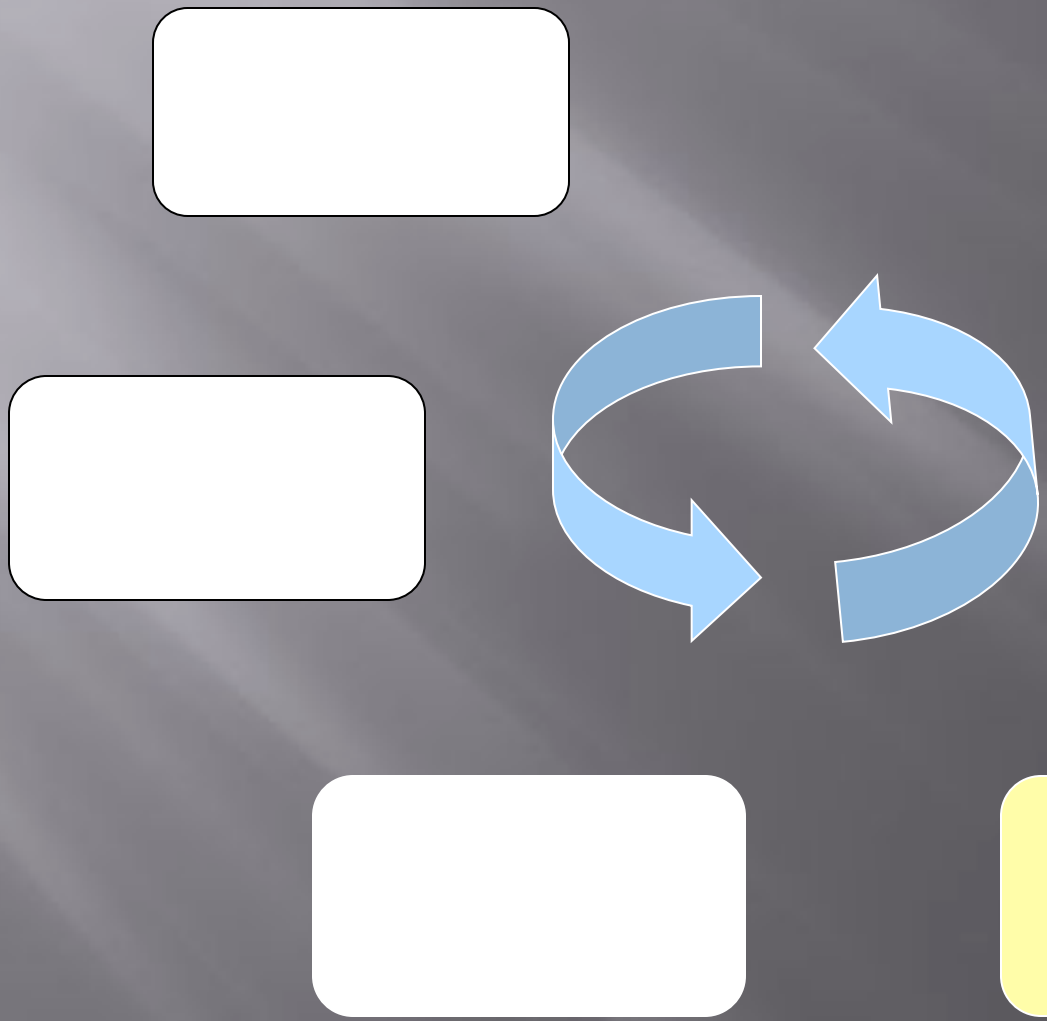


Peer – review

The Accreditation Process



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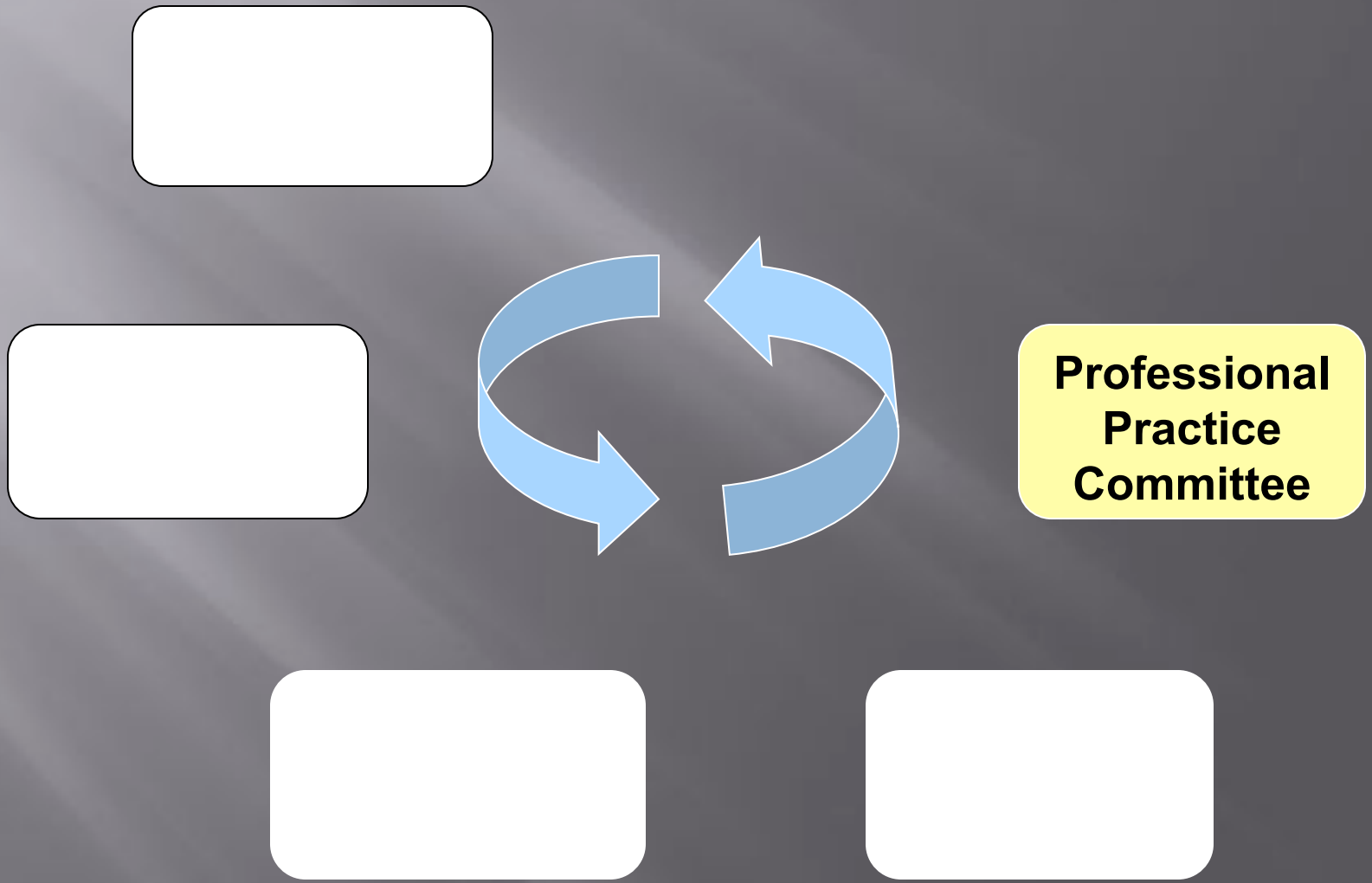
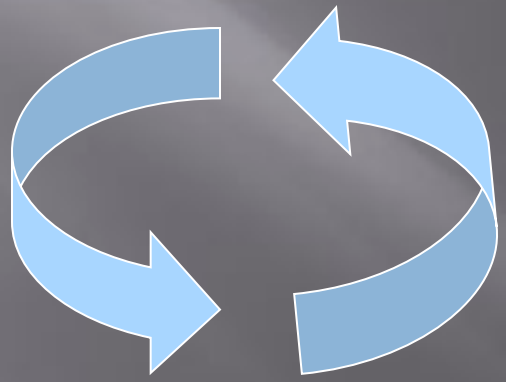


The Accreditation Process

Accreditation

Court of Electors



Self-review

- Health Record Audit
- Clinic Documentation
- Environment and Facilities
- Staff Questionnaire
- Observation of ECT
- Referring Psychiatrist Questionnaire
- Patient Questionnaire

Peer-review Day

Peer-review Team

- Multi-disciplinary team:
  - Consultant Psychiatrist
  - Consultant Anaesthetist
  - Nurse
- All with experience in ECT
- Led by member of team with training and experience in reviews
- Explore and validate results of self-review focusing on ensuring all Type 1 standards are met

Timetable

Time	Activity
0.00 – 10.301	**Reviewer briefing**
10.30 – 11.00	**Introductory meeting for both teams**
11.00 – 12.00	**Discussion of Documentation**
12.00 – 12.30	**ECT Treatment Scenarios**
12.30 – 1.15	**Lunch with clinic staff**
1.15 – 1.45	**Inspection of Environment and Facilities**
1.45 – 3.00	**Staff Interview**
3.00 – 3.20	**Review team debrief**
3.20 – 4.00	**Clinic staff debrief**

Report

- Both peer-review team and clinic sent copy of report prior to review
- Compiled from each of 7 self-review areas
- Each section will contain a peer-review summary of areas of achievement and action points
- Final section for general impressions and overall action points
- Feedback on day from review and clinic team

Clinic Staff Needed on Peer-review Day

- Lead Consultant Psychiatrist
- Consultant Anaesthetist
- ECT nurse
- ODA/ ODP
- Other medical professionals involved

Feedback

- Informal feedback at end of day – accreditation rating not suggested
- Clinic team to feedback to peer-review team/ ECTAS
- Report compiled from peer-review day
- Report sent to clinic for comment

The Accreditation Process

- AAC suggest Accreditation rating
- Validated by Special Committee for Professional Practice
- Awarded one of 4 categories:
  1. Approved with excellence
  2. Approved
  3. Approval deferred
  4. Not approved
- Accredited for 3 years with annual self-review
- Right to Appeal

Levels of Accreditation

- Accredited with excellence (all type 1 standards and 95% or more of all standards)
- Accredited (all type 1 and less than 95% of others) (But more than 80% of standards met)
- Not accredited (fails one or more type 1 standards or meets less than 80% total standards and cant remedy this within an agreed period)

Estimated Accreditation Time-scale

- Self-review 3 months
- Peer-review 6 weeks later
- Draft report to clinic 3 weeks later (after checking by lead peer-reviewer)
- AAC 1-2 months after peer-review
- Clinic notified of suggested accreditation rating
- Final Report and certificate 6 weeks after Special Committee
- Approximately 6 - 9 months

Accreditation Advisory Committee (AAC)

- Chair: Prof. Chris Freeman now Dr Jill Emerson
- Multi-disciplinary Committee (12 members)
- Clinic report discussed in detail with self-review results and peer-review comments
- Lead reviewer input at AAC
- Accreditation result suggested
- Meet every 2-3 months

Clinic Deferral

- Clinic deferred if any Type 1 standards/ many Type 2s are not met
- Given between 3 & 6 months to rectify problems
- ECTAS to see written evidence issues have been resolved
- Possible re-inspection
- Re-considered by AAC
- Re-considered by SCPPE

Reasons for Deferral

- Out of the first 26 clinics that were considered for accreditation, 14 were deferred in the first instance:
  - 2 due to documentation
  - 2 due to documentation and consultant time
  - 2 due to documentation and medical equipment
  - 3 due to lead consultant psychiatrist time and responsibilities
  - 5 due to no dedicated anaesthesia assistant

Activity so far

- 96 clinics joined (74%)
- 67 completed accreditation process
- Standard much higher than we expected
- Currently seven deferred
- One failed
- Two failed but made last minute changes
- One we have just recommended immediately stop giving ECT
- The worst is yet to come? those clinics yet to join?

ECTAS email group

- Very active
- Several postings per week
- Multitude of different clinical problems
- Anaesthetists, nurses and managers not just psychiatrists
- Max Fink now honorary member

Recommendations for Europe/ USA

- Don’t go for individual accreditation or privileging, waste of time
- Wont improve standards
- ECT is a process
- ECT is a team activity
- Depends on size of country, number of clinics, closeness of clinical community

SEAN

- 20 clinics in Scotland (population6 million)
- All members (free service)
- All clinics use same electronic database and pathway. (Data collecting centrally on every patient, every treatment)
- All patients have MADRAS before and after each episode
- Data for every clinic published on line every year, freely available
- All critical events published (about 20 year)

ECTAS or SEAN model?

- SEAN had advantage of central funding at start
- Would SEAN work across much larger area/ population?
- Would SEAN work if substantial number of very poor clinics?
- Gives a more complete package
- Currently has less external authority

SEAN

- Small country though remote areas
- Little private practice single health care system
- Most clinicians know each other or know of each other
- Amazing interest by anaesthetists
- Increased status and job satisfaction for ECT team particularly for lead nurses

Commonest problems

Documentation

- Incomplete
- Out-dated
- Not completed correctly during self-review

Medical Equipment

- No capnograph
- No NIBP machine/ manual blood pressure monitoring
- Out-dated anaesthetic equipment

Consultant Psychiatrist time

- **Lack of dedicated sessional time for ECT**
- **Lack of responsibility for:**
  - **- Development of treatment protocols**
  - **- Training and supervision of clinical staff**
  - **- Liaising with and advising other professionals**
  - **- Audit and quality assurance**
  - **- Continuing professional development**

Dedicated Anaesthesia Assistant

"The Association of Anaesthetists recommends that a trained anaesthesia assistant should always be present during anaesthesia. Only in extreme emergencies as judged by the anaesthetist should anaesthesia proceed without an assistant."

Recording ASA grade and recording change in ASA grade

- **Taken from Chapter 2: 'The Anaesthesia Team'. Publication by the Association of Anaesthetists of Great Britain and Ireland, 2005.**

Health Record Audit

- Only 91% had a clear statement why ECT prescribed
- Only 94% had a full physical examination recorded
- 31% of patients did not have an assessment of cognitive functioning and memory

Training

- National training day (Streamed for psychiatrists, nurses and anaesthetists)
- National team day
- 3 day National ECT nurse training

- We enquire about these at visits

Issues for discussion?

- Are we the ECT police?
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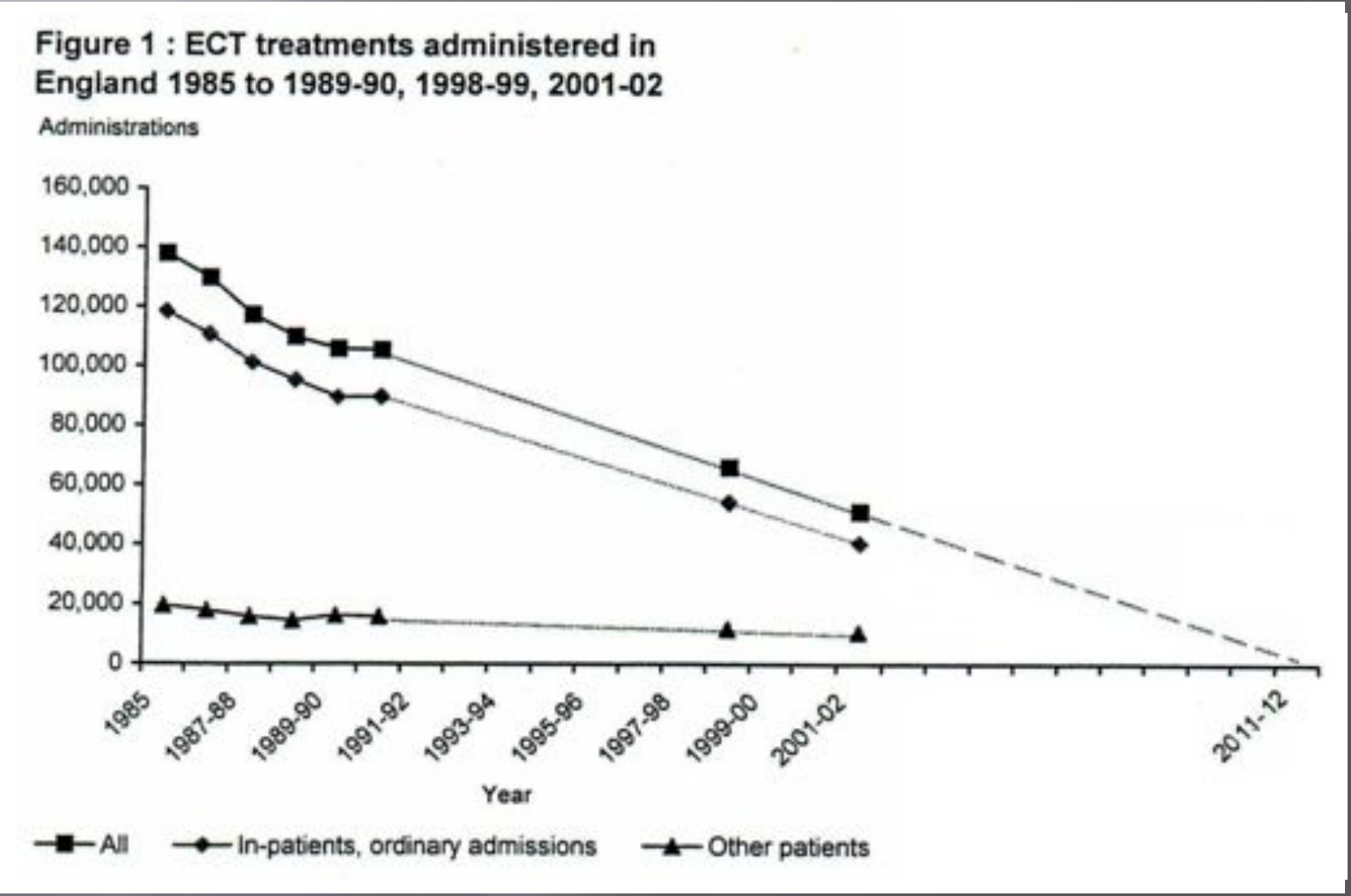
ECT use- the future?



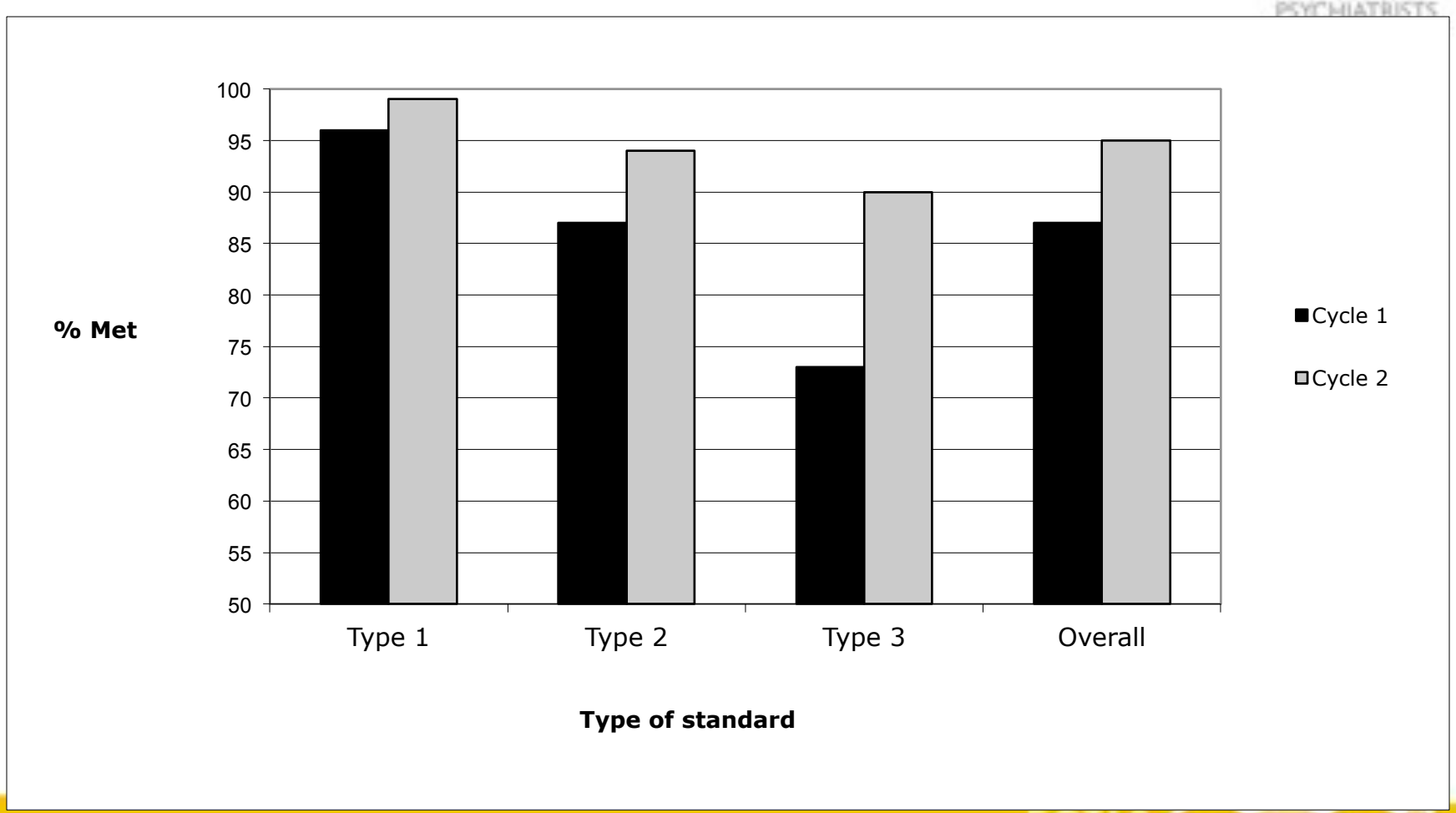
Department of Health Statistical Bulletin 2003/08

- ECTAS c200 standards, standards reviewed yearly with the bar raised each year
- Considerably harder to receive excellence in 2009 than in 2004

Average overall improvement:

- 87% of standards met cycle 1;
- 95% of standards met in cycle 2;
- Six clinics meeting 100% of standards

Improvement in Cycle 2



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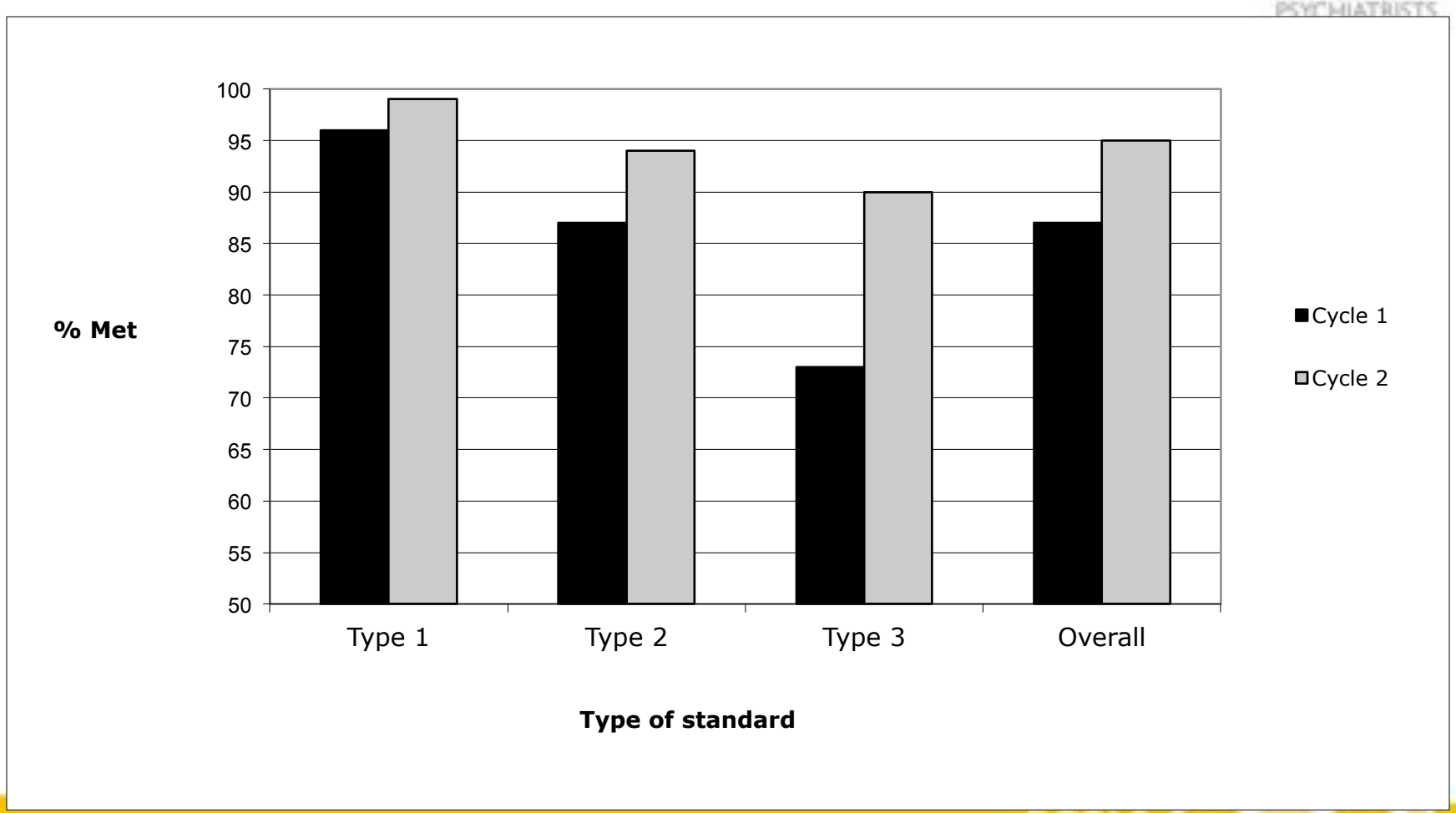
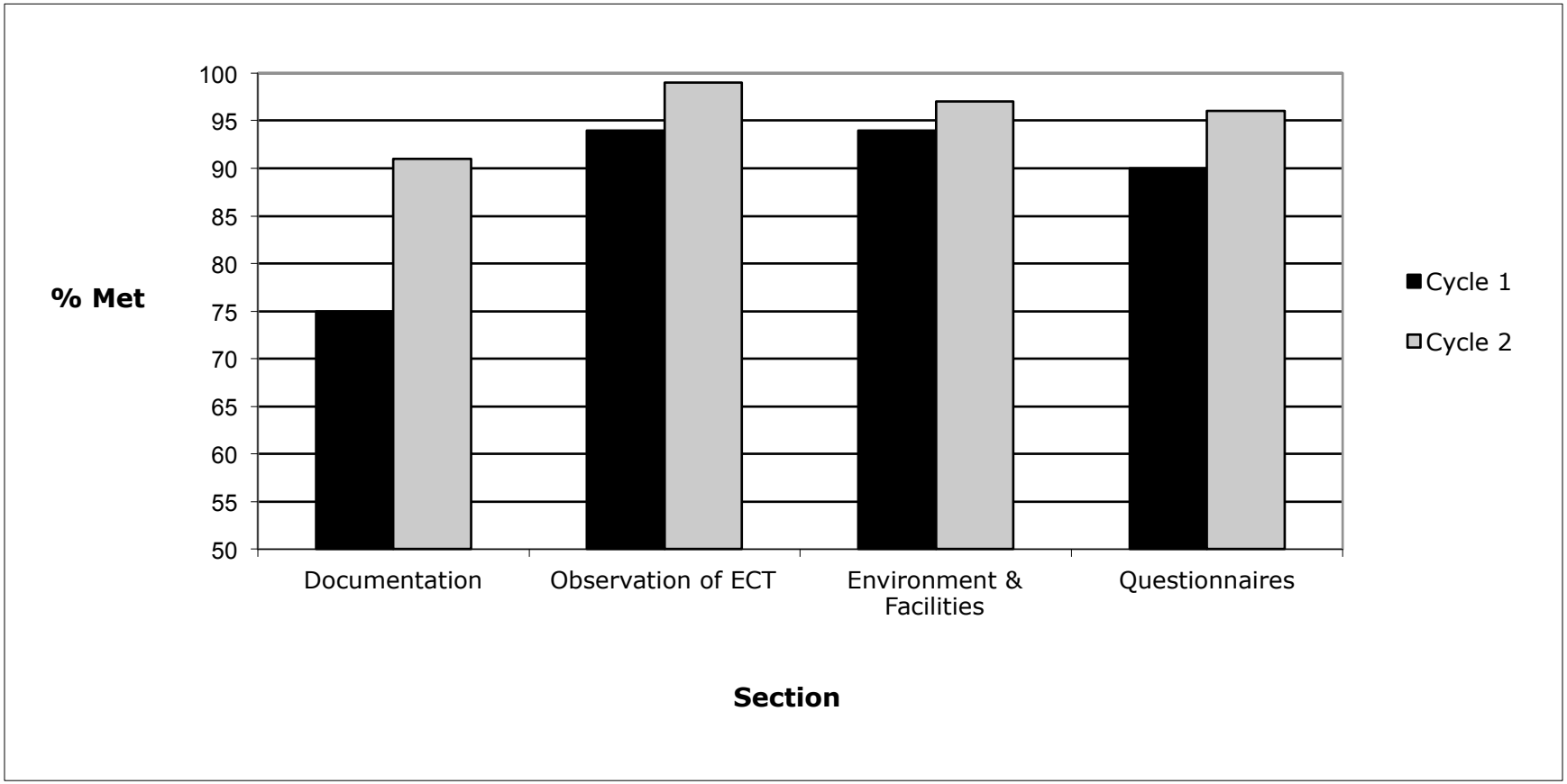
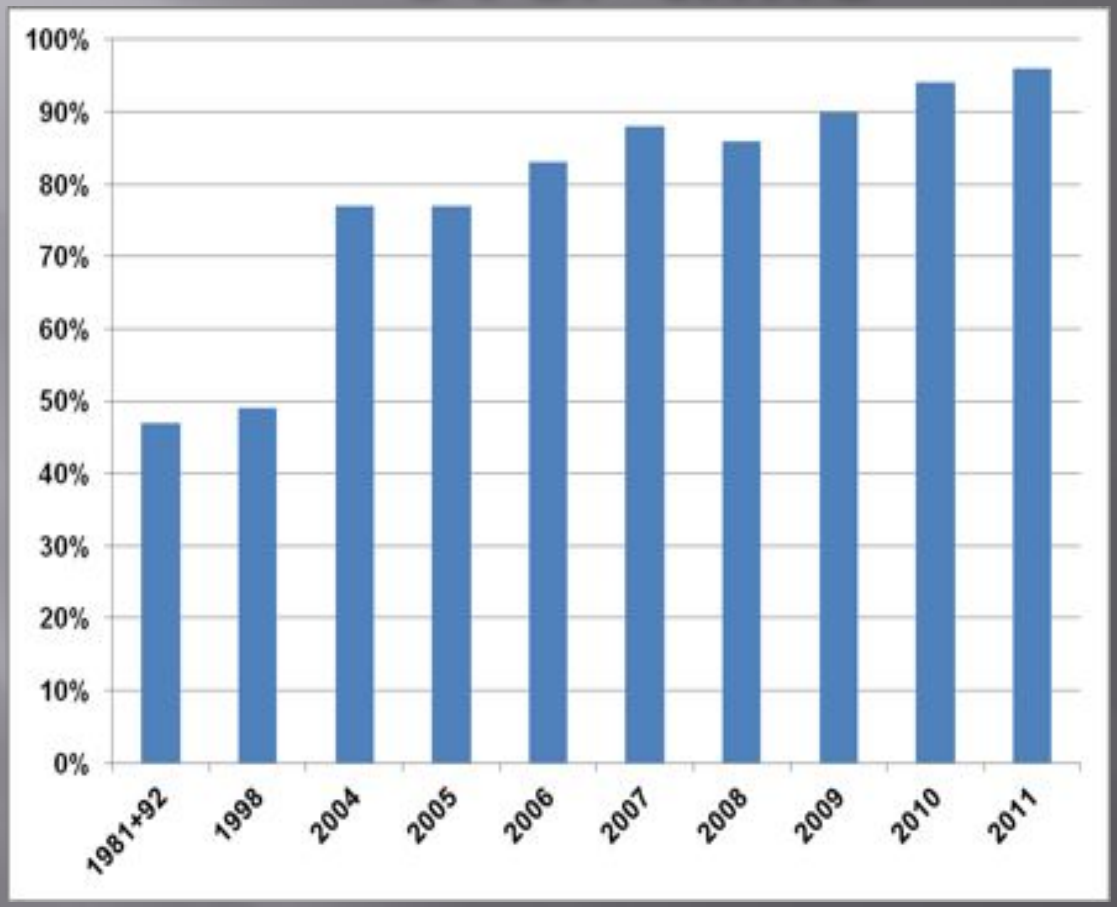


Improvement by section

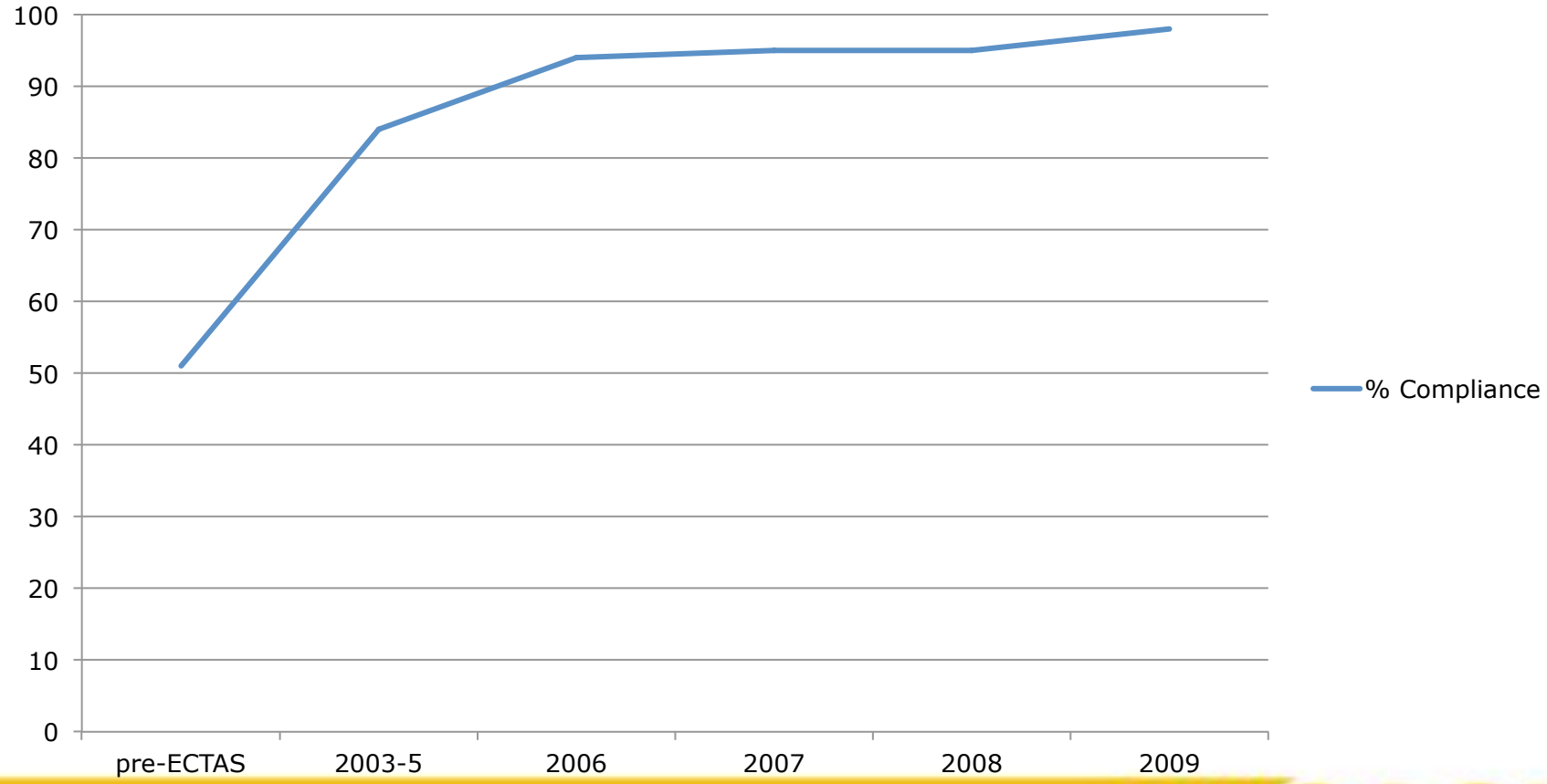


Percentage of standards met over time



Overall Improvement of ECT Clinics since ECTAS

Figure 1: Overall compliance with 5 ECTAS standards mapped from 1981 - 2009



Continuing Excellence

- Clinics who have completed a minimum of 2 cycles – the most recent at level 1 (excellent)
- Optional
- Renewed yearly – cost is significantly cheaper
- Annual questionnaire to ensure key indicators remain unchanged
- Option to complete part of the self review
- Max 3 years

Competency Based Training for Nurses

- 3 day course over 3 months
- Accredited by the RCN
- Free of charge to ECT lead nurses who's clinic is a member of ECTAS, £150 for others.
- To date 176 nurses have attended
- Next course planned forJune 2013

ECTAS email list serve

- Active
- Constant stream of queries
- Honorary international members
- Replies collated and published on website

Recent standard discussions

- Do we really need a capnograph as Type 1 ?
- Do patients really need to wear a name band ?
- What level of training do recovery nurses need
- What follow up in terms of cognitive assessment and who should do it?
- Should accreditation teams see actual patient notes and do patients need to give consent?

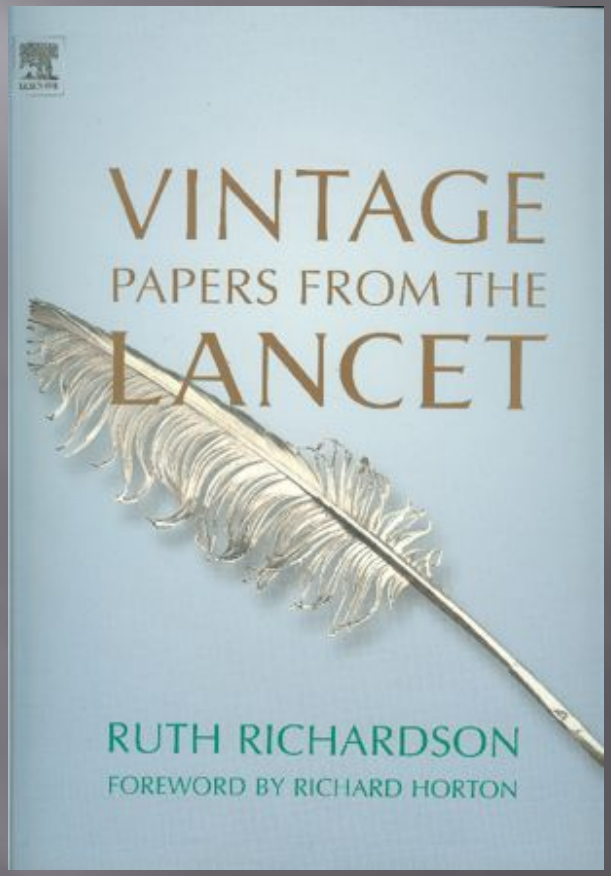
Future developments

- National collection of outcome data
- Involve patients and carers in inspection visits

Contact details

- **SEAN** **www.sean.org.uk**
- **ECTAS**
- **http://www.rcpsych.ac.uk/cru/ECTAS.htm**
- Contact us: **ECTAS@cru.rcpsych.ac.uk**
- Telephone: 020 7977 6696/ 6695
- Address: Royal College of Psychiatrists' Research Unit, 4th Floor, Standon House, 21 Mansell Street, London E1 8AA

Recent Developments


VINTAGE
PAPERS FROM THE
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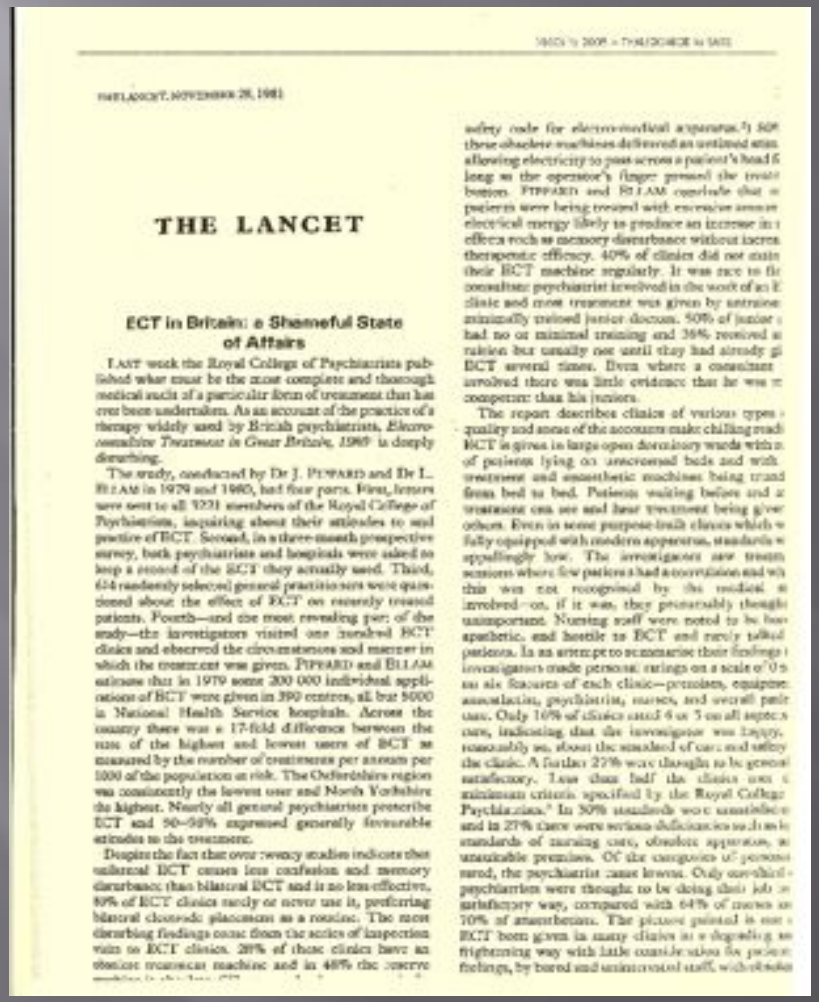

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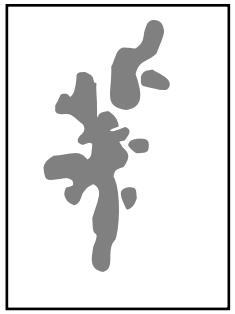
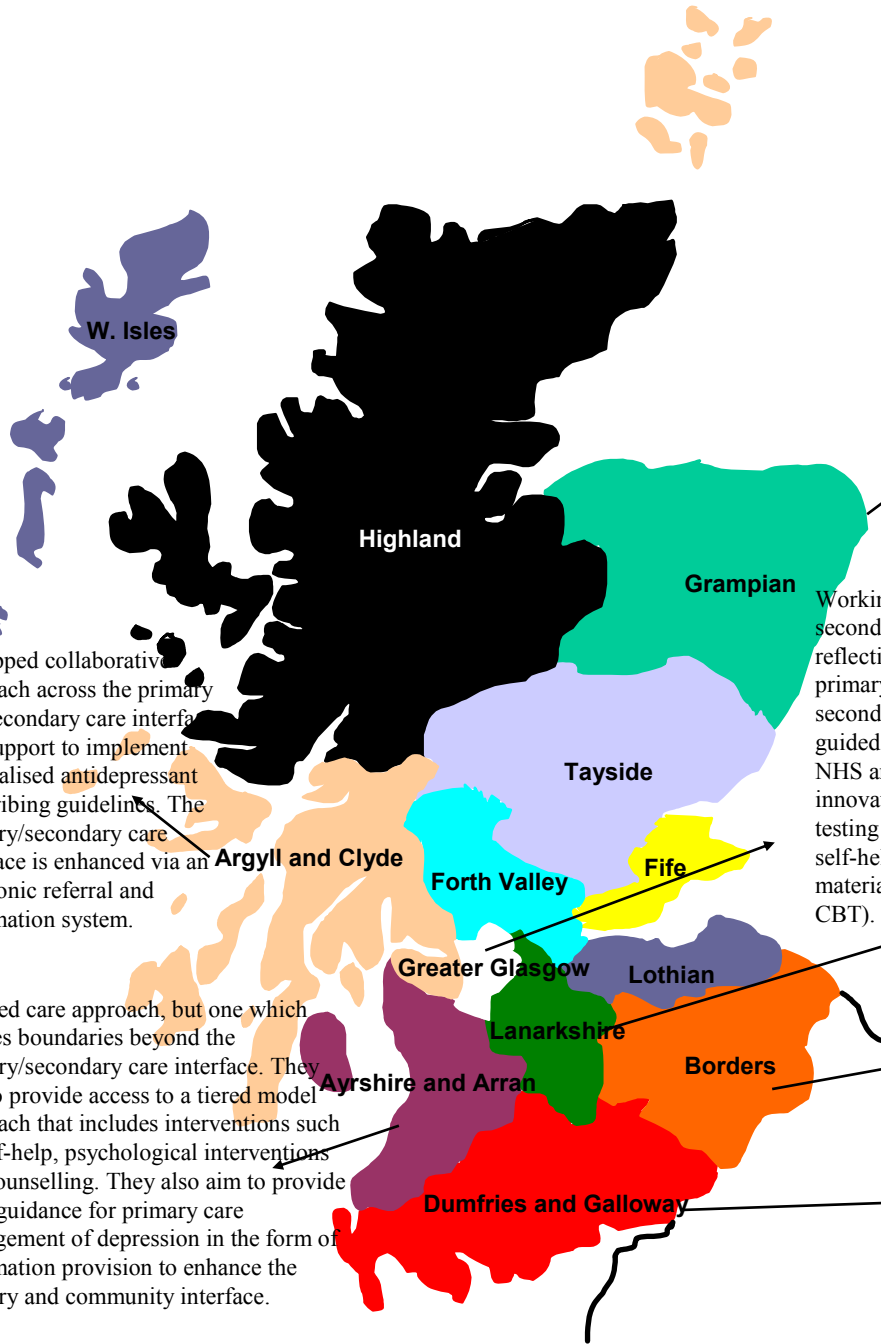
The report describes clinics of various types quality and some of the accounts make chilling read ECT is given in large open dormitory wards with m of patients lying on uncovered beds and with treatment and anaesthetic machines being transf from bed to bed. Patients waiting before and a treatment can see and hear treatment being give others. Even in some purpose-built clinics which w fully equipped with modern apparatus, standards w appallingly low. The investigators saw treatm sessions where few patients had a conversation and wh this was not recognised by the resident st involved—or, if it was, they presumably thought unimportant. Nursing staff were noted to be hos apathetic, and hostile to ECT and rarely talked patients. In an attempt to summarise their findings i investigators made personal ratings on a scale of 0 to six features of each clinic—premises, equipme anaesthetic, psychiatric, nurses, and overall patie care. Only 16% of clinics rated 6 or 5 on all aspects care, indicating that the investigator was happy, reasonably so, about the standard of care and safety the clinic. A further 27% were thought to be genera satisfactory. Less than half the clinics met minimum criteria specified by the Royal College Psychiatrists.[2] In 30% standards were unsatisfacto and in 23% there were serious deficiencies in the standards of nursing care, obsolete apparatus, or unsuitable premises. Of the categories of person cured, the psychiatrist cause known. Only one-third psychiatrists were thought to be doing their job in satisfactory way, compared with 64% of nurses an 70% of anaesthetists. The picture painted is not ECT been given in many clinics in a degrading an frightening way with little consideration for patient feelings, by bored and uninterested staff, with drinks





Integrated primary care model involving Primary Care Mental Health Workers. Different types of workers (with different backgrounds and skills) will be implemented in different local authority areas of Grampian. Hence within the model of integrated primary care newer models are being tested here.

A stepped collaborative approach across the primary and secondary care interface and support to implement rationalised antidepressant prescribing guidelines. The primary/secondary care interface is enhanced via an electronic referral and information system.

Working at the primary and secondary care interface but reflecting elements of integrated primary care models in that the secondary care service provides guided self-help clinics in a range of NHS and community settings. The innovations within this model include testing a range of ways of accessing self-help and the delivery of self-help materials (such as computerised CBT).

Stepped care approach across the primary and secondary care interface to develop and implement a tiered approach to psychological interventions. The Focused Intervention Team will conduct assessments and identify and respond to individual patients needs, re-assigning them to appropriate levels of service as required.

Stepped care approach, but one which crosses boundaries beyond the primary/secondary care interface. They aim to provide access to a tiered model approach that includes interventions such as self-help, psychological interventions and counselling. They also aim to provide local guidance for primary care management of depression in the form of information provision to enhance the primary and community interface.

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Integrated primary care model involving non-medically qualified self-help workers delivering the range of skills reflected within graduate primary mental health workers. This service is relatively well established and is now rolled out across the entire HB region.