

PROTOCOL FOR: ECT: Care of the Patient Receiving

- POLICY:**
1. The anesthesia care provider is responsible for managing the patient's airway, oxygenation, and hemodynamic stability during ECT.
 2. ECT attending is responsible for verifying electrode placement, checking impedance, administering the electrical stimulus, and evaluating seizure response and completion.
 3. The ECT RN is responsible for verifying the presence and/or functioning of equipment prior to ECT treatment and reporting equipment and supply concerns to the nursing manager. This includes:
 - a. Check of code cart, defibrillator, suction and oxygen (wall and tank on code cart)
 - b. Check of pulse oximeter and cardiorespiratory monitor
 - c. Check that glucometer quality control is up to date
 - d. Inspection of ECT cables and performance of self check on primary and secondary machines
 - e. Determining that sufficient supplies are available
 4. Inpatients will remain in the ECT recovery area until the discharge criteria have been met or until otherwise evaluated for discharge by the anesthesia care provider. General discharge criteria are:
 - a. stable vital signs for a minimum of 30 minutes prior to discharge; no respiratory distress
 - b. ability to swallow and cough
 - c. absent or minimal nausea, vomiting, dizziness or pain
 - d. ability to safely ambulate consistent with pre-treatment status
 5. Outpatients will be discharged to home from the ECT service after authorization by the anesthesia care provider and the ECT attending. Criteria for discharge include full return of reflexes, adequate respirations, cognitive function, steady gait commensurate with preadmission status, and:
 - a. postanesthesia recovery score (PARS) \geq 9
 - b. modified Ramsey score (MRS) = 2
 - c. pain rating acceptable to patient
 - d. psychiatric risk assessment is clinically appropriate for outpatient status

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- OUTCOMES:**
1. The patient will receive safe treatment and be free from any untoward effect from ECT Treatment.
 2. The patient will return to pre-ECT physical condition within 2 to 3 hours of receiving ECT treatment, as evidenced by:
 - a. BP +/- 20% of baseline levels, or as prescribed
 - b. pulse strong and regular
 - c. absence of new dysrhythmias
 - d. absence of vertigo or orthostatic changes
 - e. return to normothermia w/ skin warm and dry
 - f. absence of shivering
 - g. return to baseline orientation to person and place, within parameters clinically appropriate for ECT recovery

**CLINICAL
ASSESSMENT AND**

CARE: Pre-treatment

1. Complete nursing pre-ECT assessment prior to each scheduled ECT treatment.
2. Respond to patient's concerns and feelings. Educate the patient concerning the procedure and explain to the patient the necessary tasks associated with ECT. Initiate education interventions based on knowledge deficits.
3. Document baseline TPR, BP, O2 sat and pain score.
4. Establish vascular access and hang ordered infusion.
5. Follow Diabetes Mellitus Management: Periprocedural Care (Nursing Practice Manual) for patients with diabetes.
6. Administer pre-ECT medication as prescribed.
7. Confirm patient compliance with NPO requirements and Medication on the Day of Surgery, per Dept. of Anesthesiology Guidelines for Preoperative Preparation (see appendix).
8. Complete pre-procedure checklist, resolve all issues identified.
9. Complete Falls Risk assessment. Apply allergy and falls risk bracelets, as appropriate.
10. Ensure ECT consent is valid (signed within 30 days or treatment date).
11. Verify H&P are current (within 30 days).

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12. If ECT is court-ordered, verify proper documentation present (up to 45 days).
13. Review pre-ECT assessment with ECT attending prior to each treatment to confirm medical clearance; obtain signature of ECT attending prior to start of treatment.
14. Examine patient's mouth, convey any concerns to anesthesia care provider or ECT attending

Intra-treatment Care

1. Apply ECG electrodes, BP cuff, and pulse oximetry sensor (not on same extremity as BP cuff).
2. Prepare EEG electrodes, per treatment specifications.
3. Prepare scalp and stimulus ECT electrodes (unilateral vs. bilateral) and apply paste to electrodes.
4. Apply nerve stimulator, per order.
5. Initiate Universal Protocol immediately prior to treatment.
6. Document medications, stimulus parameter, seizure response and vital signs (RN to obtain strip from monitor).

Post-Treatment Care

1. Receive report from anesthesia care provider.
2. Perform a comprehensive assessment of major body systems, with priority given to airway patency, respiratory drive, cardiovascular sufficiency, and LOC.
3. Assess and document P, R, BP, SPO2 and pain level q 15 min. x 2, or more frequently per RN assessment, reporting any of the following:
 - a. BP not within 20% +/- baseline values, or as prescribed.
 - b. new dysrhythmias
 - c. vertigo or orthostatic changes
 - d. unexplained disorientation to person or place
 - e. change in breathing patterns or inability to clear airway.
4. Administer fluids per order, ensure IV patency and assess for s/s infiltration, per protocol for Peripheral IV Therapy (NPM).
5. Position patient to maintain airway patency and comfort; groom as needed.
6. Assess sensory and motor function per VS frequency.

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7. Maintain quiet environment, privacy, and side rails up. Orient patient to person and place.
8. Administer supplemental oxygen per order and patient's SPO2 levels. Document O2 flow rate and SPO2 levels.
9. Observe for and report cyanosis, perfuse diuresis, nausea / vomiting, delirium, psychomotor agitation, seizure activity, or other unexpected activity.
10. Document PARS level and Ramsey score.
11. Assess general response to treatment and side effects such as headache and memory loss.
12. Review discharge instructions (HCH 1821) with the patient and the identified care provider.
13. Give outpatients and their identified provider the day and time of their appointment for follow-up and/or treatment

Transfer to Inpatient Psychiatric Unit:

1. Give verbal report to the charge nurse or the RN on the inpatient unit who is assigned to the patient. The report should include any adverse reactions, abnormal vital signs, patient's general condition and anticipated time of transfer.
2. Remove saline lock per order of anesthesia care provider.
3. Assist the patient into a wheelchair or stretcher for transport. The mode of transport is dependent on the patient's condition. Ensure that stretcher side rails are raised.
4. On arrival to the inpatient unit, assist the patient into bed.
5. Post treatment orders will be implemented by staff of the inpatient unit.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 5/05

REVISION DATES: 6/06, 8/08