

grateful and 32% resentful. The emotive subject of compulsory ECT is reflected by the need for a second opinion in the absence of informed consent. The patients answering this question were those who perceived themselves as being forced to have ECT and they had not necessarily had a second opinion.

There are a number of deficits to this survey. The analysis of data was severely limited by conducting it anonymously. Further analysis with regard to diagnosis, age, sex, and mental state when completing the questionnaire were not possible. In addition, the sample was biased as only out-patient attenders were included. Patients were, however, assumed to be improved as they were now living in the community.

Nevertheless the results indicate that, despite initial refusal of treatment, most of the people were subsequently grateful for their compulsory detention and treatment. Patient choice and personal liberty are of great importance but only if one's mental state enables an informed choice to be made. Assuming one has the right to receive treatment for a mental disorder, whether insight is impaired or not, then continuing legislation to allow compulsory treatment is necessary.

It is an area which merits further examination. Patients should have their views represented accurately rather than have others assume their objec-

tions on their behalf. This could lead to beneficial amendments being made to the current legislation to the satisfaction of those most affected by it. One possibility raised was for frequently detained patients with recurrent mental disorders to make a contract, when well, to give permission for future compulsory admission and treatment, without having to reach the severity, or suffer from the delays of current legislation. Far from reducing patient choice, this would give patients a greater say in their future treatment.

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Audit in practice

ECT – current practical administration

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In the current climate of interest in audit (Standing Medical Advisory Committee, 1990) and a desire at our hospital to embark on criterion based projects, we set out to undertake a simple audit project surveying the practice of ECT. The aim was to audit the treatment facilities, the treatment procedure and the supervision and training. It was hoped that the full cycle of audit – setting goals, measuring activity, and then effecting change – would be achieved (Shaw & Costain, 1989)

The study

The Chiltern Wing, Sutton Hospital is a self-contained unit with three general psychiatrists, one rehabilitation psychiatrist and six SHO/registrars. Of the 50 in-patients, about one to two patients per month receive ECT. We chose a study period of six months during which eight patients received ECT and seven were included in the audit. One patient's treatment was not audited because ECT

TABLE I

Good practice area	Good practice scores			
	Maximum score possible	Range of scores	Mean score	Mean score as % of maximum
N = 2 Facility	10	/	9	90%
N = 6 Training & supervision	3	1-3	1.5	50%
N = 7 Selection of patients	8	2-7	4.1	52%
Information for consent	12	2-9	6.0	50%
Paperwork for consent	2	/	2.0	100%
Monitoring of treatment	4	1-4	2.5	64%
Contraindications	7	0-7	3.6	51%
N = 12 Preparation & premedication	5	2-4	2.9	58%
Anaesthetic	5	4-5	4.6	92%
ECT administration	7	4-6	5.4	77%

was administered before the patient was seen by the audit team member.

Good practice checklists were constructed by us, derived from *'The Practical Administration of ECT'* (Royal College of Psychiatrists, 1989). Three checklists were used to rate the treatment facilities, training and supervision, and the clinical use of ECT. The clinical use of ECT was rated in sections which were: selection of patients, giving of consent and its documentation, monitoring of treatment, preparation of patients and checking for contraindications, and administration of the actual treatments by the psychiatrist, anaesthetist and nurse.

The treatment facilities were rated independently by the two audit team members and the training checklist was completed by the six SHO/registrar. All other information was obtained from case-notes, or by direct patient questioning or by observation of the treatment. For example, details of patient selection, consent forms, physical examination and monitoring of the treatment were obtained from case-notes. Patient interviews were undertaken to rate the procedure of giving informed consent. Questions took the format of, "Did any doctor explain the following points to you on this admission?", and covered the procedure, the indications for ECT at the time of giving consent and the possible after-effects. Patients were interviewed after written consent was obtained and before their first ECT administration.

ECT administration was rated by the ECT nurse for 12 consecutive treatments. This meant all registrars gave ECT during the study period, the anaesthetic being given by the same anaesthetist throughout. A checklist was devised to rate failed or ineffective ECT

administrations, but none occurred during the study period.

Findings

Results were scored on the basis of one point for good practice being present and 0 if it was absent. Table I shows the maximum possible score, the mean score, the range and the mean score as a percentage of the maximum.

The good practice area concerning the treatment facility looked primarily at the construction of the building and the high score reflects the modern design of the unit. The comfort of the waiting area was the area of bad practice. The room was dimly lit, was used as a store for the X-ray machine, had uncomfortable chairs, old peeling paint and holiday magazines on the table.

The training and supervision score was low. In particular, the good practice point of watching several ECT administrations by an experienced operator was recorded by only one of the six SHO/registrar. However, the checklist covered three points only and was therefore not comprehensive. Further, we could have considered rating practice in another hospital since none of the SHOs were in their first appointment.

The good practice areas concerning selection of patients, monitoring of treatment and evaluation of contraindications relied on medical case-notes for obtaining information. Scores are therefore an indirect measure of practice. Record keeping is particularly important in monitoring treatment where clinical decisions should be documented, and in

initial preparation, where blood test results and contraindications need to be carefully recorded. Use of records in this way was therefore thought to be a valid method of audit. In this area of good practice, prescribing one treatment at a time only was rarely seen.

The good practice area concerning selection of patients was more difficult to interpret because of the variable clinical presentation of patients' depression. The checklist was designed to select patients with delusional depression and disturbance of all vegetative functions. A good practice score of 100% would therefore imply that only highly selected patients were given ECT which is not necessarily the best practice. The score of 52% is therefore closer to ideal practice than it seems. However, good practice was often rated absent because the clinical state was not recorded in detail within four weeks of prescribing the first ECT.

The scores for the good practice area concerning consent were affected by the level of concentration, memory and recall of the patients which was frequently defective in this sample of severely depressed patients. However, the score of 50% (lowest score) suggests that practice could be improved by better information giving by doctors. The checklist examined areas of information giving covering the nature of the treatment, the reason for the treatment and its possible sequelae. No subject area was covered especially well or badly. In contrast to the above area, the good practice area concerning paperwork was rated as 100%, which may be explained by the statutory nature of the practice (e.g. signing consent forms).

The good practice area of administration of ECT was generally good, especially the practice of the anaesthetist. The technique of moistening the scalp and of using the cuff technique were rarely seen. Similarly the area concerning the immediate preparation of the patient included two recurrent poor practice items, which were giving of premedication atropine and not washing the patient's hair, and these resulted in a low area score.

Comment

In general, the audit was simple to conduct and produced some important results which led to real

change. Firstly, a consultant psychiatrist has been nominated as responsible for the training and administration of ECT. Secondly, an educational video has been obtained to be shown to incoming SHO/registrars to improve their knowledge. Thirdly, the practice of routine administration of atropine has been abandoned, and finally, the waiting area has been redecorated and made more comfortable.

The project confirmed some areas of suspected bad practice such as decoration of the waiting room, training and supervision, the giving of information before consent, record keeping, giving of atropine, and moistening of the scalp. Other areas showed better than expected practice, such as monitoring of treatment, giving the anaesthetic and the paperwork.

The audit improved practice in a number of different ways in this project. It prompted immediate action which may have happened later without the audit (e.g. redecorating of the suite). It provided clear guidelines (e.g. for use of atropine) and allowed rapid agreement across all care professionals. Lastly, it set goals and enabled measuring of standards and the implementation of improvements which will lead directly to further improvements in patient care.

A repeat of this audit would prove very interesting in one year's time to see if practice has improved and, if so, the full cycle of audit would be completed. We would recommend that all practitioners administering ECT should undertake an audit of their practice based on the Royal College guidelines.

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