original papers

Psychiatric Bulletin (2007), **31**, 414–417. doi: 10.1192/pb.bp.107.014860

KERRY KERSHAW, LAUREN RAYNER AND ROBERT CHAPLIN

Patients' views on the quality of care when receiving electroconvulsive therapy

AIMS AND METHOD

To examine patients' views on the quality of care they received before, during and after electroconvulsive therapy (ECT), a questionnaire was completed by 389 patients who had received ECT at ECT Accreditation Service (ECTAS) member clinics.

RESULTS

The nine key standards set by ECTAS relating to quality of patient care were rated as having been met by 65% or more respondents. Most patients found staff friendly and reassuring and often commented on how this had helped reduce their anxiety prior to ECT. Patients were less positive about standards relating to being introduced to staff prior to ECT, and the quality of the waiting and post-recovery areas.

CLINICAL IMPLICATIONS

Patient views are important indicators of quality of care and should be used to improve ECT practice. Anxiety about ECT is helped by supportive and caring staff. Improvements could be made to practices related to waiting for and recovering from ECT.

Electroconvulsive therapy (ECT) is an effective treatment for patients with major depressive disorder, mania and catatonia (Kho *et al*, 2003; UK ECT Review Group, 2003). However, audits have repeatedly shown deficits in the standard of the delivery of ECT (Lelliott & Duffett 1998). In response to these problems, the ECT Accreditation Service (ECTAS) was launched in 2003, with the objective of improving the quality of ECT in the UK. ECTAS aimed to achieve this by maintaining a database of standards in the administration of ECT, reviewing ECT clinics and accrediting those judged to provide a satisfactory service to patients. The ECTAS standards were developed from key documents, including the ECT Handbook (Royal College of Psychiatrists, 2005), the National Institute for Health and Clinical Excellence's (NICE) appraisal of ECT (National Institute for Clinical Excellence, 2003) and the Scottish National Audit of ECT (CRAG Working Group on Mental Illness, 2000). They were subject to extensive consultation with all professional groups involved in ECT and with service users and their representative organisations (Cresswell *et al*, 2005).

A patient-centred approach is increasingly regarded as crucial for the delivery of high-quality care. This is particularly important considering the finding that for some patients ECT is a frightening and unpleasant experience (Fox, 1993). In recent years there has been much interest in the views and experiences of patients who have undergone ECT (Rose *et al*, 2003; Philpot *et al*, 2004), although this has not been focused on patients' perception of the quality of care they received. The aim of this study is to determine whether the care of patients receiving ECT met the standards of best practice set by ECTAS.

Method

The ECTAS process involves a period of self-review against standards of best practice, followed by a peer review visit to validate these findings. There are approximately 150 ECT clinics in England, Wales and Northern Ireland. ECTAS membership is voluntary, and at the time of the study 80 ECT clinics had signed up to the service. This study was carried out in ECTAS member ECT clinics between September 2004 and February 2006.

Upon joining ECTAS, member clinics were sent 20 copies of a patient questionnaire, as part of their self-review. The questionnaire was designed by health professionals and service users to assess the experience, knowledge and attitudes of patients treated with ECT. There were nine questions relating to quality of care, that could be answered 'yes', 'no', 'partly' or 'don't know'. Each was followed by a space for additional comments. There were two open-ended questions relating to quality of care, and patients were also able to make general comments about their experience of ECT at the end of questionnaire.

Questionnaires were distributed by staff at ECTAS member clinics to patients who had recently undergone ECT. They were completed anonymously by 389 patients, who posted them to staff at ECTAS. In total, 1600 questionnaires were sent out to member clinics. However, because some clinics did not send out all 20 questionnaires, the response rate can only be estimated. For the 18 most recently reviewed clinics, ECTAS recorded the number of questionnaires the clinic sent to patients, as well as the number of questionnaires returned. For these clinics the response rate was 37%. Data were analysed quantitatively, to assess the proportion of patients whose care met the chosen standards. Qualitative data were analysed thematically by the three authors separately, who then met to agree a final coding framework. Themes were ranked according to frequency of response. Data from clinics on improvements made as a result of the ECTAS recommendations were also collected.

Results

Table 1 shows questions asked and quantitative results.

original papers

Standards of the quality of care

In response to the question 'Were you accompanied to the ECT clinic by a member of staff?' 90% of patients who responded to this question (*n*=340 out of 377) said that they had been, with 78% (*n*=279 out of 358) responding that they knew the accompanying member of staff and 70% (*n*=256 out of 368) responding that the staff member stayed with them throughout the treatment. Additional comments in the spaces after these questions were analysed in themes. The most frequent theme was that of general praise for the staff members and the importance of being accompanied to the clinic (*n*=28). Patients also commented that it was reassuring to know the member of staff who accompanied them (*n*=8), as illustrated in the quotation below.

> 'I was particularly fortunate in being cared for by staff with whom I had been familiar for years'.

They also responded positively about that person being able to stay with them throughout the treatment (*n*=8).

In response to a question as to whether they felt staff were friendly and reassuring 95% of respondents (*n*=357 out of 377) answered 'yes' and 96% (*n*=360 out of 375) thought the clinic was clean and comfortable.

In response to the question, 'How long did you have to wait before your ECT?' 68% of patients (*n*=249 out of 368) responded that they waited for less than 20 min, 11% (*n*=42 out of 368) waited between 20 and 40 min, and 3% (*n*=12 out of 368) waited longer than 40 min. The impact of not having to wait on allaying anxiety was illustrated by this patient:

> [Waiting] 'Usually 5–10 minutes. That was great, usually I walked straight in which REALLY helped as I was anxious'.

There were 18% (*n*=70 out of 368) of the respondents who could not remember how long they waited. In the comments section for this question, the majority of responses indicated that they had little or no wait, or that they did not feel they had had to wait long. However, some patients left less positive comments (*n*=4):

> 'There seemed to be no appointment system therefore we were often waiting quite a long time as everyone was supposed to arrive at 9:00am'.

With regard to care after ECT, 89% of the respondents (*n*=332 out of 372) stated that they were properly cared for immediately after treatment and 88% agreed that the clinic staff ensured they had made appropriate arrangements for travel and supervision after the treatment. Free-text comments in response to the question 'Please write down ways in which the aftercare provided could have been improved' were positive from 75 respondents, who stated that care could not be improved; 14 mentioned that they required more personal attention, with 2 mentioning more help with disorientation. One example of a respondent claiming to have experienced poor care is given below:

> 'Left confused and hungry and thirsty till taken back to the ward'.

There were 7 patients who commented that they would have appreciated a more comfortable place to rest after treatment, and 5 mentioned that they would have liked to have been offered refreshments.

In response to a question asking patients' views on how the experience could have been improved, 10 patients referred to too much waiting either before or after treatment; 5 patients commented that they would have liked more reassurance from staff, and a further 5 stated that they would have appreciated more support afterwards. There were 133 patients who remarked that they could not think of anything that could have improved the experience for them.

In response to the question 'When you arrived, were you introduced to all those who would be present during your treatment?' 65% (*n*=240) of the total 367 respondents indicated that they were and 18% (*n*=66) indicated that they were not. Eleven patients left additional comments that this was reassuring and 2 patients stated that they were not introduced to the clinic team, but would have liked to have been.

Table 1. Questions asked and quantitative results

Questions	Yes *n* (%)	No *n* (%)	Partly *n* (%)	Don't know *n* (%)
Were you accompanied to the ECT clinic by a member of staff?	340 (90.2)	25 (6.6)	3 (0.8)	9 (2.4)
Did the accompanying member of staff stay with you throughout the treatment?	256 (69.6)	38 (10.3)	10 (2.7)	64 (17.4)
Did you know the member of staff who accompanied you?	279 (77.9)	32 (8.9)	26 (7.3)	21 (5.9)
When you arrived were you introduced to all those who would be present during your treatment?	240 (65.4)	66 (18.0)	24 (6.5)	37 (10.1)
Did clinic staff check that you still agreed to have ECT before your treatment?	215 (78.0)	69 (19.0)	4 (1.1)	76 (20.9)
Were clinic staff friendly and reassuring?	357 (94.7)	2 (0.5)	6 (1.6)	12 (3.2)
Was the clinic clean and comfortable?	360 (96.0)	0 (0)	3 (0.8)	12 (3.2)
Do you think that you were properly cared for immediately after treatment?	332 (89.2)	6 (1.6)	14 (3.8)	20 (5.4)
[Day patients only] Did clinic staff check that you would be accompanied home, have appropriate responsible adult supervision and were not going to drive a vehicle?	119 (88.1)	6 (4.4)	5 (3.7)	5 (3.7)

https://doi.org/10.1192/pb.bp.107.014860 Published online by Cambridge University Press

original papers

Patients' overall views

Out of the 389 respondents 161 (41%) additionally replied to the open-ended question asking for their overall views of ECT. Fifty four patients spontaneously made reference to having received 'good quality of care' during treatment; 35 patients left positive comments about staff, the majority relating to humanistic or caring qualities. Words frequently used in describing clinic staff were 'comforting', 'reassuring', 'kindness', 'sympathetic' and 'support'. The attitude of staff members was also praised – 'non-judgemental', 'unpatronising' (n=2) – as well as their professionalism (n=5).

A recurrent theme identified from analysis of the 'overall views' question was patients' fear of ECT and discomfort during the procedure (n=22). A number of patients commented that their feelings of fear were lessened or allayed by the support of clinic staff (n=8), and the information they provided (n=2):

> '. . . when I start a course of ECT. At that time the treatment feels frightening and humiliating: the ECT staff and doctors have always been reassuring and professional. The ECT department at [the] hospital has been excellent!'

> 'The whole procedure terrified me initially – just the thought of it. But the nursing staff were excellent. They explained everything to me and reassured me, putting me right at ease'

> 'It would be a help to be more informed on the ECT treatment. It would also help to take the fear out of the treatment'.

Staff supporting family members was another aspect of care raised by patients (n=6):

> 'All the staff in the ECT unit at [the] hospital are very friendly, are caring in their approach to each other, their patients and relatives. Nothing is too much trouble and they ensure that everyone understands what is going to happen'

> 'Staff at ECT clinic very caring and helpful to both my wife and myself'.

The importance of feeling monitored and safe was another prominent theme (n=6).

> 'I have had ECT in the past . . . and this was by far the most comfortable and reassuring in the use of up-to-date equipment, sufficient space in case of problems'

> 'They have a consultant anaesthetist and an operating department assistant and a consultant psychiatrist and a senior house officer who never leaves until all the patients are ready to return to the wards'.

Less positive responses were left by 17 patients. Suggestions for improvement included: provision of a quiet area in which to lie down after treatment (n=2), an improved waiting area (n=4), more privacy (n=3), less waiting (n=2), better information on ECT (n=8). One patient also commented on feeling pressurised into having more treatments than they thought was necessary and another felt like they were on a 'production line', commenting:

> 'On the whole an unpleasant experience which I found very degrading. I didn't like the production line type of way it was done'.

The experience of having to travel to another hospital for treatment was also described as traumatic (n=2), for example

> 'I was transferred to *Y* from my local area due to lack of funding, this I found very traumatic'.

Clinic responses to ECTAS feedback

Feedback from ECTAS member clinics has demonstrated how advice given during the accreditation process has led to improvements in the quality of care provided to patients. Examples include increased privacy for patients waiting for ECT, and improvements in the quality of the waiting area and post-recovery room:

> '[We] now regularly use outpatient rooms for individual consent checks/private waiting areas in accordance with service user needs. This means that if a patient wants to have their relative with them whilst waiting for treatment, we are able to offer a private area'

> 'Waiting areas [have been] made more welcoming e.g. provision of magazines, newspapers, new seats, additional leaflet rack'

> '[We now have] new soft furnishings for the post-recovery area'.

Discussion

Strengths and weaknesses

The main strength of the study was its multicentred design with a nationwide representation of patients' views coming from over half of the country's ECT clinics. A further strength was that although the questionnaires were distributed by the clinics, the patients were aware that the data would be analysed independently. The principal limitation is that the clinics participated on a voluntary basis, and so the data did not come from a representative sample of all ECT clinics. Another drawback was the inability to calculate the actual number of patients receiving questionnaires from those clinics; hence the response rate could only be estimated. This modest response rate could be due to a number of factors, for example patients who receive ECT are severely ill, they may be experiencing cognitive side-effects and are often elderly, making it more difficult for them to complete the questionnaire. The sample, therefore, may not be representative of all patients. Further studies could improve the response rate by providing an independent advocate to assist patients in completing the questionnaire, and conducting a follow-up mailing.

Main findings

Overall, the majority of patients who responded reported a good standard of care. Over 70% of patients rated eight of the nine key standards as having been met. The nine key standards were rated as having been met by more than 65% of respondents. These standards referred to the accompaniment of the patient to the treatment room by a member of staff, the cleanliness of the clinic, the friendliness of staff, care immediately after ECT and waiting times. The standard that was rated as being met the least was that of the patient being introduced to everyone present in the ECT suite (65%).

https://doi.org/10.1192/pb.bp.107.014860 Published online by Cambridge University Press

original papers

The free text section revealed that the perception of staff having human or caring qualities was very important to patients, and was mentioned more often than their technical abilities. ECT was shown to provoke considerable anxiety in some patients. This may be reduced by personal attention and reassurance from clinic staff, confidence in the safety of the equipment and procedure, reduced waiting and as much privacy as possible.

The qualitative data also highlighted patients' concerns about the quality of care they received. In a minority of cases, patients complained about inadequate care and, more seriously in a smaller minority, about a lack of personal attention or lack of care for their disorientation. A few raised concerns about the quality of their immediate aftercare, including insufficient personal care and, more specifically, the lack of a quiet area to lie down and recover. Discomfort caused by long waiting times was also mentioned. This finding is consistent with the revised ECTAS standard which stipulates that patients should have to wait no longer than 30 min prior to treatment, with an explanation being offered if the wait is for some reason longer (Cresswell *et al*, 2006). Travelling long distances to other hospitals to have ECT was also found to increase patients' anxiety about the treatment. In light of the current trend of clinic closure and amalgamation, it is important that clinic staff are aware of the impact this may have on patients, and offer extra support where necessary.

Clinics should continue to involve family members in the treatment process, if relevant, which helps to reassure both the patient and their family members, who often share the burden of the illness. This ethic is consistent with the work of Sjöblom *et al* (2005), who have emphasised the importance of family involvement in the treatment of people with mental health problems.

Although most studies investigating patients' views about ECT are concerned with reporting effectiveness and side-effects, Sienaert *et al* (2005) studied overall patient satisfaction in a small patient sample receiving ECT at one clinic in Belgium. The researchers also found high levels of reported anxiety among patients having ECT, and high levels of satisfaction with clinic staff. Their study indicated that overall satisfaction with ECT was not related to its effectiveness or lack of side-effects. The current study adds to the literature in suggesting that other factors, such as reassurance about the safety of the procedure and personal attention from staff, should be considered when assessing patient's satisfaction with ECT.

Implications for practice

Most patients report a high quality of care while having ECT. Patients, who are often anxious about ECT, are helped by care and support from staff, reassurance about the safety of the procedure and personal attention and care on recovery. In particular, our study highlights the importance of providing suitable areas in which patients can wait before and after ECT, and the need to minimise waiting times. Patient feedback is crucial to the delivery of improved care. Clinics should seek regular feedback from patients on their experience of ECT, and use patients' views to continually raise standards of care.

Declaration of interest

All the authors work with the ECT Accreditation Service at the Royal College of Psychiatrists' Centre for Quality Improvement.

Acknowledgements

We thank all ECTAS member clinics, and Adrian Worrall for his support and guidance.

References

CRAG WORKING GROUP ON MENTAL ILLNESS (2000) *National Audit of Electroconvulsive Therapy (ECT) in Scotland*. Scottish Executive Health Department, Clinical Resources and Audit Group.

CRESSWELL, J., RAYNER, L., & HOOD, C. (2005) *The ECT Accreditation Service (ECTAS): Standards for the Administration of ECT* (3rd edn). Royal College of Psychiatrists' Research and Training Unit.

CRESSWELL, J., RAYNER, L., HOOD, C., *et al* (2006) *The ECT Accreditation Service (ECTAS): Standards for the Administration of ECT*. College Centre for Quality Improvement.

FOX, H. (1993) Patients' fear of and objection to electroconvulsive therapy. *Hospital and Community Psychiatry*, **44**, 357–360.

KHO, K. H., VAN VREESWIJK, M. F., SIMPSON, S., *et al* (2003) A meta-analysis of electroconvulsive therapy efficacy in depression. *Journal of Electroconvulsive Therapy*, **19**, 139–147.

LELLIOTT, P. & DUFFETT, R. (1998) Auditing electroconvulsive therapy. The third cycle. *British Journal of Psychiatry*, **172**, 401–405.

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (2003) *Guidance on the Use of Electroconvulsive Therapy* (Technology Appraisal 59). National Institute for Clinical Excellence.

PHILPOT, M., COLLINS, C., TRIVEDI, P., *et al* (2004) Eliciting users' views of ECT in two mental health trusts with a user-designed questionnaire. *Journal of Mental Health*, **13**, 403–413.

ROSE, D., WYKES, T., LEESE, M., *et al* (2003) Patients' perspectives on electroconvulsive therapy: systematic review. *BMJ*, **326**, 1363.

ROYAL COLLEGE OF PSYCHIATRISTS (2005) *The ECT Handbook* (2nd edn) (Council Report CR128). Royal College of Psychiatrists.

SIENAERT, P., DE BECKER, T., VANSTEELANDT, K., *et al* (2005) Patient satisfaction after electroconvulsive therapy. *Journal of Electroconvulsive Therapy*, **21**, 227–231.

SJÖBLOM, L., PEJLERT, A. & ASPLUND, K. (2005) Nurses' view of the family in psychiatric care. *Journal of Clinical Nursing*, **14**, 562–569.

UK ECT Review Group (2003) Efficacy and safety of electroconvulsive therapy in depressive disorders: systematic review and meta-analysis. *Lancet*, **361**, 799–808.

***Kerry Kershaw** PhD student, Royal College of Psychiatrists and Goldsmiths College, Royal College of Psychiatrists' Research and Training Unit, Standon House, 21 Mansell Street, London E1 8AA, email: psp01kk@gold.ac.uk, **Lauren Rayner** ECT Accreditation Service Project Worker, Royal College of Psychiatrists' Research and Training Unit, London, **Robert Chaplin** Research Fellow, Royal College of Psychiatrists' Research and Training Unit, London, and Consultant Psychiatrist, Oxfordshire & Buckinghamshire NHS Partnership Mental Health Trust, Warneford Hospital, Oxford

https://doi.org/10.1192/pb.bp.107.014860 Published online by Cambridge University Press