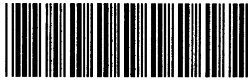
UNIVERSITY OF VIRGINIA HEALTH SYSTEM



PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PSYCHIATRIC SERVICES ELECTROCONVULSIVE THERAPY (ECT) PLAN OF CARE FLOWSHEET ADDENDUM (TO FORM 010101 ADULT CLINICAL DATA FLOW SHEET)

Treatment # ________________

PRE-ECT

Mark N/A if not applicable.

Initiated by *Initials*	**DATE**	**INTERVENTIONS**	**Responsible Staff**	**Comments**
		Conduct ECT Work-up	MD	
		Provide Patient/ Family Education	MD/RN	
		Obtain Patient/Family/AR Consent	MD	
		Complete Pre-ECT checklist on day of treatment	RN	
		Implement Physicians Pre-ECT orders	RN	
		Administer Anti-Hypertensive medications with minimal fluid	RN	
		Notify ECT staff of abnormal vital signs, blood glucose and/or change in physical or mental status	RN	

POST-ECT

Initiated by *Initials*	**DATE**	**INTERVENTIONS**	**Responsible Staff**	**Comments**
		Assist patient with first ambulation	RN	
		Upon arrival to unit assess: Vital Signs	RN	
		Orientation		
		Schmidt Score		
		Pain Level		
		Reorient as needed	RN/PCA	
		Implement Falls Protocol measures as needed	RN/PCA	
		Offer food and fluids once patient is fully alert	RN/PCA	
		Notify MD of abnormal vital signs, severe confusion, extreme falls risk and/or other post-ECTcomplications	RN	
		Review pain relief measures already implemented by ECT staff	RN	
		Implement pain relief measures as needed and reassess for pain within one hour as per protocol	RN	
		Assess readiness for re-integration into the milieu. Encourage patient to begin participating in activities and resume Pre-ECT treatment plan	ALL STAFF	

☐ All interventions achieved to meet post-op goal. Patient returned to acceptable pre-ECT baseline. ____________ ____________
INITIALS DATE

CARE PROVIDERS

PRINT NAME	SIGNATURE	TITLE	INITIALS	SHIFT