Appendix A: Printable Patient Audit sheet
Use this to record your patient cases before entering the data on the online tool.

1. Demographics		
1.1	Patient identifier	
1.2	Gender	• Male • Female • Other/patient prefers not to say

1.3	Ethnicity	• White
		  ○ British,
		  ○ Irish
		  ○ Traveller
		  ○ Any other White background)
		• Asian/Asian British
		  ○ Bangladeshi
		  ○ Chinese
		  ○ Indian
		  ○ Pakistani
		  ○ Any other Asian background
		• Black/Black British
		  ○ African
		  ○ Caribbean
		  ○ any other Black background
		• Mixed/multiple ethnic backgrounds
		  ○ mixed - White and Black
		  ○ mixed White and Asian
		  ○ mixed any other background)
		• Other
		  ○ Arab
		  ○ Other
		• prefer not to say

1.4	Year of birth	
1.5	What setting does this patient live in?	• Own home • Residential care home • Nursing home • Other (please specify)
1.6	In what health setting was the patient seen?	• NHS – outpatient • NHS – community • Private clinic • At home • Other (please specify)

1.7	Parkinson's phase	• Diagnosis • Maintenance • Complex • Palliative
2. Referral		
2.1	Year of Parkinson's diagnosis	
2.2	Year of individual's first access to SLT input	
2.3	When the person was first referred to any SLT service, at what stage of their Parkinson's were they?	• Diagnosis • Maintenance • Complex • Palliative • Not known
2.4	Referred by for current episode of care:	• Elderly care clinic • General neurology clinic • Parkinson's nurse specialist • General/non PDNS nurse • Allied health professions colleague (PT, OT) • SLT colleague • Self/relative • Other (please specify)
2.5	Reason for referral to service involved in the current audit Tick all that apply	• Speech • Language • Cognition • Swallow • Drooling • Not specified
2.6	Is this the first episode of SLT care for this patient in any SLT service?	• Yes • No • Not known
2.7	Was the target time from referral to first SLT appointment met for this episode of care?	• Yes • No, and no reason documented • No, but reason documented (e.g. clinician leave)

2.8	What has been offered in the current episode of care?	• Initial assessment • Review • Individual treatment • Group treatment • Group and individual treatment
3. Assessments		
3.1	Was there documentation of on-off phase at assessment?	• Yes • No
3.2	Is an assessment of communication recorded at initial assessment? **If no, go to Q3.7**	• Yes • No • No, but reasons for not appropriate to assess documented • No, referred for swallow/drooling assessment only
3.3	Did the communication assessment also include a screening question about swallowing?	• Yes • No
3.4	Was communication reassessed at reviews?	• Yes • No reference to assessments documented • No, but reasons for not appropriate to assess documented • Initial assessment only • No, referred for swallow assessment only
3.5	Is an initial audio or video recording included in the record?	• Yes and available • Yes but not available • No, Trust/Board governance rules do not permit acquisition or storage of digital data • No, equipment not available • No, client did not consent • No
3.6	Are strengths and needs for communication in current and likely environments documented?	• Yes • No

<table>
<tr><td>3.7</td><td>Was an assessment of swallowing recorded at initial assessment?

If no, go to question 3.10</td><td>• Yes
• No, but reasons for not appropriate to assess documented
• No reference to assessments documented
• No, referred for communication assessment only</td></tr>
<tr><td>3.8</td><td>Was swallowing reassessed at reviews?</td><td>• Yes
• No
• No, but reasons for not appropriate to assess documented
• Initial assessment only
• No, referred for communication assessment only</td></tr>
<tr><td>3.9</td><td>Was drooling assessed?</td><td>• Yes - formal published assessment used
• Yes - informal observation checklist used
• Yes - clinical observations documented
• Yes - patient report recorded
• No, as not reported/ observed
• No</td></tr>
<tr><td>3.10</td><td>Is there a clear plan of management based on assessment outcomes?</td><td>• All plans detailed in notes
• Some restricted plans documented
• No plans documented</td></tr>
<tr><td>3.11</td><td>Which speech subsystems were assessed and documented?

Tick all that apply</td><td>• Phonation including voice quality
• Loudness/amplitude level and variation
• Prosody including pitch, pitch range and variation
• Oromotor skills
• Articulation and speech rate
• No assessments documented but justification documented
• No assessments and no justification documented</td></tr>
<tr><td colspan="3">Questions 3.12 to 3.16 only to be completed if Q3.2 answered ‘yes’
If questions 3.2 answered ‘no’ go to question 3.17</td></tr>
<tr><td>3.12</td><td>What tasks/contexts does assessment cover?

Tick all that apply</td><td>• Speaking
• Reading
• One to one context
• Group context</td></tr>
</table>

3.13	Was intelligibility assessed?	• Standardised diagnostic intelligibility test completed • Informal assessment, non-standardised tool/subsection of other test completed • Informal assessment (e.g. rating scale) completed • No assessment/results documented but justification given • No assessment documented and no justification given
3.14	Is word finding assessed? **Tick one**	• Formal standardized word finding assessment • Informal word finding assessment • Observations recorded • Self report documented but not assessed • No
3.15	Was the need for AAC identified and addressed?	• Yes • No • Not applicable
3.16	Communication - does assessment cover: **Tick all that apply**	• communication participation • the impact of Parkinson's on communication • the impact of communication changes on partner and/or carer
	Results of assessment	
3.17	Were assessment results and rationale for management plan discussed with patient and carer?	• Yes • No, but justification documented • No and no justification
3.18	Was information about communication and/or swallowing provided to patient and carer?	• Yes, verbal and written information provided • No, but justification documented • No and no justification
3.19	Where notes recommend onward referrals (e.g. ENT, video fluoroscopy), have these been made?	• Yes • None and reasons documented • None and reasons not documented • No onward referrals recommended
3.20	If a patient is in complex or palliative phase, is there evidence of anticipatory care planning in the last 12 months?	• Yes • No • Not in complex or palliative phase • Not indicated

4. Interventions		
4.1	Communication – which of the following interventions were offered? **Tick all that apply**	• Pitch (range) • Prosody • Improvement of vocal loudness • Strategies to optimise intelligibility • Word finding/language change • Patient education/advice • Managing patient participation • Managing patient impact • Managing generalisation outside clinic • Carer education/advice • Managing career impact • Other • Not applicable – seen for swallowing/drooling only
4.2	Swallow – which of the following interventions were offered: **Tick all that apply**	• Strategies for safer swallowing • Fluid and diet modification • Positioning • Feeding advice for carers • Expiratory Muscle Strength Training • Information on risks and warning signs • Other (please describe) • Not applicable – seen for communication/drooling only
4.3	Drooling – which of the following interventions were offered: **Tick all that apply**	• Strategies to manage saliva • Swallow reminder tools • Referral on for medication • Other (please describe) • Not applicable – seen for communication/swallowing only
4.4	Were reports made back to the referrer/other key people at the conclusion of an intervention period (or when treatment lasts a longer time there are interim reports)?	• Yes • No • Not applicable as assessment/intervention still in progress
4.4a	Did reports detail the intervention, duration, frequency, effects and expected prognosis and provide results from (re)assessments?	• Yes • No

5. About the Speech and Language Therapist		
5.1	What band (grade) is the speech and language therapist who carried out the initial assessment of this person?	• 4 • 5 • 6 • 7 • 8a • 8b • 8c
5.2	Approximately what percentage of people seen by the audited therapist in a year have Parkinson's? i.e. the individual who is seeing the person for this episode of care	• 0-19% • 20-39% • 40-59% • 60-79% • 80-99% • 100% • Unknown
6. Evidence base		
6.1	Which of the following did the audited therapist use to inform clinical practice or guide intervention? **Tick all that apply**	• Own clinical experience • Advice from colleagues • RCSLT Clinical Guidelines (CQ Live) • RCSLT Communicating Quality Live • 2017 NICE Guideline: Parkinson's disease: Diagnosis and management in primary and secondary care and other relevant NICE guidelines • National Service Framework for Long Term Neurological Conditions (NSF – LTNC) guidelines • Published evidence in a peer reviewed journal • None • Other (please specify)