2025 UK Parkinson's Audit: Speech and language therapy - patient audit case 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
		  o British
		  o Irish
		  o Gypsy or Irish Traveller
		  o Roma
		  o Any other White background
		• Asian/Asian British
		  o Bangladeshi
		  o Chinese
		  o Indian
		  o Pakistani
		  o Any other Asian background
		• Black/Black British/Caribbean/African
		  o African
		  o Caribbean
		  o any other Black background
		• Mixed/Multiple ethnic groups
		  o Asian and White
		  o Black African and White
		  o Black Caribbean and White
		  o Any other Mixed/Multiple background
		• Other ethnic group
		  o Arab
		  o Any other ethnic group
		• 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	How was this person assessed?	• In person • Virtually - by video • Virtually - by telephone
1.8	Parkinson's phase	• Diagnosis • Maintenance • Complex • Palliative
2. Referral		
2.1	Year of Parkinson's diagnosis	
2.2	Has the person received previous speech and language therapy specifically for Parkinson's?	• Yes, go to Q2.3 • No, skip to Q2.4 • Offered but declined • Unknown
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	Who made the referral to speech and language therapy for the current episode of care?	• Elderly care consultant • Neurologist • Parkinson's nurse specialist • General/non-PDNS nurse • GP • Allied health professional colleague (OT/Physio) • Dietician • Social care worker • Self-referral/relative • Other (please specify) • Unknown

2.5	What was the time between the date of the referral letter and the date of the initial appointment for this episode of care?	• 1 to 4 weeks • 5 to 8 weeks • 9 to 12 weeks • 13 to 18 weeks • More than 18 weeks
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?	• Yes • No (skip to Q3.5) • No, referred for swallow/drooling assessment only (skip to Q3.5)
3.3	Did the communication assessment also include a screening question about swallowing?	• Yes • No
3.4	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
3.5	Was an assessment of swallowing recorded at initial assessment?	• Yes • No, but reasons for not appropriate to assess documented • No reference to assessments documented • No, referred for communication assessment only
3.6	Was drooling assessed?	• Yes - formal published assessment used • Yes - informal observation checklist used • Yes - clinical observations documented • Yes - patient report recorded • No, as not reported/ observed • No
Questions 3.7 to 3.11 only to be completed if Q3.2 answered YES		
3.7	Which speech subsystems were assessed and documented?	• Phonation including voice quality • Loudness/amplitude level and variation • Stimulability of volume

	Tick all that apply	• 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
3.8	Was intelligibility assessed? Choose one	• 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
3.9	Is word finding assessed? Choose one	• Formal standardised word finding assessment • Informal word finding assessment • Observations recorded • Self report documented but not assessed • No
3.10	Was the need for AAC identified and addressed?	• Yes • No • Not applicable
3.11	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	
3.12	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
3.13	If the patient is in the 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	• Compensatory strategies for safer swallowing (eg clearing swallows, postural moves) • Fluid and diet modification • Positioning • Feeding advice for anyone involved in supporting eating and drinking • Environmental/external advice • Expiratory Muscle Strength Training • Information on risks and warning signs • Cough skill training • Swallow re-training eg CTAR, Shaker, VAST, NMES • 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 botulinum toxin, new medical management or adjustment of current medical management • Other (please describe) • Not applicable – seen for communication/swallowing only
4.4	Was a letter sent to the referrer?	• Yes • No
4.4a	If no:	• Not current practice • Therapy ongoing but letter to be sent on completion

		• No requirement as discussed directly with referrer at MDT review
	If yes:	
4.4b	Did the letter include details of the therapy assessment?	• Yes • No
4.4c	Did the letter include therapy outcome scores?	• Yes • No
4.4d	Did the letter include strategies and recommendations?	• 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?	• 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 (continues overleaf)	• Own clinical experience • Advice from colleague or supervisor • 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 • Allied Health Professionals' competency framework for progressive neurological conditions

		• Published evidence in a peer reviewed journal (read within last 12 months) • Information from Parkison's UK website' • Postgraduate training (eg attending course/lectures specific to Parkinson's) within last 24 months • Other (please specify below) • None