

2017 UK Parkinson's Audit
Occupational therapy
Standards and guidance

2017 UK Parkinson's Audit

Occupational therapy



College of
Occupational
Therapists

Audit of national standards relating to Parkinson's care, incorporating the Parkinson's NICE guideline and the National Service Framework for Long Term Neurological Conditions quality standards.

Aim

The aim of the occupational therapy audit is to establish if occupational therapy services are providing quality services for people with Parkinson's, taking into account recommendations made in evidence-based guidelines.

Objectives

1. To evaluate if occupational therapy services are currently providing assessment and interventions appropriate to the needs of people with Parkinson's, taking into account recommendations made in evidence-based guidelines.
2. To identify areas of good practice and areas for improvement to inform local, regional and UK-wide discussions leading to action plans to improve quality of care.
3. To establish baseline audit data to allow:
 - UK-wide mapping of variations in quality of care
 - local and UK-wide mapping of progress in service provision and patient care through participation in future audit cycles

Background

The Parkinson's occupational therapy audit is part of the UK Parkinson's audit coordinated by Parkinson's UK and led by a steering group of professionals.

This is the fourth round in which occupational therapists will be able to take part, along with physiotherapists and speech and language therapists. Consultants in elderly care and neurology (and their Parkinson's nurses) can participate in the parallel patient management audit. The occupational therapy audit has received research governance approval by the College of Occupational Therapists. The audit questions for this round of the audit have been refined to reflect feedback from the 2015 audit.

Standards

The occupational therapy audit has been structured according to *Occupational therapy for people with Parkinson's: Best Practice Guidelines*¹ and the National Service Framework for Long Term Conditions². It has also been structured according to principles of occupational therapy for Parkinson's, as outlined by the NICE guideline³.

The principles of occupational therapy for Parkinson's include:

- early intervention to establish rapport, prevent activities and roles being restricted or lost and, where needed, to develop appropriate coping strategies
- patient centred assessment and intervention
- development of goals with the individual and carer
- employment of a wide range of interventions to address physical and psychosocial problems to enhance participation in everyday activities, such as self care, mobility, domestic and family roles, work and leisure (NICE 2006, quoted in *Occupational therapy for people with Parkinson's: Best Practice Guidelines* 2010 p16)

The NICE guideline (2006, p14) states that occupational therapy should be available for people with Parkinson's, and that particular consideration should be given to:

- maintenance of work and family roles, employment, home care and leisure activities
- improvement and maintenance of transfers and mobility
- improvement of personal self-care activities, such as eating, drinking, washing and dressing
- environmental issues to improve safety and motor function
- cognitive assessment and appropriate intervention

¹ Aragon A, Kings J (2010) *Occupational therapy for people with Parkinson's: Best Practice Guidelines* College of Occupational Therapists. In Partnership with Parkinson's UK and College of Occupational Therapists Specialist Section Neurological Practice. Available at http://www.parkinsons.org.uk/sites/default/files/publications/download/english/otparkinsons_guidelines.pdf

² Department of Health. *National Service Framework for Long Term Neurological Conditions*. (2005) Available at www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions

³ National Institute of Health and Clinical Excellence. *Parkinson's Disease: Diagnosis and Management in Primary and Secondary Care Clinical Guidelines* 35. (2006) Available at <https://www.nice.org.uk/guidance/CG35>

Methodology

This audit is open to all occupational therapy services and individual occupational therapists that work with people with Parkinson's in the UK, whether hospital or community based, clinic or domiciliary service (excluding acute hospital inpatients).

Standards agreed to be pertinent to occupational therapy have been transformed into a set of audit standards and statements reviewed by specialist occupational therapists. The full list of questions is given in Table 1 (Service audit) and Table 2 (Patient audit) at the end of this document.

A process flow chart (*How do I take part?*) can be found on page X of this document. Please note the importance of logging your participation in this national clinical audit with your Audit Department.

Patient sample

The minimum audit sample size is 10 consecutive people with idiopathic Parkinson's patients referred to an occupational therapy service and seen during the audit data collection period, which runs from 1 May 2017 to 30 September 2017.

Take account of the need to capture this minimum sample when deciding locally on your start date for collecting a consecutive patient sample. The data collection tool will have the capacity to capture as many consecutive patients as therapists wish to audit.

The inclusion criteria for audited patients are as follows:

- a) Patients who are currently receiving active intervention (including education/counselling) at the start of the audit period.
- b) Those who are seen on a review appointment (irrespective of whether they then go to start another episode of active treatment) during the audit period.
- c) Patients newly referred to your service who undergo full assessment (again irrespective of whether they then proceed to immediate active intervention rather than being placed on review).

Data collection and entry

The audit tool contains three sections:

- A **service audit** section, which consists of some general questions about your service (which needs to be completed only once by a manager or senior colleague familiar with the service set-up and running).
- A **patient audit** section, which allows you to enter data on individual patients. These include both newly seen people with Parkinson's and follow ups, but each person should only be documented once, even if they attend more than once during this period.
- An **instant reporting** section, which will be built automatically as you enter your data, and produces pie charts for selected questions.

In some circumstances, people may have to audit notes from across a department, although we would prefer that, where possible, information is audited from one specific service in a particular type of setting.

Ideally the person entering data on the tool should not be the person who completed the notes but this may not always be possible. When reviewing someone else's notes, it may be necessary to speak with the clinician or therapist who wrote them.

It is good practice for the auditor to keep the occupational therapy notes separate from the medical notes. If possible, both sets of notes should be used to complete the audit.

Patient data can be entered on the data collection tool which you have downloaded and saved locally and added to at your convenience. Complete a separate entry for each patient with Parkinson's. Remember to save the data each time you add new information.

Appendix A of this document is a version of the patient questions that you can print and use to record data in your clinics, if this would be useful.

A user guide for the data collection tool will be available, providing full instructions and information.

All data must be submitted by 30 October 2017. No submissions will be accepted after that date.

'No, but...' answers

This concept has been borrowed from the National Stroke Audit. A 'No, but...' answer implies there is a pre-determined accepted reason for non-compliance with the standard. The denominator for compliance can then be determined only for those patients where the standard was relevant – ie 'No, but...' answers can be removed from calculations of compliance.

Confidentiality

Patients

Please ensure that any information you submit for the audit does not include any personally identifiable information about your patients. Identifiable information is any information you hold about a service user that could identify them. This includes personal details such as names, addresses, pictures, videos or anything else which might identify the service user. Anonymised information is information about a service user that has had all identifiable information removed from it⁴.

When you complete the patient section of the audit, you will see that there is space for a patient identifier. It is suggested that you use code letters or a number here to help you keep track (for example the patient's initials or hospital number). **This data will not be included in the data you submit to Parkinson's UK – the data collection tool will prevent this.** It will help if you keep a list of the code letters or numbers securely yourself, so that if there is any query about the information you have submitted, you can track back to the original patient.

Employers

The Healthcare Quality Improvement Partnership (HQIP) recommends that services participating in a national clinical audit should be named in the audit reports. The audit reference report will list all participating organisations. It is therefore vital that you inform your clinical audit department about your participation in the audit.

Participants

Individual therapists who participate and submit data will not be named in the audit report.

Data security

The data collection tool which will be available for download from the audit webpage will be password protected, allowing no one but eligible participants to enter and make changes to the data. The password will be emailed to the named lead for each service. Please make sure that the password is protected and can't be accessed by other people.

⁴ Health Professionals Council. *Confidentiality – guidance for registrants*. (2012) Available at <http://www.hpc-uk.org/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf> [accessed 6 January 2017]

To ensure the security of your data, we also advise you to save and use your version of the tool on a secure computer at work and not on your personal computer at home. We ask you to comply with your organisation's Data Protection guidelines at all times.

After the data has been sent to Parkinson's UK it will be stored in password-protected files at Parkinson's UK in accordance with NHS requirements. Within Parkinson's UK, access to the raw data set is restricted to Kim Davis, Clinical Audit Manager, members of the Clinical Steering Group and Alison Smith, the Data and Analytics Adviser.

Raw data will not be accessible in the public domain. Services will be asked to report any discrepancies in the data received by the audit team in a summary sheet before data analysis begins.

Patient Reported Experience Measure

All services participating in the audit are encouraged to participate in the Patient Reported Experience Measure (PREM). The PREM takes the form of a short paper questionnaire to be distributed to up to 50 consecutive patients between 1 May and 30 September 2017. These patients do not necessarily have to be those included in the main clinical audit.

The questionnaire asks 11 questions about patients' views of their Parkinson's service, and should take only five to 10 minutes to complete. If a carer has accompanied the patient on their clinic visit, they may assist the patient in completion of the form. Patients should feel comfortable and not overlooked while completing their questionnaire.

No identifiable information is collected, and the patient will seal their completed questionnaire in the envelope provided. These envelopes will then need to be collected before the patient leaves the clinic, and all the envelopes will then be returned to the audit team at Parkinson's UK in the large postage-paid envelope provided.

Each service will be provided with the following resources:

- 50 x copies of a paper questionnaire.
- 50 x sealable envelopes.
- 50 x patient information leaflets.
- An A3 laminated poster.
- A large postage-paid envelope for return of sealed envelopes to the audit team.

A minimum of 10 questionnaires will need to be returned for a service's data to be included in the data analysis.

How the audit results will be communicated

The findings of both the clinical audit and the PREM will be presented in the form of a UK-wide summary report and an individual report for each service, benchmarking the results of individual services against the national average for each audit question in their specialty.

The summary report will contain detailed analysis and comments on the data along with key recommendations for commissioners and clinicians. A bespoke patient and carer version of the summary report will also be produced, along with a reference report which will include all of the results, and a list of all participating services.

A link to the reports will be sent to all audit participants, trust audit contacts and strategic health authority/health board audit contacts. The reports will also be in the public domain via the Parkinson's UK website.

Data collected during the audit will be used to generate a national picture of service delivery and to compare this with the expectations detailed in national guidance. This data will provide valuable information about priority areas within the existing healthcare provision and will support the development of commissioning. Information generated through this collaboration will be used in campaigning on behalf of people with Parkinson's.

The UK Parkinson's Excellence Network brings together health and social care professionals to transform the care that people with Parkinson's receive across the UK. The Network is there to ensure:

- that everyone affected by Parkinson's has access to high quality Parkinson's services that meet their needs. Their care should be delivered by an expert, integrated, multi-disciplinary team including a consultant, specialist nurse and range of therapists, whose involvement is key to maximising function and maintaining independence
- there are clear pathways to timely, appropriate information, treatments and services from the point of diagnosis, including access to specialist mental health services and the full range of information and support to take control of the condition offered by Parkinson's UK
- services will be involved in continuous quality improvement through audit and engagement of service users in improvement plans

Participating in the PREM will give individual occupational therapy services direct feedback from their service users about the quality of care, accessibility and general satisfaction.

How do I take part

Am I eligible to take part?

Any healthcare professionals who work regularly with people with Parkinson's can take part. This includes speech and language therapists, physiotherapists, occupational therapists, Parkinson's nurses, neurologists and geriatricians. You need to submit data on a minimum of 20 (patient management) or 10 (therapies) patients seen during the audit period (1 May to 30 September 2017) for your data to be included in the audit.

How do I take part if I am eligible?

Register your service

Complete and submit a registration form at parkinsons.org.uk/audit by 31 March 2017 for each service you wish to audit. You will then be emailed a service number and a password for the data collection tool – you will need these to enter your audit data. In mid-April you will be sent an Audit Pack containing Patient and Carer Information Leaflets and the materials required for the Patient Reported Experience Measure (PREM).

Inform your audit department

Please log your participation in this clinical audit with your audit department and discuss with Information Governance to determine if Caldicott approval is required.

Establish a local audit project group

Include key professional and medical staff collecting data – discuss the logistics for running the audit, and plan for disseminating the results and action planning. Agree a start date for acquiring patient sample. Agree a target sample size.

Data collection

You will be able to download a copy of the data collection tool from parkinsons.org.uk/audit from mid-April 2017, along with a data collection tool. Data entry begins on 1 May 2017.

1. Enter brief details about your service (the Service Audit).
2. Enter details of consecutive patients seen during the audit period 1 May 2017 to 30 September 2017 (the Patient Audit).
3. During this period, hand out Patient Reported Experience Measure questionnaires to up to 50 consecutive patients – these do not need to be the same patients you include in the main audit.

More information

If you have any queries, or for more information, please contact Kim Davis, Clinical Audit Manager, on 020 7963 3916 or email audit@parkinsons.org.uk

Table 1: Service Audit – questions, data items/answer options and help notes

	Question	Data items/answer options	Help notes
Your details			
1.1	Name of Lead Therapist completing the Service Audit	Free text	
1.2	Contact email of Lead Therapist	Free text	
Service Description			
2.1	Describe the setting in which you usually see individuals with Parkinson's	<ul style="list-style-type: none"> • Integrated medical and therapy Parkinson's clinic • In-patient acute service • In-patient rehabilitation service • Community rehabilitation service e.g. intermediate care • Social services including reablement • Outpatient/ day hospital • Other (please specify) 	Choose one – the most common setting for the service
2.2	Does your service specialise in the treatment of individuals with neurological conditions?	<ul style="list-style-type: none"> • Yes • No 	
2.3	Does your service specialise in the treatment of individuals with Parkinson's?	<ul style="list-style-type: none"> • Yes • No 	
Individuals with Parkinson's			

3.1	Approximately how many referrals of individuals with Parkinson's are made to your service per year?	<ul style="list-style-type: none"> • Free text 	New referrals, i.e. not those 'referred' for review who have previously been seen by this service. An approximate total is all that is required
3.2	Approximately what percentage of the individuals referred to your service annually have a diagnosis of Parkinson's?	<ul style="list-style-type: none"> • 0-19% • 20-39% • 40-59% • 60-79% • 80-100% 	
Occupational therapy Professionals			
4.1	Within your service, can you access Parkinson's related continuing professional development (at least yearly)?	<ul style="list-style-type: none"> • Yes • No 	Training includes in-service within the Trust/similar body /Board/Local Health Board or external courses
4.2	Are there any documented induction and support strategies for new occupational therapists working with individuals with Parkinson's?	<ul style="list-style-type: none"> • Yes, specifically in relation to patients with Parkinson's • Yes, as part of more general competencies • No 	
4.3	What support (e.g. education, advice) is available to individual therapists working in the service?	<ul style="list-style-type: none"> • They can consult any member of the Parkinson's specialist MDT as they are a member themselves • They can consult members of a general neurology/elderly care specialist service of which they are a member • They do not work directly in specialist Parkinson's clinics but can readily 	Choose one

		<p>access a Parkinson's specialist MDT/Parkinson's Nurse Specialist</p> <ul style="list-style-type: none"> • They do not work directly in a specialist clinic but can readily access advice from a specialist neurology or elderly care MDT • They have no access to more specialised advice 	
Clinical Practice			
5.1	How does your service approach assessment of an individual with Parkinson's?	<ul style="list-style-type: none"> • MDT assessment • Interview with patients and carer • Assessment during group work • Functional Assessment • Standardised assessment • Other (please specify) 	Tick all that apply
5.2	How do you usually see your patients with Parkinson's?	<ul style="list-style-type: none"> • Individually • In a group setting • Both individually and in groups 	
5.3	Please list the standardised assessments that you use:-	<ul style="list-style-type: none"> • Assessment of Motor and Process Skills • Canadian Occupational Performance Measure (Law et al 2005) • Functional assessment measure (FAM) • Functional Independence Measure (FIM) • Nottingham Extended Activities of Daily Living Assessment (NEADL) (Nouri and Lincoln 1987) 	Tick all that apply

		<ul style="list-style-type: none"> • Fatigue Impact Scale (FIS) (Whitehead 2009) • PRPP Assessment (Perceive, Recall, Plan & Perform Assessment) • Parkinson’s Disease Questionnaire (PDQ39 or PDQ 8) • Unified Parkinson’s Disease Rating Scale (UPDRS) • Model of Human Occupation Screening Tool (MOHOST) • Non-motor Questionnaire • ACE-111(Addenbrookes Cognitive Examination 111) • MMSE-2 (Mini Mental State Examination - 2) • Mattis Dementia Rating Scale (MDRS) • Scales for Outcomes in Parkinson’s Disease – Cognition (SCOPA-COG) • Rivermead Behavioural Memory Test (RBMT) • Behavioural Assessment of Dysexecutive Syndrome (BADS) • Other (please specify) 	
5.4	What needs are addressed through your interventions?	<ul style="list-style-type: none"> • Work roles • Family roles • Domestic activities of daily living • Leisure activities • Transfers and mobility • Personal self care activities such as eating, drinking, washing and dressing • Environmental issues to improve safety 	Tick all that apply

		<p>and motor function</p> <ul style="list-style-type: none"> • Mental wellbeing, including cognition, emotional and/or neuro-psychiatric problems • Management of fatigue • Education of condition and self-management • Social interaction/social support • Other (please specify) 	
5.5	Where do you carry out the intervention?	<ul style="list-style-type: none"> • Individual's home • Community setting • Outpatient/day hospital/centre • Inpatient hospital 	

Table 2: Patient audit: Audit standards, questions and supporting information

	Question	Data items/answer options	Help notes
1. Demographics			
1.1	Patient identifier	This can be used by you to identify audited patients	This data will be removed by the data entry tool when you submit your data
1.2	Gender	<ul style="list-style-type: none"> • Male • Female 	
1.3	Ethnicity	<ul style="list-style-type: none"> • White <ul style="list-style-type: none"> ○ British, ○ Irish ○ Traveller ○ Any other White background) • Asian/Asian British <ul style="list-style-type: none"> ○ Bangladeshi ○ Chinese ○ Indian ○ Pakistani ○ Any other Asian background • Black/Black British <ul style="list-style-type: none"> ○ African ○ Caribbean ○ any other Black background • Mixed/multiple ethnic backgrounds <ul style="list-style-type: none"> ○ mixed - White and Black ○ mixed White and Asian ○ mixed any other background) 	

		<ul style="list-style-type: none"> • Other <ul style="list-style-type: none"> ○ Arab ○ Other ○ prefer not to say 	
1.4	Year of birth		
1.5	What setting does this Patient live in?	<ul style="list-style-type: none"> • Own home • Residential care home • Nursing home • Other (please specify) 	
1.6	In what setting was the individual seen?	<ul style="list-style-type: none"> • NHS – inpatient • NHS – outpatient • NHS - Community • Private clinic • At home • Other 	
1.7	Parkinson's phase	<ul style="list-style-type: none"> • Diagnosis • Maintenance • Complex • Palliative 	<p>Definitions of phases</p> <p>Diagnosis</p> <ul style="list-style-type: none"> • From first recognition of symptoms/sign/problem • Diagnosis not established or accepted. <p>Maintenance</p> <ul style="list-style-type: none"> • Established diagnosis of Parkinson's • Reconciled to diagnosis • No drugs or medication 4 or less doses/day • Stable medication for >3/12 • Absence of postural instability. <p>Complex</p> <ul style="list-style-type: none"> • Drugs – 5 or more doses/day • Any infusion therapy (apomorphine or duodopa) • Dyskinesia • Neuro-surgery considered / DBS in situ

			<ul style="list-style-type: none"> • Psychiatric manifestations >mild symptoms of depression/anxiety/hallucinations/psychosis • Autonomic problems – hypotension either drug or non-drug induced • Unstable co-morbidities • Frequent changes to medication (<3/12) • Significant dysphagia or aspiration (for this audit, dysphagia should be considered a prompt for considering end of life issues). <p>Palliative</p> <ul style="list-style-type: none"> • Inability to tolerate adequate dopaminergic therapy • Unsuitable for surgery • Advanced co-morbidity (life threatening or disabling).
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2. Referral

	<p>Standard A: Occupational therapy should be available and considered at diagnosis and during each regular reviews for people with Parkinson’s. (NICE: R12, R80)</p> <p>Standard B: Occupational therapists reviewing people with Parkinson’s should give particular consideration to (NICE R80):</p> <ul style="list-style-type: none"> • maintenance of work and family roles, employment, home care and leisure activities • improvement and maintenance of transfers and mobility • improvement of personal self-care activities, such as eating, drinking, washing and dressing • environmental issues to improve safety and motor function • cognitive assessment and appropriate intervention
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	Standard C: There is timely integrated assessment involving all relevant health agencies leading to individual care plans, which ensure that staffs have access to all relevant records and background information about the person's condition, test results and previous consultations. (NSF QR1)		
2.1	Who made the referral to OT?	<ul style="list-style-type: none"> • Neurologist • Geriatrician • Parkinson's nurse • Physiotherapist • GP • Dietician • Social care worker • Self-referral • Other • Unknown 	
2.2	Year of Parkinson's diagnosis		
2.3	Date of referral letter for this episode	(dd/mm/yyyy)	Where the patient made the appointment themselves via a single point of access system, use the date contact was made.
2.4	Date of initial OT intervention for this episode	(dd/mm/yyyy)	
2.5	Has the person received previous OT for Parkinson's?	<ul style="list-style-type: none"> • Yes – please go to Q2.6 • No – please go to Q2.7 • Unknown – please go to Q2.7 	Has the person has been seen by an occupational therapist working in any setting?
2.6	If yes, how many episodes of OT has s/he	(free text)	

	received for Parkinson's related problems, prior to this referral?		
2.7	Has this referral been triggered as a result of a medical review?	<ul style="list-style-type: none"> • Yes • No • Unknown 	
2.8	What was the reason for referral to OT?	<ul style="list-style-type: none"> • Work roles • Family roles • Domestic activities of daily living • Leisure activities • Transfers and mobility • Personal self-care activities such as eating, drinking, washing and dressing • Environmental issues to improve safety and motor function • Mental wellbeing, including cognition, emotional and/or neuro-psychiatric problems • Management of fatigue • Other (please specify) 	Tick all that apply
2.9	Was all the information essential for OT assessment and intervention on referral?	<ul style="list-style-type: none"> • Yes, most of it • Yes, some of it • No 	<u>Resources:</u> <ul style="list-style-type: none"> • NSF QR1 - An integrated approach to assessment of care and support needs, and to the delivery of services is key to improving the quality of life for people with LTC. The most effective support is provide when local health and socials services team communicate ; have access to up to date case notes and patients held records and work together to provide a co-ordinated

			service
2.10	If 'no', what information was missing?		(Free text box)
2.11	As an occupational therapist, do you feel that the patient was referred at an appropriate time?	<ul style="list-style-type: none"> • Yes • No • Don't know 	
2.12	Were reports made back to the referrer/other key people at the conclusion of the intervention period (or interim reports where treatment lasts a longer time)?	<ul style="list-style-type: none"> • Yes • No, but will be done at the end of this intervention • No 	
3. Goals identified			
	<p>Standard D: People with Parkinson's should have a comprehensive care plan agreed between the individual, their family and/or carers and specialist and secondary healthcare providers (NICE R5)</p> <p>Occupational therapy process frameworks, principle 3: Development of goals in collaboration with the individual and carer with regular review (Occupational Therapy for People with Parkinson's: best practice guidelines, College of Occupational Therapists, 2010, p16).</p>		
3.1a	What occupational goals were identified?	<ul style="list-style-type: none"> • self-care • productivity • leisure 	<p>Tick all that apply</p> <p>'The principles of occupational therapy for Parkinson's include development of goals in collaboration with the individual and carer, with regular review' (Occupational Therapy for people with Parkinson's: best practice guidelines 2010 p16). https://www.cot.co.uk/publication/cot-</p>

			<p>publications/occupational-therapy-people-parkinsons-disease</p> <p>'Goal setting:- Goals identified by the Patient, in partnership with the therapist' (Figure 1, Jain et al 2005, reproduced Occupational Therapy for people with Parkinson's: best practice guidelines 2010 2010 p18)</p> <p>Resources:</p> <ul style="list-style-type: none"> • 'Falls: assessment and prevention of falls in older people' NICE clinical guideline no. 21 (https://www.nice.org.uk/guidance/cg161) • 'Occupational therapy in the prevention and management of falls in adults' (2015) Practice guideline www.cot.co.uk/sites/default/files/general/public/Falls-guidelines.pdf • Scotland: Up and About – prevention and management of falls in Scotland http://www.healthcareimprovementscotland.org/default.aspx?page=13131
3.1b	Who identified goal(s)?	<ul style="list-style-type: none"> • Patient • Therapist • Family • Collaboration 	Tick one
3.2	End of life care – who identified goals?	<ul style="list-style-type: none"> • Patient • Therapist • Family • Collaboration • Not appropriate at this stage 	Tick one

4. Intervention strategies used			
4.1	Initiating and maintaining movement	<ul style="list-style-type: none"> Promoting occupational performance abilities through trial of intrinsic cueing techniques Promoting functional abilities through trial of extrinsic cueing techniques Promoting functional ability throughout a typical day, taking account of medication Promoting functional ability throughout a typical day, taking into account fatigue None of the above treatment strategies applicable 	<p>Tick all that apply</p> <p>E.g. imagining action to be carried out in detail before starting movement E.g. stepping over line on the floor, use of metronome</p>
4.1a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> Lack of training in the technique Lack of experience in the technique Lack of time/not a priority Lack of resources Other (please state) 	
4.2	Engagement, motivation, learning and carry-over	<ul style="list-style-type: none"> Promoting mental wellbeing Promoting new learning None of the above strategies applicable 	<p>Tick all that apply</p> <p>E.g. intervention to address emotional, cognitive and/or neuropsychiatric impairment E.g. ensuring full conscious attention, demonstration of movement, 'backward chaining'</p>
4.2a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> Lack of training in the technique Lack of experience in the technique Lack of time/not a priority Lack of resources Other (please state) 	

4.3	Environmental adaptations/assistive technology – did intervention include assessment for:	<ul style="list-style-type: none"> • Small aids and adaptations • Wheelchair and seating • Major adaptations • Assistive technology • Other (please state) • None of the above treatment strategies applicable 	<p>Tick all that apply</p> <p>E.g. grab rails, perching stool, adaptive cutlery</p> <p>E.g. telecare, digital technologies</p>
4.3a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state) 	
4.4	Ensuring community rehabilitation and social support – were referrals made to:	<ul style="list-style-type: none"> • Social services OT • Social worker/carers • Other allied health professions • Respite care • Voluntary services • Access to work • Other (please state) • None of the above treatment strategies applicable 	Tick all that apply
4.4a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state) 	

4.5	Providing advice and guidance to support patient's self-management	<ul style="list-style-type: none"> • Work advice and resources • Specific ADL techniques • Cognitive strategies • Fatigue management • Relaxation/stress management • None of the above treatments strategies applicable 	Tick all that apply
4.5a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state) 	
4.6	Providing information and support for family and carers	<ul style="list-style-type: none"> • Optimising function • Safe moving and handling • Support services • Managing changes in mood, cognition or behaviour • Other (please state) • None of the above treatment strategies applicable 	Tick all that apply
4.6a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state) 	

4.7	Providing support to enable choice and control	<ul style="list-style-type: none"> • Positive attitude/emotional set • Developing self awareness/adjustment to limitations • Increasing confidence • Explore new occupations • Other (please state) • None of the above treatment strategies applicable 	Tick all that apply
4.7a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state) 	
5. About the Occupational Therapist			
5.1	What is the NHS banding/social service grade of the person who assessed this person?	<ul style="list-style-type: none"> • 4 • 5 • 6 • 7 • 8a • 8b • 8c • Social service grade – junior occupational therapist • Social service grade – senior occupational therapist • Private practitioner 	

5.2	Approximately what percentage of people seen by the audited therapist in a year have Parkinson's?	<ul style="list-style-type: none"> • 0-19% • 20-39% • 40-59% • 60-79% • 80-99% • 100% • Unknown 	
6. Evidence base			
6.1	Which of the following sources of information inform your clinical practice around the management of Parkinson's?	<ul style="list-style-type: none"> • Clinical experience • Advice from colleague or supervisor • Recommendations given in OT Best Practice Guidelines? (Parkinson's UK & COT 2010) • Information from Parkinson's UK website • National Service Framework for Long term Conditions (2005) • NICE - Parkinson's disease: diagnosis and management in primary and secondary care (2017) • Published evidence in a peer reviewed journal • Training courses • Webinars, Social Media • None • Other (please specify) 	Tick all that apply

Appendix A: Printable Patient Audit sheet

	Question	Data items/answer options
2. Demographics		
1.1	Patient identifier	
1.2	Gender	<ul style="list-style-type: none"> • Male • Female
1.3	Ethnicity	<ul style="list-style-type: none"> • White <ul style="list-style-type: none"> ○ British, ○ Irish ○ Traveller ○ Any other White background) • Asian/Asian British <ul style="list-style-type: none"> ○ Bangladeshi ○ Chinese ○ Indian ○ Pakistani ○ Any other Asian background • Black/Black British <ul style="list-style-type: none"> ○ African ○ Caribbean ○ any other Black background • Mixed/multiple ethnic backgrounds <ul style="list-style-type: none"> ○ mixed - White and Black ○ mixed White and Asian ○ mixed any other background) • Other <ul style="list-style-type: none"> ○ Arab ○ Other

		prefer not to say
1.4	Year of birth	
1.5	What setting does this Patient live in?	<ul style="list-style-type: none"> • Own home • Residential care home • Nursing home • Other (please specify)
1.6	In what setting was the individual seen?	<ul style="list-style-type: none"> • NHS – inpatient • NHS – outpatient • NHS - Community • Private clinic • At home • Other
1.7	Parkinson's phase	<ul style="list-style-type: none"> • Diagnosis • Maintenance • Complex • Palliative
2. Referral		
2.1	Who made the referral to OT?	<ul style="list-style-type: none"> • Neurologist • Geriatrician • Parkinson's nurse • Physiotherapist • GP • Dietician

		<ul style="list-style-type: none"> • Social care worker • Self-referral • Other • Unknown
2.2	Year of Parkinson's diagnosis	
2.3	<p>Date of referral letter for this episode</p> <p>(Where the patient made the appointment themselves via a single point of access system, use the date contact was made.)</p>	
2.4	Date of initial OT intervention for this episode	
2.5	Has the person received previous OT for Parkinson's?	<ul style="list-style-type: none"> • Yes – please go to Q2.6 • No – please go to Q2.7 • Unknown – please go to Q2.7
2.6	If yes, how many episodes of OT has s/he received for Parkinson's related problems, prior	

	to this referral?	
2.7	Has this referral been triggered as a result of a medical review?	<ul style="list-style-type: none"> • Yes • No • Unknown
2.8	<p>What was the reason for referral to OT?</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Work roles • Family roles • Domestic activities of daily living • Leisure activities • Transfers and mobility • Personal self-care activities such as eating, drinking, washing and dressing • Environmental issues to improve safety and motor function • Mental wellbeing, including cognition, emotional and/or neuro-psychiatric problems • Management of fatigue • Other (please specify)
2.9	Was all the information essential for OT assessment and intervention on referral?	<ul style="list-style-type: none"> • Yes, most of it • Yes, some of it • No
2.10	If 'no', what information was missing?	

2.11	As an occupational therapist, do you feel that the patient was referred at an appropriate time?	<ul style="list-style-type: none"> • Yes • No • Don't know
2.12	Were reports made back to the referrer/other key people at the conclusion of the intervention period (or interim reports where treatment lasts a longer time)?	<ul style="list-style-type: none"> • Yes • No, but will be done at the end of this intervention • No
3. Goals identified		
3.1a	What occupational goals were identified? Tick all that apply	<ul style="list-style-type: none"> • self-care • productivity • leisure
3.1b	Who identified goal(s)? Tick one	<ul style="list-style-type: none"> • Patient • Therapist • Family • Collaboration
3.2	End of life care – who identified goals? Tick one	<ul style="list-style-type: none"> • Patient • Therapist • Family • Collaboration • Not appropriate at this stage

4. Intervention strategies used		
4.1	<p>Initiating and maintaining movement</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Promoting occupational performance abilities through trial of intrinsic cueing techniques • Promoting functional abilities through trial of extrinsic cueing techniques • Promoting functional ability throughout a typical day, taking account of medication • Promoting functional ability throughout a typical day, taking into account fatigue • None of the above treatment strategies applicable
4.1a	<p>If any specific treatment strategies above were applicable but not used, what was the reason for this?</p>	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)
4.2	<p>Engagement, motivation, learning and carry-over</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Promoting mental wellbeing • Promoting new learning • None of the above strategies applicable
4.2a	<p>If any specific treatment strategies above were applicable but not used, what was the reason for this?</p>	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)

4.3	<p>Environmental adaptations/assistive technology – did intervention include assessment for:</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Small aids and adaptations • Wheelchair and seating • Major adaptations • Assistive technology • Other (please state) • None of the above treatment strategies applicable
4.3a	<p>If any specific treatment strategies above were applicable but not used, what was the reason for this?</p>	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)
4.4	<p>Ensuring community rehabilitation and social support – were referrals made to:</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Social services OT • Social worker/carers • Other allied health professions • Respite care • Voluntary services • Access to work • Other (please state) • None of the above treatment strategies applicable
4.4a	<p>If any specific treatment strategies above were applicable but not used, what was the reason for this?</p>	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)

4.5	Providing advice and guidance to support patient's self-management Tick all that apply	<ul style="list-style-type: none"> • Work advice and resources • Specific ADL techniques • Cognitive strategies • Fatigue management • Relaxation/stress management • None of the above treatments strategies applicable
4.5a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)
4.6	Providing information and support for family and carers Tick all that apply	<ul style="list-style-type: none"> • Optimising function • Safe moving and handling • Support services • Managing changes in mood, cognition or behaviour • Other (please state) • None of the above treatment strategies applicable
4.6a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)

4.7	Providing support to enable choice and control Tick all that apply	<ul style="list-style-type: none"> • Positive attitude/emotional set • Developing self awareness/ adjustment to limitations • Increasing confidence • Explore new occupations • Other (please state) • None of the above treatment strategies applicable
4.7a	If any specific treatment strategies above were applicable but not used, what was the reason for this?	<ul style="list-style-type: none"> • Lack of training in the technique • Lack of experience in the technique • Lack of time/not a priority • Lack of resources • Other (please state)
5. About the Occupational Therapist		
5.1	What is the NHS banding/social service grade of the person who assessed this person?	<ul style="list-style-type: none"> • 4 • 5 • 6 • 7 • 8a • 8b • 8c • Social service grade – junior occupational therapist • Social service grade – senior occupational therapist • Private practitioner
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	therapist in a year have Parkinson's?	<ul style="list-style-type: none"> • 40-59% • 60-79% • 80-99% • 100% • Unknown
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6.1	<p>Which of the following sources of information inform your clinical practice around the management of Parkinson's?</p> <p>Tick all that apply</p>	<ul style="list-style-type: none"> • Clinical experience • Advice from colleague or supervisor • Recommendations given in OT Best Practice Guidelines? (Parkinson's UK & COT 2010) • Information from Parkinson's UK website • National Service Framework for Long term Conditions (2005) • NICE - Parkinson's disease: diagnosis and management in primary and secondary care (2017) • Published evidence in a peer reviewed journal • Training courses • Webinars, Social Media • None • Other (please specify)