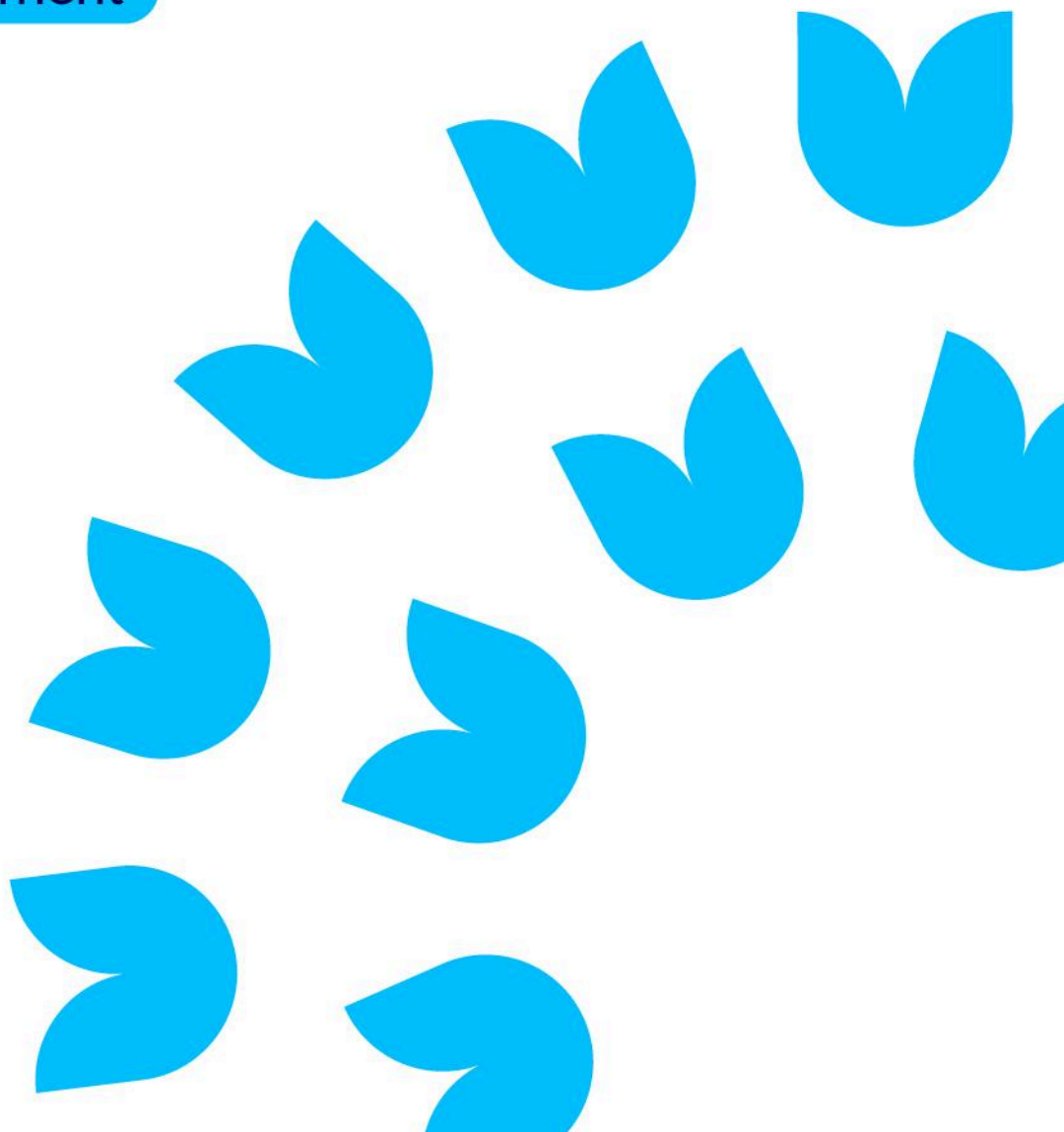


2025 UK Parkinson's Audit

Patient management:
Elderly care and neurology

Guidance document



UK Parkinson's Audit

Patient management: Elderly Care and Neurology

Audit of national standards relating to Parkinson's care, incorporating the Parkinson's NICE guideline¹ and NICE quality standards.²

Aim

The objective of the Parkinson's patient management audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson's complies with national guidelines including the Parkinson's NICE guideline and NICE Quality Standards.

Objectives

1. To encourage clinicians to audit compliance of their local Parkinson's service against Parkinson's guidelines, by providing a simple peer reviewed audit tool with the facility for central data analysis to allow benchmarking with other services.
2. To identify areas of good practice and areas for improvement to inform local, regional and UK-wide discussions leading to action plans and quality improvement initiatives 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

The audit focuses on care provided by consultants who specialise in movement disorders in neurology and in elderly care, and Parkinson's nurse specialists. It includes patients at all phases of Parkinson's: early treatment, maintenance, complex care and palliative care.

¹ National Institute of Health and Clinical Excellence. *Parkinson's Disease in Adults NG71*. (2017) Available at <https://www.nice.org.uk/guidance/ng71>

² Nice Quality Standard QS164 <https://www.nice.org.uk/guidance/qs164>

It incorporates monitoring the physical status and current needs for support and, as appropriate, making referrals and providing treatment, education and support, and co-ordination of services among care providers and the patient and carer.

Background

A multi-professional steering group³ was established in 2007 by Parkinson's UK, to develop national Parkinson's audit tools with the facility for central benchmarking. Standards are derived from the NICE guideline but incorporate other national guidance relevant to Parkinson's care.

The audit is led by a steering group of professionals. This is the ninth round of the audit and includes parallel audits of the services provided to people with Parkinson's by occupational therapists, physiotherapists, speech and language therapists and inpatient pharmacy services. The audit questions for this round have been refined to reflect feedback from the 2022 audit.

Methodology

The patient management audit is designed to examine how a patient has been managed and assessed over the previous year, rather than on a single visit, as this is more representative of actual patient care. For most patients, this will capture one or two assessments over a year if the service complies with the NICE guideline requirement for at least six to 12 monthly review.

Eligible services will see patients in connection with the regular management of their Parkinson's - ie non-acute services.

Please note the importance of logging your participation in this national clinical audit with your Audit Department.

Definition of a service

There is considerable variation in how Parkinson's services are organised and delivered throughout the UK.

³ College of Occupational Therapists Specialist Section for Neurological Practice, Royal College of Speech and Language Therapists, Chartered Society of Physiotherapy, Parkinson's Disease Nurse Specialist Association, British Geriatric Society Movement Disorder Section, The British and Irish Neurologists Movement Disorder Section.

A service is roughly defined as that provided by consultants with (or without) a Parkinson's nurse, or by Parkinson's nurses alone without consultant input, to a geographical area, regardless of who commissions the constituent parts. Clinicians and nurse specialists are best placed to decide what constitutes a discrete service. To facilitate benchmarking, each patient management submission includes a brief service audit to clarify:

- how their service is delivered - consultant(s) alone, consultant(s) plus nurse, or nurse alone
- the geographical/commissioning areas covered
- the specialty - ie neurology or elderly care

The service as described is allocated an audit service number. If the consultant and Parkinson's nurse input into the service is provided from different organisations they will both be linked to that service number and appear in the report as a joint audit service.

The following will allow meaningful benchmarking:

1. Neurology and elderly care will be analysed as separate services. They should conduct separate audits and submit data separately, even if patients share the same Parkinson's nurse input and cover the same geographical area.
2. Discrete services should be logged as separate audit sites and separate data submitted.
3. Parkinson's nurses should conduct the audit in collaboration with their patients' consultant service(s) where applicable - and vice versa.
4. The audit can be completed purely from the consultant input received only in services without Parkinson's nurse cover.
5. Clinicians working across more than one discrete service - eg a consultant working with different Parkinson's nurses in different commissioning/geographical areas - should return separate audits for each service.

Patient case sample

The minimum audit sample size is 20 consecutive people with idiopathic Parkinson's seen during the audit data collection period, which runs from 1 May 2025 to 30 September 2025.

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 clinicians wish to audit.

A sample of 20 patients per audit has been chosen to minimise work for healthcare professionals providing input into more than one discrete service eg a Parkinson's nurse auditing both neurology and elderly care patients, or a consultant who may work with different nurses in different commissioning areas.

Patients should only be included if the service is responsible for the person's ongoing management - ie not if seen as tertiary referral for advice.

Data entry

Data is entered on an on-line tool; the link is available from www.parkinsons.org.uk/audit.

- The **service audit** section consists of general questions about your service (and needs to be completed only once by a member of the team familiar with the service set-up and running).
- The **patient audit** section allows you to enter data on individual patients.

A printable version of the patient case form that you can use to record data in your clinics is available on the audit web page.

Data entry must be completed by 31 October 2025 when the data will be downloaded for analysis.

'No, but...' answers

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 submitted 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 it.⁴

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) – please do not use NHS numbers. It will help if you keep a list of the code words 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.

Participating health professionals

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

Data security

The data collection forms, which will be available online for data entry, will be accessed using a username and password chosen by each user. The password will require a minimum length and complexity according to usual online security

⁴ Health Professionals Council. Available at <https://www.hcpc-uk.org/registration/meeting-our-standards/guidance-on-confidentiality>

methods. Please make sure that your username and password are well protected and can't be accessed by other people. Colleagues will be able to collect and enter data for the audit, and you will be able to be able to view entries made by colleagues in

your local team. We ask that you comply with your organisation's Data Protection guidelines at all times.

After the data has been accessed by 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 the Clinical Audit Manager, members of the Clinical Steering Group and the Data Analyst who will carry out the analysis. Raw data will not be accessible in the public domain.

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 2025. These patients do not necessarily have to be those included in the main clinical audit.

The questionnaire asks 9 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 patient information leaflets
- 50 x sealable envelopes
- 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 PREM data to be included in the data analysis. Services from different specialties who work as part

of one multidisciplinary team and see the same cohort of patients can combine their PREM forms – just enter all of the appropriate service numbers on each form.

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

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. The full data tables will also be available, along with a list of 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 UK-wide reports will also be in the public domain via the Parkinson's UK website. Individual Service Reports are only accessible within the relevant Trust.

How the data will be used

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, as well as guide the development of UK-wide quality improvement initiatives.

Parkinson's UK Excellence Network

The Parkinson's UK 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 with 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 Parkinson's UK's full range of [information and support](#) to allow people to take control of the condition
- services will be involved in continuous quality improvement through audit and engagement of service users in improvement projects.

Thank you for your participation in the 2025 UK Parkinson's Audit

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Elderly care and Neurology – service audit

No.	Question	Data items/ Answer options	Help notes
1. General information about your service			
<p>Standard A: Adults with Parkinson's disease are referred to physiotherapy, occupational therapy or speech and language therapy if they have problems with balance, motor function, activities of daily living, communication, swallowing or saliva. (NICE QS164 – 3)</p> <p>Standard B: Services for adults with Parkinson's disease provide access to clozapine and patient monitoring for treating hallucinations and delusions. (NICE QS164 – 5)</p> <p>Standard C: Adults with Parkinson's disease who are in hospital or a care home take levodopa within 30 minutes of their individually prescribed administration time. (NICE QS164 – 4)</p> <p>Standard D: Regional discussion of complex cases (MDT). (National Neurosciences Advisory Group – Parkinson's Disease Healthcare Pathway, Optimal clinical pathway for adults: Movement Disorders – p.17)</p>			
1.1	Did this service take part in the Parkinson's audit 2022?	<ul style="list-style-type: none"> • Yes • No 	
1.2	Does your service have a current database of patients?	<ul style="list-style-type: none"> • Yes • No 	
1.3	What is the most common model of service provision for the medical/nurse specialist input to this service?	<ul style="list-style-type: none"> • Doctor alone • Joint/parallel doctor and nurse specialists clinics 	<ul style="list-style-type: none"> • Joint/parallel – PDNS works in clinics with the Consultant (but AHPs located elsewhere)

		<ul style="list-style-type: none"> • Integrated clinics (doctor/nurse specialist/therapy in same venue) • Community nurse service - with input from/contact with consultant(s) • Nurse-led service (patients with no named consultant) • Community nurse service with no input from/contact with patients named consultant(s) 	<ul style="list-style-type: none"> • Integrated clinics – doctor/nurse specialist/therapy working together in the same clinic whether in person or online • Community nurse service - with input from/contact with consultant(s) - to cover those services who have access to patient notes and all input to these patients, including Parkinson’s Specialist Practitioners. • Nurse-led service (patients with no named consultant). • Community nurse service with no input from/contact with patients’ named consultant(s) - to cover services without access to patient notes and therefore not aware of all input to these patients.
1.4	Are remote routine consultations offered?	<ul style="list-style-type: none"> • Yes - by video • Yes - by telephone • Yes - by video and telephone • No 	
1.5	Are patients routinely provided with information regarding Parkinson's, either written or by referral to Parkinson's Connect?	<ul style="list-style-type: none"> • All clinics • Most clinics (>75%) • Some clinics • Not routinely available 	Routinely available means accessible to patients such as on tables or in racks and/or accessible to staff to distribute to patients.

1.6	Can your service refer to the following specialties with experience in Parkinson's?	<ul style="list-style-type: none"> • Occupational therapy • Physiotherapy • Speech and language therapy • Psychiatry/mental health/psychology 	Tick all that apply
1.7	Does your service have access to a regional MDT meeting for discussion of complex cases?	<ul style="list-style-type: none"> • Yes • No 	MDT may include neurology and/or care of the elderly consultant with specialist expertise in movement disorders, Parkinson's nurse specialist, psychiatrist, palliative care specialist as relevant. MDT should include at least three different health professionals.
1.8	Does your service have local pathways to provide access to clozapine and for patient monitoring?	<ul style="list-style-type: none"> • Yes • No 	
1.9	Does your hospital have a local Parkinson's guideline incorporating a recommendation that Levodopa must be administered within 30 minutes of prescribed time?	<ul style="list-style-type: none"> • Yes • No 	

1.10	Does your service have access to wearables?	<ul style="list-style-type: none"> • Yes • Yes, but limited • Would like to use, but not currently available • No 	<p>NICE - Devices for remote monitoring of Parkinson's Disease 4.3 - page 28: https://www.nice.org.uk/guidance/dg51/resources/devices-for-remote-monitoring-of-parkinsons-disease-pdf-1053866615749</p>
1.10a	If yes: tick all that apply	<ul style="list-style-type: none"> • Kinesia 360 • KinesiaU • PDMonitor • Personal KinetiGraph (PKG) • STAT-ON • Other (please specify) 	
2. Assessments			
2.1	Is a validated standardised assessment tool routinely available in clinic venues to assess and monitor cognitive function?	<ul style="list-style-type: none"> • All clinics • Most clinics (>75%) • Some clinics • Not routinely available 	<p>Validated standardised assessments:</p> <ul style="list-style-type: none"> • MoCA • MMSE • ACR-R (revised Addenbrooke's Cognitive Examination) • SCOPA-Cog • clock drawing test
2.2	Is a validated standardised assessment tool routinely available in clinic venues to assess low mood/ depression)?	<ul style="list-style-type: none"> • All clinics • Most clinics (>75%) • Some clinics • Not routinely available 	<p>Validated standardised assessments:</p> <ul style="list-style-type: none"> • GDS (Geriatric Depression Scale) • HADS (Hospital Anxiety and Depression Scale) • BDI-II Beck Depression Inventory • UPDRS • Montgomery-Asberg Depression Rating Scale • PHQ-9 (Patient Health Questionnaire-9) or PHQ-2

2.3	Is a validated standardised assessment tool routinely available in clinic venues to assess anxiety?	<ul style="list-style-type: none"> • All clinics • Most clinics (>75%) • Some clinics • Not routinely available 	Validated standardised assessments: <ul style="list-style-type: none"> • HADS (Hospital Anxiety and Depression Scale) • GAD-7 (Generalised Anxiety Disorder Assessment) • Beck Anxiety Inventory • HAM-A (Hamilton Anxiety Rating Scale) • Parkinson's Anxiety Scale • GAI (Geriatric Anxiety Inventory)
3. Consultants			
3.	Consultants		
3.1	Audit Lead consultant name		
3.2	Specialty	<ul style="list-style-type: none"> • Geriatrician • Geriatrician with special interest in Parkinson's • Neurologist • Neurologist with special interest in Parkinson's 	Choose one
3.3	Employing Trust/Board/Local Health Board		
3.4	Contact telephone number		
3.5	Contact email		

3.6	How many consultants routinely provide medical input for this service?	<ul style="list-style-type: none"> • The number of consultants • Names of the other consultants 	<p>Routinely means regular clinic commitment.</p> <p>Include: Any consultant who sees Parkinson's patients for diagnosis and ongoing management. Non specialist consultants should be included if they keep Parkinson's patients under their care.</p>
3.7	Have all consultants providing medical input to this service attended Movement Disorder specific external CME in the last 12 months?	<ul style="list-style-type: none"> • Yes • No 	The question refers to external CME, i.e. regional, national or international education updates relevant to Parkinson's.
3.7a	If no, please enter X out of X consultants have attended	Free text	
4. Parkinson's Nurse Specialists			
4.1	Can patients in this service access a Parkinson's Nurse Specialist or equivalent?	<ul style="list-style-type: none"> • Yes – Parkinson's Nurse Specialist • Yes – other healthcare professional • No 	Parkinson's Nurse Specialist includes equivalent roles such as Parkinson's Specialist Practitioner.
4.2	Parkinson's Nurse Specialist details	<ul style="list-style-type: none"> • Name • Employing Trust/Board/Local Health Board • Contact telephone number and email 	Parkinson's Nurse Specialist includes equivalent roles such as Parkinson's Specialist Practitioner.

4.3	Have all Parkinson's Nurse Specialists associated with this service attended Parkinson specific external CME in the last 12 months?	<ul style="list-style-type: none"> • Yes • No • No Parkinson's Nurse Specialist 	This question refers to external CME i.e. regional, national or international education updates relevant to Parkinson's.
4.3a	If no, please enter X out of X Parkinson's Nurse Specialists have attended	Free text	
4.4	What is the main arrangement for contact between Consultants and Parkinson's Nurse Specialists?	<ul style="list-style-type: none"> • Regular contact in Multidisciplinary meeting, joint or parallel clinic • Regular face to face contact outside clinic • Regular telephone/email contact with occasional face to face contact • Telephone/email contact only • No or rare contact • No Parkinson's Nurse Specialist 	Regular is defined as at least twice a month.

Elderly care and Neurology – patient audit

No.	Question	Data items/Answer options	Help notes
1. Descriptive data			
1.1	Patient identifier		Used locally to identify audited patients
1.2	Gender	<ul style="list-style-type: none"> • Male • Female • Other/patient prefers not to say 	
1.3	Ethnicity	<ul style="list-style-type: none"> • White <ul style="list-style-type: none"> ○ British ○ Irish ○ Gypsy or Irish Traveller ○ Roma ○ Any other White background • Asian/Asian British <ul style="list-style-type: none"> ○ Bangladeshi ○ Chinese ○ Indian ○ Pakistani ○ Any other Asian background • Black/Black British/Caribbean/African <ul style="list-style-type: none"> ○ African ○ Caribbean ○ any other Black background • Mixed/Multiple ethnic groups <ul style="list-style-type: none"> ○ Asian and White 	

		<ul style="list-style-type: none"> o Black African and White o Black Caribbean and White o Any other Mixed/Multiple background • Other ethnic group <ul style="list-style-type: none"> o Arab o Any other ethnic group • prefer not to say 	
1.4	Year of birth		
1.5	Year of Parkinson's diagnosis		If 2023, 2024 or 2025 (newly diagnosed), there are to two additional questions (see end of document)
1.6	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

			<ul style="list-style-type: none"> • Neuro-surgery considered / DBS in situ • 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).
1.7	Living Alone	<ul style="list-style-type: none"> • Yes • No, • No, at residential home • No, at nursing home 	
2. Specialist Review			
Standard A: People diagnosed with Parkinson's disease should be seen at regular intervals of 6–12 months to review their diagnosis. (NICE NG71 1.2.5)			
2.1	How have consultations with this patient taken place in the	<ul style="list-style-type: none"> • In person • Virtually - by video • Virtually - by telephone 	

	last 12 months? (Tick all that apply)		
2.2	Time since most recent medical review (by doctor or nurse specialist)	<ul style="list-style-type: none"> • Less than 6 months • 6-12 months • More than 1 year • More than 2 years • Never 	
3. New / Recent Parkinson's medication			
<p>Standard B: When starting treatment for people with Parkinson's disease, give people and their family members and carers (as appropriate) oral and written information about the following risks, and record that the discussion has taken place: Impulse control disorders with all dopaminergic therapy (and the increased risk with dopamine agonists).</p> <ul style="list-style-type: none"> • Excessive sleepiness and sudden onset of sleep with dopamine agonists. • Psychotic symptoms (hallucinations and delusions) with all Parkinson's disease treatments (and the higher risk with dopamine agonists). (NICE NG71 1.3.8) 			
3.1	Is there documented evidence of a conversation with the patient/carer and/or provision of written information regarding potential adverse effects for any new medications?	<ul style="list-style-type: none"> • Yes • No • Not applicable – patient not started on Parkinson's medication for the first time during the previous year 	<p>The written information can include a copy of clinic letter if adverse effects are listed, or the Parkinson's UK medication leaflet. The manufacturer's package insert does not meet this standard.</p> <p>Resources: Parkinson's UK medication leaflets: https://www.parkinsons.org.uk/content/drug-treatments-parkinsons</p>

4. Specific adverse effect monitoring

Standard C: Advise people with Parkinson's disease who have daytime sleepiness and/or sudden onset of sleep not to drive (and to inform the DVLA of their symptoms) and to think about any occupation hazards. (NICE NG71 1.5.1)

Standard D: Recognise that impulse control disorders can develop in a person with Parkinson's disease who is on any dopaminergic therapy at any stage in the disease course. (NICE NG71 1.4.1)

4.1	Is this patient on Parkinson's medication?	<ul style="list-style-type: none"> • Yes • No (to go Q5.1) 	
4.2	Is this patient a current driver?	<ul style="list-style-type: none"> • Yes (answer Qs 4.3 to 4.6) • No 	
4.3	Has this patient been given DVLA/insurance advice?	<ul style="list-style-type: none"> • Yes • No 	
4.4	Has this patient been asked about excessive daytime somnolence at the wheel?	<ul style="list-style-type: none"> • Yes • No 	
4.5	Has safe driving advice been given and documented?	<ul style="list-style-type: none"> • Yes • No 	
4.6	Evidence patients taking dopaminergic drugs are monitored re: impulsive/compulsive behaviour	<ul style="list-style-type: none"> • Yes • No • Not applicable - not on dopaminergic drugs 	Evidence means documentation that the patient was specifically asked about the presence of compulsive behaviour symptoms during the previous year if on any dopaminergic medication e.g. MAOI, Levodopa, dopamine agonist

			Resources: Impulse Control Disorders in Parkinson Disease (Weintraub) https://www.ncbi.nlm.nih.gov/pubmed/20457959
5. Access to research			
5.1	Is there evidence that the patient has been made aware of how they can participate in research should they wish to?	<ul style="list-style-type: none"> • Yes • No 	
6. Power of Attorney			
<p>Standard E: Offer people with Parkinson's disease and their family members and carers (as appropriate) oral and written information about the following, and record that the discussion has taken place:</p> <ul style="list-style-type: none"> • Advance care planning, including Advance Decisions to Refuse Treatment (ADRT) and Do Not Attempt Resuscitation (DNACPR) orders, and Lasting Power of Attorney for finance and/or health and social care. (NICE NG71 1.9.2) 			
6.1	Is there evidence the patient/carer has been offered information about, or has set up a Lasting Power of Attorney?	<ul style="list-style-type: none"> • Yes • No 	<p>Resources:</p> <ul style="list-style-type: none"> • https://www.gov.uk/power-of-attorney/make-lasting-power • Scotland: https://www.publicguardian-scotland.gov.uk/power-of-attorney

7. Advance Care Planning

Standard F: Offer people with Parkinson's disease and their family members and carers (as appropriate) oral and written information about the following, and record that the discussion has taken place:

- Progression of Parkinson's disease.
- Possible future adverse effects of Parkinson's disease medicines in advanced Parkinson's disease.
- Advance care planning, including Advance Decisions to Refuse Treatment (ADRT) and Do Not Attempt Resuscitation (DNACPR) orders, and Lasting Power of Attorney for finance and/or health and social care.
- Options for future management.
- What could happen at the end of life.
- Available support services, for example, personal care, equipment and practical support, financial support and advice, care at home and respite care. (NICE NG71 1.9.2)

Standard G: Offer people with Parkinson's disease and their family members and carers (as appropriate) opportunities to discuss the prognosis of their condition. These discussions should promote people's priorities, shared decision-making and patient-centred care. (NICE NG71 1.9.1)

7.1	Are there markers of advanced disease e.g. dementia, increasing frailty, impaired swallowing, cardio-respiratory disease, nursing home level of care required?	<ul style="list-style-type: none"> • Yes • No (go to Q8.1) 	
7.2	Are there any documented discussions regarding end of life care issues/care plans within the last 12 months?	<ul style="list-style-type: none"> • Yes • No 	Resources: <ul style="list-style-type: none"> • NHS End of Life Care Programme Guide: Capacity, Care Planning and Advance Care Planning in life limiting illness

			<p>https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ACP_Booklet_2014.pdf</p> <ul style="list-style-type: none"> • Parkinson's UK information: https://www.parkinsons.org.uk/information-and-support/preparing-end-life • Scottish Palliative Care Guidelines, including care planning and guidance on capacity: https://rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/ • Wales: https://www.gov.wales/end-of-life-care
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8. Parkinson's assessment

1. Non-motor assessments during the previous year

8.1.1	Blood pressure documented lying (or sitting) and standing	<ul style="list-style-type: none"> • Yes • No • No but, doesn't stand 	
8.1.2	Evidence of enquiry/assessment re cognitive status	<ul style="list-style-type: none"> • Yes • No 	
8.1.3	Evidence of enquiry re hallucinations/psychosis	<ul style="list-style-type: none"> • Yes • No 	
8.1.4	Evidence of enquiry re: low mood/depression	<ul style="list-style-type: none"> • Yes • No 	

8.1.5	Evidence of enquiry re: anxiety	<ul style="list-style-type: none"> • Yes • No 	
8.1.6	Evidence of enquiry re communication difficulties	<ul style="list-style-type: none"> • Yes • No 	
8.1.7	Evidence of enquiry re problems with swallowing function	<ul style="list-style-type: none"> • Yes • No 	
8.1.8	Evidence of screening for malnutrition (weight documented at least yearly)	<ul style="list-style-type: none"> • Yes • No 	
8.1.9	Evidence of enquiry re problems with saliva	<ul style="list-style-type: none"> • Yes • No 	
8.1.10	Evidence of enquiry re bowel function	<ul style="list-style-type: none"> • Yes • No 	
8.1.11	Evidence of enquiry re bladder function	<ul style="list-style-type: none"> • Yes • No 	
8.1.11	Evidence of enquiry re Parkinson's-related pain	<ul style="list-style-type: none"> • Yes • No 	
8.1.12	Evidence of enquiry re sleep quality	<ul style="list-style-type: none"> • Yes • No 	

2: Motor and ADL assessment during the previous year			
6.2.1	Evidence of enquiry re balance and falls	<ul style="list-style-type: none"> • Yes • No • No, but assisted for transfers and doesn't walk 	
6.2.2	Evidence fracture risk/osteoporosis considered	<ul style="list-style-type: none"> • Yes • No 	
8.2.3	Evidence of enquiry re problems with transfers (e.g. out of bed/chair/off toilet/car)	<ul style="list-style-type: none"> • Yes • No • No, but early/mild disease, active lifestyle 	
8.2.4	Evidence of enquiry re problems with personal care (e.g. washing/bathing/dressing/hair/nails)	<ul style="list-style-type: none"> • Yes • No 	
8.2.5	Evidence of enquiry re difficulty eating and drinking (i.e. cutlery/managing rinks etc. not swallowing)	<ul style="list-style-type: none"> • Yes • No • No, but PEG fed and takes nil by mouth 	
8.2.6	Evidence of enquiry re domestic activities	<ul style="list-style-type: none"> • Yes • No • No, but in care home 	

	(cooking/cleaning/ shopping)		
8.2.7	Evidence of enquiry re problems with function at work	<ul style="list-style-type: none"> • Yes • No • No, but retired or doesn't work 	
3: Integrated multi-disciplinary care during the previous year			
8.3.1	Evidence of referral/input from Parkinson's nurse	<ul style="list-style-type: none"> • Yes • No • No, but declined referral/input 	
8.3.2	Evidence of physiotherapy referral/assessment/input	<ul style="list-style-type: none"> • Yes, for therapy/assessment • No • No, but declined referral/input • No, but clear documentation no therapy need • No, but no achievable physiotherapy goals • No, but no service option 	<p>The option "No but clear documentation no therapy need" should only be used if there is clear documentation of relevant enquiries/assessments re physiotherapy related problems (gait / balance/ posture/transfers).</p> <p>Use "No but no achievable physiotherapy goals" option only if no change and extensive prior physiotherapy input.</p>
8.3.3	Evidence of occupational therapy referral/assessment/input	<ul style="list-style-type: none"> • Yes, for therapy/assessment • No • No, but, declined referral/input 	<p>The option "No but clear documentation no therapy need" can only be used if there is clear documentation of assessment/enquiry re problems</p>

		<ul style="list-style-type: none"> • No, but clear documentation no therapy need • No, but no achievable occupational therapy goals • No, but no service option 	<p>with activities of daily living and/or difficulties at work if working.</p> <p>Use “No but, no achievable occupational therapy goals” option only if no change and extensive prior occupational therapy input.</p>
8.3.4	Evidence of speech and language therapy referral/input for communication, swallowing and/or saliva issues	<ul style="list-style-type: none"> • Yes, for therapy/assessment • No • No, but declined referral/input • No, but clear documentation no therapy need • No, but no achievable SLT goals • No, but no service option 	<p>The option “No but clear documentation no therapy need” can only be used if there is clear documentation of assessment/enquiry re communication, swallowing and/or saliva issues. Use “No but, no achievable SLT goals” option only if no change, extensive prior SLT input and alternatives already explored.</p>
8.3.5	Evidence of mental health assessment/ referral/ input	<ul style="list-style-type: none"> • Yes, for therapy/assessment • No • No, but declined referral/input • No, but clear documentation no need • No, but no service option 	
8.3.6	Evidence of dietician assessment/ referral/ input	<ul style="list-style-type: none"> • Yes, for therapy/assessment • No • No, but declined referral/input • No, but clear documentation no need • No, but no service option 	
8.3.7	Evidence of social work referral/input	<ul style="list-style-type: none"> • Yes • No • No, but declined referral/input 	<p>Use “No but social care needs being met” option only if there is evidence that current care arrangements are working well or that the person is independent in mobility and personal care.</p>

		<ul style="list-style-type: none"> • No, but documented as self funding and referred to other sources of support and information re care • No, social care needs being met. 	
8.3.8	Evidence that patient and/or carer has been signposted to Parkinson's UK	<ul style="list-style-type: none"> • Yes • No • No, but previously signposted • No, but declined 	

Additional questions for newly diagnosed patients:

	Question	Answer options	Help notes
1.	Is there written evidence that your newly / recently diagnosed patient has been given written information (eg the Parkinson's UK newly diagnosed pack) about their condition?	<ul style="list-style-type: none"> • Yes • No 	Signposting to a website is not sufficient to choose 'yes' for this question. Written evidence includes email to the patient including relevant links.
2.	Is there evidence that your newly / recently diagnosed patient was referred to a PDNS or equivalent within 3 months of diagnosis?	<ul style="list-style-type: none"> • Yes • No • No, but declined referral • No PDNS/equivalent 	