****

|  |
| --- |
| **NCAP EIP audit 2021/22** |
| **Case note audit form** |
|  |
| **Notes for completion** |

**Audit forms should be completed by the clinician/clinical team responsible for the patient's care.**

**Please complete one audit form for each patient.**

Your audit lead will tell you which of your patients have been selected. Patients have

been randomly selected from all patients in your team who meet the criteria for the NCAP EIP audit. It is essential that you **do not make your own selection** of which patient to audit.

**How to complete this audit form**

All data must be collectedby **31/10/2021** and submitted online by **30/11/2021**. Please contact your local audit lead if you are unsure how this is being managed in your Health Board/Organisation.

Please refer to the ‘NCAP Audit Tool Guidance’ document for information on how to complete this questionnaire, including definitions and guidance for each item.

Audit forms should be completed using information from the paper and/or electronic

case records and clinical knowledge of the patient. There may be items for which you

need to speak to a member of clinical staff who has known the patient for a longer

period than yourself, e.g. EIP care coordinator or Psychiatrist.

**Please note this a paper copy of the online tool, so all questions appear. When data is entered online some questions only appear based on previous answers, so not all questions will appear each time. Please refer to the guidance for more information on question routing.**

**Further assistance and information**

If you require any further assistance, please contact the NCAP project team on

NCAP@rcpsych.ac.uk

**All questions in this tool are mandatory.**

**Local NCAP audit lead:**

**Organisation ID for your Health Board** (i.e. ORGXX):

**Organisation ID for your local EIP team** (i.e EIPXXXX):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

**Initials of data collector/clinician:**

**NCAP ID** (to be completed by local NCAP audit lead):

**Patient details**

**Q1. Gender:**

|  |  |
| --- | --- |
|  | *Male* |

|  |  |
| --- | --- |
|  | *Female*  |

|  |  |
| --- | --- |
|  | *Other/Non-binary*  |

**Q2. Ethnicity:**
**White Black or Asian or Mixed Other ethnic
 Black British Asian British groups**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | *British* |  | *African* |  | *Bangladeshi* |  | *Asian & white* |  | *Chinese* |
|  |
|  | *Irish* |  | *Caribbean* |  | *Indian* |  | *Black African* |  | *Any other* |
|  |  |  | *& white* | *ethnic background* |
|  |  |  |  |  |
|  | *Any*  |  | *Any*  |  | *Pakistani* |  | *Black Caribbean* |  | *Refused* |
| *other white background* | *other blackbackground* |  | *& white* |  |
|  |
|  |  |  | *Any other*  |  | *Any other mixed*  |  | *Unknown/ Not documented* |
|  |  | *Asian background* | *background* |  |

**Q3. Was this person in work, education or training at the time of their initial assessment?**

|  |  |
| --- | --- |
|  | *Yes* |

|  |  |
| --- | --- |
|  | *No* |

**Q4. Does this person have an identified family member, friend or carer who supports them?**

*Please note that this information will NOT be taken into account when analysing provision of Family Intervention.*

|  |  |
| --- | --- |
|  | *Yes* |
|  |  |
|  | *Yes, but the patient does not wish for this person to be contacted/it’s not felt to be*  |
|  | *in the patient’s best interests for them to be involved in their care* |
|  |  |
|  | *No* |

**Q5. Have the following outcome measures been completed for this person?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | *Never* | *Once* | *More than once* | *N/A* |
| *HoNOS* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *HoNOSCa* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| *DIALOG* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| *QPR* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Other* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

*If other, please provide details:*

**Q5a. Please enter the HoNOS scores from the initial assessment**
*Guidance: HoNOS scores should only be entered if the assessment was carried out between* ***01/11/2020*** *and* ***31/10/2021****, while the person was on the EIP caseload. If the initial assessment was carried out prior to 01/11/2020, please enter the person's earliest scores within the 12-month period i.e. the assessment closest to 01/11/2020.*

0 = No problem
1 = Minor problem requiring no action
2 = Mild problem but definitely present
3 = Moderately severe problem
4 = Severe to very severe problem
9 (Not known) = HoNOS assessment carried out but insufficient information to make a rating
N/A = No HoNOS assessment carried out between 01/11/2020 and 31/10/2021

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | *0* | *1* | *2* | *3* | *4* | *9 (Not known)* | *N/A* |
| *Problem drinking or drug -* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *taking (item 3)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Problems associated with*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *hallucinations and delusions*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *(item 6)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Problem with activities of daily*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *living (item 10)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

**Q5b. Please enter the HoNOS scores from the most recent follow-up assessment**
*Guidance: HoNOS scores should only be entered if the assessment was carried out between* ***01/11/2020*** *and* ***31/10/2021****, while the person was on the EIP caseload.*

0 = No problem
1 = Minor problem requiring no action
2 = Mild problem but definitely present
3 = Moderately severe problem
4 = Severe to very severe problem
9 (Not known) = HoNOS assessment carried out but insufficient information to make a rating
N/A = No follow-up HoNOS assessment carried out between 01/11/2020 and 31/10/2021

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | *0* | *1* | *2* | *3* | *4* | *9 (Not known)* | *N/A* |
| *Problem drinking or drug -* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *taking (item 3)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Problems associated with*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *hallucinations and delusions*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *(item 6)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Problem with activities of daily*  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *living (item 10)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

 **Q6. Has this person commenced a course\* of any the following treatment(s), delivered by a person with relevant skills, experience and competencies?** *\*Received at least one session of a course. Please note that in order to count as ‘took up’ for CBTp, the session received should be a CBTp therapy session, and not just part of the initial assessment - initial CBTp assessment appointments do not count.*

**Psychological and other interventions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *Took up\** | *Refused*  | *Not offered*  | *Waiting* |
| *Cognitive Behavioural* |  |  |  |  |
| *Therapy for Psychosis*  |  |  |  |  |  |  |  |  |  |  |  |  |
| *(CBTp)* |  |  |  |  |
|  |  |  |  |  |
| *Family Intervention* |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |
| *Supported employment* |  |  |  |  |
| *programme (such as* |  |  |  |  |
| *Individual Placement* |  |  |  |  |  |  |  |  |  |  |  |  |
| *and Support (IPS) or education programmes)* |  |  |  |  |

**Q7. Has this person commenced a course of antipsychotic medication?**

|  |  |
| --- | --- |
|  | *Yes – less than 6 months ago* |
|  |  |
|  | *Yes – within the last 6-12 months* |
|  |  |
|  | *Yes – more than 12 months ago* |
|  |  |
|  | *No* |

**Q8. Has this person had two adequate but unsuccessful trials of antipsychotic medications?**

|  |  |
| --- | --- |
|  | *Yes* |
|  |  |
|  | *No* |

**Q8a. Has this person been offered clozapine?**

|  |  |
| --- | --- |
|  | *Yes, the person accepted clozapine* |
|  |  |
|  | *Yes, the person refused clozapine* |

|  |  |
| --- | --- |
|  | *No* |

**Q9. Has this person's carer(s) commenced a course of a carer-focused education and support programme?**

|  |  |
| --- | --- |
|  | *Yes* |
|  |  |
|  | *No* |

**Physical health screening and interventions**

Physical health screening and interventions could have been carried out at any time between **01/11/2020** and **31/10/2021**, while the person was on the EIP caseload.

**Q10. Smoking status**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | *Current smoker* à | *Enter number of cigarettes smoked per day:* |  |  |  |  |
|  |  |
|  | *Ex-smoker or non-smoker* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal to provide information on more than one*  |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |

**Q11. Alcohol consumption**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | *Harmful or hazardous use of alcohol\** |
|  | *Yes à* |  |
|  |  |  | *Alcohol use that is NOT harmful or hazardous* |
|  |  |
|  | *No* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal to provide information on more than one*  |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |

\*Identification of harmful or hazardous use of alcohol is described in NICE guideline CG115 https://www.nice.org.uk/guidance/cg115. It may be assessed using structured measures such as the ‘AUDIT’ or based on enquiring about quantity, frequency and any health or social consequences of alcohol consumption.

Where there is a record of drinking that is neither harmful nor hazardous e.g., ‘rarely drinks’/ ‘drinks in moderation’ this should be recorded as ‘Alcohol use that is NOT harmful or hazardous.

**Q12. Substance misuse**

|  |  |
| --- | --- |
|  | *Yes* |
|  |  |
|  | *No* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal to provide information on more than one*  |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |

**Q13. BMI/Weight**

**Is information about weight/BMI recorded in the patient’s notes?**

|  |  |
| --- | --- |
|  | *Yes (please enter value below)* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal to be weighed/ measured on more than one* |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |
|  |  |
|  | *Person was pregnant/ gave birth within last 6 weeks (weight not measured)* |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | . |  |

*BMI (Body Mass Index) (****Kg/m2****)*

**Q14. Blood pressure**

**Is information about blood pressure recorded in the patient’s notes?**

|  |  |
| --- | --- |
|  | *Yes (please enter at least one value below)* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal to take blood pressure on more than one* |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |

|  |  |  |
| --- | --- | --- |
|  |  |  |

*Systolic (****mmHg****)*

**and/or**

|  |  |  |
| --- | --- | --- |
|  |  |  |

*Diastolic (****mmHg****)*

**Q15. Glucose**

**Is information about glucose recorded in the patient’s notes?**

|  |  |
| --- | --- |
|  | *Yes (please enter at least one value below)* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal of blood test on more than one* |
|  | *occasion after it is assured that the person has been given the information on* |
|  | *which to make an informed decision* |
|  |  |
|  | *Person was pregnant/ gave birth within last 6 weeks (glucose screening not carried*  |
|  | *out)* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  | . |  |  |

*Glycated haemoglobin or HbA1c (****mmol/mol****)*

**and/or**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | . |  |  |

*Fasting plasma glucose (****mmol/l****)*

**and/or**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | . |  |  |

*Random plasma glucose (****mmol/l****)*

**Q16. Cholesterol**

**Is information about cholesterol recorded in the patient’s notes?**

|  |  |
| --- | --- |
|  | *Yes (please enter at least one value below)* |
|  |  |
|  | *Not documented* |
|  |  |
|  | *Documented evidence of refusal of blood test on more than one occasion* |
|  | *after it is assured that the person has been given the information on which to make* |
|  | *an informed decision* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | . |  |  |

*Total cholesterol (****mmol/l****)*

**and/or**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | . |  |  |

*Non-HDL cholesterol (****mmol/l****)*

**and/or**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | . |  |

*QRISK score (****%****)*

**and (optional)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | . |  |

*Total cholesterol: HDL ratio measurement*

**INTERVENTIONS**

Physical health interventions could have been carried out at any time between **01/11/2020** and **31/10/2021**, while the person was on the EIP caseload.

To ascertain if an individual requires intervention based on their physical health

screening, please refer to the [Lester UK Adaptation of the Positive Cardiometabolic Health Resource](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/ncap-e-version-nice-endorsed-lester-uk-adaptation.pdf?sfvrsn=39bab4_2).

**Q17. Interventions for smoking cessation** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Brief intervention* |
|  |  |
|  | *Smoking cessation education*  |
|  |  |
|  | *Smoking cessation therapy*  |
|  |  |
|  | *Referral to smoking cessation service* |
|  |  |
|  | *Individual/group behavioural support* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person has*  |
|  | *been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Q18. Interventions for harmful alcohol use** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Brief intervention and advice*  |
|  |  |
|  | *Education about alcohol consumption*  |
|  |  |
|  | *Referral to alcohol misuse service*  |
|  |  |
|  | *Motivational interviewing* |
|  |  |
|  | *Referral to psycho-education programme* |
|  |  |
|  | *Individual/group behavioural support* |
|  |  |
|  | *Pharmacological intervention for harmful use of alcohol commenced or reviewed*  |
|  | *(acamprosate, disulfiram or naltrexone)* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person has*  |
|  | *been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Q19. Interventions for substance misuse** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Brief intervention/advice* |
|  |  |
|  | *Substance use education* |
|  |  |
|  | *Referral to detoxification programme*  |
|  |  |
|  | *Referral to substance misuse service* |
|  |  |
|  | *Referral to psycho-education programme*  |
|  |  |
|  | *Motivational interviewing* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person has* |
|  | *been given the information on which to make an informed decision* |
|  |
|  | *No intervention needed*  |

|  |  |
| --- | --- |
|  | *Not documented* |

**Q20. Interventions for weight gain/obesity** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Mental health medication review with respect to weight (e.g. antipsychotic)* |
|  |  |
|  | *Advice or referral about diet* |
|  |  |
|  | *Advice or referral about exercise* |
|  |  |
|  | *Lifestyle education regarding risk of diabetes* |
|  |  |
|  | *Referral for lifestyle education regarding risk of diabetes* |
|  |  |
|  | *Weight management programme* |
|  |  |
|  | *Referral for weight management programme* |
|  |  |
|  | *Referral for lifestyle education* |
|  |  |
|  | *Combined healthy eating and physical education programme* |
|  |  |
|  | *Referral for combined healthy eating and physical education programme* |
|  |  |
|  | *Pharmacological intervention for obesity commenced or reviewed* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person has* |
|  | *been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Q21. Interventions for hypertension** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Mental health medication review with respect to high blood pressure*  |
|  | *(e.g. antipsychotic)* |
|  |  |
|  | *Advice or referral about diet/ salt intake* |
|  |  |
|  | *Advice or referral about exercise* |
|  |  |
|  | *Referral to general practice service*  |
|  |  |
|  | *Referral to secondary care physician* |
|  |  |
|  | *Referral for antihypertensive therapy* |
|  |  |
|  | *Antihypertensive therapy* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person has* |
|  | *been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed as repeat blood pressure reading normal* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Q22. Interventions for diabetes/high risk of diabetes** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Mental health medication review with respect to glucose regulation (e.g. antipsychotic)* |
|  |  |
|  | *Referral to general practice service*  |
|  |  |
|  | *Referral to secondary care physician* |
|  |  |
|  | *Diet modification* |
|  |  |
|  | *Advice or referral about exercise* |
|  |  |
|  | *Metformin therapy* |
|  |  |
|  | *Referral for diabetic care* |
|  |  |
|  | *Diabetic care* |
|  |  |
|  | *Referral to structured lifestyle education programme* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person* |
|  | *has been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Q23. Interventions for dyslipidaemia** *(select all that apply)*

|  |  |
| --- | --- |
|  | *Mental health medication review to lower blood lipids (e.g. antipsychotic)* |
|  |  |
|  | *Advice or referral about diet* |
|  |  |
|  | *Advice or referral about exercise* |
|  |  |
|  | *Referral to primary or secondary care physician* |
|  |  |
|  | *Lipid lowering therapy* |
|  |  |
|  | *Referral for lipid lowering therapy* |
|  |  |
|  | *Documented evidence of refusing intervention after it is assured that the person* |
|  | *has been given the information on which to make an informed decision* |
|  |  |
|  | *No intervention needed* |
|  |  |
|  | *Not documented* |

**Referral to treatment**

**Q24. Date referral received by EIP service or secondary care mental health services**

|  |
| --- |
| DD/MM/YYYY |

**Q25. Date the patient was assessed by an EIP specialist**

|  |
| --- |
| DD/MM/YYYY |

**Q26. Was the patient allocated to an EIP service care coordinator?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Yes* à | *If yes, please specify the date:* | DD/MM/YYYY |
|  |  |
|  | *No* |

**Q27. Was the patient engaged by an EIP service care coordinator?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Yes* à | *If yes, please specify the date:* | DD/MM/YYYY |
|  |  |
|  | *No* |

**END OF AUDIT FORM**

**Thank you for completing this audit form on behalf of this patient**