**Tick list of audit standards (with source references) (King et al, 2022)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1a. PROCESS STANDARDS (CORE)** | | **Yes** | | **No** |
| 1. **An initial clinical interview was completed**   (Strauss, Sherman & Spreen, 2006; Lezak, Howieson & Loring, 2012; Watt & Crowe, 2018) | |  | |  |
| 1. **The purpose of the assessment and what to expect in the testing session was discussed with the patient, and documented**   (Strauss et al, 2006; Board of Directors (AACN) 2007; NHS. England, 2017; British Psychological Society (BPS), 2019a) | |  | |  |
| 1. **Informed consent to proceed with testing (written or verbal) was obtained and documented, or where capacity to consent was lacking, a Best Interests decision was documented**   (Mental Capacity Act, 2005; Strauss et al, 2006; Board of Directors (AACN), 2007); BPS, 2017, 2018) | |  | |  |
| 1. **Checks were made with the patient about usual visual/hearing aids, that they were used/worn used during the assessment OR commenting on potential effects of their absence**   (Strauss et al, 2006; Lezak et al, 2012) | |  | |  |
| 1. **Testing was completed by appropriately qualified professionals and under appropriate clinical supervision in accordance with relevant guidance (in the UK, the BPS requires GBC (Graduate Basis for Chartered membership), and states 1-hour supervision per week for a full-time assistant psychologist)**   (International Test Commission, 2001; Board of Directors (AACN), 2007; American Psych Assoc (APA), 2014: BPS, 2017a) | |  | |  |
| 1. **A face-to-face (or video-call) feedback session was offered**   (Pope, 1992; Poston & Hanson, 2010; Postal & Armstrong, 2013; NHS England, 2017; Rosado et al., 2017) | |  | |  |
| 1. **A report detailing test outcomes and interpretation was written**   (Donders, 2001; Schoenberg & Scott, 2011; Lezak et al, 2012; Mountjoy et al, 2017) | |  | |  |
| 1. **Where ethnicity or cultural factors are identified, the impact of this in relation to specific tests are considered (e.g. how this may impact on effort or render scores invalid)**   (Brickman, Cabo & Manly, 2006; Board of Directors (AACN), 2007; Lezak et al, 2012, APA, 2014) | |  | |  |
| Cultural issue identified and commented upon |  | |  |  |
| Cultural issue identified and not commented upon |  | |  |  |
| No obvious cultural issue present |  | |  |  |
| No report produced |  | |  |  |

|  |  |  |
| --- | --- | --- |
| **1b.** **REPORT STYLE AND CONTENT STANDARDS (CORE)** | **Yes** | **No** |
| 1. **1. The report is concise, not exceeding 4 sides of A4 *(or insert report length for the individual service as appropriate),* unless clinically necessary.**   (Donders, 2001; Strauss et al, 2006; Donders, 2016; Postal et al, 2017) |  |  |
| **2. Where appropriate, technical or scientific terms are applied accurately and unambiguously. Acronyms or difficult terms explained/defined in the report**  (Griffin & Christie, 2008; Lezak et al., 2012; BPS DoN, 2012; APA, 2014) |  |  |
| 1. **3. Includes a concise summary and conclusions section that draws the reader’s attention to the key points**   (Donders, 2001; Gorske & Smith, 2009; Tzotzoli, 2012; Donders, 2016; Postal et al, 2017) |  |  |
| **4. Provides a clear description of the purpose of the referral/referral question.**  (Donders, 2001; Griffin & Christie, 2008; Tzotzoli, 2012; Donders, 2016) |  |  |
| **5. Qualitative descriptions of the patient’s mental health is corroborated with self-report mood measure(s)**  (Strauss et al, 2006; Vogt et al, 2017; Lezak et al., 2012) |  |  |
| **6. Previous medical history is documented in the clinical notes and considered within the report where appropriate. (Includes a summary of the patient’s past and present physical health and medical history, or clearly points to where this can be obtained (i.e. a previous letter).)**  (Tzotzoli, 2012; Lezak et al, 2012) |  |  |
| **7. Current medications are documented in the clinical notes and the effects considered. Where relevant this is documented in the report (e.g if they are likely to alter cognition?)**  (Board of Directors (AACN), 2007; Boake, 2008; Lezak et al., 2012; BPS, 2019b) |  |  |
| **8. Educational/vocational background was asked about and considered (as evidenced in clinical notes and/or neuro report) AND/OR a test of premorbid functioning was completed.**  (Board of Directors (AACN), 2007; Boake, 2008; Lezak et al., 2012) |  |  |
| **9. Outlines the patient’s current living circumstances, social history and, if relevant, family history of medical difficulties.**  (Strauss et al, 2006; Gorske & Smith, 2009; Tzotzoli, 2012; Lezak et al, 2012) |  |  |
| **10. Points made are backed up with examples / data (e.g., direct quotations, test scores).**  (Tzotzoli, 2012; Schneider et al, 2018;)) |  |  |
| **11. Process observations are taken during testing, and considered in the report. (e.g. fatigue, anxiety, motivation)**  (Boake, 2008; Lezak et al., 2012; Tzotzoli, 2012; BPS, 2019b) |  |  |
| **12. Report contains evidence of formulation/ synthesising/ integrating data to reach clinical conclusions e.g. any potential confounding factors (e.g., depression, anxiety, fatigue) are outlined, as well as their potential implications for test validity.**  (Board of Directors (AACN), 2007; Gorske & Smith, 2009; Jurado & Pueyo, 2012; APA, 2014; Mountjoy et al, 2017) |  |  |
| **13. Objective assessment of performance validity (effort) is evidenced and referred to in the report**  (Bush et al., 2005; Sweet el al, 2021, and Heilbronner et al 2008 (both representing AACN); BPS, 2009; BPS, 2021; Lezak et al, 2012) |  |  |
| **14. Use of consistent test score labels/descriptors to describe test scores, agreed across the service** (e.g. extremely high score, high score, above average score, average score, below average score, low score, extremely low score)  (Guilmette et al, 2020; BPS, 2018a) |  |  |
| **15. Conclusions make sense in the context of the report: they are well formulated based on the evidence gathered in the assessment.**  (Schoenberg & Scott, 2011; Donders, 2016; BPS, 2019b) |  |  |
| **16. The patient’s views/comments/opinion from their verbal feedback is reflected appropriately in the report where appropriate.**  (Pope, 1992; Griffin & Christie, 2008; Lezak et al., 2012; NHS. England, 2017; Rosado et al., 2017; Mountjoy et al, 2017) |  |  |
| **17. Report concludes with recommendations (e.g for symptom management / referral on / further clinical input / discharge from the service).**  (Board of Directors (AACN), 2007; Tzotzoli, 2012; Postal et al, 2017) |  |  |
| **18. Patient is copied into report (unless they express a wish not to receive it, or can access their own medical records)**  (Minhas, 2007; Newton, 2008; Academy of Medical Royal Colleges, 2018; NHS England, 2018). |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **1c. PROCESS STANDARDS (SUPPLEMENTARY)** | | **Yes** | **No** |
| 1. **Clinical notes made/held for every face-to-face session**   (APA, 2016; BPS, 2018, 2019) | |  |  |
| 1. **Feedback session offered in a timely manner *(within 4 weeks of test completion*, *or insert timescale as appropriate to the individual service*)**   (Pope, 1992; Board of Directors (AACN) 2007; Gorske & Smith, 2009) | |  |  |
| Feedback within 4 weeks |  |  |  |
| Feedback outside of 4 weeks |  |
| No report, no feedback recorded |  |
| **3. Where risk issues are identified during the process, the report outlines these and explains how they are being managed.**  (APA, 2016**;** BPS, 2017) | |  |  |
| No risk identified |  |  |  |
| Risk identified & reported on |  |
| Risk identified & not reported |  |
| No report written |  |
| **4. Discussions about whom the report is to be shared with are documented.**  Board of Directors (AACN), 2007) | |  |  |
| **5. A service leaflet detailing what to expect in the neuropsychological assessment was given.**  (BPS, 2019a) | |  |  |
|  | |  |  |
| **1d. REPORT STYLE AND CONTENT STANDARDS (SUPPLEMENTARY)** | | **Yes** | **No** |
| 1. **1. Uses informative headings or a clear structure that enable easy access to important information.**   (Tzotzoli, 2012; Schneider et al., 2018) | |  |  |
| 1. **2. Writing style avoids repetition of information in the same sections**   (Strauss et al, 2006; Donders, 2016; Schneider et al., 2018) | |  |  |
| 1. **3. Reports observations/test performance on memory function. (e.g. orientation, working memory, verbal, visual learning, autobiographical, recall/recognition, immediate and delayed, prospective)**   (Vogt et al, 2017; Schneider et al., 2018) | |  |  |
| 1. **4. Reports observations/test performance on language skills. (e.g. spontaneous speech, word-finding, reading, writing, repetition, comprehension, naming)**   (Vogt et al, 2017; Schneider et al., 2018) | |  |  |
| 1. **5. Reports performance on tests/observations of attention/ executive function (e.g. initiation, attention, fluency, rule adherence, set shifting, planning, approach to tests, ability to hold in mind test rules, inhibition, impulsivity, empathy)**   (Vogt et al, 2017; Schneider et al., 2018) | |  |  |
| 1. **6. Reports observations/test performance on processing speed (e.g. speed of information processing, speed of responses, motor speed)**   (Schneider et al., 2018) | |  |  |
| 1. **7. Reports observations/test performance on visuospatial abilities (e.g. line orientation, figure copy, visual scanning, drawing, clock drawing)**   (Vogt et al, 2017; Schneider et al., 2018) | |  |  |
| 1. **8. Summary of findings from range of different sources (e.g. collateral data, clinical history, session observations, test scores etc.) and congruence between sources.**   (Schoenberg & Scott, 2011; Tzotzoli, 2012; Schneider et al., 2018) | |  |  |