



THE LISTER HOSPITAL

chelsea

Patient Feedback

A questionnaire about the quality of our service for patients, their carers, family and friends

Please complete every section of this form by ticking the appropriate box alongside each question. Where sections or questions are not applicable please ignore. Questionnaires will be analysed by external consultants and returned to the hospital. Your rights to anonymity are fully covered under the data protection act and no personal information will be released to any other party.

Committed to excellence

Your opinions make a difference

At the Lister Hospital we aim to provide the highest standards of care for every patient and a quality service to our visitors. To help us measure our level of achievement we would be grateful if you took a few moments to complete this questionnaire. We regard your opinions and comments as extremely valuable and we use them to identify areas of success and opportunities for improvement. Naturally, all observations will be treated in the strictest of confidence unless you indicate otherwise.

Once completed, simply fold over and seal the flap on the reverse of this leaflet and hand it to reception on, or prior to, your departure. Alternatively, should you need more time for consideration, put it into any post box. No stamp is necessary as we have paid the postage.

Thank you in advance for your help and assistance.

A handwritten signature in black ink, appearing to read 'J. R. Barr', written in a cursive style.

James Barr
Hospital Director

Prior to your admission

Did you receive an information pack from the hospital?

Yes No

If yes, did it give you all the information you needed?

Yes No

If no, how could we have improved it?

Your Admission

Please give your opinion of:

Excellent
Very Good
Good
Fair
Poor

The greeting on arrival (friendliness of reception staff)

Promptness of your admission

The way we explained your room facilities

The way we explained the nurse call system

The helpfulness of porters

Your overall impression of the admission process

How could we have improved your admission?

Your Consultant

Was the proposed course of treatment clearly explained to you?

Yes, completely

Yes, to some extent

No

Were you asked to give your consent to your proposed treatment?

Yes

No

Don't know

Was the expected outcome clearly explained to you?

Yes, completely

Yes, to some extent

No

When asking your consultant important questions, did you get answers you could understand?

Yes, always

Yes, sometimes

No

I had no need to ask questions

Do you feel you received sufficient post operative information?

Yes

No, I had no need of post operative information

Did you have confidence and trust in the doctors treating you?

Yes, always

Yes, sometimes

No

Your Nursing

When you had important questions to ask a nurse, did you get answers you could understand?

- Yes, always
 Yes, sometimes
 No
 I had no need to ask questions

Do you have confidence and trust in the nurses treating you?

- Yes, always
 Yes, sometimes
 No

Please give your opinion of:

How well we kept you informed

Individual attention given

The response to nurse call

Our awareness of your condition

The consistent standard of your nursing care

The way we anticipated your needs

The way we calmed your fears

Your overall impression of nursing care

	Excellent	Very Good	Good	Fair	Poor
How well we kept you informed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual attention given	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The response to nurse call	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our awareness of your condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The consistent standard of your nursing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way we anticipated your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way we calmed your fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your overall impression of nursing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How could we have improved your nursing care?

Please answer the following question only if you were in any pain:

Please give your opinion of:

The way we advised/prepared you for post operative pain

How well we assessed the level of your pain

The way we administered your medicine at the right time

How well we did everything we could to help control your pain

How could we have improved the way we managed your pain?

	Excellent	Very Good	Good	Fair	Poor
The way we advised/prepared you for post operative pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well we assessed the level of your pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way we administered your medicine at the right time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well we did everything we could to help control your pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Professional Services

How would you rate?

Physiotherapy

RMO (Resident doctor)

	Excellent	Very Good	Good	Fair	Poor
Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RMO (Resident doctor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Imaging (X-Ray)

Pharmacy

	Excellent	Very Good	Good	Fair	Poor
Imaging (X-Ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Accommodation

Room no: _____

Were you ever bothered by noise? (tick all that apply)

- No Yes, from other patients
 Yes, from hospital staff Yes, from something else
If yes, was it...? Day Night

How would you rate each of the following?

	Excellent	Very Good	Good	Fair	Poor
In room entertainment (TV/Radio etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathroom facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Room facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Décor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of visitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendliness / helpfulness of housekeeping/cleaning staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendliness / helpfulness of maintenance staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your overall impression of accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How could we have improved your accommodation?

Cleanliness

How would you rate each of the following?

	Excellent	Very Good	Good	Fair	Poor
Cleanliness of your room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleanliness of your toilet / bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleanliness of hospital public areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

As far as you know did doctors wash or clean their hands between touching patients?

- Yes, always Yes, sometimes
 No Don't know / can't remember

As far as you know did nurses wash or clean their hands between touching patients?

- Yes, always Yes, sometimes
 No Don't know / can't remember

Catering

How would you rate each of the following?

Variety / choice of food

Excellent
Very Good
Good
Fair
Poor

Correctness of order

Promptness of service

Temperature of food

Quality of food service

Friendliness / helpfulness of catering staff

Overall impression of catering

How could we have improved your catering?

General Questions

Did you feel you were treated with respect and dignity while you were in hospital?

Yes, always

Yes, sometimes

No

Did you want to be more involved in decisions made about your care and treatment?

Yes, definitely

Yes, to some extent

No

If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

Yes, definitely

Yes, to some extent

No

No, family or friends were involved

If you had any scheduled tests, X-rays or scans were they performed on time?

Yes, always

Yes, sometimes

No

If you had any messages or calls, did we deal with them efficiently?

Yes, always

Yes, sometimes

No

If you had any financial queries, did we deal with them efficiently?

Yes, always

Yes, sometimes

No

If you had any other administrative queries, did we deal with them efficiently?

Yes, always

Yes, sometimes

No

Going Home

How would you rate each of the following?

Excellent
Very Good
Good
Fair
Poor

Assistance with planning your departure

Speed of departure process

Convenience of departure time

Instructions for your aftercare

Your overall impression of the discharge procedure

Did a member of staff explain the medicines you were to take at home in a way you could understand?

Yes, completely

Yes, to some extent

No

I had no medicines/didn't need an explanation

Were you advised of the possible side effects of your medication?

Yes, fully

Yes, to some extent

No

I didn't need an explanation

Were you told who to contact if you had any questions after discharge?

Yes

No

How could we have improved your discharge?

Overall

Excellent
Very Good
Good
Fair
Poor

Overall rating of quality of care

Overall rating of value for money

If you have visited us before do you think we are

Getting better

Staying the same

Getting worse

Would you recommend us?

Yes

No

About you

Date of admission? _____

Are you?

Inpatient

Day patient

Name of your consultant? _____

Is this your first visit to this hospital?

Yes

No

Are you?

Male

Female

How old are you?

16 or under

17-24

25-40

41-64

65+

On what basis did you receive treatment?

Insured

Self pay

Embassy

NHS

Other

What were the main influences on your choice of this hospital? (*tick all appropriate*)

GP

Location

Website

Insurance Company

Advertisement

Consultant

Previous Visit

Personal Recommendation

Other _____ (*specify*)

Additional Comments

Would you like to mention any staff by name who gave especially good service and say what made them special?

Please tick and include your name and address below only if you would like a reply to comments raised.

Please tick box and include your telephone number if you are prepared to participate in a brief telephone survey.

Name: Telephone:

Address:

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