PATIENT QUESTIONNAIRE

"YOUR VISION IS OUR FOCUS"

To help us ensure that we provide a quality service that meets your needs, we would appreciate you taking the time to answer this questionnaire. To answer most of the questions you just tick the answer that applies to you. If an answer is not relevant to your experience, just tick the "not applicable" box. We welcome your comments and have provided space on the form for them. The survey is totally confidential and you are not required to identify yourself. However, there is an option to do so if you wish. The information received is used to improve the care and service for our patients and data that is not identified may be used for research and analysis purposes by an authorised external body.

Where possible, please answer all questions. If a question does not apply to you, then simply select "not applicable".

PART 1: About you. (Where applicable, please *tick one box under each heading below).*

Your age is: _____

Your Postcode: _____

Gender: □ Female □ Male □ X – (Indeterminate/Intersex/Unspecified)

Which language do you mainly speak at home?

(Please mark one box only. If more than one language, please indicate the one that you speak most often).

□ English □ Arabic □ Cantonese □ Dutch
□ Filipino/Tagalog □ German □ Greek □ Hindi
□ Italian □ Lebanese □ Macedonian □ Mandarin
□ Maori □ Polish □ Serbian □ Spanish
□ Vietnamese □ Other (please specify) _____

Are you of:

□ Aboriginal origin □ Torres Strait Islander origin
□ Both of the above □ None of the above

In general, how would you rate your health:

□ Excellent □ Very good
□ Fair □ Poor

Are you:

□ Insured □ Uninsured

If insured, which Health Fund do you belong to? _____

Who referred you to Adelaide Eye & Laser Centre?

□ My General Practitioner □ My Surgeon □ My Optometrist □ Self Referred
□ Family/Friend □ Other (please specify) _____

PART 2: About the most recent time you were admitted to our day hospital.

The following questions are about the most recent time you were admitted to our day hospital. Please think about your entire experience with our day hospital, including all staff you came in contact with and all areas visited.

1. Appointment / Waiting Times

	Rate our day hospital for the following: *(Please tick in box)*	Very good (5)	Good (4)	Average (3)	Poor (2)	Very poor (1)	Didn't apply (0)
1a	The information made available to me to prepare for my appointment.						
1b	The way I was treated on the phone.						
1c	The overall waiting times I experienced.						
Comments / Suggestions for Improvement							

2. Location and Physical Access

	Rate our day hospital for the following: *(Please tick in box)*	Very good (5)	Good (4)	Average (3)	Poor (2)	Very poor (1)	Didn't apply (0)
2a	Availability of drop off areas.						
2b	Availability of car parking.						
2c	Information on the location and public transport available to get to the day hospital (eg: location maps, brochures, instruction from the staff).						
2d	Inside and outside signs at the day hospital.						
2e	Disability access.						
Comments / Suggestions for Improvement							

3. Care, Services and Treatment

	Rate our day hospital for the following: *(Please tick in box)*	Always (5)	Mostly (4)	Sometimes (3)	Rarely (2)	Never (1)	Didn't apply (0)
3a	I was treated with respect and dignity during my stay.						
3b	My views and concerns were listened to.						
3c	My individual needs were met. (If answer is always/mostly, skip to Q3e)						
3d	When a need could not be met, staff explained why.						
3e	If I needed assistance, staff helped me within a reasonable timeframe.						
3f	The staff caring for me, explained things in a way I could understand.						
3g	The staff were able to allay any worries or fears I had.						
3h	I felt cared for.						
3i	As far as I could tell, the staff involved in my care communicated with each other about my treatment.						
3j	I received pain relief that met my needs.						
3k	When I was in the hospital, I felt confident in the safety of my treatment and care.						

3l I experienced unexpected harm or distress as a result of my treatment or care.
(if answer is no, skip to Q3n)

☐ Yes, physical harm ☐ Yes, Emotional distress ☐ Yes, both ☐ No

3m My harm or distress was discussed with me by staff.

☐ Yes ☐ No ☐ Not sure ☐ Didn't want to discuss

3n Overall, the cleanliness of our day hospital was:

☐ Very Good (5) ☐ Good (4) ☐ Average (3) ☐ Poor (2) ☐ Very poor (1)

3o Overall, the quality of the treatment and care I received was:

☐ Very Good (5) ☐ Good (4) ☐ Average (3) ☐ Poor (2) ☐ Very poor (1)

Comments / Suggestions for Improvement

4. Information

	Rate our day hospital for the following: *(Please tick in box)*	Always (5)	Mostly (4)	Sometimes (3)	Rarely (2)	Never (1)	Didn't apply (0)
4a	The information about my rights and responsibilities was easy to understand and helpful.						
4b	I was kept informed as much as I wanted about my treatment and care.						
4c	My family or carer were kept informed as much as I wanted on my treatment and care.						
4d	The information about my consent to have treatment was easy to understand and helpful.						
4e	I was provided with enough information about the prevention of infections, for example, notifying the day hospital if I had any infections, how to prevent getting an infection following the procedure.						

4f Which best describes your experience of the overall information provided by the Day Hospital.
(Tick the box below next to the answer which best describes your experience)

□ Did not tell me much at all (1) □ Gave me only limited information (3) □ Kept me adequately informed. (4)
□ Kept me very well informed (5) □ Overwhelming, too much (2)

Comments / Suggestions for Improvement

5. The Billing Process

	Rate our day hospital for the following: *(Please tick in box)*	Very good (5)	Good (4)	Average (3)	Poor (2)	Very poor (1)	Didn't apply (0)
5a	The advice and information on the cost of my procedure or treatment before admission.						
5b	The information about my financial consent to have treatment was easy to understand and helpful.						

Comments / Suggestions for Improvement

6. Decision Making and Involvement

	Rate our day hospital for the following: *(Please tick in box)*	Always (5)	Mostly (4)	Sometimes (3)	Rarely (2)	Never (1)	Didn't apply (0)
6a	I was involved as much as I wanted in making decisions about my treatment and care.						
6b	My carer or family had enough opportunities to talk to the staff, if they wanted to.						
6c	My carer or family were involved in my care as much as I wanted them to be.						
Comments / Suggestions for Improvement							

7. Discharge Process

	Rate our day hospital for the following: *(Please tick in box)*	Very good (5)	Good (4)	Average (3)	Poor (2)	Very poor (1)	Didn't apply (0)
7a	The arrangements made for any services I needed following my discharge.						
7b	The information about how to manage my care at home.						
7c	The information about how to manage my medicines at home.						
7d	The instructions for any follow-up appointments after my procedure or treatment.						
7e	The information for emergency medical care including an emergency telephone contact number and place or treating doctor.						
Comments / Suggestions for Improvement							

8. Transfer

Rate our day hospital for the following: ***(Answer this section if you were transferred to another facility directly from our day hospital)***		Very good (5)	Good (4)	Average (3)	Poor (2)	Very poor (1)	Didn't apply (0)
8a	Staff explained the reason for my transfer.						
8b	My carer or relative were notified about my transfer.						
8c	My carer and I were involved in all parts of my transfer, as much as possible.						
8d	Staff made my transfer as easy and comfortable as possible.						
Comments / Suggestions for Improvement							

9. Recommendation

		(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		0 - Not at all likely										10 – Extremely likely
9a	How likely would you be to return to our day hospital if you required a procedure in the future? *(Please tick the box which best describes your experience – **0 - Not likely at all** and **10 being extremely likely**)*											
9b	How likely would you be to recommend the care, treatment and services of our day hospital to family and friends? *(Please tick the box which best describes your experience – **0 - Not likely at all** and **10 being extremely likely**)*											
Please tell us why you selected the above score (9b)												
Any other comments including suggestions.												

Thank you for your input.

Would you like to discuss any aspect of this questionnaire?	□ Yes □ No

If you would like to supply us with your details or if you have ticked Yes above, please provide your contact details below and a member of our Quality Committee will contact you.

Name: _____

Day time contact telephone number: _____

Thank you for your time in completing this questionnaire.
Please return to our Quality Manager in the enclosed reply paid envelope.

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