

Survey Review Document

Survey Created: 10 May 2012, 10:25

Survey Changed: 10 May 2012, 10:42

Client: Midlands Burn Care Network

Survey: Outpatients 2012

Start Message:

The Midlands Burn Care Network thanks you for agreeing to complete our 5 minute survey. Your views are important to us and will remain anonymous

End Message:

Thank you for completing this survey. Your views will help us improve patient care

1. Please tick the box that best describes you

(Multiple Choice, select one only)

Patient

Carer

2. Are you being treated following

(Multiple Choice, select one only)

A Burn injury

Plastic Surgery

3. Were you given a choice of appointment times?

(Multiple Choice, select one only)

Yes

No, but I did not need or want a choice

No, but I would have liked a choice

Do not know

4. Were you seen on time?

(Multiple Choice, select one only)

Yes

No

5. How long did you have to wait to be seen?

(Multiple Choice, select one only)

Less than 5 minutes

Between 6 and 15 minutes

Between 16 and 30 minutes

Between 31 and 60 minutes

More than one hour

6. Were you informed of the reason for the delay?

(Multiple Choice, select one only)

Yes

No

7. How helpful were the clinic team when you first arrived for your appointment?

(Multiple Choice, select one only)

Very helpful

Fairly helpful

Not very helpful

Not at all helpful

8. Who did you expect to see when you came to the clinic?

(can answer more than one if needed)

(Multiple Choice, multiple answers allowed)

- Consultant
- Nurse
- Doctor (other than consultant)
- Physiotherapist
- Occupational Therapist
- Psychologist

9. Did you see the clinical staff that you expected to see?

(Multiple Choice, select one only)

- Yes
- No

10. Did each member of the team introduce themselves to you?

(Multiple Choice, select one only)

- Yes
- No
- Some of the team
- I cannot remember

Pick the box that best describes how staff have been today in

	Very good	Good	Poor	Very poor
11. Involving you in making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Giving you enough time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Explaining about your treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Listening to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pick the box that best describes how the staff respected your privacy and dignity

	Not at all	A little	Frequently
15. My treatment was interrupted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Did the staff talk about you as if you were not there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you feel embarrassed or vulnerable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cleanliness and Hygiene. Pick the appropriate box

	Yes	No
18. Was the clinic area clean and tidy?	<input type="checkbox"/>	<input type="checkbox"/>
19. Were there hand gels available?	<input type="checkbox"/>	<input type="checkbox"/>
20. Did you see the staff use the hand gel?	<input type="checkbox"/>	<input type="checkbox"/>
21. Did you use the hand gel?	<input type="checkbox"/>	<input type="checkbox"/>

22. Have you taken any painkillers before coming to your dressing clinic appointment today?

(Multiple Choice, select one only)

- Yes, I am taking regular painkillers
- Yes, because I was coming to my appointment

No

23. How would you best describe the level of pain or discomfort that you experienced during your treatment?

(Multiple Choice, select one only)

- None
- Mild
- Moderate
- Severe

24. Were you given an Information leaflet which included advice on pain relief / caring for your dressings.

(Multiple Choice, select one only)

- Yes
- No

25. Did you feel safe in our care today

(Multiple Choice, select one only)

- Yes
- No

Pick the box that best describes the care received from the team

	Excellent	Good	Fair	Poor	Very Poor	Did not see
26. Medical team (doctors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Nursing team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Physiotherapy team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Occupational therapy team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Please rate your overall satisfaction with your clinic visit today

(Multiple Choice, select one only)

- Very satisfied
- Fairly satisfied
- Fairly dissatisfied
- Very dissatisfied

31. About you: Are you?

(Multiple Choice, select one only)

- Male
- Female

32. About you: How old are you?

(Multiple Choice, select one only)

- Less than 16 years old
- 16 to 34
- 35 to 64
- 65 and over

33. Please add any further comments

(Open Ended)

- Free Format Text