

THE DISCHARGE PROCESS

Before you left the hospital were you given all the information that you required?

- Yes, completely Yes, to some extent No

Did a member of staff tell you about medication side effects to watch for when you went home?

- Yes, completely Yes, to some extent No I had no medication

Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- Yes No Don't know/Can't remember

YOUR CONSULTANT Name of your consultant: _____

How likely are you to recommend your consultant to friends and family if they need similar care or treatment?

- Extremely likely Likely Neither/Nor
 Unlikely Extremely unlikely Don't know

Did your consultant show you understanding when assessing your need for treatment? *Yes, definitely* *Yes, to some extent* *No*

Did your consultant explain everything to you in a way that was easy to understand? *Yes, definitely* *Yes, to some extent* *No*

Did you have sufficient time with your consultant during this visit or hospital stay? *Yes, definitely* *Yes, to some extent* *No*

Did you have confidence that your consultant would deliver the appropriate care for you? *Yes, definitely* *Yes, to some extent* *No*

We would like to hear any feedback you have about your consultant:

COMMENTS & SUGGESTIONS

In what way might our services be improved?

If you have any comments or suggestions please give them here

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

THANK YOU - YOUR FEEDBACK IS APPRECIATED

If you have any concerns requiring a response from the Hospital, please put these in writing and address them to the Chief Executive Officer, or email Andrew.barker@weymouthhospital.com

Sep 2018 004

WEYMOUTH STREET HOSPITAL

Patient Satisfaction Survey



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COMMITTED TO EXCELLENCE

Thank you for coming to Weymouth Street Hospital.

As part of our continual search for ways of improving the Hospital we would be very grateful if you could find time to fill in this questionnaire and return it to us. Please complete each section of this form by ticking the appropriate box alongside each question. Please ignore sections or questions that are not applicable. The information contained in this questionnaire will be used ONLY for the purposes of this patient survey and will not be shared with any party other than Phoenix Hospital Group and the contractor carrying out the survey on our behalf. If you have given contact information, this will not be recorded. Reports are produced anonymously and used only to help improve the service we offer. Your rights to anonymity are fully covered under the Data Protection Act 2018.

Andrew Barker

Andrew Barker

Chief Executive Officer, Phoenix Hospital Group

ABOUT YOU

- Are you: Inpatient Daypatient
- Was this your first admission to the hospital? Yes No
- How was your treatment funded? Insured Self Pay
 NHS Other

YOUR OVERALL EXPERIENCE

We would like you to think about your overall experience in the hospital during your visit:

How likely are you to recommend our hospital to friends and family if they need similar care or treatment?

- Extremely likely Likely Neither
 Unlikely Extremely Unlikely Don't know

Please give your overall opinion of the quality of your care

	Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did we compare to your expectations? Exceeded Met Fell below

Would you come back to Weymouth Street Hospital? Yes No

YOUR ADMISSION

Before you arrived at the hospital were you given all the information you required?

- Yes, completely Yes, to some extent No I did not need any

Please give your opinion of:

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Your welcome at reception | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The promptness of your admission | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Explanation of room facilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The way we explained the nurse call system | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your overall admission | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

YOUR NURSING CARE

If you had important questions to ask your nurse did you get answers you could understand?

- Yes, always Yes, sometimes No N/A

Were you treated with consideration and courtesy by your nurses?

- Yes, always Yes, sometimes No

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

- Yes, always Yes, sometimes No

Did the nurses explain what would be done before giving you any care or treatment?

- Yes, always Yes, sometimes No

Please give your opinion of:

- | | | | | | |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Individual attention given | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Response to nurse call | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Assistance with pain relief | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overall impression of nursing care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

YOUR ACCOMMODATION

Room No: _____

Please give your opinion of:

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Television and radio and facilities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Room décor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cleanliness of your room/bathroom | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Friendliness/helpfulness of housekeeping staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How we cared for your visitors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overall opinion of your accommodation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

CATERING

Please give your opinion of:

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| The variety/choice of food | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Correctness of your order | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The quality of food served | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The friendliness/helpfulness of catering staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How well we dealt with any special dietary needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Overall opinion of catering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

GENERAL QUESTIONS

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

- Yes, definitely Yes, to some extent No No family were involved

Did you find someone on the hospital staff to talk to about your worries and fears?

- Yes, definitely Yes, to some extent No I had no worries or fears

Were you involved as much as you wanted to be in decisions about your care and treatment?

- Yes, definitely Yes, to some extent No

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

- Yes, always Yes, sometimes No

Were you given enough privacy when discussing your condition or treatment?

- Yes, always Yes, sometimes No N/A

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

- Yes, always Yes, sometimes No