

Experience of Care Questionnaire – 2018

Please answer the following questions about what your experience of care at [insert care setting before distributing] has been like over the [insert timeframe before distributing – you may want to use ‘last month’ or ‘during this admission’].

[Note: You may wish to modify the following paragraph and box below with a specific description of the ‘care team’ the responses should relate to.]

Please write in the box below whom you will keep in mind as your ‘care team’ as you answer the questions. There is no right or wrong answer – it’s just helpful for us to know who you are referring to.

[Options for providing further ‘care team’ clarification, use this box to:

- Describe exactly who the care team refers to or put in the covering letter, or
- Provide tick boxes for different roles/team members, or
- Be very specific about the roles/team members you want the patient/individual to refer to]

Please answer the questions by ticking the box that most applies to you.

1. In the [insert last month or during this admission], how often have you felt

		Always	Most of the time	Some times	Rarely	Never	Not required
a.	...that you have had enough opportunity to ask questions?						
b.	...that you have been able to talk with members of your care team as openly as you would wish?						
c.	...that you have been as involved as you would like in decisions about your care and treatment?						
d.that things that are important to you are considered in planning your care?						
e.	...that your care team works well together?						

(1 Cont.) In the [insert last month or during this admission], how often have you felt.....							
		Always	Most of the time	Some times	Rarely	Never	Not required
f.	...that your care team treats you with respect and dignity?						
g.that the care and support provided by your care team meets your physical needs (e.g. pain, breathlessness, fatigue, mobility)?						
h.	...that the care and support provided by your care team meets your emotional needs (e.g. feeling low, feeling worried, feeling anxious)?						
i.	...that your care team treats you as a whole person (e.g. takes into account your beliefs, hopes, traditions, customs, spirituality)?						
j.	...that your care team helps you to have as much privacy as you want?						
k.safe in your place of care?						
l.	...that when you need advice or help urgently, your care team responds quickly?						

Comments on Question 1(a) to 1(l) (especially if you've answered 'rarely' or 'never' to any of the questions above, we would really like to understand more). If you would like us to know who you are, please insert your name in the box at the end of this questionnaire.

2. In the [insert last month or during this admission], has your care team given you ...

		Yes, as much as I need	Yes, to a great extent	Yes, to some extent	No	Not required
a.	...information that you can understand about your condition?					
b.	...information that you can understand about your prescribed medicines?					
c.	...support to get help with your personal care (e.g. dressing, washing, eating)?					
d.	...support to get help with practical matters (e.g. social benefits, wills, finances, legal matters, form filling)?					
e.	...support to get any equipment or aids that you need (e.g. oxygen, hospital bed, wheelchair)?					
f.	...support to do things that you enjoy (e.g. spending time with family and friends, reading, going outdoors)?					
g.	...support to involve your family and those close to you, as much as you wish, in decisions about your care?					

Comments on Question 2(a) to 2(g) (especially if you've answered 'no' or 'yes, to some extent' to any of the questions above, we would really like to understand more). If you would like us to know who you are, please insert your name in the box at the end of this questionnaire.

3. In the [insert last month or during this admission], how often have the people important to you (e.g. your family, friends, carers) been offered help and support by your care team?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always	Most of the time	Sometimes	Rarely	Never	Not sure	Not required

4. Do you know whom to contact if you have any concerns or problem?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	No	Not sure

5. If there is anything else you would like to tell us about your experience – what was good and what could be improved, please use the box below to write this down.

Additional comments:

Your name (optional).....

Your contact details (optional).....