



CROMWELL
HOSPITAL

Committed to Excellence

In/Day Patient Feedback



CROMWELL HOSPITAL

Committed to Excellence

Your opinions make a difference

At the Cromwell Hospital we aim to provide the highest standards of care for every patient, and a quality service to our visitors.

We regard your opinions and comments as extremely valuable. We use them to identify areas of success and opportunities for improvement. To help us measure our level of achievement we would be grateful if you could complete this questionnaire. Your answers will be analysed by an external organisation and returned to the hospital. Your rights to anonymity are fully covered under the Data Protection Act 1998, and no personal information will be released to any other party.

Tick the appropriate box to each question, where applicable. Where sections or questions do not apply, please ignore. Once completed, fold over and seal the flap on the reverse of this questionnaire. Please hand it to the staff at Main Reception. 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

Your Admission

Prior to your admission, did you receive a 'Welcome to Cromwell Hospital' information booklet?

Yes No

If yes, did you find it useful?

Yes No

On admission, how would you rate each of the following?

Your welcome by reception

Excellent
Very Good
Good
Fair
Poor

The registration process

Explanation of hospital payment procedures

Explanation of room facilities

Explanation of nurse call system

Helpfulness of porters

Your overall impression of the admission process

Were we prepared for your arrival?

Yes No

Your Consultant

Was the proposed course of treatment clearly explained to you?

Yes, completely

Yes, to some extent

No

Was the expected outcome 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

When you had important questions to ask your consultant, did you get answers you could understand?

Yes, always

Yes, sometimes

No

Do you feel you received sufficient information after your treatment?

Yes

No

Were you treated with consideration and courtesy by your consultant?

Yes, always

Yes, sometimes

No

Was there an explanation of consultant payment procedures?

Yes

No

Don't know/can't remember

Excellent
Very Good
Good
Fair
Poor

Please give your overall impression of your consultant care

Your Nursing

Was your nursing care consistent?

Yes No

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

Yes, always
 Yes, sometimes
 No

Were you treated with consideration and courtesy by your nurses?

Yes, always
 Yes, sometimes
 No

How would you rate your nursing for each of the following?

Admission to your ward/room

Keeping you informed

Response to nurse call

Awareness of your condition

Effectiveness of staff in assessing pain

Effectiveness of actual pain relief

Dispensing medicines at the right time

Overall impression of your nursing care

	Excellent	Very Good	Good	Fair	Poor
Admission to your ward/room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping you informed	<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"/>
Awareness of your condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effectiveness of staff in assessing pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effectiveness of actual pain relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dispensing medicines at the right time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall impression of your nursing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Professional Services

How would you rate?

Physiotherapy

Radiology (X-Ray)

RMO (Resident doctor)

Pharmacy

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

Other professional services received (please specify)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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, specify.....?

 Day Night

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

 Yes, always Yes, sometimes No

Were you given enough privacy when being examined or treated?

 Yes, always Yes, sometimes No

How would you rate each of the following?

Internal directions

Excellent
Very Good
Good
Fair
Poor

In-room entertainment (TV/Radio etc.)

Bathroom facilities

Room temperature

Cleanliness

Décor

Care of visitors

Friendliness/helpfulness of housekeeping staff

Friendliness/helpfulness of maintenance staff

Overall impression of your accommodation

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 served

Friendliness/helpfulness of catering staff

Overall impression of catering services

General Questions

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

Timing Of Your Stay **this section to be completed by Day Patients only**

How long before surgery/treatment were you admitted? _____ hours

Was this the right length of time for you? Yes No

If no, would you have preferred?

- Longer
 Shorter
 Overnight

How long after surgery/treatment were you discharged? _____ hours

Was this the right length of time for you? Yes No

If no, would you have preferred to rest?

- Longer
 Shorter
 Overnight

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

Assistance with financial queries

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

Was your take-home medication ready at departure?

Yes

No

Not applicable

Did you receive appropriate advice for your care at home?

Yes, completely

Yes, to some extent

No

I didn't need any information

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

Yes

No

Excellent
Very Good
Good
Fair
Poor

Your overall impression of the departure process

Overall

Overall rating of quality of care

Overall rating of value for money

If you have visited us before do you think the levels of our service are:

Improving

Staying the same

Need improvement (specify) _____

Would you recommend the hospital to family/friends?

Yes

No

What did you like most about your visit to the Cromwell Hospital?

What did you like least about your visit to the Cromwell Hospital?

About You

Is this your first In/Day patient stay?

- Yes No

Are you?

- Male Female

Your age group?

- 0-16 17-35
 36-55 56-75
 Over 75

Date of admission _____

Length of stay

If Inpatient _____ days

On what basis did you receive treatment?

- Insured Self pay
 NHS
 Other (specify)

How were you admitted?

- Planned
 Emergency

Name of consultant/s _____

If Day Patient _____ hours

What was the main influence on your choice of this hospital? (tick all appropriate)

- GP Insurance Company Consultant
 Website Advertisement Previous Visit
 Personal Recommendation
 Other _____ (specify)

Occasionally we may need to telephone patients to find out more about their experience. Please tick and include your telephone number if you would be prepared to receive a brief telephone call.

Please tick and include your email address if you would be happy to receive information about the hospital.

Name: **Tel:**

Address:
.....

Email:

Moisten this adhesive strip, fold and stick to front cover so that the reply address is visible



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Cromwell Hospital Patient Survey
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