

Doncaster Local Involvement Network (LINK) Discharge Procedure Survey Doncaster Hospitals' Patients

Doncaster LINK is your official independent Local Involvement Network. Our aim is to improve the links between your health and social care services.

We wish to give you the opportunity to say what you think about these services – what is working well and what is not so good.

Doncaster LINK is currently looking at what happens when patients are discharged from hospital.

If you have been an inpatient since January 2009 in any of the Doncaster hospitals it would be most appreciated if you could please spend a few minutes to complete the attached survey. This could help make a difference to future patient care.

Please return the completed form as soon as possible in the freepost envelope provided or alternatively to the address shown at the bottom of page 2 of the survey.

If you need help completing this survey you may ask a relative or friend to help you.

Thank you for taking part in the survey. The results will be made available in due course.

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For office purposes only, please insert the first part of your postcode

Section A

- Q1 Have you been an inpatient? Yes No
- Q2 Hospital Name and Ward No?
- Q3 Did you need any aids or adaptations at home?
(e.g. crutches, walking stick, toilet seat etc) Yes No
- If Yes, were they available upon discharge? Yes No
- Q4 Gender? Male Female
- Q5 Age Group? Under 18 18 – 39 40 – 59 60 – 70 Over 70

Section B

Communication

- Q6 Were you given a copy of your 'After Care Package' and contact numbers of agencies involved?
Yes No Do Not Know
- Q7 Was everything explained in a way you/your carer could understand?
Yes No Do Not Know
- Q8 Were you given a copy of the letter from the hospital to your GP?
Yes No

Medication

- Q9 Did waiting for medication delay your discharge?
Yes No By how long?
- Q10 Upon discharge, were the following about your medication explained to you in a way you could understand?
- | | | | | | | | | |
|---|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Purpose | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any changes | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any side effects | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Instructions on how to take given | | | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Written info given | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Were you sent home with old medication? | | | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Section B (continued)

Arrival Home

Q11 How did you get home?

Hospital Transport Ambulance Taxi Private Car Other

Q12 When you arrived home did you require any of the following?

Medical Assistance Physical Assistance Rehabilitation Services Carer N/A

If yes, who provided your assistance?

.....

Q13 How long did you require assistance?

1-3 Wks 1 Month Longer

How could this help have been improved?

.....

Q14 Since your discharge have you been VISITED by any of the following?

Your Doctor Social Services Rehabilitation Services Community Practice/Nurse
Occupational Therapist None

Q15 Since your discharge have you SPOKEN over the phone to any of the following?

Your Doctor Social Services Rehabilitation Services Community Practice/Nurse
Occupational Therapist None

Q16 How often have your changing needs for assistance been reviewed?

Frequently Infrequently Never

Q17 Any Other Comments? (If necessary please use a separate sheet)

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Please return completed survey to:

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