

Measure # 38a: PREPARED Survey – Patient Version

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Additional Notes:

- The measure instruments are also available from the following website:
<http://www.unisa.edu.au/cahe/Resources/DCP/Information.asp>

CAHE Post-Discharge Patient Questionnaire

Section 1: Questions about you, the patient

1. Name of Hospital Ward from which you were discharged:

2. Home post code: _____

3. Today's Date: _____ / _____ / 20

4. Your gender: Male / Female

5. Your date of birth: _____ / _____ / 19

6. What was the reason for your last admission to hospital? :

7. What date and day of the week were you discharged from hospital? :

8. What time of the day were you discharged from hospital (include am or pm)? : _____

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We are interested in how much information you received in hospital to prepare you for coping at home

Section 2: While you were in hospital:

<p>1 How much information did you receive about the medications that you were to take home? <i>Please tick only one box</i></p>	As much as I needed	<input type="radio"/>
	Some, but not enough	<input type="radio"/>
	None	<input type="radio"/>
	Not taking any medications	<input type="radio"/>
<p>2 How much information did you receive about the side effects of the medications that you were to take at home? <i>Please tick only one box</i></p>	As much as I needed	<input type="radio"/>
	Some, but not enough	<input type="radio"/>
	None	<input type="radio"/>
	Not taking any medications	<input type="radio"/>
<p>3 Were you given written instructions about your medications? <i>Please tick only one box</i></p>	Yes	<input type="radio"/>
	No	<input type="radio"/>
	Not taking any medications	<input type="radio"/>
<p>4 If YES did someone spend time explaining the written instructions? <i>Please tick only one box</i></p>	Yes	<input type="radio"/>
	No	<input type="radio"/>
<p>5 How much information did you receive on how you would manage your usual activities when you went home? (e.g. shopping, showering, bathing etc) <i>Please tick only one box</i></p>	As much as I needed	<input type="radio"/>
	Some, but not enough	<input type="radio"/>
	None	<input type="radio"/>
<p>6 How much information did you receive on community services you might use once you went home? (e.g. Domiciliary Care, District Nurse, Meals on Wheels etc) <i>Please tick only one box</i></p>	As much as I needed	<input type="radio"/>
	Some, but not enough	<input type="radio"/>
	None	<input type="radio"/>
	No services needed	<input type="radio"/>
<p>7 How much information did you receive on equipment you might need once you went home? (e.g. rails, shower chair, walking aids etc) <i>Please tick only one box</i></p>	As much as I needed	<input type="radio"/>
	Some, but not enough	<input type="radio"/>
	None	<input type="radio"/>
	No equipment needed	<input type="radio"/>

Section 3: Before you were discharged from hospital:

1 Did anyone arrange community services for you to use at home? (e.g. Domiciliary Care, District Nurse, Meals on Wheels etc)
Please tick only one box

Yes	<input type="radio"/>
No	<input type="radio"/>
No-one needed to:- Services were already in place	<input type="radio"/>
No-one needed to: No services needed	<input type="radio"/>

1a. If you answered **YES**, have the services commenced? **or** If you answered **SERVICES WERE ALREADY IN PLACE**, have the services recommenced?

Yes	<input type="radio"/>
No	<input type="radio"/>

1b. If **NO**, why?

.....

2. Did anyone arrange equipment for you?
Please tick only one box

Yes	<input type="radio"/>
No	<input type="radio"/>
No-one needed to:- Equipment already in place	<input type="radio"/>
No-one needed to: No equipment needed	<input type="radio"/>

2a. If **YES**, do you have this equipment now?

Yes	<input type="radio"/>
No	<input type="radio"/>

2b. If **NO**, why?

.....

3. Was there any other information you would have liked while you were in hospital, to prepare you for coping at home?
Please tick only one box

Yes	<input type="radio"/>
No	<input type="radio"/>

3a. Please tell us more about this

.....

.....

Section IV: After the patient was told he/she could leave hospital:

- 1** How confident did **you** feel about managing at home?
Please tick only one box
- | | | |
|--|---------------|---|
| | Confident | 0 |
| | Unsure | 0 |
| | Not confident | 0 |
- Please tell us more about this
-
-
- 2** Were there any delays on the day you left hospital?
Please tick
- | | | |
|--|-----|---|
| | Yes | 0 |
| | No | 0 |
- 3.** If **YES**, what were the delays?
Please tick as many as you wish
- | | | |
|--|-------------|---|
| | Transport | 0 |
| | Medications | 0 |
| | Don't know | 0 |
| | Other | 0 |
- Please indicate*
-

Section V: Now you have been out of hospital for a while:

- 1** Has anything been worrying you about managing at home?
Please tick
- | | | |
|--|-----|---|
| | Yes | 0 |
| | No | 0 |
- 1a.** Please tell us more about this
-
-
-
- 2** Has anything been done to deal with your worries?
Please tick
- | | | |
|--|-----|---|
| | Yes | 0 |
| | No | 0 |

2a. Please tell us more about this

.....

.....

3 Are you a carer for someone else? Yes

For whom? (Spouse, child, other relative, friend, other) No

Please circle

4. Have any unexpected problems occurred since you have been home? Yes

Please tick No

4a. Please tell us more about this

.....

.....

5. If the you have already received community services, have these services met your needs?... Yes

Please tick No

Everyone = you, the patient and any one else involved

5a. Please tell us more about this

.....

.....

6. If equipment was provided for the patient, did it make things easier for you? Yes

Please tick No

6a. Please tell us more about this

.....

.....

Section VI: in the first week after you left hospital

1 How many times did you see

*(Please put the number of times on **each** line)*

- | | |
|--|---|
| Your local doctor | Your specialist doctor |
| Physiotherapist | Chemist |
| Occupational Therapist | Meals on Wheels |
| Domiciliary Care | Other health professionals |
| District Nurse | Any other people who have helped you |
| Hospital outpatient/
Emergency clinic | <i>Please write who they were on the line below</i> |

.....

2 Did you receive any of the following services?

*(Please put the number of times on **each** line)*

- | | |
|--------------------------|-----------------------|
| Home modifications | <input type="radio"/> |
| Assistance with shopping | <input type="radio"/> |
| House cleaning | <input type="radio"/> |
| Other (Please indicate): | <input type="radio"/> |

.....

2 Have **you** had to spend any extra money as a result of the patient's visit to hospital? *(such as taxi fares, petrol, etc)*
Please tick

2a. If so, what are these costs approximately?

- | | | | |
|---------------------|----|---|----|
| Taxi fares | \$ | Petrol | \$ |
| Extra shopping | \$ | Gap payments for health services | \$ |
| Extra chemist costs | \$ | Private Health Services | \$ |
| Other | | <i>Please write who they were on the line below</i> | |

.....

3. Have **you** had to use any extra electricity as a result of looking after the patient?
Please tick

- | | |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No | <input type="radio"/> |

Section VII: Looking back to the time the patient left hospital

- 1** Overall, how prepared did you feel for returning to home?
Please tick
- | | | |
|--|---------------------|-----------------------|
| | Totally prepared | <input type="radio"/> |
| | Moderately prepared | <input type="radio"/> |
| | Unprepared | <input type="radio"/> |

- 2.** Were there any particular aspects of your preparation for discharge whilst in hospital, that you would like to further comment on?

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- 3.** Were there any particular aspects of the patient’s care after leaving hospital that you would like to comment further on?

.....

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.....

There is also space for you to write on the back of this page if you want to write more

Section VIII: This sheet will be removed and used as a consent form for us to contact your doctor

1 When you were in hospital, what were you told to tell your usual doctor (GP) when you saw him/her?

.....

2 Who is your usual doctor (GP) and what is his/her address?

.....

3 Do you usually see any other doctors (GP's) Yes
Please tick No

If **YES**, How many -----

4 Do you consent to us contacting your usual GP about his/her views about your recent discharge from hospital? Yes
Please tick No

If **YES**, please print your name and sign

PRINT YOUR NAME DATE:

SIGNATURE

Thank you for taking the time to complete this questionnaire. Please put it in an envelope and deliver to:

Name: _____

Office/Delivery: _____

(Office use: for completed forms please enter the name of the nominated person and their address/office above)