

 **2019**

**Community Specialist Palliative Care Team Survey to relatives, friends and carers**

**Please tell us what you think**

If you can tell us about your experience of the care given by our Community Specialist Palliative Care Team, to your relative, friend or the person you cared for, it will help us develop our services in the future. (The patient may have been visited at home by any of the following Team members; Clinical Nurse Specialists, Social Workers, Doctors and Physiotherapists.)

Please help us by filling out this short questionnaire and ticking the statement nearest to your view. You can also add any further comments if you wish. We may use any comments you make on our leaflets, website etc, but they will remain anonymous.

In this survey we have used the word ‘patient’ to describe the person who was cared for by the Community Specialist Palliative Care Team.

Please return the survey in the pre-paid envelope provided.

If you would like to tell us about your experience in more detail, please speak to your Hospice contact. We would love to hear from you**.**

Thank you very much for helping us – it is greatly appreciated.

Registered Charity No. 285300

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| --- | --- | --- |
| **1.Did the home visits from the Hospice Community Team start at the right time for you?**  **Comments:** | Yes  |  |
| Too soon |  |
| Not soon enough |  |
| Not sure |  |
|  |

|  |  |  |
| --- | --- | --- |
| **2. Did the Community Team introduce themselves?****Comments:** | Always |  |
| Sometimes |  |
| Never |  |
| Not sure |  |
|  |

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| --- | --- | --- |
| **3. Did the Community Team explain their roles?****Comments:** | Always |  |
| Sometimes |  |
| Never |  |
| Not sure |  |
| **4. Do you feel the Community Team treated the patient with:**  Always Sometimes Never Not Sure

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Compassion**  |  |  |  |  |
| **Understanding** |  |  |  |  |
| **Courtesy** |  |  |  |  |
| **Respect** |  |  |  |  |
| **Dignity** |  |  |  |  |

**Comments:** |
| **5. Were you involved as much as you wanted to be in decisions about the patient’s care and treatment?** **Comments:** | Always |  |
| Sometimes |  |
| Never |  |
| Not sure |  |
| Not applicable |  |
| **6.Were you offered help to access financial benefits?** **Comments:** | Yes |  |
| No |  |
| Not sure |  |
| Not applicable |  |
| **7. If you asked questions, did you get an answer you could understand?** **Comments:** | Always |  |
| Sometimes |  |
| Never |  |
| Not sure |  |
| I did not ask questions |  |
| **8. Did you have the opportunity to talk to staff about how your life changed because of the patient’s illness and what this meant to you?** **Comments:** | Yes |  |
| No |  |
| Not sure |  |
| Not applicable |  |

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| **How would you assess the overall level of support given to you?**Excellent Good Satisfactory Poor Not sure Not Applicable

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Emotional support** |  |  |  |  |  |  |
| **Spiritual support** |  |  |  |  |  |  |
| **Support with practical needs** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Comments:** |
| **9.Did the Community Team work well with other services** **eg GP, District Nurses?****Comments:** | Yes |  |
| N No |  |
| Not sure |  |
| Not applicable |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **10. Did you have any difficulties contacting the Community team if you needed them?** Yes No Not Sure Not Applicable

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| --- | --- | --- | --- | --- |
| **During the day (Mon-Fri 9am – 5pm)** |  |  |  |  |
| **During the weekend (Sat & Sun 9am-5pm)** |  |  |  |  |
| **During the night** |  |  |  |  |

 **Comments:** |
| **11. Would you have been able to care for the patient at home without the help of the Community Team?** **Comments:** | Yes |  |
| No |  |
| Not sure |  |
|  |
| **12. Please rate your overall experience of the following, provided by the Community Specialist Palliative Care Team.**Excellent Good Satisfactory Poor Not sure Not Applicable

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Relief of pain** |  |  |  |  |  |  |
| **Relief of other symptoms** |  |  |  |  |  |  |
| **Communication with you about care**  |  |  |  |  |  |  |
| **Information given on what to do after death** |  |  |  |  |  |  |

**Comments:** |

|  |  |  |
| --- | --- | --- |
| **13. If the patient needed medication, did you have any problems accessing it?**  **Comments:** | Yes |  |
| No |  |
| Not sure |  |
| Not applicable |  |

|  |  |  |
| --- | --- | --- |
| **Did the Community Team acknowledge and respect your cultural needs?****Comments:** | Always |  |
| Sometimes |  |
| Never |  |
| Not sure |  |
| Not applicable |  |
| **Were you offered an interpreter (if appropriate)****Comments:** | Yes |  |
| No |  |
| Not sure |  |
| Not applicable |  |
| **14. Did the patient say where he/she wanted to die?** **Comments:** | Hospital |  | Residential Home |  |
| Hospice |  | No preference |  |
| At home |  | Not discussed |  |
| Nursing Home |  | Not applicable |  |
| **15. Where was the patient when he/she died?** **Comments:** | Hospital |  |
| Hospice |  |
| Home |  |
| Nursing Home |  |
| Residential Home |  |
| **16. If the preferred place of death** **was not possible, what were the****reasons? (You can tick more than one)** **Comments:** | Family/carer reasons |  | Hospital discharge delay |  |
| Uncontrolled symptoms |  | Place of death not discussed |  |
| Community support not meeting needs |  | Other reason: |  |
| Emergency situation |  |
| Bed not available in Hospice |  | Not applicable |  |
|  |
| **17. Have you received adequate information and an invitation to access our Bereavement Support Services?** **Comments:** | Yes |  |
| No |  |
| Not sure |  |
| Not applicable |  |
|  |  |
| **18. Would you know how to make a complaint or raise a concern about Hospice care, if you wanted to? Comments:** |  | Yes |  |
| No |  |
| Not sure |  |
|  |
| **19. Did you trust the Hospice to hold the patient’s personal information securely and confidentially?** **Comments:** | Yes |  |
| No |  |
| Not sure |  |
|  |
| **Overall, how do you rate the care you received?****Comments:**  | Excellent |  |
| Good |  |
| Satisfactory |  |
| Poor |  |
| Not sure |  |
| **21. Would you recommend the service to friends or family?** **Comments:** | Extremely likely |  |
| Likely |  |
| Neither likely or unlikely |  |
| Unlikely |  |
| Extremely unlikely |  |
| Don’t know / not applicable |  |

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| --- | --- | --- |
| **22. The patient lived in the London Borough of:** | Barnet |  |
| Enfield |  |
| Haringey |  |

**23. Do you have any more comments or suggestions to help us develop our service? Is there anything we could have done better? Please let us know on a separate sheet.**

**Thank you so much.**