MERCY MEDICAL CENTER

INPATIENT SURVEY

We appreciate your taking the time to complete this survey. Please place a check or X inside the appropriate square. If you had no experience with a particular item, leave it blank. When you have completed the survey, please mail it in the enclosed envelope. Thank you.

REGISTRATION

VP = Very Poor P = Poor F = Fair G = Good VG = Very Good

	VP	P	F	G	VG
1. Ease of the admission process	☐	☐	☐	☐	☐
2. Courtesy of the person who admitted you.	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

ROOM

	VP	P	F	G	VG
1. Appearance of the room	☐	☐	☐	☐	☐
2. Cleanliness of the room	☐	☐	☐	☐	☐
3. Courtesy of the person who cleaned your room	☐	☐	☐	☐	☐
4. Temperature of room	☐	☐	☐	☐	☐
5. Noise level in and around the room	☐	☐	☐	☐	☐
6. How things worked (TV, call button, lights, bed, etc.)	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

MEALS

	VP	P	F	G	VG
1. Quality of the food	☐	☐	☐	☐	☐
2. Courtesy of the person who served you	☐	☐	☐	☐	☐
3. If you were placed on a special diet/restricted diet, how well it was explained	☐	☐	☐	☐	☐
4. Temperature of the food (cold foods cold, hot foods hot)	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

NURSES

	VP	P	F	G	VG
1. Courtesy of the nurses	☐	☐	☐	☐	☐
2. Nurses attention to your needs	☐	☐	☐	☐	☐
3. Skill of the nurses	☐	☐	☐	☐	☐

Please continue on the next page

MERCY MEDICAL CENTER

	VP	P	F	G	VG
4. Nursing staff kept you informed	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

PHYSICIAN

	VP	P	F	G	VG
1. Time physician spent with you	☐	☐	☐	☐	☐
2. Courtesy of the physician	☐	☐	☐	☐	☐
3. How well the physician kept you informed	☐	☐	☐	☐	☐
4. Skill of physicians	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

TESTS AND TREATMENT

	VP	P	F	G	VG
1. Wait time for tests and treatment	☐	☐	☐	☐	☐
2. Concern showed for your comfort during tests and treatment	☐	☐	☐	☐	☐
3. Skill of person taking your blood	☐	☐	☐	☐	☐
4. Courtesy of person taking your blood	☐	☐	☐	☐	☐
5. Skill of person starting your IV	☐	☐	☐	☐	☐
6. Courtesy of person starting your IV	☐	☐	☐	☐	☐
7. Courtesy of radiology/x-ray staff	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

SPECIAL SERVICES

	VP	P	F	G	VG
1. Your rating of volunteers	☐	☐	☐	☐	☐
2. Your rating of Therapy Services (i.e., Physical, speech, etc.)	☐	☐	☐	☐	☐
3. Your rating of staff who transported you	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

FAMILY AND VISITORS

	VP	P	F	G	VG
1. Staff's attitude towards family and visitors	☐	☐	☐	☐	☐
2. Staff's attitude towards family and visitors	☐	☐	☐	☐	☐

Please continue on the next page

MERCY MEDICAL CENTER

Comments - describe good or bad experience (please write **inside** the rectangle below)

DISCHARGE

	VP	P	F	G	VG
1. Extent to which you felt ready to be discharged	☐	☐	☐	☐	☐
2. Speed of discharge process	☐	☐	☐	☐	☐
3. Information you were given about caring for yourself at home	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

PERSONAL ISSUES

	VP	P	F	G	VG
1. Staff's concern for your privacy	☐	☐	☐	☐	☐
2. How well your pain was controlled	☐	☐	☐	☐	☐
3. Degree to which staff addressed your emotional/spiritual needs	☐	☐	☐	☐	☐
4. Response to concerns/complaints made during your stay	☐	☐	☐	☐	☐
5. Effort staff made to include you in decisions about your treatment	☐	☐	☐	☐	☐
6. Adequacy of precautions taken to protect your safety (hand washing, gloves, etc.)	☐	☐	☐	☐	☐
7. Safety and security felt in the hospital	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

OVERALL ASSESSMENT

	VP	P	F	G	VG
1. Overall rating of care given at hospital	☐	☐	☐	☐	☐
2. Likelihood of recommending this hospital to others	☐	☐	☐	☐	☐

Comments - describe good or bad experience (please write **inside** the rectangle below)

Patient Age ..... ☐☐☐

	M	F
Sex:	☐	☐

Patient's Name (optional): _____

Telephone Number (optional): _____

Thank you for completing this survey!