Evaluation of a Trauma Service: Patient and Family Perspectives

Author

Wake, Elizabeth, Battistella, Tania, Dale, Kate, Scott, Matthew, Nelson, Renee, Marshall, Andrea P

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TITLE: Evaluation of a Trauma Service: Patient and Family Perspectives

Abstract:

Background: Patient satisfaction is an indicator of the quality of care that underpins a patient's health care experience. A focus on both the patient and the family is important when evaluating satisfaction from the perspective of patients with trauma and is consistent with delivery of patient and family centred care. Using the literature to guide development, we designed and implemented a questionnaire to evaluate attitudes and experiences of patients and families case managed by the Trauma Service. This paper reports the findings of this quality improvement project.

Methods: A cross sectional cohort pragmatic design was used. The questionnaire was conducted with 142 trauma patients and 49 family members. Data included hospital admission data, application of a satisfaction tool and free text comments.

Results: Both patients and their family members rated the trauma service highly in the satisfaction scoring. Differences in the communication practices encountered by patients and families were identified.

Conclusions: Strategies to involve family members and promote family centred care are required in the context of trauma patients to improve the safety, quality and satisfaction of the care they receive whilst being managed by the trauma service.

Key Words

Multiple Trauma

Patient-Centred Care

Family-centred Nursing

Patient Satisfaction

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INTRODUCTION:

Patient satisfaction is an indicator of the quality of care that underpins a patient's health care experience (Muntlin, Gunningberg, & Carlsson, 2006) and is usually gauged by surveying patients using a patient satisfaction tool to understand views and perspectives on the quality of care they receive (Sacks et al., 2015). Using patient experiences is a valuable strategy to inform practice and the development of services and is consistent with a patient-centred approach to care (ACSQHC, 2012).

Patient satisfaction data can be collected through a wide array of tools of which there are several validated ones available (Al-Abri & Al-Balushi, 2014). However, using generic tools that are not specific to patient groups can result in valuable information going undetected (Janssen C, 2007). Furthermore, the lack of 'personalisation' can affect the level of patient engagement which suggests a 'one size fits all approach' may not yield optimal results (Jerofke-Owen, 2018). As a result, patient or condition specific tools have been developed and used to evaluate multiple concepts including patient experience, hospital quality, patient expectations and patient centred care (PCC) (Hibbard, 2013).

Within the area of trauma, the reduction of trauma-related mortality, due to advances in trauma care delivery (Gabbe, 2007), means the focus has shifted to patient-reported outcomes as a marker of quality care. Multi-trauma patients can require complex coordinated care by multiple clinical teams and frequently experience long periods of hospitalisation, therefore, understanding their perceptions of satisfaction is essential to ensure the delivery of high-quality, patient-centred care (Ardolino, 2012).

Determinants of satisfaction of trauma patients with acute hospitalisation was explored by Janssen C (2007) . Using validated tools (Cologne Patient Questionnaire (CPQ) and SF-36) they determined that the perceived quality of psychosocial care had a significant effect on patient's satisfaction with their hospital stay. While this study highlights key factors influencing

satisfaction of seriously injured patients, the use of generic tools may not have captured all relevant information related to their experience through their recovery.

Bobrovitz, Santana, Ball, Kortbeek, and Stelfox (2012) developed and validated a quantitative survey instrument (Quality of Trauma Care Patient-Reported Experience Measure QTAC-PREM) to measure patient and family experiences with care following major injury. They found overall ratings of satisfaction to be high however issues such as information and communication were highlighted as areas for improvement. S. J. Gabbe BJ, Gosling CM, Wilson K, Hart MJ, Sutherland AM, et al (2013) used in-depth, semi-structured interviews with 120 trauma patients and identified communication, information provision and post-discharge care to be areas that patients identified as requiring improvement and highlighted that a single point of contact for coordinating post-discharge care was desirable.

Whilst the above work has helped develop our understanding of the experiences of trauma patients, they provide limited information on satisfaction with care from the perspective of the patient's family. This is important given many patients who experience trauma may not be able to effectively engage due to the ongoing burden of injury (de Jongh MAC, 2017). Furthermore, family members can experience negative effects of unexpected hospitalisation of a relative with reports of Post-Traumatic Stress Disorder occurring in family members up to 3 months after the patient has been discharged from the Intensive Care Unit (ICU) (Azoulay, 2005). This suggests that a focus on both the patient and the family is important when evaluating satisfaction from the perspective of patients with trauma and is consistent with delivery of patient and family centred care which is an expectation of public, government and healthcare providers worldwide (ACSQHC, 2012; Frampton, 2016). Kellezi et al. (2015) explored the information needs of both trauma patients and their carers' and found that this altered over time. Whilst this study recognised and provided insight to the needs of family members of trauma patients the evidence remains sparse.

Purpose:

In 2013, we established a Trauma Service at our institution and case management of patients commenced in February 2014. The function of the Trauma Service is to case manage and coordinate the care of the multi-trauma patient. Patients are managed by the service if they receive a Trauma Call; sustained injury to more than body region or injury involving chest or abdomen; and/or where the mechanism of injury was significant. The Trauma Service reviews the patient twice daily and collaborate with the wider multi-disciplinary team on the care delivery to the patient. Trauma case management has been shown to decrease complication rates, increase allied health referral rates and decrease the time to allied health intervention (Curtis, 2006). In 2015 we evaluated the service from the perspective of multi-trauma patients and their families. While the QTAC-PREM was an appropriate tool to use, we did not have adequate resources to administer a survey of this length and were concerned with potential participant burden owing to the large number of response items. Using the literature to guide development, we designed and implemented a questionnaire, which encompassed both quantitative and qualitative items, to evaluate attitudes and experiences of patients and families case managed by the Trauma Service. This paper reports the findings of this quality improvement project.

METHODS:

Design

A cross sectional cohort pragmatic design was used with both quantitative and qualitative data collected to enable assessment of patient and family satisfaction with the Trauma Service.

Setting

The study setting was a 750-bed tertiary health service located in Australia. The institution receives over 1500 trauma call activations annually; approximately 300 of these presentations are classified as major trauma and have an Injury Severity Score (ISS) ≥ 12.

Sample

A convenience sample of trauma patients over the age of 16 years who were admitted to hospital and estimated by the Trauma Service clinical team to have an ISS of 12 or above (major trauma) were approached and invited to participate; family members were also invited participants. We didn't approach patients or family members unable to speak or write in English and patients without cognitive capacity (as assessed by a health professional). Following discharge from hospital, ISS coding was applied to the patients' injuries by a member of the Trauma Service (trained in ISS coding) to ascertain the minor and major trauma patients. Fifteen percent of the minor trauma group were randomly selected to remain within the project as evidence suggests that focusing on major trauma alone underestimates the burden injury has to patients (Richmond TS, 2014).

Following the initial review of the patient by the Trauma Service, patients and their family members were provided with a detailed explanation of the project and an information summary sheet prior to obtaining informed verbal assent to contact after discharge. A National Ethics Application Form (NEAF) was assessed by the institutions Human Research Ethics Committee and the need for ethical approval was waived on the basis that this was a quality activity.

Data Collection

Data were collected for all participants from January to December 2015. Patient demographic data collected from the Trauma database, included age and gender; clinical data included diagnosis, mechanism of injury, ISS, length of ICU stay, length of hospital stay and hospital discharge disposition. Demographic data for family included age, relationship to the patient, residential location and if they cohabited with the patient.

Questionnaire items were selected and adapted from the validated Family Satisfaction ICU (FS-ICU) survey tool (Heyland, Tranmer, & Kingston General Hospital, 2001); item responses used a 5-point Likert scale (1 = Excellent, 2 = Very good, 3 = Good, 4 = Fair, 5 = Poor, 6 = NA). The FS-ICU tool was selected as it aligned closely to the care components relevant to the care of trauma patients. The 'Provision of Information' and 'Satisfaction with Care' sections were selected for inclusion as they contain items that have been previously identified problematic for trauma patients (S. J. Gabbe BJ, Gosling CM, Wilson K, Hart MJ, Sutherland AM, et al, 2013) (Bobrovitz et al., 2012).

We also asked participants if they had initiated contact with the Trauma Service either during the admission or after discharge and to provide the rationale as to why they had contacted them. In addition, all participants were asked if they had any comments or suggestions that they felt would be helpful (please refer to supplementary Figure 2). Responses were collected via telephone within two months of patient discharge from acute care services. Participants were asked for consent at the start of the survey and asked if they recalled the Trauma Service from their time in hospital. For participants who could not recall the Trauma Service or were unable to provide consent then the survey was discontinued. The surveys were undertaken by an experienced research assistant who was not involved in patient care, with responses documented on the survey forms. Calls lasted between 4 and 17 minutes in duration and were audio recorded to allow for quality audit of the data and transcribed verbatim to capture responses to the open-ended questions. Participants who were unable to be contacted after three attempts were deemed lost to follow-up.

Data Analysis

Descriptive statistics were used to analyse demographic data and survey responses. Normally distributed continuous variables were described according to mean and standard deviations (SD). Where the data was not normally distributed, median values and inter quartile ranges (IQR) were reported. Categorical variables were summarised using counts and percentages. IBM SPSS Statistics for Windows (Version 24; SPSS Inc., Armonk, NY. IBM Corp) was used for statistical analysis.

Qualitative data from interview transcripts were reviewed for accuracy and completeness prior to data analysis. Responses to open-ended questions were analysed using inductive content analysis methods (Braun, 2006). The first and second authors read all transcripts to obtain an overview of the data. The first author (EW) then inductively analysed the data applying coding to paragraphs in the transcripts based on the content to identify themes. The first and second authors (EW and TB) then group together and developed the themes to construct a complete picture of the data. Only themes agreed to by consensus of the team were included and any disagreements were discussed and resolved through re-examination of the transcripts.

RESULTS:

Recruitment

Total of 1114 patients over the age of 16, were case managed by the Trauma Service in 2015. Based upon the estimated ISS scores a convenience sample of 320 patients were approached for assent to be contacted after discharge.

204 patients were classed as minor trauma (ISS < 12); 30 patients (15%) were randomly selected to remain within the project. Four of the 204 patients were major trauma (ISS ≥ 12) but were missed from inclusion.

One-hundred and forty-two patients and 49 family members were contacted following discharge; 112 patients were major trauma (ISS ≥ 12, 78.9%) and 30 patients were non-major (ISS < 12; 21.1%). A detailed patient flow is depicted in Figure 1.

Response Rates

Ninety-three patient interviews were completed (65.5%). Of the 49 patients who were not interviewed, 44.9% (n=22) were lost to follow up despite multiple contact attempts. Twenty patients (40.8%) were unable to recall the Trauma Service so the interview was ceased at this point and three patients were undergoing cognitive assessment and therefore assent for the interview could not be gained.

Relative's interviews followed a similar pattern with 67.3% (n=33) interviews conducted. Sixteen interviews were not completed (32.7%); three family participants (18.8%) were unable to recall the Trauma Service and 11 (68.8%) were unable to be contacted after hospital discharge.

Twenty-eight patients had a family member participate whilst five family participants participated where the patient was unable to provide data.

Patient Characteristics

Patient Characteristics are summarised in Table 1. Ninety-six patients (67.6%) were male and their median age was 42 (IQR 29 – 55) years. Blunt force trauma was the major cause of injury (n=135; 95.1%) and the median ISS was 14 (IQR 12 – 21). The most frequent cause of injury was motor vehicle accidents (MVA) (n= 45; 23.9%) and motorbike accidents (MBA) (n=33; 23.2%). The median length of hospital stays (LOS) was 7.5 days (IQR 2-19). Forty-nine (34.5%) patients had an ICU admission with a median LOS of 24 hours (IQR 24 – 28). The majority of patients (n=118; 83.1%) were discharged home; (n = 8; 5.6%) required inpatient rehabilitation. Despite the small sample size, results were largely reflective of patients who were case managed by the Trauma Service during 2015.

There were minimal differences between the patients who were interviewed and those that were lost to follow up in terms of age, gender, ISS and hospital length of stay. The length of ICU stay was almost double the number of hours in the lost to follow up group compared to that of patients who were interviewed.

Participating family were mainly female (n=38; 77.6%) and the wife (n=13; 43.3%) or mother (n=8; 26.7%) of the patient; the majority cohabited with the patient (n=26 ;89.7%).

Interview Data - Likert Responses

Responses to the questions are detailed in Table 2. Across all the six items, responses indicated the majority of participants rated the communication by the Trauma Service to be excellent or very good with overall patients rating it higher than family. A difference between patient and family responses was noted within the category of 'Provision of consistent information' with 81.8% of family rating the Trauma Service excellent/very good compared with 89.2% of patients. Within the category of 'Providing links to other services', responses were the lowest rated with both patients and family rating excellence 59.1% and 45.5%. This category had the highest respondents for not applicable (11.8% and 24.2%).

Interview Data – Open Responses

The responses to open ended questions were organised into the following themes: (1) Coordination and integration of care (2) Emotional and Physical Support; and (3) Information, communication and education.

Both patients and family members reported overwhelming positive feedback regarding the Trauma Service with the majority referring to how the service had assisted in providing them with information and explaining what was to happen. Patients reported that the service provided "*a consistency across my care*" [*female patient, aged 41,non-transport injury* #39] and felt "*the service was the linchpin*" [*female patient, aged 55, non-transport injury, #P*8] of the care they received; "*They (trauma service) were brilliant, they explained everything to me,*

what was happening" [*male patient, aged 25, non-transport injury,* #P62] and "*they helped me get an overview of what was actually happening*" [*male patient, aged 59, road traffic injury,* #P46].

Feedback described that the service provided an emotional and physical comfort to patients as they felt they had extra support whilst in hospital; "*they really paid attention and were nice and caring*" [*male patient, aged 46, non-traffic injury,* #P29] and "*they took a personal interest*" [*male patient, aged 69, non-traffic injury,* #P54]. Family members were reassured by the care implemented by the service to their loved ones by referrals to other disciplines such as physiotherapy and social work and appeared to take comfort in how the service cared for the patient "*making sure that the pain relief was in place so he didn't experience discomfort*" [*wife of male patient, aged 64, non-traffic injury, # P19*] and "*I was very aware they were supporting him in the next stage*".

The feedback on communication practices from other health professionals within the hospital was highlighted by all participants but differed in nature. Patients found the numerous medical teams who provided them with information about their condition and treatment confusing stating "*too many people talking about different things*" [male patient, aged 19, non-traffic injury] and *"there was miscommunication between specialists"* [*male patient, aged 27, non-traffic injury* #P27]*; "I didn't know if I was coming or going"* [*male patient, aged 51, road traffic injury,* #P11] . However, family members raised concerns regarding trying to access the information which led to feelings of frustration and annoyance; "*I just wanted some information about his injuries which I wasn't getting*" [*mother of male patient, aged 26, road traffic injury, #P7*] and "*I would ask questions and didn't really get told anything*" [*partner of male patient, aged 26, road traffic injury,* #P57].

The differences impacted how participants felt about the discharge process. Patients found the communication around the discharge caused apprehension stating they felt "*confused*" [*male patient, aged 33, road traffic injury, #P60*; male patient, aged 56, road traffic injury, #P25] and wanted clarity regarding discharge instructions and follow-up appointments. Whereas, the

lack of access to information caused family members to experience anxiety when the patient was discharged stating they felt that it was "*too early*" [*wife of male patient, aged 40, non-traffic injury, #P118; husband of female patient, aged 67, non-traffic injury, #P 15; partner of male patient, aged 53, road traffic injury, #P21; mother of male patient, aged 26, road traffic injury, #P7*]; and "*Been in hospital for 2 months and found out they were being discharged 2 days before*" [*son of female patient, aged 81, road traffic injury, #P80*] .

DISCUSSION:

To our knowledge, this study is novel it its qualitative approach to understand both the trauma patient and their family's experiences. The results of our study found overwhelming positive feedback, by both patients and their family members, associated with the introduction of a trauma service at our institution. Communication practices demonstrated by the trauma service was rated highly by all participants with open ended responses indicating the trauma service provided a vital role not only with the coordination of the trauma patient's care but also in providing emotional and physical support to both patients and their families.

Our data demonstrates that the experience of communication practices differs for families to that of their injured relative. Families rated communication lower than the patients, highlighting dissatisfaction in accessing information from the health care team as an area that can be improved. In addition, within the category of 'Providing links to other services', almost one quarter of families responded with 'not applicable'; this suggests that they were unaware that the trauma service provided this function.

Patients found the information provided to them was more consistent when compared to the families. This is likely due to the increased opportunities for communication to occur with the clinical teams whereas families reported they had difficulty in accessing the information. This is supported by Kellezi et al. (2015) who found that carers often lacked opportunities to talk to health professionals.

Despite the information provided being rated as more consistent, the involvement of multiple clinical teams caused confusion for patients. Braaf S (2018) suggests that engaging with large numbers of health professionals from various specialities can result in variable communication effectiveness and impact the quality of care received.

The literature documents that family members of trauma patients often experience high levels of anxiety and stress which may impact on the ability to understand the information provided to them (Newcomb & Hymes, 2017). This was highlighted in our study in the number of families who failed to recall the trauma service visiting the patient during their hospital admission. In addition, poor communication with families may increase the burden that they feel regarding decision making on behalf of the patient. This predisposes family members to fatigue, anxiety and post-traumatic stress disorder (Anderson, Arnold, Angus, & Bryce, 2008). Developing strategies to include and inform family of referrals to other services, could help to alleviate some of the stress and anxiety they experience. It may also provide support for families during the discharge process, thus reducing the caregiver burden. One such strategy is the inclusion of families in bedside handover which has increased the appreciation shown by families as they have the opportunity to listen and interact as partners (Tobiano, Chaboyer, & McMurray, 2013). This should occur when family members are present but also ensure families are contacted and provided with opportunities to engage in shared decision making (IPFCC, 2017) when they are not able to attend. There are issues with privacy and confidentiality in involving families in handover and therefore patient consent should be obtained. However, previous studies have indicated that this is felt more by the nursing staff (Chaboyer et al., 2009) than patients and families (McMurray, Chaboyer, Wallis, & Fetherston, 2010).

Families are an essential part of the trauma patients' recovery with some evidence to suggest that if patients and families are treated liked a dyad then outcomes are improved (Schulz et al., 2002). With the development of Patient Centred Care (PCC) there is growing recognition that incorporating patient and family perspectives into care, represents an important untapped quality improvement opportunity (Boyd et al., 2017). The absence of guidance for patient and

family centred injury care likely reflects the limited research to date in this area (Boyd et al., 2017).

Communication is an essential part of providing safe patient care (Kitson & Muntlin Athlin, 2013) and has been highlighted to be a factor in determining satisfaction (Janssen C, 2007). In order to improve the patient and family experience it is important that we understand what patients and families want and value (Byczkowski et al., 2016). Patient reported outcome measures have a valuable role in routine clinical practice to promote PCC and can improve communication and a patient's satisfaction (Turner GM, 2019). The RESTORE study which is (B. S. Gabbe BJ, Fitzgerald M, Judson R, Harrison JE, Lyons RA, Ponsford J, Collie A, Ameratunga S, Attwood D, Chirstie N, Nunn A, Cameron PA, 2015) aimed to explore prospectively over a five-year period, injured patients views regarding trauma care delivery Patient Reported outcome Measures (PROMs). Whilst this study will assist in understanding the longer-term patient experience, routine engagement with families to understand their needs has not been addressed leaving a potential gap within the evidence base.

Limitations

This single centre project with limited resources in terms of staff and budget available to the trauma service at the time prevented use of a previously validated tool (Bobrovitz et al., 2012) ; this may have limited the external validity of our findings, but the pragmatic approach used allowed for us to collect the data to inform our practice. Despite the limited numbers of participants, the evaluation of the service within the context of the clinical area supports uptake and rapid practice change of identified areas of concern. The exploration of family views is also limited by the number of family participants and the depth to which their experiences were explored.

The convenience sampling method used can prevent comparison to the wider trauma population, yet when compared to the annual trauma service patient data (2015), we found it to be largely representative.

The high loss to follow up rates we experienced, may have been due to the prolonged duration of time between hospital discharge to patient contact (66 days patient's vs 52 days family). During the study period, ISS coding was applied after discharge from acute care which caused a delay in contacting participants. We have since changed to a prospective ISS coding model which addresses this shortcoming and we believe will reduce lost to follow-up rates in the future.

Future Research

Whilst this paper has identified different needs of trauma patients and their family members differ a further in-depth exploration will be required to more comprehensively understand this phenomenon.

CONCLUSION

This study demonstrated that patients and families were highly satisfied with service provided by the trauma service but encountered differences in the communication practices received.

Recognition and identification of the different experiences and needs following trauma can assist the development of both patient and family centred care which in turn can increase satisfaction and promote the safety and quality of health care delivered/experienced to this population. Future work should explore how the trauma service can build upon the results of this project and help to engage both the patient and the family members more effectively.

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Key Points:

The Trauma Service team is highly valued by both patients and their families, in delivering care to trauma patients and their families in terms of their high-level communication skills; their ability to coordinate care and provide emotional and physical support.

Involving trauma patients and their families in the care they receive may help to reduce the stress and anxiety often experienced by this patient group throughout their hospital admission and increase satisfaction with the care they receive.

Engaging with trauma patients and their families in ascertaining their needs remains an under explored area of trauma care delivery literature.

Figure 1: Flow Diagram of Recruitment and Follow Up Rates

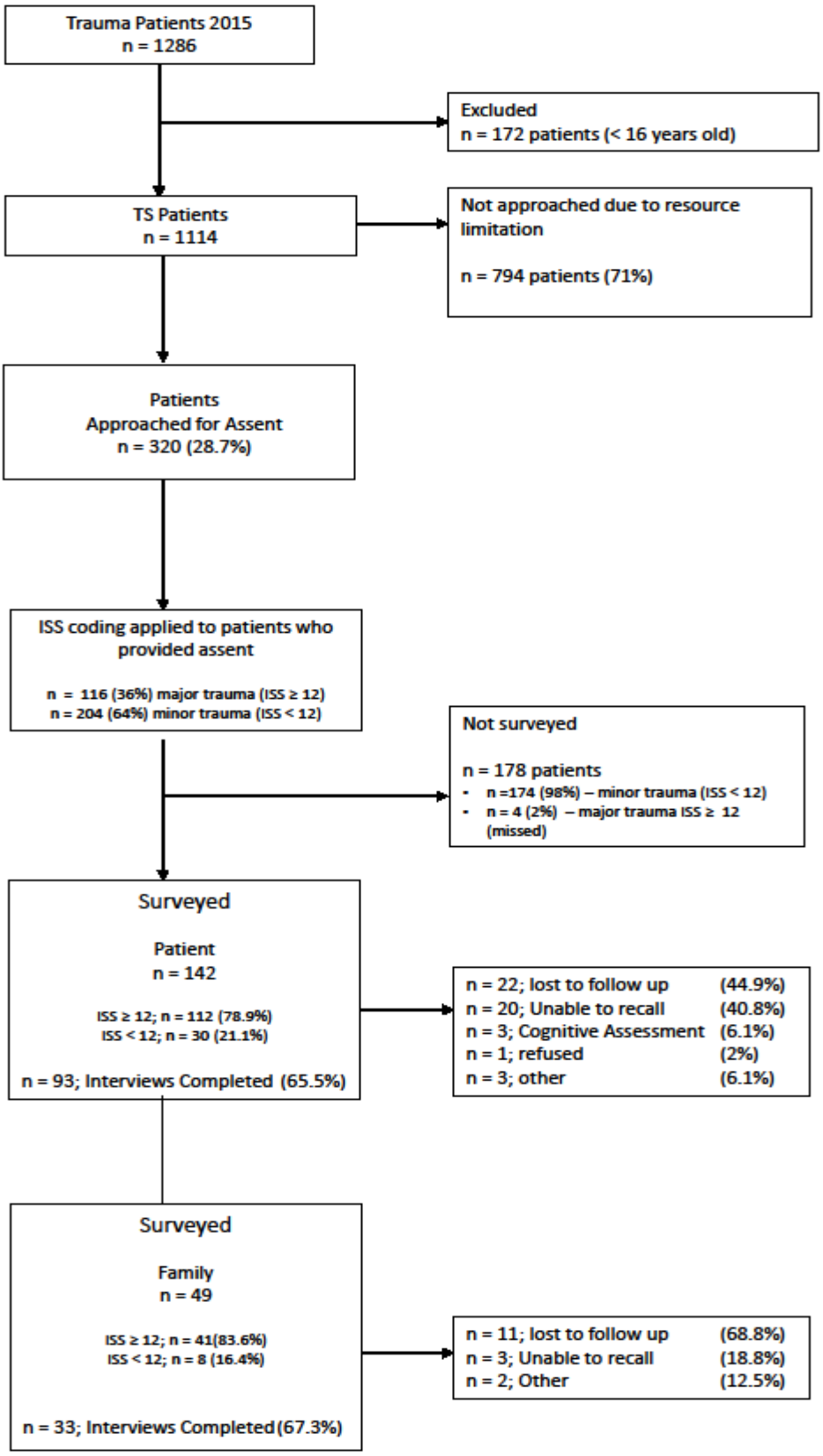

Table 1. Patient Demographic Information (n=142)

	Survey Group (*n*=142)		Lost to Follow Up (*n*=49)		All 2015 TS Patient ≥ 16 (*n*=1099)	
	n	%	*n*	%	*n*	%
Age (median, IQR)	42 (29 – 55)		39 (27 – 54)		37 (25 – 53)	
Gender - Male	96	67.6	30	61.2	788	71.7
ISS (median, IQR)	14 (12 – 21)		14 (12 – 22)		5 (1-12)	
MOI						
- **Blunt**	135	95.1	47	95.9	1012	92.1
- **Penetrating**	4	2.8	1	2	61	5.6
- **Burn**	0	0	0	0	13	1.2
- **Other**	3	2.1	1	2	13	1.2
Cause of Injury						
- **MVA**	45	31.7	16	32.7	352	32
- **MBA**	33	23.2	7	14.3	172	15.7
- **Bicycle**	10	7	5	10.2	107	9.7
- **Fall**	28	19.7	12	24.5	229	20.8
- **Other ***	26	18.3	9	18.4	239	21.8
Hospital LOS Days (median, IQR)	7.5 (2 – 19)		8 (2 – 18)		1 (0 – 4.0)	
ICU LOS Hours (median, IQR)	68.5 (44 – 150.25)		129.5 (60.75 – 230)		49 (22 – 140)	
Discharge Disposition						
- **Home**	122	85.9	46	93.9	920	83.7
- **Acute Care**	7	4.9	0	0	55	5.0
- **Rehabilitation**	9	6.3	1	2	49	4.5
- **Died**	0	0	0	0	36	3.3
- **Other**	4	2.8	1	2	39	3.5

** Assault, self-harm, water sports, animal*

Table 2. Patient/Family Responses (n and %)

	Excellent		Very Good		Good		Fair		Poor		NA	
Patients n = 93 **Family n = 33**	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Frequency of Communication												
- **Patient**	68	73.1	20	21.5	2	2.2	3	3.2	0	0	0	0
- **Family**	23	69.7	7	21.2	2	6.1	0	0	0	0	1	3.0
Provide links to services												
- **Patients**	55	59.1	17	18.3	5	5.4	4	4.3	1	1.1	11	11.8
- **Family**	15	45.5	6	18.2	3	9.1	1	3	0	0	8	24.2
Explanations provided												
- **Patients**	74	79.6	13	14.0	1	1.1	4	4.3	1	1.1	0	0
- **Family**	24	72.7	7	4.9	0	0	1	.7	1	.7	0	0
Information Provided												
- **Patients**	69	74.2	15	16.1	4	4.3	2	2.2	0	0	3	3.2
- **Family**	24	72.7	6	18.2	0	0	0	0	1	3	2	6.1
Courtesy and respect												
- **Patients**	84	90.3	4	4.3	0	0	1	1.1	1	1.1	3	3.2
- **Family**	30	90.9	3	9.1	0	0	0	0	0	0	0	0
Consistent Information												
- **Patients**	68	73.1	15	16.1	5	5.4	0	0	1	1.1	4	4.3
- **Family**	19	57.6	8	24.2	2	6.1	0	0	0	0	4	12.1

***NA – not applicable*

Supplementary
Figure 2. Patient and Family Survey Questions

Patient Satisfaction Survey Questions

Instructions to participants:

In the following questions, please identify the best response that reflects your views:

Participant Number		Date of Interview	
Did you contact the Trauma Service during your admission		○ Yes ○ No	
If so, please can you explain what the reason was for contacting the Trauma Service			
Satisfaction with Care			
How satisfied were you with how often the Trauma Service communicated to you about your condition?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor	
How satisfied where you with the way that the Trauma Service provided links to other services for you such as Social work, Physiotherapy, Occupational Therapists, Dietician etc?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor	
Information Needs			
How satisfied were you with how well the Trauma Service staff provided you with explanations that you understood?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor	
How satisfied were you with how well the Trauma Service staff informed you of what was happening to you and why things were being done?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor	
How satisfied were you with how well the Trauma Service staff demonstrated courtesy, respect and compassion to you?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor	
How satisfied are you with how well the Trauma Service staff provided consistent information?		○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair	

	○ 5 Poor
Did you contact the Trauma Service since your discharge?	○ Yes ○ No
If so, please can you explain what the reason was for contacting the Trauma Service	
How satisfied are you with the discharge information you were provided with?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair 5 Poor
Please can you add any comments or suggestions that you feel may be helpful to the staff of this hospital	

Family Satisfaction Survey Questions

Participant Number		Date of Interview	

Instructions to participants:

Please answer the following questions to help us know a little about your relationship to the patient:

Are you:

- Male
- Female

Do you live with the patient?

- Yes
- No

If no, where do you live?

- Gold Coast
- Out of Town

You are the patients:

- Wife
- Husband
- Partner
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other (please specify) ……

In the following questions, please identify the best response that reflects your views:

Did you contact the Trauma Service during your admission	○ Yes ○ No
If so, please can you explain what the reason was for contacting the Trauma Service	
Satisfaction with Care	
How satisfied were you with how often the Trauma Service communicated to you about your relatives' condition?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor

How satisfied where you with the way that the Trauma Service provided links to other services for your relative such as Social work, Physiotherapy, occupational therapists, dietician etc?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
Information Needs	
How satisfied were you with how well the Trauma Service staff provided you with explanations about your relative's condition that you understood?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
How satisfied were you with how well the Trauma Service staff informed you of what is happening to your relative and why things are being done?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
How satisfied were you with how well the Trauma Service staff demonstrated courtesy, respect and compassion to your relative?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
How satisfied are you with how well the Trauma Service staff provided consistent information?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
Did you contact the Trauma Service since your relative's discharge?	○ Yes ○ No ○
If so, please can you explain what the reason was for contacting the Trauma Service.	
How satisfied are you with the discharge information you were provided with?	○ 1 Excellent ○ 2 Very Good ○ 3 Good ○ 4 Fair ○ 5 Poor
Please can you add any comments or suggestions that you feel may be helpful to the staff of this hospital	