HIW - Patient Flow - Stroke Pathway Patient Questionnaire

**Healthcare Inspectorate Wales (HIW)**, as the independent inspectorate and regulator of healthcare in Wales, is responsible for checking that people in Wales receive good quality healthcare.

We are currently undertaking a **National Review** to assess the impact of any delay in assessment or treatment for patients. We are using the **stroke pathway** to assess the quality of patient flow. We want to understand what is being done to mitigate any harm to those awaiting care and how the quality and safety of care is being maintained throughout the stroke pathway.

**Your experience** will help us to identify good practice and improvements where required, to provide better care for patients in Wales.  
  
**Please help us by completing this short questionnaire**. You should only complete this questionnaire if you, someone you care for or a family member has been taken to hospital with symptoms of a stroke in the last year.

The questionnaire is anonymous so no-one will be able to identify you from your answers.The summary of results will be used alongside any evidence collected through our fieldwork as part of our overall findings.

Alternatively you can complete our online survey which you can access through the QR provided (using the camera or scanner on your phone).

**Thank you for your help**.

|  |  |  |
| --- | --- | --- |
|  | **Could you tell us in what capacity you are completing the form?**  (Please tick all that apply) | |
|  | I am a patient |  |
|  | I am a relative / carer of a patient |  |
|  | Other (please specify) |  |

|  |  |  |
| --- | --- | --- |
|  | **Before you had your stroke, had you considered yourself to be at risk of having a stroke?** | |
|  | Yes |  |
|  | No |  |
|  | Not considered it |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | **Before you had your stroke, had you discussed the potential risk factors of a stroke with a healthcare professional?** | | |
|  | | Yes - GP |  | |
|  | | No |  | |
|  | Yes - other (please specify) | | |  |

|  |  |
| --- | --- |
|  | **In which local authority area do you live** |
|  |  |

Thinking of the last visit you made to hospital with stroke symptoms, please answer the following questions.

|  |  |  |
| --- | --- | --- |
|  | **When did you attend hospital with stroke symptoms?** | |
|  | Pre March 2020 |  |
|  | Between March 2020 to March 2021 |  |
|  | After March 2021 |  |

|  |  |  |
| --- | --- | --- |
|  | **What kind of stroke did you have?** | |
|  | Haemorrhagic (bleed on the brain) |  |
|  | Ischaemic (clot on the brain) |  |
|  | Not sure |  |

|  |  |  |
| --- | --- | --- |
|  | **How long after the onset of symptoms did you contact healthcare services?** | |
|  | As soon as I started to experience symptoms |  |
|  | Within the first 4 hours |  |
|  | Within 24 hours |  |
|  | Over 24 hours |  |

|  |  |  |
| --- | --- | --- |
|  | **How did you travel to the hospital?** | |
|  | In an ambulance |  |
|  | Other (please describe) |  |

**Travelling by Ambulance***Only complete the section (questions 9 – 10) if relevant. If you not, please skip to question 11.*

|  |  |  |
| --- | --- | --- |
|  | **How long did you wait for the ambulance to get to you?** | |
|  | Less than 30 minutes |  |
|  | 30 minutes to 1 hour |  |
|  | 1 hour to 2 hours |  |
|  | 2 hours to 4 hours |  |
|  | Over 4 hours |  |

|  |  |  |
| --- | --- | --- |
|  | **Did your symptoms become worse while waiting for the ambulance?** | |
|  | Yes |  |
|  | No |  |

**Arrival at Hospital**

|  |  |  |
| --- | --- | --- |
|  | **Which hospital did you attend?** | |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **How long before you arrived at hospital did the symptoms start?** | |
|  | Less than an hour |  |
|  | Hour to 4 hours |  |
|  | Over 4 hours |  |
|  | Not known |  |

**Assessment**

|  |  |  |
| --- | --- | --- |
|  | **How soon after arriving at hospital were you seen by a nurse or doctor?** | |
|  | Within 15 minutes |  |
|  | Between 15 minutes and an hour |  |
|  | Over an hour |  |
|  | I don't know / I was too unwell to notice |  |

|  |  |  |
| --- | --- | --- |
|  | **How long did you wait before receiving a scan, after your arrival at hospital?** | |
|  | Less than 30 minutes |  |
|  | 30 minutes to an hour |  |
|  | Over an hour |  |
|  | I didn't have a scan |  |
|  | Don't know / I was too unwell to notice |  |

**Your Treatment**

|  |  |  |
| --- | --- | --- |
|  | **What treatment did you have?** | |
|  | Clot busting medication (Thrombolysis) |  |
|  | Surgery (Thrombectomy) |  |
|  | Oral Medication |  |
|  | Not known |  |
|  | Other (please specify): |  |

|  |  |  |
| --- | --- | --- |
|  | **Were you transferred to another hospital for your treatment?** | |
|  | Yes |  |
|  | No |  |
|  | Not sure |  |

**Other Hospital**

*Only complete section (questions 17 – 19) if relevant. If you not, please skip to question 20.*

|  |  |  |
| --- | --- | --- |
|  | **Why were you transferred to another hospital?** | |
|  | For specialist care |  |
|  | For rehabilitation |  |
|  | Oral Medication |  |
|  | Not sure |  |
|  | Other (please specify): |  |

|  |  |  |
| --- | --- | --- |
|  | **Which hospital were you transferred to?** | |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **How long did you wait for your transfer?** | |
|  | Within 24 hours |  |
|  | Over 24 hours |  |
|  | Not sure |  |

**Stay at Hospital**

|  |  |  |
| --- | --- | --- |
|  | **Did you stay at the hospital?** | |
|  | Yes, on a stroke ward |  |
|  | Yes, not on a stroke ward |  |
|  | No |  |

*Only complete section (questions 21 – 23) if relevant. If not, please skip to question 24.*

|  |  |  |
| --- | --- | --- |
|  | **What was your length of stay at hospital?** | |
|  | Less than a week |  |
|  | A week to a month |  |
|  | A month to 6 months |  |
|  | Over 6 months |  |
|  | Still in hospital |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **To what extent do you agree or disagree with each of the following statements:** | | | | | |
|  | | Stron-gly agree | Agree | Dis-agree | Stron-gly dis-agree | N/A |
| Staff treated me with dignity and respect | |  |  |  |  |  |
| Staff provided care to me when I need it | |  |  |  |  |  |
| I had time to eat my food at my own pace | |  |  |  |  |  |
| Staff helped me to eat and drink if I needed assistance | |  |  |  |  |  |
| I always had access to water on the ward | |  |  |  |  |  |
| Staff helped me with my toilet needs in a sensitive way | |  |  |  |  |  |
| I always had access to a buzzer that I could use | |  |  |  |  |  |
| When I used the buzzer, staff came to me | |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Did you feel that the ward was appropriate for your care and treatment needs?** | |
|  | Yes |  |
|  | No |  |

**Your Care**

|  |  |  |
| --- | --- | --- |
|  | **Did you feel that you were listened to by staff regarding your health, care and treatment needs?** | |
|  | Yes |  |
|  | Sometimes |  |
|  | No |  |

|  |  |  |
| --- | --- | --- |
|  | **Did you feel that you were given enough information to help you understand your health, care and treatment?** | |
|  | Yes |  |
|  | No |  |

|  |  |  |
| --- | --- | --- |
|  | **Were you involved as much as you wanted to be in decisions about your health, care and treatment?** | |
|  | Yes |  |
|  | No |  |
|  | Not applicable - too unwell |  |

|  |  |  |
| --- | --- | --- |
|  | **Were your family/ friends involved as much as you wanted to be in decisions about your health, care and treatment?** | |
|  | Yes |  |
|  | Sometimes |  |
|  | No |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **Did you receive the therapies and health intervention that you needed whilst at hospital?**  For example physiotherapy or speech and language therapy | |
|  | Yes, as much as I needed |  |
|  | Yes but not as much as I needed |  |
|  | No |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **Were you aware of any delays at any point during your care and treatment?** | |
|  |  |  |

**Discharge**

|  |  |  |
| --- | --- | --- |
|  | **Did hospital staff ask about your home circumstances when planning your discharge from hospital?** | |
|  | Yes |  |
|  | No |  |
|  | **Did hospital staff discuss your discharge plans with family and friends?** | |
|  | Yes |  |
|  | No |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **Were you able to share any concerns you had about your discharge with staff?** | |
|  | Yes |  |
|  | No |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **When completing this survey, what is your status?** | |
|  | I am still in hospital |  |
|  | I have been discharged |  |

**Discharge from Hospital**

*Only complete section (questions 34 – 39) if relevant. If you not, please skip to question 40.*

|  |  |  |
| --- | --- | --- |
|  | **Did you have to wait for a social care package?** | |
|  | Up to a week |  |
|  | Between a week and a month |  |
|  | Between a month and three months |  |
|  | Over three months |  |
|  | No wait |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **Did you feel that the timing of your discharge was appropriate?** | |
|  | Yes |  |
|  | No - I was discharged too soon |  |
|  | No - there were delays in my discharge |  |
|  | Comments: |  |

|  |  |  |
| --- | --- | --- |
|  | **Where were you discharged to?** | |
|  | Own home |  |
|  | Care home |  |
|  | Other hospital |  |
|  | Rehabilitation ward |  |
|  | Relative's home |  |
|  | Other (please specify): |  |

|  |  |  |
| --- | --- | --- |
|  | **Were you provided with an aftercare information pack when you left hospital?**  This could include leaflets/ contact details/ support groups available to access when home e.g. Stroke Association | |
|  | Yes |  |
|  | Yes, but it did not include everything I needed |  |
|  | No |  |

|  |  |  |
| --- | --- | --- |
|  | **When preparing for discharge, were you made aware of any medication that you needed to take when home?** | |
|  | Yes |  |
|  | No |  |
|  | Not applicable |  |

|  |  |  |
| --- | --- | --- |
|  | **Following your discharge, did you receive the therapies and health care that you needed?**  Such as follow up review with stroke consultant, ongoing therapies, mental health referral. | |
|  | Yes |  |
|  | Yes, but not all that I needed |  |
|  | No |  |
|  | Not applicable |  |

**Language**

|  |  |  |
| --- | --- | --- |
|  | **Which is your preferred language?** | |
|  | Welsh |  |
|  | English |  |
|  | Other (please specify) |  |

**Welsh Language**

*Only complete. Section(questions 41 – 43) if relevant. If not, please skip to question 44.*

|  |  |  |
| --- | --- | --- |
|  | **Were you actively offered the opportunity to speak Welsh throughout your patient journey?** | |
|  | Yes |  |
|  | Sometimes |  |
|  | No |  |
|  | If yes, did that make a difference to you? |  |

|  |  |  |
| --- | --- | --- |
|  | **Did you feel comfortable using Welsh within the hospital/ward, regardless of whether you were asked your language preference?** | |
|  | Yes |  |
|  | No |  |

|  |  |  |
| --- | --- | --- |
|  | **Was healthcare information available to you in your preferred language?** | |
|  | Yes |  |
|  | No |  |
|  | Not applicable |  |

**Overall Experience**

|  |  |  |
| --- | --- | --- |
|  | **Overall, how would you rate the service you received?** | |
|  | Very good |  |
|  | Good |  |
|  | Poor |  |
|  | Very poor |  |

|  |  |  |
| --- | --- | --- |
|  | **How could the NHS improve the service it provides to stroke patients?** | |
|  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Is there anything else that you would like to tell us about the service you received?** | |
|  |  |  |

**Use of responses**

We will present our findings in an inspection report, which will be published on our website: [**www.hiw.org.uk**](http://www.hiw.org.uk/).

We often use real comments from patients in our reports to show the general public what patients are saying about the quality of the service provided. The comments are anonymous as we do not know who has completed each questionnaire.

|  |  |  |
| --- | --- | --- |
|  | **Do you agree that HIW can use the comments that you may have provided in the free text boxes of this questionnaire within its inspection report?** | |
|  | Yes |  |
|  | No |  |

**Equality**

|  |  |  |
| --- | --- | --- |
|  | **Do you feel you can access the right healthcare at the right time?**  (Regardless of your Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation) | |
|  | Yes |  |
|  | No |  |
|  | Prefer not to say |  |
|  | Comments: |  |

|  |  |  |
| --- | --- | --- |
|  | **Have you faced discrimination when accessing or using this health service on grounds of:** | |
|  | No | |
|  | Age |  |
|  | Disability |  |
|  | Gender reassignment |  |
|  | Marriage and civil partnership |  |
|  | Pregnancy and maternity |  |
|  | Race |  |
|  | Religion or belief |  |
|  | Sex |  |
|  | Sexual orientation |  |
|  | Other |  |
|  | Prefer not to say |  |
|  | Comments: |  |

**Tell Us About You**

|  |  |  |
| --- | --- | --- |
|  | **Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?** *What we mean by ‘physical and mental health conditions or illnesses’ – This is about health conditions, illnesses, or impairments you may have. Consider conditions that always affect you and those that flare up from time to time. These may include for example, sensory conditions, developmental conditions or learning impairments.* | |
|  | Yes |  |
|  | No |  |
|  | Prefer not to say |  |

|  |  |  |
| --- | --- | --- |
|  | **What is your age?** | |
|  | 17 or younger |  |
|  | 18-29 |  |
|  | 30-49 |  |
|  | 50-69 |  |
|  | 70 and above |  |
|  | Prefer not to say |  |

|  |  |  |
| --- | --- | --- |
|  | **What is your sex?**  *A question about gender identity will follow* | |
|  | Female |  |
|  | Male |  |
|  | Prefer not to say |  |

|  |  |  |
| --- | --- | --- |
|  | **Is the gender you identify with the same as your sex registered at birth?** | |
|  | Yes |  |
|  | No |  |
|  | Prefer not to say |  |
|  | Enter gender identity, if you wish: | |

|  |  |  |
| --- | --- | --- |
|  | **Which of the following best describes your sexual orientation?** | |
|  | Heterosexual or Straight |  |
|  | Gay or Lesbian |  |
|  | Bisexual |  |
|  | Prefer not to say |  |
|  | Other sexual orientation |  |

|  |  |  |
| --- | --- | --- |
|  | **What is your religion?** | |
|  | No religion |  |
|  | Christian *(including church of England, catholic, protestant and all other Christian denominations)* |  |
|  | Buddhist |  |
|  | Hindu |  |
|  | Jewish |  |
|  | Muslim |  |
|  | Sikh |  |
|  | Prefer not to say |  |
|  | Any other religion: |  |

|  |  |  |
| --- | --- | --- |
|  | **What is your ethnic group?** | |
|  | White |  |
|  | Mixed/Multiple ethnic groups |  |
|  | Asian/Asian British |  |
|  | Black/African/Caribbean/Black British |  |
|  | Other ethnic group, please describe: |  |
|  | Prefer not to say |  |

**Thank you for completing this questionnaire.**

If you would like to speak to HIW to discuss any aspects of the care you have received at this dental practice or any elements of this questionnaire, please ring **0300 062 8163** or send us an email at [**hiw@gov.wales**](mailto:hiw@gov.wales)**.**

Information on our legal duties in relation to the data collected in this survey can be found on our website:[**https://hiw.org.uk/privacy-policy**](https://www.hiw.org.uk/privacy-policy)