



RESIDENT FEEDBACK SURVEY

Welcome to the Sun Parlor Home's 1st Resident Feedback Survey!

The completed survey can be mailed back in the envelope provided or you can drop it off in the Bank Mail Slot before Friday, February 14, 2014.

Thank you for taking the time to complete this survey. Your feedback will help us improve the care and services we provide our residents. We value your opinions – whether they are positive or negative. We also appreciate any comments and suggestions.

Rest assured that the answers to this survey will be treated confidentially and where applicable in accordance with the Personal Health Information Protection Act (PHIPA). Your name, room number and date of birth will not appear anywhere on this survey. All results will be collated by an independent analyst to maintain feedback integrity. Please complete only ONE of EITHER this paper version or the on-line version at <https://www.surveymonkey.com/s/SPHResidentFeedbackSurvey2014>.

If at any time, you would like to stop, or have something to say, please feel free to interrupt me.

ANSWER KEY:

Yes = MOST or ALL of the time

Sometimes = SOME of the time, Not always

No = RARELY or NEVER

N/A = Question does not apply to you

Don't Know = You don't have enough information to answer the question

[VOLUNTEER INSTRUCTIONS: Unless otherwise indicated, if response is Sometimes/No, please ask resident to provide specific details in Comments section below the question.]

1. SURVEY COMPLETED BY	
<input type="checkbox"/>	Resident
<input type="checkbox"/>	Completed on Behalf of Resident (example: volunteers, students, staff, etc.)
<input type="checkbox"/>	Completed by Family Member/Friend/Third Party

RESIDENT ACTIVITIES		YES	SOMETIMES	NO	N/A	DON'T KNOW
2.	Do you participate in the activities offered by the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	If NO, is this important to you?	<input type="checkbox"/>		<input type="checkbox"/>		
4.	Do the organized activities meet your interests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESIDENT ACTIVITIES		YES	SOMETIMES	NO	N/A	DON'T KNOW
5.	Do we offer activities at an appropriate time? a) If SOMETIMES/NO, when is the best time to offer activities? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you provided input or suggestions for activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	a) If YES/SOMETIMES, did anyone follow up with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Are holidays, personal anniversaries (weddings, birthdays) and important anniversaries (insert names) celebrated and recognized appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you receive assistance, such as supplies, books, etc., from the Home for things you like to do (example: reading, writing letters, computer, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are there any comments you wish to make about the resident activities offered at the home? _____ _____						
11. Are there specific activities/outings/special events that you would like to see offered that are not currently available? _____ _____						

SERVICES		YES	SOMEWHAT	NO	N/A	DON'T KNOW
12.	Do the therapy programs assist you to be as independent as possible (e.g. <i>Physiotherapy, Occupational Therapy, etc.</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Are you satisfied with the care provided by your doctor? (If resident doesn't have a doctor, rate as N/A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Are you satisfied with the care provided by the nurse practitioner? (If resident doesn't have a nurse practitioner, rate as N/A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Are you satisfied with the services provided by the Pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Are you satisfied with the services provided by the Dental Clinic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SERVICES		YES	SOMEWHAT	No	N/A	DON'T KNOW
17.	Do we meet your religious and spiritual needs? [If resident doesn't have spiritual needs, rate as N/A]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Are you satisfied with the hair dresser services offered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Can you get money from your trust fund/on-site bank when you need it, including on weekends? a) If SOMETIMES/NO, what times are most suitable? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Are there any comments you wish to make about the services provided at the home? _____ _____ _____						

INFORMATION AND COMMUNICATION		YES	SOMETIMES	No	N/A	DON'T KNOW
21.	Are you informed of your condition and treatment plan by the members of your care team (<i>includes doctor, nurses, physiotherapist, etc.</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Are you involved in decisions about your care and daily routine (food preferences, sleeping, dressing and bathing schedules)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Do you feel comfortable expressing your feelings and opinions to staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Do you receive monthly statements of account of transactions in your trust account and for your accommodation charges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Are there any comments you wish to make about information and communication at the home? _____ _____ _____						

DIGNITY		YES	SOMETIMES	No	N/A	DON'T KNOW
26.	Do you feel that staff and volunteers treat you with respect, politeness and courtesy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Does the staff follow up on your requests in a timely manner (<i>e.g. call bells, concerns/complaints</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Do you avoid providing feedback for fear of retaliation (<i>e.g. abuse, withholding care, discharge</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIGNITY		YES	SOMETIMES	No	N/A	DON'T KNOW
	If yes or sometimes, please provide details: _____ _____ _____					
29.	Do we respect your personal privacy (knocking before entering your room) and physical privacy (privacy curtains drawn during personal care)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Are there any comments you wish to make about the level of respect you are shown at the home? _____ _____						

SAFETY AND SECURITY		YES	SOMETIMES	No	N/A	DON'T KNOW
31.	Within the last 12 months, have you been mistreated verbally or physically in the home?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32.	If YES, was the situation handled to your satisfaction? Please provide details:_____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33.	Within the last 12 months, have you had any missing personal items (clothing, jewellery, money, etc.)?	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.	a) If YES, was the situation handled to your satisfaction? Please provide details:_____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.	Within the last 12 months, have you been treated roughly by staff? If yes, please provide details:_____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.	Do you feel safe in the home and on the home's external property (courtyards, patios, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SAFETY AND SECURITY		YES	SOMETIMES	No	N/A	DON'T KNOW
37. Are there any comments you wish to make about safety and security at the home?						

BUILDING AND ENVIRONMENT		YES	SOMETIMES	No	N/A	DON'T KNOW
38.	Is the temperature comfortable for you day and night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39.	Is the lighting adequate for you in all areas of the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40.	Is the noise level acceptable day and night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41.	Is the home clean and well maintained (<i>for example, repairs, decorating, or painting</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42.	Is your room clean and tidy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43.	Are your clothes cleaned and returned within two days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. If you could improve one thing in your home environment, what would it be?						

FOOD		YES	SOMETIMES	No	N/A	DON'T KNOW
45.	Are you offered a choice at meal times (main entrée and beverage)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46.	Does the food taste good and look appetizing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47.	Is the food served at the proper temperature (<i>e.g. is hot food hot and cold food cold</i>)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48.	Are snacks and beverages being offered between meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49.	Do you feel rushed through your meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50.	Is the overall dining experience pleasurable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Are there any comments you wish to make about the food or food services at the home?						

RESIDENT CARE		YES	SOMETIMES	NO	N/A	DON'T KNOW
52.	Do you currently have any discomfort, or have you had discomfort such as pain, heaviness, burning or hurting with no relief? If Yes or Sometimes, please provide details: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53.	Do the staff help you clean your teeth (as necessary)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54.	What type of teeth do you have? <input type="checkbox"/> No dentures (your own teeth) <input type="checkbox"/> Full dentures <input type="checkbox"/> Partial dentures					
55.	Do the staff help you with your nail care (as necessary)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56.	If you are currently using a bladder control brief, is it well concealed under your clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57.	Is the bladder control brief comfortable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58.	Does the bladder control brief meet your bladder control needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59.	Are there any comments you wish to make about your personal care? _____ _____ _____					

OVERALL QUALITY OF CARE		YES	SOMETIMES	NO	N/A	DON'T KNOW
60.	Are you provided care and treatment in the official language of your choice (English or French)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61.	Do you feel there is enough staff available to provide the care and assistance needed without having to wait a long time? a) If SOMETIMES/NO, specify the care/assistance needed and the time of day this usually happens: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.	Do you feel that your personal care providers know your care routine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.	Are your overall care needs being met?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.	Overall, how would you rate the quality of care and services you receive?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Terrible <input type="checkbox"/>

OVERALL QUALITY OF CARE	YES	SOMETIMES	No	N/A	DON'T KNOW
65. Are there any comments you wish to make about the overall quality of care you receive?					

SMOKING	YES	MAYBE	No
66. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. If no, are you satisfied with the current smoking locations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. If yes, are you satisfied with the current smoking locations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL QUESTIONS	YES	MAYBE	No
69. Would you recommend our home to a family member or friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. What do you like most about the home?			

71. Do you have suggestions for improvement for the home?			

RESIDENT'S DEMOGRAPHIC INFORMATION	
72. Residential Home Area	I live in this area of the Home: <input type="checkbox"/> 4 East <input type="checkbox"/> 3 East <input type="checkbox"/> 3 West <input type="checkbox"/> 2 East <input type="checkbox"/> 2 West <input type="checkbox"/> 2 South <input type="checkbox"/> 1 South <input type="checkbox"/> 1 West (Special Care)
73. Duration of stay	I have lived in this Home for: <input type="checkbox"/> Less than 5 months <input type="checkbox"/> 6-11 months <input type="checkbox"/> 1-4 years <input type="checkbox"/> 5 years and over

Thank you for your feedback!