Appendix B6: Feedback Form

Australian Government
Australian Institute of Health and Welfare

Pilot Community-based Palliative Care Client Data Collection 2006

Feedback Form

Information provided on this feedback form will help to ensure that future collections can be improved and made more user-friendly to complete.

The feedback provided by palliative care agencies will be collated and may be included in a national report. Please be assured that all feedback will be treated with strict confidentiality and feedback cited in published sources will not be identifiable.

If possible, complete one form on behalf of your agency's experience. If this is not possible, you can submit multiple copies.

If you have any concerns or need any help completing this form, please contact the Helpline on 1800 443 182 or pcdwgsec@aihw.gov.au

Please return this feedback form and the other completed client forms to your state/territory returning officer (see Guidelines document page 13).

Please complete:

AGENCY NAME: _____

AGENCY IDENTIFIER: _____

***CONTACT NAME/PHONE:** _____

* *(Optional)* A member of the project team may contact you to discuss your answers in this form.

Note that additional comments on questions 1-7 below can be provided at question 10 (page 3) of this form.

1. Overall, how easy/difficult did your agency find the survey form to complete? e.g. survey form layout, questions easy to comprehend.

very easy **1** **2** **3** **4** **5** **very difficult**

2. Did you use the guidelines document? **YES / NO**

   If yes, how helpful did you find the Guidelines document?

very helpful **1** **2** **3** **4** **5** **not helpful**

3. Did anyone in your agency access the collection help line and/or the collection help website?

YES / NO **If yes, which?** **HELPLINE/WEBSITE**

   If so,

   HELPLINE—how helpful was this service?

very helpful **1** **2** **3** **4** **5** **not helpful**

   WEBSITE—how helpful was this service?

very helpful **1** **2** **3** **4** **5** **not helpful**

4. Appendix A of the Collection Guidelines provides information on 'Letters of name'. From the information provided, would your agency be able to report letters of name for patients? If yes, how would it be collected and recorded?

YES / NO

(If yes).....

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5. Is your agency able to report on the statistical local area (SLA) of the place of usual residence of the patient receiving palliative care? (see Appendix A of the Guidelines for more information).

YES / NO

(If yes).....

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6. Approximately how many clients refused consent and therefore did not participate in this collection?

7. Service contacts—Questions 5 and 6 on Form C collect information about the purpose of each service contact. What information (if any) does your agency systematically record about service contacts? Is your agency able to record information about the types of assistance provided in more detail, e.g. medical care, nursing care, physiotherapy, domestic assistance, etc. If so, do you record the primary (main) type of assistance or all types of assistance?

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8. We are interested in learning more about your agency's practices in relation to admitting/discharging patients. For example, are patients discharged every time they go to hospital? If not, in what circumstances are they discharged? Is a comprehensive assessment routinely undertaken for patients returning from hospital or other care?

9. We are also interested in learning more about bereavement support and bereavement counselling that is provided by palliative care agencies—including when and how it is provided. For example, does your agency provide bereavement support and/or bereavement counselling? Under what circumstances is a new client record created for a carer/family/friend who is receiving bereavement support or bereavement counselling?

10. General comments on the Pilot Community-based Palliative Care Client Data Collection:

The following table lists selected questions that formed the Pilot Community-based Palliative Care Client Data Collection. For each question, note whether you had difficulties understanding the question, the guidelines to the question, and answering the question. If your agency's response is ***Yes*** to any of these questions, please provide further explanation in the space provided.

	Did you have difficulty <u>understanding or answering</u> this question or the corresponding guidelines for this question?
Client ID (identifier)	**YES/NO** Comments .....

	Did you have difficulty <u>understanding or answering</u> this question or the corresponding guidelines for this question?
FORM A (Patient Details)	
A2. Date of birth and date of birth accuracy indicator	YES/NO Comments .....
A5. Indigenous status	YES/NO Comments .....
A8. Living arrangements	YES/NO Comments .....
A9. Carer availability status	YES/NO Comments .....
A10. Co-residency status of patient's main carer	YES/NO Comments .....
A11. Main carer's relationship to the patient	YES/NO Comments .....
FORM B (Episode of Palliative Care)	
B2. Source of referral to agency	YES/NO Comments .....
B3. Episode start date	YES/NO Comments .....
B4. Patient's principal diagnosis	YES/NO Comments .....
B5. Phase of care at first assessment	YES/NO Comments .....

	Did you have difficulty <u>understanding or answering</u> this question or the corresponding guidelines for this question?
B6. Episode end date	YES/NO Comments .....
B7. Reason for ending episode	YES/NO Comments .....
B8. Date of death and date of death accuracy indicator	YES/NO Comments .....
B9. Place of death	YES/NO Comments .....
FORM C (Episode of Palliative Care Service Contact)	
C2. Service recipient type	YES/NO Comments .....
C3. Service delivery setting	YES/NO Comments .....
C4. Session type	YES/NO Comments .....
C5. Main purpose of service contact	YES/NO Comments .....
C6. Other purpose(s) of service contact	YES/NO Comments .....
C7a–10a. Occupation of service providers 1-4	YES/NO Comments .....

	Did you have difficulty <u>understanding or answering</u> this question or the corresponding guidelines for this question?
C7b–10b. Is service provider a specialist palliative care provider 1-4	YES/NO Comments .....
C7c–10c. Contact method of service providers 1-4	YES/NO Comments .....
FORM D (Episode of Grief and Bereavement Counselling)	
D1. Episode start date	YES/NO Comments .....
D2. Episode end date	YES/NO Comments .....
D3. Date of death of patient and accuracy indicator	YES/NO Comments .....
D1a–5a Service contact date 1–5	YES/NO Comments .....
D1b–5b Session type 1–5	YES/NO Comments .....
D1c–5c Type of assistance provided 1–5	YES/NO Comments .....
D1d–5d Occupation of service provider 1–5	YES/NO Comments .....
D1e–5e Contact method of service provider 1–5	YES/NO Comments .....

The suggestions and comments made by your agency are invaluable and much appreciated.
THANK YOU!