



Tunbridge Wells
& District

ABI SERVICE USERS QUALITY QUESTIONNAIRE

The purpose of this Questionnaire is to obtain feedback on the quality of NHS and community services currently available for those with an Acquired Brain Injury (ABI) and their carers. This will be used to guide and improve the current level of support.

The Questionnaire is the result of collaborative work between Headway Tunbridge Wells & District, KABIF (Kent Acquired Brain Injury Forum), the West Kent Primary Care Trust, Kent Community Health NHS Trust and other associated organisations.

The Questionnaire is open to anyone with a brain injury and/or their carer. Please let us know if you would like extra copies.

The information you provide on this questionnaire will be treated **confidentially**. Any comments taken from this questionnaire and used in reports will not be identified in any way.

Should you require any further information regarding this questionnaire or require some assistance completing it, do not hesitate to call Headway Tunbridge Wells on 01892 619001 and ask to speak to Di Drummond.

Please complete the form and return to:
The Manager – Confidential
Headway Tunbridge Wells & District
3 Culverden Park
Tunbridge Wells
TN4 9QT

***Please return the questionnaire within three weeks from the day
you receive the form***

Thank you for your participation

ABI Service User Questionnaire

Please complete the questionnaire from your own experience and perspective and tick all boxes relevant to you

Please write the first part of your postcode here eg TN1

Date

Which organisation sent you this questionnaire?

SECTION 1: ABOUT YOU

1.1 Are you?

- An individual with an acquired brain injury
Related to a person with an acquired brain injury
A carer

1.2 Are you or the person you care for (i.e. the person with an acquired brain injury)

- You Male Female
The person with ABI Male Female

1.3 What is your age or the person you care for (i.e. the person with an acquired brain injury)?

- You 10-25 26-40 41-60 61+
The person with ABI 10-25 26-40 41-60 61+

1.4 What is your ethnicity and that of the person you care for? (i.e. the person with an acquired brain injury) *Please circle once or twice the appropriate group*

- White** British Irish Other White
Mixed White & Black Caribbean White & Black African White & Asian Other
Asian or Asian British Indian Pakistani Bangladesh Other Asian
Black or Black British Caribbean Black African Other Black
Chinese or other Ethnic group Chinese Other

SECTION 2: ABOUT THE BRAIN INJURY

2.1 At what age was the brain injury sustained? _____

2.2 When did the injury occur?

- Up to 1 year ago
1 - 2 years ago
3 - 5 years ago
6 - 10 years ago
More than 10 years ago

2.3 Was it: Acquired Brain Injury Traumatic Brain Injury

Acquired brain injury - defined as any brain injury that has occurred since birth. There are many possible causes, including stroke, haemorrhage, infection, hypoxic/anoxic brain injury and medical interventions

Traumatic Brain injury - damage to the brain through the head receiving a severe blow or jolt, for example in an accident, fall or assault

2.4 How did the injury occur?

.....

SECTION 3: INITIAL NHS TREATMENT

3.1 Where was initial **HOSPITAL** treatment given?

Local to you Hospital Name

London Hospital Name.....

Other Hospital Name.....

3.2 Please tick any specialist unit where treatment was received.

A & E Intensive Care Unit Neurological Unit

General Hospital Ward If Other - please indicate

3.3 Were you given information about the brain injury?

Yes No

If YES, please tick all departments that provided you with information

A & E Intensive Care Unit Neurological Unit

General Hospital Ward If Other - please indicate

3.4 If you didn't understand anything in the information or whilst treatment was taking place, did staff help by explaining terms?

Yes No

3.5 Did staff explain the likely outcome of the brain injury?

Yes No

3.6 Did you receive information about rehabilitation?

Yes No

If YES, please tick all departments that provided you with information

A & E Intensive Care Unit Neurological Unit

General Hospital Ward PALS (Patient Advice & Liaison Service)

Other - please indicate

3.7 Did you receive information about Social Services?

Yes No

If YES, please tick all departments that provided you with the information

A & E Intensive Care Unit Neurological Unit

General Hospital Ward PALS Social Services

Other - please indicate

- 3.8 Did you receive information about any Community Support Services?
 Yes No
 What Service?
- If YES, please tick which departments provided you with the information
 A & E Intensive Care Unit Neurological Unit
 General Hospital Ward PALS Social Services
 Other - please indicate
- 3.9 Did you receive any financial advice or information on benefits and costs of care and, if appropriate, legal contacts?
 Yes No
 If YES, please tick which departments provided you with the information
 A & E Intensive Care Unit Neurological Unit
 General Hospital Ward PALS Social Services
 Other - please indicate
- 3.10 When information was provided, in what form was it delivered?
 Verbal
 E-mail
 Leaflets
 Booklets
 Other - please indicate
- 3.11 When information is provided how would you have preferred to receive it?
 Verbal
 E-mail
 Leaflets
 Booklets
 Other - please indicate
- 3.12 Which of the following therapies if any, did you receive whilst in hospital
 Physiotherapy
 Speech and language therapy
 Occupational therapy
 None
 Other - please indicate
- 3.13 On a scale of 1-5 how satisfied were you with the services you received during the initial NHS treatment?
 1 very dissatisfied
 2 fairly dissatisfied
 3 neither satisfied nor dissatisfied
 4 fairly satisfied
 5 very satisfied

SECTION 4: TREATMENT ON DISCHARGE

4.1 After you were DISCHARGED was rehabilitation given in any of the following settings?

- | | | | | |
|----------------------------|-----|--------------------------|----|--------------------------|
| Outpatient rehabilitation | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Residential settings | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Community rehab unit | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Long term residential care | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If you answered YES to any category in question 4.1 please answer the following questions.

If you answered NO to ALL categories in question 4.1, please go to Section 5

4.2 How quickly was rehabilitation provided in one of the settings in question 4.1?

- Within 1 month
- Within 2 months
- Within 4 months
- Within 6 months
- More than 6 months

4.3 Where was the rehabilitation provided?

- London
- Kent
- Sussex
- Surrey
- Other please indicate

Please provide details of the location e.g. which hospital

.....

4.4 For each type of therapy please answer yes or no as appropriate.

Therapy	Did you receive treatment?	Did you think your treatment was long enough?	Were achievable goals set?	Were you involved in this process?
Consultant Neurorehabilitation	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Clinical Neuropsychologist	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Psychologist	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Occupational Therapist	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Speech & Language Therapist	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Physiotherapist	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Social Worker	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>

Case Manager	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Nurse	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
Other, please give details				

Please use the space below to provide any further comments on the above services.

4.5 On a scale of 1-5 how satisfied were you with the services you received on discharge?

- 1 very dissatisfied
- 2 fairly dissatisfied
- 3 neither satisfied nor dissatisfied
- 4 fairly satisfied
- 5 very satisfied

SECTION 5: SUPPORT WITHIN THE COMMUNITY

5.1 Once you were BACK HOME, please indicate whether help was provided from any of the professionals below

	Yes	No
Clinical Neuropsychologist	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Neuropsychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>
Speech and Language Therapist	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>
Nurse	<input type="checkbox"/>	<input type="checkbox"/>
GP	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker	<input type="checkbox"/>	<input type="checkbox"/>
Other - Please indicate		

5.2 If you have ticked NO to any service listed in question 5.1, do you think it would it have been beneficial to have received help from that profession?

- Yes No

Please specify which service(s).....

5.3 What prevented you from accessing these services?

- Finance
- Transport
- Not eligible
- Waiting time
- Other - Please indicate

5.4 Was your GP informed by hospital/rehab staff of potential on-going health needs?

- Yes No

- 5.5 Is your GP able to provide help/support for your condition?
 Yes No
- 5.6 Has your GP informed you of any of the following services?
- | | | | | |
|-----------------------|-----|--------------------------|----|--------------------------|
| Social services | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Headway | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Carers' organisations | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Other | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
- Please indicate
- 5.7 On a scale of 1-5 how satisfied were you with the services you received once back home?
- | | | |
|---|--------------------------|------------------------------------|
| 1 | <input type="checkbox"/> | very dissatisfied |
| 2 | <input type="checkbox"/> | fairly dissatisfied |
| 3 | <input type="checkbox"/> | neither satisfied nor dissatisfied |
| 4 | <input type="checkbox"/> | fairly satisfied |
| 5 | <input type="checkbox"/> | very satisfied |

SECTION 6: SUPPORT WITHIN THE HOME

- 6.1 Are family/carers actively involved in continuing with rehabilitation?
 Yes No
- 6.2 Do family/carers provide active help/support for the brain injured person in any of the following areas?
- | | Yes | No |
|-------------------------------|--------------------------|--------------------------|
| Physical movement | <input type="checkbox"/> | <input type="checkbox"/> |
| Motivation | <input type="checkbox"/> | <input type="checkbox"/> |
| Communication | <input type="checkbox"/> | <input type="checkbox"/> |
| Remembering | <input type="checkbox"/> | <input type="checkbox"/> |
| Organisation | <input type="checkbox"/> | <input type="checkbox"/> |
| Behaviour management | <input type="checkbox"/> | <input type="checkbox"/> |
| Handling money | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional support | <input type="checkbox"/> | <input type="checkbox"/> |
| Other – Please indicate | | |
- 6.3 Do you receive support?
 Yes No
- If Yes, please indicate what type of support you receive
- | | |
|---------------------------|---|
| Sessional support worker | <input type="checkbox"/> |
| Day service | <input type="checkbox"/> |
| Holiday respite | <input type="checkbox"/> |
| Voluntary/charitable orgs | <input type="checkbox"/> Please state |
| Other- Please state | |
- 6.4 Would you prefer to share the caring with other agencies?
 Yes No
- If Yes, ideally would this be:
- | | | | | | |
|-----------|--------------------------|-----------|--------------------------|--------------|--------------------------|
| Full time | <input type="checkbox"/> | Part time | <input type="checkbox"/> | Occasionally | <input type="checkbox"/> |
|-----------|--------------------------|-----------|--------------------------|--------------|--------------------------|

6.5 Please indicate below how important receiving the following provisions are:

	Not at all important	Not important	Neither	Important	Very important
Sessional support worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holiday respite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary/charitable orgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate:

6.6.1 Which of the following do you feel are important?

	Not at all important	Not important	Neither	Important	Very important
Support for your personal needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for your emotional needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support for educational ambition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support to resume vocational/voluntary/paid work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support with budgeting/finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time for yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate:

6.7 On a scale of 1-5 how satisfied were you with the services you received in your home?

- 1 very dissatisfied
- 2 fairly dissatisfied
- 3 neither satisfied nor dissatisfied
- 4 fairly satisfied
- 5 very satisfied

SECTION 7: YOUR SUGGESTIONS FOR IMPROVEMENT

7.1 Is there anything that you feel could be improved within the ABI services you have come into contact?

7.2 What would make a difference now?

1

2

3

7.3 Are there any other comments you would like to make? Please use extra paper if necessary.

Thank you so much for helping us with this questionnaire. I hope that it will enable us to improve our services for people living with a brain injury.

If you would be happy to or would like to discuss any of the points you have made, in confidence, do leave a name and contact details or ring us.

Please contact me:

Name

Phone

Email

Headway Tunbridge Wells & District
01892 619001 headwaytwells@hotmail.com