Patient Experience | Psychiatry Inpatient

Directions: Please answer each statement based on your current hospitalization experience. If a question does not apply to you, please select "*Does not apply.*" We encourage you to answer truthfully and candidly.

Treatment Team Relationship	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree	Does Not Apply
My Doctor/Provider treated me with care and respect.						
My Doctor/Provider valued my opinion even if we didn't always agree.						
My Doctor/Provider helped me understand my treatment options.						
I had input into decisions about my treatment.						
My Social Worker helped me include family or other supports in my treatment if I wished.						
My cultural and personal preferences were respected during my treatment.						

Environment	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree	Does Not Apply
The unit was clean.						
I felt physically safe on the unit.						
I had access to quiet space if I needed it.						
Healthy food options were available.						
I had enough access to fresh air and/or natural light.						
I was satisfied with the services available on the weekends.						
I was supported in keeping busy and finding social/recreational activities.						

Treatment Effectiveness	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree	Does Not Apply
The symptoms/problems that brought me to the hospital have improved.						
Group therapy was helpful.						
I have skills to help manage symptoms/problems I face in daily life.						
My medications will help me.						
I will have the resources I need to be successful after I leave the hospital.						
I received a clear explanation of my diagnosis and symptoms.						

Nursing Team Presence	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree	Does Not Apply
Nurses were caring and respectful.						
Counselors/Technicians were caring and respectful.						
Nurses were attentive to my needs.						
Counselors/Technicians were attentive to my needs.						
Staff paid attention to what was happening on the unit.						
Staff worked together to care for me.						
I was satisfied with the accessibility of supportive services (e.g., interpreters and accommodations for individuals with disabilities).						

How likely is it that you would recommend this hospital to a family member, friend, or colleague?

Not at all Likely					Likely					Extremely Likely
0	1	2	3	4	5	6	7	8	9	10

How can we improve? Please let us know if you have suggestions to improve our care.

What did we do well? Please let us know what we are doing well and any staff who you would like to recognize.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1171. The time required to complete this information collection is estimated to average 7.25 minutes for questions 1-26 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop, Baltimore, MD 21244-1850.

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Demographic Questions [Optional]	**Suggested Item Choices**
Did you receive assistance completing this survey?	Yes No
Age	12 – 17 18 – 24 25 – 34 35 – 44 45 – 54 55 – 64 65 – 74 75 and over
Gender	Female Male Transgender Male Transgender Female Non-binary Other Prefer Not to Say
Sexual Orientation	Heterosexual/Straight Homosexual/Gay Homosexual/Lesbian Bisexual Other Prefer Not to Say
Race/Ethnicity	Asian/Pacific Islander Black or African American Hispanic or Latino Native American or American Indian Biracial/Multiracial White Other Prefer Not to Say
Religious/Faith Tradition	Buddhist Christian Hindu Islam Judaism Mormon None/No Religious or Faith Tradition Other Prefer Not to Say
Disability Status	None Deaf or Hearing Problems Blind or Vision Problems Learning Difficulty Difficulty Walking Difficulty Thinking/Remembering Other Prefer Not to Say

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Original Research Article:

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Note. This version is not to be used for CMS purposes**;** please see the measure developer's website for the CMS version in English and Spanish.

For questions or feedback, please contact the measure developer:

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