



Quality Resource Management

**Service User  
Questionnaire for People  
with Physical Disabilities  
and/or  
Acquired Brain Injury**

**About You** *(Please tick appropriate box for each question)*

**1 Do you live alone?**

Yes  No

**2 Do you have someone who normally cares for you?**

Yes  No

**3 If you have answered yes to question 2, please state who normally cares for you?**

Young Person aged under 18  Other family member   
Friend  Neighbour   
Other

**3a) If your carer is aged under 18, please state their age in the box.**

**4 Do you or your partner need help/support with your children?**

Yes  No   
Not applicable

**4a) If you or your children need help/support on a day-to-day basis, do you receive the help you need?**

Yes, fully  Yes, partly   
No, not at all  Not applicable

**4b) If you or your children need help/support in a crisis, do you receive the help you need?**

Yes, fully  Yes, partly   
No, not at all  Not applicable

**5 Are you able to access community facilities (eg schools / hospitals / libraries etc)?**

- |                |                          |                |                          |
|----------------|--------------------------|----------------|--------------------------|
| Yes, fully     | <input type="checkbox"/> | Yes, partly    | <input type="checkbox"/> |
| No, not at all | <input type="checkbox"/> | Not applicable | <input type="checkbox"/> |

**5a) If you have answered "partly" or "Not at all" please explain why not. Also, please state which facilities you would like to be able to access.**

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**6 What is your disability or condition? Please tick all that apply**

- |                               |                          |                       |                          |
|-------------------------------|--------------------------|-----------------------|--------------------------|
| Stroke                        | <input type="checkbox"/> | Motor Neurone Disease | <input type="checkbox"/> |
| Osteoarthritis                | <input type="checkbox"/> | Spina Bifida          | <input type="checkbox"/> |
| Parkinsons Disease            | <input type="checkbox"/> | Spinal Injuries       | <input type="checkbox"/> |
| Acquired Brain Injury         | <input type="checkbox"/> | Multiple Sclerosis    | <input type="checkbox"/> |
| Rheumatoid Arthritis          | <input type="checkbox"/> | Polio                 | <input type="checkbox"/> |
| Chronic Fatigue Syndrome / ME | <input type="checkbox"/> | Cerebral Palsy        | <input type="checkbox"/> |
| Other, please specify         | <input type="checkbox"/> |                       |                          |

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**7 Is your disability progressive?**

Yes  No   
Don't know

**8 Which of the following groups contains your age?**

16 – 18  46 – 55   
19 – 25  56 – 65   
26 – 35  Over 65   
36 – 45

**9 How would you describe your ethnic origin?**

**Asian/Asian British:**  **Black/Black British:**   
Indian, Pakistani, Caribbean, African,  
Bangladeshi, Other Any other black background

**Mixed Heritage:**  **Other ethnic groups:**   
White/Black Caribbean, please state which  
White/Black African, .....  
White/Black Asian, Any .....  
other mixed background

**White: White British,**   
White Irish,  
Any other white background

**10 Is English your first language? (The one you normally use when you are talking to family and friends)**

Yes  No

**11 If no, please state the language you use at home.**

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## **About Your Accommodation**

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**12 Please give your postcode or, if you do not know this, the village or town in which you live. This information will only be used to make sure we have the views of people from all over Devon.**

Your Postcode ..... The town or village .....  
where you live

**13 Is your current accommodation:**

Owner occupied  Rented – private

Rented – Local Authority  Rented –  
Housing Association

Residential or nursing home  Other, please specify

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**14 Is your accommodation suitable to meet your current needs?**

Yes, fully  Yes, partly   
No, not at all

**15 Has your home been adapted?**

Yes  No

**15a) If your home has been adapted, how long did it take to have the adaptations made?**

0 – 3 months  4 – 12 months   
13 months or longer

**15b) If you are waiting for adaptations, how long have you been waiting?**

0 – 3 months  4 – 12 months   
13 months or longer

## Information you have received

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**16 If English is not your first language, are you offered information in your preferred language?**

Always  Sometimes   
Never  Not applicable

**16a If you require a translation/interpreting service is this provided for you?**

Always  Sometimes   
Never  Not applicable

**17 If you require information in alternative formats e.g. Large Print, Audio tape or Braille, is this provided for you?**

Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
Never	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**18 Have you been able to get relevant information when you need it about your disability or condition?**

Yes, full information	<input type="checkbox"/>	Yes, some information	<input type="checkbox"/>
No, not at all	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**19 Have you been able to get relevant information when you need it about your treatment?**

Yes, full information	<input type="checkbox"/>	Yes, some information	<input type="checkbox"/>
No, not at all	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**20 Have you been able to get relevant information when you need it about your ongoing care arrangements?**

Yes, full information	<input type="checkbox"/>	Yes, some information	<input type="checkbox"/>
No, not at all	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**21 Have you been able to get relevant information when you need it about your right to have your needs assessed?**

Yes, full information	<input type="checkbox"/>	Yes, some information	<input type="checkbox"/>
No, not at all	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**22 Have you been able to get relevant information when you need it about the services that might be available to you**

Yes, full information	<input type="checkbox"/>	Yes, some information	<input type="checkbox"/>
No, not at all	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>

**23 Have you been able to get relevant information when you need it about how your care & treatment is changed or reviewed**

Yes, full information  Yes, some information   
No, not at all  Not applicable

**24 Have you been able to get relevant information when you need it about charges/paying for services**

Yes, full information  Yes, some information   
No, not at all  Not applicable

**25 Was the information about charges/paying for services easy to understand?**

Always  Sometimes   
Never  Not applicable

**26 Do you use any of the following to access information:**

NHS Direct  Helpdesk   
Self-help groups  Internet   
Libraries  Specialist Disability  
Advice Group   
General Advice Group  Other, please specify

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**27 Would you like more information?**

Yes  No

**27a If you answered yes to question 27, please state below what information you would like.**

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.....  
.....

**28 How would you like this information made available?**

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**29 How best would you describe how well informed you feel?**

Very informed	<input type="checkbox"/>	Informed	<input type="checkbox"/>
Not informed	<input type="checkbox"/>		

**30 Do you have access to the internet where you live?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**31 Would you like to have access to the internet?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**32 If you have answered yes to question 31, would you need help and support to enable you to use the internet?**

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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### 33 The Services You Receive

Please tick the services you have received in the last 12 months. Where you have used services please tick to show how satisfied you were with the quality and quantity of the service you received

	3 = very satisfied	2 = satisfied	1 = not satisfied	How satisfied were you with the								
				Do you feel you NEEDED the service? PLEASE TICK		QUALITY of the service? PLEASE TICK			QUANTITY (how much) of the service you received? PLEASE TICK			Length of time you waited for the service to start? PLEASE TICK
	Yes	No		3	2	1	3	2	1	3	2	1
			Please tick which services you have received in the last 12 months									
	Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>											
a)	Hospital in-patient stay related to your disability											
b)	Hospital in-patient stay not related to your disability											
c)	In-patient rehabilitation unit											

3 = very satisfied		2 = satisfied		1 = not satisfied			How satisfied were you with the										
		Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>		Please tick which services you have <b>received</b> in the <b>last 12 months</b>	Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>		QUALITY of the service? <b>PLEASE TICK</b>			QUANTITY (how much) of the service you received? <b>PLEASE TICK</b>			Length of time you waited for the service to start? <b>PLEASE TICK</b>				
					Yes No		3 2 1			3 2 1			3 2 1				
d)	Residential or nursing home care																
e)	Respite care in your own home																
f)	Respite care in a residential / nursing home																
g)	Clinical psychology																
h)	Hospital Consultant																
i)	GP (Doctor)																

3 = very satisfied    2 = satisfied    1 = not satisfied		How satisfied were you with the										
		Do you feel you <b>NEEDED</b> the service? PLEASE TICK		QUALITY of the service? PLEASE TICK			QUANTITY (how much) of the service you received? PLEASE TICK			Length of time you waited for the service to start? PLEASE TICK		
Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>		Yes	No	3	2	1	3	2	1	3	2	1
j)	Specialist nurse e.g. Parkinsons nurse											
k)	Community Nurse											
l)	Speech / Language Therapy											
m)	Occupational Therapy											
n)	Physiotherapy											
o)	Care Manager / Social Worker											
p)	Social Services Helpdesk											

		3 = very satisfied			2 = satisfied			1 = not satisfied			How satisfied were you with the											
		Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>			Please tick which services you have <b>received</b> in the <b>last 12 months</b>			Do you feel you <b>NEEDED</b> the service?			QUALITY of the service? PLEASE TICK			QUANTITY (how much) of the service you received? PLEASE TICK			Length of time you waited for the service to start? PLEASE TICK					
								Yes			No			3			2			1		
q)	Home Care																					
r)	Day Care																					
s)	Community Enabler																					
t)	Direct Payments																					
u)	Wheelchair provision																					
v)	Wheelchair maintenance																					

3 = very satisfied		2 = satisfied		1 = not satisfied		How satisfied were you with the											
		Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>			Please tick which services you have <b>received</b> in the <b>last 12 months</b>		Do you feel you <b>NEEDED</b> the service?		QUALITY of the service?			QUANTITY (how much) of the service you received?			Length of time you waited for the service to start?		
							PLEASE TICK		PLEASE TICK			PLEASE TICK			PLEASE TICK		
							Yes No		3 2 1			3 2 1			3 2 1		
w)		Wheelchair delivery and repair service															
x)		Artificial limbs															
y)		Independent Living Equipment (e.g. walking aids, bathing hoists)															
z)		Equipment (sticks, aids, stair lifts, hoists)															
aa)		Housing adaptations – major															

3 = very satisfied		2 = satisfied		1 = not satisfied		How satisfied were you with the											
		Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>			Please tick which services you have <b>received</b> in the <b>last 12 months</b>	Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>		QUALITY of the service? <b>PLEASE TICK</b>			QUANTITY (how much) of the service you received? <b>PLEASE TICK</b>			Length of time you waited for the service to start? <b>PLEASE TICK</b>			
						Yes No		3 2 1			3 2 1			3 2 1			
ab)	Housing adaptations – minor																
ac)	Housing support																
ad)	Health and Social Services Transport																
ae)	Hospital transport																
af)	Disability information and advice																

3 = very satisfied		2 = satisfied		1 = not satisfied		How satisfied were you with the									
		Please tick the boxes on <b>SERVICES RECEIVED, NEED, QUALITY AND QUANTITY</b>		Please tick which services you have <b>received</b> in the <b>last 12 months</b>		Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>		Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>		Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>		Do you feel you <b>NEEDED</b> the service? <b>PLEASE TICK</b>			
						Yes		No		3		2		1	
ag)	Any other service – please state														
ah)	Any other service – please state														





**36. If you would like to be involved in on-going consultation about this review and on improving services for people with a physical disability and acquired brain injury please provide the details requested below.**

Name: .....

Address: .....

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Telephone number: .....

e-mail address: .....

Thank you for completing this questionnaire.

Please post this questionnaire in the pre-paid envelope (you do not need a stamp) by 30th June 2003 to:

**QRM,  
60 Wyndham Street,  
Barry, Vale of Glamorgan,  
South Wales**



Quality Resource Management

QRM,  
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