

PATIENT FEEDBACK

Group:4

- 1. Dr. Rupa kumar**
- 2. Dr. Manoj**
- 3. Mr. Vijay kumar**
- 4. Mr. Vinoth Kannan**
- 5. Mr. Karuppasamy**
- 6. Mr. S. Karthikeyan**

Reviewed By:

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MEANING OF FEEDBACK

Patient feedback consists of the views and opinions of patient and service users on the care they have experiences.

REASONS TO GET FEEDBACK

1. To Understand what reviews really mean.
2. To Manage your reputation.
3. To Improve Care.
4. To Boost patient engagement.
5. To Reduce Patient leakage.

BENEFITS OF PATIENT FEEDBACK

1. Monitor the quality of services being delivered patients.
2. Understand more about a practices patient base and how they utilize available services.
3. Determine patients preference for services.
4. Assess patients reactions to change made within the practice.
5. Raise awareness of new services provided at the practice.
6. .Improve patients engagement and response.
7. Recover potential service failures.
8. Retain loyal patients.
9. Improve support staff and physician satisfaction.

PROCESS OF FEEDBACK



PURPOSE OF FEEDBACK

Address

Issues

Correct

Misconceptions

Facilitate
Improvement

Hospital Feedback	
<i>Rating</i>	
(Strongly agree Agree Disagree Strongly disagree)	
Use the key notes provided above to answer the assessment statements below. Objectivity is highly recommended to avoid failure in future.	
The Nurses and Doctors are patient when dealing with patients	
Professionalism in the hospital is of high standards	
Drugs offered do not have side effects	
The patients are attended to promptly	
There is a high level of understanding between the staff and the patients	
I have not heard any major complaints about the hospital	
The hospital has dealt with conflicts that arose between staff and the patients	
Time management is a priority to the hospital staff and management	
<i>We wish you a quick recovery</i>	

PATIENT FEEDBACK FORMS

Date: _____

Type of feedback: Compliment Complaint

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Email Address: _____

Relationship to Patient:

Self Spouse Parent Dependent Child Legal Guardian

Nature of your comment:
Please check the boxes below which best describe the nature of your comment; provide details on the next page.

Complaint:
Date incident occurred: _____

- Substandard Care (e.g. misdiagnosis; negligent treatment; delay in treatment; etc)
- Unprofessional Conduct (e.g. breach of privacy; record alteration; provider impairment; etc)
- Office Practice (e.g. inattentive; rude or abusive behavior; failure to adequately address patients needs; etc)
- Substandard Facilities or Equipment (e.g. cleanliness concerns; cluttered; equipment inoperative; etc)
- Scheduling or Appointment Issues (e.g. difficulty scheduling; not timely; etc)
- Prescribing Issues (e.g. medication errors; over/under prescribing; failure to respond; etc)
- Other: _____

Narrative Comments (please be as clear and concise as possible; use extra pages if necessary):

_____ Please Turn Over

_____ Please Turn Over

Thank You