Form Approved
OMB Form No. 0917-0036
Expiration Date: May 31, 2015

# BLACKFEET COMMUNITY HOSPITAL
# "WE CARE SURVEY"

| *How Do You Feel About the Services Provided to You Today in the:* *DEPARTMENT* | Outstanding | Above Average | Average | Below Average | Unsatisfactory |
|---|---|---|---|---|---|
| ***Healthcare Provider Rating:*** | | | | | |
| 1. Please Rate the **Nurse** | | | | | |
| 2. Please Rate the **Doctor/Provider** | | | | | |
| 3. Rate **Overall Service** provided | | | | | |
| ***Hospital-Wide Rating*** | | | | | |
| 1. **Inside** Appearance | | | | | |
| 2. **Outside** Appearance | | | | | |

***Hand Hygiene:*** *Circle Yes, No or N/A (Not Applicable)*

| Did staff clean hands with soap or alcohol rub: | Nurses | | | Medical Staff | | | Other Staff | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. **BEFORE** touching patient | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| 2. **AFTER** touching patient | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| 3. Didn't notice | Yes | No | | Yes | No | | Yes | No | |

**Did you notice anything during your visit that you felt was unsafe? ☐ No ☐ Yes if so, explain on back.**

Comments (use back of form if needed)

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*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 0917-0036. This time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the times estimate(s) or suggestions for improving this form, please write to U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention, PRA Reports Clearance Officer.*