

New Zealand Pharmacy Patient Survey

Dear Pharmacy patient

We would be grateful if you would complete this survey about your visits to any pharmacy in the District Health Board area during the past 12 months.

The pharmacist(s) and pharmacy staff want to provide the highest standard of care. Feedback from this survey will enable them to identify areas that may need improvement. Your opinions are therefore very valuable. Your answers to this survey are confidential and neither you nor your pharmacy can be identified.

Please answer ALL the questions that apply to you. There are no right or wrong answers.

Thank you.

1 In the past 12 months,
how many times have you
been to a pharmacy?

Not been to
a pharmacy

1

1-2
times

2

3-4
times

3

5-6
times

4

7 or more
times

5

2 The last time you visited a
pharmacy, did you collect
a **prescription** for:

Yourself

1

Someone else

2

Both

3

3 Were all the medicines on your prescription
in stock or did you have to return to collect
some later?

All medicines
were in stock

1

Some medicines were
not in stock and had to
be collected later

2

	10 minutes or less	11-20 minutes	21-30 minutes	31-60 minutes	More than one hour	
4 a) About how long did you have to wait before you were given your medicines?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	
	Very poor	Poor	Fair	Good	Very good	Excellent
b) How do you rate this?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

	Very difficult	Difficult	OK	Easy	Very easy	Does not apply
5 If you arrived by car , how easy was it to find a carpark nearby?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

6 How do you rate **the pharmacist** for **providing advice** (written or verbal) on:

	Very poor	Poor	Fair	Good	Very good	Excel- lent	Does not apply
a) How the medicines you received should be taken or applied ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
b) What the expected outcome of the treatment was?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
c) What to do if side effects were to occur?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
d) Precautions you should take with this medicine (e.g. whether you can drive a car or operate machinery)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
e) How to store the medicines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
f) How to dispose of the medicines no longer in use?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
g) How to manage a current health problem or a longer term health condition you may have?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇
h) How to lead a healthier lifestyle	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇

7

- a) **Do you know** the hours that this Pharmacy is open for business?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- b) How do you rate the **hours** that this Pharmacy is open for business?
- | | | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | Very poor | Poor | Fair | Good | Very good | Excellent |
| | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |
- c) What **additional** hours would you like the pharmacy to be open? (please tick all that apply)
- | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | Early morning | Evenings | Week-ends | None, I am satisfied |
| | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ |

8 Please rate **the pharmacy staff** on:

- | | | | | | | | |
|--|-----------|------|------|------|-----------|-----------|----------------|
| | Very poor | Poor | Fair | Good | Very good | Excellent | Does not apply |
|--|-----------|------|------|------|-----------|-----------|----------------|
- a) Treating you with **dignity** and **respect**
- | | | | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ | <input type="checkbox"/> ₇ |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
- b) Discussing your medicine(s) in such a way that you felt you were offered **privacy**
- | | | | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ | <input type="checkbox"/> ₇ |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
- c) **Answering** any questions you may have had
- | | | | | | | | |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ | <input type="checkbox"/> ₇ |
|--|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|

9 Thinking about how much you had to pay for the prescription medicine you received from the pharmacy, how **affordable** was it for you personally?

- | | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---|
| Very expensive | Expensive | Average | Affordable | Very affordable | Does not apply
(You did not have to pay) |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

10 All things considered, how **satisfied** are you with this pharmacy? (please tick only one box)

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Completely dissatisfied | Dissatisfied | Average | Satisfied | Completely satisfied |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

Finally, it will help us to understand your answers if you could tell us a little about yourself:

11 Are you: ¹ Male ² Female

12 How old are you? _____ years

13 Do you have any **long-standing illness, disability or infirmity**? By long-standing we mean anything that has troubled you over a period of time or that is likely to affect you over a period of time. ¹ Yes ² No

14 Which **ethnic group(s)** do you belong to? (please tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> ¹ New Zealand European | <input type="checkbox"/> ⁶ Niuean |
| <input type="checkbox"/> ² Māori | <input type="checkbox"/> ⁷ Chinese |
| <input type="checkbox"/> ³ Samoan | <input type="checkbox"/> ⁸ Indian |
| <input type="checkbox"/> ⁴ Cook Island Māori | <input type="checkbox"/> ⁹ Other (such as Dutch, Japanese, Tokelauan), Please state: |
| <input type="checkbox"/> ⁵ Tongan | |

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15 Which of the following best describes you? (please tick one box)

- | | |
|---|--|
| <input type="checkbox"/> ¹ Employed (full or part time, including self-employed) | <input type="checkbox"/> ⁵ Looking after your home/family |
| <input type="checkbox"/> ² Unemployed and looking for work | <input type="checkbox"/> ⁶ Retired from paid work |
| <input type="checkbox"/> ³ At school or in full time education | <input type="checkbox"/> ⁷ Other (please describe) |
| <input type="checkbox"/> ⁴ Unable to work due to long term sickness | |

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16 We are interested in any other comments you may have. Please write them here.

Is there anything particularly good about your pharmacy?

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Is there anything that could be improved?

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Do you have any other comments?

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.....
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Thank you for taking time to complete this questionnaire.