**E-APPENDIX B – Dutch questionnaire administered to frail elderly**

**hospitalized patients to measure their experiences regarding the provision of individualized and integrated care**

**The following questions are related to your personal information.**

1. **What is your year of birth?**
2. **Are you male or female?**

male

female

1. **How is your health at this moment?**

excellent

very good

good

fair

poor

I don’t know

**The following section contains questions regarding your last hospital stay in department X in hospital Y.**

1. **Were you informed sufficiently by your doctor regarding the different various options for treating your health problems?**

not at all

sometimes

often

every time

I don’t know

If you were not completely satisfied with the information provided by your doctor, please describe what went wrong:

1. **Were you able to indicate which treatment and/or care you preferred?**

not at all

sometimes

often

every time

I don’t know

1. **During your hospital stay, could you co-decide what was important to your care?**

not at all

sometimes

often

every time

I don’t know

If you were not completely satisfied, please describe what went wrong:

1. **During your hospital stay, were you supported in keeping busy and finding social contacts and activities?**

not at all

a little

good

very good

not applicable

I don’t know

1. **Did you know to whom you can go within the hospital with questions, problems or complaints?**

yes

no

I don’t know

1. **Before discharge, did you talk with a member of the hospital staff regarding the care you would need after discharge?**

yes, sufficiently

yes, but not sufficiently

no

I don’t know/I don’t remember

1. **Did a member of the hospital staff inform the key people and/or care providers of your discharge from the hospital?** *(e.g., your primary care physician, informal caregiver, homecare worker, rehabilitation center, elderly consultant, or pharmacist)*

no

some (but not all) were informed

yes

I don’t know

1. **During your hospital stay, did you experience one or more of the following events?**

* Did you fall during your hospital stay?

*yes*  *no*  *I don’t know*

* Did you become confused during your hospital stay?

*yes*  *no*  *I don’t know*

* Did you develop pressure ulcers?

*yes*  *no*  *I don’t know*

* Did medication errors occur?

*yes*  *no*  *I don’t know*

* Did you develop a urinary tract infection?

*yes*  *no*  *I don’t know*

* Did you develop a wound infection?

*yes*  *no*  *I don’t know*

* Did you experience complications with your surgery and/or treatment?

*yes*  *no*  *I don’t know*

* Other, please specify:

**ADDITIONAL QUESTIONS**

1. **Would you recommend this department to family and/or friends?**  YES  NO
2. *If yes, why would you recommend this department?*

1. *If no, why wouldn’t you recommend this department?*

1. **Do you have any other comments?**

1. **If you have a question, comment or complaint regarding your last hospital admission and would like our help, please provide your personal information below.**

Name:

Address:

Phone:

1. **Who completed your questionnaire?**

I did (independently)

I completed the questionnaire with help from someone I know well

Someone else completed the questionnaire for me

1. **When did you complete this questionnaire (dd-mm-yyyy)?**  **- -**