POPPI

Provision Of Psychological support to People in Intensive care

POPPI study questionnaire

Completing this questionnaire

Today's date

		/			/	2	0		
D	D		M	M		Y	Y	Y	Y

Did you complete this questionnaire
(please tick)

- Alone ○
- With help ○
- Someone else completed it for you ○
  (e.g. family member, friend, carer)

I do not wish to complete this questionnaire ○
(please tick)

Please return your questionnaire in the stamped, addressed envelope provided

Emotional Reactions

These questions are about reactions people may have after intensive care.

*Please circle **ONE** response to indicate how often a problem has bothered you **IN THE PAST MONTH**.*

Q1 Have you had upsetting thoughts or images about your time in intensive care that came into your head when you didn't want them to?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q2 Have you had bad dreams or nightmares about your time in intensive care?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q3 Have you relived your time in intensive care, acting or feeling as if it were happening again?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q4 Have you felt emotionally upset when you were reminded of your time in intensive care (e.g. feeling scared, angry, sad, guilty)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q5 Have you had physical reactions when you remember your time in intensive care (e.g. breaking into a sweat, heart beating fast)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q6 Have you tried not to think, talk or have feelings about your time in intensive care?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q7 Have you tried to avoid activities, people or places that remind you of your time in intensive care?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Emotional Reactions

These questions are about reactions people may have after intensive care.

*Please circle **ONE** response to indicate*
*how often a problem has bothered you **IN THE PAST MONTH**.*

Q8 Have you found that you were not able to remember an important part of your time in intensive care?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q9 Have you had much less interest in important activities?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q10 Have you felt distant or cut off from people around you?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q11 Have you felt emotionally numb (e.g. unable to cry, have loving feelings)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q12 Have you felt as if your future plans or hopes would not come true?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q13 Have you had trouble falling or staying asleep?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q14 Have you felt irritable or had fits of anger?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Emotional Reactions

These questions are about reactions people may have after intensive care.

*Please circle **ONE** response to indicate how often a problem has bothered you **IN THE PAST MONTH**.*

Q15 Have you had trouble concentrating (e.g. forgetting what you read, losing track of a story on television)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q16 Have you been too alert (e.g. checking to see who is around you, not being comfortable with your back to a door)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

Q17 Have you been jumpy or easily startled (e.g. when someone walks up behind you)?

Not at all	Once per week or less	2 – 4 times per week	5 or more times per week

The next two questions are about the timing of emotional reactions people may have after intensive care.

*Please circle the **ONE** answer that is closest to your experience.*

Q18 If you reported any problems in your answers to questions 1-17, then how long have you experienced these problems?

Not at all	Less than 1 month	1 to 3 months	More than 3 months

Q19 If you reported any problems in your answers to questions 1-17, then how long after leaving intensive care did these problems begin?

I have not had these type of problems	Less than 1 month	1 to 3 months	More than 3 months

Mood

*How often have you felt any of the following during **THE PAST WEEK**?*

*Please circle **ONE** answer for each item.*

Q1 I was bothered by things that usually don't bother me

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q2 I had trouble keeping my mind on what I was doing

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q3 I felt depressed

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q4 I felt that everything I did was an effort

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q5 I felt hopeful about the future

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q6 I felt fearful

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q7 My sleep was restless

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q8 I was happy

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q9 I felt lonely

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

Q10 I could not 'get going'

Less than 1 day	1 – 2 days	3 – 4 days	5 – 7 days

POPPI

Health

*Under each heading, please tick the **ONE** box that best describes your health **TODAY**.*

Q1 Mobility

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

Q2 Self-care

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

Q3 Usual activities *(e.g. work, study, housework, family or leisure activities)*

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

POPPI

Health

*Under each heading, please tick the **ONE** box that best describes your health **TODAY**.*

Q4 **Pain / Discomfort**

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

Q5 **Anxiety / Depression**

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

Health

We would like to know how good or bad your health is **TODAY**.

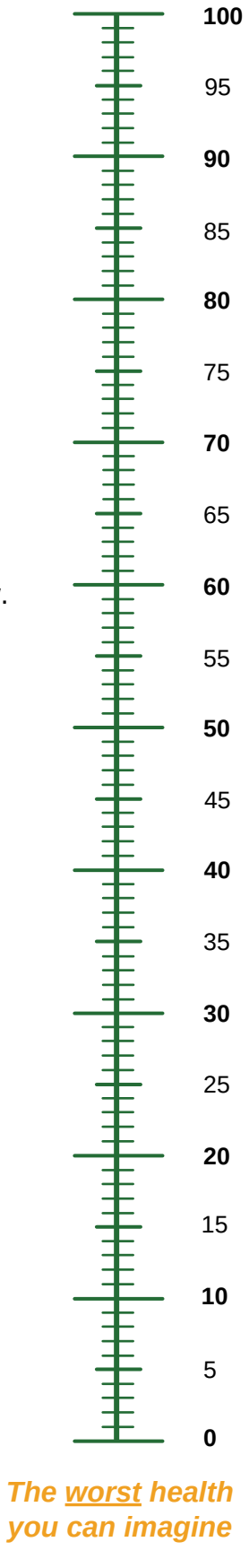
This scale is numbered from **0** to **100:**

- **100** means the **best** health you can imagine
- **0** means the **worst** health you can imagine

Mark an **X** on the scale to indicate how your health is **TODAY**.

Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



Health services

These questions will help us understand the care you needed after leaving the hospital.

Please answer the multiple choice questions by putting a ✓ in **ONE** box for each question.

Q1 Where are you now?

- ◯ At home (your own home, or a relative's home)
- ◯ In residential care (e.g. nursing home, hospice)
- ◯ In short-term rehabilitation
- ◯ In long-term rehabilitation
- ◯ In hospital
- ◯ Other (please specify): _____

Q2 Hospital stays

Since you left hospital on
have you stayed overnight in hospital for any reason?

- ◯ **No** – *Please go to Q3*
- ◯ **Yes** – *Please give details about the number of stays below*

For EACH TIME you stayed in hospital please answer the following:

	Number of nights		1 – 3 nights	4 – 10 nights	11 or more nights	Did you spend any part of your stay in intensive care?
1st stay		*Or tick...*	◯	◯	◯	◯
2nd stay		*Or tick...*	◯	◯	◯	◯
3rd stay		*Or tick...*	◯	◯	◯	◯
4th stay*		*Or tick...*	◯	◯	◯	◯

**If you have stayed in hospital more than 4 times, please could you provide information on these further hospital stays in Q7 of the questionnaire.*

Health services

Q3 Visits to hospital outpatients

Outpatient visits are when a patient comes to the hospital to see a specialist (e.g. consultant) but does not stay overnight.

Since you left hospital on
have you visited hospital outpatients about ANY ASPECT of your health?

- ○ **No** – *Please go to Q4*
- ○ **Yes** – *Please give details about the number of outpatients visit(s) below*

Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
☐	*Or tick...*	○	○	○

Q4 Visits to health care providers

Since you left the hospital on
have you visited any of the health care providers listed below
about ANY ASPECT of your health?

- ○ **No** – *Please go to Q5*
- ○ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Did you visit this provider?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
GP	○	☐	*Or tick...*	○	○	○
Nurse at your GP clinic	○	☐	*Or tick...*	○	○	○
Nurse at hospital or elsewhere	○	☐	*Or tick...*	○	○	○
Health visitor	○	☐	*Or tick...*	○	○	○
Critical care follow-up clinic	○	☐	*Or tick...*	○	○	○

Health services

Q5 Visits to your home by health care providers

Since you left hospital on
have you had home visits from any of the following health care providers about ANY ASPECT of your health?

○ **No** – *Please go to Q6*

○ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Were you visited at home by this provider?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
GP	○		*Or tick...*	○	○	○
Nurse from your GP clinic	○		*Or tick...*	○	○	○
Health visitor or district nurse	○		*Or tick...*	○	○	○

Q6 Visits to other service providers

Since you left hospital on
have had contact (either visits to the provider or home visits) with any of the following service providers about ANY ASPECT of your health?

○ **No** – *Please go to Q7*

○ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Have you had contact with any of these providers?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
Occupational therapist	○		*Or tick...*	○	○	○
Speech and Language therapist	○		*Or tick...*	○	○	○
Physiotherapist	○		*Or tick...*	○	○	○
Psychiatrist	○		*Or tick...*	○	○	○
Psychiatric nurse	○		*Or tick...*	○	○	○
Psychologist	○		*Or tick...*	○	○	○
Counsellor	○		*Or tick...*	○	○	○

Health services

Q7 **Other services not listed so far**

Since you left hospital on
have you had further hospital stays or used any any other health care services for ANY ASPECT of your health that you haven't included previously?

○ **No** – *Please go to Q8*

○ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Type of service provider	Number of visits	Reason

Q8 Your views are important to us. Please feel free to provide any other comments you have in the box below.

Thank you for your time