Rubies Nursing Care

TELL US WHAT YOU THINK

We value your comments and suggestions for improving our service so please tell us what you think and give this form to your Disability Support Worker or any Rubies Nursing person or place in the Suggestion Box at the office.

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Are you a –

- ❒ Client
- ❒ Family member/representative
- ❒ Staff member
- ❒ Staff member on behalf of a client
- ❒ Other

Name (optional): ..... **Date:** .....

COORDINATOR TO COMPLETE

Date Received: .....

Action Plan	Who	By When	Date Completed

CLOSURE

Evaluation *(If appropriate, describe how action/improvements were evaluated and the result):*

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Outcome or end result: *(Tick applicable boxes)*

☐ Issue resolved - no improvements implemented

☐ Improvement implemented

☐ Other *(Describe)* .....

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CLOSED OUT/COMPLETE:

Coordinator/TL Signature: ..... **Date:**.....