# Psychiatric Inpatient Experience (PIX)

**Directions:** Please answer each statement based on your current hospitalization experience. If a question does not apply to you, please select "*Does not apply*." We encourage you to answer truthfully and candidly.

| **Treatment Team Relationship** | **Strongly Agree** | **Somewhat Agree** | **Neutral** | **Somewhat Disagree** | **Strongly Disagree** | **Does Not Apply** |
|---|---|---|---|---|---|---|
| My Doctor/Provider treated me with care and respect. | | | | | | |
| My Doctor/Provider valued my opinion even if we didn't always agree. | | | | | | |
| My Doctor/Provider helped me understand my treatment options. | | | | | | |
| I had input into decisions about my treatment. | | | | | | |
| My Social Worker helped me include family or other supports in my treatment if I wished. | | | | | | |

| **Environment** | **Strongly Agree** | **Somewhat Agree** | **Neutral** | **Somewhat Disagree** | **Strongly Disagree** | **Does Not Apply** |
|---|---|---|---|---|---|---|
| The unit was clean. | | | | | | |
| I felt physically safe on the unit. | | | | | | |
| I had access to quiet space if I needed it. | | | | | | |
| Healthy food options were available. | | | | | | |
| I had enough access to fresh air and/or natural light. | | | | | | |
| I was satisfied with the services available on the weekends. | | | | | | |
| I was supported in keeping busy and finding social/recreational activities. | | | | | | |

| **Treatment Effectiveness** | **Strongly Agree** | **Somewhat Agree** | **Neutral** | **Somewhat Disagree** | **Strongly Disagree** | **Does Not Apply** |
|---|---|---|---|---|---|---|
| The symptoms/problems that brought me to the hospital have improved. | | | | | | |
| Group therapy was helpful. | | | | | | |
| I have skills to help manage symptoms/problems I face in daily life. | | | | | | |
| My medications will help me. | | | | | | |
| I will have the resources I need to be successful after I leave the hospital. | | | | | | |

| **Nursing Team Presence** | **Strongly Agree** | **Somewhat Agree** | **Neutral** | **Somewhat Disagree** | **Strongly Disagree** | **Does Not Apply** |
|---|---|---|---|---|---|---|
| Nurses were caring and respectful. | | | | | | |
| Counselors/Technicians were caring and respectful. | | | | | | |
| Nurses were attentive to my needs. | | | | | | |
| Counselors/Technicians were attentive to my needs. | | | | | | |
| Staff paid attention to what was happening on the unit. | | | | | | |
| Staff worked together to care for me. | | | | | | |

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 0938-1171. The time required to complete this information collection is estimated to average 7.25 minutes for questions 1-26 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop, Baltimore, MD 21244-1850.

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| **Demographic Questions** [Optional] | **Suggested Item Choices** |
|---|---|
| Did you receive assistance completing this survey? | Yes<br>No |
| Age | 13 – 17<br>18 – 24<br>25 – 34<br>35 – 44<br>45 – 54<br>55 – 64<br>65 – 74<br>75 and over |
| Gender | Female<br>Male<br>Transgender Male<br>Transgender Female<br>Non-binary<br>Other<br>Prefer Not to Say |
| Sexual Orientation | Heterosexual/Straight<br>Homosexual/Gay<br>Homosexual/Lesbian<br>Bisexual<br>Other<br>Prefer Not to Say |
| Race/Ethnicity | Asian/Pacific Islander<br>Black or African American<br>Hispanic or Latino<br>Native American or American Indian<br>Biracial/Multiracial<br>White<br>Other<br>Prefer Not to Say |
| Disability Status | None<br>Deaf or Hearing Problems<br>Blind or Vision Problems<br>Learning Difficulty<br>Difficulty Walking<br>Difficulty Thinking/Remembering<br>Other<br>Prefer Not to Say |

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