**Device Evaluation Form**

**Medicall Nurse Call Bell**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of times used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your occupation or specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Did you receive training in how to use this product? | | | | | | |
| ❑ Yes **[Go to next question]** | | | | ❑ No **[Go to question 4]** | | |
| 1. Who provided this instruction? (Check all that apply.) | | | | | | |
| ❑ Product representative | | ❑ Hospital staff | | | ❑ Other | |
| 1. Was the training you received adequate? | | | | | | |
| ❑ Yes | | | | ❑ No | | |
| 1. Describe the range of mobility of the patient. | | | | | | |
| Mobile | Partial paralysis (10cm) | | Partial paralysis (1m) | | | Full paralysis |

Please answer all questions that apply to your duties and responsibilities. If a question does not apply to your duties and responsibilities, **please leave it blank**.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **During the Pilot Test of this Device . . .** | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
| 5. | The time it took to initiate a call was faster than that of a conventional call button. | 1 | 2 | 3 | 4 | 5 |
| 6. | The device was easy to find. | 1 | 2 | 3 | 4 | 5 |
| 7. | The device placed less false calls than conventional call buttons. | 1 | 2 | 3 | 4 | 5 |
| 8. | The device had similar number of wires as conventional call buttons. | 1 | 2 | 3 | 4 | 5 |
| 9. | The device provided multiple modes of feedback. | 1 | 2 | 3 | 4 | 5 |
| 10. | The device performed reliably. | 1 | 2 | 3 | 4 | 5 |
|  | **During the Pilot Test of this Device . . .** | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
| 11. | The device not self-activate without my intention. | 1 | 2 | 3 | 4 | 5 |
| 12. | I feel safe using this device. | 1 | 2 | 3 | 4 | 5 |
| 13. | The device did not increase patient discomfort. | 1 | 2 | 3 | 4 | 5 |
| 14. | The device improved my daily load of tasks. | 1 | 2 | 3 | 4 | 5 |
| 15. | The device did not cause me to change any way I worked with the patients. | 1 | 2 | 3 | 4 | 5 |
| 16. | I could have used this product without special training. | 1 | 2 | 3 | 4 | 5 |
| 17. | This device is cost efficient. | 1 | 2 | 3 | 4 | 5 |
| 18. | The delay to activation on the device is appropriate. | 1 | 2 | 3 | 4 | 5 |
| 19. | The device is easily cleaned. | 1 | 2 | 3 | 4 | 5 |
| 20. | The device meets my clinical needs. | 1 | 2 | 3 | 4 | 5 |
| 21. | The device is safe for clinical use. | 1 | 2 | 3 | 4 | 5 |

**Additional comments for any responses of “Strongly Disagree” or “Disagree”:** \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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