



## Helping Children's Centres to improve home safety: a new research study. Parents' questionnaire

We are carrying out a study to look at how Children's Centres can provide home safety advice to families. We would like to know about falls, poisoning and fires because these are common types of accidents. We would be grateful if you could fill in this questionnaire and return it in the envelope provided or give it to the researchers in the Children's Centre. Your answers will be used to help Children's Centres give better advice to parents.

**To thank you for your time we will send you a £5 gift voucher when you send back the questionnaire.**

**Is your child 0 - 2 years old** *Please place a tick to show your answer*

Yes  No

**Are you over 16 years old?**

Yes  No

**If you have answered NO** to either of these questions, please do not continue with the questionnaire. Either return it in the envelope provided or give it to the researchers in the Children's Centre

**If you answered YES** to both questions please complete the rest of the questionnaire.



## Home safety

- 1.1. **Do you have any of the following in your home to help prevent accidents?**  
(please tick *one* box on each row)

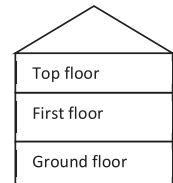
Items	Yes	No	Not relevant. Please explain why: eg. live in a flat with no stairs
a) Safety gates at the bottom and/or top of the stairs			
b) Safety gates elsewhere			
c) Corner covers for furniture			
d) Locked medicine cupboard			
e) Fridge lock			
f) Cupboard and/or drawer locks			
g) Spark guard (eg. to stop sparks from open fire)			
h) Fixed fire guard in front of open, electric or gas fire			
i) Fire blanket			
j) Fire extinguisher			
k) A torch next to the bed			
l) Other safety items (please describe)			

- 1.2 **Which three things do you think could be most likely to cause a fire in people's homes *generally*?**

1. ....

2. ....

3. ....



1.3. **Do you have a smoke alarm on every floor of your home?**  
Please don't include cellars (please tick *one* box on each row).

Floor	Yes	No	Don't know	Not relevant. Please explain why
Top floor				
First floor				
Ground floor				
Basement				

**If you have smoke alarms please complete the questions on this page.**  
**If you have *no* smoke alarms please go to question 1.8 on the next page.**

1.4. **If you have smoke alarms, is the alarm on each floor of your home working?**  
Please don't include cellars (please tick *one* box on each row).

Floor	Yes	No	Don't know	Not relevant. Please explain why
Top floor				
First floor				
Ground floor				
Basement				

1.5. **If you have smoke alarms, how often do you test them?**

Floor	More than once a week	Every week	Every month	Every 6 months	Don't know	Not relevant Please explain why
Top floor						
First floor						
Ground floor						
Basement						

1.6. **How long is it since you replaced the batteries in your smoke alarms?**

Less than 6 months.....

6 – 12 months.....

Between 1 and 2 years.....

2 years or more.....

Don't know.....

1.7. **If you have a smoke alarm, do you know what it sounds like?**

Yes  No  Don't know

1.8. These are some of the things people do before going to bed. How often do you do any of these? Please tick one box for each activity

Activity	Never	Once a week or less	2-3 days/ week	4-5 days/ week	6-7 days/ week	Not relevant	Don't know
a) Close all internal doors.							
b) Check front door is locked.							
c) Make sure your front door key is kept somewhere it could easily be reached in case there is a fire.							
d) Close stair gates (if you have them).							
e) Make sure exits from the house are clear of toys/other items.							
f) Make sure window key locks are available to you (but not to your children).							
g) Put any medicines away.							
h) Turn off lights.							
i) Turn electrical appliances off at the sockets eg TV, game consoles.							
j) Turn off electric/gas fires.							
k) Make sure a fireguard/ spark guard is in place.							
l) Check that the oven and all the rings on the cooker are turned off.							
m) Make sure cigarettes are put out.							
n) Put matches/lighters out of reach of children.							
o) Blow out candles.							
p) Other (please describe).							

1.9. Which three things do you think could be most likely to cause a fire *in YOUR own home?*

- 1. ....
- 2. ....
- 3. ....

**Safety actions**

2.1. What would you do if you woke up in the middle of the night, you could smell smoke and/or your smoke alarm was sounding?

*Please include everything that you can think of.*

.....  
.....  
.....

2.2 a) Does your family have a fire escape plan? This is a plan of what you would do to escape from the house if a fire broke out or the smoke alarm went off.

Yes  No  Don't know

If no, go to question 2.3 on page 8. Otherwise answer 2.2 b – f

2.2 b) Have you discussed this with all adults and older children living in your household?

Yes  No  Don't know

2.2 c 1) Have you tried the plan out by practising what you would do if there was a fire?

Yes  No  Don't know

c 2) If you haven't, please tell us why:.....

.....

2.2 d) Please describe in as much detail as possible what your fire escape plan includes.

.....

.....

.....

2.2 e) Does your family have a second fire escape plan? This is a plan of what you would do if you couldn't use your first plan.

Yes  No  Don't know

If no, go to question 2.3 on page 8, if yes answer question 2.2f

2.2 f) Please describe in as much detail as possible what your second fire escape plan includes.

.....

.....

.....



2.3. Families often get safety information from lots of people and places.

How satisfied are you with the home safety information provided over *the last year* by each of the following people or places? (Please tick *one* box on each row.)

People or place	Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Haven't received any information from them
a) GP or Practice Nurse						
b) Health Visitor						
c) Children's Centre staff						
d) School or nursery						
e) Local groups, eg. Mother and Toddler						
f) Other – please tell us who this was below ..... ..... ..... .....						

2.4. a) Have you talked to anyone from the Fire and Rescue Service about fire safety?

Yes  No  Don't know

b) If yes, did they visit you at your home and do a home safety check?

Yes  No  Don't know



2.5 Please could you tell us who gave you advice about the things below?

Has anyone told you about.....

a 1) .....preventing falls? Yes  No

a 2) Who gave you this advice?.....

b 1) .....preventing poisonings? Yes  No

b 2) Who gave you this advice?.....

c 1) .....preventing fires? Yes  No

c 2) Who gave you this advice?.....

2.6 If there was a fire in your home or your smoke alarm sounded at night, where do you think your child might be when you went to look for them? (please tick *one* box on each row)

Items	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not relevant. Please explain why: eg child can't get out of cot
<b>My child is likely to be:</b>						
a) in bed asleep						
b) awake in bed/cot waiting for you						
c) outside their bedroom door						
d) looking for you in your bedroom						
e) hiding under their bed						
f) hiding in a cupboard or wardrobe						
g) waiting for you by the front door						
h) already outside your home waiting for you						
i) somewhere else, please describe						

**Previous accidents**

3.1.a) **Has your child/children ever been hurt at home in a fall that needed medical attention?** Yes  No

b) **If yes, can you tell us briefly what happened, please?**

*(How long ago? In what way was your child hurt e.g. bruise, broken bone? )*

.....  
.....  
.....  
.....

3.2.a) **Has your child/children taken anything at home that could have been poisonous that needed medical attention?**

Yes  No

b) **If yes, can you tell us briefly what happened, please?**

*(How long ago? What did your child eat/swallow?)*

.....  
.....  
.....  
.....

3.3.a) **Have you ever been at home when a fire took place?**

Yes  No

b) **If yes, can you tell us briefly what happened?**

*(How long ago? How did the fire start? Was anyone hurt?)*

.....  
.....  
.....  
.....

3.4. a) Have you ever found any of your children playing with matches or lighters?

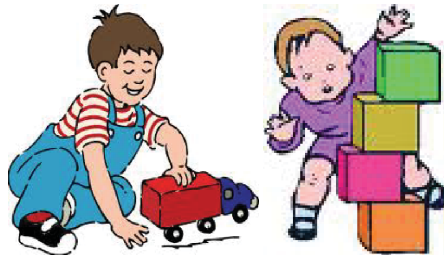
Yes  No

b) If yes, please tell us what happened in as much detail as possible.

.....  
.....

3.5. What are your top three safety tips for families with children under three years old to prevent fires, poisoning or falls?

1.....  
2.....  
3.....



We would be grateful if you could tell us something about yourself by answering the following questions.

4.1 What is your postcode? .....

*If you don't know your postcode, please give us the first line of your address and area in which you live:.....*

.....

4.2 Who is in your family? Please put a number in each box for the number of adults and children

Number of adults who live in your household (18 years and older)

Number of children who live in your household (under 18 years)

4.3 **Age group of parent(s) who live in the household:** *Please put a tick in the*

*box for the age of each parent.*

<b>Mother</b>	16-20 years	<input type="checkbox"/>	<b>Father</b>	16-20 years	<input type="checkbox"/>
	21-25 years	<input type="checkbox"/>		21-25 years	<input type="checkbox"/>
	26-30 years	<input type="checkbox"/>		26-30 years	<input type="checkbox"/>
	31-35 years	<input type="checkbox"/>		31-35 years	<input type="checkbox"/>
	36-40 years	<input type="checkbox"/>		36-40 years	<input type="checkbox"/>
	41-45 years	<input type="checkbox"/>		41-45 years	<input type="checkbox"/>
	46 yrs or more	<input type="checkbox"/>		46 yrs or more	<input type="checkbox"/>
	Not applicable	<input type="checkbox"/>		Not applicable	<input type="checkbox"/>

4.4 **What ages are your children?** *Please tell us the number of children for each age group who live at in the household.*

Number of children

Under 1 year old

1 - 2 years.....

3 - 4 years.....

5 - 9 years .....

10 - 14 years.....

15 - 17 years.....

4.5 **What type of home do you live in?** *Please tick one box*

	House	Flat
Privately rented	<input type="checkbox"/>	<input type="checkbox"/>
Rented: social housing/housing association/council housing	<input type="checkbox"/>	<input type="checkbox"/>
Owner occupied	<input type="checkbox"/>	<input type="checkbox"/>
Live at parents' or other relative's home	<input type="checkbox"/>	<input type="checkbox"/>
Temporary accommodation	<input type="checkbox"/>	<input type="checkbox"/>
Other – please describe eg. hostel	<input type="checkbox"/>	<input type="checkbox"/>

4.6 a). If you live in a house, bungalow or flat, how many other families live with you?

Number of other families

4.6 b) If you live in a flat, what floor is your flat on?

Number of floor

4.6 c) If you live in any other accommodation, what floor is it on?

Number of floor

4.7 a) How many people in your household smoke?

Nobody smokes  1 person  2 people  3 or more people

b) How many cigarettes does each person smoke a day?

*(Place the number of cigarettes smoked in the box for each person)*

Person 1

Person 2

Person 3

4.8 How often do people in your household have a drink containing alcohol?

*Please tick one box on each line for people aged over 14 in your household. If there are more than 3 people just do this for the oldest 3.*

	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
Person 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4.9 How many drinks containing alcohol do people in your household have on a typical day when they have a drink?**

*Please tick one box on each line for people aged over 14 in your household. If there are more than 3 people just do this for the oldest 3.*

	None	1 or 2	3 or 4	5 or 6	7 - 9	10 or more
Person 1						
Person 2						
Person 3						

**4.10 How often do members of your household have six or more drinks on one occasion?**

*Please tick one box on each line for people aged over 14 in your household. If there are more than 3 people just do this for the oldest 3.*

	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
Person 1					
Person 2					
Person 3					

**5.1 What is your first language?:**

English

Other  please describe.....

5.2 What is your ethnic group? Please tick one box only.

**White:**

British  Irish:

Other  Please describe.....

**Asian or Asian British:**

Pakistan  Bangladeshi  Indian

Other  Please describe.....

**Black or black British:**

Caribbean  African

Other  Please describe.....

**Mixed background:**

White & Black Caribbean  White & Black African

White & Asian

Other  Please describe.....

Chinese:

Any other ethnic group?  Please describe .....

5.3 Did you complete this questionnaire yourself? yes  no

If no who helped you, please? .....

**Thank you for completing this questionnaire.**

**Please return this completed questionnaire in the FREEPOST envelope to:**

Keeping Children Safe Research Team [Local research team address]

For Office use only: **UIC:**