HSE
Health & Safety Executive

UNIVERSITY of York

CONFIDENTIAL

SSHeW Study

Stopping Slips among Healthcare Workers (SSHeW)

A randomised study of slip resistant shoes to prevent slips among healthcare workers.

FINAL QUESTIONNAIRE
Intervention participants

Thank you for agreeing to take part in this study.

The footwear in this study has been found to be slip resistant when tested using the Health and Safety Executive Grip rating scheme. The responses you give in this questionnaire will help us find out if wearing this footwear can prevent slips when in the workplace.

For office use only

Centre number: ☐☐

Participant's trial ID number: ☐☐☐☐☐☐

Date questionnaire sent: ☐☐ / ☐☐ / 2 0 ☐☐
Day / Month / Year

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS QUESTIONNAIRE

Please answer ALL the questions. In this study we want to learn about how many slips however minor, people experience during their working day, and whether or not these slips result in falls and/or injuries. In this study a slip is defined as a loss of traction of your foot on the floor surface, which may or may not result in a fall. A fall is defined as an unexpected event in which you come to rest on the ground, floor, or lower level.

If you find it difficult to answer any question, please give the best answer you can. You may find your study diary helpful when completing these questions.

Please follow the instructions for each section carefully.

For each section, if you are asked to put a cross in the box, please use a cross rather than a tick, as if you were filling out a ballot paper.

For example in the following question, if your answer to the question is 'yes', you should place a cross firmly in the box next to yes.

Do you drive a car? ☒ Yes ☐ No

If you are asked to write your answer, please do so by entering your answer in the boxes provided, for example:

How old are you? | 3 | 1 | years

Please use a **black or blue** pen for all the questions.

Please do not use a pencil or any other coloured pen. If you make a mistake then please cross out the incorrect entry, by placing a single line through the words or numbers, and write the correct information to the side. For example ~~DOB 12/03/1980~~ 12/03/1989.

If you have any queries or problems completing this questionnaire please contact the trial co-ordinator, [redacted], telephone number [redacted], email [redacted].

This section asks how many slips (however minor) and falls you have had in the past 14 weeks, if you were hurt, and if you needed hospital treatment or any time off work.

Please enter the date you are completing this questionnaire:

☐☐ / ☐☐ / ☐☐☐☐
Day *Month* *Year*

1 Over the past 14 weeks, have you had any time off work **for any reason**, for example taken holiday or sick leave?

Yes ☐ No ☐

If 'Yes', how many hours did you take off in total? ☐☐☐.☐

2 How many times did you slip (with or without falling) whilst at work in the past 14 weeks?
(If none please answer '000') ☐☐☐

If you did not have a slip please go to question 8.1 on page 7.

2a If you had a slip whilst at work in the past 14 weeks how many of these resulted in a fall (where you came to rest on the ground, floor or lower level)?
(If none please answer "000") ☐☐☐

Please provide the date of the first slip which resulted in a fall:

☐☐ / ☐☐ / ☐☐☐☐
Day *Month* *Year*

2b If you had a slip whilst at work in the past 14 weeks how many of these resulted in an injury?
(If none please answer '000') ☐☐☐

2c Thinking about each slip in which you hurt yourself, please tell us the type of injuries you had over the page. If you haven't hurt yourself as a result of a slip please go to question 8.1 on page 7.

Slip 1

3.1 (Place a cross in the box against all the injuries that apply)

☐ Some superficial wounds, e.g. bruising, mild swelling, cut abrasion

☐ Broken bone(s), please specify type of bone(s) __________

☐ Pulled muscles/sprained ligaments

☐ Other, please specify: __________

3.2 Did the slip result in a fall? Yes ☐ No ☐

3.3 Did you have to take any time off work because of this injury? Yes ☐ No ☐

If 'Yes', how many hours did you take off in total? ☐☐☐.☐ *hours*

3.4 Did you need any care from a healthcare professional because of this injury? Yes ☐ No ☐

If 'NO', go to 'Slip 2' on page 5.

3.4a Thinking about the care you received from the NHS because of this injury, how many times have you seen the following healthcare professionals?

i. Seen your **GP** at your GP practice or at home? ☐☐

ii. Seen a **nurse** at your GP practice or at home? ☐☐

iii. Seen an **occupational therapist**? ☐☐

iv. Seen a **physiotherapist**? ☐☐

v. Seen a **podiatrist**? ☐☐

vi. Other please specify? __________ ☐☐

3.4b Thinking about the care you have received from the NHS **IN** the hospital because of this injury, how many appointments/visits have you:

i. Attended a **hospital clinic** as an outpatient? ☐☐

ii. Visited **Accident and emergency**? ☐☐

iii. Visited hospital as a **day case**? ☐☐

(admitted and discharged in the same day, e.g admitted at 2am and discharged at 10am OR admitted at 8am and discharged at 10pm)

iv. How many nights have you stayed in hospital as an **in-patient** as a results of this injury? *(admitted and discharged on a different day)* ☐☐

Slip 2 (If not applicable, please go to question 7 on page 7)

4.1 (Place a cross in the box against all the injuries that apply)

- ☐ Some superficial wounds, e.g. bruising, mild swelling, cut abrasion
- ☐ Broken bone(s), please specify type of bone(s) ______
- ☐ Pulled muscles/sprained ligaments
- ☐ Other, please specify: ______

4.2 Did the slip result in a fall? Yes ☐ No ☐

4.3 Did you have to take any time off work because of this injury? Yes ☐ No ☐

If 'Yes', how many hours did you take off in total? ☐☐☐.☐ *hours*

4.4 Did you need any care from a healthcare professional because of this injury? Yes ☐ No ☐

If 'NO', go to 'Slip 3' on page 6.

4.4a Care from the NHS **NOT IN** the hospital related to this injury, how many times have you:

i. Seen your **GP** at your GP practice or at home? ☐☐

ii. Seen a **nurse** at your GP practice or at home? ☐☐

iii. Seen an **occupational therapist**? ☐☐

iv. Seen a **physiotherapist**? ☐☐

v. Seen a **podiatrist**? ☐☐

vi. Other please specify? ______ ☐☐

4.4b Care from the NHS **IN** the hospital related to this injury, how many times have you:

i. Attended a **hospital clinic** as an outpatient? ☐☐

ii. Visited **Accident and emergency**? ☐☐

iii. Visited hospital as a **day case**? ☐☐

(admitted and discharged in the same day, e.g admitted at 2am and discharged at 10am OR admitted at 8am and discharged at 10pm)

iv. How many nights have you stayed in hospital as an **in-patient** as a results of this injury? *(admitted and discharged on a different day)* ☐☐

Slip 3 (If not applicable, please go to question 7 on page 7)

5.1 (Place a cross in the box against all the injuries that apply)

- [ ] Some superficial wounds, e.g. bruising, mild swelling, cut abrasion
- [ ] Broken bone(s), please specify type of bone(s) ______
- [ ] Pulled muscles/sprained ligaments
- [ ] Other, please specify: ______

5.2 Did the slip result in a fall? Yes ☐ No ☐

5.3 Did you have to take any time off work because of this injury? Yes ☐ No ☐

If 'Yes', how many hours did you take off in total? ☐☐☐.☐ *hours*

5.4 Did you need any care from a healthcare professional because of this injury? Yes ☐ No ☐

If 'NO', go to question question 7 on page 7.

5.4a Care from the NHS **NOT IN** the hospital related to this injury, how many times have you:

i. Seen your **GP** at your GP practice or at home? ☐☐

ii. Seen a **nurse** at your GP practice or at home? ☐☐

iii. Seen an **occupational therapist**? ☐☐

iv. Seen a **physiotherapist**? ☐☐

v. Seen a **podiatrist**? ☐☐

vi. Other please specify? ______ ☐☐

5.4b Care from the NHS **IN** the hospital related to this injury, how many times have you:

i. Attended a **hospital clinic** as an outpatient? ☐☐

ii. Visited **Accident and emergency**? ☐☐

iii. Visited hospital as a **day case**? ☐☐

(admitted and discharged in the same day, e.g admitted at 2am and discharged at 10am OR admitted at 8am and discharged at 10pm)

iv. How many nights have you stayed in hospital as an **in-patient** as a results of this injury? *(admitted and discharged on a different day)* ☐☐

6 If you had more than 3 slips that resulted in injuries, please list the additional injuries sustained here:

i.

ii.

iii.

7 Are you fully recovered from you injuries? Yes ☐ No ☐

8.1 How many times did you fall at work for **reasons other than a slip in the past 14 weeks?** (For example, tripped or miss stepped).
(If none please answer '000' and go to question 9 on page 8)

Please provide the date of the first fall: ☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

If you haven't hurt yourself as a result of a fall please go to question 9 on page 8.

8.2 How many of these falls resulted in an injury? ☐☐☐

8.3 What sort of injury did you have
(Place a cross in the box against all the injuries that apply)

☐ Some superficial wounds, e.g. bruising, mild swelling, cut abrasion

☐ Broken bone(s), please specify type of bone(s)

☐ Pulled muscles/sprained ligaments

☐ Other, please specify:

8.4 Did you have to take any time off work because of your fall? Yes ☐ No ☐

If 'Yes', how many hours did you take off in total? ☐☐☐.☐ *hours*

8.5 Did you need any care from a healthcare professional because of this injury? Yes ☐ No ☐

If 'NO', go to question 9 on page 8.

8.5a Care from the NHS **NOT IN** the hospital related to this injury, how many times have you:

i. Seen your **GP** at your GP practice or at home? ☐☐

ii. Seen a **nurse** at your GP practice or at home? ☐☐

iii. Seen an **occupational therapist**? ☐☐

iv. Seen a **physiotherapist**? ☐☐

v. Seen a **podiatrist**? ☐☐

vi. Other please specify? ____________ ☐☐

8.5b Care from the NHS **IN** the hospital related to this injury, how many times have you:

i. Attended a **hospital clinic** as an outpatient? ☐☐

ii. Visited **Accident and emergency**? ☐☐

iii. Visited hospital as a **day case**? ☐☐

(*admitted and discharged in the same day, e.g admitted at 2am and discharged at 10am OR admitted at 8am and discharged at 10pm)*

iv. How many nights have you stayed in hospital as an **in-patient** as a results of this injury? *(admitted and discharged on a different day)* ☐☐

9 How often during the past 14 weeks did you worry about slipping whilst you were at work? *(Please cross one box only)*

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

10 How often during the past 14 weeks did you worry about falling whilst you were at work? *(Please cross one box only)*

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

This section asks about your experiences of wearing the trial shoes

11 Did you receive a pair of trial shoes? Yes ☐ No ☐

If ‘Yes’, what date did you receive them? ☐☐ / ☐☐ / ☐☐☐☐
Day *Month* *Year*

If ‘No’, please go to question 20 on page 11.

12 Over the past 14 weeks, typically how often did you wear the trial shoes whilst you were at work? *(Please cross one box only)*

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

13 Did you wear your trial shoes outside of worktime? Yes ☐ No ☐

14 Did you feel more or less likely to slip at work when wearing the trial shoes compared to the shoes you would normally wear at work? *(Please cross one box only)*

Less likely to slip	More likely to slip	Neither more or less likely	Did not wear the shoes
☐	☐	☐	☐

15 Did you feel more or less likely to fall at work when wearing the trial shoes compared to the shoes you would normally wear at work? *(Please cross one box only)*

Less likely to fall	More likely to fall	Neither more or less likely	Did not wear the shoes
☐	☐	☐	☐

16 Thinking about your experiences of wearing the shoes you were given for the trial please tell us if: *(please cross one box only per question)*

a.	You liked their appearance?	Yes ☐	No ☐	
b.	You liked the style of shoe?	Yes ☐	No ☐	
c.	You thought they were a good quality shoe?	Yes ☐	No ☐	
d.	They were a good fit?	Yes ☐	No ☐	
e.	They were comfortable to wear?	Yes ☐	No ☐	
f.	They caused blisters/callouses, foot or other problems?	Yes ☐	No ☐	
	If 'Yes' did you seek treatment?	Yes ☐	No ☐	
	Have these fully resolved?	Yes ☐	No ☐	
g.	They improved or resolved any usual problems you have with your feet?	Yes ☐	No ☐	N/A ☐
h.	They made problems you have with your feet worse?	Yes ☐	No ☐	N/A ☐
i.	They made your feet sweat/smell?	Yes ☐	No ☐	
j.	You were able to wear an insole in the shoe?	Yes ☐	No ☐	N/A ☐
k.	They wore out quickly?	Yes ☐	No ☐	

17 Did you have any problems as a result of wearing the trial shoes or taking part in the study? Yes ☐ No ☐

If ‘Yes’, please specify:

18 Would you wear this type of shoe for work again? Yes ☐ No ☐ Not sure ☐

18a If you would not wear this type of shoe again please tell us why:

19 Would you be willing to buy this range of shoes to wear at work when your current work shoes need replacing? Yes ☐ No ☐ Not sure ☐

Please tell us about any other comments you have about the trial shoe:

20 **General comments (optional)**

If you have any thoughts about the SSHeW study that you would like to share with the research team, then please write your comments in the box below. For example, you might want to describe your experience of taking part in this study.

Thank you for taking the time to complete this questionnaire.
Please return it to the York Trials Unit in the pre-paid envelope provided.