SSHeW: Slip Data Collection Sheet

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

Centre number: ☐☐ **Participant's trial ID number:** ☐☐☐☐☐☐

Please confirm that you had a slip at work between: ☐☐ / ☐☐ / 2 0 ☐☐
Day / Month / Year

and ☐☐ / ☐☐ / 2 0 ☐☐ Yes ☐ No ☐ *(please cross one box only)*
Day / Month / Year

If 'No', there is no need to complete the rest of the form, as it is not relevant. Please return it in the pre-paid envelope provided.

If 'Yes', we would like to find out some information about this slip If you reported more than one slip during that week, then please tell us about the worst slip you had. In this study we are defining a slip as a loss of traction of your foot - you can slip without falling.

Please enter the date you are completing this questionnaire: ☐☐ / ☐☐ / ☐☐☐☐
Day / Month / Year

How many hours did you work in the week from: ☐☐ / ☐☐ / ☐☐☐☐
Day / Month / Year

and ☐☐ / ☐☐ / ☐☐☐☐ ☐☐.☐ *hours*
Day / Month / Year

1.1 Please tell us if you had a: Slip without falling (however minor) ☐ Slip and fall ☐
(Please cross one box only)

1.2 Please tell us the date of this slip? ☐☐ / ☐☐ / ☐☐☐☐
Day / Month / Year

1.3 Were you wearing shoes provided by the trial when you slipped?
(Please cross one box only)
Yes ☐ No ☐ I don't know ☐

1.4 Where did you slip? *(Please cross one box only)*

- ☐ On a ward or other clinical area in a hospital
- ☐ In a non-clinical area in a hospital e.g. office, corridor
- ☐ In an catering area where food is prepared or served
- ☐ Outside
- ☐ Inside a patient's home
- ☐ Other, please specify: _____

1.5 When you slipped what type of surface were you walking on? *(Please cross one box only)*

A smooth surface ☐ A textured surface ☐

1.6 Did you suffer any injuries as a result of your slip? *(Please cross all that apply)*

- ☐ No injury
- ☐ 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: _____

If you did not have an injury please go to Question 2 on page 3.

1.7 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*

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

If 'No', please go to Question 2 on page 3.

1.8a 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: _____ ☐☐

1.8b 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)* ☐☐

2. If you wish to tell us anything else about your slip please write it below.

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

I have no problems in walking about ❑
I have slight problems in walking about ❑
I have moderate problems in walking about ❑
I have severe problems in walking about ❑
I am unable to walk about ❑

SELF-CARE

I have no problems washing or dressing myself ❑
I have slight problems washing or dressing myself ❑
I have moderate problems washing or dressing myself ❑
I have severe problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ❑
I have slight problems doing my usual activities ❑
I have moderate problems doing my usual activities ❑
I have severe problems doing my usual activities ❑
I am unable to do my usual activities ❑

PAIN / DISCOMFORT

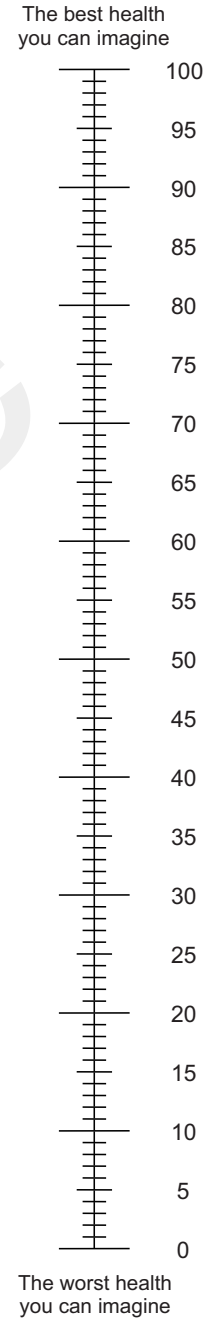
I have no pain or discomfort ❑
I have slight pain or discomfort ❑
I have moderate pain or discomfort ❑
I have severe pain or discomfort ❑
I have extreme pain or discomfort ❑

ANXIETY / DEPRESSION

I am not anxious or depressed ❑
I am slightly anxious or depressed ❑
I am moderately anxious or depressed ❑
I am severely anxious or depressed ❑
I am extremely anxious or depressed ❑

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



For office use only

1. Did the slip result in an adverse event?
   If 'Yes', complete an adverse event form

Yes ☐ No ☐