CONFIDENTIAL

SSHeW Study

Stopping Slips among Healthcare Workers (SSHeW)

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

POST 14 WEEK INJURY FOLLOW UP QUESTIONNAIRE

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 questionnaire we would like to know about the care you have received due to an injury you have had at work.

If you find it difficult to answer any question, please give the best answer you can.

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].

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

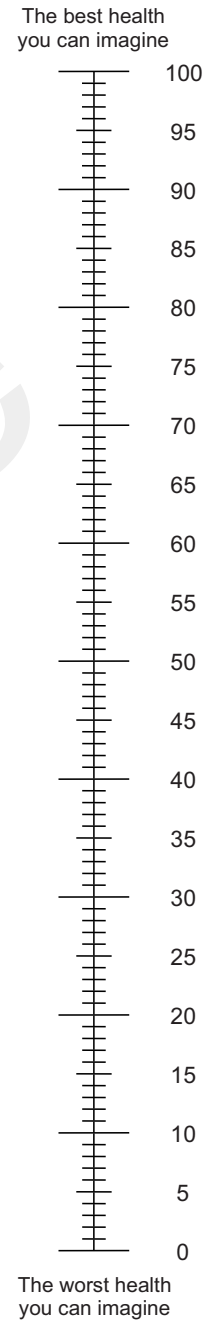
I have no pain or discomfort ❑
I have slight pain or discomfort ❑
I have moderate pain or discomfort ❑
I have severe pain or discomfort ❑
I have extreme pain or discomfort ❑

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 = ☐



SECTION 2:

1. Did you have to take any time off work because of this slip in the past 4 weeks? Yes ☐ No ☐

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

2. Have you received any care from a healthcare professional because of this injury in the past 4 weeks? Yes ☐ No ☐

   If 'No', go to Q3.

   If 'Yes', please answer 2a and 2b. Please fill in all of the boxes even if you have not had any visits for that particular service. This information is really important for us.

   For example, if you did not use a particular service then please put a '0' in both boxes: 0 0

   I you have used a service three times then please write 0 3

2a. Thinking about the care you received from the NHS because of this injury, how many times in the past 4 weeks have you seen the following healthcare professionals:

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

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

   iii. An occupational therapist? ☐☐

   iv. A physiotherapist? ☐☐

   v. A podiatrist? ☐☐

   vi. Other please specify? _____ ☐☐

2b. Thinking about the care you received from the NHS **IN** the hospital because of this injury, how many times in the past 4 weeks 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*) ☐☐

3. Are you now fully recovered from this injury? (*Please cross one box only*) Yes ☐ No ☐

If 'Yes' how many days ago did you feel you had fully recovered? ☐☐☐

If 'No' are you happy for us to contact you again in 4 weeks to ask you these questions again? Yes ☐ No ☐

Please enter the date you are completing this questionnaire:

☐☐ / ☐☐ / ☐☐☐☐
Day *Month* *Year*

4. **General comments (optional)**

If you have any thoughts or comments about your injury that you would like to share with the research team, then please write them in the box below

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