Keeping Children Safe From Accidents

keeping children SAFE AT HOME

Please complete this questionnaire for your child born on .....

Is your child ☐ Male ☐ Female

Please tell us the date you completed this questionnaire .....

Your answers really are important to us. Thank you for taking the time to help us with this study.

cc study CONTROL ques Age group 2 V2.2 11.02.2011

Part 1. About your child's development, health and behaviour

All children develop at their own rate so we would like to ask you what your child can do. There are no right or wrong answers.

1.1 Please tell us whether your child does each thing often, has only done it once or twice or has not started to do it yet.

Please ✓ one box on each line

	Often	Once or twice	Not yet
Crawling			
Shuffling along the floor on his/her bottom			
Walking			

1.2 At the moment, how likely do you think it is that your child could:
(If your child is too young to be able to do some of these things, put a tick in the "not likely" box)

Please ✓ one box on each line

	Very likely	Quite likely	Not likely	Don't Know
Reach, or climb on to a worktop				
Reach, or climb on to something to reach a cupboard at adult eye level				
Open cupboards, drawers or medicine cabinets with locks or safety catches on them				
Open a fridge with a lock or safety catch on it				
Open a container with a child resistant cap				
Open a lockable medicine box				
Get medicines out of blister packs				
Touch things that you have told him/her not to				
Open a stair gate or safety gate				
Reach, or climb on to something to reach a pan on the cooker				
Reach, or climb on to something to reach a hot water tap				
Reach to pull a table cloth hanging over the side of a table				
Turn a hot water tap on by him/herself				
Climb into the bath by him/herself				
Climb onto furniture e.g. sofa, chair, bed				
Climb out of a cot				
Roll off a bed or high surface				
Climb up to a top bunk bed				

1.3 Does your child have any long-term conditions (e.g. problems with hearing, eye sight, development, fits etc) that have been diagnosed by a health professional?
Long-term means anything that your child has had for at least 3 months or is expected to continue for at least the next 3 months.

☐ Yes ☐ No

If YES, please tell us what conditions your child has:

.....

1.4 How was your child's health **IN THE LAST 24 HOURS**? Please put an "x" on the line below to indicate how good or how bad your child's health was:

Worst possible health _____ Perfect health

PLEASE COMPLETE 1.5 IF YOUR CHILD IS AGED 2 YEARS OR OVER
FOR CHILDREN AGED UNDER 2 YEARS – please go to 1.7

1.5 Below is a list of things that might be a problem for your child. Please tell us how much of a problem each one has been for your child during the **LAST TWO WEEKS** by circling:

0 if it is never a problem
1 if it is almost never a problem
2 if it is sometimes a problem
3 if it is often a problem
4 if it is almost always a problem

There are no right or wrong answers.

In the **LAST TWO WEEKS**, how much of a problem has your child had with….

Physical Functioning (problems with…)	Never	Almost Never	Some times	Often	Almost Always
1. Walking	0	1	2	3	4
2. Running	0	1	2	3	4
3. Participating in active play or exercise	0	1	2	3	4
4. Lifting something heavy	0	1	2	3	4
5. Bathing	0	1	2	3	4
6. Helping to pick up his or her toys	0	1	2	3	4
7. Having hurts or aches	0	1	2	3	4
8. Low energy level	0	1	2	3	4

Emotional Functioning (problems with…)	Never	Almost Never	Some times	Often	Almost Always
1. Feeling afraid or scared	0	1	2	3	4
2. Feeling sad or blue	0	1	2	3	4
3. Feeling angry	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Worrying	0	1	2	3	4

Social Functioning (problems with…)	Never	Almost Never	Some-times	Often	Almost Always
1. Playing with other children	0	1	2	3	4
2. Other kids not wanting to play with him or her	0	1	2	3	4
3. Getting teased by other children	0	1	2	3	4
4. Not able to do things that other children his or her age can do	0	1	2	3	4
5. Keeping up when playing with other children	0	1	2	3	4

1.6 Does your child attend school or day care? *(please ✓ one box)*

☐ Yes - Please complete the next 3 questions

☐ No - Please go to 1.7

School Functioning (problems with…)	Never	Almost Never	Some times	Often	Almost Always
1. Doing the same school activities as peers	0	1	2	3	4
2. Missing school/daycare because of Not feeling well	0	1	2	3	4
3. Missing school/daycare to go to the Doctor or hospital	0	1	2	3	4

1.7 Have you taught your child any rules or instructions about keeping safe at home? If your child is too young to teach some of these rules to, put a tick in the "No" box next to each rule.

	Have you taught your child these rules? *Please ✓ one box for each question*		**If YES**, how often does your child follow these rules? *(Please ✓ one box for each question)*				
	Yes	No	Always	Most times	Some times	Occasionally	Never
What to do or not do when parents are cooking using the top of the cooker							
What to do or not do with hot things in the kitchen e.g. kettle							
What to do or not do when he/she is in the bathtub							
About things in the kitchen that he/she is not supposed to climb on							
What to do or not do when he/she sees cleaning products							
What to do or not do if there is medicine on the work top							
What to do or not do if the floor is slippery							
About running in the house							
About jumping on the bed or furniture							
What to do or how he/she is supposed to behave when going down the stairs							
About carrying big things or lots of things while going down stairs							
About leaving things on the stairs							

1.8 Please tell us how often your child did each of the things described below during the **LAST TWO WEEKS** by ticking one of the boxes. You may not be able to answer some of the questions because you may not have seen your child in that situation, e.g. if the question is about going down a slide and your child did not do this in the last 2 weeks, then tick the "Not Applicable" box.

Please ✓ one box on each line

	Never	Very rarely	Less than half the time	About half the time	More than half the time	Almost always	Always	Not applicable
While bathing, how often did your child sit quietly?								
While bathing, how often did your child splash, kick or try to jump?								
While participating in daily activities, how often did your child move quickly from one place to another?								
While participating in daily activities, how often did your child seem full of energy, even in the evening?								
During sleep how often did your child toss about in the bed?								
During sleep how often did your child sleep in one position only?								
When playing outdoors with other children, how often did your child seem to be one of the most active children?								
When playing outdoors with other children, how often did your child sit quietly and watch?								
When being dressed or undressed, how often did your child squirm and try to get away?								
When being dressed or undressed, how often did your child stay still?								
When playing indoors, how often did your child run through the house?								
When playing indoors, how often did your child climb over furniture?								
While playing outdoors, how often did your child:								
Like making lots of noise?								
Want to climb to high places (e.g. up a tree or on a climbing frame)?								
Choose to take chances for the fun and excitement of it?								
Not like going down high slides at the play ground?								
Want to jump from heights?								
Want to go down the slide in unusual ways (e.g. head first)?								

	Never	Very rarely	Less than half the time	About half the time	More than half the time	Almost always	Always	Not applicable
While playing indoors, how often did your child:								
Like rough and rowdy games?								
Enjoy playing boisterous games like chase?								
Enjoy vigorously jumping on the bed or settee?								
Not like rough or rowdy games?								
Enjoy activities such as being spun etc?								

Part 2. About your home

Every home has things that may not seem very safe for children. We want to find out which things really are safe or not. Please answer the questions below as honestly as possible.

Please think about THE LAST 24 HOURS:

2.1 Please tell us where your medicines and cleaning products were IN THE LAST 24 HOURS.

	Did you have this in your home? *(Please ✓ one box)*		**IF YES** At what level was it? *(Please ✓ all that apply)*		**IF YES** Where was it? *(Please ✓ all that apply)*		
	Yes	No	At adult eye level or above	Below adult eye level	Cupboard, medicine cabinet, drawer or fridge with lock or safety catch	Cupboard, medicine cabinet, drawer or fridge without lock or safety catch	Other place without lock e.g. shelf, handbag, work surface
Painkillers e.g. Calpol							
Iron or vitamins							
Cough mixture							
Antidepressants or sleeping tablets							
Any other medicines in the kitchen							
Any other medicines in the bathroom							
Any other medicines anywhere else in the house							
Bleach							
Dishwasher products							
Oven cleaner							
Toilet cleaner							
White spirit/ turpentine							
Rat or ant killer							
Garden chemicals e.g. weed killer							
Any other household products							

Still thinking about THE LAST 24 HOURS:

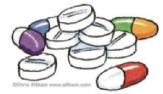
2.2 Did all your medicines have child resistant caps or blister packs? ☐ Yes ☐ No

2.3 Had any medicines been put in a container different from the one they came in? ☐ Yes ☐ No

2.4 Were all medicines kept in a locked medicine box? ☐ Yes ☐ No

2.5 Were any medicines kept in the fridge? ☐ Yes ☐ No

If YES, was the fridge closed with a lock or safety catch? ☐ Yes ☐ No



2.6 Did all your cleaning products have child resistant caps? ☐ Yes ☐ No

2.7 Had any cleaning products been put in a container different from the one they came in? ☐ Yes ☐ No

2.8 Did you use a safety gate to stop your child/children getting in to the kitchen? ☐ Yes ☐ No

2.9 Was there anything your child could climb on to reach work tops, shelves, cupboards etc, in any of your rooms? ☐ Yes ☐ No

2.10 Did you use protective corner covers on any of your furniture? ☐ Yes ☐ No

2.11 Did your child use a baby walker? ☐ Yes ☐ No

2.12 Did your child use a stationary play centre (like a baby walker without wheels) ☐ Yes ☐ No

cc study CONTROL ques Age group 2 V2.2 11.02.2011

Still thinking about THE LAST 24 HOURS:

2.13 Did your child use a playpen? ☐ Yes ☐ No

2.14 Did your child use a travel cot instead of a playpen? ☐ Yes ☐ No

2.15 Did you have a kettle with a curly flex or a cordless kettle? ☐ Yes ☐ No

2.16. Where was your kettle? *(Please ✓ one box)*

☐ At the front of the work top or table ☐ Between the front and back of the work top or table

☐ At the back of the worktop or table ☐ On the front ring of the cooker

☐ On the back ring of the cooker ☐ Other (*please describe*).....

2.17 How hot was your hot tap water? *(Please ✓ one box)*

☐ Very hot – you couldn't have a bath without adding a lot of cold water

☐ Hot – you would need to add some cold water to the bath

☐ Warm enough– you don't need to add any cold water to the bath

☐ Not very warm – not warm enough to have a bath in

2.18 Do you know the temperature of your hot tap water? *(Please ✓ one box)*

☐ Lower than 54^{0}C ☐ 54^{0}C or higher ☐ Don't know

2.19 Were all carpets or rugs in your home firmly fixed to the floor? ☐ Yes ☐ No

2.20 Do you have any stairs in your home? ☐ Yes ☐ No (if no, go to question 2.29)

2.21 Did you use any stair gates or safety gates in your home? ☐ Yes ☐ No

If YES, where did you use them? *(Please ✓ all that apply)*

☐ Bottom of stairs ☐ Top of stairs

☐ Other (*please tell us where*).....

Still thinking about THE LAST 24 HOURS:

2.22 Were any of your stair gates on the stairs left open? ☐ Yes ☐ No

2.23 Which of the following describe how your stairs look? *(Please ✓ all that apply)*

☐ Carpeted ☐ Exposed wood ☐ Exposed metal or concrete

☐ Lino/vinyl covered ☐ Don't know ☐ Other *(please describe)*.....

2.24 Please put a tick in the box that best describes your agreement with each of the following:

Please ✓ one box on each line

	Agree	Neither agree nor disagree	Disagree
The stairs are too steep			
The stairs are too narrow			
The stairs are poorly lit			
The steps are in need of repair			
The banister/handrail is in need of repair			
The stair covering is in need of repair			
The stairs are safe to use			

2.25 Are there any handrails on the wall next to your stairs? *(Please ✓ one box)*

☐ Yes on all stairs ☐ Yes on some stairs ☐ No

2.26 Is there a banister/railings at the side of your stairs to stop people from falling through? *(Please ✓ one box)*

☐ Yes on all stairs ☐ Yes on some stairs ☐ No

If YES, how wide are the biggest gaps between the railings? .....*(please write in number of inches)*

2.27 Do any of your stairs have a landing part way up? ☐ Yes ☐ No

2.28 Are any of your stairs spiral or winding stair cases? ☐ Yes ☐ No

Thinking about the LAST WEEK:

2.29 How often did these things happen in the **LAST WEEK**? If you did not have the things the question is asking about e.g. high chair, tick the "does not apply" box. For questions that ask about older children, if you do not have older children, tick the "does not apply" box.

Please ✓ one box on each line

	Does not apply	Every day	Most days	Some days	Never
Your child was held, even for a moment, by someone holding a hot drink?					
Your child was held, even for a moment, by someone using the cooker?					
Hot drinks were passed over your child's head?					
Hot drinks were left within the reach of your child e.g. coffee table, work top, other low surface?					
Hot drinks or hot liquids were put on a table with a table cloth?					
The front rings of the cooker were used?					
Pan handles were turned towards the back of the cooker whilst cooking?					
Your child was left in the bathroom, without an adult whilst the bath was running, even for a moment e.g. to collect clothes, nappies or answer the phone?					
Your child was left in the bath without an adult, even for a moment e.g. to collect clothes, nappies or answer the phone?					
A bath was run for your child by an older child?					
An older child looked after your child in the bath?					
The bath was run using cold water first?					
The temperature of your child's bath water was checked using a thermometer or other gadget?					
The temperature of your child's bath water was checked using a hand or elbow?					
There were things on your floors that could be tripped over?					
Your child was left on a raised surface e.g. table, sofa, adult bed, even for a moment?					
Your child's nappy was changed on a raised surface e.g. bed, changing table, work top?					
Your child was put in a car seat or bouncing seat on a raised surface e.g. table, work top, even for a moment?					
There were wires or cables trailing across the floor?					
Your child climbed onto or played on furniture e.g. bed, chair, sofa?					

	Does not apply	Every day	Most days	Some days	Never
Your child climbed onto or played on garden furniture?					
There were things on your stairs that could be tripped over?					
Your child used a high chair without being strapped in with the harness/straps?					
Your child played in the garden without an adult in the garden?					
A safety gate was used to stop your child getting into the garden?					
The back door was locked to stop your child getting into the garden?					

2.30 Please tell us how often these things happened in the **LAST WEEK**. If you did not have or did not use some of these medicines or cleaning products please tick the "does not apply" box.

Please ✓ one box on each line

The following were put away IMMEDIATELY after use:	Does not apply	Every time	Most times	Some times	Never
Painkillers (e.g. Calpol)					
Iron or vitamins					
Cough mixtures					
Antidepressant or sleeping tablets					
Other medicines					
Bleach					
Dishwasher products					
Oven cleaner					
Toilet cleaner					
White spirit/turpentine					
Rat or ant killer					
Garden chemicals e.g. weed killers					
Any other household products					

Part 3. About the worries of family life

3.1 The statements below describe things that often happen in families with young children. These things sometimes make life difficult. Please read each statement and tick how often it happens to you and then tick how much of a "hassle" you feel it has been for you in the **PAST 6 MONTHS**. **Please answer these questions thinking about all of your children.**

	How often it happens				**Hassle (low to high)**				
	Rarely	Sometimes	A lot	Constantly	1 low	2	3	4	5 high
Continually cleaning up messes of food or toys									
The children's schedules (like pre-school or other activities) interfere with your own household needs									
The children are constantly underfoot, interfering with other chores									
Having to change your plans because of unexpected child needs									
The children get dirty several times a day needing changes of clothing									
Difficulties in getting children ready for outings and leaving on time									
Having to run extra errands to meet the children's needs									
Fights with brothers or sisters require a referee (if you only have one child, please write "only one child")									

3.2 Please read each statement and tick the box next to each one which comes closest to how you have been feeling in the **PAST WEEK**. Don't take too long over your replies: your first reaction to each item will probably be better than thinking about it for too long.

I feel tense or 'wound up':		**I feel as if I am slowed down:**	
Most of the time		Nearly all of the time	
A lot of the time		Very often	
Time to time, occasionally		Sometimes	
Not at all		Not at all	
I still enjoy the things I used to enjoy:		**I get a sort of frightened feeling like 'butterflies in the stomach':**	
Definitely as much		Not at all	
Not quite so much		Occasionally	
Only a little		Quite often	
Not at all		Very often	
I get a sort of frightened feeling like something awful is about to happen:		**I have lost interest in my appearance:**	
Very definitely and quite badly		Definitely	
Yes, but not too badly		I don't take as much care as I should	
A little, but it doesn't worry me		I may not take quite as much care	
Not at all		I take just as much care as ever	
I can laugh and see the funny side of things:		**I feel restless as if I have to be on the move:**	
As much as I always could		Very much indeed	
Not quite so much now		Quite a lot	
Definitely not so much now		Not very much	
Not at all		Not at all	
Worrying thoughts go through my mind:		**I look forward with enjoyment to things:**	
A great deal of the time		As much as I ever did	
A lot of the time		Rather less than I used to	
From time to time but not too often		Definitely less than I used to	
Only occasionally		Hardly at all	

I feel cheerful:		**I get sudden feelings of panic:**	
Not at all		Very often indeed	
Not often		Quite often	
Sometimes		Not very often	
Most of the time		Not at all	
I can sit at ease and feel relaxed:		**I can enjoy a good book or radio or TV programme:**	
Definitely		Often	
Usually		Sometimes	
Not often		Not often	
Not at all		Very seldom	

4. About your family

4.1 How many children, including step-children, (under 5) do you have living with you? ..... *(Please give number)*

4.2 How many children, including step-children, (aged 5-16) do you have living with you? ..... *(Please give number)*

4.3 The total number of adults and children living in our home is: ..... *(Please give number)*

4.4. I am the child(ren's) *(Please ✓ one box)*

☐ Mother ☐ Father ☐ Grandparent ☐ Other *(Please say what)* .....

4.5 How many brothers and sisters (including step-brothers/step-sisters) does your child have?

..... older brothers and sisters ..... younger brothers and sisters *(Please give number)*

4.6 Does your child live? *(Please ✓ one box)*

☐ In one house only

☐ In a residential home

☐ Part time in one house and part time in another house [please answer the remaining questions about the house where they spend most of their time]

4.7 How many adults, over the age of 16, live in the house with your child? *(Please ✓ one box)*

☐ One parent ☐ Both parents ☐ One parent and other adults

☐ Both parents and other adults ☐ Other (Please describe) .....

4.8 How many adults living in the house with your child work in a paid job? *(Please ✓ one box)*

☐ None ☐ One ☐ Two ☐ More than two

4.9 What kind of house does your child live in? *(Please ✓ one box)*

☐ Rented house ☐ House owned by, or being bought by family

☐ Other *(Please say what)*.....

4.10 My family usually has the use of a car ☐ Yes ☐ No

4.11 My family receives one or more state benefits as well as child benefit ☐ Yes ☐ No

4.12 The postcode where my child lives is:.....

If you are the mother of the child in this survey, please answer the next question. Otherwise please go to question 4.14

4.13 When my first child was born my age was: .....years

4.14 I am *(Please ✓ one box)*

☐ White (e.g. White British, Irish, other white background) ☐ Black (e.g. Caribbean, African)

☐ Asian (e.g. Indian, Pakistani, Bangladeshi, Chinese) ☐ Other *(Please say what.....)*

4.15 The total number of rooms in our home is: ..... *(Please give number)*
(***do not count bathrooms or toilets or rooms that can only be used for storage such as cupboards***)

4.16 Who else looks after your child? *(Please ✓ all that apply)*

☐ Day Nursery ☐ Preschool ☐ Playgroup ☐ School

☐ Childminder ☐ Family/grandparents ☐ Friends ☐ N/A

☐ Other *(Please say who)* .....

4.17 In a typical week how many hours is your child cared for by somebody else away from the family home (please include all those ticked in 4.16)?

..... hours *(please give number)*

4.18 Is there anything else you would like to tell us about the things that you do at home to keep your child/children safe?

.....

.....

.....

.....

.....

Thank you very much for filling in this questionnaire. Your answers are very important in helping us stop children's accidents.

Please send this back to us in the FREEPOST ENVELOPE

We will need your name and address so that we can send you your gift voucher. Please fill in the pink form and send it back with your questionnaire

Thank you very much for filling in this questionnaire. Your answers are very important in helping us stop children's accidents.

Please send this back to us in the FREEPOST ENVELOPE

We will need your name and address so that we can send you your gift voucher

Please fill in the pink form and send it back with your questionnaire

☐☐ ☐☐☐☐☐☐ ☐☐ ☐☐

cc study CONTROL ques Age group 2 V2.2 11.02.2011