Keeping Children Safe: Measuring the cost of children's accidents

These questions ask about how much your child's accident cost you, your family and the NHS in the FIRST TWO WEEKS after the accident and whether your child is getting better.

Part 1. About your child's recent visit to the Accident and Emergency (A&E) Department, Minor Injuries Unit or Walk In Centre

These questions are about your child's visit to the A&E Department, Minor Injuries Unit or Walk-In Centre after an accident, on __/__/____

1.1 **Please tell us which hospital/unit/centre you went to:** *(please ✓ all that apply)*

- ☐ Queen's Medical Centre, Nottingham
- ☐ Norfolk and Norwich University Hospital, Norwich
- ☐ Frenchay Hospital, Bristol
- ☐ Bristol Royal Hospital for Children
- ☐ Royal Victoria Infirmary, Newcastle
- ☐ Queen Elizabeth Hospital, Gateshead
- ☐ North Tyneside Hospital, North Shields
- ☐ Wansbeck Hospital, Ashington
- ☐ NHS Walk-In Centre (*please give name)* _____
- ☐ Minor Injuries Unit (*please give name)* _____
- ☐ Other (*please describe)* _____

1.2 **Did your child stay in hospital for ONE OR MORE NIGHTS because of their accident?**

(Please ✓ one box)

☐ Yes ☐ No

If **YES**, please tell us the date when they first stayed in hospital (admission date) and the date when they left hospital (discharge date).

Admission date ..... Day..... Month..... Year

Discharge date ..... Day..... Month..... Year

1.3 **Did your child have any of these tests in the A&E Department, Minor Injuries Unit, Walk-In Centre or on the ward?** (*Please ✓ one box for each line)*

	Yes	No	Don't Know
Blood test			
Urine test			
X-ray			
Scan (ultrasound, MRI or CT scan)			
Other(s) (please describe)			

1.4 Did your child have any of these treatments in the A&E Department, Minor Injuries Unit, Walk-In Centre or on the ward?

(*Please ✓ one box for each line)*

	Yes	No	Don't know
Observation (kept in A&E, Minor Injuries Unit or on ward so child can be checked to make sure there are no problems)			
Advice			
Medicine given by mouth			
Medicine given by injection			
Cream put on their skin			
Medicine given to take home			
Dressing for wound or burn			
Stitches			
Paper stitches (steri-strips) or wound glue			
Bandage, sling or support			
Splint (equipment to stop injured part of body moving)			

Manipulation of broken or fractured bone (putting bone back in line)			
Manipulation of dislocated joint (putting joint back in place)			
Operation to fix broken or fractured bone using metal plate, pins or wires			
Cast to hold broken or fractured bone in place (e.g. plaster, resin, fibre-glass cast)			
Physiotherapy			
Stomach wash out			
General anaesthetic (being put to sleep for an operation)			
Local anaesthetic (injection to numb part of body)			
Tetanus injection			
Drip			
Blood transfusion			
Chest drain			
Oxygen through mask or tube to help breathing			
Tube in throat for child who cannot breathe for themselves			
Resuscitation (to restart breathing or heart)			
Other(s) *(please describe)*			

1.5 **Do you think your child is now completely better and their accident is not affecting them anymore?** *(Please ✓ one box)*

☐ Yes ☐ No

Part 2. Visits to your GP for your child's accident

2.1 **In the FIRST TWO WEEKS after the accident, how many times has your child visited any of these health professionals at your <u>GP's surgery</u> because of their accident?** *(Please put '0' if <u>none</u>)*

	Number of visits
GP	.....
Practice nurse	.....
Other (please say who) _____	.....

Part 3. Visits to other health professionals for your child's accident

3.1 **In the FIRST TWO WEEKS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident?** *(Please put '0' if none)*

	Number of visits	Treatment site (e.g. home, clinic, name of hospital)	Did you pay for this visit?	
			Yes	No
Doctor / Consultant				
Health visitor				
Physiotherapist				
Nurse (Don't include GP visits here)				
Other (please say who)(Don't include visits to Practice Nurse here)				

Part 4. Stays in hospital AND visits to the Day Case Unit for your child's accident

4.1 **In the FIRST TWO WEEKS after the accident, has your child had to stay in hospital overnight or visit a day case unit because of their accident?** *(Please ✓ one box)*

☐ Yes – please fill in the table below

☐ No – please go to Section 5

	Admission Date	Discharge Date	Name of the hospital	Name of consultant *(if known)*	Name of ward *(if known)*
Stay 1					
Stay 2					
Stay 3					
Stay 4					
Stay 5					

Part 5. Medicine and medical supplies for your child's accident

5.1 **In the FIRST TWO WEEKS after the accident, has your child taken any PRESCRIBED medicines because of their accident?** *(Please ✓ one box)*

☐ Yes – please fill in the table below

☐ No - please go to Section 5.2

Please list all medicines prescribed by a doctor or nurse because of your child's accident.

Name of medicine	About HOW OFTEN and HOW LONG did your child take this medicine?
e.g. paracetamol, calpol, nurofen	e.g. four times a day for 2 weeks
1.	
2.	
3.	
4.	
5.	

5.2 **In the FIRST TWO WEEKS after the accident, has your child taken any medicines that were BOUGHT WITHOUT A PRESCRIPTION because of their accident?** *(Please ✓ one box)*

☐ Yes – please fill in the table below

☐ No - please go to Section 5.3

Please list all the medicines bought without a prescription because of your child's accident?

Name of medication	About HOW OFTEN and HOW LONG did your child take this medicine?
e.g. paracetamol, calpol, nurofen	e.g. four times a day for 2 weeks
1.	
2.	
3.	
4.	
5.	

5.3 **In the FIRST TWO WEEKS after the accident, have you GOT ANY AIDS OR MADE ANY CHANGES to help your child in the home or garden because of their accident?** *(Please ✓ one box)*

☐ Yes – please fill in the table below

☐ No – please go to Section 6

Type of Aid/Changes made *(e.g. Wheel chair)*	**Cost of item (if known)**	**Who bought this or gave you this?** *(e.g. (yourself, family, NHS, social services, other)*
1.		
2.		
3.		
4.		
5.		

Part 6. Childcare and other costs

6.1 **When you took your child who had the accident to see a health professional, did you need to get someone to look after your other children and/or other people you care for?** (*Please ✓ one box)*

☐ Yes ☐ No ☐ Not applicable

If YES,

a) Who looked after your children or the other people you care for? *(please ✓ all that apply)*

☐ Relative

☐ Friend

☐ Professional carer *(e.g. childminder)*

b) In total, how long did they look after your children and/or the other people you care for?
..... Days ..... Hours

6.2 **In the FIRST TWO WEEKS after the accident, has your child who had the accident needed extra care that you paid for because of their accident?** *(Please ✓ one box)*

☐ Yes ☐ No

If YES,

How many days care did your child have? ..... Days

How many hours care per day? ..... Hours

Part 7. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child in the FIRST TWO WEEKS after their accident. Please only include care they have provided because of the accident, not care they would usually provide. [Please include your first visit to the A&E Department, Minor Injuries Unit or Walk-In Centre.]

Please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	**Carer 1**	**Carer 2**
What is the relationship of this person to your child?	☐ Parent ☐ Relative (not parent) ☐ Friend ☐ Other *(please describe)*	☐ Parent ☐ Relative (not parent) ☐ Friend ☐ Other *(please describe)*
Total number of days taken off work or usual activities, in the FIRST TWO WEEKS after the accident, by this person to care for your child. Only include care provided because of the accident. e.g. if you took 3 days off work in the first week after the accident, and grandmother took 1 day off work in the first week and 1 day off work in the second week to look after your child, you would write "3" in the carer 1 box and "2" in the carer 2 box.	..... Days	..... Days
Did this person lose any money from work because they were caring for your child?	☐ Yes ☐ No	☐ Yes ☐ No
Sex of this person	☐ Male ☐ Female	☐ Male ☐ Female

Age of this person	☐ Less than 21yrs ☐ 21-29yrs ☐ 30-39yrs ☐ 40-49yrs ☐ 50-59yrs ☐ 60+yrs	☐ Less than 21yrs ☐ 21-29yrs ☐ 30-39yrs ☐ 40-49yrs ☐ 50-59yrs ☐ 60+yrs
What best describes this person's usual activities? Please ✓ ONE BOX only	☐ Works full-time ☐ Works part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Housewife/husband ☐ Other (please describe)	☐ Works full-time ☐ Works part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Housewife/husband ☐ Other (please describe)

Part 8. Travel

8.1 **In the FIRST TWO WEEKS after the accident, did you spend any money on travelling to the A&E department, Minor Injuries Unit or Walk-In Centre because of your child's accident?** [Please include your first visit] *(Please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……..

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) .....

8.2 **In the FIRST TWO WEEKS after the accident, did you spend any money on travelling to the hospital (other than to the A&E department, Minor Injuries Unit or Walk-In Centre) because of your child's accident?** *(Please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……..

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

8.3 **In the FIRST TWO WEEKS after the accident, did you spend any money on travelling to the GP's surgery because of your child's accident?** *(Please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……..

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

8.4 **In the FIRST TWO WEEKS after the accident, did you spend any money travelling anywhere else because of your child's accident?** *(Please ✓ one box)*

☐ Yes ☐ No

If YES, please tell us where you travelled to and give details below.

Travelled to _____

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……..

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

Part 9. Other accidents

Most children have accidents at some time. How well they get better may be affected by having other accidents afterwards. This is why we are asking you about any other accidents your child has had recently.

9.1 **Has your child visited the A&E department, Minor Injuries Unit or Walk-In Centre because of an accident since __/__/____.**

☐ Yes ☐ No

If YES, please tick why they went to A&E, Minor Injuries Unit or Walk-In Centre
(Please ✓ all that apply)

☐ A slip, trip, fall or tumble on stairs or steps

☐ A slip, trip, fall or tumble on the same level

☐ A slip, trip, fall or tumble from furniture

☐ Swallowing medicine or pills

☐ Swallowing cleaning products or garden chemicals

☐ A scald from hot water, other hot liquid or steam

☐ Other accident (*Please describe*)……

What sort of accident was it? *(Please ✓ all that apply)*

☐ Loss of consciousness

☐ Bang on the head

☐ Broken bone

☐ Burn or scald

☐ Swallowed household cleaner/other poison/pills

☐ Cut needing stitches

☐ Cut or graze

☐ Other accident

Part 10. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

Worst possible health — Perfect health

Part 11. Quality of life (PedsQL™)

PLEASE COMPLETE PART 11 IF YOUR CHILD IS AGED 2 YEARS OR OVER

FOR CHILDREN AGED UNDER 2 YEARS – PLEASE GO TO PART 12

Directions

On the following page 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 FIRST TWO WEEKS after the accident 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 FIRST TWO WEEKS after the accident, 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

11.1 **Does your child attend school or day care?** *(Please ✓ one box)*

☐ Yes ☐ No

If YES *Please complete the next 3 questions*
If No *Please go to Part 12*

In the FIRST TWO WEEKS after the accident, how much of a problem has your child had with……

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/day care 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

Part 12. Any Other Comments

12.1 Please tell us the date you filled in this questionnaire: ...../...../.....

12.2 Are there any other costs that you have had to pay because of your child's accident and you have not been asked about them in this questionnaire? If YES, please tell us about them below:

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this questionnaire. Please send it back in the FREEPOST envelope.


keeping children
SAFE AT HOME