

CONFIDENTIAL

SSHeW Study

Stopping Slips among Healthcare Workers (SSHeW)

Participant Baseline Questionnaire



For office use only

Centre number:

Participant's trial ID number:

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS 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 Laboratory's Grip rating scheme. The responses you give in this questionnaire will help us find out if wearing this footwear can prevent slips and falls when worn in the workplace.

Please answer ALL the questions. Although some of the questions may not seem relevant to you or may appear similar, they do give us valuable information. 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 other 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. Whilst 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.

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? 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 ~~42/03/1980~~ 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]

Section 1:

This section asks about any falls and slips you have had at work in the past 12 months and about some general information about you.

Please enter the date on which you are completing this questionnaire:

/ / 2 0

Day *Month* *Year*

1. Are you employed by
(Please cross one box only)

An NHS Trust

An agency

Other please specify:

1a. Do you have less than 6 months remaining on your contract? Yes

No

(Please cross one box only)

2. What is your date of birth?

/ /

Day *Month* *Year*

3. Are you required to adhere to a uniform/dress code policy?

Yes

No

4. On average, how many hours a week do you work?

.

5. What is your job? (Please cross one box only)

Doctor/consultant

Qualified Nurse/midwife

Physiotherapist

Porter

Occupational Therapist

Healthcare assistant

Ward Clerk

Pharmacist/
pharmacy technician

Social worker

Support worker

Podiatrist

Administrator/
receptionist/secretarial

Other qualified staff/
healthcare professional

Catering

Imaging (radiographer,
ultra-sonographer)

Other please specify:

6. As part of your job, where are you predominantly required to work?
(Please cross one box only)

- In a clinical room/area On a ward In the community
- In a laboratory In pharmacy In podiatry
- In an office In theatre Indoor hospital ground/corridors
- In a food preparation area/area where food is served?

6a. Are you ever required to work in the community? Yes No

7. How much of your time do you spend on your feet at work? (Please circle one option only)

Most of the time Some of the time A little of the time

8. Are you provided with footwear by your employer?
(Please cross one box only) Yes No

Section 2:

This section asks about any slips (however minor) or falls you have had in the past 12 months.

1. Have you had a slip (however minor and irrespective of whether you fell) at work in the past 12 months? (Please cross one box only) Yes No Don't know

1a. If 'Yes', how many slips did you have in the past 12 months?

1b. Did you suffer any injuries as a result of any of these slips? Yes No

1c. How many hours did you have off work due to slips in the past 12 months? .

1d. How many nights did you have to spend in hospital due to these slips in the past 12 months?

2. Have you had a fall (however minor) at work in the past 12 months?

(Please cross one box only)

Yes

No

Don't know

2a. If 'Yes', how many falls did you have in the past 12 months?

2b. Did you suffer any injuries as a result of any of these falls? Yes No

2c. How many hours did you have off work due to falls in the past 12 months? .

2d. How many nights did you have to spend in hospital due to these falls in the past 12 months?

3. How often do you worry about slipping or falling in the workplace?

(Please circle one option only)

All of
the time

Most of
the time

Some of
the time

A little of
the time

None of
the time

Section 3:

This section asks about some general information about you.

1. Are you Male Female Prefer not to say

2. Please tell us your height feet inches or cm

3. Please tell us your weight stone lbs or . kgs

4. Did your education continue after the minimum school leaving age? Yes No

5. Do you have a degree or equivalent professional qualification? Yes No

6. To which of these ethnic groups do you belong? (Please cross one box only)

White/British

Asian/Asian British

Black/Black British

Mixed/Multiple ethnic groups

Other ethnic group please specify:

Section 4:

This section asks about your footwear.

1. How long do your usual work shoes last before they need replacing? months

2. Where do you normally buy your work shoes from?

(Please cross all that apply)

High street store

Online specialist shoe store/catalogue

My workplace provides them

3. What brand of shoes do you tend to wear?

(Please cross all that apply)

Shoes for Crews

Magnum

Alexandra

J&M Medical

General high street brand

General sports shop brand

Other please specify:

4. What style of shoes do you tend to wear at work?

(Please cross all that apply)

Trainers

Pumps

Work/safety boots

Clogs

Heeled shoes/boots
(over 1-inch heel height)

Flat shoes/boots
(completely flat, no heel height)

Casual/dress shoe or boot (graduated sole/heel height up to an inch in height)

Other please specify:

5. Does your usual style of shoe have a secure fastening over the top of your foot (such as laces or velco strap)?

Yes

No

6. If you were eligible to take part in the SSHeW trial what style and size of footwear from the trial brochure would you like to wear during the trial?

(Please select one style and size from the SFC footwear brochure)

Style

Size

Centre number:

Participant's trial ID number:

Date completed: / / 2 0
Day Month Year

Contact sheet

If you would like to take part in the SSHeW study please can you tell us your:

Title

Forename

Surname

Home address

Postcode

Work address

Postcode

Mobile telephone number

Home telephone number

Email

If we need to phone you, what is the best time of day to contact you?
(Please cross all that apply)

7.00am to 9.00am

9.00am to 12.00pm

12.00pm to 2.00pm

2.00pm to 5.00pm

5.00pm to 6.00pm

**Thank you for taking the time to complete these questions.
Please return this form to the York Trials Unit in the pre-paid envelope provided.**