

CONFIDENTIAL

Surgical Wounds Healing by Secondary Intention – SWHSI-2



Participant Baseline Questionnaire Booklet FOR STUDY PARTICIPANT COMPLETION

Site ID:

Participant ID:

Visit Date: / /
day month year

This project is funded by the National Institute for Health Research Health Technology Assessment Programme (Project number 17/42/94)

Participant ID:

Instructions for this Case Report Form

The purpose of this questionnaire booklet is to find out about your surgical wound and the impact it has on your daily activities. The answers you give in this questionnaire booklet will be treated confidentially.

The questions should be answered by either

- putting a tick in a box
- putting a cross on a line

When you have finished, please check that you have answered all questions, and return the questionnaire booklet to a member of staff at the clinic.

Please answer ALL the questionnaire. Although some of the questions may not seem relevant to yourself, your answers do give us valuable information.

If you have further questions or need help with filling in this questionnaire booklet, please ask the SWHSI-2 trial nurse or doctor. Alternatively, please contact a member of the trial team, whose details you will find on your SWHSI-2 Trial Patient Information Leaflet.

You will note that certain questions have been repeated, this is deliberate and essential for the study, and we thank you in advance for your cooperation in filling out every section of this questionnaire booklet.

Please turn overleaf to start filling in this questionnaire booklet.

Participant ID:

Please complete the boxes below with the date you are completing this questionnaire booklet:

/ /

day month year

Section A – Bluebelle Wound Healing Questionnaire

Since you have had an open wound...

| | Not at all | A little | Quite a bit | A lot |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Was there redness spreading away from the wound? (erythema/cellulitis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Was the area around the wound warmer than the surrounding skin? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any part of the wound leaked clear fluid? (serous exudate) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any part of the wound leaked blood-stained fluid? (haemoserous exudate) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has any part of the wound leaked thick and yellow/green fluid? (pus/purulent exudate) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the area around the wound become swollen? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the wound been smelly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the wound been painful to touch? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you had, or felt like you have had, a raised temperature or fever? (fever >38°) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Yes | No | |
| 10. Have you sought advice because of a problem with your wound, other than at a planned follow-up appointment? | | <input type="checkbox"/> | <input type="checkbox"/> | N/A |
| 11. Have you been back into hospital for treatment of a problem with your wound? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you been given antibiotics for a problem with your wound? | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Has your wound been scraped or cut to remove any unwanted tissue? (debridement of wound) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Has your wound been drained? (drained of pus / abscess) | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Have you had an operation under general anaesthetic for treatment of a problem with your wound? | | <input type="checkbox"/> | <input type="checkbox"/> | |

Bluebell Wound Healing Questionnaire © University of Bristol 2017
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Please proceed to Section B

Section B - EQ-5D-5L

This section asks about your health in general.

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

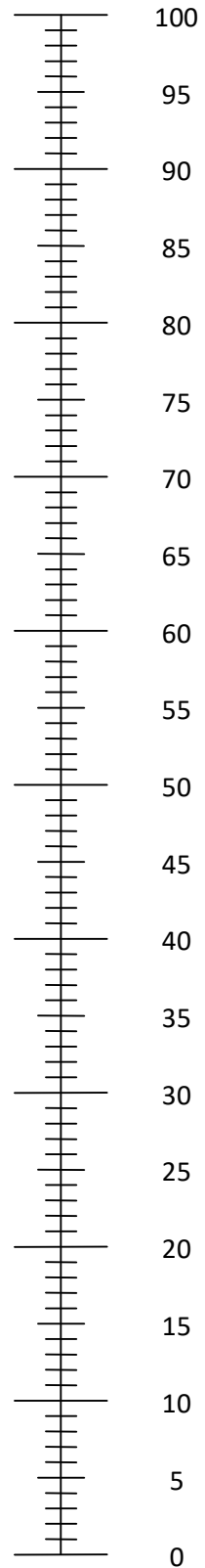
I am extremely anxious or depressed

Participant ID:

- We would like to know how good or bad your health is TODAY.
- The 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 =

The best health
you can imagine



The worst health
you can imagine

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Please proceed to Section C

Participant ID:

Section C – Pain

We would like to know how good or bad your wound pain is **TODAY**.

The scale below is numbered from 0 to 100. 100 means the worst pain you can imagine and 0 means no pain. Please mark a cross on the line below to indicate how bad your wound pain is today.

No pain |-----| Worst imaginable pain

(for office use only)

Please proceed to Section D

Section D– Resource Use

This final section asks about the health care you have received related to your wound over the past 6 weeks.

Care from the NHS NOT in the hospital:

1. **In the past 6 weeks**, have you had any contact with the following health professionals in the community **IN RELATION TO YOUR WOUND CARE?**

Yes No

| Have you had contact with | | | Total number of visits (If none enter "0") |
|---------------------------|------------------------------|-----------------------------|---|
| A GP at home | Yes <input type="checkbox"/> | No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| A GP at the surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| | | | |
| A nurse at home | Yes <input type="checkbox"/> | No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| A nurse at the surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |

Care from the NHS IN the hospital:**A) INPATIENT CARE (e.g. admitted and discharged on a different day)**

2. **In the past 6 weeks**, have you been admitted to hospital as an **in-patient** to have further treatment **IN RELATION TO YOUR WOUND?**

Yes No

Note: Please do not include the visit related to your initial treatment resulting in your wound when you are answering this question.

If 'Yes', how many nights were you in hospital for? nights

Participant ID:

B) OUTPATIENT CARE (e.g. not admitted to hospital or discharged on the same day)

3. In the past 6 weeks, have you had any **outpatient visits** to the hospital **IN RELATION TO YOUR WOUND?**

Yes No

Note: Please do not include the visit related to your initial treatment resulting in your wound when you are answering this question.

If 'Yes', please provide information in the table below:

| Surgical outpatient appointments | Had an appointment? | Total number of visits |
|--|--|---|
| Vascular, Colorectal or Plastics (e.g. for follow up) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Pain Clinic (e.g. for managing pain related to your wound) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Physiotherapy (e.g. for rehabilitation) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Tissue Viability Service (e.g. for wound review and/or wound dressing) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Specialty Dressing Clinic (e.g. for wound review and/or wound dressing) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Diabetic Foot Clinic (e.g. for wound review and/or wound dressing) | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Other visits | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Please provide details of the visit type: | | |
| 1) <input type="text"/> | | <input type="text"/> <input type="text"/> |
| 2) <input type="text"/> | | <input type="text"/> <input type="text"/> |
| 3) <input type="text"/> | | <input type="text"/> <input type="text"/> |

4. Finally, in the past 6 weeks have you visited **Accident and Emergency (A&E) IN RELATION TO YOUR WOUND?**

Yes No

If 'Yes', how many times? times

Participant ID:

Return to normal activities

5. Are you currently employed or self employed?

Yes No

If 'Yes', are you:

In full time employment (30 hours or more a week)

In part time employment (less than 30 hours a week)

Private treatments: Could you please tell us about **any additional medical treatments you have received, which you have paid for (e.g. personal cost or personal private insurance health care) IN RELATION TO YOUR WOUND.**

Please also include any private health care paid for by company insurance.

6. Over the **past 6 weeks**, have you received any private treatments?

Yes No

If 'Yes', how many times have you:

| | |
|---|---|
| Seen a doctor for a clinical assessment? <i>(Please record the number of times in the boxes)</i> | <input type="text"/> <input type="text"/> <i>If none enter '0'</i> |
| Seen a nurse for a clinical assessment? <i>(Please record the number of times in the boxes)</i> | <input type="text"/> <input type="text"/> <i>If none enter '0'</i> |
| Seen a physiotherapist for a clinical assessment or treatment? <i>(Please record the number of times in the boxes)</i> | <input type="text"/> <input type="text"/> <i>If none enter '0'</i> |

Hospital Transport

7. During the **past 6 weeks**, have you used hospital transport e.g. medicar (or got an allowance for hospital transport) **IN RELATION TO YOUR WOUND?**

Yes No

If 'Yes', how many times? times Can't remember

Medications

8. During the **past 6 weeks**, have you been taking any medications **IN RELATION TO YOUR WOUND?**

Yes No

If '**Yes**', please cross the box(es) in the table below to indicate the medication that you have taken and whether it has been **prescribed** (by a doctor or other health professional) or you have **bought** the medication yourself. Please also record the **number of days** you have used the medication.

| Name of Medication | | Number of days | Prescribed | Bought |
|--|--------------------------|----------------------|--------------------------|--------------------------|
| Paracetamol | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Co-codamol | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tramadol | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine Phosphate | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Short acting morphine | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Long acting morphine | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other morphine based tablets | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Morphine oral suspension | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Amitriptyline | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregabalin | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gabapentin | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diclofenac | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ibuprofen | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other, please specify: <input type="text"/> | | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other, please specify: <input type="text"/> | | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Participant ID:

9. Are you a carer or being cared for by others (i.e. family members, care staff)?

Carer

Being cared for by others

Neither of the above

Thank you for taking the time to fill in this questionnaire.

Please check all the pages to make sure that you have answered every statement.