

**Occupational Therapy Services Community**

**Gwasanaethau Therapi Galwedigaethol yn y Gymuned**

**BATH LIFT REVIEW**

**Date of Review:- ...................................**

**Telephone 🞏 Visit 🞏**

**Date of last review:- ……………………………**

**Clinical reason for review:- …………………………………………………………..**

**Person’s Details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Person’s Name:** | |  | | | **L.A. No:** | | **Date of Birth** |
| **Address:** | |  | | |  | |  |
| **Review Address:** | |  | | |  | |  |
| **Is Person Continuing Health Care Funded** | | | | | **Yes/No** | | |
|  | | |  | | | | |
| **Occupational Therapy Worker Details** | | | | | | | |
| **Name:** |  | | | **Telephone:** | |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relevant Medical Information/Reported Health Features**  Please include cognitive/sensory and behavioral issues | |  | | |
| **Have Person’s Medical Conditions or Medication changed since last review?** | |  | | |
| **Type of Bathlift** |  | | **Issue Date** |  |
| **Last Service** |  | | **Next Service** |  |
| **Weight Limit** |  | | **Is Person within Weight Limit?** |  |

**Review Questions**

**Is there any other means that the person can access washing facilities safely?**

Comments:- **Yes 🞏 No 🞏**

**If Yes, is the person eligible for the provision of a bath lift? Yes**  **No**

**Are you experiencing any difficulties using the bath lift?** **Yes 🞏 No 🞏**

Comments:-

**Do you live alone?** **Yes 🞏 No 🞏**

Comments:-

**Are you able to use the bath lift on your own?** **Yes 🞏 No 🞏**

**If No – who assists**

Contact Details:-

**How often do you use the bathlift?** ………………………………………………………….

Comments:-

**Do you have any way of calling for help?** **Yes 🞏 No 🞏**

Comments:-

**Are you aware bath oils should not be used with the bathlift?** **Yes 🞏 No 🞏**

Comments:-

**Can you describe/demonstrate how you are getting on and off the bathlift?**

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Is this different to the recommended transfer technique?** **Yes 🞏 No 🞏**

Comments:-

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Any other identified Issues not relating to the bath lift?**

**NB COT service will signpost and advise where appropriate**

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**Eligability Criteria for provision of Bathlift:**

Low  Moderate  Substantial  Critical

**Have direct payments been offered to the person? Yes**  **No**

If no, state reason why

**Does the Person appear to have any Capacity issues relevant to this review?**

**Yes**  **No**

**If yes, please complete the Community Occupational Therapy Service Capacity Assessment before completing Identified Needs section in the person’s best interests**

**Risk Reduction Plan**

To reduce the risk further list below any actions required to reduce the risk rating.

e.g. training/instructions, position wires against wall.

|  |  |  |
| --- | --- | --- |
| Action | Person responsible to action | Date actioned |
|  |  |  |

**Action Required**

* Return of bath lift YES 🞏 NO 🞏
* Reassessment of alternative bath lift YES 🞏 NO 🞏
* Level Access Shower/further Assessment needed YES 🞏 NO 🞏
* Other OT Needs YES 🞏 NO 🞏  
    
  **Is a Review for clinical reasons required?** YES 🞏 NO 🞏
* Please explain why and review period and type needed  
  ………………………………………………………………………………………………...  
  …………………………………………………………………………………………………
  + Review in: 6 months 🞏 Review in 12 month 🞏

* + Review type: Telephone Call 🞏 Face to Face 🞏

Signature of Assessor: …………………………………….……….. Date: …………..……..

Print: ……………………….……….…… Designation……………………………………….

Base: …………………………………………………………..…. Tel No: ………………….



|  |
| --- |
| **Community Occupational Therapy Services**  **Gwasanaethau Therapi Galwedigaethol yn y Gymuned** |

**Bath Lift Review Signature Slip**

Type of bath lift:- ..................................

I have had a review of my bath lift on ……………………

I understand how to use the bath lift correctly and understand how to safely maintain the bath lift. If any defect is noticed or my needs change, I will notify the Newport City Council Contact Centre immediately by telephoning 01633 656656 (opening times: - 8:00am – 8:00pm Monday to Friday (except bank holidays) and 9:00am – 1:00pm Saturday) and I will not use the bath lift until it has been checked/repaired/replaced.

I understand that this equipment will be periodically reviewed by the Community Occupational Therapy Service and Vision Products in accordance with statutory regulations.

I agree to allow access to the equipment and agree to undertake any review / service requested. If I do not, this will result in the equipment being removed.

Does the person have a copy of the User Guide YES 🞏 NO 🞏

**I have been informed and understand that equipment is on loan from and remains the property of the Gwent Wide Integrated Community Equipment Store (GWICES) and eligibility, suitability and safety must be reviewed as appropriate.**

Signed: - ……………………………….. Date: - …………….

Print name: - …………………………..

Service User/Carer

Signed: - ………………………………. Date: - ……………..

Occupational Therapist/Social Work Assistant

Print name: - ……………………………..

*Social Services Copy*

**CONSENT AND AGREEMENT**

Information recorded during this assessment process may be shared with others involved in your care. This will help them understand your needs and avoid having to repeat some parts of the assessment. I understand that at times sharing of information will be undertaken in the best interests of my care and that consent may not always be necessary.

|  |
| --- |
| **Consent to Share Information: tick as appropriate** |
| ( ) I understand that the information collected in this assessment process will be used to  provide care for me. I agree that it may be shared with other health and social care  professionals, including GPs and appropriate voluntary organisations, in order to  provide care for me. |
| ( ) I understand the above; but there is specific personal information that I do not want  information to be shared with. Please give details below. |
| ( ) The person is unable to give consent; e.g. unable to sign. Please give details below. |
| ( ) Person does not give consent |
| Details: |
| Does person want relatives informed of assessment / condition / treatment ? Y ( )N ( )  If yes, person authorised to receive information:  Name: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. Relationship: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. ..  Name: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. Relationship: .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. .. |
| Name of person: Signature of person: |
| Date: |

|  |
| --- |
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I understand that this equipment will be periodically reviewed by the Community Occupational Therapy Service and Vision Products in accordance with statutory regulations.

I agree to allow access to the equipment and agree to undertake any review / service requested. If I do not, this will result in the equipment being removed.

Does the person have a copy of the User Guide YES 🞏 NO 🞏

**I have been informed and understand that equipment is on loan from and remains the property of the Gwent Wide Integrated Community Equipment Store (GWICES) and must be serviced and reviewed as appropriate.**

Signed: - ……………………………….. Date: - …………….

Print name: - …………………………..

Service User/Carer

Signed: - ………………………………. Date: - ……………..

Occupational Therapist/Social Work Assistant

Print name: - ……………………………..

*Persons Copy*