

**Occupational Therapy Services Community**

**Gwasanaethau Therapi Galwedigaethol yn y Gymuned**

**BATH LIFT ASSESSMENT**

**Date of assessment: ...................................**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |

**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 considering provision of a bath lift in the person’s best interests.**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Does the person live alone?  Comments:-  Will the bath lift be used when the person is alone?  Comments:  Does the person have a means of calling for help in an emergency whilst using the bathlift?  Comments: |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Does the person have good sitting balance?  Comments:  Is the person likely to have the ability to lift their legs over the side of the bath (physically and cognitively)?  Comments:-  If No who will assist?  Is the person likely to be able to remove/replace the battery safely and easily?  If No, consider Neptune/Aquila which have large batteries and large buttons.  Comments:-  Does the person appear to have any cognitive difficulties which may affect their ability to use the bath lift safely?  Comments:-  Is the person likely to be able to recognise and avoid entrapment?  E.g. one sided neglect due to CVA  Comments:- |  |  |
| Does the person have any medical conditions that put them at risk when using the bath lift?  Epilepsy?  Recent total hip replacement?  Effects of medication causing drowsiness?  Other:- e.g. sensory issues  Comments  Does the person have a medical need to bath?  Incontinence?  Skin conditions?  Other?  Comments  Does the person have any pressure areas?  Poor skin integrity?  Is a padded seat cover needed?  Comments:- |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Will the person or carer need to take the bath lift out of the bath?  Comments:-  Would it reduce the risk for other family members to use bathlift also?  If yes a risk assessment will need to be done to cover this. |  |  |

**Eligibility criteria for provision of bathlift:**

**How often is the bathlift likely to be used?** ………………………………………………………….

Comments:-

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

**Yes 🞏 No 🞏**

Comments:-

**Is the person eligible for the provision of a bath lift? Yes 🞏 No 🞏**

Low  Moderate  Substantial  Critical

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

If no, state reason why……………………………………………………………………………………………………………….

***Has the person been informed that equipment is on loan from the Gwent Wide Community Equipment Store and eligibility, suitability and safety must be reviewed as appropriate?***

**Yes 🞏 No 🞏**

If no, state reason why……………………………………………………………………………………………………………….

**Risk Reduction Plan**

To reduce the risk further, list below any actions required to reduce the risk rating i.e. training/instructions

|  |  |  |
| --- | --- | --- |
| Action | Person responsible  to action | Date actioned |
| Service user advised NOT to use the bathlift until assessed by prescribing OT worker |  |  |

Signature of assessor: …………………………………….……….. Date: …………..……..

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

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

**Assessment of Bath Lift (post delivery)**

**Personal Details**

|  |  |
| --- | --- |
| Name: | SWIFT Number: |
| Address: | Date Of Birth: |
| Telephone Number: | Assessment Date:  Assessment Time: |
| Location: | |

**Bath Lift Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Bathlift** |  | **Issue Date** |  |
| **Last Service Date** |  | **Next Service Date** |  |
| **Weight Limit of Bathlift** |  | **Is Person within Weight Limit?** |  |

Does the person understand the charging of the bath lift? **Yes 🞏 No 🞏**

Comments:-

Is the person aware bath oils should not be used with the bathlift? **Yes 🞏 No 🞏**

Comments:-

Do all 4 suckers fit securely to bottom of the bath? **Yes 🞏 No 🞏**

Comments:-

Does the bath lift have flaps on it? **Yes 🞏 No 🞏**

If so which sides? **Right 🞏 Left 🞏**

Do the flaps on the bathlift catch on any handles or obstructions? **Yes 🞏 No 🞏**

Comments:-

**Description of demonstration of use of the bathlift?**

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

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

Comments:-

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

Does the person experience any pain when transferring on/off the bath lift? **Yes 🞏 No 🞏**

Comments:-

Is there adequate leg room when bath lift is lowered? **Yes 🞏 No 🞏**

Comments:-

Are the grab rails in correct position? **Yes 🞏 No 🞏**

Comments:-

Can they recognise and avoid entrapment? **Yes 🞏 No 🞏**

E.g. one sided neglect due to CVA

Comments:-

**Risk Reduction Plan**

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

e.g. training/instructions.

|  |  |  |
| --- | --- | --- |
| Action | Person responsible to action | Date actioned |
| Service User to have means of summoning assistance in case of emergency whilst using bathlift |  |  |

**Action Required**

* Return of bath lift YES 🞏 NO 🞏
* Reassessment of alternative bath lift YES 🞏 NO 🞏
* Level Access Shower/further Assessment needed 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 Assessment Signature Slip**

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

I have had an assessment 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 serviced by 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: - ……………………………..

*Social Services Copy*

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

Occupational Therapist/Social Work Assistant

Print name: - ……………………………..

*Persons Copy*