Home Environment

Lighting Assessment

(HELA)

**Developed by:**

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**Home Environment Lighting Assessment (HELA)**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Rater: \_\_\_\_\_\_\_\_\_\_\_\_**

**Directions:** Identify location(s) where tasks requiring lighting are performed. Separate HELA forms can be used for each location. Ensure client is wearing glasses and has optical devices available if used.

**Part 1: Description of Lighting Environment – Pre Intervention – Near Task Location**

**General Description:**

|  |  |
| --- | --- |
| **Location** | \_\_\_ Kitchen \_\_\_ Living room \_\_\_ Family room    \_\_\_ Dining Room \_\_\_ Office \_\_\_ Bedroom    \_\_\_ Other: |
| **Client Position**  (Ex: sitting in office chair) |  |
| **Position of lamp/fixture relative to client & material**  (Ex: 2’ table lamp w/ burgundy shade L side of desk; material centered on desk) | Fixture 1:  Fixture 2:  Fixture 3: |
| **Describe material(s) viewed in this location** | \_\_\_ Book \_\_\_ Newspaper \_\_\_ Magazine    \_\_\_ ebook \_\_\_ Bills/correspondence \_\_\_ Other: |
| **Electrical outlet available in this location** | \_\_\_ Yes \_\_\_ No |

**Description of Window Treatment(s) and Outdoor Lighting - Check all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Curtains, opaque |  | Blinds |
|  | Curtains, sheer |  | Shades |
|  | Valence |  | Shutters |
|  | Other: |  | Other: |
| Outdoor lighting conditions at the time of the light meter reading (check one):  \_\_\_ Bright \_\_\_ Cloudy \_\_\_ Dark \_\_\_ Partly cloudy \_\_\_ Dusk | | | |
| Note time of day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am/pm | | | |

**Description of Lighting Sources**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Check all**  **that apply** | **Type of light fixture/ lamp/source** | **# light bulbs** | **Bulb type**  I = incand.  CF = comp. fluor.  H = halogen | **Wattage** | **Indicate if used during activity** |
|  | **Ceiling lamp**  1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Dimmer switch |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Recessed can light(s); 1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Recessed can light(s); dimmer |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Dimmer switch |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | **Ceiling light with fan**  1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Dimmer switch |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | **Floor lamp**  Stationary, 1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Stationary, 3-way bulb |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Adjustable, 1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | **Table lamp**  Stationary, 1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Stationary, 3-way bulb |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Adjustable, 1 setting |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Adjustable, 3-way bulb |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Touch lamp |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | **Natural light**  Window(s)  Describe location: |  |  |  | \_\_\_ Yes \_\_\_ No |
|  | Sky light(s)  Describe location:  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | \_\_\_ Yes \_\_\_ No |

**Light Meter Assessment** **& Photo**

|  |  |
| --- | --- |
| **Directions:**Position client where they typically perform task. Ask client to hold material (book, magazine, etc) in typical manner. Place light sensor on center of material to measure lighting with meter. Share pre-intervention lighting level with client. | Light meter reading: \_\_\_\_\_\_\_\_lux |
| **Photo** (optional)**:** Take photo of lighting environment, including lamp(s) and/or fixture(s). Have client sit and position material in usual manner. | Consent obtained: Yes No  Photo taken: Yes No |

**Pre Intervention MNRead**

**Glare:**

|  |  |
| --- | --- |
| Some people have difficulty with glare from oncoming headlights, bright sunlight or shiny countertops. Do you have difficulty with glare in this location? | \_\_\_ Yes \_\_\_ Sometimes \_\_\_ No |

**Re-positioning of material:**

|  |  |
| --- | --- |
| When you \_\_\_ (read, etc.), do you need to re-position your material to obtain better lighting or to reduce glare? | \_\_\_ Yes \_\_\_ Sometimes \_\_\_ No |

**Quality of Near Task/Lighting? Experience - Pre intervention:**

|  |  |
| --- | --- |
| How much eye strain or sense of tiredness in your eyes do you experience while \_\_\_\_ (reading, etc.) in this location?  Comments: | 1. = a great deal   2 = a moderate amount   1. = very little 2. = none |
| How satisfied are you with the length of time you are able to \_\_\_\_  (read, etc.)?  Comments: | 3 = completely satisfied  2 = somewhat satisfied  1 = somewhat dissatisfied  0 = completely dissatisfied |
| How much do you enjoy \_\_\_\_ (reading, etc.) in this lighting environment?  Comments: | 1. = a great deal 2. = a moderate amount 3. = very little 4. = not at all |

**Part 2: Lighting Intervention – Near Task Location**

**Guidelines:** Indicate all types of lighting modifications made in location where client performs near tasks. Intervention will be provided in collaboration with the client.

**Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **Lighting Modifications** |
|  |  | Change wattage in existing fixture;  Indicate initial wattage \_\_\_\_ Indicate revised wattage \_\_\_ |
|  |  | Change in type or # of light bulb in existing fixture;  Indicate initial #/type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Indicate modified #/type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Re-positioning of lighting fixture or lamp shade |
|  |  | Change lamp shade |
| **Yes** | **No** | **Lighting Modifications** |
|  |  | Provision of table based task lamp |
|  |  | Provision of floor base lamp |
|  |  | Provision of portable lamp (Ex: flashlight) |
|  |  | Provision of other lamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Glare reduction methods (Ex: tints, hat, adjust shade, curtains, use table cloth on glass) |
|  |  | Re-position reading material |
|  |  | Other: |
| Comments: | | |

**Part 3: Light Meter Assessment & Photo - Post Intervention – Near Task Location**

|  |  |
| --- | --- |
| Outdoor lighting conditions at the time of the light meter reading (check one):  \_\_\_ Bright \_\_\_ Cloudy \_\_\_ Dark \_\_\_ Partly cloudy \_\_\_ Dusk | |
| Note time of day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am/pm | |
| Directions:Position client where they typically perform task. Ask client to hold material (book, magazine, etc) in typical manner. Place light sensor on center of material and measure lighting with meter. Share post-intervention lighting level with client. | Light meter reading: \_\_\_\_\_\_\_\_lux |
| Photo (optional)**:** Take photo of lighting environment, including lamp(s) and/or fixture(s). Have client sit and position material in usual manner. | Consent obtained: Yes No  Photo taken: Yes No |

**Post Intervention MNRead**

**Part 4: Lighting Modification Satisfaction Follow Up Survey – Near Task Location**

**Directions:** The Lighting Modification Satisfaction Survey can be used as a follow up measure immediately post intervention, at discharge or the client could be contacted by phone 3-5 weeks post intervention.

|  |  |
| --- | --- |
| **Script: *“I would like to ask you about the lighting modifications that we made in your home.***  ***My notes indicate that we made the following changes to the lighting in your \_\_\_\_ area in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_ room. . . ”*** | |
| * Are lighting modifications for the \_\_\_\_\_\_\_ area still in place? | \_\_\_ Yes \_\_\_ No |
| If Yes, are they in use . . . | \_\_\_ Consistently  \_\_\_ Sometimes  \_\_\_ Do not use at all |
| If No, what are the barriers? | \_\_\_ Do not like fixture/lamp  \_\_\_ Do not like light bulb  \_\_\_ Client prefers what he/she had previously  \_\_\_ Other: Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is \_\_\_\_\_ more enjoyable/easier with the lighting modifications?  Comments: | \_\_\_ Yes \_\_\_ No |
| Are you able to \_\_\_\_\_\_ in this location for longer periods of time?  Comments: | \_\_\_ Yes \_\_\_ No |

**Quality of Near Task Experience - Post intervention – Near Task Location**

|  |  |
| --- | --- |
| How much eye strain or sense of tiredness in your eyes do you experience while \_\_\_\_ (reading, etc.) in this location?  Comments: | 3 = a great deal  2 = a moderate amount  1 = very little  0 = none |
| How satisfied are you with the length of time you are able to \_\_\_\_ (read, etc.)?  Comments: | 3 = completely satisfied  2 = somewhat satisfied  1 = somewhat dissatisfied  0 = completely dissatisfied |