****

**Vision Rehabilitation –**

**Interim Practice Guidance Post-COVID-19**

**7 May 2020**

This document is for managers and practitioners. It highlights the issues that are likely to face sensory services in the next few weeks and it proposes some principles and suggestions that will help services to be re-established as movement restrictions are eased.

Blind, partially sighted and deafblind people have been significantly affected by life under lockdown and the nature of the disability has, for many, exposed their vulnerability and isolation in society.

Vision rehabilitation is not an optional extra or non-essential service. For many people the ability to live life after losing sight has been made harder by some of the necessary, but restrictive, measures put in place.

Some Vision Rehabilitation Workers (also known as Rehabilitation Officers, Visual Impairment or ROVIs) have been redeployed during this period but the majority have been only making contact with clients by phone. Vision Rehabilitation Workers are skilled registered professionals. Their understanding of their clients, and their skills in supporting people in crisis should be valued and respected as we move forward.

**Workflow Issues**

* Gradual return of referrals for support as Certificates of Vision Impairment (CVI) are processed again following resumption of eye treatment in hospital; Eye Clinic Liaison Officers (ECLO) return to hospital settings; hospital discharge starts to re-involve wider community rehabilitation (e.g. ROVIs in addition to Occupational Therapy and Physiotherapy); clients and family resume referrals as priorities return to normal.
* Return of referrals for vision rehabilitation from areas of healthcare that have been dormant during the height of the pandemic e.g. stroke care, falls clinics and A&E.
* Potential for significant backlog of work as new referrals are added to the previously-unidentified needs of clients that have been contacted whilst in lockdown. Many sensory teams have been undertaking lengthy welfare phone calls; many have raised previously unidentified needs, the solutions to which will require formal referral for rehabilitation.
* Potential for further pressure on caseloads if some ROVIs need to shield for health reasons.

**Impact of COVID-19 on Vision Rehabilitation Workers**

There is a significant risk of damage to emotional resilience of workforce due to:

* Sense of powerlessness in meeting the needs of clients at the end of a phone and in the probability that the situation is unlikely to return to normal for a considerable time.
* Increase in caseloads (see workflow above) and increase in client’s waiting time.
* Increased pressure on managers filtering down to ROVIs to reduce caseload and waiting lists as well as reduce cost of care packages.
* Frustration at poor understanding from some managers of the difficulties faced by visually impaired and deafblind people.
* Disruption to supervision patterns or supervision that places focus on case-closure rather than welfare.
* Concern that government guidance may be ignored in relation to requirements around personal protective equipment.
* Professional isolation. Some ROVIs are lone workers in a local authority. Lack of networking opportunities may have been exacerbated during this time.
* The working practice for some blind or partially sighted ROVIs may be affected. Some ROVIs may carry out some tasks with a support worker/PA, and this additional dimension will need to be considered. We would encourage professionals (and any support worker) in this situation to discuss the risks and propose solutions with their employer. Travel on public transport (either to work or for client visit) may be a particular area for discussion. It may be that some visually impaired ROVIs may choose to adapt their practice in the short term and we would expect managers to support this.

**Impact of COVID-19 on clients**

In addition to the needs that would accompany any new referral for vision rehabilitation, there is growing evidence of additional needs arising from the current situation:

* Emotional distress, heightened anxiety and heightened depression resulting from isolation. The client may themselves be a carer or they may rely on a carer in the family. On-set of visual impairment can create dependency and where a caring situation has broken down, there may be additional support needs in the immediate future.
* Emotional distress and new training needs arising from “able” blind and partially sighted people finding that they have been disabled by isolation measures e.g. inability to shop independently, walk/exercise by themselves, read letters without a family member’s help, abuse from members of the public arising when a visually impaired person has not been able to social distance in queues.
* Current or recent clients needing to relearn skills due to inability to practice or loss of confidence during isolation. Some clients may not be able to resume where they left off and may suffer set-backs in their “rehabilitation journey”.

**Adaptations to practice**

The Department of Health and Social Care published [ethical guidelines](https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care) at the start of the crisis that may provide an ethical basis for decision-making whilst the emergency legislation is in place.

**General principles around adapting practice**

These are general principles that you should consider applying to people that the service supports. Government guidance and the guidance of your employer must also be followed.

In many cases more than one of these approaches used together will need to be considered.

1. Positive risk approach

We advocate that there needs to be a recognition that many blind, partially sighted and deafblind people are at risk if vision rehabilitation services are **not** put in place or maintained. There may be a greater risk to an individual (or their carer’s) wellbeing through not providing a service than there is a risk of infection. A positive-risk approach may be required to weigh up this balance.

1. Recognition that some case work will require home visits

A recognition that some case work will be very difficult to undertake in any way other than “face-to-face” but may still be essential e.g. route learning to essential destination (e.g. health facility/shop) where no alternative exists; rehab for client who needs to maintain a carer role and without access to other support; discussion with an isolated client where you need to ensure meaning is understood and capable of being remembered.

1. Greater emphasis on role of remote triaging

A more detailed level of pre-visit assessment, by phone or video-call is essential to establish the level of risk involved in any potential visit. This must include ascertaining if the client is vulnerable or whether the client meets the case definition for a possible or confirmed case of COVID-19. An additional call should also be made on the day of any visit to check that the client remains free of COVID-19 symptoms.

A longer-than-normal call by phone or video-conference will also help to gauge how best to use the time that it is necessary to spend physically at a client’s home. It may help to make an initial call to set up a more formal arrangement to call again at a mutually agreed time which could give the client time to prepare and to bring in any family members that they wish to be present. Trying to undertake a phone assessment with someone who is not able to use the phone (and where no other person is on hand) will not be delivering an equitable service – an alternative must be found.

1. Use of Personal Protective Equipment (PPE) and anti-viral gel

Links to government guidance on PPE are found in appendix one and appendix two of this document. You should follow the guidance of your employer and the government. However, government guidance is less specific in situations where a home visit is carried out to a **household** where nobody is either “extremely vulnerable” or exhibiting symptoms of COVID-19. A significant proportion of visually impaired people do not fall into the category of “vulnerable” in medical terms as defined by the government and this should be factored into any risk assessment (see social distancing strategies below).

Acquisition of PPE will be essential for case work where close contact is essential and ROVIs (and support worker) must determine the level required based on their assessment of the situation. They must also be familiar with procedures for donning, doffing, disposing or disinfecting of any equipment, as directed by the guidance (see appendix three).

Many people with sight problems have an additional hearing loss or other communication difficulties. They may rely on lip-reading or other facial expressions. With this in mind face-masks may hinder communication; use of a faceshield (which would give added eye protection) as an alternative, should be considered.

It may form an acceptable level of risk for face-masks/faceshields to be worn for only part of a visit (e.g. rehabilitation work in close proximity) but leave the face uncovered for giving verbal instructions at a greater distance. This may be the case where the client is neither vulnerable nor suspected of being infectious.

ROVIs will need to carry a permanent supply of anti-viral hand-gel or wipes for when handling or handing over equipment.

1. Social distancing strategies

Social distancing strategies are likely to be a significant feature of practice-adaptations in the immediate future and potentially longer term. Adoption of the required distance wherever possible in home visiting should be assessed e.g. undertaking a general assessment sitting at distance in same room (but ensuring the room will be large enough and that the number of participants can be limited). It may be feasible for the ROVI to mark-up a microwave or set up low vision station or lighting at a distance from client and then withdraw to observe the client and get verbal feedback. The ROVI could then consider the necessity (or otherwise) of narrowing the social distance to proceed with further guidance. Further intervention may raise the required level of PPE.

1. Greater use of family or third party support

It may be helpful to deliver hands-on guidance whilst the ROVI maintains a social distance. This approach may have the additional benefit of re-enforcing the new learning, but care needs to be taken in case this would exacerbate any pre-existing problems of family dynamics. Examples might include: Orientation &Mobility – the ROVI stands at two metre distance and demonstrates cane technique to carer and then instructs carer to mirror ROVI technique with client (use of a tandem bar may be appropriate); ROVI walks behind client more than normal, or stands at a greater distance than normal in front and observe client coming towards them (additional measures may be needed if client cannot hear you telling them to stop as they reach you).

1. Greater use of technology to facilitate rehab

Technology may significantly reduce the need for face-to-face rehabilitation for some people e.g. use of video conference/webinar with client or with carer (or groups thereof) to demonstrate equipment or techniques. Example: You Tube video or self-made video via Whats App/Skype etc. of how to hold a magnifier and scan using Steady Eye Strategy. The ROVI will need to satisfy themselves (and document in writing) that the risk of harm or of misapplication of learning is low. If the client is not known to the ROVI they may not be able to assess the client’s ability to memorise new techniques or observe physical factors such as balance problems.

1. Greater use of technology to replace old techniques

Professionals are discovering that some clients are far less technology-averse than might have been assumed, particularly where the benefits are immediate and easy to learn. Examples might include enabling client or their family to download apps like “Seeing AI” or “Be My Eyes” etc. or you may be able to promote greater use of Amazon Echo or similar. Teaching of these may be possible via video-conference with family (with or without client).

**Some new ways of working may evolve from this whole experience and clients may learn new communication skills. However, many of the measures involving distance or remote access will never replace direct observation. Direct observation allows for immediate feedback and identification of risks. The suggestions in this document are intended to be temporary measures to ease workflow and help clients to achieve outcomes.**

Government guidance around COVID-19 will change as the situation changes and this guidance will be updated where necessary. Guidance around outdoor restrictions is likely to change and we hope to offer further guidance around Orientation and Mobility work in the near future.

May 7 2020

[www.rwpn.org.uk](http://www.rwpn.org.uk)

**Appendix One**

The latest government guidance on PPE is available at:

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe>

**Appendix Two**

Government guidance on “recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector (note that this does not apply to people who are not extremely vulnerable or where householders are not a possible or confirmed case)

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878750/T2_poster_Recommended_PPE_for_primary__outpatient__community_and_social_care_by_setting.pdf>

**Appendix Three**

Government guidance on donning and doffing PPE (including a video with additional verbal description)

<https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures>