# Vision rehabilitation: Interim practice guidance in response to COVID-19

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**Developed by:**

    

# Vision rehabilitation – interim practice guidance in response to COVID-19

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## Summary

This guidance comes in two parts:

1. **Strategic considerations** for Directors and their management teams in planning current and future vision rehabilitation services.
2. **Operational guidance** for practitioners and their service managers that will help services to be re-established as contact and movement restrictions are eased.

Blind, partially sighted and deafblind people have been significantly affected by life under lockdown and the nature of their disability has, for many, exposed their vulnerability and isolation in society. Like many social care services, vision rehabilitation has had to adjust to managing the impact of Coronavirus Disease 2019 (COVID-19) on both clients and staff while providing much needed care and support. Teams have worked hard to implement solutions which part-meet client needs, whilst protecting the health of both client and staff. And, as with other social care services, discussions and planning need to begin about how to safely resume full services, including those which require home visits.

ADASS, along with key partners in the voluntary and third sector recognise the importance of vision rehabilitation as a preventative service which enables blind and partially sighted people to maintain independence and wellbeing [1]. Vision rehabilitation provides expert advice to blind and partially sighted people on how to maintain and live in their home safely, and equips them with the crucial daily living and mobility skills they need to get out and about with safety and confidence and participate in community life. It can also prevent, reduce or delay the need for more costly care and support. Now, more than ever, it is important to offer this vital service in a safe and meaningful way.

Now that many local authorities and partner agencies are considering issues of reset and recovery this also presents an opportunity to examine the vision rehabilitation offer in their area, and ensure that they reflect ADASS’s position statement on vision rehabilitation [1] and the wider guidance it references, and relevant regulatory decisions.

## Key Points:

In considering the vision rehabilitation offer in local areas the following should be considered:

* Directors and their management teams should be aware of the contents of the ADASS position statement on vision rehabilitation [1], and referenced guidance. In particular:
	+ They should ensure that a formal adult eye care pathway is in place and being used in their local authority, which reflects the 2015 Vision UK pathway [2], developed in partnership with ADASS.
	+ They should be satisfied that services are delivered that meet RNIB’s “10 principles of good practice in vision rehabilitation” [3], and that clients have timely access to specialist assessment, advice, aids and equipment, and daily living and mobility training [4].
* They should be mindful, within their overall budget, to ensure that vision rehabilitation is adequately resourced for the population served [5].
* They should ensure that any proposals to amend existing waiting lists for assessment or service should involve individual risk assessments of the referrals or cases by a Vision Rehabilitation Worker (also known as Rehabilitation Officers, Vision Impairment or ROVIs).
* They should ensure that, while COVID-19 contact restrictions are in place, ROVIs are supported to explore blended approaches to working, have access to Personal Protective Equipment (PPE) for those aspects of vision rehabilitation that can only be conducted safely in-person, and that reasonable adjustments for vision impaired ROVIs, and their personal assistants, are revisited by their manager.
* They should ensure that, as COVID-19 restrictions are relaxed, their vision rehabilitation service is not disadvantaged by wider adult social care pressures.

## Part 1: Strategic considerations

### Summary

COVID-19 restrictions are impacting on referrals to vision rehabilitation, as well as putting pressures on staff and clients. One of the key findings of a survey of 450 blind and partially sighted people in April and May 2020 carried out by RNIB [6] was that 66 per cent of blind and partially sighted respondents felt less independent now compared to before lockdown:

“There is also a strong theme around the loss of independence for blind and partially sighted people who are now relying more on support than they previously did. For some, it feels like a backwards step and is beginning to negatively impact on people’s confidence.”

These pressures need to be accounted for in planning for current and future services.

During lockdown, the majority of local authority ROVIs have been making contact with clients by phone or online, and have been able to provide advice and replacement equipment. Social distancing restrictions have meant that only emergency in-person assessment and support has been possible .

This will increase the risk of dependency, with a consequent increase in need for assessed services, and of additional risks of falls and injuries. Lack of provision of early intervention vision rehabilitation services has been shown to disproportionately increase health and social care costs elsewhere in the system [7].

### Demand, workforce and service planning considerations

#### Impact of COVID-19 on referrals

As services start to normalise, the following sources of referrals and work will need to be planned for:

* Gradual return of referrals for support, as
	+ Certificates of Vision Impairment (CVI) are processed again as routine eye treatment resumes 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);
	+ referrals from children’s and education services by Qualified Teachers of Visual Impairments (QTVI) for habilitation (some ROVIs are additionally qualified to train vision impaired children and young people), as schools return;
	+ clients and family resume referrals as priorities return to normal.
* Return of referrals for vision rehabilitation from areas of healthcare that have been operating at reduced levels of activity during the pandemic, e.g. stroke care, falls clinics and A&E.
* Potential for a significant backlog of work, as new referrals are added to previously unidentified needs of clients that have been contacted whilst in lockdown. Many sensory teams have been undertaking lengthy welfare phone calls, and many have discovered previously unidentified needs, the solutions to which may 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 ROVIs

Working practice for blind or partially sighted ROVIs, directly employed by a local authority, who employ a personal assistant (PA) will need to be considered. Managers of people who employ PA(s) in this situation should be encouraged to discuss and mitigate risks with them. It may be that some vision impaired ROVIs may choose to adapt their working practice in the short term, and their employers should support this.

Managers should be aware of the risk of damage to emotional resilience of the vision rehabilitation workforce due to:

* A sense of reduced effectiveness in meeting the needs of clients at the end of a phone, and in the probability that the situation is unlikely to return to what was previously considered normal for a considerable time.
* An increase in caseloads (see pressures above) and increase in client waiting time.
* Perceived pressure to reduce caseload and waiting lists, as well as the need to manage resources, where professional judgement indicates that better outcomes could be achieved if greater resource was available.
* Feelings of frustration at limited awareness of the benefits of their specialist service within the wider adult social care environment, and of the difficulties faced by vision impaired and deafblind people.
* Disruption to supervision patterns, or supervision that places focus on case-closure rather than wellbeing.
* Concern that shortages of, and difficulties in obtaining, personal protective equipment (PPE) for ROVIs, if that were the case, may lead to risks being taken in service delivery.
* Professional isolation – many ROVIs work alone within a local authority. Lack of networking opportunities may have been exacerbated during this time.

#### Impact of COVID-19 on clients

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

* Wellbeing needs, 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. Onset 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, deal with negativity from members of the public arising when a vision 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 setbacks in their “rehabilitation journey”.

## Part 2: Adaptations to practice

This section has been adapted from interim guidance provided by the Rehabilitation Workers Professional Network (RWPN), and is intended for distribution to specialist practitioners and their service managers.

Government guidance around COVID-19 will change as the situation evolves. As lockdown lifts the guidance in respect of a number of areas is changing e.g. outdoor restrictions and group meetings is likely to change, and practitioners and their managers should regularly check the RWPN web site [8] for updated best practice guidance. The Test and Trace programme may also lead to the need for individuals to self isolate and also creates the possibility of local lockdowns dependant on rate of infection.

The Department of Health and Social Care published ethical guidelines [9] 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 practitioners should consider applying in working with people that they support. Government and employer guidance must be followed in applying these principles.

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

#### Positive risk approach

There should 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 through the risk of infection. A positive-risk approach will be required to weigh up this balance.

#### 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 videoconference will also help to gauge how best to use the time at a client’s home. It may help to make an initial call to set up a more formal appointment 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.

Assessment work may be done entirely remotely where this is possible. Consider the medium through which remote work is done – ask the individual what technology platform they use or are most familiar with and use this one. If the person uses Zoom – then the practitioner should use Zoom.

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, such as an advocacy service.

#### Recognition that some case work will require home visits

There needs to be recognition that some case work will be very difficult to undertake in any way other than “face-to-face”, but is still essential. Consider how a blended approach could be used – what information can only be effectively gained by face to face. If a face to face meeting is required consider if this could be supplemented by remote working for work that takes place before/after e.g.

* route learning to an essential destination (e.g. health facility, work, or shop) where no alternative exists;
* rehab for a client who needs to maintain a carer role, and is without access to other support;
* discussion with an isolated client, where you need to ensure meaning is understood and capable of being remembered.

For the protection of both ROVI and client, Public Health England guidance currently in place for working in people’s homes, including social distancing, the use of PPE, face coverings and hand hygiene, should be followed by both parties.

#### Use of PPE and anti-viral gel

You should follow government guidance on the use of PPE [10], and of your employer. As antigen, and ultimately antibody, tests for the COVID-19 virus become more available, staff should be encouraged to participate, to reduce the risk of inadvertent transmission to clients.

Government guidance for working with adults in home settings [11] should be followed. A significant proportion of vision impaired people do not fall into the category of “clinically vulnerable”, 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 casework where close contact is essential, and ROVIs (and any 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 and/or disinfecting of any equipment [12].

Many people with sight problems may have an additional hearing loss or other communication difficulties. They may rely on lip-reading or other facial expressions. With this in mind, facemasks may hinder communication; use of a face-shield (which would give added eye protection) or a facemask with a clear panel in front of the mouth, as an alternative, should be considered. Clients should also wear a facemask or covering to reduce the risk of to ROVIs and support workers. When using facemasks be sure to adapt your voice so it does not sound muffled or unclear.

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 distance of at least 2 metres. This may be the case where the client is neither vulnerable nor suspected of being infectious.

Where other hand washing facilities are not available, ROVIs will need to carry a sufficient supply of hand sanitising gel, and wipes for when handling or handing over equipment.

#### 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 a 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 close intervention may raise the required level of PPE.

Ensuring a room has natural ventilation is also a good way to mitigate risk.

#### 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 reinforcing 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 and 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).

#### Greater use of technology to facilitate rehabilitation

Technology may significantly reduce the need for face-to-face rehabilitation for some people, through the use of video conferencing or webinar with a client or carer (or groups thereof). This can allow the demonstration of equipment or techniques, such as a YouTube video or self-made video via WhatsApp/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, a ROVI may not be able to assess the client’s ability to memorise new techniques or observe physical factors such as balance problems.

#### 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 the equipment easy to learn. A great number of people have adopted technology to keep in touch with friends and relatives so should be more willing to use the same technology to interact with professionals.

Examples might include enabling the client or their family to download apps like “Seeing AI” or “Be My Eyes” etc. or promoting greater use of “virtual assistants” such as Amazon Echo, or similar. Teaching of these may be possible via videoconference with the family (with or without the client).

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