Meeting the needs of visually impaired people using HEFT services

Introduction

This document sets out recommendations for policy, procedures and staff training needs in relation to the care and support of people who use HEFT's range of services and happen to have a visual impairment. Please note a specific policy on Accessibility which will cover Visual Impairment is being developed in early 2017.

The need for this work arose following a complaint from the family of a woman who was an in-patient at Good Hope Hospital during summer 2014. The lady had quite poor sight, and events brought to light the fact that the hospital had no specific policies, procedures or staff training for dealing with the particular needs of visually impaired people who were in-patients for non-ophthalmic reasons.

This work began with research into current practice and levels of staff understanding about blindness and partial sight, not within the ophthalmology department, but as evidenced across both Good Hope and heartlands hospitals.

The study was not intended as an investigation into one particular complaint; however, an exploration of the occurrence that triggered the review did reveal some issues which provide an opportunity for wider learning within the Trust.

Subsequent investigation indicates that this work not only has implications for the Heart of England Trust, but that polices for addressing the needs of visually impaired people are lacking in most UK hospitals.

The Trust engaged Richard Cox of Seeing Sense, an independent consultant about the needs of visually impaired people. This is his work, and is set out using these headings:

Acknowledgements

I wish to record my thanks to the staff at Good Hope Hospital including a number of individual nurses, sisters, ward managers and senior nursing staff. In general I found them to be open, collaborative and keen to see this aspect of patient care better understood and supported.

I also wish to thank the many visually impaired people across the UK who took the trouble to contribute their experiences as part of a survey undertaken nationally. It was disturbing that many of these repeated common themes, and it is clear that improvements nation-wide are overdue.

Thanks finally to the local and national voluntary organisations that deal every day with the needs of people who are blind and partially sighted, who put effort into canvassing the views of their service users.

Richard Cox

Seeing Sense

Bringing clarity to impaired vision

www.seeing-sense.com

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Research undertaken

The research for this work included:

- Interviews with a number of patients and their "Carers"
- An analysis of the notes of a patient whose family had complained about in-patient care at Good Hope Hospital
- Doctors, ward managers and nursing staff on several wards, clinics and in A&E were interviewed
- Staff from several local and national voluntary organisations for visually impaired people were consulted
- They assisted in undertaking a survey of the experiences of visually impaired people across the UK
- On-ward and in clinic environmental observations were undertaken to assess potential hazards and visual challenges
- On-line international searches and approaches to other health trusts were undertaken to identify existing good practice
- Views were sought from a leading optometrist specialising in low vision, and a Trust director who also happens to have a visual impairment.

The Findings

Identification

1. There is no consistent and reliable mechanism for identifying in-patients who are visually impaired, whether for planned admissions to wards, or admitted via A&E, AMU and other routes.
2. Many out-patient clinics lack consistent mechanisms to identify patients who have a visual impairment.
3. When visual impairment has been identified, it is not effectively communicated amongst staff.
4. The red tray / jug system used on some wards is ambivalent: some staff take it to mean "help needed with feeding", others view it as a more general indication of patient need for assistance. This system is therefore not recommended as the sole identifier of visual impairment.
5. Where a patient has had prior ophthalmic contact with the Trust, their notes for this are kept separately in that department. The result is that it is not possible for details of any diagnosis or treatment to appear in the general notes held by the other wards in relation to a non-ophthalmic admission. Thus there is a significant gap in the information available to staff about a patient while in hospital.
6. Particular groups of people are much more likely to experience impaired sight, and therefore patients in these categories require more thorough assessment, and staff working with them require better informed approaches to practice.

Incidence

There is no reliable way of estimating how many of those who use HEFT services are visually impaired, but this information will act as guidance to incidence of those with significant levels of visual impairment:

Sight loss affects people of all ages, but increasing age significantly increases the likelihood of failing vision.

- One in five people aged 75 and over.
- One in two people aged 90 and over.
- Nearly two-thirds of people living with sight loss are women.
- People from black and minority ethnic communities are at greater risk of some of the leading causes of sight loss.
- Adults with learning disabilities are **10 times** more likely to be blind or partially sighted than the general population.

Source: RNIB website Oct 2015

In addition, a significant percentage of those who have falls did so because visual impairment was a primary of secondary factor.

Assessment

1. The effects of visual impairment on practical day to day patient care in hospital are not well understood, recorded or acted upon, at all levels of staff.
2. Some staff have a rather limited appreciation of the presence or effect of visual impairment. Patients were assessed as either having glasses (= assumed poor sight) or they didn't (= assumed good sight). Neither of these is true. Similarly, patients were often simplistically categorised as blind (assumed totally), or they could see (assumed fully): there was a lack of understanding of how impaired sight was a separate disability to the absence of any sight that requires its own recognition and separate approach to care.

3. The current tools for visual impairment assessment serve to reinforce this approach. They tend to focus on clinical factors rather than considering the overall impact on the patient's quality of care or safety during their stay.

Impact

1. There was a noticeable inconsistency between wards in the level of understanding and support given to visually impaired patients.
2. Patients can become isolated if they cannot see enough to initiate conversation or respond to being addressed, if not directly by name.
3. Placing patients in single bedded accommodation because they have special needs can exacerbate this, adding to isolation and loneliness.
4. The current assessment processes do not assist in reaching a meaningful understanding of needs related to impaired sight, or act as a trigger for any practice adjustments that may be required.
5. This leads to impaired communication to and from patients. This can impact their quality of care and increase risk.
6. "No-one told me my dinner had been put out for me, or that it had been taken away again!"
   Staff do not always adapt their practice to meet the specific needs of patients with a visual impairment. This can lead to reduced intake of fluids, food and medication, but this is not always identified by staff who wrongly assume uptake has proceeded normally. If the patient has not had these things drawn to their attention food and drink may be left unconsumed, and medication lost or overlooked. This outcome was referred to repeatedly in the national survey of visually impaired patients.
7. Some wards present particular hazards to patients who are visually impaired. For example, natural routes from bed or day areas to toilets sometimes involve navigation of varied types of clutter, such as medical or cleaning equipment left in the path to and from these areas.

Resolution

1. A few simple procedural adjustments, together with staff training, could significantly improve the situation for in-patients and reduce some risks. These practice changes are set out separately.
2. Each individual patient or their Carers are the leading experts in their vision-related needs, and best placed to describe their level of impairment. Their advice should be sought about how to make any necessary adjustments to care.
3. The problem is not unique to the Trust: there are many reports from visually impaired people of a similar lack of effective assessment and poor staff understanding and practice at hospitals throughout the UK.
4. The study has shown that on-ward issues are only part of the hospitals' responsibility to address the needs of visually impaired people: appointment letters, signage, lighting and staff training for cleaners, caterers, receptionists, security staff, clinic staff and other patient-facing services also need attention. This again was a strong theme reported in the national survey
5. The creation of trained Visual Impairment Champions on each ward and clinic could have a significant positive impact on addressing some of the difficulties highlighted in these findings

Policy Recommendations

People who are blind or partially sighted are entitled to the same quality of provision from the Trust as any other patient.

Their particular needs will be addressed by making reasonable adjustments to their clinical and social care, in compliance with disability and equality legislation and the recent introduction of NHS Accessibility guidance.

This requires effective mechanisms for the identification of visual impairment, both at outpatient clinics, on wards and at other Trust services.

For patients where the incidence of visual impairment is known to be a high probability, assessment to check for this shall be automatic. This includes patients over age 75, admissions due to falls, patients with learning difficulties and some specific ethnic backgrounds.

Identification of visual impairment will trigger an assessment to determine the degree of visual loss and the individual adjustments to care that are required. This will be based on an understanding of their particular disability and functional difficulties, as obtained from the patient themselves or their Carers.

A Sensory Impairment Care Plan and daily review form implemented across the Trust to facilitate this. It will be integrated into the metrics information and held with the Nursing Core Notes at the foot of the patient's bed.

Any ophthalmic diagnosis or treatment due to pre-existing contact with the Trust should be held within the main patient records.

Staff have a duty to ensure their colleagues and other staff are also aware of the needs of each patient with visual impairment, thus providing consistency of care in this regard. This requires an effective method of identification of visual impairment to be apparent at point of patient contact, and for this to be included in hand-over details when staff come off duty.

Patient consent will be obtained when implementing any mechanism (such as a symbol above the bed) which highlights their vision-related needs, whilst maintaining their dignity.

The Trust will ensure it complies with accessibility legislation, NHS protocols and good practice in providing reasonable adjustments to its physical environment to accommodate the needs of those with impaired vision. For example, ensuring signage on all its sites complies with RNIB guidance about size of text, colour contrast and lighting.

The Trust will ensure it complies with accessibility legislation, NHS protocols and good practice in providing reasonable adjustments to its administrative processes. This includes appointment letters, literature and menus available in larger font on request for all departments, and by default for all ophthalmology services.

The effectiveness of these polices will be reviewed annually from the date of implementation to ensure they are being reflected in improved practice.

Practice Recommendations

In essence, dealing with visual impairment can be reduced to staff exploring three key questions with the patient or their carer:

- Do you have poor sight?
- How does it affect you?
- What do you want me to do to take account of it in the way you are cared for?

The following explores these approaches in more detail.

Identification

1. When patients are admitted via A&E, a simple assessment of the presence of visual impairment may have been carried out where possible, but unless it has direct relevance to the immediate treatment required it is unlikely that this will be in any depth, though it should be recorded in the patient notes.
2. If an individual subsequently becomes an in-patient by being transferred to a ward from A&E, an indication of sight problems should trigger a more accurate and detailed assessment of visual impairment, including recording any known diagnosis, assessment of visual acuity and consideration of the implications for the patient's medical and social care.
3. Any ophthalmic diagnosis or treatment due to pre-existing contact with the Trust should be held within the main patient records and available to staff in all departments.
4. These patients are at significantly greater risk of some of the leading causes of sight loss: those who are aged 75 and over, or who are from certain black and minority ethnic communities, or have suffered a fall, or have learning difficulties. These patients therefore require automatic screening for the presence of visual impairment.
5. An admission due to a fall should trigger an assessment for visual impairment. If this is present, then an Occupational Therapist, Eye Clinic Liaison Officer (ECLO) or Visual Impairment Rehabilitation Worker should determent whether optometric or environmental changes (glasses, better lighting, hand rails etc.) would be appropriate as part of discharge arrangements.

Assessment

Where visual impairment has been identified, it is essential that a **Sensory Impairment Care Plan** is completed, included in the metrics information and held with the Nursing Core Notes at the foot of the patient's bed.

The Visual Impairment Care Plan includes an Assessment Section and a Daily check list. It holds specific information about identified needs, including:

- Visual impairment effects: Central vision / peripheral vison loss, ability to recognise people, read menus, find their way independently to toilet etc.
- Whether glasses are required for reading / distance / vision is not improved by glasses. Many visually impaired people cannot benefit from glasses, and will not necessarily have the appearance of limited vision.
- Identified risks: does or drinking eating require assistance, can the patient locate and use the assistance call button, and are they unsteady on their feet?
- Separate out visual impairment presenting behaviours from some dementia symptoms. An eye condition known as Charles Bonnet Syndrome can lead to visual confusion or hallucinations.
- Specifically asking the patient if they have any other care needs that relate to their visual impairment.

Assessment Interpretation: staff need to understand the implications of the assessment findings on their practical interaction with visually impaired patients. For example, for a given eye condition, are the staff likely to be recognised by the patient? If not, they should make sure to name themselves and their role on each contact with the patient.

The patient is the expert on their own sight and its limitations (or their Carer is). They need to be able to express their own needs and the challenges their sigh impairment brings. This should be recorded on the Sensory **Impairment Care Plan.**

Awareness

Once visual impairment has been identified, all staff need to know / be reminded of the fact at each contact with a patient.

A simple, unambiguous and effective way of drawing attention to the presence of sight loss should be implemented at three key places:

1. Use of a prominent symbol above the bed of those patients identified as visually impaired. This should be used once patient consent has been obtained through use of a yes/no permission question on the **Sensory Impairment Care Plan.** The yellow symbol to use represents a “shaded eye”. This is easy to understand and widely used.

2. A similar sticker should be attached to the front of main patient notes and the front sheet of the Nursing Core Notes
3. A similar flag should be displayed on the front page of electronic handover screens

Good practice

- On approaching a bed, staff should identify themselves and the purpose of their arrival
- If delivering e.g. drink, meal, medication, establish that the patient clearly knows its location
- On leaving, verbally make departure clear
- At nursing staff handover, the presence and needs of visually impaired patients should be one of the issues specifically mentioned
- Where there are changes made on a ward, these should be explained to visually impaired patients. For example, a moved bed, the arrival or departure of another patient.
- Staff should re-introduce themselves at an early opportunity after each shift handover: many patients will not recognise them again.

A simple acronym to may assist staff to remember what is required.

- For example SIGHT **AID: Announce** your presence, **Inform** the patient what you are doing, **and Describe** any changes on the ward.

Environment

On-ward environment

- The natural pathways from each bed to the toilet must be kept as clear as possible, with tripping hazards avoided in particular.
- Patients need to be clear about how to control their own lighting.

- Being placed closer to windows gives better natural light, but check that glare does not trouble the patient.

Staff training needs

- Implement Visual Impairment Champions similar to those dedicated to dementia
- Learning a few simple indicators to the presence of visual impairment
- Understanding the different effects that various common eye conditions have on patient's experience
- To appreciate that not wearing glasses does not mean vision is necessarily good, and that some eye conditions are not visible to the untrained eye
- To understand the less-obvious effects of impaired vision as well as those of (less common) totally blind patients, including an awareness of the effects of Charles Bonnet Syndrome.
- Learning how to complete a Sensory Impairment Care Plan assessment and daily check
- Learning how to (safely) guide a visually impaired person
- Appreciation of the way in which various environmental and practice issues affect the effectiveness of patient care. These include lighting, tripping hazards, recognising staff, the difficulty of seeing white tablets in a white container, and so on.

Cross-site accessibility issues

- A fuller audit of signage, lighting and other environmental factors across each Trust site is required
- There also needs to be clear guidelines about the size of print used in appointment letters and patient-facing publications.
- The website should follow accessibility guidelines and include documents downloadable in accessible formats.

Available Resources

Foe clinical advice and assistance, the ophthalmology department at each trust hospital site should be consulted.

The (pending) Eye Clinic Liaison Officer based in the Ophthalmology Department at Good Hope will act as a resource for specialist guidance about the non-medial aspects of patient care.

Seeing Sense website www.seeing-sense.com for a Free DVD called "Living with failing Sight" that explores the emotional and practical impacts of sight loss.

The RNIB website www.rnib.org.uk for more information about specific eye conditions and how to access wider resources.

Training Recommendations

Staff training about meeting the needs of visually impaired people using HEFT services should include:

- Indicators that a patient may be visually impaired, even if it is not self-declared
- Why the presence or absence of glasses is no indicator of visual impairment
- Understanding the differences between total loss of vision and severely impaired sight, and the modification to approaches to patient care this requires
- The main different eye conditions and how they vary in their effect on vision and what a patient can / cannot distinguish
- The impact of the presence / lack of good lighting on different eye conditions and visual situations
- How to apply this knowledge to common ward situations
- Visual Impairment Champions who have received more detailed raining should be identified and trained on each ward and clinic.