

## A practical approach to the management of low vision in the domiciliary setting.

### Paper One: Understanding Community Care

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1 CET Point

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# A practical approach to the management of low vision in the domiciliary setting.

## Paper One: Understanding Community Care

**Introduction:** Over two million people in the UK have significant sight loss<sup>1</sup>. The overwhelming majority with a visual impairment is the elderly<sup>2</sup> with over 80% of individuals included on the Severely Sight Impaired and Sight Impaired registers for the United Kingdom over 75 years of age.<sup>2-4</sup> Visual impairment affects about 10% of people aged 65-75, and 20% of those aged 75 or older. There is additionally a strong relationship between impaired vision in older people and both reduced quality of life and increased risk of accidents, particularly falls<sup>5</sup>.

Age-related macular degeneration is the single most significant cause of visual impairment, accounting for approximately half of all registered cases.<sup>3-4</sup> With the management of systemic disease improving, the average age of the population is set to increase further (Table 1) with an accompanying increase in the number of 'elderly years'.

It therefore follows that there will be a significantly higher proportion of the population with degenerative conditions, placing a greater demand upon services for the elderly. Over the coming years, we must prepare ourselves for a significant change in our working practices. With greater demand for services for visually impaired people, this will undoubtedly include the provision of low vision aids<sup>6</sup>.

The UK Vision Strategy<sup>7</sup> seeks a major transformation in the UK's eye health, eye care and sight loss services. A determined and united cross-sector approach will make that change a reality.

Three strategic outcome areas are identified in the strategy:

- Improving the eye health of the people of the UK
- Eliminating avoidable sight loss and delivering excellent support for people with sight loss
- Inclusion, participation and independence for people with sight loss

Within the optometric sector, a significant step forward in recent years has been a steady integration with other disciplines, such as local health authority care managers and rehabilitation officers; it is now widely understood that this move is a fundamental requirement of any successful low vision service.

It is the intention of this article to break down the barriers to low vision. The emphasis will be on management of the elderly visually impaired patients within a domiciliary setting. As optometrists and dispensing opticians, we must not only be able to prescribe magnification and low vision aids, but must also be able to deliver the most appropriate advice and information to our patients on the relevant local and national benefits and services.

### Working within the domiciliary setting

It is not unusual to successfully prescribe a device in the consulting room, only to have it returned with the complaint that it does not work whilst the patient is in their favourite chair in their own home. One of the greatest advantages, therefore, of providing low vision services as a domiciliary service, is to be able to view and evaluate the patient's needs directly. Factors such as lighting, posture and habitual working distances are assessed more effectively within the home; therefore it follows that the provision of a low vision device following a domiciliary visit should be more successful. If however, the domiciliary visit is taken place within a pre-designated room within a care home, it may still be possible to follow up with an assessment with the patient sitting in their regular chair.

Most basic skills detailed here may also be applied to working with younger patients. However, there will be additional information and legislation governing their rights within the work environment or within the school setting which is beyond the remit of this article. In such cases these patients are often best referred onto specialist practitioners who have the resources and contacts to address their needs more appropriately.

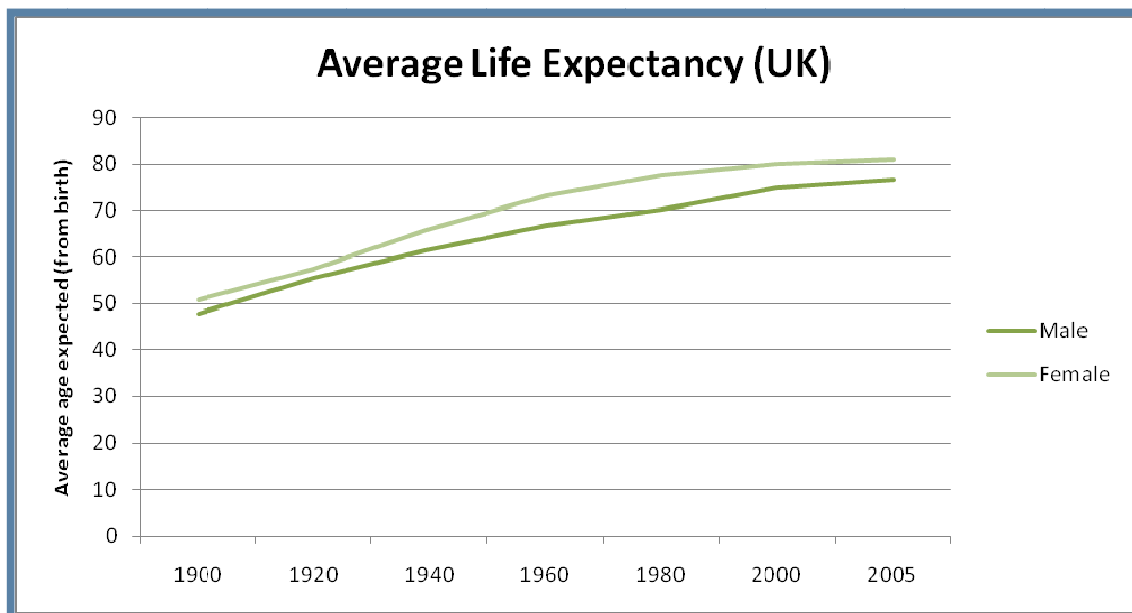


Table 1: Average UK Life Expectancy: data source. (Source: The Office of National Statistics).

## Definitions of Visual Impairment

Using the correct term or vocabulary with patients and other health care professionals is important at the outset. If a name or term is used out of context or inappropriately, some patients may feel offended or distressed. Some practitioners may be unwilling to 'categorize' a patient but it is more often than not in the patient's interest to have their problem clearly identified and defined. This assists in ensuring their protection both legally and functionally and allows for a greater access to advice, information and services to meet their needs.

Globally accepted definitions: The International Classification of Functioning, Disability and Health (ICF)<sup>8</sup>

*'A person with low vision is one who has impairment of visual functioning even after treatment and / or standard refractive correction and has a visual acuity of less than 6/18 to light perception, or a visual field of less than 10° from the point of fixation, but who uses, or is potentially able to use, vision for the planning and / or execution of a task.'*

WHO Definition of Low Vision, 1993

The World Health Organisation (WHO) definitions aim to provide a unified language and standard framework for the description of health and health-related states which

includes visual impairment. The ICF defines the following terms:

### Impairment of function

The term 'impairment' is taken to mean,

*'Any loss or abnormality of a psychological, physiological or anatomical structure or function'*

Impairment refers to the functional consequence of a disease or disorder. In visual terms it refers to the physical loss experienced by the patient. Impairments include, for example, a loss of visual acuity, a loss of visual field, a colour vision defect or a reduction in contrast sensitivity.

### Disability

The term 'disability' is taken to mean,

*'Any restriction or inability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being'*

When the impairment impacts upon the ability to perform certain tasks, then the patient may be described as having a 'disability'. However, not all impairments will lead to a disability. A congenital colour vision defect will have no impact on the ability to read small print, and a presbyope, who requires spectacles to read, may have a visual impairment but is no longer disabled by it when they put their spectacles on.

### Using the term 'Handicap'

The term handicap is still used unwittingly by many individual health care workers but is no longer defined within the ICF document. It is still worth mentioning it here so that the practitioner is aware of its original definition and use within the healthcare profession. The term handicap was originally defined as,

*'Any disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending upon age, sex and social and cultural factors) for that individual.'*

The use of the term handicap widened the context from the individual to the environment in which they function.

To some, the inability to read small print may be a nuisance, but to others it can be a major source of 'handicap'. For example, an individual who is unable to read his printed bank statements may be handicapped by the loss of privacy.

However, a person will not be handicapped if the impairment or disability does not stop them from doing what they want to do: it either has not affected the way in which they live, or that they have overcome the consequences of the disability.

Careful questioning within the low vision assessment will assist in determining levels of disability for individual tasks; the following case example assists in illustrating this point:

### Case example: Elderly lady, living alone

Our patient is in the early stages of age-related macular degeneration. In the initial stages of the disease, our patient complains of distortion (*the impairment of function*). Although irritating, this does not affect her ability to perform certain tasks although she does

complain that it takes her slightly longer to read her correspondence and she needs more light to look at the television listings in her regular newspaper. Although regularly frustrated by this, she manages well enough.

With progression of the disease, a loss of central acuity and positive scotoma (*additional impairments of function*) prevents her from reading the paper altogether and she needs to enlist the help of her neighbour to help her with her correspondence.

In time, the gradual progression of an accompanying age-related cataract reduces her acuity even further. Her ability to comfortably complete simple tasks such as making a cup of tea or sorting the laundry prevents her from maintaining an independent lifestyle. With basic needs affected even safety within her own home is compromised.

For many people the impairment and disability resulting from their disease or disorder may lead them to review their lifestyle; some managing more than others. Most would consider the above examples disabling. The loss of independence could certainly be considered a 'handicap' if it impacts critically upon her quality of life.

The definition of handicap was, and still is, controversial. Instead, a patient may now be described as being 'disabled by' aspects of the environment. What is most important (and particularly from the patient's perspective) is for us all to understand why we have these definitions in the first place.

## United Kingdom certification and registration process

It is important to clarify the differences between certification and registration:

Although many different definitions of visual impairment exist for the purpose of legislation throughout the world, in the UK, patients are either *certified* as severely sight impaired or sight impaired, before being included on a local authority or primary care trust *register*. The Social Services Department, or local voluntary group acting on behalf of the Primary Care Trust, has a duty to maintain this register.

As discussed, although a patient may be certified with an impairment, they may not be disabled by their condition. On the other hand, a visually impaired person whose sight

is not 'bad enough' for certification may have a number of disabilities resulting from a loss of function.

### Certification: the Certificate of Visual Impairment (CVI)

The CVI, Fig 1a finalised in 2005, was the result of consultation with a number of different parties, including service users, academics and a large number of groups and associations, for example, the Royal College of Ophthalmologists and the Royal National Institute of Blind People (RNIB).<sup>9</sup>

The primary function of the CVI is to formally certify someone as either sight impaired (previously referred to as 'partially sighted') and severely sight impaired (previously 'blind'), so that the local health authority or council can place them on a locally maintained Register.

The CVI may therefore act as a referral for a social care assessment if that person has not previously been brought to the attention of social services. However, it is not the exclusive route.

The second function of the CVI is to accumulate epidemiological data that can be used in the planning of future services.

### UK definitions: Severely Sight Impaired

The National Assistance Act of 1948<sup>10</sup> states that a person can be certified as severely sight impaired if they are,

*'So blind as to be unable to perform any work for which eye sight is essential'*  
(National Assistance Act Section 64(1))

The primary impairment of visual function considered is the patient's visual acuity. Only the condition of the person's eyesight is taken into account; other physical or mental conditions are ignored. The three groups are outlined in Table 2.

UK Definitions of Severely Sight Impaired (previously Blind)		
<p><b>Group 1: People who are below 3/60 Snellen</b></p> <p><i>Certify</i> as severely sight impaired: Most people who have visual acuity below 3/60 Snellen.</p> <p><i>Do not certify</i> as severely sight impaired: People who have a visual acuity of 1/18 Snellen unless they also have considerable restriction of visual field.</p> <p>According to the explanatory notes, the CVI states that in many cases it is better to test the person's vision at one metre:</p> <p>'1/18 Snellen indicates a slightly better acuity than 3/60 Snellen. But it may be better to specify 1/18 Snellen because the standard test types provide a line of letters, which a person who has a full acuity should read at 18 metres.'</p> <p><i>Other points that are considered,</i></p> <ol style="list-style-type: none"> <li>1. How recently the person's eyesight has failed: A person whose eyesight has failed recently may find it more difficult to adapt than a person with same visual acuity whose eyesight field a long time ago.</li> <li>2. How old the person was when their eyesight failed: An elderly person whose eyesight has failed recently may find it more difficult to adapt than a younger person with the same defect.</li> </ol>	<p><b>Group 2: People who are 3/60 but below 6/60 Snellen</b></p> <p><i>Certify</i> as severely sight impaired: People who have a severely contracted field of vision.</p> <p><i>Do not certify</i> as severely sight impaired: People who have a visual defect for a long time and who do not have a severely contracted field of vision. For example, people who have congenital nystagmus, albinism, myopia and other conditions like these.</p>	<p><b>Group 3: People who are 6/60 Snellen or above</b></p> <p><i>Certify</i> as severely sight impaired: People in this group who have a contracted field of vision especially if the contraction is in the lower part of the field.</p> <p><i>Do not certify</i> as severely sight impaired: People who are suffering from homonymous or bitemporal hemianopia who still have central visual acuity 6/18 Snellen or better.</p>

Table 2: The UK Definitions of Severely Sight Impaired.

Certificate of Vision Impairment (CVI)  
**Certificate of a Person as  
 Sight Impaired (partially sighted) or as  
 Severely Sight Impaired (blind)**

**Part 1: To be completed by the patient or representative**

My specific attention has been drawn to the paragraph entitled 'Patient Consent' on page 6 which requires that my express consent is given to the use of my personal information, and to the 'Information for driving licence holders'.

I understand that my council or care trust will arrange for me to be registered with them if I so wish.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

I am  the patient  
 the patient's representative.

**To be completed by the consultant ophthalmologist**

I consider (tick one)	<input type="checkbox"/> That this person is sight impaired (partially sighted)
	<input type="checkbox"/> That this person is severely sight impaired (blind)

Date of examination \_\_\_\_ (dd) \_\_\_\_ (mm) \_\_\_\_ (yyyy)

*NB: The date of examination is taken as the date from which any concessions are calculated*

Consultant's Signature \_\_\_\_\_

Consultant's Name \_\_\_\_\_  
 Hospital address \_\_\_\_\_

Epidemiological Analysis: please send a copy of all pages (except pages 6 and 7) to the Royal College of Ophthalmologists, c/o certifications office, Moorfields Eye Hospital, City Road, London, EC1V 2PD  
 The CVI replaced the previous BD8 & CVI 2003 from 1 September 2005 Updated: August 2007

Figure 1a Certificate of Vision Impairment

Documents may be downloaded at : [www.dh.gov.uk](http://www.dh.gov.uk)

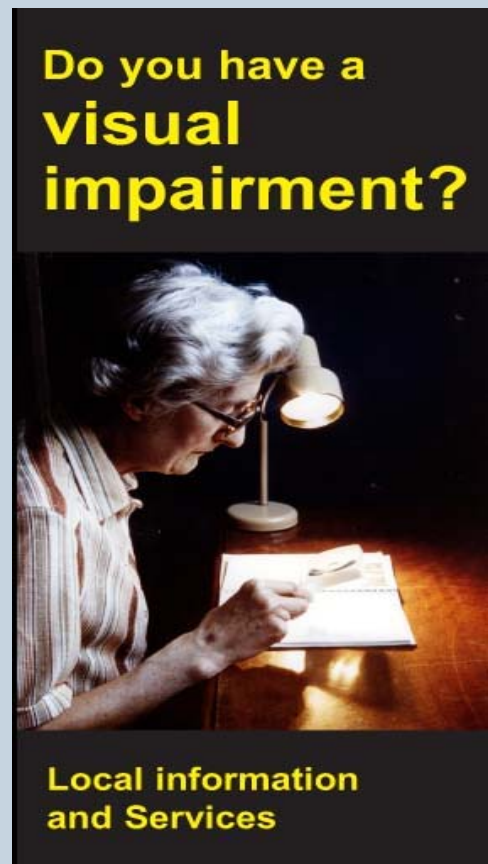


Figure 1b: Low Vision Leaflet

## UK definitions: Sight Impaired

There is no legal 'definition' of sight impairment. The guidelines from the Department of Health state that a person can be certified as sight impaired if they are,

*'substantially and permanently handicapped by defective vision caused by congenital defect or illness or injury'*

The guidelines are outlined in [Table 3](#).

Patients who are certified as sight impaired are entitled to the same help and assessment of needs from their local social services as those who are certified as severely sight impaired. However, they may not be eligible for certain financial benefits and tax concessions

compared to those who are certified as severely sight impaired.

## Taking the decision to Certify

The decision to certify is taken by the consultant ophthalmologist. The patient will sign the certification document and in so doing, has agreed for a copy of the document to be forwarded onto:

- The Primary Care Trust or Local Authority for inclusion on the local Register
- The patient's General Medical Practitioner
- The Office for National Statistics (ONS)

Notification may be additionally forwarded to:

- Department of Employment in those persons of working age seeking employment
- Department for Work and Pensions (formerly the Department of Social Security, or DSS) in the case of persons receiving income support.

## The Route to an assessment of needs and accessing the social care network

In accordance with *Progress in Sight*,<sup>10</sup> published by the Association of Directors of Social Services, on receipt of the CVI the patient's social services department (or its agents) should contact the person and arrange for the following:

- The Social Services Team will organise a home visit to consider the patient's individual needs and to discuss individual entitlements, both national and local.
- Their inclusion on the local authority's register (with the person's consent) and for them to be issued with a standardised registration card. The date of registration is taken to be the date that the Ophthalmologist signed the certification document.

As the CVI is an important source of information, if a person moves to another area, that information should be shared with the new local social services. This then avoids the need for re-certification.

### UK Definitions of Sight Impaired (previously Partially Sighted)

As a general guide, patients are certified as sight impaired, when they have a visual acuity recorded as,

Group 1	Group 2	Group 3
3/60 to 6/60 Snellen with full field	Up to 6/24 Snellen with moderate contraction of the field, opacities in media or aphakia	6/18 Snellen or even better if they have a gross defect, for example hemianopia, or if there is a marked contraction of the visual field, for example in retinitis pigmentosa or glaucoma

In addition, other guidance includes,

1. Infants and young children who have congenital ocular abnormalities leading to visual defects should be certified as sight impaired unless they are obviously severely sight impaired.
2. Children aged 4 and over should be certified as severely sight impaired or sight impaired according to the binocular corrected vision

Table 3: The Department of Health Guidelines of Sight Impaired

## Additional documents to assist access to social care services

The CVI is not the only route to accessing social care services for those patients who are struggling as a result of their visual impairment. The introduction of the Low Vision Leaflet (LVL) **Figure 1b** and Referral of Vision Impairment (RVI) documents create additional routes for referral for social care services, allowing the route to social care assessments to become decoupled from the formal processes of certification and registration.

### The Low Vision Leaflet (Figure 1b)

The Low Vision leaflet (LVL) is a standard referral letter that can be given to patients by an optometrist or dispensing optician. The leaflet assist patient who wish to self-refer themselves to social services thus providing

additional opportunities to obtain assistance independent or in advance of a CVI being completed.

### Referral of Vision Impairment (RVI)<sup>11</sup>

The content of the Referral of Vision Impairment or RVI document is similar to the LVL, and is there to be used by hospital eye clinic staff. Staff will use this letter to request a social needs assessment from the local authority, for example when registration is not appropriate, or timely.

With the introduction of these two referral letters, patients now have greater access to information and services from the time that the problem has been formally identified rather than having to wait for the lengthy process of referral and registration to occur.

## Rights to Community Care Services

Duties placed on Primary Care Trusts come under the National Health Service and Community Care Act (1990)<sup>12</sup>. Community Care Legislation is based on a government White Paper, 'Caring for People.' This states that anyone who has problems with, for example, a mental illness, a learning disability or a physical disability, should be able to obtain care services and support which, 'enables them to live in their own home and to retain as much independence as possible.'

Therefore, if a person is able to demonstrate a 'need' for a specific service or assistance, then the local authority has a duty to provide it. This assessment of needs will take place irrespective of whether the patient is certified or registered as either severely sight impaired or sight impaired.

That being the case, why register at all? The main reason for registration is to enable access for any service that comes 'at a price'; for example, claiming for all financial benefits; it is also necessary for many travel concessions and for obtaining practical assistance from some voluntary groups.

Furthermore, the important in maintaining a register is that local authorities can plan the provision of services for those visually impaired people within the local community. For example, central government funding would not be made available to a Local Health Authority if there was nobody registered there at all.

### The home visit - the rehabilitation officer

During the needs-assessment within the home, the visiting rehabilitation worker will put together a number of recommendations, pulled together in a Care Plan.<sup>13</sup>

Examples of daily living skills:

- Ensuring effective use of colour contrast & lighting
- Encouraging the use of large print, writing frames, pension book guides, labels, signature guides, envelope guides, large print bank statements, coin holders and identifying bank notes
- Demonstrating daily living equipment e.g. clocks, watches scales and calculators.
- Small self-adhesive tactile raised markers known as 'bump-ons' placed on cooker, washing machine and other controls

- Advice on home safety and in the garden
- Communication and mobility training

Following the assessment and the Care Plan, a Care Manger is appointed as the individual who is responsible for bringing the whole range of different services together to meet the person's individual and unique needs. Ideally, the programme will be monitored, as the patient's needs change. However, if a patient's needs have recently changed, and if it has been a while since the Social Services Department has assessed their needs, then it would be appropriate to suggest that they have another assessment.

After the assessment and Care Plan, there is then a duty to provide. Sometimes a service will be needed that the Primary Care Trust cannot directly supply, for example mobility training. If the need for mobility training is accepted, then the trust has a duty to provide it and thus will outsource the service from elsewhere.

Although entitlement to services is independent of registration, patients and their families are often not aware that they are entitled to a full assessment of their needs. Local optometrists and dispensing opticians are therefore encouraged to give the patient the Low Vision Leaflet to assist in reducing the delay for assessment.

## Summary

Research has found that the delivery of effective low vision services is a positive experience for the vast majority of people, with the provision of low vision aids, training and support considered to be invaluable.

Low vision services reduce the disabling impact that serious sight problems can have. A lack of low vision services can mean more residential care and rising costs for local authorities<sup>13</sup>. Therefore, in order to provide a comprehensive service to patients, it is sensible to become aware of low vision services provided at a local level, and how a patient can obtain access to them. This is particularly important for those patients we are unable to deal with effectively within the consulting room.

Effective communication between the various groups and professional bodies involved in the provision of services is essential to provide consistency across the country. This is particularly true, given the large number of professionals involved in service provision.

Jane Macnaughton MCOptom 2011

## Multiple Choice Questions

1. The largest percentage of people registered as severely sight impaired in the UK is:
  - A. Equally spread through age groups
  - B. Under one year old
  - C. Aged 75 years or over
  - D. Of working age
2. The purpose of the Low Vision Leaflet (LVL) is:
  - A. To provide a quicker route to certification
  - B. To assist the patient in self-referral to local community care workers
  - C. To provide a list of local agencies who provide low vision services
  - D. All of the above
3. Which of the following statements is *true*? The Referral of Visual Impairment (the RVI),
  - A. Requires a consultant's signature to allow details to be released to the patient's General Medical Practitioner
  - B. May be used by eye clinic staff to assist referral for social care
  - C. Provides an easier access for employees to obtain financial help from the Department of Employment
  - D. All of the above
4. Which of the following statements is *true*? Registration is necessary,
  - A. In order to claim for severe disablement allowance
  - B. To apply for funding from Social Services for the cost of mobility services
  - C. To be given a low vision assessment through the Hospital Eye Service
  - D. To receive a special General Ophthalmic Service (GOS) voucher toward the cost of complex magnifiers
5. Which of the following statements about Certification is *true*?
  - A. Certification is necessary before Local Health Authority registration
  - B. Certification is necessary in order to have a low vision assessment through the Hospital Eye Service
  - C. Certification is completed by the patient's General Medical Practitioner
  - D. Certification is necessary when requesting a needs assessment from Social Services
6. One of the functions of the Certificate of Vision Impairment (CVI) is to,
  - A. Provide information on local services for visually impaired people
  - B. Provide a direct routine for the patient to discuss registration with the ophthalmologist
  - C. Provide epidemiological data that assists in the planning of future services for visually impaired people at a national level.
  - D. All of the above

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