Caring for Residents who are blind or have low vision

Caring for patients who are blind or have low vision	
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People who are blind, or have low vision, have special needs for interpreting their environment. By following simple guidelines you can help make their hospital stay as easy and as comfortable as possible.

On this page:

Caring for Residents who are blind or have low vision

A good start

- Introduce yourself and address the Resident by name, so they know you are talking to them and not to another patient in the next bed.
- Introduce the resident to any roommates.
- Ask the resident what they are able to see. Few residents are totally blind.
- Ask the resident what assistance they need instead of assuming what they need.
- Ensure that the resident is included in discussions about procedures and medical plans. Being blind or vision impaired does not mean they cannot hear or understand what is being said.
- Say goodbye when you finish a conversation and indicate when you are leaving the room.

Residents in bed

- Put a 'Resident Identifier sign' above the resident’s bed and/or door stations - See below.
- Consider extra adjustable lighting for the resident with useful residual vision.
- The resident may prefer a corner bed to help make location easier, to avoid confusion with another patient's equipment and to help them arrange their belongings more easily.
- Don't unnecessarily move the resident's belongings. If items are moved, let them know their new location.

- Always inform the resident before undertaking any procedure; it can be very unnerving for the resident to be touched without warning.
- Make sure the Resident's ears and other sensory organs are not obscured.
- Knowing the time can help provide structure to their daily routine. Ensure the resident has access to a radio, talking clock, talking watch, Braille watch or clock with large numbers.

Resident identifier sign

Vision Australia has developed a sign specifically designed for use in health facilities to improve the quality of care for residents who are blind or have low vision.

The sign states: "I am vision impaired. Please introduce yourself and let me know when you leave. Please ask if I need assistance."

The signs are displayed above the person’s bed and assist hospital staff in identifying which people have low vision, thereby improving the quality of care to these people.

Clients or their families can print off their own copy (supplied below) and take them into the household themselves. Please be aware that the resident **must** give consent for this sign to be used.

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Mobile residents

- Orient the resident to their room by starting from a central point, such as their bed.

- When orienting the resident to a new area, walk with them rather than giving only verbal directions. This helps them learn distances and pick up sensory cues, so next time they can make the trip independently.
- Keep pathways and corridors clear of obstacles where possible and inform the resident of any changes to their environment.
- Ask the resident if they would like to take your arm for guiding purposes. If so, let them hold your arm above the elbow with their thumb to the front.

Mealtimes

- Read aloud menu items and let the resident choose their meal.
- Tell the resident when their meal has arrived and where their tray is placed.
- Colour contrast can be important for people who are vision impaired. Placing a dark tray or cloth under a light plate can define the plate edges making it easier for them to locate the food.
- Describe the contents of the tray. You can either use the clock-face method, e.g. the meat is at 6 o'clock, or by saying items are at the top, bottom, right or left side of the plate. Meat should be placed at 6 o'clock, as this is easiest for cutting.
- Ask the resident if they would like assistance with removing packaging from items.
- Ask the resident if they need assistance with their meal, rather than offering to cut their food.
- Provide any hot drinks in non-spill containers and tell the resident where they are placed.

Nursing management

Moore and Miller (2003) point out that care for residents with visual impairment must be carefully individualised, while fostering normalisation. Effective communication and, most importantly, acknowledging the resident with visual impairment as a human being with the same range of needs and feelings as a person who has normal sight, may achieve this.

An awareness and understanding of the concept of individual needs and how best to address them are also essential. Maslow's (1954) five-stage hierarchy of needs model (Fig 1) serves as a useful basis for considering these needs. The model is underpinned by the theory of human motivation, which has five classes of need arranged in hierarchical order from the most basic up to the highest level. Gratification of needs is the key concept of this theory. When a need is gratified at one particular level, the next highest need emerges. The following discussion demonstrates how this theory translates into practice in meeting the needs of both young and older patients with visual impairment.

Applying Maslow's theory of needs

Physiological needs

The significant biological and physiological needs of residents with visual impairment are those associated with eating and drinking. Because the degree of a person's visual impairment will determine the degree of assistance required with eating and drinking, good practice involves ascertaining from the resident (after asking tactfully if help is required) his/her normal routine at mealtimes. For example, the resident can be asked where it is best for certain items such as cutlery, cup, glass, and plate to be placed.

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Eating can be made easier and more enjoyable if the type of food and its position on the plate can be identified.

This can be done by using the ‘hands of the clock’ method, for example, meat at 12 o’clock, peas at six, potatoes at nine o’clock. Cutting up food into small, manageable portions before the meal, particularly for a child, may also be useful.

Overfilling of cups or glasses, especially with hot fluids, is best avoided so as to prevent any spilling and potential scalding of mouth and lips. The level of the liquid should always be indicated to the resident.

With cool liquids this can be done by allowing the resident to feel for the level of the liquid by placing his or her index finger just inside the vessel. Hygiene is important where food is concerned, and facilities for handwashing should be provided both before and after a meal, because many residents will need to ‘feel’ their food.

Residents with diabetic eye disease may be particularly anxious about managing the onset of a hypoglycemic attack that has been precipitated by a poor correlation between dietary intake and prescribed diabetes therapy. Assessment of the residents current treatment and dietary needs is therefore essential. Residents with diabetic eye disease may inadvertently misinterpret blood test results, making it difficult to determine the dose of insulin they should take before their meal. Some residents also have problems with differentiating between blue and green colours while interpreting the results of a urine test.

Safety needs

According to Moore and Miller (2003), visual impairment in older people has been associated with falls that often result in fractures, dislocations, and lacerations. Limited mobility, and difficulties in carrying out the activities of living, are also associated with visual impairment. Undoubtedly, a resident with visual impairment experiences some degree of disorientation as a result of being placed in the strange environment of a hospital. Escorting the resident around the new environment as and when required will help to meet the need for safety, promote some orientation and instill a feeling of security. The resident must always be asked sensitively whether help is required and then be allowed to take the nurse's arm or hand. The nurse should walk one step ahead, giving appropriate directions, and warn of any impending obstacles along the route. When approaching a door, the nurse should stand on the same side as the door handle, open the door, step through and hand the door handle to the resident, who then has control over closing the door. When negotiating a narrow space, the nurse's arm should be placed behind his or her back and the resident asked to walk behind the nurse. When approaching stairs, the nurse should be one step ahead of the resident, giving instructions as to whether to step up or down. Nurses should take responsibility for instigating safety measures, such as good lighting, placing the bedside locker on the side most appropriate for the individual resident, and ensuring that the call bell is placed within easy reach. Appropriate supervision must also be provided when a patient needs to visit the toilet.

Moore and Miller (2003) document the fears and uncertainties about the future expressed by older men with macular degeneration. Inevitably, hospitalisation provokes such fears. The prospect of undergoing ophthalmic

surgery, for example, the removal of a cataract, or retinal detachment surgery, means having to confront uncertainties and fears about the possibility of not being able to gain further useful vision, or even total loss of vision. There is evidence that well-informed individuals have less anxiety and depression and are better able to manage their health and treatment than those who are not informed (Partridge and Hill, 2000).

Nurses are able to instill a resident's eye drops and ointment effectively, and, conversely, to supervise the residents technique for safe instillation of eye medication or any other drug, may help to relieve anxiety and provide some reassurance.

It is vital that residents understand the implications of non-compliance with drop therapy. For example, a resident with chronic simple glaucoma may face further deterioration of vision, or even blindness, if treatment is not adhered to. Health promotion is thus a significant aspect of the nurse's role.

Belonging needs

First meetings with a resident with visual impairment are important because the goals are mutual and first impressions will influence the resident's expectations.

A compassionate and empathic approach is therefore instrumental in meeting the person's expectations and in establishing a caring relationship based on mutual trust. Some older residents with visual impairment also have hearing deficits and mobility problems. Patience and good listening skills are essential when caring for them. These skills are especially important when

communicating with non-English speaking residents from diverse cultural backgrounds.

Admission and discharge procedures may take much longer with a resident with visual impairment than with one who is normally sighted, and the nurse can make a difference to a resident's time in hospital by allowing adequate time for the overall planning of care and educating the resident to care for him or herself. This may mean modifying practice;

In the absence of vision, touch is the next most important sense. Thus, when approaching a resident, nurses should introduce themselves by extending a warm, calm and welcoming greeting. Loveridge (2000) suggests that touch can assist in developing a therapeutic relationship.

Esteem needs

When trying to orient residents to their new environment, it is helpful to show them the layout of the household by allowing them to 'feel' their way to areas such as the bathroom, toilets and social area. This means placing their hands in contact with the physical structures of the environment; for example, a wall or a piece of furniture. This will help not only their orientation but also their balance. More importantly, it helps to encourage some independence, which is conducive to promoting confidence and maintaining self-esteem.

Similarly, introducing the resident to immediate neighbours will establish social orientation and acceptance. When a nurse approaches a resident to speak to him or her it is important to speak in a normal tone of voice, as this is non-threatening. Often there is a tendency to speak loudly just because the resident happens to have visual impairment.

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When a procedure needs to be undertaken at the bedside, the nurse should give advance warning of approaching by starting to speak before reaching the bedside so as not to startle the resident. Similarly, a verbal indication when leaving the bedside minimises the embarrassment of the resident;s continuing a conversation in the nurse's absence. Some residents feel that their visual impairment has threatened their identity, as they have had to make a number of psychological, emotional, and intellectual adjustments to their loss of sight. Helping them to regain some control over their condition, or the underlying systemic disease causing it, may be the way to help to restore their self-esteem and confidence. For example, residents who have diabetic retinopathy and who can monitor their own blood glucose levels and administer their insulin injections safely signal their re-empowerment as individuals.

Confronting progressive visual loss means having to become more self-aware and more knowledgeable about creating personal strategies for maintaining an acceptable lifestyle. Providing these residents with information about low-vision aids such as talking books, large-print reading materials, small hand-held magnifiers, and telescopic devices can facilitate their adaptation to visual loss and the utilisation of rehabilitation strategies.

Similarly, helping residents to resume general social activities and skills, hobbies, and travelling, can facilitate the maintenance of family and peer contact. This often helps to prevent the onset of depression, a well-documented psychosocial implication of visual impairment. Indeed, recent visual loss is one factor that has been linked with difficulties in carrying out daily activities, diminished sense of well-being, and depression (Moore and Miller, 2003).

Self-actualisation needs

This stage refers to the need to find self-fulfilment and realise one's potential. For the resident who has visual impairment this translates into being able to optimise the current level of vision so as to be able to continue to achieve personal growth and development and fulfil any personal aspirations. Visual impairment can result in a loss of status, responsibility and a sense of achievement. This can often disrupt roles and create economic demands and stress within the resident's family (Moore and Miller, 2003). The need for continued personal growth and self-fulfilment therefore becomes significant. The nurse can help by encouraging the resident to view any potential problems caused by visual impairment as challenges and situations requiring solutions rather than as insurmountable problems. For example, residents with low vision who enjoy reading or need to continue to read extensively as part of their job or study could be informed that visual reading may be supplemented with speech output devices such as spoken computer programs and books on audiotape. In addition, providing the family with information about the functional implications of visual impairment will increase understanding of the behaviour and feelings of the family member with the visual loss. This will facilitate the individual's continued personal growth, and is a basis for the realising of his or her potential.

Implications for practice

The application of a patient-centred model underpinned by the concept of needs has several implications for practice. If nurses are to meet the challenges of managing residents with visual impairment, they must be able

to demonstrate in their planning and implementation of care that they have knowledge and skills in several particular areas..

Conclusion

Maslow's five-stage hierarchy of needs model offers a means of raising awareness of the care requirements of both young and older residents with visual impairment. Using the model has highlighted the challenges involved when planning and managing their care. Meeting individual needs through effectively managed care may help to make a difference to residents with visual impairment.

Effective communication is instrumental in achieving this, and remains the single most important aspect of nursing practice. Nurses who have a knowledge and understanding of ocular pathology and the nature of visual impairment may be able to provide the effective communication and care management skills required to meet the special needs of residents who have visual impairment, their families and significant others.

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I am vision impaired

Please **introduce yourself** and let me know when you leave.

Please **ask** if I need assistance.