Vision and eye healthcare study in residential aged care facilities

Study report

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Date: 8 February 2018

1. Executive Summary

It is imperative that the prevention and treatment of vision loss and provision of low vision services are high priorities in aged care in Australia, given the prevalence of vision loss among older people and the significant impacts and risks associated with vision loss.

Vision issues include macular degeneration (the main cause of blindness and major vision loss in people over 50), glaucoma, diabetic retinopathy, untreated cataract, uncorrected refractive error and many other conditions.

People with vision loss are significantly more likely to access the aged care system and they enter residential aged care three years earlier on average than other older people. The rate of vision loss amongst people in residential aged care facilities is significantly higher than in older people living in the community.

Vision loss in residents of residential aged care facilities can have many negative consequences, including significantly increasing the risk of falls and hip fractures. Falls are more common amongst residents of aged care facilities than the general population, with up to half of all residents falling at least once a year. Vision loss has a significant impact on other aspects of quality of life, reducing social independence by two times and trebling the risk of depression.

Macular Disease Foundation Australia (the Foundation) is aware from previous studies that residential aged facilities have little guidance or support in ensuring eye health of older people is understood and incorporated into the routine personal and clinical care of their residents.

In 2015, the Foundation was awarded a grant (4-Z2FYOE) from the Australian Government Department of Social Services for a project which aims to 'reduce the incidence and impact of vision impairment' in residential aged care facilities.

The specific objectives of the project are to:

- Undertake comprehensive eye testing of approximately 200 residents to demonstrate the prevalence of eye disease in RACFs
- Gain a comprehensive knowledge base of current practices regarding the diagnosis, monitoring and recording of eye conditions in participating residential aged care facilities (RACFs)
- Identify how the management of residents is adjusted based on their vision status. This will include an understanding of the legislative environment and different corporate policies and procedures
- Develop a practical guide to best-practice eye care for RACFs which could include an online education program, publications or DVD programs based on the audit results and 'minimum standards of care' recommendations
- Launch and disseminate resources
- Identify changes in practice following the introduction of best-practice resources by reauditing participating RACFs

In 2016, as the first stage of the project, the Foundation undertook a study of the eye health and vision care of 193 residents in eight RACFs across Sydney, with the full support and cooperation of the eight facilities, who all expressed a keen desire to participate in a project that aimed to improve the quality of life for residents.

The study included testing the vision and eye health of the 193 residents and examining their clinical records. A survey of the facilities' management staff was undertaken to obtain information about policies and procedures within the facilities relating to the management of residents' vision and vision impairment.

The Foundation has also reviewed the legislative and regulatory environment for residential aged care, and the current reform agenda for aged care in Australia.

This report identifies that more than three-quarters (78%) of the 193 residents examined had some form of eye disease requiring ongoing monitoring or treatment noted in their clinical records. Once tested by the study orthoptist and ophthalmologist, at least 141 residents (73%) were found to have some form of eye disease, and this number is likely to be higher as glaucoma was not always able to be diagnosed through testing on-site. Fifty-six of these residents were found to have untreated cataracts. Of particular note was that up to 68% of the residents tested had some degree of age-related macular degeneration.

These are extraordinary findings given that a vision disorder was the primary health condition in only 4.8% of all residential aged care admissions across Australia in 2015, and was not identified as the primary health condition of any of the 193 residents studied. It suggests that eye disease is a significant co-morbidity of residents of RACFs in Australia.

Importantly, a significant proportion of the residents tested did not provide reliable information about their eye health or vision, and nor were the RACF records a reliable or consistent source of information about eye diseases of residents, with eye disease diagnosed by the study orthoptist and ophthalmologist under-reported in the clinical record. This leads to a conclusion that care and management plans for residents should be based on other sources such as doctor and optometrist records and post-admission low vision assessments. However, the report also identifies that optometrist and medical specialists' reports are usually communicated to the resident's general practitioner rather than the RACF and none of the RACFs offered a low vision assessment to residents with low vision.

Accordingly, recommendations are made on a 'model of vision care' and how this might be incorporated into the routine personal and clinical care of residents in RACFs.

The report provides further evidence of under-utilisation of low vision aids by those who would benefit, despite the wide array of options available. Sadly, lack of access to vision services, aids, equipment and assistive technology is a continuing issue for residents in RACFs, as it is for all older people whose vision impairment is diagnosed after the age of 65 years and who are therefore ineligible for the National Disability Insurance Scheme (NDIS). This issue continues to fall between the silos of disability and aged care, leaving those in need in a highly disadvantageous, unfair and inequitable position.

The establishment of a national low vision aids, equipment and assistive technology scheme is recommended, that is available to all older people where they are receiving aged care services or not and is agnostic to where aged care is delivered, in keeping with current reform directions.

The report identifies that systems and processes for management of personal and clinical care within RACFs are driven by the regulatory environment and legislated requirements. Recommendations are therefore made on improving the quality framework for residential aged care, including to legislation, guidance materials for assessing RACFs against mandatory standards and education and resources for residential aged care providers and their staff.

Given the importance in the aged care reform agenda of consumers driving quality and innovation, recommendations are also made to increase the awareness and knowledge of best practice for eye health and management of vision loss in RACFs amongst consumers and their families.

Residential aged care is costly, both to government and consumers, and every effort should be made to ensure that the care provided maximises the well-being of consumers and minimises the risk of harm and of incurring further cost to the health and aged care systems.

There is an urgent need to reform vision care within the aged care system. With the aged care system undergoing major reform, the time is right to ensure that current and future users of the aged care system have access to appropriate vision care.

2. Key findings

Prevalence of eye disease in residents

Of the 193 residents included in the study, 151 residents (78% of total) had some form of eye disease requiring ongoing monitoring or treatment noted in their clinical records within the RACF. This included people with any age-related macular degeneration (AMD), diabetic retinopathy (including diabetic macular edema), other retinal conditions, glaucoma, elevated intraocular pressure (IOP), or untreated cataract. Sixty residents (31%) had more than one of the above eye diseases.

After vision and eye health testing conducted as part of this study, a similar number of residents were found to have some form of eye disease, although the distribution of the conditions varied considerably from the clinical records. Of the 193 residents tested, 141 (73%) were diagnosed with at least one of macular degeneration, other retinal pathology, glaucoma, raised IOP or diabetic retinopathy or untreated cataract in one or both eyes.

While 119 residents (62%) were diagnosed with some degree of macular degeneration, only 46 of these were noted in the facility's clinical record for the patient. A further 12 residents were identified in clinical records as having AMD, but this was unable to be verified by the study orthoptist or ophthalmologist as the residents' physical limitations or frailty prevented taking adequate quality photos or scans. If it is assumed that the 12 residents did indeed have AMD, a total of 131 residents or 68% had some degree of AMD.

Thirteen residents were diagnosed with glaucoma or elevated IOP in the study vision and eye health testing but only six of these were noted in the facility records. Another 21 residents had a clinical record noting a diagnosis of glaucoma, but due to limited on-site testing conditions this was unable to be confirmed. Combining the testing and clinical record, it is possible that up to 34 people (17%) had glaucoma or raised IOP.

Significantly, 49 people (25%) had vision worse than 6/12 in the better eye, classifying them as having low vision. Eight people (4%) were legally blind.

Urgent treatment needs identified

Two of the residents with wet AMD were recommended to have an urgent (within one week) appointment with an ophthalmologist, and overall, 28 residents (15%) were recommended to receive further professional follow up (optometrist or ophthalmologist) outside their normal regular check-up.

Management of low vision and other vision impairment

Six of the eight RACFs have policies and procedures to manage residents with low vision and other vision impairment. This management is recorded in several locations including the care plan and nursing notes which reflect daily management of the resident, medical notes and the communication and sensory assessment form. There did not appear to be a central location where this information was stored in any of the facilities, making quick or reliable access difficult.

Management of vision impairment is reviewed when the care plan is reviewed.

Significantly, none of the RACFs offered a low vision assessment to residents with low vision. Facilities in the study typically do not provide Amsler grids to people for self-testing of changes in vision.

Accuracy, upkeep and utilisation of clinical information

A significant proportion of the 193 residents included in the study did not provide reliable information about their eye health or vision and their RACF records were not a reliable or consistent source of information about eye diseases, with diagnosed eye disease under-reported.

Eye disease diagnosed pre-admission will most likely be recorded in admission documentation. However, undiagnosed eye disease or new eye disease developed after admission may not be known to RACF staff if the resident or family do not report it, the findings of optometry reports are not communicated to staff, ophthalmologists' reports are not received or admission documentation is not updated.

All facilities in this study utilised a visiting optometry service to provide basic vision care and eye checks. However, if optometrists identify eye disease, they will typically report this to the resident's general practitioner. They may also provide a hard copy report to the RACF however it is unclear whether this is routinely communicated verbally to RACF management and whether it is acted upon by the RACF.

Staff training and education

Five of the eight RACFs reported providing education for staff on vision care. However, vision education was not mandatory and staff competencies were not assessed. Face to face training about vision and eye health was undertaken by RACF staff including by the registered nurse. External vision care providers were involved in staff education in three facilities and online training resources were also used.

Access to low vision aids

All facilities reported making adjustments for low vision residents and most reported offering low vision aids. It is not known however what low vision technology is available and utilisation of low vision aids other than spectacles was very low with only 8 residents (16.3% of those with low vision) reporting that they used low vision aids. Aids that are being used are regular and hand held electronic magnifiers as well as a table top large screen magnifier and a computer.

Residents with AMD had very low levels of low vision assessment and use of aids, with only one of 22 residents with AMD and low vision using a low vision aid.

Of critical importance, aids, equipment and assistive technology to assist with management of vision loss are not included in the specified care and services for residential care in aged care legislation. Further, residents of government-funded residential aged care are ineligible for state and territory based aids and equipment and assistive technology schemes, which provide some, but varying, access to vision aids and assistive technology.

Residents typically had spectacle lenses and frames in good condition and five out of the eight RACFs had a hard copy policy for the management of spectacles. The overall good situation for glasses is consistent with the relative frequency of optometry visits in these RACFs, and that the primary purpose of their visits relates to checking glasses.

However, there was no standard method for identifying residents' spectacles. Several facilities did not have a formal process while others had more than one method of identifying glasses.

Access to ophthalmology

Only a quarter of all residents had an ophthalmology consultation recorded in their clinical records. Of these residents, 96% had an identified eye disease but an ophthalmology report was available in only 60% of cases.

The major barriers to seeing an ophthalmologist were identified as transport to the ophthalmologists' rooms, cost and gaining family/carer consent.

Regulation and quality assurance

Current regulation of residential aged care facilities does not pay sufficient attention to ensuring best practice in identification and management of residents' eye health. There are few specific requirements of residential aged care facilities in relation to the eye health of their residents.

The Quality of Care Principles, a legislative instrument under the *Aged Care Act 1997* require facilities to provide assistance to residents to address difficulties arising from impaired vision and to access treatment, health practitioner services, rehabilitation support and individual and specialised therapy services as needed but do not specify what assistance might be provided in relation to impaired vision, other than cleaning spectacles.

The Results and Processes Guide for the current mandated Accreditation Standards for residential aged care facilities contains more detailed information on processes for managing sensory loss including vision loss but these processes are very general and are not requirements of residential aged care providers.

However, achieving accreditation is a requirement for becoming an approved residential aged care provider, and the study findings suggest that systems and processes within RACFs follow closely guidance materials from the Australian Aged Care Quality Agency, currently the sole assessing agency.

These guidance materials are currently under review, due to the Australian Government decision to develop a single quality framework for aged care, including a single set of standards to apply to all aged care services. There is therefore an opportunity to ensure that guidance materials are more specific about best practice vision and eye health care in RACFs.

3. Recommendations

Management of vision and eye health in residential aged care

1. That the model of care for the management of vision and eye health at Appendix 1 be adopted by residential aged care facilities (RACFs) to ensure:

- strengthened arrangements for the provision of optometry services covering referral requirements, routine and ad hoc attendance, clinical assessment frequency, documentation, reporting, referral to ophthalmologist notification, service reminders, provision of glasses and communication with family/carers for new and existing residents about vision and eye disease
- enhanced communication about eye appointments and vision management between the RACF and family/carers and eye healthcare providers
- a formal request to the ophthalmologist to visit the RACF when appropriate transport is not available for a resident to attend an external ophthalmology appointment
- awareness of vision as a risk factor for falls, mobility issues and increasing dependency in activities of daily living and the importance of referral to an optometrist for an eye health test
- the offer of a low vision assessment to the resident/family/carers when visual acuity is less than 6/12 in both eyes
- a systematic approach to the identification of residents' spectacles and subsequent documentation
- use of the Amsler grid on a weekly basis for those diagnosed with age-related macular degeneration as part of a care plan.

Clinical and care plan documentation

2. That comprehensive record keeping (resident's vision and eye health status) be commenced on entry to the RACF including diagnosed eye disease, ophthalmologist's details and optometry visits along with consistent and routine updating.
3. That eye health information be included in the Care Plan and on the Sensory & Communication Form
4. That RACFs arrange with residents and/or their families and carers to obtain ophthalmology reports from residents' GPs or ophthalmologists
5. That components of the model of care be included in any commercial contract with optometric service providers.

Vision & eye health training and education for staff

6. That relevant RACF staff including nursing, care assistants and activities staff undertake mandatory vision and eye health education at orientation with annual refreshers and complete an annual 'assessment of vision and eye health' knowledge test.
7. That routine vision and eye health education includes:

- information about common eye diseases
- an explanation of key terminology used in vision and eye health reports
- awareness and early detection for eye disease and low vision

- impact of low vision on quality of life and independence
- low vision aids and technology education

8. That the Aged Care Workforce Strategy Taskforce be provided with a copy of this report to inform its consideration of requirements for new workforce training and continuing professional development in aged care.

9. That RACFs are made aware of resources available from the Foundation for eye health and low vision education, including through the Australian Government Aged Care Channel and the Australian Aged Care Quality Agency annual Better Practice conferences.

Regulation and accreditation

10. That guidance material for the single quality standards to apply to all aged care services in Australia be developed with reference to the above recommendations.

11. That further specification of the assistance to be provided with vision care be included in the specified care and services in the Quality of Care Principles when these are next reviewed.

12. That the National Screening and Assessment Form and supplementary assessment tools be reviewed in relation to their adequacy in assessing eye health.

13. That consideration be given to including the incidence of falls in the National Quality Indicator Program, as this may be an indicator of the effectiveness of resident's vision care.

14. That consideration be given to developing a quality of life indicator for inclusion in the National Quality Indicator Program, given the impact of vision loss on quality of life and independence.

Consumer education

15. That the My Aged Care website include up to date and accessible information on eye health in older people and the information that consumers and their families require to determine if residential aged care facilities are following best practice vision care.

Access to vision aids and assistive technology

16. That the My Aged Care website service finder contain accurate and updated information on low vision service providers
17. That a nationally funded, accessible, affordable and consistent low vision aids, equipment and assistive technology program be established to replace the current state/territory government programs.
18. That consistent access to appropriate vision aids and equipment and assistive technology be established across the aged care system regardless of where the care is delivered.

Funding model for residential aged care

19. That the Resource Utilisation and Classification Study in residential aged care consider the extent to which vision loss, as a significant co-morbidity of aged care residents, drives costs of care or potentially drives costs of care in residential aged care.

9. Appendices

Appendix 1 Draft model of care for vision and eye health in residential aged care facilities

Appendix 1