Allied Health Professional case studies: Orthoptist

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The evolution of the Orthoptists role in supporting patients with Idiopathic Intracranial Hypertension

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Description

The natural habitat of the Orthoptist is within the Ophthalmology service. As the communication, knowledge and skill set of the Orthoptist are transferable to other areas, increasingly the Orthoptist can be an asset in a variety of departments. The aim of this work in the short-term was to improve health and in the long-term, protect health in the population of patients with Idiopathic Intracranial Hypertension (IIH) within the Neurology Service. The IIH service is situated in The Institute of Neuroscience on the Queen Elizabeth Hospital campus in Glasgow. IIH is a rare condition which can be associated with weight gain/obesity mainly in women 18-45. The condition is associated with raised CSF (Cerebrospinal fluid). It can cause disabling daily headaches and visual loss, which can be permanent. The raised CSF can cause papilloedema (swollen optic discs) and this can affect vision. The role of the Orthoptist in a new patient with IIH is to assess vision, visual fields and take a detailed history from the patient regarding the onset of symptoms. At this early-stage conversations with the patient are had around weight and lifestyle. The Orthoptist's role in ongoing management is to enable patients to understand their long-term condition and help them aim to maintain a healthy lifestyle.

Context

IIH is considered a rare disease. It has been found 1-3 in 100,000 people in the UK (and 2.6 in Scotland) in the normal population have this condition. The rates are increased in people with obesity up to 20 per 100,000. (IIH.org.uk 2022)

In the UK the increase in obesity of the population was already widely known and currently there are almost two-thirds of the adult population defined as overweight Body Mass Index (BMI) 26 Kg/m^2 or obese over 30Kg/m^2. (Obesityactionscotland.org Nov 2019)

It has been documented that the rates of IIH are increasing in the UK. (Subramaniam 2017)

Within the Neuro-Ophthalmology service it was recognised that there was an increasing number of patients with IIH in the clinic and not enough time to assess the patient and to manage the causes of IIH effectively or empathetically. The aims were to try to support health improvement and behaviour change in this long-term condition and reduce the need for multiple visits and admissions to hospital. Although this service is based in NHS Greater Glasgow and Clyde the service provides care to patients from NHS Lanarkshire, NHS Dumfries and Galloway and NHS Ayrshire and Arran.

Method

A joint approach was designed and rolled out to increase capacity to have a dedicated service for these patients. Training was secured for the Orthoptist with the Glasgow weight management team which centered on education in nutrition, exercise and motivational interview techniques. The Orthoptist underwent training in further Ophthalmic skills such as Optical Coherence Topography (OCT) training, slit lamp skills and medical exemption certificate (masters module certificate). A joint approach was designed and rolled out to increase capacity to have a dedicated service for these patients. A need was identified for managing patients as they become stable to help the patients move on and be happily discharged with an understanding of how to keep the IIH in remission by continuing with healthy lifestyle changes. This culminated in a dedicated Orthoptic-led service for static and stable patients without a need to be seen by the Neurologist. To enable the patients in this clinic to manage their lifestyle the Orthoptist gathered as many leaflets and access to digital help as they could to support the patient long-term. A leaflet was designed and printed by the Orthoptist and Neurologist to give clear information, including answers to frequently asked questions and explain how to access help for this condition.

Outcomes

Now the service is running well and one of the measurements of impact is the rate of DNAs (did not attend). Nationally across a wide range of specialties in Ophthalmology the DNA rate is between 8% and 14%. Within this IIH service the DNA rate is 6% which is based also on figures collated before the Covid lockdown. Also, on the impact of Covid on the service it has been necessary to use telephone consultations at times. This has been of benefit to the patients with anxiety regarding hospital attendance and at times an inability to access GP and Optician services over lockdown.

Many of the patients have a preference to discuss weight and other health factors with an AHP than a consultant. This can be beneficial as a rapport can be built with the patient which means an honest and sometimes difficult dialogue can be made easier with a familiar practitioner.

Using the “What matters to you?” day the patients were asked about this specific clinic and any changes they would like to see. The feedback was almost entirely positive. Only one patient requested that the physical layout of the clinic was altered, and that suggestion was acted on. Even in the waiting area the patients find support with one another as they are aware that the clinic is wholly for IIH patients.

It is more cost effective to reduce the number of appointments that the patient requires with:

- The consultant
- Being equipped to manage their own condition
- Understanding how to access help without presentation to A&E
- Supporting health improvement for possible future conditions ie type II diabetes

Key learning points

The role of the Orthoptist in public health is very important and they are well equipped to promote health improvements in several areas. The learning from Orthoptists in having difficult conversations was important in benefitting themselves and the patients and it has been reassuring to get support

with this aspect. It has also been satisfying that if there is any training required or support it is easy to find resources.

There are significant areas that require improvement regarding patient support and self-management. As this service is accessed by four NHS areas further input and collaboration are suggested to reduce waiting times. Recent staff shortages have now highlighted this issue to the other NHS areas. There are very motivated Orthoptists that would be able to support these patients closer to home and the training is available to do this following this model. The ideal model of Public Health for AHPs is ultimately where the service should be aiming to be across all Health Boards. There is a great interest in enhanced Orthoptic roles which should be more in keeping with holistic approaches to the patient and with the patient than individual specialties.

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Implementing a public-health style questionnaire into the Orthoptic case history: A prospective case report

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Description

Case history taking is the first line of contact we have with our patients and sets the scene for open conversation. As Orthoptists, we often focus on specific medical-related questions which enable differential diagnosis and management. However, to Make Every Contact Count (MECC) we should be giving patients the opportunity to raise wider health concerns (physical, mental or social) so we can signpost to support services. Due to the COVID-19 pandemic, face to face contact has been kept to a minimum with patients often feeling rushed or confused without opportunity to have a conversation with healthcare professionals. A recent study showed 80% of patients reported a decline in their mental, social and physical health throughout the pandemic.[1] It therefore raises the question of the best method to gather enough information to ensure MECC can be utilised for all patients within their allocated appointment time in the outpatient environment. In this case study, a pre-consultation public health questionnaire designed to focus on wider patient well-being is proposed. This case study is a prospective review and a follow-up report will be published with recorded outcomes of the service evaluation.

Introduction and Context

A conventional case history typically takes the form of a 5–10 minute conversation at the beginning of the consultation involving closed questions directed to the patient, often focused on specific ocular symptoms. As part of a proposed service improvement, a pre-consultation questionnaire will be implemented to gather wider public health information before seeing the patient. The aim is to keep the questionnaire informal and non-invasive whilst giving patients the opportunity to voice any wider health concerns including mental health and quality of life as part of MECCs. We have also developed 'business card' style leaflets with targeted public health information which can be given to the patient dependent on the questionnaire responses. The questionnaire has been designed specifically for the service improvement, using a similar style to pre-existing, validated public health questionnaires.[2] Kobashi et al showed that 64% (n=46) of patients with a nerve palsy had 2 or more modifiable risk factors such as diabetes, hypertension, hyperlipidemia, smoking, alcohol abuse, depression and obesity.[3] Furthermore, patients with mental health disorders had an increased risk of accommodation and convergence anomalies which decrease quality of life.[4] There are also studies which show substance and alcohol use can exacerbate myasthenia gravis and decompensate heterophorias which leads to diplopia.[5] These risk factors can be identified via the questionnaire and

additional information, via the business card model, can be given to the patient to enable education and access to support services.

Promoting MECC and supporting public health education is a key aim of this service improvement and aligns with the NHS Long Term Plan.[6] However, a secondary aim is to use the standardised data collected from the questionnaires to improve the department's understanding of the patient demographic within the outpatient clinics. This allows resources, clinic support services and staff training to be tailored to the patient demographic. Once the service improvement is implemented, a follow up report will be published where the responses will be audited and any further service improvements proposed as a result of the questionnaire will be presented.

Method

The questionnaire is proposed as a service improvement at Stepping Hill Hospital. The questionnaire was used for patients aged 18 and over attending for an Orthoptic-only appointment. Nine Orthoptists agreed to take part in the service improvement. The questionnaire included 9 closed questions with Likert scale or multiple-choice, as seen in Figure 1. The final comment on the questionnaire is for staff to document if any MECC information was given and if so, for what area of public health. This will be audited to explore if the questionnaire resulted in an uptake of MECC information. Informal verbal consent was required before completing the questionnaire and identifiable patient information was anonymised. The questionnaire did not form part of the patient record once complete. The questionnaire was designed to be completed prior to the Orthoptic assessment and should take no more than 5 minutes to complete. The questionnaire responses were reviewed in conjunction with a full Orthoptic assessment. At the end of the consultation, the patient was offered information signposting wider support networks, depending on the question responses. The MECC information was gathered from a range of validated websites and charities. Figure 2 shows an example of the patient information leaflet. The leaflets are available for 21 areas of public health support, ranging from stop smoking services to dementia groups. The questionnaire is available in accessible formats. Visually impaired patients were offered the choice of having the questionnaire in larger font or having the questionnaire read aloud to them. At the end of the 3-month trial the questionnaire responses will be audited and results included in the retrospective case study.

Outcomes

As this is a prospective case study no results have been collected. A retrospective, follow-up case study will be presented to gauge the number of participants who were able to access further support or information as a result of the public health questionnaire being used as part of the Orthoptic case history. The questionnaire has been developed specifically for this project and therefore it has not been peer reviewed. As a result, a focus group style verbal discussion including administrative staff, Orthoptists and patients allowed for some initial feedback before the questionnaire was rolled out:

1. "I feel the questionnaire gives patients opportunity to raise wider health issues without the anxiety which can be inflicted with face-to-face conversation." Orthoptist

2. "It may add to patient stress before their consultation, particularly if the patient arrives late." Clinical administrator

3. “Due to the nature of our patient demographic some patients may not be able to access the questionnaire in text/written format due to visual impairment.” Specialist Orthoptist

4. “I feel like I didn’t have a chance to tell anybody how I was feeling after my stroke, any opportunity to access wider support or information is great.” Stroke patient

Comment 1 identifies a good point which was a driver for implementing the public health questionnaire. The questionnaire reduces both patient and clinician anxiety which surrounds starting healthy conversations around sensitive topics. Furthermore, having structured information to hand ensures a proactive approach to public health. The patient can choose what they wish to disclose via the questionnaire rather than being questioned directly which may discourage attendance at future appointments.

In response to comment 2, it is important the questionnaire is not viewed as a ‘compulsory’ part of the patient assessment: healthy conversations are a patient choice.

Comment 3 raises a valid argument; if the implementation of the questionnaire is successful, the aim is to make the questionnaire accessible in different formats for all patients such as online or braille format. This relates to the wider effort required to ensure that MECCs and public health initiatives are accessible to all patients within the healthcare setting.

Key learning points

1. Case history taking offers a good ‘ice breaking’ environment where you can start healthy conversations from the outset. Providing a short questionnaire focused on general physical, mental and social health empowers the patient to guide the conversation.

2. Our role is not to counsel but to listen and signpost appropriately. It is important that we respect when patients do not want to take part.

3. The questionnaire is not intended for new patients only and therefore could be offered at a follow up appointment. The questionnaire can also be repeated.

4. The service could be improved significantly if a pre-consultation questionnaire could be sent out via online links and other accessibility formats prior to the patient attending the hospital. The aim is for the questionnaire to take less than 5 minutes to complete.

5. The literature and NHS Long Term Plan supports early signposting and prevention. This can improve recovery period of ischemic palsies, lower risk of recurrent palsies, better mobility due to cardiovascular health and lower risk of falls. Supporting public health and MECC reduces the likelihood of inpatient admissions beyond the eye clinic.

6. Case history is often overlooked and condition-specific, further standardisation allows us to understand the needs of our patient demographic on a public health scale.

7. As a department we are working to improve the scope of the ‘business card’ style services offered. Currently there are contact details for public health concerns such as smoking, financial support and gambling addictions. Having contacts to hand means you can act on the concerns raised via the questionnaire proactively and patients feel supported.

8. A follow up case-study will be released following implementation of the questionnaire after a 3 month period. Auditing the responses will allow us to understand outpatient cohort and further support their needs.

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Figure 1: **Well-Being Questionnaire (Please circle your answer)**

1. How are you feeling today?

   1 2 3 4 5

   (1 being low- 5 being very happy)

2. Do you have interests/hobbies that you enjoy and support your wellbeing?

   Yes No

   (This could be walking, coffee mornings, reading or anything you enjoy!)

3. How many days per week do you consume alcohol on average?

   1 2 3 4 5 6 7

   (1 being 1 day per week - 7 being 7 days per week)

4. Do you smoke?

   Yes Never I used to smoke but have stopped

   (Even 1 cigarette rarely would be 'yes')

5. Are you a carer?

   Yes No

   (This can be looking after a parent/partner, does not have to be full time)

6. How do you cope with daily stresses?

   1 2 3 4 5

   (1 being unable to cope - 5 being stressed doesn't impact me)

7. How many minutes exercises do you perform weekly?

   I do not exercise Less than 150 minutes More than 150 minutes

   (Exercise counts as intended walking, skipping, resistance training etc)

8. On how many days per week do you eat 5 portions of fruit or vegetables?

   1 2 3 4 5 6 7

   (1 being 1 day per week - 7 being 7 days per week)

9. Do you feel you need support with any other aspects of your wellbeing?

   Please write any further suggestions below:

Patient information given:

Figure 2: Making Every Contact Count 'business card' style for dementia patients:

Dementia drop-in support sessions Stockport:

1. The kitchen at Chestergate
   Monday 11am-1pm 0161 804 4400 hello@pureinnovations.co.uk
2. Tea Dance Offerton Community centre 2pm-4pm 07794810032
3. Woodbank walking group
   Tuesdays 1.30pm at Vernon Park Café
4. Singing for the Brain Hazel Grove Civic Hall 0161 477 6999
   stockport@alzheimers.org.uk
5. Reddish dementia friendly café Wednesdays 12pm-3pm St Agnes Church North Reddish 07498996634
6. Activity memory group
   Tuesdays 12.30-2.30pm Bramhall United Reformed Church
   0161 969 4151

The Orthoptic visual processing difficulties (VPD) clinic during covid-19 lockdown. The affectivity of telephone consultation implementation rather than face to face visits

Kathryn Whitfield, Advanced Orthoptist

Description

At Warrington and Halton NHS Teaching Hospital Orthoptists have been providing telephone consultation opportunities to parents of children who are struggling with their learning due to possible visual processing difficulties.

Orthoptists are health care professionals with a degree in Orthoptics. They diagnose and treat a variety of differences and one extended role is in helping children with visual processing difficulties (VPD).

VPDs are characterised by a difficulty interpreting what the eyes see. It involves looking at how a young person struggles with reading and strategies that can be implemented to help them. For example, some students will lose their place when reading and skip words which interferes with their comprehension. Some children will get visual distortions of print despite excellent visual acuity. Other children may struggle with an aspect of visual perception such as their visual memory.

The cohort of children discussed below are new patients who would normally be seen and assessed for visual difficulties that may be interfering with their reading ability. These children were all referred into the service using the detailed referral sheet, by teachers or health care professionals prior to Covid-19. During lockdown, all children were being schooled at home either by the school via zoom, or by their parents. The VPD team wanted to help those children to feel more comfortable when reading and enable them to have the tools and strategies to help each child access the curriculum equally to their peers.

Context

The aim of the study was to assess whether telephone consultations would be as effective in diagnosing visual processing difficulties. Would the information gained without an actual face to face assessment allow Orthoptists to make a sound conclusion and offer appropriate advice?

The Orthoptist would then later see the child face to face and gain a qualitative understanding of the impact the virtual assessments had on the learning skills of the patient.

A full, detailed history was taken from the parents and that information was used to form a picture of likely difficulties. Strategies and advice were then offered to compensate for these possible difficulties and exercises that would target specific areas of improvement. For example, Orthoptists were able to reassure parents who were frustrated with their child's progress and reassure them that those difficulties may be related to a visual processing difference. This enabled a supportive

environment for the child as the parents then understood that it was a treatable issue rather than a behaviour choice.

The VPD team provided an opportunity for a healthy conversation to take place such as addressing sleep or diet issues and offering signposting for advice.

All the advice, strategies and exercises were those used in the clinic. They were easy strategies to implement at home, for example making a reading ruler or window from paper to help the child to keep their place, changing the background colour/font size and style of the computer screen or playing games to help the child improve their visual perception skills.

The referrals into the Orthoptic VPD clinic are from educational settings across our local areas of Halton, Warrington and Widnes. The list of new patients who had been referred in the months March, April, May and June were collated onto an accessible spreadsheet. The parents of each patient were contacted and offered the opportunity to talk about their referral and a telephone consultation was done then or booked for a future date when convenient. The same questions were followed and advice was targeted dependent on the parent's and the child's answers and original referral. A lot of the time the phone was on speaker and the Orthoptists was able to have a full discussion with the whole family.

The aim of the assessments was to help children who would be working from home and finding it difficult. The Orthoptists wanted to make sure that the children were well supported in their educational setting. Another aim was to reduce the workload when the team were able to see routine patients again. The VPD team wanted to make good use of the quietest period when they were not able to see non-emergency patients face to face.

Method

Training of the 6 Orthoptists with the extended specialist role of VPD clinicians, to undertake virtual assessments took place during individual face to face or virtual meetings and was led by the lead of the service, Kathryn Whitfield. A standard operating procedure was implemented and reviewed by the team. Any difficulties were addressed and modified. Prior to completing telephone consultations, the clinicians watched Kathryn doing these virtual assessments and guidelines for reports to school were drawn up and continually modified. The assessment was based on a full history that is completed at every child's first visit which enables the clinician to gain a full detailed picture of likely difficulties. The history sheet that we complete is standardised and we know the strategies that work for each area of difficulty following years of audit and service improvement.

Kathryn Whitfield is also the co-lead of the British Orthoptic Society clinical advisory group for VPD so this information was discussed on the members forum of the website. This information was made available for other clinicians to follow if requested.

The VPD clinicians telephoned the parents of children who were referred into the Orthoptic visual processing difficulties clinic. During questioning about the general health of the child they ask lots of questions which are clinically relevant to learning and vision such as diet and sleep. Prior to referral into the clinic the class teacher or school special needs coordinator completes a detailed questionnaire about the child's learning. For example, do they lose their place frequently when reading? The Orthoptist discussed the specific school concerns and discussed what the parents had noticed, and together, came up with strategies to help the child. Parental permission was obtained to write a report and copy it to school, with every consultation. The advice could then be continued

at school once the child returned and until they could safely return for a face to face Orthoptic clinic appointment.

There had been a small use of telephone consultations prior to lockdown. VPD Orthoptists previously asked that parents contact us if they wished, before appointments, to discuss any issues over the phone. This was purely at parental request due to sensitivity of the child when discussing past family history such as those children who are adopted.

Outcomes

There is no current patient quantitative evidence of the impact of these telephone consultations but the verbal feedback from the parents has been excellent so far. One quote from a parent was “the reading ruler that you suggested has had a huge impact on my son’s learning and understanding since I spoke to you”. In the clinic the lead of the VPD team performs yearly audits to provide evidence that the clinics are achieving the goals of helping children to read more effectively and therefore access the curriculum despite learning difficulties. The audit for 2021 is looking at patient and school satisfaction so when this time comes it would be hoped that despite not being able to see patients face to face, the Orthoptists were still able to provide an accessible and worthwhile consultation.

In December 2020 the VPD team lead sent out a questionnaire to all the schools in the area asking them what they felt the impact of the Orthoptic Visual Processing Difficulties clinic has on the learning of the child prior to and during lock-down. It was explained what the team had been doing during lock down to ensure that patients were being cared for. Feedback from schools was excellent. Schools are happy that they receive detailed reports, including suggestions on how to support these vulnerable children.

At the end of every consultation questions were taken. The majority of the time, the team were thanked for their advice and strategies and the feedback has been brilliant. Results from the December questionnaire sent to schools has shown that 100% of schools so far are happy with the service that is provided.

During a time when activity was low for patient contact, the VPD team were able to keep appointment activity up for this Orthoptic service. Once able to see patients face to face again, the VPD team continued with the telephone consultations to take a full history. This meant that the appointment time could be reduced to allow time to clean the room between patients and allow a greater number of patients to be seen. Rather than a new patient appointment being 1 hour it was reduced to 45 minutes allowing an additional patient slot to be created thereby increasing productivity.

Key learning points

The Orthoptic VPD team were initially very keen to start with the NHS ‘Attend Anywhere’ innovation. They found that the telephone consultations worked so well that they wanted to continue with them post-lock-down which they did. It cut down the face to face time that was spent with patients and during the initial post Covid climate this was reassuring to staff and patients. This was done for a 3 month trial period.

New patient slots were allocated to telephone consultations with a 30 minute time limit. These patients were then later seen on a 45 minute face to face appointment slots. Feedback from patients

and staff was initially good but there was increasing frustration from parents who wanted the full assessment.

Following a VPD staff meeting when these changes were discussed, it was decided to change the referral process. Instead of the history being discussed via a series of verbal questions, the team have asked schools and parents to complete this at home on paper, send it in to the lead of service and it will be discussed at the appointment which has gone back to an hour long face to face appointment slot. Telephone consultations have been abandoned at this time as there is no replacement for face to face assessments now that clinics are back running to full capacity. The new referral tool enables the Orthoptist to have full information prior to the assessment and the appointment time can be clinically utilised with physical assessments involving observation of the patient.

The difficulty was in keeping the consultation time down. As there were no visible cues to the parents that they were running out of time, they often spent a long time discussing their concerns about their son/daughter on the phone.

There was a 3-month trial of combining face to face and telephone consultations but following team discussion, the VPD team decided to change the referral process as mentioned above to cut out the need for the telephone consultation. It was useful when there was no alternative, but there is no substitution for a full face to face assessment which allows correct utilisation of physical assessments as well as the non-verbal cues and nuances that are so important for the wholistic clinical assessment.

References

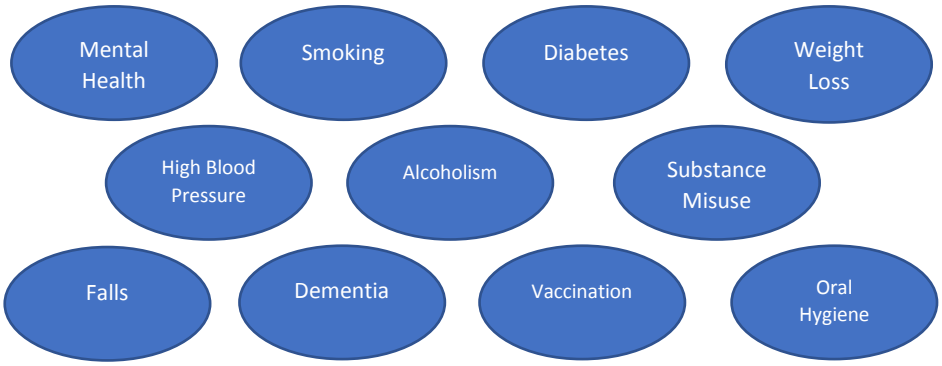
British and Irish Orthoptic Society

Preceptorship Public Health Initiative: New Graduates

As Orthoptists, Public Health conversations form part of our everyday interactions with patients. We should aim for this to be embedded naturally, rather than this being an 'add on' in our conversations. We should identify opportunities to have Healthy Conversations within clinics, more so now than ever, owing to the impacts of Coronavirus!

What conversations might we have with patients?

Some conversations are 'easier' to have with patients than others – i.e. a patient with Thyroid Eye Disease and discussing the benefits of stopping smoking, due to the evidence linked with our Orthoptic Knowledge. In these scenarios, we may feel more comfortable having this conversation. However, Public Health covers a large spectrum of issues…



What Is Public Health?

- Allowing patients to *think* about their current Health and Lifestyle
- Being Encouraging and Supporting
- Signposting

What Public Health is NOT

- Pressuring Patients to Change
- Counselling
- Knowing all the Answers
- Lengthy Conversations
- Reciting lots of statistics to patients

How To! Cue, Conversation, Conclusion

Cue – A hook which enables the patient to raise a subject with the health professional or vice versa.

- Example: A patient presents with an accommodative spasm and appears stressed.
- Example: There is a strong smell of alcohol on the patient's breath as they speak to you.

TASK: Can you think of any more Cues which may present themselves in clinic?

…… …… ……

Conversation – The brief intervention – Give the opportunity to 'explore' the change and think about the positive impact it can have. You can 'Pop in a Positive'! Patients may have a negative view if they have tried to make this change before and not been successful.

- "It's great that you're thinking about taking that first step to making a change."

- "It sounds like you have been successful before, even if it only has been for a few days."
- "There are some great online resources that can help you learn about managing stress."

TASK: What positive phrases can you think of to form part of the conversation?

……. …… ……

Open Discovery Questions are a useful way to encourage patients to actively think about a change in their life and explore how they may begin this change.

- What support do you need?
- How would you like to approach this change?
- If this is something you would like to change, would you like to tell me about it?

TASK: Can you think of any more Open Discovery Questions which could be used?

……. ……. …….

Conclusion – Signpost to follow up/specialist support services. Knowing what is available in the local area is important to determine a patient's outcome. Keep it brief, up to date and relevant!

TASK: Which services are available to signpost patients to? Research your <u>local</u> support.

……
……
……
……
……

<u>Real Examples</u>

① A patient with acquired downbeat nystagmus presented to the Orthoptic Clinic.

Cue: She expressed that she had found the Coronavirus Lockdown period particularly challenging.

Conversation: "What sort of support did you have in place prior to the Coronavirus lockdown and in what ways did you find these helpful?"

"Occupational Therapists were helping me to fill in forms for work-related adjustments which started to make me feel more comfortable and positive about going to work, but this had stopped due to the lockdown. I had been attending a support group for people with Brain Injuries to talk about similar problems."

"It's brilliant that you found this support so useful before lockdown, let's see if we can restart these avenues of support now."

Conclusion: A letter to the GP detailing the diagnosis and management of her condition with an additional line of the patient's request to access additional local support. The Occupational Therapy Team were also copied into this letter, at the patient's request. The patient felt as if she had made progress by coming to the Orthoptic appointment and was very grateful that support could resume.

② A patient has an acquired 6th Nerve Palsy and uncontrolled blood pressure.

Cue: Using the time we cut and fit prisms onto glasses, we could use this an opportunity to ask if a patient has any questions.

Conversation: "So, how common is double vision?"

Discuss reasons behind the patient's double vision or give them the opportunity to think about their overall blood pressure control. "It's a really positive step that you're thinking about controlling your blood pressure. If you are looking to resolve/improve the double vision, would you like to tell me about how I can help?"

Conclusion: The patient felt they would benefit from visiting their GP to access a home Blood Pressure Monitor. This was documented in the notes and at the follow up visit, the double vision had completely resolved. The patient felt much better in themselves, with much improved BP control.

Record Interactions - Have a Go!

TASK: Identify opportunities within Clinic and 'Have a Go'. You should document in the notes when a Healthy Conversation has taken place so the next Orthoptist may discuss outcomes with the patient at the next visit. They may discuss if any positive changes have been made to a patient's lifestyle and if further support and signposting is required.

	Date	Cue	Conversation	Conclusion
1.				
2.				
3.				

The more we attempt to have these conversations, this improves our confidence as clinicians in raising delicate issues. Patients should consult their GP if they fall or are attempting to lose weight.

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Orthoptic Public Health example. Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Domiciliary Orthoptic Assessments for patients unable to attend the Hospital Eye Service after a stroke or who have a neurological disorder

Understanding the problem

Domiciliary visits are common practice in therapy professions such as occupational therapy, physiotherapy and speech and language therapy following stroke and other acquired brain injuries, enabling patients to have a smooth transition from hospital back into their homes, and giving those with limitations to attending hospitals the ability to access services.

In Warrington and Halton, patients who are discharged home from hospital who need ongoing therapy have up to 6 weeks of continued therapy from the Early Supported Discharge (ESD) team of occupational therapists and physiotherapists, and are then referred onto the community neurotherapies team.

Up to 60% of stroke patients have a visual complication which may persist when they leave hospital. If pre-existing visual problems are taken into consideration, this increases to 72% of patient (Rowe, 2016). Many patients with Parkinson's Disease (PD), Multiple Sclerosis (MS) or who have other neurological conditions may also have visual and ocular disorders such as diplopia (double vision) related to their condition. These visual problems can affect their ability to perform activities of daily living, increase their risk of falls, and affect their emotional well-being.

Across the country unfortunately Orthoptic assessments are not routinely offered at home, with assessments normally limited to ward based testing and outpatient clinics. This is not an equitable service for all patients and no reasonable adjustments are made for patients unable to make it to the hospital. The patients who are house bound have assessments limited to optometrists and sensory support teams, leaving them without a Specialist Orthoptic assessment for diagnosis and management of their condition.

Since March 2015, Orthoptists employed by Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHHFT) offer and provide Orthoptic assessments at home for those patients who cannot attend an outpatient clinic and would otherwise be left untreated and unsupported.

Aims and Objectives

1. To provide equitable access to orthoptic assessments for all patients who require the service in the Warrington, Widnes and Runcorn area.
2. To spread awareness of the service to encourage other orthoptists to offer the service elsewhere in the country.
3. To meet Royal College of Physicians Guidelines for stroke (2016) providing clinical pathways for ongoing support after discharge.

Method and approach

Since March 2015 Orthoptists have been part of the stroke service within WHHFT. They undertake both ward-based and outpatient assessments, and home visits. Patients with an identified barrier to attending the hospital for an outpatient appointment are offered an assessment and treatment at home by an Orthoptist.

The service has been well received from patients and colleagues in multiple disciplinary teams (MDT), and we have built good relationships and also receive referrals from Parkinson's nurses and MS nurse teams locally.

In 2018 we conducted a small retrospective audit of patients seen for an orthoptic domiciliary assessment and collected feedback from service users and colleagues in the ESD team.

Patients in which there is a barrier to attending hospital are offered a home visit. They include;

- Patients with transport issues such as family not yet equipped to bring them to hospital, those who find the journey too tiresome due to their condition, or those who are bedbound and an assessment at home is more important in their normal environment
- Patients with a cognitive impairment who find the busy and complex hospital environment distressing.
- Those patients in care homes as giving assessments and advice at the care homes is a large part of a patient's rehabilitation and adaptation to their visual impairment.

Results and evaluation

We completed a small retrospective audit of orthoptic home assessments from 1st September 2017 – 31st August 2018.

Out of 402 patients seen by the orthoptic stroke and neurological team 22 patients had a home visit (5.4%). 20 of the patients had a diagnosis of Cerebrovascular Accident, 1 Parkinson's Disease, 1 MS.

The average age at time of assessment was 78.8 years.

17 of the patients required only one home visit. This was because of improving or declining health, or as they had recovered and did not require follow up.

The visual impairments found were;

- visual field defects (11)
- visual inattention (7)
- eye movement problems/double vision (7)
- nystagmus (4)
- visual perception problems/visual hallucinations (2)

All patients received targeted advice relating to their condition, including a personalised vision passport and leaflets. Where appropriate the advice was extended to the wider MDT especially in the case of care homes, and to the patient's family. Three patients had their diplopia (double vision) treated with prisms at home. Two patients were registered as sight impaired without attending the hospital, giving them access to services they required. Six patients had ongoing visual field and visual inattention therapy continued at home following their discharge and therapy on the stroke ward. We made onward referral for 10 patients (45%) to domiciliary optometrists, visual impairment teams, and the ophthalmology department for those who needed assessments from other services. If this service would have been unavailable, the patients would have had assessments from domiciliary optometrists and visual impairment teams, with telephone support from Orthoptists, however the specialist support, assessment and treatment options from an Orthoptist would have not been possible without home assessments.

During this audit we collated comments from patients and colleagues experiences of the service;

- "Great service…great that sight was taken into consideration at intermediate care home after discharge and feedback given to family who live far away and the next care home in Norfolk. I recommend the service".
- "We couldn't have got to hospital, if that option wasn't there, there was no other option".
- "It was a huge help. She was very immobile at the time and it was very difficult when we tried to get to hospital in an ambulance".
- "Service has been extremely helpful and helped with other aspects of my rehabilitation".
- "Her eye problem was picked up very quickly…everything has been done to make her life easier including referral to assisted living team. Can't fault the service, personnel or attention given to Mum".
- "It helps us as therapists to better treat our patients if we know they have received a thorough assessment of their vision…I can look at the leaflet you provide which summarises your findings. This helps us be able to plan functional assessments and treatment more effectively…allows the patient to be seen in their familiar environment; giving them opportunity to discuss more realistic problems and difficulties."

Key learning points

Offering this service ensures that patients have equitable access to Specialist Orthoptic assessments and treatment. It aligns orthoptic services with other therapy teams working with patients with a stroke, or other neurological impairment.

Ensuring the orthoptists have a lone worker policy and risk assessment in place and any risks attached to the home are communicated.

Plans for spread

1. To continue to advertise the service locally in order for all those who require the service to have access to it.
2. To share this example of good practice so that other orthoptists can evolve their practice to respond to the changing needs of the patients (NHSE, 2017), developing in-reach support models of rehabilitation (NHSE, 2014), and to continue to step outside traditional boundaries to transform care (NHSE, 2017).

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Key contacts

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Title : **Orthoptists role in optimising general health - an example of using Making Every Contact Count (MECC) in practice**

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Description

Orthoptists help diagnose and treat patients with eye movement disorders and visual impairment. We interact with patients of all ages, background and ethnicity on a daily basis. Our conversations are not only focused on their eye health but also their general health and well-being. Many patients feel comfortable in expressing other health concerns in clinic as they are already being assessed for eye related issues. This gives an opportunity to start healthy conversations naturally and provide advice as well as signpost to other services if necessary, for example, health care professionals or charities. 'Making every contact count' (MECC) is an approach that many orthoptists use to help improve overall patient satisfaction and outcomes. Informal 'social prescribing' approaches are discussed to show how this can positively impact on the patient's physical and mental health through our consultations.

Context

The aim of this case study is to highlight the role of orthoptists having a positive impact on patients' general health, by exploring the outcomes of MECC in our assessment.

At Stockport NHS Foundation Trust, Orthoptists have been implementing opportunities to 'make every contact' for any patients that are struggling with their vision or eye movement disorders. We are allied health care professionals whose service covers the population of Stockport, meaning we see a variety of both child and adult patients[1]. Consequently, we are able to have appropriate conversations regarding the patients' general health, implemented within the discussions of the appointment. One of the conditions we help to diagnose and monitor is Ocular Myasthenia Gravis (OMG).

OMG is an autoimmune and rare disease which leads to muscle weakness. Often it mimics cranial nerve palsies, gaze palsies and other neurological palsies. It can affect people of all ages, typically occurring more in females than males. Due to the presentation of OMG being incredibly variable[2], it can be a stressful situation for patients as there can be a delay in diagnosis and therefore treatment,

if all the relevant information has not been obtained. Often signs and symptoms include, complaints of tiredness, fatigue, eye lid drooping, and double vision[3]. Asking the appropriate questions regarding mental health, smoking, blood pressure, diabetes and substance abuse can assist in coming to a timely diagnosis as well as gauge how their general health may be impacting their overall well-being/mental health. Orthoptists are well suited to identify opportunities as we can have meaningful conversations to provide comfort to patients and improve the overall outcome of their health.

Method

A 36-year-old Gentleman presented with double vision, fatigue, shortness of breath and tiredness in 2019. He was seen in Orthoptics twice and was also followed up in Ophthalmology. In the Orthoptic assessments his symptoms were consistent, however his ocular movements and deviation varied. He was followed up monthly due to the inconsistent presentation. Once the diagnosis of OMG was made, his follow up time was reduced to every few months to watch for the progression.

The Orthoptic assessment was crucial to not only help diagnose but also to assist with the patient's mental health and wellbeing. When symptoms were discussed, he mentioned shortness of breath, which led to an open conversation about smoking and how this may be affecting his health negatively[4]. In the case history of the assessment, he expressed that he felt dizzy due to the double vision, which led to him having falls and incidents at home e.g. pouring hot water over his hand. Consequently, he was given an eye patch to wear due to the unstable nature of his ocular movements, to eliminate the double vision. He was also prescribed steroids by his Neurologist to alleviate his symptoms.

As the patient has Type 2 diabetes, he expressed his concerns regarding his weight gain, which was adding to his recent diagnosis of depression. The patient openly expressed this information, which allowed for an informal 'social prescribing' approach to signpost to Myasthenia charities and other support groups both nationally and locally as required. This shows a positive impact on the patient's mental health in our consultation[5]. All this information was verbally given to the patient, and also written down in the case notes, so that these topics can be raised at each visit to see if any advice was heeded or if any further advice/signposting is required.

Outcomes

The outcomes of this patient are both subjective and objective. The patient's satisfaction at appointments, conversations documented in the records and the improvement of his condition, reveals how our assessments are helping him.

As his double vision was improving, he was given an eye patch to wear at home, in the intermittent instances of the double vision. He felt the patch gave him his independence back by keeping him steady, resulting in less incidents. This helps lower the risk of admission to other pressurised services such as A&E, creating space for other urgent matters.

He was referred to the Eye Care Liaison Officer (ECLO)[6], but also due to his diabetes, the Orthoptist advised him on healthy eating and living[7]. After this, he was more aware of how making better choices lowers vascular risk factors, which can positively impact on his mental and physical

wellbeing. This was supported by the 5 steps to mental wellbeing[8]. Healthier lifestyle choices can reduce the likelihood of needing healthcare services long-term, reducing the pressure on the NHS.

Furthermore, this case study showed that patients are willing to discuss vulnerable situations with Orthoptists. These conversations can offer support and guidance but ultimately, the choices are theirs to make. The gentleman joined a support group for men dealing with mental health conditions and researched (myaware) MG charities[9], which helped him immensely to not feel isolated. MECC may be cost-effective in the long-term, as the extra support could help prevent future health concerns, possibly reducing frequent use of NHS services.

Unfortunately, there was no staff feedback or satisfaction survey conducted for a measurable patient outcome. Pre-designed questionnaires could measure changes at each visit, to avoid the potential for error based on subjective observations. This can be implemented in the future to help us collect qualitative and quantitative data to support MECC in our role as orthoptists.

Key learning points

It can seem challenging to have these additional conversations regarding a patient's general health in the allotted appointment time, and when the patient may feel they are irrelevant to the specificity of the appointment. However, when worded appropriately, these conversations can lead to improving quality of life. At Stockport NHS Foundation Trust, we have worked on creating 'business cards' and leaflets for a range of general health conditions that can be given out to the relevant patients. These contain information regarding services and charities that the patient can contact should they wish to. This social prescribing approach helps to inform and empower the patient with regards to their wellbeing.

Orthoptists can provide good health care by looking at the impact on the patient as a whole rather than only diagnosing and treating the eye condition, thus offering a patient centred approach. It is important that we continue to raise these issues sensitively with our Orthoptic patients and to share information with others so we can learn through experiences. This case study shows that we can encourage the patient to implement healthy living choices, even if they do not appear to be directly linked with their initial ocular condition, positively affecting the patients' mental and physical health in our routine consultations.

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