Supervision Guidance for Vision Rehabilitation and Habilitation Workers

Rehabilitation Workers Professional Network 2020

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Rehabilitation Workers Professional Network

The Rehabilitation Workers Professional Network (RWPN) is the professional body of Vision Rehabilitation and Habilitation Workers in the United Kingdom. RWPN was established in 2013 and became a Company Limited by Guarantee. RWPN also holds the professional register of Vision Rehabilitation Workers and dual-qualified workers.

RWPN exists to:

- Set and maintain professional standards for the workforce to safeguard them and the people they work with
- Promote the value of vision rehabilitation for blind and partially sighted people
- Support the workforce in the day-to-day execution of their role by providing information, advice, guidance and learning opportunities

Who is this guidance for?

This guidance is for Vision Rehabilitation and Habilitation Workers, their managers and the organisations that employ them.

Note: Vision Rehabilitation Workers are employed under a number of alternative titles including Rehabilitation Officer Visual Impairment (ROVI), Rehabilitation Worker Visual Impairment and Vision Rehabilitation Therapist.

Note: Unless otherwise stated, this guidance will use the term Vision Rehabilitation Worker, but the guidance would apply equally to Habilitation professionals.

Why is this guidance being issued?

1) Occupational Risk

Vision rehabilitation is all about enabling people who are either losing or have lost their sight, to remain safe and independent. This means supporting them to relearn how to do things they used to do with full sight. It can also mean enabling people who have never had sight to learn new skills (this is usually referred to as "habilitation"). Some of the people that Vision Rehabilitation Workers support have additional disabilities such as hearing loss, learning disability, physical disabilities, dementia or mental health problems. A number of the key tasks of a Vision Rehabilitation Worker, when working with an individual, are intrinsically risky because of the lack of vision and, if these tasks are poorly taught or are undertaken by an unqualified person, they can lead to serious injury or loss of life.

RWPN has undertaken an "Assessment of Professional Risk". The purpose of this **occupational assessment** is to help managers, commissioners and other colleagues to understand the nature of the work and to ensure they have the right provisions in place to support the workforce. It identifies the range of risks in the role of a Vision Rehabilitation Worker and the factors that may reduce or eliminate these risks. **Professional supervision plays a fundamental role in reducing risk**.

2) Lack of appropriate professional supervision

However, despite this clear evidence of professional risk, we know that the majority of Vision Rehabilitation Workers do not get appropriate supervision to carry out their role in a way that ensures the risks to their service users are managed or that the professional dilemmas arising from these risks are understood by managers.

In 2017, a survey of Vision Rehabilitation Workers commissioned by the Royal National Institute of Blind People (RNIB) and RWPN found that

one third of respondents (31%) reported that their managers possessed a related qualification (such as Occupational Therapy or Social Work) but had little or no experience of running a rehabilitation service. 9% were supervised by a manager who had no experience of being a front-line practitioner in social care or the NHS. Only 28% of respondents stated that their managers had specialist qualifications in vision rehabilitation.

3) Limited understanding of factors that make case management of vision rehabilitation work different from other preventative interventions

There are a number of factors that make work with people who are losing their sight different from other related disciplines. These factors will affect the length of time that the Vision Rehabilitation Worker may need to spend working with someone, which, in turn, may affect the rate at which they are able to take on new allocated cases.

Losing sight carries a significant emotional burden and creates anxiety and depression. Nollett et al. (2016) found that 43% of patients attending low-vision rehabilitation appointments were found to have significant depressive symptoms, and almost 75% of those were receiving no treatment for depression. Additionally there is growing evidence that an individual's vision rehabilitation outcomes are most effectively met when their emotional as well their practical difficulties are addressed.

One aspect of vision rehabilitation that is not fully understood outside the profession is Orientation and Mobility training. The technical and environmental aspects of this training often mean that casework-duration can be counted in months rather than weeks. Ensuring that an individual is confident crossing roads, locating buildings and using public transport necessarily takes time and it is vital that Vision Rehabilitation Workers ensure the service user remains safe from harm. Orientation and Mobility training can also place a significant emotional burden on a service user at a time when they feel vulnerable. The service user may

need an adjustment period to appreciate the value in using equipment such as a white cane, an object that they may perceive as re-enforcing feelings of stigma or vulnerability.

In relation to case flexibility the Association of Directors of Adult Social Services (ADASS)(2016) states:

> Vision rehabilitation is a preventative service and must be provided before imposing eligibility criteria...Vision rehabilitation must be free and available to meet assessed needs, and for some people this may take longer than six weeks. However, it should not be available for an unlimited amount of time, and should be reviewed to ensure that it is achieving its goal; if not then the person should be referred for a care assessment. Local authorities should also consider the impact and consequences of ending any preventative services. Read the position statement in full.

4) Professional isolation and work-related stress

The small number of Vision Rehabilitation and Habilitation Workers in the United Kingdom means that the majority of workers employed in any given local authority setting work in a team of three workers or less.

> In the context of developing emotional resilience Grant and Kinman (2013) state that “in the practice setting, a supportive work environment and social support from colleagues in particular have been found to protect helping professionals against burnout and compassion fatigue”.

So, whilst it is likely that a lack of appropriate clinical supervision can occur in other professions, the availability of peer support from colleagues can act as a short-term buffer against isolation. This is not the case for Vision Rehabilitation Workers.

5) The supervision needs of professionals who are visually impaired

A significant percentage of the workforce are themselves either blind or partially sighted. RWPN recognises this as a strength for those professionals in terms of having personal experience of sight loss but equally knows, from what members report, that supervision is not always carried out in a way that considers equality duties. In addition, where workers have Personal Assistants (PAs), this can add an additional dimension to supervision and management. These issues are examined in a later section of this guidance.

Effective supervision is one of the most important measures that organisations can put in place to ensure positive outcomes and quality services for the people who use social care and children's services. This is achieved in a number of direct and indirect ways.

What is supervision?

Skills for Care (2007) defines supervision as "an accountable process which supports, assures and develops knowledge, skills and values of an individual, group or team". Skills for Care states that:

> "Effective supervision is one of the most important measures that organisations can put in place to ensure positive outcomes and quality services for the people who use social care and children's services. This is achieved in a number of direct and indirect ways, as follows:
> • Effective workload management
> • Monitoring of individual performance and quality of service provided
> • Reflection and guidance on focus of work and methods used
> • Ensuring commitment to positive outcomes and effective working with others (within setting, within service and across services as appropriate)

• Maintaining motivation and job satisfaction through clarity on work objectives, positive feedback, critical reflection, personal support and continuing personal and professional development
• Consequent positive impact on staff retention and continuity of service
• Integral part of performance management arrangements"

The British Association of Social Work and the College of Social Work state (2011) that supervision needs to cover three functions and all these functions are important in order for supervision to be effective:

1. Line management, which is about accountability for practice, governance and quality of service.
2. Professional supervision (sometimes described as case supervision, or clinical supervision) to enable and support quality practice. A key aspect of this function is reviewing and reflecting on practice issues.
3. Continuing professional development to ensure social workers have the relevant skills, knowledge, understanding and attributes to do the job and progress their careers.

Different types of supervision

Supervision can be delivered by different people depending on the purpose of that supervision and the situation the supervisee finds themselves in.

The College of Occupational Therapists (COT) (2015) describes ten different types of support and guidance that an Occupational Therapist (OT) might seek, and identifies the person who might provide it, depending on the context for, and function of, the supervisory relationship. Almost all of these contexts have considerable cross-over to vision rehabilitation practice and RWPN endorses the description.

COT identifies certain categories of supervision where an adequately experienced OT or someone with a "higher level of knowledge and skills

in the relevant area" should provide the supervision. These categories include **professional matters** (professional ethics, CPD and registration), **clinical work** (the skills and knowledge to do the work confidently and safely, management of particular cases, identifying solutions to problems, improving practice and increasing practice-related understanding and knowledge). **Tutor support in higher education, Placement education and Group support** are also identified as areas where an OT's experience is best practice.

COT identifies categories such as **Service organisation and management and service performance management** as areas where the supervision need not necessarily be undertaken by an OT.

Professional/Clinical Supervision

The Care Quality Commission (2013) says that "professional supervision is often interchangeable with clinical supervision. This term is sometimes used where supervision is carried out by another member of the same profession or group. This can provide staff with the opportunity to:

- Review professional standards
- Keep up-to-date with developments in their profession
- Identify professional training and continuing development needs
- Ensure that they are working within professional codes of conduct and boundaries.

In CQC's guidance they summarise by saying that clinical supervision "is about maintaining the professionalism of these staff groups in working with people who use services".

As Berger and Mizrahi (2001) stress, effective clinical supervision is based on the knowledge and qualification of the supervisor in conjunction with their expertise in practice. RWPN believes clinical supervision can only be provided by someone who can enable the supervisee to underpin and root their practice in a sound understanding of the core values, beliefs, knowledge and core skills that are fundamental to vision rehabilitation. As such it should only be provided by someone who is an experienced

vision rehabilitation profession *or someone who has substantial experience in the sector and experience of managing vision rehabilitation professionals*.

Social Care Institute for Excellence SCIE (2013) emphasise the value of providing both management and specialist supervision in a multi-disciplinary setting, pointing out:

1. Reflective supervision provides the opportunity for a social worker to balance the needs of the client, the needs of the organisation, the requirements of the profession and their own professional needs.

2. The quality of practice and performance in social work (mental health) can be enhanced by having both management and clinical or professional supervision.

3. Clear lines of accountability and communication are necessary if different aspects of supervision are delivered by different people. This should ensure that significant information about a particular case is managed appropriately.

How supervision is provided

Effective Supervision in Adult Social Care (2015) is an excellent summary of how supervision can be provided and structured and is published by Skills for Care. This is a link to the free summary. In relation to vision rehabilitation the following models may apply:

One-to-one supervision is the most familiar structure for supervision, and may be conducted in a formal setting or could contain an element of practice observation.

Peer supervision and group support. In addition to clinical supervision peer supervision can provide a mechanism for exploring cases, sharing experiences, using group discussion to problem-solve and develop a

network of support. Peer supervision could be provided by people with a similar level of experience.

Group supervision, particularly focused around peer case review, may create similar support outcomes but should be facilitated by a Vision Rehabilitation Worker and someone with experience of managing group dynamics and drawing out participants and ensuring ground rules are adhered to. RWPN publishes peer review guidance https://www.rwpn.org.uk/The-Profession to support this process.

Long-arm supervision is when the supervision is provided by an experienced worker but not based in the same location, but may be conducted by Skype or telephone where distance makes face-to-face meetings difficult or where there is a lack of appropriate supervision within the work setting. However, there should be a line of management or responsibility on-site as well to provide immediate support, even if this is not from an individual with vision rehabilitation experience.

Supervising someone with additional needs

The Equality Act 2010 requires employers to be flexible and to make 'reasonable adjustments' for disabled people to enable them to do their jobs. Disabled Vision Rehabilitation or Habilitation Workers are best placed to explain how their disability impacts on their working life and their work-life balance. Therefore it is paramount that they agree with line management what reasonable adjustments are required and how these requirements are shared and with whom. It is the supervisor's responsibility to factor these adjustments into the supervision process.

A significant percentage of the vision rehabilitation workforce has a visual impairment. Visual impairment, in common with a number of other conditions, can fluctuate significantly, based on both personal and environmental factors. A workplace-needs-assessment may enable the service and the individual to get the right support.

Visually impaired workers, in common with a number of other disabled people, may use a paid Personal Assistant (PA) or Support Worker in the workplace. Sometimes the PA is employed directly by the worker, sometimes via an agency and sometimes directly by the employer of the worker. The disabled Vision Rehabilitation Worker's supervisor must ensure they have a clear understanding of the way in which the PA supports their supervisee and the reason why this support is necessary. Clarity in the way a PA supports the worker is essential to the safe and effective execution of the Vision Rehabilitation Worker's role. Both the disabled Vision Rehabilitation Worker and their employer should be mindful of the supervision needs of the PA and ensure that it takes place. It may be appropriate that this supervision is carried out by a third person such as another worker or a peer.

What if there is no specialist supervision available?

RWPN's 2017 workforce survey found that, whilst the large majority of Vision Rehabilitation Workers report receiving supervision, only a quarter received supervision from a qualified Vision Rehabilitation Worker. This guidance has set out the reasons why the lack of appropriate technical/clinical supervision carries risks both for the service users and the professionals. A professionally isolated worker, even if they are experienced, may be at greater risk of poor or unsafe practice. **Vision Rehabilitation Workers should ask for clinical supervision and service providers should consider alternative ways of providing this if this is not currently in place.**

If supervision is delegated, the person delegating supervision should be satisfied that the person to whom they are delegating supervision is competent to do so: i.e. they have the requisite knowledge and skills. If this is a Vision Rehabilitation or Habilitation Worker the delegator should check that this person is on the appropriate RWPN professional register. There should be clarity in any such arrangement as to where the ultimate responsibility lies for the work of the supervisee.

Alternative ways to access supervision
A negotiated arrangement with an appropriately trained Vision Rehabilitation/Habilitation Worker from elsewhere within the organisation or from a neighbouring statutory or voluntary sector provider, or a freelancer where face-to-face meetings are facilitated.

A negotiated arrangement, as above, but undertaken by an internet-based system or on the phone.

Peer or group supervision either in one location or by an internet-based system.

If such a mechanism is put in place then it would be good practice to set out a supervision agreement where the terms of engagement are clearly documented. These terms might include:

- Who the agreement is between and when it is to be reviewed
- What the respective responsibilities of supervisor and supervisee are
- The lines of accountability and boundaries between clinical supervision and employer's line management supervision. Areas that clinical supervision would not cover should be identified
- Type of meeting, frequency, location (including physical space) and timing of supervision
- Who takes responsibility for organising the supervision, setting an agenda and agreeing what both participants might need to prepare prior to the meeting
- Who takes supervision notes and how records will be kept, considering data protection policies and legislation
- The extent of confidentiality and how it might/should be broken

RWPN Mentoring Scheme
Mentoring has a different purpose from supervision. According to Bolton (2014) mentoring "enables sharing of vital, often confidential, issues:

uncertainties, hopes and fears...tentative suggestions for action...questions of role...and stories of success or failure". Mentors can offer empathy and non-judgemental critique, and can create a relationship where assumptions and behaviours can be challenged and altered, and crucially, this can happen outside the often-hierarchical nature of supervision. A mentoring process can assist the supervision process by helping the worker to identify issues of concern in their working life and unpick the difficulties and barriers they are facing. These concerns can then be brought forward to supervision with some proposed solutions or goals. Any mentoring arrangement in work time should seek the consent of the employer.
RWPN has a mentoring scheme for its members made up of fellow professionals, some of whom are themselves visually impaired. This scheme may offer additional support and we would be happy to talk to potential mentees.

Who says supervision is required?

The Health and Safety at Work Act (1974)

The act requires a general duty of employers to "ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees" and includes, in particular "the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees".

National Occupational Standards (NOS) Sensory Service Standards

Skills for Care (2006) state that National Occupational Standards:

- describe best practice in particular areas of work
- bring together the skills, knowledge and values necessary to do the work as statements of competence
- **provide managers with a tool for a wide variety of workforce management, quality control and specification tasks**
- are the basis for training and qualifications

In terms of supervision, Skills for Care state that National Occupational Standards “require individual staff working with vulnerable clients to identify lines of communication, responsibility, and protocols for risk management”. They add that “each individual within the workforce is responsible, as an agent of the organisation, under the Health and Safety at Work Act, for their safety and for the safety of those in their care. NOS have embedded within them actions and activities that are based on ‘safe practice’. **So training and management of staff can be carried out with reference to achieving these standards.**”

The NOS of direct relevance to supervision and continued professional development is standard 10 - “Work within the values and principles of habilitation/rehabilitation practice and ensure your own professional development”, which stipulates that professionals “critically reflect upon your own practice and performance using supervision and support systems”.

Principle 17 requires the Vision Rehabilitation/Habilitation Worker to “review and identify supervision, support and professional development requirements that are:

- P17.1 specified by your organisation
- P17.2 specified by the regulatory councils
- P17.3 grounded in best practice

Principle 18 requires that the Vision Rehabilitation/Habilitation Worker identify:

- P18.1 your own achievements, strengths, weaknesses and development needs
- P18.2 your own best practice
- P18.3 gaps in your expertise, the impact these might have on practice and the actions that are required to address them
- P18.4 ways you could improve critical self-reflection

- P18.5 your reaction to stress and how you manage stressful situations

Principle 19 requires the Vision Rehabilitation/Habilitation Worker to "continually review and update your own practice through continuing professional development opportunities"

Principle 20 requires the Vision Rehabilitation/Habilitation Worker to "seek and use professional and organisational supervision and support to:

- P20.1 guide current and inform future practice
- P20.2 identify continuing professional development needs that will reduce stress and enhance performance
- P21 take action to meet continuing professional development needs
- P22 participate in education and training to ensure you maintain an up-to-date knowledge of practice procedures and techniques"

RWPN Code of Ethics and Professional Conduct

The Code of Ethics requires members to:

- to understand the terms and purpose of supervision, both managerial and technical, and actively participate in the supervision process
- to advocate for professional supervision at regular intervals from a senior Rehabilitation Worker or other appropriate professional and requires management
- to arrange/provide appropriate professional management and technical supervision opportunities for all Rehabilitation Workers

RNIB 10 Principles of Good Practice in Vision Rehabilitation

Standard 10 states that "all blind and partially sighted people are provided vision rehabilitation by someone who is trained to understand their sight loss needs. Continuing professional development is

evidenced as part of their practice through their employer or professional body.

If a member identifies a lack of appropriate supervision and, after discussion with their employer, feels that this supervision is not forthcoming or is adequate, they can contact RWPN to discuss how the situation can be resolved.

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