

# Best practice standards for adult audiology

**Published by RNID**  
19-23 Featherstone Street  
London EC1Y 8SL  
ISBN 0900634 96 0

# Best practice standards for adult audiology

**July 2002**

This document was part-funded by Department of Health  
and was produced by a Taskforce led by RNID

with representation from:

**British Association of Audiologists (BAAT), British Association of Audiological Physicians (BAAP),  
British Association of Audiological Scientists (BAAS),  
British Association of Otolaryngologists (BAOL),  
British Society of Audiology (BSA), British Society of Hearing Therapists (BSHT),  
Department of Health, A General Practitioner, A Health Authority,  
Hearing Concern, LINK Centre for Deafened People,  
MRC Institute of Hearing Research, National Association of Deafened People (NADP)**

**England, Scotland, Wales and Northern Ireland were all represented on the Taskforce.**

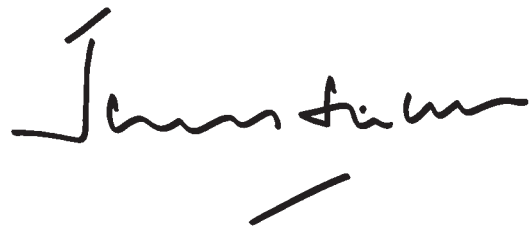
RNID's vision is of a world where deafness and hearing loss are not barriers to opportunity and fulfilment. An integral part of this vision is a modernised NHS audiology service using the latest technology.

RNID has campaigned long and hard for improvements in audiology. We are now at the heart of managing the transformation of NHS hearing aid services in England in partnership with the Department of Health. We are delighted at the investment in audiology in England, Scotland and Wales that has given much-needed impetus to the process of change.

But we want to ensure that as many people as possible can benefit from advanced digital hearing aids. This can only happen within the context of a fully modernised audiology service, one that has as its prime objective, the best possible quality of life for deaf and hard of hearing people. A key element of modernisation is the introduction of *Best practice standards for adult audiology* – a blueprint to enable services to achieve high standards of digital hearing aid fitting and aftercare.

RNID has worked closely with professional bodies, other voluntary sector organisations and users of audiology services to produce these standards. Both clear and realistic, they establish benchmarks against which service performance can be improved. They are aimed at maximising audiology services' impact on the lives of millions of deaf and hard of hearing people.

Together with the NHS, we now call on all audiology services to implement these standards as soon as possible.

A handwritten signature in black ink, appearing to read 'James Strachan', with a short horizontal line underneath.

**James Strachan**  
**Chief Executive RNID**

# Support for *Best practice standards for adult audiology*

**Jacqui Smith**

**Minister of State, Department of Health**

I am delighted that RNID has produced these standards. The Department of Health part-funded the work and was involved in the development of the standards because we believe they add significant value to our enterprise of modernising audiology services. The *Best practice standards for adult audiology* describe the route to optimising hearing ability and quality of life.

These standards describe a service which all audiology departments will want to work towards. These efforts, together with Department of Health investment into Modernisation of Hearing Aid Services will produce the best possible outcomes for deaf and hard of hearing service users.

**Jane Hutt**

**Minister for Health and Social Services, Wales**

As Minister for Health and Social Services for Wales I welcome this publication and commend it to the attention of NHS Wales Audiology Departments.

We are committed to modernising Audiology services across Wales and are presently funding a major programme of work to improve services to patients. RNID has assisted in the management of this work.

**Malcolm Chisholm**

**Minister for Health and Community Care, Scotland**

The Scottish Executive is fully committed to the long-term modernisation of all patient services including those provided to address hearing impairment. It welcomes any measures aimed at furthering that goal.

## Executive summary

The development of *Best practice standards for adult audiology* was initiated and led by RNID, which recognised the need for a document detailing requirements of a modern, quality audiology service. The work was part-funded by the Department of Health and the document was written for service providers and service commissioners by service providers and service commissioners together with service users.

A best practice standard is the optimum quality of service that is achievable and measurable. These standards have been drawn up in the interest of service users and in order to work towards equity in service provision throughout the NHS.

The value of *Best practice standards for adult audiology* is that:

1. The standards are realistic for the NHS.
2. They describe a quality of audiology service that patients should reasonably be able to expect.
3. They provide a framework for service development.
4. They reflect consensus between those involved in delivering the service and those using it.
5. They cover all aspects of importance to service users and those commissioning services for their population:
  - the patient outcomes that the service is designed to achieve
  - the investigations, care, support and information available
  - ease of access to the different service elements
  - respect for patients and patient involvement as active partners in the care process.
6. They also incorporate all the aspects that need to be considered by those responsible for planning and managing the service. These can be divided into the inputs, processes and outputs that all contribute to a quality service:
  - **inputs** (location and design of accommodation; how the service is resourced, staffed, skilled, equipped and organised; integration with other services and organisations; information and communication systems)
  - **processes** (how people access the service for the first time and for continuing care; how responsive the service is to individual needs; how appointments are scheduled; how the staff interact with patients; how decisions are reached and recorded; ensuring that service users have all the information they need; maintaining confidentiality)
  - **outputs** (outcomes for service users in terms of hearing benefit and improvements to quality of life; measuring, auditing and reviewing service performance and outcomes on a regular basis).

7. They provide a useful tool for audit and planning.
8. They can be readily updated as technology and ways of working develop.

*Best practice standards for adult audiology* was drafted in parallel with some major developments in NHS audiology and hearing aid services in England and Wales.

In 2000, the Department of Health, in partnership with RNID and the Institute of Hearing Research, embarked on a centrally funded project to modernise NHS hearing aid services in England. This is a phased programme of modernisation, introducing modern (digital) hearing aid technology and IT together with new service procedures and patient protocols. It started with an evaluation phase involving twenty NHS Trusts. By April 2002 they had fitted 20,000 people with digital hearing aids. In 2002/3, thirty more Trusts will upgrade their infrastructure and begin the modernised service, while at least a further fifteen services will be equipped and trained ready to provide the new service in 2003/4.

Meanwhile the Welsh Assembly committed funds in 2001/2 to modernise audiology services throughout Wales, enabling them to upgrade audiology accommodation, obtain new equipment and IT and train staff in new procedures. In 2002/3, further funding has been made available for extra audiology staff and for new technology hearing aids.

*Best practice standards for adult audiology* reflects these developments, and audiology departments are urged to work towards implementing these standards alongside modernisation of their hearing aid service. In a time of rapid change and modernisation that is focused on one particular function of the audiology service (ie hearing aid provision), standards and regular audit assume an especially important role. They make it possible to track and evaluate the impact of the changes on the service as a whole and on the people who use audiology services.



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# Chapter 1

## Background

1

# 1 The NHS context

## 1.1 Devolution

Apart from workforce planning, professional standards and regulation, most health powers are now devolved to the Executives in Scotland, Wales and Northern Ireland. Therefore, although the Department of Health has produced the NHS Plan described below, there will also be plans for the NHS in Scotland, Wales and Northern Ireland developed by each Administration.

## 1.2 The NHS Plan

The NHS Plan for investment and reform (published in July 2000) is based on the following 10 core principles:

1. Providing a universal service for all based on clinical need, not ability to pay.
2. Providing a comprehensive range of services.
3. Shaping services around the needs and preferences of individual patients, their families and their carers.
4. Responding to different needs of different populations.
5. Continuous quality improvement (quality of life as well as clinical quality).
6. Supporting and valuing staff.
7. Devoting public funds for healthcare solely to NHS patients.
8. Working together with others to ensure a seamless service (The Health Act 1999 introduced more flexible arrangements for partnership working between health, social services and education in commissioning and providing services).
9. Keeping people healthy and working to reduce health inequalities.
10. Respecting patient confidentiality and providing open access to information.

The NHS Plan states that the future role of the Department of Health will involve championing the interests of patients by applying both pressure and support. It will do this by:

1. Setting the priorities for improving the nation's health, and allocating funding to local health services.
2. Working with patients and the professions to develop national standards of care.
3. Putting in place a robust management and support framework to deliver those standards.
4. Monitoring and holding the NHS to account so that patients know how well the NHS is performing.
5. Intervening on behalf of patients only where NHS organisations are failing to deliver proper standards of care.

The NHS Plan also sets out the framework for an evidence-based health service, with developments underpinned by research-based evaluation and monitoring.

Examples of a 'postcode lottery' continue to be found within the NHS, whereby patients in some areas are denied access to a type of treatment or a quality of provision that is available to people elsewhere in the country. Bodies such as the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) have been established to counteract these discrepancies and promote equitable access to a high standard of care.

### **1.3 Integration of Health and Social Care**

The integration of Health and Social Care into Care Trusts will provide the opportunity to integrate audiological rehabilitation with the provision of appropriate assistive listening devices, providing a seamless service as recommended by the Audit Commission in its report Fully equipped (March 2000).

### **1.4 Reports from the Audit Commission and NICE**

There have been two Government reports that have contributed to the debate on audiology services in 2000. The Audit Commission and the National Institute for Clinical Excellence (NICE) both reported, from different perspectives, on hearing aids. The Audit Commission report Fully equipped (March 2000) recognised that substantial improvements could be made to people's lives through the provision of more advanced hearing aids. NICE reached a similar conclusion. In July 2000 NICE issued Guidance on Hearing Aid Technology in which they concluded that audiology services should be improved through the provision of more sophisticated hearing aids better matched to individual user needs, bilateral fitting where this will benefit the user, and more time spent per patient. NICE Guidance must be implemented locally and funds are available for this purpose.

### **1.5 Service modernisation**

#### **England**

In April 2000 the Department of Health embarked on a project to modernise NHS hearing aid services in England. This is a phased programme of modernisation, starting with a test-bed of 20 NHS Trusts. It introduces modern (digital) hearing aid technology together with new service procedures and patient protocols. Further funding was announced in December 2001 in order to extend the modernisation programme.

## **Wales**

In April 2001 the National Assembly for Wales initiated a project to improve service infrastructure and train staff in the new hearing aid technologies at all Audiology departments in Wales. This project is known as the Modernising Audiology Services in Wales (MASW) Project. From April 2002 additional recurring monies have been allocated to provide for the fitting of advanced technology hearing aids at all centres.

## **Scotland**

At the time of publication, the Scottish Executive has initiated a review of audiology services.

## **1.6 Workforce planning and development**

The Department of Health is working to introduce robust workforce planning mechanisms for the NHS. It is also supporting audiology professionals and educators in their efforts to develop an integrated career structure for audiologists and funding new training.

## **2 Developing national standards for adult audiology**

### **2.1 RNID project with support from the Department of Health**

The Department of Health, in addition to funding and overseeing the project to modernise NHS hearing aid services, has a role as defined by the NHS Plan to “work with patients and the professions to develop national standards of care”.

With respect to national standards for audiology, the Department is part-funding an RNID project on ‘Hearing aids and rehabilitation’. The chief aims of this project are to review current practice within the NHS and develop a set of best practice standards for adult audiology services in collaboration with service users, audiology professionals, service commissioners and the Department of Health.

### **2.2 The Taskforce**

In order to develop the *Best practice standards for adult audiology* a Taskforce was set up comprising representatives of service users, audiology professionals, service commissioners and the Department of Health, led by RNID. England, Scotland, Wales and Northern Ireland were represented on the Taskforce.

## 2.3 The Best practice standards document

This document results from the work of the Taskforce and analysis of the consultation responses. The Taskforce met six times between May 2000 and April 2001 to consider drafts and to produce a standards document for wider consultation. Between meetings much information and comment was exchanged via the Internet. Taskforce members were at all times encouraged to consult members of the groups they were representing and all working papers were available on request. The open consultation phase was September 2001-January 2002 after which time the Taskforce met to agree final changes to the document.

## 2.4 A charter for service users

RNID will also produce a charter for service users based on the *Best practice standards for adult audiology*. This will be designed to increase people's awareness of the service they should be able to expect from audiology departments. It will also encourage people to seek referral in order to reduce the disability they experience as a result of hearing loss.

# 3 The function of Best practice standards in the NHS

## 3.1 Defining quality and promoting fairness

A best practice standard is the optimum quality of service that is achievable and measurable at a particular time in the life of the NHS. Standards are set in the interest of service users and in order to work towards equity in service provision throughout the NHS. Standards should be realistic for the NHS and agreed by the professional groups involved in delivering the service and by representatives of service users. They should also be subject to periodic review as technology, treatments and techniques develop, and as evidence of effectiveness is collected and analysed. These Standards will be reviewed at least every five years or sooner if appropriate in the light of updates of the evidence base in audiology or other changes.

National standards help services to realise the following core principles underpinning the NHS Plan:

Providing a universal service

Providing a comprehensive range of services

Providing a seamless service

Continuous quality improvement

Respecting patient confidentiality and providing open access to information.

### **3.2 Assuring quality and consistency of care: *Clinical Governance***

*Clinical governance* is a key element in the NHS Plan for reform. It is the process by which each part of the NHS assures the quality and consistency of its clinical decisions and care. It involves monitoring, maintaining and driving up levels of performance as measured against national standards. Standards are set in terms of both clinical quality and quality of life for patients. Regular clinical audit is the measurement part of this process.

### **3.3 Continuous quality improvement**

The ability of any particular local service to meet national standards will depend on the availability of appropriate human and financial resources. For some services, a standard may be something to aspire to rather than being achievable with currently available resources. The value of the standards in these cases is that they provide a framework for service development; they are standards which patients should reasonably be able to expect from an audiology service.

Where evidence exists demonstrating the link between practice and quality of outcomes, this evidence base has been used in the development of the *Best practice standards for adult audiology*.

### **3.4 Measuring the effect of change**

In a time of rapid change and modernisation in the NHS as a whole, and in audiology in particular, standards and regular audit assume an especially important role. They make it possible to judge whether the changes made have led to the intended improvements, which elements of change are the most potent, and whether there are unwanted effects on other aspects of the service that need to be addressed.

## **4 The scope of the Best practice standards for adult audiology**

### **4.1 Covering all key service elements in hearing rehabilitation**

A major function of audiology services is to reduce the disability caused by hearing loss through appropriate and timely care involving assessment, provision of aids to hearing, and provision of support services in a rehabilitative environment. The *Best practice standards for adult audiology* cover all these service elements, together with the relevant service policies, procedures and protocols.

## **4.2 Covering accessibility and public information**

The Standards apply to the service provided for individuals seeking help for the first time and for those requiring continuing support. They cover accessibility, responsiveness and also the provision of information about audiology services and other sources of support so that those people who have not sought help, or who have done so but failed to gain optimum benefit, will be encouraged and feel confident to use the service.

## **4.3 Covering planning, staffing and infrastructure**

The Standards describe the accommodation and professional qualifications/competencies needed to carry out different procedures. They quantify the accommodation and staffing requirements in relation to the size of the population served. They also cover information systems, service planning, service integration and working in partnership.

## **4.4 Covering clinical governance**

The Standards incorporate ways of assuring service quality including staff development, performance monitoring, measurement of outcomes and regular audit.



# Chapter 2

## Minimum staffing and accommodation requirements

2

In 1984 Haggard and Armstrong-Bednall published a set of requirements of structure and resource for an adequate audiology service. In practice few services have ever fulfilled these requirements. In light of recent developments in audiology, including the Modernising NHS Hearing Aid Services project, the Taskforce responsible for these standards revisited the criteria and updated the requirements. This section sets out the minimum staffing and accommodation requirements that would enable a service to comply with the *Best practice standards for adult audiology*.

## A. Staffing

### 1 Service processes

For the present analysis, the following 13 process categories within an adult service will be used. (These are not categories of patient, since an individual may overlap several categories. Procedures will vary depending on the individual needs of the patient.)

Process categories associated with patients who require aural rehabilitation:

1. Adult hearing aid provision including rehabilitation
2. Direct referral to audiology for hearing aid(s)
3. Outpatient hearing aid provision to older/disabled people
4. Domiciliary or residential care hearing aid provision
5. Hearing aid reassessment/review

Process categories associated with clinical assessment, investigation and appropriate rehabilitation of patients:

6. Adult ENT outpatient
7. Comprehensive auditory and vestibular investigation
8. Further conditional electrophysiological investigations
9. In-patient testing (eg pre- or post-surgery or treatment; pre-, per- and post-chemotherapy)
10. Additional or complex rehabilitation (eg deafened adults, the use of bone-anchored hearing aids, adults with learning difficulties, obscure auditory dysfunction)
11. Tinnitus management
12. Balance rehabilitation
13. Transfer of child to adult service

In the original paper by Haggard and Armstrong-Bednall the terms ‘Medical Technical Officer’, ‘Audiological Scientist’ and ‘Hearing Therapist’ were used to describe the

audiology staff delivering the service. In this document the generic title ‘audiologist’ is used instead, in view of the current discussions with regard to a common training structure and career pathway.

## 2 Procedures and resources required for process categories 1-13 in paragraph 1

### 2.1 Adult hearing aid provision including rehabilitation (ENT referral)

- Three or four visits required, ie Assessment, Fitting, Fine-tuning (if appropriate) and Follow-up.

Procedures: (i) audiometry, impedance audiometry, conditional bone conduction audiometry; (ii) disability assessment and rehabilitative prognosis. Selection of aid class and earmould type, earmould impressions [(i) & part of (ii) are usually carried out in one visit]; (iii) introduction to environmental aids; (iv) selection of aid, fitting, verification (behavioural and/or acoustical) of performance of aid, instruction and advice on hearing aid maintenance and aid use, basic rehabilitative advice; (v) fine tuning of aid/s (vi) follow up/progress visit.

- Minimum staff: basic audiologist but with access to senior audiologist for queries, or student under direct supervision of senior grade subject to the complexities of each case.
- Time per case: two hours and 45 minutes – three hours if fine-tuning involved.
- Patient reattendance: high.
- Medical involvement: most patients have a medical referral.

### 2.2 Direct referral to audiology for hearing aid(s)

- Three or four visits required: Assessment, Fitting, Fine-tuning (if appropriate) and Follow-up.

Procedures: (i) full history, examination of ears, audiometry, impedance audiometry, conditional bone conduction audiometry; (ii) disability assessment and rehabilitative prognosis. Selection of aid class and earmould type, earmould impressions [(i) & part of (ii) are usually carried out in one visit]; (iii) selection of aid, fitting, verification (behavioural and/or acoustical) of performance of aid, instruction and advice on hearing aid maintenance and aid use, basic rehabilitative advice, introduction to environmental aids; (iv) fine tuning of aid/s; (v) follow up/progress visit

- Minimum staff: senior audiologist or higher.

- Time per case: two hours and 45 minutes – three hours if fine-tuning involved.
- Patient reattendance: high.
- Medical involvement: most patients have been referred by their GP.

### 2.3 Outpatient hearing aid provision to older/disabled people

- Procedures: as for (2.1/2.2), but adapted to suit the patient.
- Minimum staff: senior, basic audiologist with access to senior audiologist for queries, or student under direct supervision of senior grade.
- Time per case: two hours and 45 minutes to three hours.
- Patient reattendance: high.
- Medical involvement: not at this stage.

### 2.4 Domiciliary or residential care hearing-aid provision

- Procedures: as for (2.3) but modified in view of location.
- Minimum staff: senior audiologist or higher.
- Time per case: two hours and 30 minutes to three hours plus travel time.
- Medical involvement: not at this stage.

### 2.5 Hearing aid reassessment/review

- Up to four visits required: Reassessment, and if new hearing aid system required: Fitting, Fine-tuning (if appropriate) and Follow-up.
- Procedures: (i) new history since last record, examination of ears, air conduction and bone conduction audiometry, conditional impedance audiometry; (ii) real ear measurement with existing aids, disability assessment with existing aids, rehabilitative expectations and prognosis, decision on suitability of existing aids; (iii) selection of new aid class and earmould type, earmould impressions [(i)-(iii) are usually carried out in one visit]; (iv) selection of aid, fitting, verification (behavioural and/or acoustical) of performance of aid, instruction and advice on hearing aid maintenance and aid use, basic rehabilitative advice, assessing need for environmental aids; (v) fine tuning of aid/s; (vi) follow up/progress visit.
- Minimum staff: senior audiologist or higher.
- Time per case: two hours and 30 minutes – two hours and 45 minutes if fine-tuning involved.
- Patient reattendance: high.
- Medical involvement: most patients are initially referred by their GP.

## 2.6 Adult ENT outpatient

- Procedures: audiogram – air conduction and bone conduction; conditional masked air and bone conduction; conditional impedance audiometry.
- Minimum staff: basic grade audiologist with senior grade to hand for advice or student under direct supervision of senior grade.
- Time per case: 25 minutes average but longer sometimes desirable.
- Patient reattendance: high.
- Medical involvement: normally adjacent but not in testing.

## 2.7 Comprehensive auditory and vestibular investigation

- Procedures: variable according to history, but including (in most cases conditionally) air conduction audiogram, impedance audiometry, reflex decay, various speech tests, vestibular tests, pulsed-tone audiogram, tests for non-organic hearing loss.
- Minimum staff: two, of which one should be a senior grade audiologist.
- Time per case: up to three hours.
- Patient reattendance: low except for Epley manoeuvre (form of treatment for benign paroxysmal positional vertigo).
- Medical involvement: reports sent to referring consultant; attendance usually not required.

## 2.8 Further conditional electrophysiological investigations

- Procedures: evoked responses and/or other special electrophysiological and related behavioural tests, according to interpretation of prior results.
- Minimum Staff: two senior grade audiologists working together.
- Time per case: up to two hours.
- Medical involvement: desirable if electronystagmography (ENG); essential if transtympanic electrocochleography (ECoG).

## 2.9 In-patient testing (eg pre- or post-surgery or treatment; pre-, per- and post chemotherapy)

- Procedures: air and bone audiometry; conditional impedance audiometry.
- Minimum staff: basic grade audiologist.
- Time per case: 20 minutes.
- Medical involvement: adjacent but not usually in testing.

## 2.10 Additional or complex rehabilitation

- Procedures: will vary according to case need.
- Minimum staff: senior audiologist with specialist training in rehabilitation (currently a Hearing Therapist may have the appropriate skills).
- Time per case: one to 10 hours or more.
- Patient reattendance: high.
- Medical involvement: most patients are initially referred by their GP or ENT specialist.

## 2.11 Tinnitus management

- Procedures: minimum of 2 visits required; (i) audiometry; (ii) tinnitus assessment and questionnaire; (iii) selection of hearing aid or white noise generator where appropriate; (iv) tinnitus counselling; (v) access to relaxation techniques; (vi) follow up/progress visit.
- Minimum staff: senior audiologist with specialist training in tinnitus management (currently a Hearing Therapist may have the appropriate skills).
- Time per case: up to six hours.
- Patient reattendance: medium .
- Medical involvement: most patients are initially referred by their GP or ENT specialist.

## 2.12 Balance rehabilitation

- Procedures: minimum of two visits required; (i) counselling about balance problems; (ii) access to relaxation methods; (iii) access to relaxation and breathing course; (v) physiotherapy assessment if necessary or appropriate; (vi) follow-up/progress visit.
- Minimum staff: senior audiologist with specialist training in vestibular rehabilitation; physiotherapist.
- Time per case: up to six hours.
- Patient reattendance: medium.
- Medical involvement: most patients are referred by an ENT specialist.

## 2.13 Transfer of child to adult service

- Procedures: minimum of one or two visits required; (i) final review by teacher of deaf and transfer of audiological information to the adult service; (ii) audiometry, impedance audiometry, conditional bone conduction audiometry; (iii) disability assessment and rehabilitative prognosis. Review of aid class and

earmould type, parameter adjustment, earmould impressions as required. [(i), (ii) & (iii) are usually carried out in one visit]; (iv) introduction to environmental aids; (v) selection of aid, fitting, verification (behavioural and/or acoustical) of performance of aid, instruction and advice on hearing aid maintenance and aid use, basic rehabilitative advice; (vi) fine tuning of aid/s; (vii) follow-up/progress visit.

- Minimum staff: basic audiologist but with access to senior audiologist for queries or student under direct supervision of senior grade.
- Time per case: minimum of one hour.
- Patient reattendance: low.
- Medical involvement: none specifically at this stage.
- Other: reports to education staff, speech therapist, social services and possible involvement of parents.

### 3 Other activities

These are the major activities that cannot be related directly to incidence of new cases, yet can be separated out as cost-centres from miscellaneous overheads.

- Repairs and batteries
- Re-impressions
- Electro-acoustic testing of aids
- Calibration
- Staff training, meetings, courses, local service monitoring projects, continuing professional development
- Training (as Provider).

### 4 Recommended minimum staffing levels

The following recommended minimum staffing levels have been calculated based on:

the procedures and resources required for the different categories of service process (see paragraph 2)

- the estimated relative volumes of these different process categories in a typical service (eg at least 40% of demand is usually for processes relating to hearing aid provision, requiring between two hours 30 minutes and three hours per case).

- The recommended minimum staffing levels are those that should enable an ‘average’ service to comply with the *Best practice standards for adult audiology*. They take into account the requirements of the Modernising NHS Hearing Aid Services programme. However, they should be treated as a guide. The particular demographic profile of the population served may require a different balance of service activity from that on which these calculations have been based. Likewise, if the local service model involves a higher-than-average proportion of the service being delivered at the primary care level, then more staff will be needed to meet the *Best practice standards for adult audiology*.

(‘Audiologists’ include audiological scientists, medical technical officers and hearing therapists. Hearing Aid Audiologists may also be included where they are contracted by the NHS Trust to deliver NHS hearing aid services.)

**The recommended minimum staffing levels are:**

- **One Whole Time Equivalent (WTE) audiologist per 15,000-20,000 of the local population (i.e. for a District of 300,000 there would be a requirement of 15-20 WTE audiologists).**
- **One WTE Administrative and Clerical (A&C) staff per 75,000-100,000 population.**

## B. Accommodation

The Audiology services covered by these standards should be delivered in an appropriate environment. The safe and effective conduct of procedures described in this document, and the comfort of patients, are dependent on accommodation of appropriate size and design. Standards exist that cover Audiology accommodation. However, these standards are not specific to Audiology services and are now dated. Recent service developments make it essential to review the appropriateness of existing standards. This section will focus on the key rooms affecting functionality of an Audiology service.

1. Audiometric hearing tests should be conducted in booths/rooms satisfying maximum permissible ambient noise levels defined in ISO 8253-1 (1989) or ISO 8253-2 (1992). For practical reasons, provision can be made to relax the indicated maximum noise levels by 10dB where it applies to soundfield and bone-conduction testing (ie for these tests 10dB more ambient noise will be permitted than is shown in the tables in ISO 8253-1 (1989) and ISO 8253-2 (1992)).

2. An adequate number of specialist and dedicated rooms should be provided given the size and age profile of the population served. It is also necessary to consider the number of points of service delivery within the service, and the profile of services delivered.\* As a guide, for routine services the following minimum scale of provision should exist for the key room types:

Hearing test rooms/booths: 1 room/booth per 50,000 head of population.

Rehabilitation rooms: 1 room/booth per 40,000 head of population.  
(eg for hearing aid provision, adjustment and counselling)

3. Each base rehabilitation centre should have a dedicated earmould workshop.
4. Each base diagnostic centre should have a dedicated diagnostic auditory and balance function assessment room.
5. The size (floor area) and layout of key rooms should be adequate for the functions carried out within them. Clinical rooms should be able to accommodate comfortably (in addition to equipment) an Audiologist, wheelchair user and at least one other person. As a guide the minimum floor areas are indicated for the key room types:

Hearing test room* (or booth and separate observation area)	11 sq m
Rehabilitation room (for work with individual patients: group work will require additional space)	13 sq m
Earmould workshop	10 sq m
Diagnostic audio-vestibular assessment room	15 sq m
Waiting area – for two test rooms	20 sq m
– for six test rooms	40 sq m

\*Where sound field testing is to be conducted, the minimum floor area should be increased to 14 sq m. NB dimensions are internal, ie following installation of sound treatment materials.

6. The minimum total floor area available for non-specialist adult Audiology services should be 150 sq m\*\* per 100,000 head of population served. This figure includes circulation space, waiting areas and office space, and includes/assumes one peripheral centre served (in addition to the main base) per 100,000 head of population.
7. Clinical rooms and offices should be distinct in use (shared use should not occur, eg a rehabilitation room should not be routinely used as an office).

- 8.** Rehabilitation rooms should have the following essential features:
  - External window, double-glazed and clear (with due consideration to privacy)
  - Wash-hand basin
  - Loop system
  - Information board
- 9.** General accommodation features: IT network connection and telephone points should be in each clinical and office room. The flooring should be sound absorbent throughout but workshop, store and WC areas should not be carpeted.
- 10.** Provision should exist for effective two-way communication between patient and tester when a booth is used for hearing tests. For hearing test rooms (ie where both patient and Audiologist are located in the same room) an emergency call system should be fitted. In addition, a CCTV monitoring system may be installed, linked to the department reception area.
- 11.** Hearing test accommodation should have air supply thermally controlled by air conditioning throughout.
- 12.** Accommodation should comply with engineering and communication requirements described in NHS Estates Health Building Note 12 (1994).
- 13.** Specialist advice from sound attenuation consultants and/or manufacturers, should be obtained at an early stage in the planning of new test accommodation or any upgrading of such facilities.
- 14.** For peripheral centres (ie outside main base, such as GP surgeries and local hospitals) the range of services may be more limited. However, the quality of accommodation should not be compromised, ie the above standards still apply. Minimum accommodation for a peripheral centre would be:
  - Hearing test room or booth
  - Rehabilitation room (which, if adequate floor space permits, may also house the test booth)
  - Waiting and reception facilities nearby
- 15.** Accommodation should satisfy access requirements for disabled people and relevant existing legislation. (See Chapter 6)
- 16.** The Audiology department should be well sign-posted consistent with NHS Estates and local NHS Trust requirements.

\*\*These are minimum figures for an all-age service based in a district general hospital, though not necessarily delivered solely at that site. The scale of provision should be increased where additional specialist services (eg cochlear implants) exist, or where a population is served at multiple centres (eg where a rural population is served).

### Evidence/rationale for staffing and accommodation standards

- Haggard M P and Armstrong-Bednall G *Requirements of structure and resource for an adequate audiology service in the post-Griffiths Health Service* British Journal of Audiology, **18**, 183-194 (1984)
- Reeves D J, Alborz A, Hickson F S and Bamford J M *Community provision of hearing aids and related audiology services* Health Technology Assessment 2000; Vol. **4**: No. 4
- M E Lutman *Planning Your New Audiology Clinic* British Association of Audiological Scientists Newsletter, Issue No.29, Spring 1997
- Health Building Note 12, Supplement 3, ENT and Audiology Clinics, Hearing Aid Centre. NHS Estates, HMSO (1994)
- *Minimum requirements for otolaryngology departments in NHS hospitals.* The British Association of Otolaryngologists (1993)
- ISO 8253-1 (1989) and ISO 8253-2 (1992)

## Performance measures

### Staffing and accommodation

#### Staffing

- Does the number of audiologists meet the recommended staffing level in section A, paragraph 4 of this chapter? Yes  No
- Does the number of administrative and clerical staff meet the recommended staffing level in section A, paragraph 4 of this chapter? Yes  No

#### Accommodation

- Does the accommodation available to the service satisfy the requirements for:
  - Maximum permissible ambient noise in all hearing test rooms/booths? Yes  No
  - Minimum number of specialist and dedicated rooms for the population served? Yes  No
  - A dedicated earmould workshop at the base site? Yes  No
  - A dedicated diagnostic auditory and balance function assessment room at the base site? Yes  No
  - Minimum floor areas for the key room types? Yes  No
  - The minimum total floor area available for Audiology services? Yes  No
  - Dedicated use of rooms (ie no routine shared use)? Yes  No
  - Essential features of rehabilitation rooms (see paragraph 8)? Yes  No
  - General accommodation features (ie for IT network connection, telephone points, and carpeting)? Yes  No
  - Effective two-way test facility communication? Yes  No
  - Air conditioned test facility accommodation? Yes  No
  - Engineering and communication requirements described in NHS Estates Health Building Note 12 (1994)? Yes  No
  - Minimum accommodation for a peripheral centre? Yes  No
  - Access for disabled people and relevant existing legislation? Yes  No
  - Sign-posted facilities consistent with NHS Estates and local NHS Trust requirements? Yes  No

If 'No' to any of these items, what are the priorities for development and what is the action plan?

---

# Chapter 3

## Service policy

3

## Standards

### 1 How policies should be made and kept

- 1.1 Clear written statements of all current service policies should be kept in a manual or database readily accessible to all staff. Key points should be displayed to inform patients.
- 1.2 Policies should follow relevant current guidance and recommendations from the Health Administrations and the National Institute for Clinical Excellence (NICE). (See Appendix C) They must also conform to obligations set out in Statutory Instruments. The head of service has the responsibility for keeping up to date with these documents.
- 1.3 Heads of service should ensure that all staff are aware of, and follow, current policies and that they are consulted about any changes.
- 1.4 Policies should be reviewed annually.

### 2 Staff training

A training policy for staff should be developed that meets both the skill requirements of the service and the professional development needs of staff. As part of continuing professional development it should include individual performance reviews and co-signed agreements on personal development plans.

### 3 The service: in general

- 3.1 Audiology services, including continuing care, should be provided at times and places and in a manner that makes them as accessible as possible to service users. (See Chapters 4 and 6) This should include appropriate staff training in communication with deaf and hard of hearing people, and facilities to assist this, such as visual call systems. A domiciliary service should be available for patients who require one, at the request of their GP.

- 3.2** All NHS audiology/hearing aid services should remain free of charge at the point of delivery. If there is any parallel trading activity within the NHS Trust, such as hearing aid dispensing, it should be made completely clear to patients that this is a separate and distinct service that in no way affects their entitlement to NHS provision.
- 3.3** The chief objective of the audiology service should be to meet promptly the audiological needs of all patients referred. Where level of provision and its impact on quality of life is concerned, there should be no discrimination on the grounds of age, gender, race, social status, religious or cultural affiliation. The particular demands of an individual's activity in their work, learning, or cultural life may require particular solutions. However, no assumptions about individual needs should be made based on personal characteristics or affiliations. Needs should be assessed and outcomes measured as part of the service protocol.
- 3.4** There should be an explicit policy on identifying and responding to special needs in order to facilitate equal access to a high quality of care. (See Chapter 9)
- 3.5** All audiology equipment should be calibrated objectively at least once a year to the appropriate national and international standards. It should also be part of departmental policy that audiometers are checked daily by a listener with known hearing threshold levels.
- 3.6** Written communications about appointments should be sent three or four weeks ahead of the visit. (See Chapters 6 and 7)
- 3.7** There should be encouragement for a partner/family member/carer/friend to accompany the patient if the patient wishes, especially for initial assessment and first hearing aid fitting appointments.
- 3.8** Policies and procedures should protect patient confidentiality. Patient records should be kept secure and confidential. Information systems should comply with current legislation relating to data protection. Consent must be obtained before discussing any details with relatives/partners/carers or disclosing any personal information to other agencies.
- 3.9** All procedures should be undertaken by staff with appropriate professional qualifications and training.

## 4 The service: hearing aid assessment, fitting and support

**4.1** Duration of appointments should be set to allow adequate time for procedures, for listening to patients, assessing needs and giving information and advice, and for obtaining outcome measures. This means allocating

- at least 60 minutes for the first assessment visit,
- at least 60 minutes for a hearing aid fitting visit,
- at least 30 minutes for a hearing aid fine-tuning appointment and
- at least 30 minutes for a follow-up visit.

Reassessment/review visits require at least 60 minutes.

**4.2** People assessed as likely to benefit from hearing aids should be offered:

- The hearing aids that will give them the best hearing benefit in everyday life from the range of models for which the NHS has a contract. (See Guidance from NICE, Appendix C)
- If none of the above is suitable, a model with features that better meet the hearing needs of the individual.
- Bilateral fittings unless there are audiological or medical reasons for unilateral fitting or unless the patient has a strong preference for one aid only at the time of the visit. Acceptability of bilateral fitting should be reviewed at subsequent appointments.
- A choice of hearing aid style, where alternatives are available that match the person's needs and capabilities.

**4.3** The service should have a clearly documented policy on the hearing aid fitting procedure/rationale that should be followed for each model of hearing aid likely to be fitted, including the method of verifying the fitting and fine-tuning.

**4.4** The service should have a clearly documented policy on earmould specification.

**4.5** For each patient, the basis for all decisions on hearing aid selection and fitting, including earmould specification, should be recorded.

**4.6** Verification that the hearing aid system is delivering appropriate (target) sound levels in the ear should be a routine component of the fitting process.

- 4.6** All patients attending for hearing aid fitting should be given clear verbal and written information and advice on the use and care of hearing aids, on hearing tactics, and on continuing support for hearing aid users, with the aim of optimising benefit and self-management.
- 4.7** All patients attending for hearing aid fitting should be given at least one booked follow-up appointment.
- 4.8** All patients should be given clear verbal and written information and advice on continuing care and rehabilitative services, equipment services and other services, organisations and groups that may be helpful to them, together with up-to-date information on how to access these. (See standards 10-17 in Chapter 7)
- 4.9** Hearing aid users should be recalled for reassessment and review of their hearing aid system no later than three years after their last assessment. The invitation should include a reply slip to return if the patient wishes to be sent an appointment date.
- 4.10** A spare hearing aid should be made available, on short or long-term loan as necessary, to people who would be severely disadvantaged by sudden hearing aid breakdown. A Monday to Friday ‘emergency’ service for replacement aids should be available.
- 4.11** A lost or damaged hearing aid from a bilateral fitting should be replaced in the same way as a unilateral fitting would be replaced.

Hearing aids remain NHS property and are provided on long-term loan. However, patients should not be charged automatically for lost or damaged hearing aids. A charge should be imposed only when there is evidence of carelessness or misuse. Department of Health guidance on this is:

“An NHS Trust may recover all or part of the cost of repair or replacement of a hearing aid only when there has clearly been misuse or carelessness. The legal position is set out in Statutory Instrument 1974, no 284. An NHS Trust wishing to recover all or part of the cost of repair or replacement has to appoint a committee of at least three people to investigate. The inquiry can be in the form of an oral hearing – and has to be if the person concerned demands it. When the committee has reported it is for the NHS Trust to decide what action to take. In the case of a child under 16 responsibility for paying the costs rests with the parent or person having charge of the child.”

## **Evidence/rationale for policy standards**

These standards will help services to realise those core principles underpinning the NHS Plan that are concerned with:

- Providing a universal service based on clinical need.
- Providing a comprehensive range of services.
- Providing a seamless service.
- Continuous quality improvement.
- Shaping services around the needs and preferences of individual patients, their families and their carers.
- Supporting and valuing staff.
- Respecting patient confidentiality and providing open access to information.

## Performance measures

### Service policy

- Are the audiology department's policy documents clear, comprehensive and subject to annual review? **Yes**  **No**

If No, what efforts are being made to meet this standard?

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- Do the policies conform to the law and follow Department of Health/NICE guidance? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Are all the audiology department's policies readily accessible to staff and are relevant policies available to patients in appropriate formats? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Do all staff understand and follow current policies? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Do all staff experience fair and appropriate training opportunities? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Are all procedures undertaken by staff with appropriate professional qualifications and training? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Is all audiology equipment calibrated objectively at least once a year to the appropriate national and international standards, and are audiometers checked daily by a listener with known hearing thresholds? Yes  No

If No, what efforts are being made to meet this standard?

---
- Are policies and protocols on hearing aid fitting consistent with standards under paragraph 4 of this section? Yes  No

Particularly:

Appointment durations	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing aids offered	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bilateral fittings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Booked follow-up appointments	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Three-yearly recall for reassessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Spare/lost/damaged hearing aids	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If No, what efforts are being made to meet these standards?

---
- Do all patients experience fair and consistent treatment? [Information from patient surveys/forum/outcome measures] Yes  No

If No, what efforts are being made to rectify this?

---
- Do patients and their family/carers find that the service is easy to access, meets their hearing needs and gives them the information, guidance and continuing support that they require? [Information from patient surveys/forum/outcome measures] Yes  No

If No, which are the main areas requiring attention, and what efforts are being made to meet the relevant standards?

---
- Is patient confidentiality fully protected? Yes  No

If No, what efforts are being made to meet this standard?

---

# Chapter 4

## Service planning

4

## Standards

### 1 Information required as a basis for service planning

- 1.1 Current statistics on the size of the population served, its age profile, geographical distribution and ethnic mix should be documented. As it is known that at least 30% of people over 55 years old are likely to have a level of hearing loss such that they would benefit from a hearing aid, judgements can be made about the extent of unmet need.
- 1.2 There should also be documentation on the predominant non-English languages spoken locally, and on aspects of the culture of significant sections of the local population that may influence accessibility of services.
- 1.3 Service performance measures (see Chapter 5) should be recorded and analysed, and significant trends documented.
- 1.4 The views of actual and potential service users on the service and its accessibility should be obtained through arranging feedback opportunities.
- 1.5 There should also be documentation on the structure and location of local Community Health and Social Services together with up-to-date details of relevant voluntary organisations and community groups.
- 1.6 Information on technological developments and service innovations in Audiology and in the NHS generally, together with evaluative data, should be documented.

### 2 Monitoring and audit

- 2.1 A scheme should be put in place for monitoring on a regular basis:
  - Adherence to recommended procedures, protocols and standards.

- Service performance including:
  - Number of referrals
  - Appointments by category
  - Non-attendance rates
  - Waiting lists and waiting times
  - Number and types of hearing aid fittings
  - Collection of outcome measures
  - Repairs
  - Expenditure by category
  - Staffing levels
  - Staff activity and training
  - Stock
  - Calibration records
  - Complaints

**2.2** There should be a programme of regular audit as a basis for service review, planning, continuous service development and reporting to management and service commissioning bodies. Service performance measures, and changes in them, should be analysed. They should also be studied in relation to:

- Routinely collected measures of patient outcome (benefit to hearing, reduction in hearing disability, improvements to quality of life, etc).
- Data systematically collected from patients on their views of the service and its accessibility (including from patients who fail to attend).

## **3 Annual review**

**3.1** Service planning should be based on an annual service review. The head of service, in consultation with staff and partner-organisations, should review the service range, performance, location, accessibility, staffing, partnerships, accommodation, equipment and facilities in the light of audit information/analysis and the needs of the local population. Priorities for service development should be identified.

**3.3** Review of accommodation and facilities should include the following aspects:

- Comfort, confidentiality, accessibility and facilities for service users (including attention to the communication needs of deaf and hard of hearing people).
- Arrangements for battery supply and repairs.

- Suitability of accommodation for both diagnostic and rehabilitation activities (including group sessions).
- Suitable administrative accommodation.
- Staff facilities, including inter-site communication and information transfer. (See Chapter 2)

**3.3** Review of staffing should include actual or potential use of trained volunteers to support hearing aid users.

**3.4** The review should address whether financial resources are sufficient to maintain and improve service performance and quality. Budgetary requirements for the following key areas should be assessed:

- Sufficient staffing to meet anticipated demands, provide a comprehensive service and ensure that waiting times for assessment, for hearing aid fitting and for reassessment appointments are no longer than one month. (See Chapters 2 and 6)
- Staff training, registration and continuous professional development to ensure that the skill requirements of the service are met, the service can take advantage of developments in technology, and staff are retained through opportunities for professional development and increased job satisfaction. (See Chapter 3)
- Purchase of a range and quality of hearing aids (and associated materials) that will provide patients with optimum hearing benefit in everyday life, and in numbers that will permit a preponderance of bilateral fittings and meet demand without introducing delays into the process. (See Chapters 3 and 6)
- Regular maintenance and calibration of audiological equipment; renewal and updating of this equipment and purchase of additional items to ensure that the service takes full advantage of developments in technology.
- Purchase and updating of IT in order that the standards on 'Information about patients and service activity' can be met. (See Chapter 5)

## 4 Joint planning

**4.1** Services should be planned jointly or at least in consultation with:

- Other relevant departments within the NHS Trust, especially ENT and therapeutic services.
- PCGs/PCTs, local GPs and continuing care services (to improve referral and support mechanisms in particular). Hearing checks and early aiding for those aged over 55 should form a key objective in service development.
- Social Services (for provision of appropriate equipment for the home). Integration of Health and Social Care provision should provide the context for joint planning to achieve a seamless hearing rehabilitation service.
- Paediatric audiology and education services (to facilitate a smooth transition to the adult service).
- Other relevant external agencies. (See standard 3 in Chapter 9)

## 5 Major service developments

**5.1** For major service developments a business case should be written for presentation to Trust managers. This should give a clear rationale for proposed developments and should detail and justify the budget requirements. If the changes will produce savings elsewhere in the service, this should be highlighted.

**5.2** The business case should also include a bid for enhanced accommodation and facilities if this is needed to ensure that the service operates efficiently and that best practice standards are met.

## **Evidence/rationale for service planning standards**

These standards will help services to realise those core principles underpinning the NHS Plan that are concerned with providing:

- A universal service.
- A comprehensive range of services.
- A seamless service.
- Continuous quality improvement.
- A service to meet the different needs of different populations.

Good monitoring and planning is essential for securing adequate resources and for using them efficiently and effectively. Joint planning leads to better service integration, improved referral mechanisms and economies in use of resources.

## Performance measures

### Service planning

- Are there files of up-to-date and comprehensive information on:
  - the population served (including its languages and cultures) **Yes**  **No**
  - service performance **Yes**  **No**
  - the views of service users **Yes**  **No**
  - related local organisations and services **Yes**  **No**
  - recent general developments in Audiology and the NHS? **Yes**  **No**

If No, what efforts are being made to meet this standard?

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- Are there procedures in place for regular monitoring and audit of service performance and outcomes? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Has the head of service (in consultation with staff) undertaken an annual review of all aspects of the service and identified priorities for service development? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

If Yes, does the review include an assessment of the financial resources needed to maintain and improve service performance and quality? **Yes**  **No**

- Are services planned jointly with related service providers (statutory and voluntary)? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---



# Chapter 5

## Information about patients and service activity

5

For many services, these standards will represent something to aspire to rather than being currently achievable, because of lack of IT. However, many of their features can be realised in paper-based systems.

Although audiology and hearing aid records are held by health services, it is expected that this information may be made available, with patient consent, to colleagues in Social Services teams and volunteer/peer support services which are accredited or run by statutory organisations.

## Standards

1. Patient records should be kept up to date.
2. Patient records must be kept secure and confidential: electronic records must be password-protected.
3. The system must comply with current legislation relating to data protection and patients must be made aware of the information kept about them.
4. Patients must be able to have copies of their audiological test results if they wish. Patients are entitled to copies of letters between clinicians about them.
5. Patient consent must be obtained before discussing any details with relatives/partners/carers and before sharing any personal information with other agencies. It must be obtained separately for each intended recipient of the information and for each type of information and purpose of use, and should be confirmed annually in cases where information is passed on over an extended period. Presence or absence of consent to disclose must be recorded. Non-NHS agencies sharing personal information should be asked to sign a confidentiality agreement.
6. All staff should be trained in the principles and use of the information system.
7. Electronic patient records and data on service activity should be established using a system that:
  - Is compatible with Health Administration's IT strategy and the information needs of the Health Trust/Board.
  - Facilitates service management and planning (patients, referrals, appointment scheduling, budget, staff, stock, training, updating of policies and procedures).
  - Facilitates communication with, and management of patients (patient details, generation of standard letters, assessment results, management history, hearing aid history, outcome measures).
  - Includes a facility to record responses to questionnaires.

- Permits direct booking of appointments by referring agent.
- Interfaces with audiological equipment.
- Needs data to be entered only once, is ‘user-friendly’ and endeavours to link seamlessly with the main hospital system.
- Allows records to be accessed and updated at every service delivery site.
- Can be searched under any field.
- Permits reports to be generated cross-tabulating any combination of data fields and generating statistics on service activity (number of patients, number of appointments by category, DNA rates, waiting lists and waiting times, staffing levels and staff activity, etc).

**8.** Electronic patient records should include for each patient:

- Unique identification.
- Complete demographic information.
- Patient contact details.
- Particular access/care requirements.
- Referral route (in and out), relevant professional contact details, information received/sent.
- Test results direct from audiometer.
- Assessment results.
- Individual management plan.
- Hearing aid model, serial number(s), settings, fitting and earmould details.
- History of hearing aid adjustments and repairs.
- Battery usage.
- Complete journal of appointments and patient management – including information sent to other professionals/agencies, eg hearing therapist, social services, disability employment advisers etc.
- Hearing aid fitting verification measures (eg REM).
- Outcome measures.
- Measures of patient satisfaction with the outcome and with the service (including access and continuing care).

**9.** Electronic patient records should be backed up on a daily basis.

**10.** The information system should facilitate the gathering of information for performance indicators specified elsewhere in the *Best practice standards for adult audiology*.

## **Evidence/rationale for information about patients and service activity standards**

Services are required to demonstrate clinical governance and be accountable to their patients and to service commissioners.

Records established using these standards will facilitate:

- Provision of an appropriate, timely and consistent service to patients.
- Respect for patient confidentiality and provision of open access to information.
- Efficient service management.
- Accurate and comprehensive service monitoring.
- Clinical audit by process and outcome.
- Evidence-based service planning.
- Evidence/data for construction of a sound case for adequate funds and resources.
- A process of continuing quality improvement.
- Comparison between services across the UK.

## Performance measures Information about patients and service activity

- Does the service have an electronic system for storing patient records and data on service activity? Yes  No

If No, what plans do you have for introducing such a system?

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- If Yes, does it meet the specification set out in standards 7 and 8 of this chapter? Yes  No

If No, what is required to improve this?

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- Is the “downtime” of the IT system monitored? Yes  No

If No, what plans do you have for introducing such monitoring?

---

- Can reports on service performance measures and individual patient management be generated on demand?

For example:

- Numbers of patients seen for different categories of appointment Yes  No
- Numbers of new hearing aid users, the types of aid and fitting they received Yes  No
- Outcome measures Yes  No
- Waiting list for first assessment and average waiting time on a month-by-month basis Yes  No
- Patients’ satisfaction with the service Yes  No
- Individual patient’s audiological management history, outcomes and satisfaction Yes  No

If No, what plans do you have for introducing such a system?

---

- Does quarterly batch sampling indicate that 100% of electronic records are:
  - Password protected? **Yes**  **No**
  - Backed up daily? **Yes**  **No**
  - Kept secure and confidential? **Yes**  **No**

If No, what plans do you have for meeting this standard?

---

- Does quarterly batch sampling indicate that at least 95% of patient records are:
  - Kept up to date? **Yes**  **No**
  - Dated and (if a manual system) written in a clear and legible form? **Yes**  **No**
  - Written with the patient's awareness and consent? **Yes**  **No**
  - Available as copies for the patient if desired? **Yes**  **No**

If No, what plans do you have for meeting this standard?

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# Chapter 6

## Access to audiology services

6

Audiology consists of diagnostic and rehabilitative services. Hearing aid provision is only one part of the range of services.

Diagnostic services range from basic audiometry, through tympanometry to advanced procedures such as evoked response audiometry, vestibular assessment, etc. Rehabilitative services include information, support and continuing care for hearing aid users, counselling; tinnitus management, balance management, communication training, advice on employment issues, support in obtaining and using assistive devices, etc. (See Chapter 9)

## Standards

### 1 Access for initial referrals

- 1.1** Initial referrals to audiology should be accepted from GPs, ENT consultants and consultants in hospital departments other than ENT.
- 1.2** People over 60 years old, concerned about their hearing, should be referred directly to audiology departments if their audiology history meets Technicians, Therapists and Scientists in Audiology (TTSA) criteria; see Appendix B for criteria) or other updated equivalent.
- 1.3** A referral from the GP may be by letter or via the National Booked Admissions Programme. In the transitional phase towards achieving a four-week waiting time, patients will require an acknowledgement of referral indicating the likely wait followed by a letter confirming an appointment date. On receipt of the referral, the audiology department should send a letter of acknowledgement to the patient indicating the waiting period. The appointment letter should be sent out no later than 10 working days before the actual appointment.
- 1.4** Following the hearing assessment, a standard letter should be sent to the referring consultant or GP for inclusion in the patient's records (if the relevant records do not accompany the patient). The letter should describe the results of assessment and details of the proposed hearing aid fitting and/or other treatment, therapy or support. It should be sent within 10 working days of the assessment appointment.
- 1.5** Self-referral for hearing checks: Services should enable patient access to Audiology services without referral from a doctor by ensuring effective mechanisms for GP notification and cross-referral are in place.

## 2 Timely and convenient access to all services

**2.1** Waiting periods for initial and subsequent appointments should comply with the following:

Referral to first assessment visit:	Not more than 4 weeks
Assessment to first hearing aid fitting appointment:	Not more than 4 weeks
First to second hearing aid fitting appointment:	Not more than 8 weeks
Advanced audiometry or other audiology services:	Not more than 4 weeks
Reassessment/continuing care:	Not more than 4 weeks from patient request
Referral for rehabilitation services:	Not more than 4 weeks

**2.2** Access to rehabilitative services and continuing care for hearing aid users will be provided by audiology departments by appointment if requested. Patients should have access to repair services every day from Monday to Friday each week. Ideally this service should be in the form of face-to-face 'open access' repair and maintenance clinics. However, where it is not possible to provide such a clinic every day, then at least three should be provided per week, and on the other days there should be a facility for leaving aids for repair and collecting them later the same day or receiving them by post the following day. The needs of those who work from Monday to Friday should be recognised.

**2.3** Hearing aids for repair should also be accepted through the post. People who use postal repairs should obtain the same speed and quality of service as those who call in for repairs. If an aid sent in for postal repair can be dealt with within the department, it should be repaired and dispatched within 24 hours of receipt.

**2.4** Established patients may contact their audiology clinic directly to request reassessment of their hearing and current hearing aid system if they do not require further medical care. Appointments should be given within four weeks of user/carer request.

**2.5** Hearing aid users should be recalled for reassessment and review of their hearing aid system no later than three years after their last assessment. The invitation should include a reply slip to return if the patient wishes to be sent an appointment date.

**2.6** Location of services should take into account the suitability of providing additional audiology services in convenient local health facilities in addition to those offered in the main department. Rehabilitation and continuing care services in particular should be provided locally if this will help a significant number of patients. Consideration should be given to the time taken by patients and staff to reach service locations.

**2.7** Domiciliary visits should be provided to patients who require one, at the request of their GP.

### **3 Accessibility**

**3.1** Access for disabled people should be ensured at all stages of patient service and should comply with the guidance attached to the Disability Discrimination Act (1995) or other updated equivalent.

**3.2** In addition to the local Trust's provision of wheelchair access and services for visually impaired people in the hospital environment, audiology departments should ensure that access to their reception and waiting areas, treatment and testing rooms etc are suitably adapted for all users. Planning should take account of the fact that the majority of users of this service will be deaf or hard of hearing.

**3.3** All staff, including reception staff, should receive disability awareness training with an emphasis on communication with deaf and hard of hearing people.

**3.4** Room acoustics and lighting should be planned or modified to assist hearing and lipreading. Where appropriate, facilities such as visual call systems, visual alarms and counter loops should be installed. A portable assistive listening device should also be available. Where a television or video player is provided in the waiting area, it should have the capability of displaying subtitles.

**3.5** Procedures should be established for discovering particular communication needs in advance and for booking communication support if required.

**3.6** Procedures should be in place to produce information in alternative formats and other languages within a reasonable timeframe.

- 3.7** For patients with special needs, a range of measures should be considered in order to facilitate equal access to a high quality of care. (See standard 2, Chapter 9)
- 3.8** All departmental staff should know how to use RNID Typetalk and each audiology department should have a textphone, access to a fax machine and e-mail. A designated member of staff should be given the responsibility for checking any fax or e-mail messages regularly.

### Evidence/rationale for access to audiology services standards

Services are required to practice clinical governance and be accountable to their patients and to service commissioners.

Access to audiology services established using these standards will facilitate:

- Provision of a universal, equitable service.
- Provision of a timely and consistent service to patients.
- Partnership working with referrers for the benefit of the patient.
- Accurate and comprehensive waiting list management.
- Clinical audit by process and outcome.
- Evidence-based service planning.
- More relaxed service users and better, more efficient communication.

There are clear benefits to established audiology patients, of a system that allows self-referral to open access clinics and appointed reassessment visits:

- Further medical referral is not required.
- Quick management and resolution of simple or urgent problems.
- Reassessment of hearing systems assists patient satisfaction and optimises benefit.
- Consistency of access for all patients.
- Reduced administration of arranging appointments.
- Junior staff may be employed for simple solutions; complex problems can be referred on by appointment if required.

Reference on community audiology and hearing aid provision:

Reeves D J, Alborz A, Hickson F S, and Bamford J M *Community provision of hearing aids and related audiology services*. Health Technology Assessment 2000; Vol. 4: No. 4

## Performance measures Access to audiology services

- Does the service operate a Direct GP Referral scheme? Yes  No

If No, what plans are being made to offer this?

---

- Does quarterly batch sampling indicate that:
  - At least 95% of appointment letters for initial referrals are sent within 10 working days? Yes  No
  - At least 95% of referrers receive an audiology report on the hearing assessment and care plan for their patient within 10 working days of the assessment? Yes  No
  - At least 90% of appointments are offered within the specified time-scales? Routine exception reporting will monitor non-conformity. Yes  No
  - At least 95% of postal repairs that can be undertaken within the department are turned around within 24 hours of receipt? Yes  No

If No to any of these, what efforts are being made to achieve this standard?

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- Does the service run face-to-face 'open access' repair clinics on at least three days per week and provide convenient access to repair services on each other weekday? Yes  No

If No, what efforts are being made to offer this service?

---

- Does the service offer domiciliary visits and a service in local health facilities? Yes  No

If No, what efforts are being made to offer these services?

---

- Are all patients sent the offer of a hearing reassessment/ review appointment every 3 years? Yes  No

If Yes, what proportion of patients respond to this recall?

---

If No, what efforts are being made to meet this standard?

---

- Does the department have patient access that complies with the Disability Discrimination Act? Yes  No

If No, what efforts are being made to achieve this standard?

---

- Are the needs of deaf and hard of hearing people reflected in the Trust strategy for implementing the DDA? Yes  No

If No, what efforts are being made to rectify this?

---

- Are the reception and waiting areas, treatment and testing rooms etc within the department suitably adapted for all users? Yes  No

For example:

- Is there a visual call system in the waiting room? Yes  No
- Do all waiting room seats have clear lines of sight to visual alert systems? Yes  No
- Is the waiting room acoustically quiet? Yes  No
- Are reception and consulting rooms arranged to aid lipreading skills? Yes  No
- Are window blinds and sufficient artificial light available in treatment rooms? Yes  No
- Is there at least one assistive listening device, with both headphones and loop, available for patients to use? Yes  No
- If there is a television or video player for patients' use, does it display subtitles? Yes  No
- Are all staff in the department aware of how to access the Typetalk service? Yes  No
- Are all staff trained in responding appropriately to communication needs, and the use of assistive listening devices, textphones and Typetalk? Yes  No

If No to any of these items, what efforts are being made to achieve this standard?

---



# Chapter 7

## Information for patients

7

## Standards

1. All verbal and written information for patients should be presented clearly and concisely, in plain language and without ambiguity. It should be accurate and honest.
2. Information (in all accessible forms) should be available in minority languages to cater for local ethnic groups.
3. A large proportion of patients will be elderly and have visual problems as well as hearing loss therefore literature should also be available in large print. Procedures should be in place to provide information in a range of alternative formats within a reasonable timescale as required.
4. All staff should receive training in deaf awareness and how to communicate appropriately with deaf people, including use of Typetalk.
5. Information should be kept up to date. All literature should be date-stamped and reviewed annually.
6. All information should be listed and patients should be made aware of the range of literature available to them.
7. Staff should be trained in the principles and use of the information system.
8. All details about service protocols, clinic venues and timetables, testing procedures and rehabilitative management that are given verbally to patients, should be backed up by written information.

For example, appointment letters should state clearly:

- Day, date, time, expected duration of appointment.
- Address of clinic, position within the building, floor, wing and room number.
- Travel directions.
- Reason for the visit.
- Name and role of staff member.
- Phone number, fax number and e-mail address to contact for further details or to change/cancel the appointment.
- A brief and polite explanation of the effects to the service of non-attendance, with encouragement to notify the clinic if unable to attend at the time given.

- 9.** Information prior to a visit should detail the probable processes, eg:
  - Having a hearing test, middle ear evaluation, speech audiometry, measuring uncomfortable loudness levels, Real Ear Measurement.
  - Having an impression for an earmould, the first hearing aid fitting appointment, the second fitting appointment.
  - Balance assessment – having an ENG, caloric testing, and possible after effects.
  - Having other advanced investigations – BSER, ECoG, facial nerve studies etc.
  - Special arrangements for those transferring from paediatric to adult audiology services.
  
- 10.** Hearing aid users should be given verbal and written information at the initial hearing aid fitting appointment about:
  - Further fitting or follow-up visit.
  - How, when and where to obtain ongoing hearing aid supplies, repairs and support, including details of community and postal services.
  - The need to get BTE aids re-tubed at least every three months.
  - Appropriate reasons for return visits.
  - How to arrange a reassessment appointment.
  
- 11.** Patients should be given verbal and written information about additional services and how to access them:
  - Counselling, lipreading and communication training etc.
  - Tinnitus management.
  - Provision of assistive devices.
  - Balance management.
  - Advice on employment/education/training.
  
- 12.** A ready supply of NHS booklets, hearing aid record books and other appropriate NHS publications should be available.
  
- 13.** The RNID leaflet scheme and the publications catalogue should be in place in audiological centres and offer patients a wider view of hearing loss and its associated problems.
  
- 14.** Details of other charities and helplines should be available, for example:  
The Link Centre for deafened adults, Hearing Concern, British Deaf Association, British Tinnitus Association, Defeating Deafness, City Literary Centre for Deaf People and Speech Therapy, Meniere's Society, National Association of Deafened People, National Deaf Children's Society etc.

15. There should be available details of lipreading classes, signing courses, local user and support groups etc, which state the venue, day, time, dates, purpose of the meetings, who will benefit from attending, how to apply and obtain more information, telephone numbers and other helpful information.
16. A system of volunteer helpers and/or 'expert patients' may be available to new patients coming to terms with using a hearing aid. Details of this service should be publicised within the department.
17. If a television or video screen is provided in the waiting area, a facility for playing videos showing skills that are not easy to describe, such as hearing aid care and earmould insertion, may be helpful.

## **Evidence/rationale for information for patients standards**

Services are required to practice clinical governance and be accountable to their patients and to service commissioners.

Compliance with these standards will facilitate:

- Provision of a universal, equitable service.
- Provision of a service that fully meets each individual's hearing-related and communication-related needs.
- Provision of a seamless service.
- Patients from all backgrounds and disabled groups being able to make informed choices.
- Provision of accurate, up-to-date, relevant information.
- A consistent stock of relevant literature.
- Consistency of information provision.
- Reduced anxiety for patients through awareness of the treatment processes.
- Confident, expert users who will maximise the benefits derived from the service.

## Performance measures

### Information for patients

- Have all staff received training in deaf awareness and how to communicate appropriately with deaf people, including use of Typetalk? Yes  No

If No, what is being done to achieve this standard?

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- Does the service have standard information for patients that is presented clearly and concisely in plain language, is also available in large print and has been translated into appropriate minority languages? Yes  No

If Yes: a) are there aspects of the literature that require more work? Yes  No

b) are there procedures for producing it in a range of alternative formats as required? Yes  No

If No, what is being done to achieve this standard?

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- Is all literature date-stamped and is there an annual audit of accuracy of the information provided? Yes  No

- Does the provision of pre-appointment information meet standards 8 and 9? Yes  No

If No, what is being done to achieve this standard?

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- Does the department have a written information pack/ leaflet, informing patients of all ongoing support services and times (see standards 10-12)? Yes  No

If No, when will this standard be met?

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- Has a list of local information sheets, leaflets, booklets been compiled? **Yes**  **No**

If No, what is being done to achieve this standard?

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- Are details of relevant local groups, courses and other services, with contact information, offered to all patients? **Yes**  **No**

If No, what is being done to achieve this standard?

---

- Is at least 90% of the verbal information given to patients backed up by written information? **Yes**  **No**

If No, what is being done to achieve this standard?

---

- Is there comprehensive information about relevant national organisations, helplines and specialist centres available for patients? **Yes**  **No**

If No, where does the service fall short?

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What is being done to achieve this standard?

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# Chapter 8

## Service procedures

## Standards

1. The following published recommended procedures, or any later revisions of them, should be followed:

Recommended Procedure/Standard	Source	Date
Pure tone audiometry using a manually operated instrument	BSA	1981
Pure tone bone conduction audiometry without masking using a manually operated instrument	BSA	1985
Masking in pure tone threshold audiometry	BSA	1986
Audiometric test methods – Part 2: Sound field audiometry with pure tone and narrow-band test signals	BS EN ISO 8253-2	1998
Audiometric test methods – Part 3: Speech audiometry	BS EN ISO 8253-3	1998
Aural impression taking	BSA	1986
Rinne and Weber tuning fork tests	BSA	1987
Measurement of uncomfortable loudness level (ULL)	BSA	1987
Format for audiogram forms	BSA	1989
Guidelines on the Direct Referral of adults from GPs to hearing aid services	TTSA	1989
Tympanometry	BSA	1992
Minimum procedure for the cleaning of speculae etc. and associated infection control	BSA	1998
Balance Interest Group guidance and caloric test protocol	BSA	1999
Transition to adult services – NDCS Quality Standards in Paediatric Audiology Vol IV (item 17.2.1)	NDCS	2000

2. Where there are no standard professionally accepted procedures, local written protocols should be established and followed by departmental staff.

Examples of areas currently requiring local protocols are:

- Assessment of the patient's psychological, social, occupational and communication needs. (See Chapter 9)
- Development of an individual care plan.
- Earmould specification.
- Verification of hearing aid fitting: Real Ear Measurement and measurement of aided thresholds.
- Tinnitus management.

- Balance management.
- Measurement of outcomes. (See Chapter 10)
- Patient records. (See Chapter 5)
- Information provision. (See Chapter 7)

**3.** Written procedures and time allocations should be established for each process in the rehabilitative schedule.

For standards on hearing aid assessment, fitting and support, see paragraph 4 of Chapter 3. For standards on other elements of rehabilitative care see Chapter 9.

- 4.** Adherence to protocols and procedures should be monitored systematically by means of:
- A series of proformas to be completed and included in the patient record.
  - Direct monitoring of clinical procedures by a senior qualified professional.

### **Evidence/rationale for service procedures standards**

Services are required to practice clinical governance and be accountable to their patients and to service commissioners.

Compliance with these standards will help to ensure:

- Accurate, safe and comprehensive assessment.
- Provision of a service that fully meets each individual's hearing-related and communication-related needs.
- An appropriate, timely and consistent service to patients.
- A seamless service.
- Informed user participation.
- The collection of data essential for clinical audit by process and outcome.
- Evidence-based service planning.
- A process of continuing quality improvement.

## Performance measures

### Service procedures

- Does the department have written protocols and procedures for each element in the assessment and rehabilitation process? Yes  No

If No, what efforts are being made to meet this standard?

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- Does quarterly batch sampling indicate that:
  - At least 95% of patient records include completed protocol monitoring forms reflecting adherence to departmental procedures? Yes  No

If No, what efforts are being made to meet this standard?

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- At least 95% of allocated appointment durations satisfy departmental protocols? Yes  No

If No, what efforts are being made to meet this standard?

---

- 100% of patients directly referred for hearing aid assessment/fitting have a medical history that complies with the TTSA criteria? Yes  No

If No, what efforts are being made to meet this standard?

---

- Does quarterly monitoring of clinical procedures by a senior qualified professional ensure that:
  - 100% of all diagnostic and reassessment audiometry complies with BSA recommended procedures? Yes  No
  - 100% of earmould impressions are taken according to BSA recommended procedures? Yes  No
  - 100% of earmould quality assurance procedures are adhered to? Yes  No
  - 100% of advanced audiology procedures comply with recommended practice? Yes  No

If No, what efforts are being made to meet these standards?

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# Chapter 9

## Rehabilitation services to support adult patients

9

Rehabilitation encompasses a wide range of services. Ideally, this range should be provided within the department, but where resources do not permit this, then there should be an established procedure for onward referral to, and liaison with, other departments or agencies. A route to rehabilitative care should be available for people with any of the conditions or needs listed in Appendix A.

Rehabilitative care should consider the patient in terms of their needs across all areas of their daily life, including social activity, employment, communication, education and training, leisure interests etc.

The full range of services should be available to all patients, wherever they access audiology services. Patients should be guided as to which services they may find of particular benefit, but information should be available on the comprehensive range for everyone who wishes it.

Wherever rehabilitation is provided, staff with specialist knowledge and training for the specific service in question should deliver the services. All such staff should be following recognised paths of professional development to ensure updating of their clinical skills in this service.

Procedures should be in place to record the agreed care plan for any patient.

## Standards

- 1** **Audiology should provide comprehensive rehabilitation services to support adult patients. The audiology service should include, or provide an established route to:**
  - 1.1** Provision of information on all aspects of hearing loss and associated conditions to increase the patient's knowledge and understanding.
  - 1.2** Assessment of the patient's needs based on the social model of disability, evaluating their psychological, social, occupational and communication needs.
  - 1.3** Provision of support, including peer support, for patients who need help adjusting to their hearing loss.
  - 1.4** Pre-hearing aid counselling and hearing aid user follow-up to instruct, support and inform hearing aid users in the use of their hearing aids.

- 1.5** Support and onward referral for patients who are unable to benefit from a hearing aid.
- 1.6** Counselling for individuals, relatives and carers affected by an acquired hearing loss. This may include dealing with issues arising at home, in education, or at work as well as supporting the patient through the psychological impact of hearing loss.
- 1.7** Communication training service for individuals/families/friends to encourage changes in communication strategies and to acquire better skills in using residual hearing. This may include instruction in lipreading, auditory training, hearing tactics, communication strategies, assertiveness, advice on manual communication modes, etc.
- 1.8** Assessment and information service for the provision of assistive devices for home, education and work in conjunction with Social Services and other appropriate departments or voluntary agencies.
- 1.9** Group therapy giving individuals and relatives an opportunity to share experiences with a peer group, as well as providing a forum for learning, eg communication courses, courses to learn more about the causes and effects of acquired hearing loss, tinnitus support, assertiveness training.
- 1.10** Relaxation therapy and training to enable individuals to cope with hearing difficulties and tinnitus/balance disorders.
- 1.11** Therapy service for severely or profoundly deafened patients to meet their unique communication and psychosocial needs, incorporating access to a specialised rehabilitation management programme.
- 1.12** Tinnitus therapy service offering assessment and programmes of management.
- 1.13** Teaching and training service to professionals and interested groups, eg deaf awareness, communication skills, etc.
- 1.14** Training and support programmes for users of specialised aids such as vibrotactile and frequency transposition aids.

- 1.15** Hyperacusis therapy/desensitisation to offer support and rehabilitation to patients experiencing oversensitivity to sound.
  - 1.16** Pre- and post-operative counselling, information and advice for patients undergoing cochlear implants, middle ear and brainstem implants, bone anchored hearing aids or any aural surgery.
  - 1.17** Management of balance problems in line with recommended procedures from the balance interest group of BSA.
  - 1.18** Support for young deaf adults in the transition from paediatric to adult services.
  - 1.19** Access to volunteer support schemes managed by the statutory services or voluntary agencies.
  - 1.20** Assessment and advice on employment issues, including information about and onward referral to relevant statutory and voluntary agencies.
- 2** **The audiology service should consider the following measures when planning an individual's rehabilitative care, particularly for those with special needs:**
- 2.1** Inclusion of carers and/or family at all stages of care.
  - 2.2** Effective sharing of information and work with carers/key workers.
  - 2.3** Provision for long-term rehabilitation management.
  - 2.4** Provision of communication support.
  - 2.5** Liaison and appointment setting for suitability of time of visit.
  - 2.6** Extending appointment duration if required to allow for communication needs/support.

- 2.7** Provision of an acceptable environment and appropriate assessment techniques.
  - 2.8** Pre-issue counselling/desensitisation prior to a hearing aid fitting.
  - 2.9** Follow-up management in familiar environments, eg at home, in day centres or in nursing homes.
  - 2.10** Inclusion of advocates by previous arrangement.
  - 2.11** Group appointments.
  - 2.12** Information in all accessible formats.
  - 2.13** Information in minority languages.
- 3** **The head of service should be responsible for ensuring good working relationships between the department and other relevant services.**
- 3.1** Other relevant services include departments within the health service where a collaborative team approach should be adopted (eg otolaryngology, speech and language therapy, physiotherapy, psychology, orthoptics). They also include bodies external to the health service such as social services, education, employment agencies, lipreading tutors, hard of hearing groups, voluntary agencies and specialist rehabilitation providers.
  - 3.2** The responsibility for facilitating partnership working may be delegated, but in this case the objectives and tasks must be documented and regular progress reports made to the head of service.
- 4** **For Standards on access to rehabilitation services, see Chapter 6.**
- 5** **For Standards on informing patients about rehabilitation services, see Chapter 7.**

## Evidence/rationale for rehabilitation services standards

Hearing aid provision must include accessible continuing care to ensure that people obtain benefit from the hearing aids they are given and an improved quality of life. For the same reason, audiology services should be proactive in reassessing patients at least every three years and providing a more appropriate hearing aid system if required for optimum benefit.

Service users whether they have hearing aids, other devices, or none, will require ongoing support for changing hearing experiences over time at work and at leisure. Some will require more intensive support in order to obtain optimum benefit from their hearing aids/other devices and to optimise their communication abilities. The provision of rehabilitation to adults using these standards will ensure:

- equity of access to the full range of audiological support that patients require to reduce the impact of the disability of hearing loss.
- that rehabilitation is available for patients with all presenting conditions.
- that clinical effectiveness is central to the provision of rehabilitation.
- that every effort is made to provide referral to appropriate services.
- that the patient's communication needs are met as fully as possible within a social model of disability.
- improved partnership working between audiology, social services, education, employment agencies, voluntary bodies and other professionals.
- that the problems highlighted by the report by the Audit Commission *Fully Equipped* (March 2000) can begin to be addressed.
- that the service can demonstrate Clinical Governance. (See Chapter 1)

Demographic changes mean that there is an increasing number of older people, many of whom experience hearing disability. They have increased expectations of the lifestyle they will enjoy in later years, including active participation in family, social and community life. Services operating to these standards will help them to maintain their independence and be active, confident members of their community. This will also increase the cost effectiveness of the service. The benefits of effective rehabilitation have been highlighted in the Audit Commission's report *Fully Equipped* (March 2000).

Evidence for the value of counselling, information and advice as part of a comprehensive service is found in:

Brooks D Counselling for the first-time user, in *'Adult Aural Rehabilitation'*, D Brooks (ed.) Chapman & Hall 1989

Andersson G et al. *Behavioural counselling for subjects with acquired hearing loss. A new approach to hearing tactics.* Scandinavian Audiology 1994; 23(4): 249-256

Ward P R *Effectiveness of aftercare for older people prescribed a hearing aid for the first time*. Scandinavian Audiology 1981; 10(2): 99-106

## Performance measures Rehabilitation services

- Does the service provide (either within the department or by offering an established route) all the rehabilitative services listed in standard 1 of this chapter? Yes  No

If No, what efforts are being made to meet this standard?

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- Has the department allocated sufficient time to provide pre-hearing aid counselling and hearing aid user follow-up and agreed the key elements that should be discussed with the patients? Yes  No

If No, when and how will the department meet this need?

---

- Has a procedure been agreed between health and social services on assessment of requirement for assistive devices and are patients informed about this service? Yes  No

If No, what efforts are being made to meet this standard?

---

- Does the department provide specialised immediate and long-term support to adults with sudden profound deafness, and/or a referral route to a specialised centre? Yes  No

Does it provide leaflets designed specifically for such people? Yes  No

Does it provide access to a peer group? Yes  No

If No, what efforts are being made to meet these standards?

---

- Does the service have appropriate staff who provide:
  - a) tinnitus counselling Yes  No
  - b) balance rehabilitation Yes  No
  - c) support to adults with sudden profound deafness Yes  No
  - d) communication training/lipreading tuition/  
assertiveness training/advice on manual communication Yes  No
  - e) group therapy/teaching/training Yes  No

If No, what efforts are being made to meet these needs?

---

- Have staff who provide the above services successfully completed relevant training courses that are recognised by their professional organisations either as part of their core training or as part of a Continuing Professional Development scheme? Yes  No

If No, what efforts are being made to meet this standard?

---

- Do the staff delivering specialised counselling (eg to people with tinnitus or with sudden profound deafness) have training in counselling skills (see British Association for Counselling Guidelines for those using counselling skills in their work – March 2000). Yes  No

Do the staff receive supervision and do they keep up to date with training? Yes  No

If No, what efforts are being made to meet this standard?

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- Are staff providing information, advice and support for people with specialised devices (eg vibrotactile or frequency transposition aids, bone anchored hearing aids, cochlear implants, brainstem implants or middle ear implants) required to undertake relevant training and keep up-to-date with developments in these areas as part of their Continuing Professional Development? Yes  No

If No, what efforts are being made to meet this standard?

---

- Does the department have an agreed procedure for the transition of young deaf adults from paediatric to adult services in line with the NDCS guidelines? Yes  No

Is there joint planning and working between relevant agencies plus transfer of patients records? Yes  No

Are young deaf adults consulted and given relevant written information at this time? Yes  No

If No, what efforts are being made to meet this standard?

---

- Does the department facilitate or provide access to peer support for hearing impaired adults and people with tinnitus? **Yes**  **No**   
If No, when and how will this standard be achieved?

---

- Do the staff providing assessments and advice on employment related issues have an agreed procedure for referrals with the relevant local employment service staff? **Yes**  **No**

Do they keep up to date with specialist equipment and developments in employment locally and nationally? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Has the department established good working relations between statutory and voluntary bodies and to ensure referrals and shared information for the benefit of patients and staff? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Are appointment durations extended if required to allow for communication needs/support? **Yes**  **No**

If No, what efforts are being made to meet this standard?

---

- Are additional measures taken to ensure positive outcomes for people with special needs? **Yes**  **No**

If Yes, what are these measures?

---

If No, what efforts are being made to meet this standard?

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How are the following services provided?

Service	Provided by	Location
Special needs assessment and support		
Rehabilitation needs assessment		
Information provision		
Pre-hearing aid counselling		
Communication training		
Assistive devices		
Group therapy		
Relaxation therapy		
Tinnitus management		
Deaf awareness training		
Specialised aids: training and support		
Support before and after aural surgery		
Support, training and therapy for suddenly deafened patients		
Employment support and referral		
Support for people with otosclerosis		
Meniere's disease advice and support		
Balance management		
Hyperacusis therapy		
Acoustic neuroma support		



# Chapter 10

## Patient outcome measures

10

The patient should be the focus of the service, not the technology, protocols and procedures in themselves. It is therefore essential to evaluate the effectiveness of the complete service in terms of the outcomes it produces for patients and their families/carers in everyday life. The question is, “What difference has the provision of devices, training or therapies actually made to people’s lives?”

Patient outcome measures should be distinguished from measures that verify the appropriateness of the hearing aid fitting (such as Real Ear Measurement and aided thresholds). Fitting verification measures should be seen as part of the hearing aid fitting process.

Patient outcome measures should also be distinguished from methods of:

- a) monitoring whether standard procedures and protocols are being followed. (See Chapter 8)
- b) monitoring service activity (eg waiting lists, waiting times, appointments in different categories, DNA rates, numbers and types of hearing aids/fittings used, staff training and continuous professional development, etc). Monitoring of service activity is covered in Chapter 5.

## Standards

- 1** Information on patient outcomes should be systematically and routinely collected.
- 2** The patient outcome measures that are used should, as far as possible, be questionnaires or scales that have been tested for their ‘validity’ (measuring what they are intended to measure) and ‘reliability’ (giving consistent results).
- 3** Measures should be reasonably straightforward for staff to administer and for patients to respond to, and questions should be in plain language. They should be available in minority languages and in a range of alternative formats as required.
- 4** If there are appropriate outcome measures that have gained general acceptance in audiology and are widely used, these should be chosen for preference.
- 5** In addition to any generic ‘Quality of Life’ measures (such as the Visual-analogue Quality of Life scale), outcome measures should be adopted that reflect the amount of reduction in the different kinds of disability that audiology patients may experience. Specific measures will be needed in relation to hearing/communication, tinnitus and balance.

Examples of appropriate measures (see references in the following ‘Evidence’ section) are:

#### Hearing/communication

- Glasgow Hearing Aid Benefit Profile (GHABP) – also provides a tool to guide individual patient management
- Abbreviated Profile of Hearing Aid Benefit (APHAB)
- Satisfaction with Amplification in Daily Life (SADL)

#### Tinnitus

- Tinnitus Handicap Inventory (THI)
- Tinnitus Questionnaire (TQ)
- Tinnitus Reaction Questionnaire (TRQ)

#### Balance

- Dizziness Handicap Inventory (DHI)

It is also possible to use a ‘Patient Generated Index’ approach in which the individual identifies the most important areas/activities of life that are affected by their condition. For each area/activity the person then rates how reality matches expectations and how much they would value an improvement. The ‘Client oriented scale of improvement’ (COSI) uses a similar approach and has become an established tool to measure hearing aid benefit and satisfaction.

- 6** There should also be routine outcome measures to capture patients’ satisfaction with the service. These should cover:
- Service accessibility.
  - Satisfaction with explanation, information and guidance given.
  - Satisfaction with consultation with them about treatment options.
  - Satisfaction with continuing care and support.

- 7** Levels of satisfaction with the service, patient outcomes as a result of hearing aid provision, and specific patient outcomes from other treatments or therapies provided, should be analysed as part of the regular audit process. (See Chapter 4)

## **Evidence/rationale for patient outcome measures standards**

Patient outcome measures are essential for evaluating the effectiveness of the complete service in terms of the outcomes it produces for patients and their families/carers in everyday life. Routine measurement of outcomes ensures that the service is:

- Aware of its achievements.
- Aware of its shortcomings.
- Alerted to any need for change.
- Has a sound basis for planning ways to effect that change.
- Knows when and how improvements have been achieved.

Regular audit with analysis of outcomes is needed if the service is to be accountable to patients and to service commissioners. It contributes to efficient use of resources and to decisions on best value.

Regular audit with analysis of outcomes also contributes to the local planning process in collaboration with related services.

It plays a vital role in establishing best practice and will inform national benchmarking in the future.

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## Performance measures

### Patient outcome measures

- Is information on patient outcomes collected systematically and routinely? Yes  No

If No, what is being done to meet this standard?

---

- If yes, do the measures used satisfy the requirements in the standards for:
  - Validity and reliability? Yes  No
  - Ease of use? Yes  No
  - Availability in appropriate alternative formats? Yes  No
  - General acceptance and use in audiology? Yes  No
  - Measures specific to different service/disability elements? Yes  No
  - Measures of patient satisfaction with the service process? Yes  No

If No for any of these points, what is being done to meet this standard?

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- Are patient outcome measures analysed as part of a regular audit process? Yes  No

If No, what is being done to meet this standard?

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# Appendix A

## Range of users of adult audiology services

An individual may have one or a combination of the conditions or needs as described below. The list is not exhaustive.

Presbycusis/gradual hearing loss

Tinnitus

Otosclerosis

Patients pre- and post-aural surgery

Meniere's disease

Balance problems

Sudden acquired profound deafness

Patients with bone-anchored hearing aids

Patients with implants (cochlear, brainstem, middle ear)

Patients using vibrotactile aids

Hyperacusis

Obscure auditory dysfunction

Acoustic neuroma

Acoustic trauma

Patients with special needs include:

Patients with learning disabilities

Patients with mental health problems

Patients with dual sensory loss

Patients from ethnic minorities

Patients whose first language is not English

Patients with reduced manual dexterity,  
eg elderly, stroke patient

## Appendix B

### Criteria for direct referral: Guidelines of the Liaison Group of Technicians, Therapists and Scientists in Audiology (TTSA), 1989

The following are the suggested criteria which should be satisfied before a patient referred directly to an audiology department by a GP may be fitted with a hearing aid.

1. The patient must be aged 60 or over.
2. The patient must have been seen by the GP and have both ears de-waxed as necessary.
3. Directly referred patients may be seen by any qualified audiology technician or scientist for their audiometry. The history-taking, the examination of the ears and the judgement of suitability for hearing aids must be done by a technician of senior grade or by a post-probationary audiological scientist (ie following successful completion of the course leading to the BAAS's Certificate of Audiological Competence).
4. The direct referral service shall apply only to patients referred for consideration for hearing aids. No other type of ENT or hearing abnormality referral may be accepted directly from a GP.
5. The technician or scientist may not proceed with the supply of any hearing aid system without ENT (or audiological medicine) advice if any of the following conditions apply:
  - a) Excessive wax in either ear.
  - b) A perforated eardrum, an active discharge or a history of discharge from either ear.
  - c) Otalgia affecting either ear.
  - d) Vertigo (as classically described 'an hallucination of movement', not to be confused with the common unsteadiness often associated with age).
  - e) Hearing loss of sudden onset.
  - f) Sudden deterioration of an existing hearing loss.
  - g) Hearing loss subject to fluctuation beyond that associated with colds.
  - h) Hearing loss where audiometry shows an average air/bone gap in excess of 30dB in either ear. The bone conduction audiometry, masked as necessary, should be tested in octaves from at least 500Hz to 2000Hz.
  - j) Asymmetrical hearing losses: as an index of suspicion a difference in bone-conducted thresholds of 20dB or greater at 0.5, 1, 2 or 4kHz may be used.
  - k) Any other unusual presenting features at the discretion of the audiology technician or audiological scientist.

Revised 09/01/89

## Appendix C

### Further information

- British Association of Audiologists (BAAT) [www.baat.org.uk](http://www.baat.org.uk)
- British Association of Audiological Scientists (BAAS) [www.baas.org.uk](http://www.baas.org.uk)
- British Association of Audiological Physicians (BAAP) [www.baap.org.uk](http://www.baap.org.uk)
- British Association of Otolaryngologists (BAOL) [www.ori-baohns.org](http://www.ori-baohns.org)
- British Society of Audiology (BSA) [www.b-s-a.demon.co.uk](http://www.b-s-a.demon.co.uk)
- British Society of Hearing Therapists (BSHT) [www.hearingtherapy.org](http://www.hearingtherapy.org)
- Department of Health [www.doh.gov.uk](http://www.doh.gov.uk)
- Department of Health, Social Services and Public Safety in Northern Ireland [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)
- Health of Wales Information Service (HOWIS) on the National Assembly for Wales internet site [www.wales.gov.uk/subihealth/index.htm](http://www.wales.gov.uk/subihealth/index.htm)
- Hearing Concern [www.hearingconcern.org.uk](http://www.hearingconcern.org.uk)
- LINK Centre for Deafened People [www.linkcentre.org](http://www.linkcentre.org)
- Modernising Audiology Services in Wales (MASW) [www.wales.gov.uk/subihealth/index.htm](http://www.wales.gov.uk/subihealth/index.htm)  
[www.rnid.org.uk](http://www.rnid.org.uk)
- Modernising Hearing Aid Services (MHAS) [www.doh.gov.uk/hearingaidproject](http://www.doh.gov.uk/hearingaidproject)
- MRC Institute of Hearing Research [www.ihr.mrc.ac.uk](http://www.ihr.mrc.ac.uk)
- National Association of Deafened People (NADP) [www.nadp.org.uk](http://www.nadp.org.uk)
- NHS National Institute for Clinical Excellence (NICE) Guidance on Hearing Aid Technology, July 2000 (Use the route: Technology appraisals > Completed appraisals > Hearing disability > Hearing aid technology > Full guidance) [www.nice.org.uk](http://www.nice.org.uk)
- Scottish Executive Health Department [www.show.scot.nhs.uk/sehd](http://www.show.scot.nhs.uk/sehd)

# Notes

# Notes



**RNID's vision is of a world where deafness and hearing loss are not barriers to opportunity and fulfilment.**

RNID is the largest charity representing the 8.7 million deaf and hard of hearing people in the UK. As a membership charity, we aim to achieve a radically better quality of life for deaf and hard of hearing people. We do this by campaigning and lobbying vigorously, by raising awareness of deafness and hearing loss, by providing services and through social, medical and technical research.

**Best practice standards for adult audiology was part-funded by the Department of Health and produced by a Taskforce led by RNID**

with representation from:

British Association of Audiologists (BAAT), British Association of Audiological Physicians (BAAP), British Association of Audiological Scientists (BAAS), British Association of Otolaryngologists (BAOL), British Society of Audiology (BSA), British Society of Hearing Therapists (BSHT), Department of Health, A General Practitioner, A Health Authority, Hearing Concern, LINK Centre for Deafened People, MRC Institute of Hearing Research, National Association of Deafened People (NADP)

England, Scotland, Wales and Northern Ireland were all represented on the Taskforce.

ISBN 0900634 96 0

£6.99

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July 2002 Registered Charity No. 207720



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