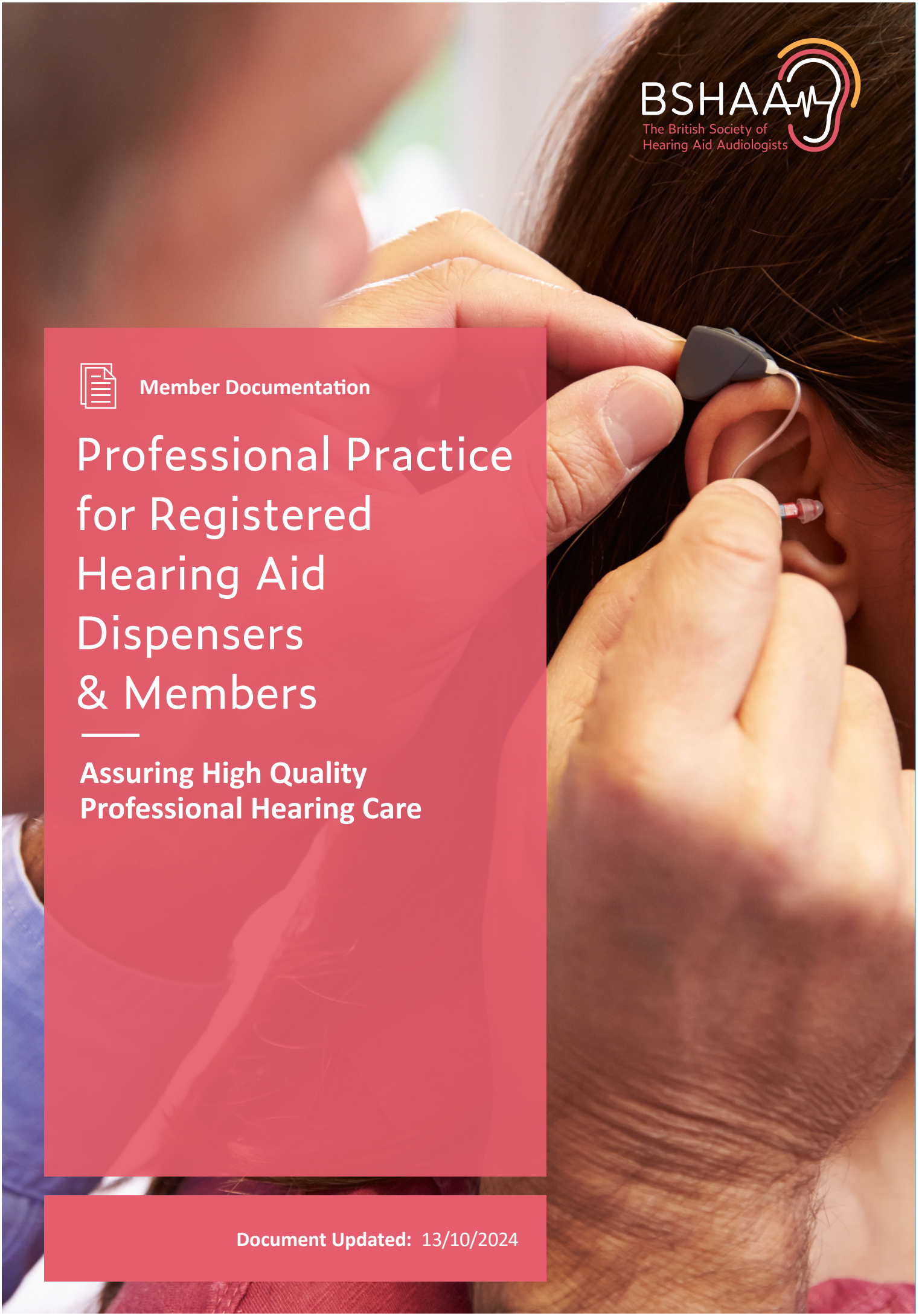


BSHAA
The British Society of Hearing Aid Audiologists

Member Documentation

Professional Practice for Registered Hearing Aid Dispensers & Members

Assuring High Quality Professional Hearing Care

Document Updated: 13/10/2024

Introduction

This booklet is written as guidance on good professional practices for practitioners who are members of

The British Society of Hearing Aid Audiologists (BSHAA).

It will be helpful with the interpretation of the Health and Care Professions Council (HCPC) Standards of Conduct, Performance & Ethics and Standards of Proficiency for Hearing Aid Dispensers (HADs).

This guidance will provide greater assurance that you will fulfill the HCPC requirements for a registrant.

Whilst this guidance is written for HCPC registered Hearing Aid Dispensers, the best practices should be adopted and followed by ALL members of BSHAA and is freely available to the sector as a whole.

For further advice or information, please contact:

BSHAA: membership@bshaa.org

Contents

Interpretation and Glossary

This document refers to "service users", "clients" and "patients", the terms are used interchangably and do not denote different descriptions and/or meanings.

What the HCPC Expects from You

Hearing Aid Audiologists who are registered Hearing Aid Dispensers must comply with the following standards set by the HCPC:

a. Standards of conduct, performance and ethics

b. Standards of proficiency

c. Standards for continuing professional development.

Further information about all of the HCPC's standards may be obtained:

a. From the HCPC's website:

http://www.hcpc-uk.org

b. By writing to the HCPC at:

Park House, 184 Kennington Park Road, London, SE11 4BU

Making and Keeping Records

Throughout this document, the importance of accurate, legible and complete records is strongly emphasised. All your activities and interactions with clients, their relatives and carers should be recorded.

1. Records should be:

   a. Objective recordings of your findings, of advice given and of other actions taken

   b. Clear and legible

   c. Made at the time and either signed and dated or securely recorded electronically

   d. In line with the latest GDPR requirements, particular care should be taken around:

      i. Storage of data

      ii. Usage of data

      iii. Sharing of data.

   Full details of which can be found on the Information Commissioners Office website at:

   https://ico.org.uk

2. You should ensure that all those for whom you are responsible, employ, manage or supervise understand the importance of accurate records relating to the services and/or advice given to clients.

3. In the absence of other guidance on health records in general, records should be retained in accordance with current legislation.

4. Previously completed records relating to an existing client who is being fitted with a new hearing aid system should be retained to accompany all new records. Such previously completed records should not be altered in any way to make any part of them illegible.

Confidentiality

1. In addition to your own professional duty to maintain client confidentiality, you should ensure that all those for whom you are responsible or supervise, should also respect the need for confidentiality in their dealings with clients, their relatives or carers and especially in respect of client records.

2. How you store clients' records and who is authorised to have access to them should take account of the importance of maintaining confidentiality.

3. In the event of a request for disclosure of a client's records by any person other than the client, you, or an appropriate person on your behalf, should obtain either written consent from the client or written confirmation that the person making the request has the authority to act on the client's behalf. If the client lacks the capacity to consent to the disclosure a decision must be made as to whether it is in the client's best interests to disclose any information, and if so what and to whom.

4. For more detailed information on the subject of confidentiality, refer to the HCPC Publication Guidance on confidentiality | (hcpc-uk.org)

Consent

1. Consent is only valid if it is "informed consent".

   Informed consent can be said to have been given if it is based upon a clear appreciation and understanding of the facts, implications and future consequences of an action.

   In order to give informed consent, your client must have adequate reasoning faculties and be in possession of all relevant facts at the time consent is given.

2. Consent can be spoken or written. If the service user has given you their consent verbally, an ongoing, up-to-date record of this must be recorded in their formal record.

3. The HCPC defines informed consent as being when “a service user has all the necessary information in a format they can understand so that they can make an informed decision about whether they want to have a particular treatment.” Plain language should also be used as much as possible, avoiding or explaining any technical terms.

4. Informed consent is particularly important for the following procedures:

   a. Otoscopic examination

   b. Pure tone audiometry

   c. Aural impression taking

   d. Aural care (Ear Wax Removal).

5. If a person is unable to make an informed decision (which includes giving consent) which is needed, the decision must be made in the person’s best interests by the person intending to provide the treatment, care or service that the patient needs.

   Making a best interests decision for another person is not a right owned by anyone. It is a defence - a person who makes a decision for another whom they reasonably believe is unable to make that decision for themselves is not liable if the decision was in the best interests of that person.

6. Treatment cannot be demanded. This applies as much in respect of a person unable to make decisions (who may be in need of care or treatment) as it does to a person who is able to make his/her own decisions. No-one can demand treatment and HADs must not provide treatment that is not in a patient’s best interests.

Onwards Referral for Medical or other Specialist Opinion

The protocol and criteria for receiving and making of a referral for medical or other specialist opinion is based on the understanding of the following key HCPC definitions:

Referral: "When a health professional asks another practitioner to take over the care of a service user because it is beyond their scope of practice or because the service user has asked for a second opinion."

Scope of practice: "The area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself."

Receiving Referrals

Service users might consult HADs in multiple ways, including but not limited to:

I. Directly without referral

II. Referral from medically qualified colleagues specialising in a field related to hearing – e.g., Ear, Nose and Throat (ENT) Surgeons, audio-vestibular physicians etc.

III. Referral from clinically qualified colleagues without relevant specialist expertise; e.g., General Practitioners, optometrists, other audiologists/HADs or those performing wax removal etc. It is recognised that not all audiologist/HADs provide enhanced level of services such as for wax removal, undertaking vestibular function testing and/or tinnitus assessments etc. They may have a local network for referring their service users to other audiologists/HADs who offer these services.

IV. Other reasons, for example, for wax removal or advice on noise protection etc.

Onwards Referral for Medical or other Specialist Opinion

I. Service users accessing services directly without a referral

People have always been able to access private hearing care directly from HADs without the need for a referral letter and this is standard practice across the UK.

Current UK norms therefore mean that service users can access hearing care directly from HADs if they fund their own care but should see their GP or self-refer to NHS Audiology if they want any provision to be NHS funded.

II. Referral from medically qualified colleagues specialising in a field related to hearing

A service user might be seen and treated by a doctor with a relevant hearing care specialty and then referred to you for ongoing management/support. It is appropriate for HADs to accept these referrals provided each HAD works within their own scope of practice. For example:

- An ENT specialist might diagnose a hearing loss and refer a service user to you for hearing assessment and hearing aids.
- You refer a service user to ENT or a GP for a medical opinion (e.g., for unilateral tinnitus, sudden hearing loss or dizziness etc.) and once treated/discharged, they are referred back to you for ongoing support with hearing loss.

Someone born with hearing loss might decide as an adult to access private hearing care and therefore the NHS audiology service might refer these service users to you.

III. Referral from clinically qualified colleagues without relevant specialist expertise

HADs should accept referrals that are within their scope of practice and where it is in the interests of the service user to do so. This is straightforward when providing services in the private sector. For example, a colleague might refer certain tinnitus patients to you if they are within your scope of practice.

There are many other scenarios in which HADs may receive referrals from other clinically qualified colleagues. Often the case presentation will influence how service users access care.

IV. Other reasons

Service users may access the hearing care service for a variety of reasons, which may or may not be related to their hearing ability. For example, they may want to get earwax removed by an appropriately qualified professional. Service users may also visit HADs for devices for music/noise protection or swim moulds etc.

Onwards Referral for Medical or other Specialist Opinion

Making Referrals

You should establish any requirement for referral of a client for a medical or other specialist opinion and/or treatment on at least the following occasions and for the following reasons:

1. When you are consulted by a client for the first time.
2. When a client has not been seen by you or other appropriately qualified professional for at least twelve months.
3. Whenever your client reports or you find a change in hearing or in any condition arising in or related to the auditory or vestibular systems which, in your professional opinion, is significant.
4. Subject to the guidelines below, the criteria for the referral of a client for a medical or other, specialist opinion and/or treatment are as follows:

a The whole or partial obstruction of the external auditory canal that would not allow proper examination of the eardrum and/or the safe and accurate taking of an aural impression. This particularly refers to the presence of wax and/or foreign bodies.

b. Abnormal appearance of the eardrum and/or the outer ear such as:

i. Inflammation of the external auditory canal or outer ear

ii. Perforated eardrum

iii. Active discharge

iv. Abnormal bony or skin growths

v. Blood in the ear canal

c. Recurring or persistent pain affecting either ear (in or around) which has lasted for more than seven days and has not responded to treatment or subsided.

d. Service users with hearing loss who are immunocompromised and have otalgia (earache) with otorrhoea (discharge from the ear) that has not responded to treatment within 72 hours[1].

e. Discharge from the ear, other than wax, which has not resolved and/or is recurring.

f. Unexplained conductive hearing loss where audiometry shows an average 20dB or greater air-bone gap across three or more of the following frequencies: 500, 1000, 2000, 3000 or 4000Hz (3000 and 4000Hz only need testing where an ABG of 20dB or more exists at one or more of the other frequencies).

Onwards Referral for Medical or other Specialist Opinion

g. A unilateral or asymmetrical hearing loss, 15dB or more asymmetry between two or more adjacent air or bone conduction frequencies (500, 1000, 2000, 4000 and 8000 Hz).

h. Sudden onset of hearing loss or sudden deterioration in hearing. Sudden is within 3 days and within the last 30 days.* (where this has occurred more than 30 days ago[2])

i. Rapid onset of hearing loss or rapid deterioration in hearing. Rapid means within the last 4 - 90 days.[2]

j. Fluctuating hearing loss not associated with an upper respiratory tract infection.

k. A middle ear effusion in the absence of, or that persists after, an acute upper respiratory tract infection.

l. Service users of Chinese, south-east Asian, North African, Inuit or Yupik family origin who have hearing loss and a middle ear effusion not associated with an upper respiratory tract infection[2].

m. Objective or persistent tinnitus that is unilateral, pulsatile or has significantly changed in nature within the last 6 months or is causing distress.

n. Vertigo or other disturbance of balance which includes dizziness, swaying or floating sensations (frequently associated with unsteadiness) that may indicate otological, neurological or medical conditions

o. If your client is under the age of 18 years.[3]

p. Facial numbness with an acquired unilateral hearing loss on the same side.[1]

q. Hearing loss that is not age-related.

r. Hearing losses which may be suitable for implantable devices such as cochlear implants, bone anchored hearing aids, middle-ear implants or auditory brain stem implants, if these might be suitable.

s. Patients with severe to profound hearing loss who do not receive adequate benefit from hearing aids.

t. Any other unusual presenting features which, in your professional opinion, should be the subject of medical or other specialist investigation.

(eg. - deterioration of hearing, many factors can affect the rate of deterioration, such as age, diet, noise or medical conditions/treatments – investigation should be arranged where deemed necessary).

In this context you must be particularly mindful of your duty to work within the limits of your scope of practice.

Footnotes

1. Immediate referral to emergency ENT to be seen within 24 hours.
2. Urgent referral to be seen within 2 weeks by ENT or audio vestibular medicine.
3. CQC registration may be required for the evaluation, fitment or supply of Hearing Aids to anyone under the age of 19 where their assessment is not taking place in or has been arranged through their educational institute.

Onwards Referral for Medical or other Specialist Opinion (cont.)

HADs would be expected to refer the signs and symptoms above for a medical opinion unless there is a clear reason not to do so. For example, if a medically qualified colleague has referred somebody with troublesome tinnitus to a HAD for support with an underlying hearing issue, then the HAD would not have to automatically re-refer the service user, although good communication between professionals and the service user would remain a priority.

However, where any of the signs or symptoms have not been referred before or not satisfactorily treated/ managed or discharged and are outside your scope of practice then you should refer the service user onwards to a suitably qualified practitioner.

For further detail on the above conditions, refer to appendix 1. found on pages 16-18.

When a Referral may not be Required

5. Clinicians, in consultation with the service user, might make a professional judgement that an onward referral is not the preferred course of action.

   This may arise:

   a. when there is sufficient evidence (ideally clinical notes) that the condition has been fully investigated by your client's GP and/or appropriate medical specialist and any treatment has been provided.

   b. If the condition has not worsened or changed significantly since the previous investigation and/or treatment.

   c. If the condition lies within the HADs scope of practice, because they have training and experience in dealing with the condition e.g., HADs appropriately trained to remove obstructions (ear wax or a foreign body such as the dome of the acoustic coupler of a hearing device) from the ear canal, and/or tinnitus management etc. Therefore, clinicians are encouraged to make their own professional judgement whether a service user's condition is outside their scope of practice.

6. When your client has made an informed decision not to accept your advice to seek a medical opinion[4], you may proceed to recommend appropriate hearing aid systems subject to the following considerations:

   a. The recommendation will not have any adverse effects on your client's health or general wellbeing

   b. You reasonably believe that your client is capable of making the informed decision either independently or with the assistance of a close member of their family, a carer or other competent advisor

   c. Clients known or suspected to be suffering from any condition affecting their ability to make informed decisions should be advised by a person who can and has the authority to act on your client's behalf and in your client's best interests

   d. Your records confirm that all necessary considerations about your client's best interests have been made.

Footnote

4. In all cases HADs should try and obtain a written consent acknowledging the risks of both not referring and also proceeding with management options such as fitting of hearing devices (where applicable). With the client's consent you should inform their GP about the descision.

When a Referral may not be Required (cont.)

Procedure for Making a Referral

7. When you identify the need to advise your client to seek a medical or other specialist opinion the following actions should be taken:

   a. You should obtain your client's consent before you provide information to their GP or appropriate specialist.

   b. If your client is under 16 years of age, before you provide information to their GP or other appropriate specialist you should obtain the consent of their parent(s) or person with parental responsibility. [5.]

   c. Your client's GP or other appropriate specialist should be informed, preferably in writing and without delay, about the reason(s) for advising your client to seek medical advice.

   d. The information to the GP or other appropriate specialist should, whenever possible, be sent directly rather than via your client.

   e. The information provided to the GP or other appropriate specialist should be as detailed as is appropriate and, when relevant, should include the client's most recent audiogram and any previous audiogram which is also relevant.

   f. The information provided to the GP or other appropriate advisor should be unambiguous and include sufficient information to ensure that your client is properly identified. This identification should be achieved by the inclusion of at least the following personal information:

      i. Their title, forenames or initials and surname

      ii. Their home address with postcode

      iii. Their date of birth

      iv. If known, their NHS number.

   g. The information provided to the GP or other appropriate specialist should be accompanied by information to facilitate any reply or request for further information.

   h. A copy of any report to the GP or other appropriate advisor should be made available on request to your client or the appropriate person acting on their behalf.

   i. A copy of any report to the GP or other appropriate advisor and of the consent to provide such a report should be retained by you with your client's other case records.

When a Referral may not be required (cont.)

8. In the event of your client being under the age of 16 years, the following should be observed before you recommend appropriate hearing aid systems: [6]

   a. All advice given and action taken is with the knowledge and consent of your client's parent(s) or guardian(s).

   b. All advice and actions taken are in your client's interests without any foreseeable risk of adversely affecting their physical or mental health, education, communication abilities or general development.

   c. Your client's hearing impairment has been the subject of all appropriate audiological assessment under the NHS.

   d. No advice is given, or action taken, which could potentially conflict with or affect any continuing treatment provided at any NHS Audiology or ENT clinic without the written approval of either your client's GP or ENT Consultant.

   e. Your client's mental or physical conditions do not require any professional competencies which are outside your scope of practice, training or experience.

   f. Any financial or other implications from the fitting of a hearing aid system have been fully considered and all those involved fully informed. This particularly applies to implications for the effectiveness of the hearing aid system resulting from your client's physical growth.

9. In all cases of immediate referrals (to be seen within 24 hours) – service users should be directed to emergency ENT care via A&E.

10. In all cases of urgent referral (to be seen within 2 weeks) where a direct pathway to urgent care ENT or audio vestibular medicine is not available, referral letters should be marked "URGENT" and referrals made to the service users' GP.

Footnotes

5. Consent by persons over 16 to surgical, medical and dental treatment.

   (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

   (2) In this section "surgical, medical or dental treatment " includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

6. CQC registration may be required for the evaluation, fitment or supply of Hearing Aids to anyone under the age of 19 where their assessment is not taking place in or has been arranged through their educational institute.

Appendix 1.

Pain	Persistent pain from a normal looking ear could be referred pain from a sinister pathology and should be investigated. **(Harrison & Cronin ,2016)**
Immunocompromised hearing loss, otalgia & otorrhea (72 hours)	Immediate referral for investigation to rule out sinister pathology such as necrotising otitis externa.
Conductive loss	Where of no obvious cause and not previously investigated, to exclude underlying treatable conditions.
Unilateral/asymmetric losses	Up to 10% of the population will have asymmetry of up to 15dB*, investigation via MRI should be considered to rule out underlying cause.* (British National Study of Hearing, Davis 1989)
Sudden losses	Sudden sensorineural hearing loss is defined as 30db or more at 3 consecutive frequencies. (Stachler et al, 2012)
Fluctuating losses	Test/retest reliability is within 5dB, changes of 10-15dB or more within a relatively short period of time may be considered to be fluctuating.

Appendix 1. (cont.)

Effusion (Glue ear)	Unilateral effusion in adults should be investigated to rule out post nasal space pathology. (Leonetti, 2013) Urgently, where of Chinese, South East Asian, North African, Inuit or Yupik family origin. (Nice NG98)
Tinnitus	Service users with bilateral tinnitus and symmetrical hearing loss are not likely to show retro-cochlear pathology under MRI and therefore may be managed if within your Scope of Practice.
Vertigo	Although the cause of the balance issues may not always be a sinister pathology, the condition is often functionally debilitating so, may require immediate attention. This is particularly important for service users who are 65 years or older as they are at the highest risk of falling, which may result in further morbidities and also mortality. (NICE, 2013; Pothula, Chew, Lesser, & Sharma, 2004)
Numbness	This may be a symptom of Bell's Palsy (where symptoms develop quickly within 48 hours); or more sinister pathologies such as Lyme disease, Parotid tumour, Stroke. Facial numbness or weakness may be accompanied by aural fullness, otalgia, drooling from mouth and pain around the jaw. (NICE, 2012).
Non-age-related losses	Most hearing loss is age related. NICE defines this in NG98 as usually starting in the 50s or 60s and as being a slowly progressive high frequency, sensorineural loss. Whilst prescribing hearing aids to "non-age-related losses" is considered to be within the scope of HCPC registered HADs, where this is of no obvious cause and has not been previously investigated – you should consider the need for onwards referral. (obvious causes should be identified during individual case history) and whilst this would not usually delay the provision of hearing aids, service users should always make an informed decision.

Appendix 1. (cont.)

Implantable devices, such as middle ear, BAHA, Cochlear or brainstem	*"In cases where the person is unable to gain adequate amplification from conventional hearing aids consideration should be given to alternative strategies including implantable devices such as cochlear implants, bone anchored hearing aids, middle ear implants or brain stem implants and referral for consideration of these should be discussed".* (Nice NG98) Whilst it is expected that any conductive element large enough to benefit from a BAHA or middle ear implant should be thoroughly investigated (if not previously done so) cochlear and/or brain stem implants are much more complex considerations and patients should always be helped to make an informed decision on their choice of care. *"Cochlear implantation should be considered for children and adults only after an assessment by a multidisciplinary team. As part of the assessment children and adults should also have had a valid trial of an acoustic hearing aid they have had a valid trial of an acoustic hearing aid for at least 3 months (unless contraindicated or inappropriate)"* (NICE TA566) Brain stem implants *"This procedure is suitable for a small proportion of patients who have complete hearing loss for whom no alternative treatment would restore hearing"* (NICE IPG108)
Severe-profound losses not receiving adequate benefit from hearing aids	Severe to profound deafness is defined as having audiometric thresholds of 80 dB HL or more at 2 or more frequencies (500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz and 4,000 Hz) bilaterally without acoustic hearing aids. (NICE TA566) Adequate benefit is not clearly defined – it is suggested as a phoneme score of more than 50% for adults on the Arthur Boothroyd word test presented at 70 dBA, this is however, drawn from consensus and not clinically evidenced. It is helpful to consider that much of the benefit provided by hearing aids is subjective and that perceived benefit can vary greatly even between service users who achieve the same objective improvement. Hearing aid dispensers are encouraged to work with service users in understanding limitations from the use of hearing aids in all cases but especially those with more complex losses. No individual cases or expectations are alike and patients should always make an informed decision.

Ensuring Informed Decisions

1. The requirements for giving informed consent are the same as for any other informed decision, because giving consent is a decision.

2. The ability of a client or appropriate person acting on their behalf to make an informed decision about whether or not to accept your advice is dependent on:
    a. The information made available to your client prior to making a decision.
    b. Your client's capacity to make an informed decision.
    c. The same information being made available to any third party whose involvement will ensure that the most appropriate and informed decision is made by or on behalf of your client.

3. You must provide your client (and their relatives or carers if appropriate) with advice on the basis of improving your client's quality of life.

4. At the conclusion of the pre-fitting procedures, your client (and their relatives or carers if appropriate) should be in a position to make an informed decision about whether or not to accept your recommendations about a hearing aid system. This should include considerations of affordability.

5. All written or printed information should be provided in an easily readable form. If any pre-printed material is accompanied by handwritten information, this should be written legibly.

6. All printed material should be made available in large print on request.

7. If your client's informed choice is not to accept your recommendations and advice, it is particularly important that a clear, written record is made about your client's non-acceptance of any of the following:
    a. Referral to their general medical practitioner or other appropriate medical or non-medical specialist.
    b. Recommendations for appropriate hearing aids including whether the fitting should be bilateral and, if unilateral, which ear should be aided.

Taking & Recording of Case Histories

1. When appropriate and acceptable to your client, all reasonable endeavours should be made to ensure that they are accompanied by a relative, advisor or carer.

2. Your client's personal details should be obtained or confirmed in either manual or electronic format. The detail should be sufficient to clearly and unambiguously identify the client concerned.

3. If the primary contact details are not those of your client, these should be recorded or confirmed as appropriate. All associated records should clearly state that the primary contact is not your client and any other relevant information should also be recorded for future reference.

4. The case history should be recorded at an early stage in the consultation process.

5. The case history record should contain all the information obtained from your client to inform you (or any other relevant person) as fully and as accurately as possible about the cause(s) and the effects of your client's hearing impairment as well as any other matters which may affect your advice.

6. The findings from the case history should be recorded either as part of written case notes or as an electronic record or both. Whichever method of recording the findings is chosen, the following should apply:

    a. Your client should be clearly identifiable.

    b. The date on which the case history was taken is stated.

    c. Descriptions of findings should be unambiguous.

7. The case history should include information at least about the following:

    a. When the hearing loss was first noticed.

    b. Nature of the onset of the hearing loss.

    c. Any actual or potential cause(s) of the hearing loss including any relevant family history or genetic influence.

    d. The detailed effects of the hearing loss on the lifestyle of your client and, in particular, situations in which hearing difficulties are regularly experienced or in which it is important to your client that the hearing handicap is minimised.

Taking & Recording of Case Histories (cont.)

e. Previous hearing assessments and hearing aid experience including when and by whom undertaken and outcomes if known.

f. Any known or reasonably foreseeable allergy or hypersensitivity which may be relevant to the use of a hearing aid system.

g. Any relevant, previous medical or surgical interventions including when and by whom undertaken and outcomes. This includes information about medications and other therapies if known.

h. Any known or suspected asymmetry of hearing loss.

i. Any of the following conditions relating to the ear(s) or hearing and whether any condition is currently experienced or is in the recent or more distant past:

    i. Tinnitus.

    ii. Vertigo.

    iii. Pain in or around the ear(s).

    iv. Discharge in or from the outer ear.

    v. Onset or progress of the hearing loss.

    vi. History of excessive noise exposure.

    vii. Any other significant conditions relating to the auditory system and the client's general physical and mental health.

j. The contact details of your client's GP.

It is recommended that the case history is supplemented by the results of a hearing needs assessment.

Clinical Procedures

Otoscopy

Otoscopy, conducted by you working within your scope of practice, should follow the current British Society of Audiology (BSA) recommended procedure.

BSA Recommended Procedure for Ear Examination:

https://www.thebsa.org.uk/wp-content/uploads/2024/10/OD104-129-Minimum-Training-Guideline-Otoscopy-and-Impression-Taking.pdf

(Accessed on 31/10/2024

Pure Tone Audiometry

Pure tone audiometry, conducted by you working within your scope of practice, should follow the current British Society of Audiology (BSA) recommended procedure for pure tone audiometry.

BSA Recommended Procedure for Pure Tone Audiometry:

https://www.thebsa.org.uk/wp-content/uploads/2023/10/OD104-32-Recommended-Procedure-Pure-Tone-Audiometry-August-2018-FINAL-1.pdf

(Accessed on 31/10/2024

Aural Impression Procedures

Aural impressions, conducted by you working within your scope of practice, should follow the current British Society of Audiology (BSA) recommended procedure.

BSA Recommended Procedure for Taking an Aural Impression:

https://www.thebsa.org.uk/wp-content/uploads/2024/08/OD104-33-Taking-an-Aural-Impression.pdf

(Accessed on 31/10/2024)


Oticon Real and Oticon Zircon styles
Oticon Real colours
miniFit receivers
MicroShells
Power flex mould*
Accessories for miniFit receivers
Grip Tips have a tacky texture to help with retention
Customised earpieces*
Micro mould
MicroShell
Power flex mould

Prescriptions and Rehabilitation/ Individual Management Plans

1. After hearing aid prescription, you should record all appropriate information relating to:
   a. The manufacturer, model and fitting style of the hearing aid(s) to be supplied.
   b. The characteristics of any earmoulds or earfitting(s).
   c. The ear(s) being fitted.
   d. The signal processing technology and associated technical features.
   e. Any reasonably foreseeable limitations of the hearing aid system to be fitted based on what is known about your client's hearing loss and related conditions, lifestyle needs, physical and mental capacities.

2. After deciding the rehabilitation/individual management plan, you should record all appropriate information relating to:
   a. The rehabilitation advice as the most appropriate to optimise outcomes based on the needs and abilities of your client and on any previous hearing aid experience.
   b. The timing and purpose of the post-fitting review appointments.

3. Your client and, when appropriate, their relatives or carers should be provided with a written summary of all of the advice given at the fitting appointment including how to obtain advice or assistance between post-fitting review appointments.

4. The actions taken and outcomes of all post-fitting review appointments, including the results of outcome measure questionnaires, should be recorded.

Remote Appointments (Tele-Health)

The recent pandemic has expedited what can be done remotely. Many manufacturers now provide remote services in order to connect, monitor and fine-tune their hearing aids via an internet connection, usually in combination with a smartphone.

This can increase patient satisfaction, enabling some level of "help, guidance and adjustment" to be available without the patient needing to visit a clinic in person.

However, this should not be used for a first fitting, save in exceptional circumstances (e.g., if a service user is in hospital and their hearing aids are being replaced due to them being lost and it is not possible to arrange a physical appointment). Where this does happen, arrangements should be made for a follow-up appointment to take place in person, as soon as practicable.

The features available to professionals vary from one manufacturer to another and whilst some do now offer the provision of in-situ-audiometry, this does not replace the requirement for Puretone audiometry for the monitoring of hearing thresholds to identify the need for audiometric onward referral; nor is it a replacement for the conducting of real-ear measurements.

HADs are reminded that confidentiality also extends to the use of electronic media as stated in the HCPC standards of proficiency and therefore remote appointments should only ever be conducted over a secure connection and in an environment where confidentiality can be maintained.

Where follow-up appointments are taking place remotely physical considerations of patient management of the hearing aids should always be made, e.g.

i. Is the patient able to fit/remove the hearing aids?
ii. Is the patient able to manage battery renewal and/or recharging?
iii. Is the patient able to conduct basic, required maintenance such as wax filter/dome replacement?

Clinical judgement must be used as to when a further physical appointment is required to resolve any concerns.

Maintaining your Practice Environment

Covid 19 Pandemic

1. The recent pandemic has taught us the importance of maintaining stringent health safety protocols within audiology. While this field is generally viewed as a low-risk pathway, practitioners must continue to adhere to the latest guidance on permissible clinical activities and the appropriate use of personal protective equipment. Following recommended triaging systems and conducting local risk assessments where necessary ensures the safety of both practitioners and patients.

Practice Environment in General

2. The overall requirement is that premises in which clients are assessed and in which service, care and attention are provided must have an appearance and functionality which is professional and safe in all the areas to which clients, their relatives or carers have access as well as being a safe environment for all those who work there.

3. When relevant, the guidance and recommendations in this document also apply to the environment in which domiciliary services are provided.

Consulting Room

4. The consulting room, whether it is the audiometric test environment or not, should comply with the following:

    a. Be safely and easily accessible from the reception area with all account being taken of the requirements of those with impaired vision and/or mobility problems.

    b. Along with its access areas, be maintained in a manner which is consistent with professional premises.

    c. The room and its access areas should not display any advertising material which would be inappropriate for professional hearing care premises or misleading as to the products and services available at or through the premises.

    d. It should be a safe and comfortable environment for all who have access to it.

    e. It should have the furnishings, equipment and ancillary items which enable you to comply with all relevant standards of professional practice including access to facilities to ensure personal and equipment hygiene.

The Value of Reflection on Practice

1. You have a personal responsibility to keep your knowledge and skills up to date in order to ensure that you remain able to provide your clients and their relatives or carers with the best possible advice at all times.

2. In order to meet your obligations for Continuing Professional Development (CPD) you should ensure that you are fully conversant with the Health and Care Professions Council's Standards for Continuing Professional Development.

3. An essential component of CPD is regular reflection on practice, recording the learning outcomes from such reflection and how these may be of benefit to future service provision.

4. You should maintain and keep up to date a portfolio containing the evidence of your CPD activities and your records of the outcomes of your reflections on practice.

   The electronic CPDme portal is available free as part of BSHAA Membership and is well suited for this purpose.

References

NICE NG98 https://www.nice.org.uk/guidance/ng98

NICE TA566 https://www.nice.org.uk/guidance/ta566

NICE IPG108 https://www.nice.org.uk/guidance/ipg108/resources/clinical-classification-codes-pdf-8715583117 (Accessed 31 October 2024)

National Community Hearing Association guidance on https://www.the-ncha.com/members/guidance-and-support/cqc-guidance/ (Accessed 31 October 2024)

Mental Capacity act https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act (Accessed 8 September 2023)

HCPC https://www.hcpc-uk.org/standards/meeting-our-standards/confidentiality/guidance-on-confidentiality/ (Accessed 9 September 2023)

HCPC https://www.hcpc-uk.org/cpd/ Accessed on 9 September 2023)

HCPC Standards or proficiency 1st Sept 2023 https://www.hcpc-uk.org/standards/standards-of-proficiency/hearing-aid-dispensers/ (Accessed 31 October 2024)

HCPC https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/ (Accessed 31 October 2024)

CPDme https://www.cpdme.com/cpdportfoliobuilder (Accessed on 9 September 2023

Covid 19 Joint Otology Pandemic guidance (Accessed on 9 September 2023)

Davis, A. C. (1989). The prevalence of hearing impairment and reported hearing disability among adults in Great Britain. International Journal of Epidemiology, 18(4), 911–917. http://doi.org/10.1093/ije/18.4.911 (accessed 13 September 2023)

Harrison, E., & Cronin, M. (2016). Otalgia. Australian Family Physician, 45(7), 493–497. https://www.racgp.org.au/download/Documents/AFP/2016/July/AFP-July-Clinical-Harrison.pdf (accessed 13 September 2023)

Leonetti, J. P. (2013). A study of persistent unilateral middle ear effusion caused by occult skull base lesions. Ear, Nose and Throat Journal, 92(4), 195–200. A Study of Persistent Unilateral Middle Ear Effusion Caused by Occult Skull Base Lesions (researchgate.net) (Accessed 13 September 2023)

Stachler, R. J., Chandrasekhar, S. S., Archer, S. M., Rosenfeld, R. M., Schwartz, S. R., Barrs, D. M., … Robertson, P. J. (2012). Clinical Practice Guideline. Otolaryngology-Head and Neck Surgery, 146(3_suppl), S1–S35. http://doi.org/10.1177/0194599812436449 (Accessed 13 September 2023)

Pothula, V. B., Chew, F., Lesser, T. H. J., & Sharma, a. K. (2004). Falls and vestibular impairment. Clinical Otolaryngology and Allied Sciences, 29(2), 179–182. Falls and vestibular impairment - Pothula - 2004 - Clinical Otolaryngology & Allied Sciences - Wiley Online

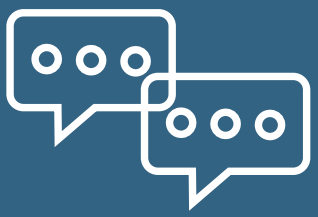
References

Library (Accessed 13 September 2023)

NICE. (2012). Clinical Knowledge Summaries. Clinical Knowledge Summaries. https://cks.nice.org.uk/bells-palsy#!topicsummary (Accessed 13 September 2023)

Determining the cause of tinnitus | Diagnosis | Tinnitus | CKS | NICE (Accessed 13 September 2023)

Document Title:	BSHAA Professional Guidance for Hearing Aid Dispensers and Members
Version Number & Date:	FINAL 13.10.2024
Author:	Michael Marchant and Richard Lindup
Consultation Directors:	Complete
Date Approved:	29.10.2024
Approved By:	The BSHAA Board
Effective From Date:	01.11.2024
Date of Review:	01.11.2026



Queries & Questions

BSHAA has taken all reasonable steps to ensure that the information in this guide is accurate and up to date.

BSHAA does not accept any liability for any errors or omissions, or for how it might be interpreted or used.

The Society welcomes comments on this document or if you have any questions or queries, please contact us through:

The British Society of
Hearing Aid Audiologists
61 Bridge Street,
Kington,
Herefordshire,
HR5 3DJ

membership@bshaa.org

bshaa.org

BSHAA
The British Society of
Hearing Aid Audiologists

Published by the British Society of Hearing Aid Audiologists, 2023