BSHAA
British Society of Hearing Aid Audiologists

BSHAA Guidance on Record Keeping

Assuring High Quality Professional Hearing Care

Introduction

How you keep client records is a fundamental part of your professional practice and interpretation of this guidance is up to you. BSHAA have set out what it considers to be best advice. The recommendation is that you should not ignore this guidance.

The Customer Care Scheme provides practical follow up advice to audiologists/companies if it feels this may help to provide a better outcome to resolve future complaints. BSHAA was asked to share these tips/good practice on record keeping.

This guidance has been produced by BSHAA Customer Services Committee in conjunction with BSHAA's Professional Development Committee, as the Committee responsible for professional standards.

The guidance has been split into two parts. The first part covers the basic record keeping requirement for all audiologists. The second part draws on experiences from actual Customer Care Scheme cases.

If you are in dispute with a client your strongest defence is a well written client record.

"If it's not written down it did not happen."

Contents

PART 1 Guidance on record keeping

This document should be read in conjunction with the BSHAA Guidance on Professional Practice for Hearing Aid Audiologists

1. When appropriate and acceptable to the client, all reasonable endeavours should be made to ensure that the client is accompanied by a relative, advisor or carer who is able to be present throughout the first consultation. Record that this request has been made. (see Section 1 in the Practical Guidance section).
2. The client's personal details should be confirmed in either manual or electronic format. The detail at this stage should be:
    i. Title.
    ii. Forename(s).
    iii. Surname.
    iv. Full postal address including postcode.
    v. Primary contact telephone number.
    vi. Date of birth.
    vii. Optionally, e-mail address, if it is a method of communication preferred by the client.
3. If the primary contact details are not those of the client, these should be recorded or confirmed as appropriate. All associated records should clearly state that the primary contact is not the 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 the client which, informs the Hearing Aid Audiologist as fully and as accurately as possible about the cause(s) and the effects of a client's hearing impairment as well as about any other matters which may affect the Hearing Aid Audiologist's advice.

6. The information recorded in the case history should be based on a series of structured questions to the client and to any relatives or carers who can contribute confirmatory or additional significant information.

7. The findings from the case history exploration 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. The client should be clearly identifiable.
    b. The date on which the case history was taken is stated.
    c. Descriptions of findings should be unambiguous.
    d. The identity of the person taking the notes.

8. Records should be retained in accordance with legislation relating to health records. In the absence of other guidance, records should be retained for a minimum of seven years.

9. 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 the client and, in particular, situations in which hearing difficulties are regularly experienced or in which it is important to the client that the hearing handicap is minimised.
    e. Previous hearing assessments and hearing aid experience including when and by whom undertaken, outcomes if known, what hearing aids were previously fitted and when.
    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 or other balance problems, if so when was the last attack?
    iii. Pain in or around the ear(s).
    iv. Discharge in or from the outer ear.
    v. Does the client have a perforated ear drum? If so how long ago?
    vi. Onset or progress of the hearing loss.
    vii. History of excessive noise exposure.
    viii. Any other significant conditions relating to the auditory system and the client's general physical and mental health.
j. The contact details of the client's general medical practitioner.
k. Is the client under any medication eg Warfarin?
l. Does the client have a history of wax discharge?

⑩ It is recommended that the case history is supplemented by the results of a hearing needs assessment.

PART 2 Practical guidance on maintenance of client records

❶ Special considerations when conducting domiciliary visits.

1.1 When making every appointment ask the client to have a support person present.

- **Record** on the client record that this request has been made.
- **Record** who the support person was, if they actively participated in the appointment and were given an opportunity to participate.
- **Ask the client to sign** a slip to acknowledge that the client has been asked for a support person to be present and has declined the request.

1.2 At the domiciliary initial assessment:

- **Advise** the client that they have a 14 day cancellation period from the date of the contract in which they can cancel and leave a cancellation slip as part of their documentation. **Record** that this has been done.
- If the product is going to be custom made and therefore does not qualify for the 14 day cancellation period **explain** this to the client, **record** that this has been explained to the client. Ask the client to sign a waiver to their right to the cancellation period. Retain this documentation/scan it into the client record.

  (See the Terms & Conditions of Sale template on the BSHAA website).
- If the client is very elderly (to avoid claims that they did not have mental capacity) explain the trial period at the beginning of the appointment and ask them to repeat this at the end of the appointment. **Record** that this has been done.
- **If in doubt** about mental capacity make another appointment and take a colleague with you.

❷ All initial assessment appointments. **Record**:

- Details of any aids that have been demonstrated.
- That the length of any trial period has been explained.
- The implications of any financial agreement have been explained.
- If a cheque has been filled in for the client at their request (avoid this if at all possible).
- That the client has been advised of any manufacturers guarantee period and what is included in the aftercare service that is offered.

❸ At the fitting appointment. **Record**:

- The date of the follow up appointment and make it prior to the expiry of the trail period.
- How well the client gets on with the instruments or if there are any difficulties with the client changing batteries/fitting the instruments.
- If the client advises anything positive and anything negative.
- That the cleaning regime has been explained and that a leaflet was left.
- Details of any structured rehabilitation programme.

❹ At the follow up appointment. **Record**:

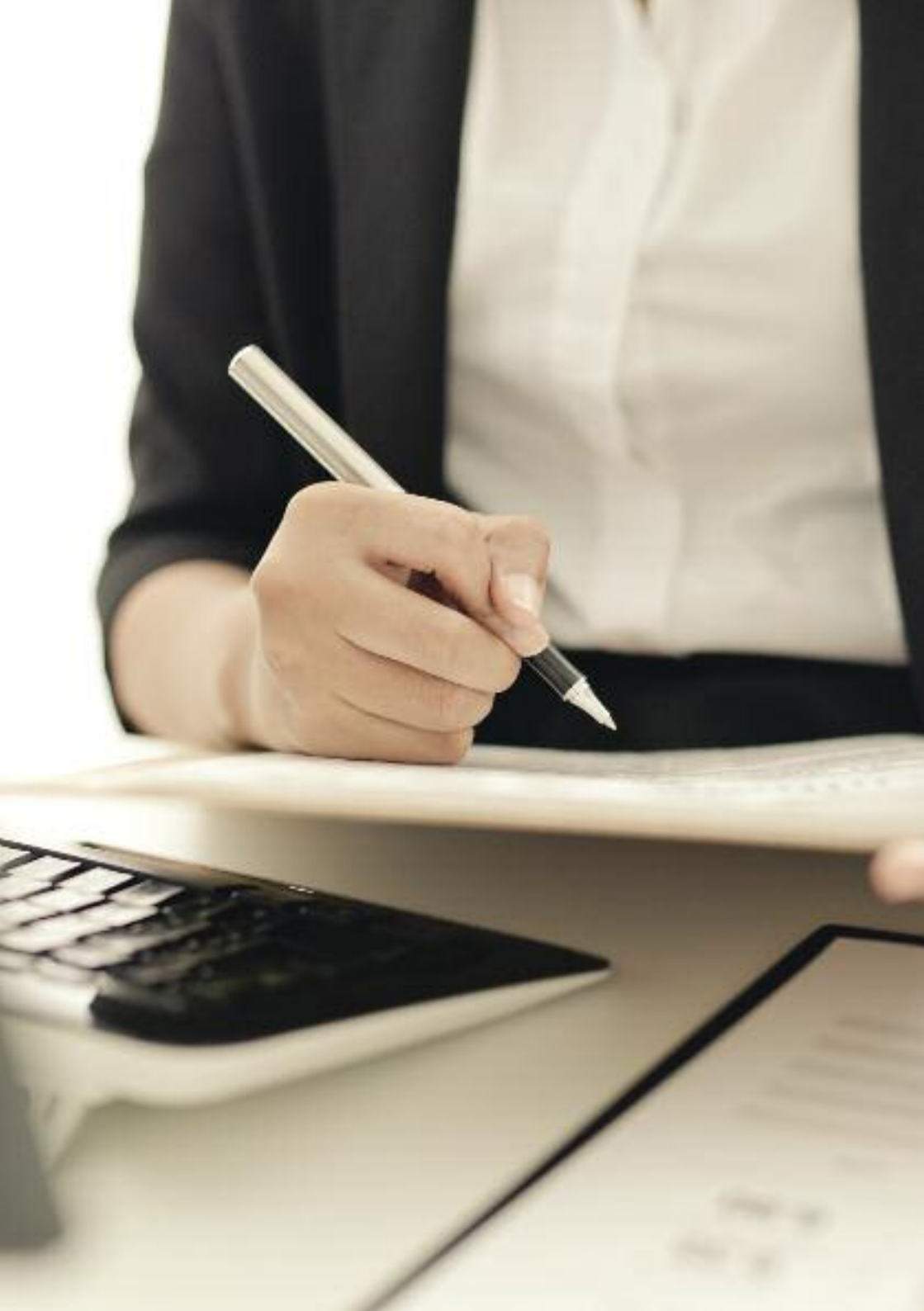
- All the issues the client has and what was done to rectify any problems.
- Reasons why any fine tuning was carried out.
- The impression of how the client is getting on with the instruments.
- Any positive things the client advises.
- Record the details of any outcome measures eg COSI, IOIHA, Glasgow.
- That the client was reminded when the trial period will come to an end.
- The terms, if replacement instruments are given instead of a refund, whether they have another trial period or not and whether this is in lieu of a refund and send this to the client in writing so there is clarity, subject to it not affecting their statutory rights.
- If a refund was requested by the client, the reason why this was not given.

❺ Subsequent appointments. **Record**:

- If the trial period is extended and give to the client written confirmation.
- If the client was wearing the instruments at the beginning of the visit.
- If the client is an experienced hearing aid user.
- Why an appointment was requested.
- What was done at the appointment.
- If the instrument has to be sent to the manufacturer and why.
- When the instrument arrives back and when it was fitted or if it was sent to the client without the need for a dispenser visit.
- The steps taken to assist to improve the hearing outcome.
- That the client has been advised to see their GP to have wax removed and retain a copy letter to the GP.
- That a picture has been captured from an Otoscope showing wax and upload to the client record, if there is a wax issue.
- That a digital photo has been taken of the aids if they are clogged with wax (including the serial number) and upload to the client record.
- Periodically record usage data, especially if the client has numerous problems and starts to claim that they hardly wear the aids.

❻ Donating Hearing aids to Charity. **Record**:

- If you have suggested to the client that they can donate their old hearing instruments.
- The serial numbers of these aids on the client record.
- That they have been asked but do not want to keep them as a spare set.



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