

Referral Guidelines for HCPC registered Hearing Aid Dispensers (Updated September 2017)

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A. Scope

This document is for Hearing Aid Dispensers (HADs)¹ who are registered with the Health and Care Professions Council (HCPC) providing guidance on receiving and making referrals for adults (over 18 years old) accessing hearing care services.

As the name suggests, this document specifically deals with the issue of receiving and making referrals in hearing care clinics. A wider guidance on the other service delivery processes is available via our guidance on professional practice for Hearing Aid Audiologists.²

Regardless of how users access hearing care services, as an autonomous professional HADs should:

- work in the best interests of service users at all times³

¹ 'Hearing Aid Dispenser' is a protected title. It is a health profession regulated by Health and Care Professions Council (HCPC) <http://www.hcpc-uk.org>

² Guidance on professional practice for Hearing Aid Audiologists. Available at: [https://www.bshaa.com/write/MediaUploads/BSHAA%20Publications/bshaa_guidance_14\[1\].pdf](https://www.bshaa.com/write/MediaUploads/BSHAA%20Publications/bshaa_guidance_14[1].pdf) Accessed on 28 October 2017

³ HCPC, 2016, Standards of conduct, performance and ethics. Available at <http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/> Accessed on 04 September 2017

- work with colleagues involved in the care of the service user, and where appropriate share relevant information²
- keep accurate records²
- make and receive appropriate referrals^{2,4}
- understand and work within your scope of practice at all times^{2,3}
- undertake the required training and gain appropriate experience before moving into a new area of practice³
- make informed and reasoned decisions and be able to justify making these if you are asked to do so³

B. 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. ENT Surgeons, audio-vestibular physicians etc
- III. Referral from clinically qualified colleagues without relevant specialist expertise – e.g. General Practitioners, optometrists, other audiologists/HADs etc. It is recognised that all audiologist/HADs do not provide enhanced level of services such as for wax removal or auditory processing disorder etc. They may have 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.

This section helps HCPC registrants meet these and other professional standards.

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. Barring a few areas, the NHS still routinely requires people to see their GP to obtain a referral letter in order to access NHS hearing services.

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 if they want to see the same HAD on the NHS. NHS pathways remain subject to local commissioning decisions. Therefore, HADs should be mindful that a local NHS contract might require service users to have a GP referral even when the service users do not need a medical/clinical opinion from the GP.

⁴ HCPC, 2014, Standards of Proficiency – Hearing aid dispensers. Available at <http://www.hpc-uk.org/assets/documents/10002CBCStandardsOfProficiency-Hearingaiddispensers.pdf> Accessed on 04 September 2017

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

HADs should accept referrals from colleagues that are within their scope of practice and where it is in the best interests of the service users to do so. This is relatively 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 (see page 4 of, HCPC, 2014, Standards of Proficiency – Hearing aid dispensers as per footnote 4 on page 2).

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.

III. Referral from clinically qualified colleagues without relevant specialist expertise

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 noise-induced hearing loss and refer a service user to you for hearing assessment and hearing aids. Another example is when 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. In other cases, somebody 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.

IV. Other reasons

Service users may access the hearing care service for a variety of reasons, which may or may not be directly 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.

C. Making referrals

Table 1 provides common signs/symptoms which might warrant referral. More detail can be found in Appendix 1 on page 6.

1	Where management of an obstruction of the external auditory canal is out of your scope of practice and the obstruction prevents a safe and accurate assessment
2	Abnormal appearance of the eardrum and/or the outer ear
3	Otalgia or persistent pain affecting either ear
4	Unexplained conductive hearing loss (20 dB or greater air-bone gap present at two or more

	of the following frequencies: 500, 1000, 2000 Hz or 4000 Hz)
5	A unilateral or asymmetrical hearing loss (20 dB or more asymmetry between two or more adjacent frequencies (octave frequencies between 500 and 8000 Hz) for bilateral hearing loss; or 15 dB or more if normal hearing in the other ear
6	*Sudden sensorineural hearing loss (hearing deterioration within 3 days in last 30 days)
7	*Rapid deterioration in hearing (in last 4-90 days)
8	Evidence of a clinically significant deterioration in hearing (15 dB or more in air or bone conduction threshold readings at two or more of the following frequencies 0.5 to 4 kHz) over 24 months
9	Fluctuating hearing loss
10	Tinnitus that is unilateral, pulsatile or objective. Also, tinnitus that is distressing or bothersome, if it is outside your scope of practice to manage it.
11	Hyperacusis, if it is outside of your scope of practice
12	Vertigo/dizziness or balance issues
13	Auditory processing disorder (normal peripheral hearing but abnormal listening ability in noisy backgrounds)
14	*Facial numbness, weakness, paralysis
15	Considering referral for implantable devices viz cochlear implants for service users with severe profound hearing loss, and bone anchored devices for permanent conductive loss

****Should be referred urgently for medical attention unless already being investigated by a medical professional (at A&E or Outpatients clinics, whichever is more appropriate)***

Table 1: Signs and symptoms that might require referral. Please see Appendix I for more detail.

HADs would be expected to refer the signs and symptoms in table 1 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, and are outside your scope of practice then you should refer for a medical opinion. For example, an increasing number of HADs have the requisite training and experience to manage some of the signs/symptoms listed in table 1 viz. removal of an obstructions (ear wax or a foreign body such as the dome of the acoustic coupler of a hearing device) from ear canal, and 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.

In all cases good record keeping, communication between professionals, and consent from the service user is important (refer to footnote 2 on page 1).

D. When a referral may not be required

HADs, 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 if:

- the condition has been fully investigated by an appropriate professional, any possible treatment has been provided and the condition remains unchanged, since the treatment/management. HADs should ensure that there are clinical notes available to them as the clinical evidence for this, where possible.
- 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 ear wax or deal with bilateral tinnitus with symmetrical hearing loss.
- the service user has made an informed and competent decision⁵ and declined a referral. In this case, HAD must make appropriate records of the basis on which this decision has been reached. They must ensure that informed consent has been obtained from the service user or their carer or other competent advisor⁶ on the basis of sufficient information⁷ including associated risks, and the records⁸ confirm all the necessary considerations about service user's best interests.

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) and inform the service user's GP about their decision.

E. Procedure for making a referral

When a referral is required, in addition to making appropriate records (refer to footnote 10 below), the following actions should be taken:

⁵ HADs must ensure that their service user has sufficient capacity to understand and act upon the information they have provided. The Mental Capacity Act lays out the legal foundations of the principle of informed consent and mental capacity, and is available here: <https://www.legislation.gov.uk/ukpga/2005/9/contents> Accessed on 21 September 2017. A useful resource for the interpretation of the Mental Capacity Act in healthcare context is available here <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/mental-capacity.aspx> Accessed on 22 September, 2017.

⁶ Service users 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 service user's behalf and in your service user's best interests

⁷ HAD must be able to answer any questions so that they can be confident that their decisions is "informed"

⁸ Please refer to BSHAA Guidance on Record Keeping available here <https://www.bshaa.com/Publications/BSHAA/bshaa-guidance-on-record-keeping> Accessed on 21 September 2017.

- Obtain service user's or their carer's informed consent (refer to footnote 7 below) before making a referral
- Referrer should be informed in writing and without undue delay, and with all the relevant and necessary information and/or test results e.g. audiograms etc.

Appendix I: Signs and symptoms that might require referral

Throughout this appendix we use the HCPC definition of scope of practice (SoP) (HCPC, 2014) for HADs, which is fully supported by BSHAA:

- "Your SoP is 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."
- "Your SoP will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain area or with a particular service user group, or a movement into roles in management, education or research"
- "As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice, you should be certain that you can work lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training or gaining experience, before moving into a new area of practice."

For more detail on the signs and symptoms that might require referral see below:

1. Refer an obstruction of the external auditory canal if
 - it prevents examination of the eardrum and/or the safe and accurate taking of an aural impression, **and**
 - it is outside of your SoP to manage the cause of the obstruction – e.g. if the cause of obstruction is impacted ear wax and it is within your SoP to manage this then this will **not** require a referral.
2. Refer service users for a medical opinion unless the service user is already being managed or has been discharged/referred to you by a medically qualified colleague that has already documented any of the below:

- i. Inflammation of the external ear canal
 - ii. Active discharge
 - iii. Abnormal findings observed during ear examination (e.g. cholesteotoma)
 - iv. Perforated eardrum, which has not been investigated previously
 - v. Visible congenital or traumatic deformity of the ear that has not previously been investigated
 - vi. Any other suspect clinical signs of the eardrum and/or the outer ear (e.g. unexplained lesions on the pinna etc.)
3. Refer persistent ear pain (otalgia) affecting either ear, where clinically indicated. For example, if the pain has completely subsided in the last week then a referral might not be required but if there is a recurring pattern the service user might benefit from referral. You should work within your SoP at all times and refer if clinically necessary. Persistent ear pain where the ear looks normal could be referred pain from a sinister pathology (Harrison & Cronin, 2016) so, a medical opinion on this should be obtained either from the GP or an ENT doctor.
4. Refer conductive hearing loss which has not previously been investigated or treated, where audiometry shows 20 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 Hz or 4000 Hz. Service users with unexplained or previously undocumented conductive hearing loss should be referred to ENT to exclude an underlying treatable condition.

Glue ear (otitis media with effusion) can cause hearing loss. Unilateral glue ear in adults should be referred as these service users might benefit from examination of post nasal space by an ENT Consultant (Leonetti, 2013). In certain syndromes, e.g. Large Vestibular Aqueduct Syndrome (LVAS), the air-bone gap can mimic middle ear disease (Merchant et al., 2007).

5. Refer a unilateral or asymmetrical hearing loss where there is
- 20 dB or more asymmetry between two or more adjacent frequencies (octave frequencies between 500 and 8000 Hz) for bilateral hearing loss; or 15 dB or more if normal hearing in the other ear. (Obholzer, Rea, & Harcourt, 2004; Nash, Majithia, & Singh, 2016).

It is important to note that the British National Study of Hearing (Davis, 1989) found up to 10 percent of general population may have 15 dB asymmetry. This significantly exceeds the prevalence of serious underlying medical conditions that are associated with asymmetric hearing loss. Therefore, referral on this basis might result in additional false positive referrals to ENT. You are, therefore, encouraged to work with local ENT departments and GPs to agree local protocols and training to improve referral pathways and reduce false positive referrals. Where this is not possible, you should continue to refer based on the established national criteria noted above.

It is important to note that the diagnostic accuracy of non-imaging screening protocols for vestibular schwannoma in service users presenting only with asymmetrical hearing loss alone remains uncertain (Hentschel, Scholte, Steens, Kunst, & Rovers, 2017).

6. Urgently refer sudden sensorineural hearing loss (SSHL) (Leung et al., 2016). SSHL is to be treated as an otologic emergency requiring immediate recognition and referral to A&E and/or Urgent Care ENT clinic. SSHL can develop rapidly with hearing loss progressing within 3 days in last 30 days. Where an initial reference point is not available, diagnose presumptive SSHL, if audiometry confirms a 30dB or more hearing loss at 3 consecutive frequencies (Stachler et al., 2012).
7. Refer rapid onset of hearing loss or rapid deterioration in hearing. 'Rapid' is from 4 to 90 days. All service users with a rapid progression recorded on the audiogram, should be considered for onward referral.
8. Evidence of deterioration of hearing outside of expected normal limits. In the adult population, hearing loss is typically gradual and slowly progressive. Epidemiological studies have shown, for example, that the average rate of change in PTA thresholds between 0.5 to 8K Hz is about 2 dB or less per year (Wiley et al, 2008; Cruickshanks et al., 2003). Therefore, a deterioration of 15 dB or more in air or bone conduction threshold readings at two or more of the following frequencies 0.5 to 4 kHz over 24 months should be referred.

Where there is a large time gap in two successive audiograms the decision to refer is best made on a case by case basis. You may compare service user's history, age, and previous records to make a professional judgement on whether they need to be referred immediately or reviewed in few weeks/months with repeat testing to make a decision on whether to refer. It is important to keep good records, explain results, and agree the plan of action with the service user.

9. Refer fluctuating hearing loss that is not associated with head colds or respiratory tract infections. Test/retest reliability of the pure tone audiometry is within 5 dB and an average change of hearing thresholds for the general population is around 2 dB per year. Significant variation in hearing thresholds (e.g.10-15 dB) within a relatively short period of time might therefore, be considered to be a fluctuating hearing loss.
10. Not all presentations of tinnitus are referable
 - Always refer tinnitus which is objective (can be heard by both the service user and examiner) unilateral or pulsatile.
 - Subjective (only heard by service user not examiner) bilateral tinnitus is most often associated with hearing loss and idiopathic. Service users with bilateral tinnitus and symmetrical hearing are not likely to show retro-cochlear pathology on MRI (Choi, Sajisevi, Kahmke, & Kaylie, 2015). Unless there are other reasons to do so, people with bilateral

tinnitus and symmetrical hearing loss are less likely to require a referral. You may support these service users if it is within your SoP.

- In other, and rarer cases, bilateral subjective tinnitus might be associated with wax, otosclerosis, significant noise exposure, ototoxicity, otitis media, head or neck injury, multiple sclerosis, diabetes, metabolic disorder or thyroid disease (Tunkel et al., 2014). This means you might also choose to refer to an ENT specialist for the diagnosis of underlying cause or confirmation that the tinnitus is idiopathic (NICE, 2010).
- In some cases, you might refer to a colleague (e.g. another HAD/audiologist, psychologist, psychiatrist, hearing therapist, or other appropriately qualified person) where the tinnitus is intrusive and may lead to sleep disturbance or be associated with symptoms of anxiety or depression.

11. Hyperacusis, (the experience where every day sounds become intrusively loud, uncomfortable, and sometimes painful) can be a symptom of a migraine, dehiscence syndrome, post head injury syndrome, Lyme disease, William's syndrome and Bell's palsy etc. Therefore, it may be important to seek a medical opinion as part of treatment plan for the service user. For further information on Hyperacusis, readers are directed to (Baguley, Andersson 2007).

12. Refer service users to an appropriate clinician (for example, GP, ENT doctor or an audio-vestibular physician, audiologists who accept direct referrals for balance etc.) who present with a recurring and unresolved vertigo (spinning sensation), dizziness or balance issues. The sensation of dizziness can last from few seconds, to few minutes; and may be present while being still or in motion. (See NHS Choices-Vertigo, 2017).

Although the cause of the balance issues may not always be a sinister pathology but often the condition is 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).

If a service user has a previous history of vertigo, dizziness or balance issues that has either completely resolved or has been investigated and treated/managed by a specialist, there is no need to refer. Documentary evidence should be sought for such previous clinical history.

13. Auditory processing disorder (APD), where peripheral hearing is often within normal limits, as assessed audiometrically, but service user presents with abnormal listening ability in noisy backgrounds. Note that service users with sensorineural hearing loss will have auditory processing issues by definition because sensorineural hearing loss results in dysfunction of auditory cells along the auditory pathways, affecting the processing of sounds and speech. However, it is to be acknowledged that some service users may present with a pre-existing hearing loss and disproportionate auditory processing difficulties owing to e.g. a central lesion such as stroke. Some cases in adults have also been linked to progressive conditions that affect the nervous system, such as multiple sclerosis (NHS Choices- Auditory Processing Disorders, 2017; Valadbeigi et al., 2013).

14. Urgently refer service users to a medical specialist who present with facial numbness, weakness, paralysis that has not been investigated previously. 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).
15. The option of cochlear implant should be offered to all service users who fit the National Institute of Clinical Excellence (NICE) criteria. National Institute of Clinical Excellence (NICE, 2009) recommends that a referral for cochlear implant should be considered as an option for service users who have a severe to profound hearing loss (defined as thresholds equal to or more than 90dBHL at frequencies of 2 and 4 kHz), and do not receive adequate benefit from acoustic hearing aids. Adequate benefit from acoustic hearing aids is defined for adults as a score of 50% or greater on Bamford–Kowal–Bench (BKB) sentence testing at a sound intensity of 70 dB SPL.

In the other implantable hearing devices, bone conduction hearing aids may be considered as an option for service users with permanent bilateral conductive hearing loss, unilateral conductive loss with untreatable ear canal stenosis, and unilateral profound sensorineural hearing loss. The minimum audiological criteria for this is to have average bone-conduction threshold (0.5- 4 kHz) better than 45dB HL for an ear-level or better than 60dB HL for a bodyworn hearing device, and air conduction pure tone average not better than 40 dBHL. (NHS England Commissioning Board, 2013).

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