

Quality Standards for Adult Hearing Rehabilitation Services



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ISBN 978-0-7559-7301-9

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Published by the Scottish Government, April 2009

Executive Summary

In January 2003, the Public Health Institute of Scotland (PHIS) published a Needs Assessment Report on NHS Audiology Services in Scotland. This report identified a number of areas in which Audiology services were failing to meet the standards expected by service users and other stakeholders. The modernisation of hearing aid services tried to address these areas as well as modernise the patient journey.

Scotland began the modernisation of its audiology services in 2003 by investing in new Digital Signal Processing (DSP) hearing aid technology, new infrastructure, information systems and training based around the patient care pathway. However, whilst there was clarity around the patient pathway there was no clarity around appropriate quality standards by which the services could be audited or on which services could base a service improvement plan.

One of the recommendations of the PHIS Report was that “NHS QIS would produce an agreed set of standards for audiology services and conduct an assessment of the service’s ability to meet these standards, taking into account established documents from voluntary bodies and professional organisations.” In its response to this recommendation, NHS QIS indicated that it would not be possible to fulfil this within a timescale that all interested parties could agree to.

It was then suggested that the work be undertaken by a sub-group of the Scottish Government’s Audiology Services Advisory Group following the NHS QIS standards development methodology and that NHS QIS would consequently quality assure the development process.

This document has subsequently been developed by a multi-disciplinary project group comprising representatives from the Audiology profession, the voluntary sector, higher education, UK health departments, senior NHS management and others.

An audit of that modernisation process has been carried out by Davis et al 2007, which used a set of draft standards, with support from the late Professor Stuart Gatehouse, against which services could be viewed for this purpose. In taking that task forward the audit group developed a Quality Rating Tool that attempted to directly assess services against those draft standards to establish whether the services

- are responsive to their needs
- empower patients to be good partners in meeting those needs
- make the best use of staff skills and resources.

The timescale of the audit meant that it had to use draft standards which have been updated in the light of their use, together with the quality rating tool.

Comments from stakeholders have been elicited about the standards, rationale and criteria for the adult hearing services quality standards, together with the quality rating tool.

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1. Quality Standards for Adult Hearing Rehabilitation Services

1.1 Context

In January 2003, the Public Health Institute of Scotland published a Needs Assessment Report on NHS Audiology Services in Scotland. This report identified a number of areas in which Audiology services were failing to meet the standards expected by service users and other stakeholders. These included:

- Inadequate facilities at base hospital, peripheral clinic and community sites.
- Shortages in qualified staff and staff skills leading to compromised service access and quality.
- Financial pressures compromising service quality, with an undue emphasis on activity at the expense of outcome.
- Poor or non-functioning inter-agency links.
- Large variations in services across NHS Boards.
- Inferior service quality and outcome in comparison to elsewhere in the UK and overseas.
- Recommendations and guidance from the NHS (particularly the Good Practice Guidance on Adult Hearing Aid Fittings), professional groups and voluntary organisations regarding service standards have not been implemented, despite the demonstration of their efficacy and effectiveness in other contexts.
- Good working practices are often not in place. Developments in Audiology services elsewhere in the UK are largely absent in Scotland.

As a result of these findings a number of recommendations were made by the Audiology Needs Assessment Group. Among these was the recommendation that “NHS Quality Improvement Scotland (QIS) should produce an agreed set of standards for audiology services, and conduct an assessment of the service’s ability to meet these standards, taking into account established documents from voluntary bodies and professional organisations”.

In its response to this recommendation, NHS QIS indicated that it would not be possible to undertake the work within a timescale that was acceptable to the Group. It was then suggested that the work be undertaken by a sub-group of the Scottish Government’s Audiology Services Advisory Group following the NHS QIS standards development methodology and that NHS QIS would subsequently quality assure the development process.

This document has been developed by a multi-disciplinary project group comprising representatives from the Audiology profession, the voluntary sector, higher education, UK health departments, senior NHS management and the private sector. In developing these standards the project group has adhered to the basic principles and guidelines laid out by NHS Quality Improvement Scotland. As a result it is expected that both the process of developing these standards and these standards will be quality assured by NHS QIS.

1.2 Background on the Development of the Standards

The development of these standards has been carried out by a multi-disciplinary group under the guidance of a sub-group of the Scottish Audiology Services Advisory Group (ASAG) and following the principles and processes of NHS Quality Improvement Scotland.

The Audiology Services Advisory Group's remit is "to monitor the development of NHS audiology services in Scotland and to provide appropriate advice to NHS Boards, the Health Department and other relevant bodies that will facilitate effective and efficient development."

For more information on QIS please see the following website www.nhshealthquality.org

1.2.1 Basic Principles

Standards developed using the NHS QIS quality assurance process are required to be clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. The standards are:

- written in simple language and available in a variety of formats.
- focused on clinical issues and include non-clinical factors that impact on the quality of care.
- developed by healthcare professionals and members of the public, and consulted on widely.
- regularly reviewed and revised to make sure they remain relevant and up to date.
- achievable but stretching.

1.2.2 Process

The way in which standards are developed is a key element of the quality assurance process. Project groups working on standards development are expected to:

- adopt an open and inclusive process involving members of the public, voluntary organisations and healthcare professionals.
- work within NHS QIS policies and procedures.
- test the measurability of draft standards by undertaking pilot reviews.

1.2.3 Format of Standards and Definition of Terminology

All standards quality assured using the NHS QIS process follow a similar format:

- Each standard has a title, which summarises the area on which that standard focuses.
- This is followed by the **standard statement**, which explains *what* level of performance needs to be achieved.
- The **rationale** section provides the reasons *why* the standard is considered to be important.

- The standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached and *how* the service will achieve this, in that it is expected that they will be met wherever a service is provided. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The number of the criteria is not a reflection of priority.

1.2.4 Assessment of Performance Against the Standards

Work to develop and define the assessment of performance against the Standards is in progress, based on the attached Quality Rating Tool. The Audiology Services Advisory Group is taking a lead in this work.

2. Adult Hearing Rehabilitation Services

2.1 Introduction to Adult Hearing Rehabilitation Services

Hearing problems arise from defects in either the middle or the inner ear. The former lead to conductive hearing losses and the latter to sensorineural hearing losses. Almost one in five of Scotland's adult population suffers from a measurable deficit in hearing which is likely to lead to difficulties in understanding speech, particularly in noisy backgrounds. The population prevalence of hearing impairment increases exponentially with increasing age. Changes in population demographics will, therefore, have important implications for future services. Additionally, population prevalence halves with every 10dB increase in hearing level. This leads to large numbers of people in the population with moderate to severe hearing problems and smaller numbers with severe and profound hearing losses, though the latter do of course have a much more severe impact. While around one in six adults could benefit from current NHS hearing services, only one third of candidates attend for management, leading to substantial un-met need in the population.

Audiology departments supply services to manage disability associated with hearing impairment. This includes, in addition to hearing aid provision, support and counseling usually delivered within a team of professionals working in association with other agencies/voluntary sector organisations e.g. in some local teams this may involve care from Hearing Therapists and Speech and Language Therapists. It should also include onward referral for those with significant residual disability to appropriate services such as agencies providing assistive listening devices, courses on non-verbal communication, cochlear implants and bone anchored hearing aids.

The services which should be offered by audiology departments with suspected hearing impairment include:

- Appropriate hearing testing, with screening for other causes of hearing impairment and onward referral as appropriate;
- Evaluation of the audiological needs of the service user;
- Agreement with the service user on the best aiding device(s) for their problems, and discussion about the likely effect of such devices on their ability to hear;
- Fitting of aids to provide sufficient and appropriate amplification;
- Training service users in the use and maintenance of their aid(s), and provision of rehabilitative support to ensure that they can use them effectively;
- Providing information on other sources of help, support, equipment and assistive devices, or referral to organisations which can provide these as appropriate;
- Ongoing repair and maintenance of hearing aids (including provision of batteries and replacement tubing).

The scope of this document does not include specialist hearing rehabilitation services but does cover the services provided for the majority of clinical activity. Examples of care pathways are shown in the Do Once and Share care pathways (www.mrchear.man.ac.uk) and those shown in good practice documents such as Transforming Adult Hearing Services (Department of Health, England. Good practice in transforming adult hearing services for patients with hearing difficulty. June 2007).

3. Hearing Aids, Hearing Aid Styles and the Rehabilitative Context for Hearing Aids

3.1 Hearing Aids

Middle ear problems leading to conductive hearing loss are potentially managed by surgery. At present there are no surgical or medical interventions for sensorineural hearing loss, and the only effective management available is the provision of amplification via hearing aids. Some conductive hearing losses are not suitable for surgery and also require management via hearing aids. Hearing aids require an appropriate rehabilitative context to be effective.

Defects in the middle ear lead to a conductive hearing loss which is a simple attenuation (quietening) of sound which often varies only relatively little as a function of frequency. However, the vast majority of hearing losses (particularly in the elderly) are sensorineural in origin and result from damage to the hair cells in the inner ear which convert sound into nerve impulses. Sensorineural hearing losses are usually more severe at high frequencies than at low frequencies. Vowels in speech have predominantly low frequency energy, while consonants are predominantly high frequencies. Thus speech can be audible though not intelligible.

In addition to simple attenuation of sounds, sensorineural hearing loss results in a number of other distortions. This results in listeners with sensorineural hearing loss being much more susceptible to the effects of background noise than their normally-hearing counterparts. Simple amplification (making sounds louder) will not necessarily remove all of the difficulties that such a listener experiences. Furthermore, while people with sensorineural hearing loss experience impaired auditory sensitivity (inability to hear quiet sounds), more intense sounds are perceived as just as loud by such individuals as they are by people with normal hearing. In particular thresholds of uncomfortable listening are not elevated in the same way as hearing thresholds. Thus listeners have a reduced range of hearing (dynamic range) between the threshold of hearing and the threshold of uncomfortable listening.

A hearing aid is required to take a signal that a listener wishes to hear and to amplify it so that its components are above threshold but not uncomfortably loud. This means that higher frequency sounds have to be amplified by more than lower frequency sounds. Hence a hearing aid has to have the capability to shape the way it amplifies sounds according to the profile of a listener's hearing loss. Hearing aids which have greater degrees of flexibility in this regard will be more effective.

Given that listeners have reduced dynamic ranges, hearing aids are required to amplify low intensity sounds by more than they will be required to amplify high level sounds. This differential amplification as a function of level will vary with frequency, because the dynamic range between thresholds of hearing and threshold of uncomfortable listening varies between low and high frequencies. This form of hearing aid processing is termed "amplitude compression", because it attempts to squeeze, or compress, the wide range of input signals into the reduced range of hearing.

Because listeners with sensorineural hearing loss experience more difficulty in noise than normal hearing listeners, hearing aids attempt to amplify the

signal by more than any noise. One option is a directional microphone. The hearing aid is more sensitive when it is pointing towards a sound source and is less sensitive to sound sources which are off to the side or behind the listener. This is effective given that people usually orientate themselves so that they are facing a sound source that they want to hear. Thus a microphone with a directional pattern can help to improve the relative levels of the signal and the noise.

Any amplifier is prone to whistling or feedback and hearing aids are no exception. If the sound delivered to a hearing impaired listener's ear is able to leak back to the microphone such feedback can occur, even in the presence of well fitting ear-moulds. Hearing aids can attempt to identify when feedback is likely to occur and to either try and cancel it or to turn down the gain in a particular frequency region so that feedback is avoided. The next section gives a short and simplified list of the sorts of processing and fitting features that are potentially available in hearing aids.

3.2 Hearing Aid Styles and Implementation

Hearing aids can be classified by the physical type and size, as well as the ways in which the processing features are achieved. The majority of hearing aids used in the NHS in Scotland are behind-the-ear (BTE), which is sometimes called postaural. More miniature devices (in-the-ear (ITE) or completely-in-the-canal (CIC)) offer greater cosmetic acceptability to listeners, though sometimes at the expense of their ability to provide the processing that is required. These are often chosen when the option is available.

Until the 1990's all hearing aids achieved their processing by analogue electronics (i.e. amplifiers and filters were employed in exactly the same way, though on a miniaturised scale, as the technology in domestic hi-fi systems). When a control required to be adjusted, this was achieved by a small screwdriver-driven potentiometer, similar to the base or treble control on a domestic music system. These are analogue hearing aids. One development was the ability to control these analogue hearing aids using digital computer systems, leading to digitally programmable hearing aids. In these hearing aids the underlying processing was still achieved by analogue technology, but was now controlled from a computer, removing the need for a series of miniaturised controls on the hearing aid.

More recently has been the development of fully digital devices where, in a similar manner to developments in music systems, the electrical signal is represented in digital format and the mathematical and signal processing is achieved using this form of technology. Potential advantages of digital processing are increased ability to shape the frequency response to match a hearing loss, greater flexibility in compression characteristics, and greater capabilities to manage feedback.

Hitherto digital hearing aids have only been available at the "top end of the market", and have been comparable in price to the most expensive analogue devices. However, as manufacturers devote more and more of their research, development and manufacturing capability to digital implementations, the relative cost penalties of digital versus analogue devices have inevitably narrowed and nearly all new hearing aid models brought to market are now digital.

3.3 The Rehabilitative Context for Hearing Aid Fittings

Digital hearing aids can be programmed so that they are tailored to match the acoustical characteristics of an appropriate target derived from the listener's hearing loss; the fitting can also be verified using real-ear measures to ensure that a hearing aid is indeed delivering an appropriate acoustical signal. The patient's listening needs can also be considered whilst programming the aid, particularly in setting up a number of different programmes for use in different situations.

There is a need for appropriate patient contact time both in fitting and follow-up to ensure an understanding of the mechanical competence with the hearing aid system (which, if not adequately performed, will undermine hearing aid use and acceptance). Fine tuning of the hearing aid can also be important, especially if based on comments after the patient has tried the aid for several weeks in different listening situations.

4. Development of the Quality Standards

In July 2006, a project working group was established with a remit to develop a set of national standards to accompany a self-assessment framework for hearing aid services in adults. The group, chaired by Martin Evans, comprises a variety of healthcare professionals involved in the delivery of audiology services, patient representatives and representatives from the voluntary sector, higher education, the UK health departments, senior NHS management and the private sector. The group's full membership can be found in Appendix 1.

The group worked in a number of facilitated sessions to identify key critical areas for clinical standards that were unique to audiology (other areas such as workforce development, efficiency, innovation and patient experience were outside the scope as they are covered by more generic NHS standards). The group identified six standards that followed the service user journey and three areas of infrastructure that were unique to audiology services. These were

- Referral pathways
- Information Provision and Communication with Individual Patients
- Assessment
- Developing an individual management plan
- Delivering an individual management plan
- Outcome
- Professional competence
- Multi-Agency Working
- Service Effectiveness and Improvement

The approach taken to develop the standards described in this document involved considering a broad range of service quality issues that share the common feature of ultimately impacting on health outcomes for service users. In an environment where the allocation of health service resources may be driven by access time targets it is particularly important to encourage recognition of other worthy (and ideally measurable) service quality issues. These standards have, therefore, been developed and constructed bearing in mind the need for an associated questionnaire-based tool to assess performance of services against the standards. The approach taken in the more detailed development of the standards was to follow the service user pathway to describe the key service quality themes. Standards 1-6 describe the service user journey and care pathway, whilst 7-9 relate to professional delivery and communication mechanisms that underpin the other standards. Whilst Audiology services have benefited from significant technological advances in recent years, achieving beneficial outcomes for service users is also heavily reliant on non-technological, holistic and customized approaches to intervention that are all reflected in the standards. In particular, the development of care tailored to the best needs of the individual is reflected by the adoption of the Individual Management Plan (IMP) as a prominent feature (*See Appendix 4*).

The group agreed that, following the production of draft standards, there should be a full consultation with service users and their carers/families, referrers and professionals delivering hearing aid services. The information collected during consultation was used to inform the content of the final standards.

4.1 Context

These standards are designed to improve service quality issues in clinical areas unique to Audiology within the NHS: elements of service quality such as cleanliness of facilities or workforce development are outside of the scope of this work as they are expected to be addressed by local healthcare governance mechanisms and/or more generic NHS standards.

Although the standards apply to NHS audiology, the hope is that their implementation will encourage and further develop collaborative working, both with fellow NHS professionals and external agencies.

In addition, awareness of and compliance with statutory requirements, such as the Disability Discrimination Act 2005, is assumed, as is awareness and understanding of consent requirements.

It would be impossible to exhaustively list the many and varied service user groups who access adult hearing rehabilitation services, therefore, it is intended that these standards apply to all service users equally.

4.2 Evidence Base

During the development of the draft quality standards for adult hearing aid services the project group considered a wide range of documents from a variety of sources and these are fully referenced in Appendix 2.

5. The Quality Standards

Standard 1. Accessing the Service

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>1a. All patients with hearing problems and their significant other(s), who require referral (for first or subsequent appointments) to audiology services are able to:</p> <p>(i) access the correct audiology service to meet their needs,</p> <p>ii) conveniently access the services they require,</p> <p>(iii) see Audiology or specialist medical professionals as first points of contact, as determined by agreed local clinical criteria,</p> <p>iv) Gain access to audiology service as quickly as any other specialist medical service.</p>	<p>Direct referral to audiology services is a more effective and efficient way of meeting patients' clinical needs where there is no robust evidence of otological pathology.</p>	<p>1a.1. All adult patients with hearing problems and their significant other(s) have access to Audiology via Direct Referral where this is clinically indicated.</p>
	<p>Allocation to the wrong referral pathways (or absence of alternative pathways) means additional inconvenience to the patient and inefficient use of time and resources.</p>	<p>1a.2. The information about referrals and the criteria which patients need to meet to be referred is clear so that they are fully understood by referrers.</p>
	<p>Correct information to an Audiology service results in more effective use of available resources.</p>	<p>1a.3. Information about referral criteria and pathways, including any changes, are widely disseminated to all potential referrers on a regular basis.</p>
<p>Public Health principles promote delivery of services close to patients for their ultimate healthcare benefit.</p>	<p>1a.4 .The proximity of patients to centres delivering audiology services is similar to other adult services in the Board/district.</p>	
<p>To provide an equality based service audiology centres must allow for all different types of patients to gain physical access to the service</p>	<p>1a.5. The audiology centres provide ease of physical access to all areas where audiology is delivered.</p>	

	<p>Simple equity implies that no patient should be penalised by having to wait longer for a direct referral to Audiology than they would have experienced by referral for a specialist medical service. Simple equity implies that patients who have previously accessed an audiology service must be able to access it again, should the need arise, without prejudice.</p>	<p>1a.6. Waiting times for direct referrals to Audiology are the same as waiting times for patients who are referred to other specialist medical services, such as ENT or Audiovestibular Medicine.</p> <p>1a.7. The maximum waiting time from referral to treatment¹ of hearing should meet the national target regardless of the referral route and regardless of whether a patient is re-accessing the service or accessing it for the first time.²</p>
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STANDARD STATEMENT	RATIONALE	CRITERIA
<p>1b. Service demand and referral data are accurately monitored, reviewed and reported against available indicators and used to guide service planning.</p>	<p>The number of incorrect referrals to the specialist medical route informs the effectiveness/clarity of the criteria and compliance of referrers to those criteria. Improvements can then be made to ensure that patients are not incorrectly referred to certain services.</p>	<p>1b.1. The number of inappropriate direct referrals is monitored and action plans implemented to address any non-compliance with referral criteria.</p> <p>1b.2. The number of inappropriate referrals to specialist medical services is also monitored. Action plans are then implemented to address any non-compliance with the referral criteria for specialist medical services.</p>

¹ Treatment is defined as fitting of hearing aid. Fitting following re-assessment is assumed.

² At time of writing, the national target in Scotland is 18 weeks from referral to treatment and work is ongoing on a document called principles and definitions for the 18 weeks referral target, which will help clarify how audiology services help to achieve the 18 week patient target when patients are referred on to other healthcare services.

	<p>Effective allocation of health resources is reliant upon accurate information on the balance between demand for services and available resources. It is important that waiting times for all stages of the patient pathway from referral through to treatment (e.g. hearing aid fitting³) for new and existing patients are collected and monitored in an effective manner. The use of IT systems to compute information such as demographic data and waiting times will inform allocation of services and help prevent an overload of patients accessing the same service and resources being strained.</p>	<p>1b.3. Waiting times are monitored within the department based upon robust data collection.</p>
	<p>Effective allocation of resources relies upon information on actual demand and potential/projected demand for specific services.</p>	<p>1b.4. The following data are collected, reviewed and used in annual service review:</p> <ul style="list-style-type: none"> • the uptake of NHS hearing aids in the local population compared with the predictive need for services, • the number and type of referrals to Audiology services, • demographics of locally served populations, including factors such as ethnic diversity, social deprivation and age. ⁴

³ Whether direct or via specialist medical service (eg ENT) referral routes.

⁴ This is to establish a benchmark and to gauge the service trends over time.

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>1c. There is effective ongoing life time maintenance of hearing aid use - including supportive care.</p>	<p>To ensure effective initial and ongoing care; agreed multidisciplinary local ear care / wax management procedures should be in place.</p>	<p>1c.1. All patients are advised of and have access to ear care / wax management services that use protocols agreed between Primary Care, Audiology and ENT services and patients.</p>
	<p>Prompt access for existing hearing aid patients to a basic repair service and replacement batteries (and onward referral as necessary) is required to help maintain long term use and benefit from hearing aid use. Uptake of such services will benefit from promotion of the service to patients.</p>	<p>1c.2. All hearing aid repairs are carried out within 2 days of the repair service receiving the hearing aid.</p> <p>1c.3. Where Audiology services are delivered away from the main Audiology base; there is at least 1 clinic per month for repair services.</p> <p>1c.4. Audiology departments will fulfil requests for replacement batteries within 2 days of the request being received.</p> <p>1c.5. Patients are actively offered information about repair/replacement battery services at each appointment. This will be provided in writing and verbally.</p>

Standard 2. Information Provision and Communication with Individual Patients

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>2a. Timely and relevant information is provided to meet the needs of hearing impaired patients and their significant other(s), in formats that accommodate their communicative abilities.</p>	<p>Good communication before, during and after intervention benefits patients – through reduction in anxieties/concerns and encouraging appropriate uptake of further care.</p>	<p>2a.1. Written information about the service, assessment procedures, types of assessment, possible interventions and clinicians involved is provided by the Audiology service for all new and existing patients and their significant other(s) prior to attending the appointment. This will include a request to contact the department in advance of an appointment if an interpreter is required.</p> <p>2a.2. Consent is gained from the patient for assessment of their hearing and their significant other(s) being present.</p> <p>2a.3. Straight after assessment, results are recorded, explained verbally and given to patients and/or their significant other(s)</p> <p>2a.4. Information is provided, by audiology, regarding services offered by other agencies (including voluntary sector organisations).</p>

	<p>Written information that is clear, up to date and in a format that is accessible to the individual facilitates understanding of the service</p>	<p>2a.5. All written information provided to patients is developed in conjunction with service user groups, has the Crystal Mark plain English approval (or similar) and is reviewed annually.</p> <p>2a.6. A written individual management plan is provided and updated at subsequent visits (<i>explained in further detail in appendix 4</i>).</p>
	<p>To avoid discrimination, services should meet the specific communication and information needs of hearing impaired patients and their significant other(s) accessing the service.</p>	<p>2a.7. All frontline staff with direct patient contact⁵ receive deaf-awareness and communication training as part of their induction, which is then updated every 3 years. This training is approved by a relevant third party such as a voluntary sector organization. The training will include deaf-blind awareness and also underline key areas of communication.⁶</p>
	<p>Technology should be used to enable audiology staff to communicate effectively with the patient group and to ensure that the information is given in a manner that the patient understands.</p>	<p>2a.8. Prior to their appointment, up-to-date technology is used to support communication between patients and the Audiology service (e.g. email, text phones, sms messaging, department websites). All staff responsible for using the technology are trained on how to use it. The application of such technology reflects the advice of representatives of local user groups.</p>

	<p>Well lit rooms help aid the ability of hearing impaired patients to lip read and improve communication generally.</p> <p>The involvement of significant others (e.g. spouse) in the rehabilitative process can provide improved outcomes.</p>	<p>2a.9. At clinics, up-to-date technology is used to support communication with patients (e.g. message boards and loop systems in reception areas and waiting rooms). All staff responsible for using the technology are trained on how to use and carry out maintenance checks on it. The application of such technology reflects the advice of representatives of local user groups.</p> <p>2a.10. All areas used for staff and patient communication are well lit</p> <p>2a.11. Significant others are routinely encouraged, through formal invitation, to participate in clinical contacts (where consent has been provided). They are also encouraged to engage with the service through patient forums to facilitate planning, satisfaction auditing and information development etc.</p>
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⁵ Including call centre staff if applicable

⁶ For example, the importance of staff introducing themselves, greeting the patient and showing empathy towards the patient.

Standard 3. Assessment

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>3a. All patients receive an individually-tailored audiological assessment which is carried out to recognised national standards, where available, and includes:</p> <ul style="list-style-type: none"> • measurement of hearing impairment, • assessment of activity limitations related to hearing impairment, • evaluation of social and environmental communication and listening needs and an evaluation of attitudes, expectation and behaviours as a result of hearing impairment, • a relevant medical history. 	<p>The need for, and content of, any Individual Management Plan requires knowledge of a patient's hearing status.</p> <p>The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures</p> <p>Measures are compromised if not gathered using equipment calibrated to national and international standards and if they are not used in a quiet test environment.</p>	<p>3a.1. The following are established for every patient:</p> <ul style="list-style-type: none"> • hearing thresholds by air and bone conduction, • thresholds of uncomfortable loudness levels⁷, • additional/further diagnostic procedures as required. • a relevant medical history. <p>3a.2. There are written BAA/BSA recommended procedures or protocols available to all staff in the department and these include air and bone conduction testing, thresholds of uncomfortable loudness levels, and tympanometry.</p> <p>3a.3. Equipment is calibrated annually and documented to international standards, and daily checks are carried out and documented to international standards.</p>

⁷ Unless clinically contraindicated

	<p>Hearing status is a necessary prerequisite, but is not sufficient information alone to configure an Individual Management Plan (IMP)</p> <ul style="list-style-type: none"> • The goal of the service is to alleviate listeners' activity limitations rather than manage hearing losses. • Services should select a validated self-report questionnaire to assess activity limitations related to hearing impairment. • Situation-specific structured questionnaires have been shown to offer significant advantages in clinical settings over more general disability and handicap inventories (e.g. GHABP). 	<p>3a.4. Hearing tests, with the exception of domiciliary visits, are always carried out in acoustical conditions conforming to national and international standards⁸.</p> <p>3a.5. A self-report questionnaire is a routine part of the assessment protocols⁹ and is used in conjunction with all information gathered relating to social circumstances, psychological impacts, communication and listening needs and expectations.</p> <p>3a.6. Information is recorded in a standardised way and is used to develop the content of the IMP. Included in this information should be details of why an assessment or intervention could not be carried out.</p>
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⁸ To enable the accurate testing of normal air and bone conduction hearing threshold levels down to 0 dB HL, ambient sound pressure levels should not exceed any of the levels shown in Tables 2 and 4 respectively from BS EN ISO 8253-1. However, it is reasonable to relax this requirement for BC testing so as to provide for testing down to 10 dB HL by adding 10 dB to the figures in Table 4.

⁹ Questionnaires will always be used unless recorded as clinically contraindicated.

Standard 4. Developing an Individual Management Plan

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>4a. An Individual Management Plan (IMP)¹⁰ is: -</p> <ul style="list-style-type: none"> • developed for each patient, initially based on information gathered at the assessment phase, • determined in conjunction with the patient and/or their significant other(s), • updated on an ongoing basis and • accessible to the clinical team. 	<p>An IMP is most effective if it takes into account a range of factors in addition to the type and level of hearing loss. An effective IMP also relies on consultation between the Audiology professional, the hearing impaired person and his or her significant other(s). Only when all parties are committed to the joint goals is an optimal outcome received.</p>	<p>4a.1. The IMP is contained within the clinical record. It contains details of:</p> <ul style="list-style-type: none"> • hearing status, • expectations, • social circumstance, • options for rehabilitation (including hearing instrument management), • referral to other agencies and • specific goals associated with assessment information. <p>4a.2. The IMP is agreed with the patient and significant other(s) at each appointment and a copy is made available for them.</p>
	<p>To be successful, IMPs need to be flexible. Flexibility within the structure of the IMP is beneficial because the content and the goals of the IMP may change over time, reflecting the positive outcomes of interventions.</p>	<p>4a.3. The specific goals of the IMP are recorded in the clinical record. The plan includes details of:</p> <ul style="list-style-type: none"> • the decision-making process, • the implementation plan and • proposed timescales

¹⁰ Examples of an IMP can be found in appendix 5.

	<p>An effective IMP will detail specific actions associated with agreed goals that take into account a listener's social, communication and listening needs, in addition to their hearing impairment and related activity limitations, e.g. living alone vs family setting vs sheltered accommodation. The IMP is flexible so that different goals can be set if the patient's circumstances/environment changes.</p>	<p>4a.4. Information is recorded in the patient's clinical record¹¹, which is updated over the period of the journey through the IMP. This consists of information about the individual's hearing impairments, expectations (goals), psychological impacts, social, communication and listening needs.</p>
		<p>4a.5. Recorded updates of patient IMP occur at each appointment to reflect changing patient goals.</p>

¹¹ For the purposes of this tool, the clinical record is defined as including NOAH data and descriptive text.

Standard 5. Implementing an Individual Management Plan

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>5a. The Individual Management Plan is implemented over a series of coordinated appointments with the opportunity for revision of outcome goals at each stage.</p>	<p>In order for agreed interventions to be effective, referral to another agency/ service for interventions should be prompt so as to be based upon an up-to-date appraisal of need.</p>	<p>5a.1. Where referral to an external agency/service is indicated, referral is made from Audiology within 7 days of appointment in at least 95% of cases.</p>
	<p>Planned and coordinated intervention leads to better outcomes. Such an approach requires recording of interventions and their effectiveness to guide on-going development of the IMP.</p>	<p>5a.2. The clinical record and IMP includes the details, justifications and effectiveness of all non-instrumental interventions implemented.¹²</p> <p>5a.3. The clinical record and IMP includes the details, justifications and effectiveness of all instrumental (hearing aid) interventions implemented.¹³</p>

¹² This will include referrals to other agencies (e.g. to voluntary sector, social services, advanced rehabilitation; counseling, assertiveness, lip-reading, etc).

¹³ This will include earmoulds selected, basic settings/acoustical characteristics of the prescribed hearing aids/s and advanced features (such as directional microphones, noise reduction algorithms and multiple programmes).

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>5b. Where provision of hearing aid(s) is required the service ensures:</p> <ul style="list-style-type: none"> • hearing aids fitted are functioning correctly, • nationally agreed procedures and protocols are followed at a local level, • that patients are offered a hearing aid for each ear where clinically indicated and • performance of hearing aid(s) is carefully matched to individual requirements and settings are recorded. 	<p>Audiologists should be confident that the aid is working to specification before fitting it to a patient so that the aid does not cause harm.</p>	<p>5b.1. Prior to issue; every hearing aid has its technical performance tested to specification.¹⁴</p>
	<p>Professional bodies and national guidelines should be followed to ensure provision meets the needs of the individual.</p>	<p>5b.2. Local protocols should be in operation concerning selection, fitting and verification of hearing aids. These should comply with the latest professional body and/or national guidance.¹⁵</p>
	<p>Laboratory based evidence suggests that many patients with bilateral hearing impairment gain more benefit from hearing aids fitted bilaterally rather than unilaterally. Emerging evidence, particularly from studies of open canal fittings, indicates more real life self-reported benefit too.</p>	<p>5b.3. At least 95% of patients who need and are clinically suitable for bilateral hearing aid fitting should be offered 2 hearing aids.</p>

¹⁴ Electroacoustic performance will be tested directly on a test box or by using REM. The acoustical consequences of any activated feature of the hearing aid(s) (e.g. directional microphones) are also verified where standard procedures exist.

¹⁵ E.g. the BAA, BSA and Scottish national guidelines.

	<p>Evidence suggests that hearing aids are most effective when their performance is carefully matched to the requirements of the individual.</p>	<p>5b.4. Real Ear Measurement (REM) of hearing aid performance is to be used to verify at least 95% of hearing aid fittings¹⁶, unless clinically contraindicated for individual patients.</p> <p>5b.5. Where REM is performed: the acoustical target is verified at three different input levels (50, 65 and 80 dB) in more than 75% of cases.</p> <p>5b.6. Where REM is performed: measurements do not deviate from the recommended target at more than one frequency (in 95% of cases) unless clinically indicated</p> <p>5b.7. The maximum power output of the hearing aid/s is checked (in 95% cases) by REM if performed, or by coupler measurement. Adjustments are made, if required, to ensure that the individual's uncomfortable loudness level is not exceeded.</p>
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¹⁶ Explained whenever IMP's are completed and recorded in patient held records.

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>5c. Following implementation of the plan, a process of ongoing support and maintenance continues.</p>	<p>On-going use and benefit from hearing aid use is likely to be increased if the process of support and maintenance includes routine audiological reviews and potential for updating the IMP. Such provision is required to accommodate the changing rehabilitation needs of individuals.</p>	<p>5c.1. Each patient is given a follow-up appointment following hearing aid fitting within a maximum time of 12 weeks.</p> <p>5c.2. A review appointment is offered to all hearing aid patients every 3 years (in at least 95% of cases). Patients are regularly advised that they can self refer for review or repairs at any time.</p>

Standard 6. Outcome

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>6a. The outcome and effectiveness of the Individual Management Plan are evaluated and recorded following a post-management assessment of the impact of intervention.</p>	<p>The management of hearing impairment, within a comprehensive management plan, involves more than a simple technical matter of hearing aid fitting. It involves the provision of a systematic approach, supported by evidence, which addresses not only the hearing impairment, but also other related activity limitations and consequent reductions in quality of life (QoL).</p> <p>Subjective outcome measures, in the form of disease-specific questionnaires, can assess the impact of a hearing impairment on the patient's communication functioning and activity limitation. This can then be used in the evaluation process to measure how effective the IMP has been.</p> <p>IMP's help to record multiple hearing aid outcomes; such as functional benefit, satisfaction and QOL within a single questionnaire. Measurement of outcome is required to shape further progression of IMP's.</p>	<p>6a.1. Validated outcome measures e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI are used to evaluate the outcome of intervention and further develop the IMP in at least 95% of cases (unless clinically contraindicated).</p>

	<p>Measurement of outcome is required to: -</p> <ul style="list-style-type: none"> • obtain feedback (including a progressive evidence base) on the effectiveness and benefit associated with the service delivered to the patient group and • facilitate further development of IMP and judge progress on patient outcomes. 	<p>6a.2. Clinical records are used to facilitate further development and judge patient progress. The records contain information about the extent to which the interventions helped meet the specified goals (outcomes).</p>
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Standard 7. Professional Competence

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>7a. The Head of Service/Clinical Lead ensures that:</p> <ul style="list-style-type: none"> • Each service provides, within a governed team approach, the clinical competencies necessary to safely and effectively support the assessments and interventions undertaken, • Where tasks are undertaken by non-registered persons (e.g. volunteers) this takes place within an established competency-based framework, • Links with external agencies are in place to provide complementary service. 	<p>To help ensure a safe and effective service, clinical audiology staff should work within their agreed Scopes of Practice and have the skills required for their contribution towards the rehabilitation of hearing impaired patients.</p> <p>Health Professions Council 'Standards of Proficiency' for practitioners statement details requirements for registered practitioners to remain registered. These are produced for the safe and effective practice of the professions they regulate and are deemed to be the minimum standards which are necessary to protect members of the public.</p>	<p>7a.1. All audiologists and clinical scientists are registered, at least voluntarily, with a registration council.</p>
	<p>Registration bodies and some employers require demonstration of regular CPD activity. Facilities to access CPD close to the point of work and the CPD being received in association with colleagues is advantageous.</p>	<p>7a.2. All clinical staff have evidence of access to an appropriately maintained CPD programme that provides for active participation - normally run internal to the service (or in formal association with another organisation).</p>

	Peer review provides a useful approach to help ensure clinical competencies are maintained.	7a.3. Competency for all clinical procedures is verified formally by peer review observation, at least every 2 years for all clinical staff undertaking such procedures. Ongoing assessment of all clinical staff's competency should also be carried out, informally, by local audiology centres.
	To ensure safe and effective outcomes for patients it is important that there are safeguards in place governing the employment and deployment of volunteers.	7a.4. Volunteer staff supporting the audiology service should work to clearly defined quality standards ¹⁷ , applicable to all such staff. These include: <ul style="list-style-type: none"> • working to locally agreed scopes of practice, • in-house training using competency-based frameworks, • recruitment compliant with national and local requirements.

¹⁷ <http://www.vds.org.uk/tabid/232/Default.aspx>

Standard 8. Multi-Agency Working

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>8a. Each audiology service has in place processes and structures to ensure collaborative working with the appropriate agency to meet the needs of patients through the pathway. These include: -</p> <ul style="list-style-type: none"> • social, • specialist audiological and • other health needs. 	<p>Multi-agency collaborative working is more likely to result in services that address the needs of those hearing impaired patients who benefit from a more supportive, social environment.</p>	<p>8a.1. Audiology takes a lead role in setting up formal quarterly meetings with collective representatives from social work; voluntary sector organisations; local volunteer schemes and patients. The remit includes the planning, development, delivery and audit of services.</p>
	<p>Having awareness of and appropriate links to specialist audiological services is more likely to result in the hearing and communication needs of patients being met.</p>	<p>8a.2. Written protocols/processes are in place to support referral to the following services/agencies: -</p> <ul style="list-style-type: none"> • Social work, • Volunteer services, • Voluntary organisations, • Local NHS mental health services, • specialist audiological and • other health needs, for example, speech and language therapy and falls prevention clinics.

	<p>Awareness of and appropriate links to other health services is more likely to result in additional health needs of hearing impaired patients being met.</p>	<p>8a.3. Audit of multi-professional and multi-agency working should be carried out annually and should include the take up of referral to these agencies.</p> <p>8a.4. The Audiology Lead should be aware of any concerns that arise from the audit and should discuss these with all agencies involved before developing plans to mitigate areas of concern raised in the audit.</p>
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Standard 9. Service Effectiveness and Improvement

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>9a Each service has processes in place to measure service quality.</p>	<p>Measurement of qualitative and quantitative data helps to inform ongoing service improvement.</p>	<p>9a.1. Patients and significant others are encouraged to complete surveys on, at least, an annual basis to determine satisfaction with different elements of the service received. These include: -</p> <ul style="list-style-type: none"> • accessibility, • proximity, • information provision, • professionalism of staff, • care and treatment and • overall service received. <p>Participation rates in the survey are checked, annually, to ensure an acceptable proportion of patients have participated and a representative sample of the local population is covered (including gender and ethnicity).</p> <p>Sufficient analysis and interpretation of findings from satisfaction surveys are carried out annually by audiology services. The information gathered will also be used to ensure fair and equal access to services in line with Scottish Government Equality Duty requirements.</p> <p>Action plans are implemented, when needed, to address areas of concern arising from surveys.¹⁸</p>

¹⁸ An example of a survey satisfaction questionnaire used by audiology services is listed in appendix 8.

		9a.2. Annual quantitative analysis on the quality/effectiveness of the service is undertaken using GHABP.

STANDARD STATEMENT	RATIONALE	CRITERIA
9b Each service has processes in place to regularly consult with patients and stakeholders.	Audiology services that seek, consider and respond to the views of users will be more likely to meet the needs of their patients.	9b.1. The audiology service has a framework in place to ensure regular consultation with patients and stakeholders. 9b.2. Results of satisfaction surveys and service QRT scores are made available and discussed with patients on an annual basis.

STANDARD STATEMENT	RATIONALE	CRITERIA
<p>9c Each service has processes in place to keep up to date with and employ key audiological innovations.</p>	<p>Use of up to date hearing instrument technology is integral to effective service delivery and ongoing improvement.</p> <p>New technologies make new models of service delivery possible.</p>	<p>9c.1 There is a named lead in Audiology services with responsibility for coordinating the identification, appraisal of potential benefits, local development and implementation of new technologies.</p> <p>9c.2. Regular, national meetings are held by audiology services to appraise new national/international technology developments. This should include evidence from pilots/trials where the new technology has been tested. The analysis should include the potential patient benefit and the impact the technology could have on workforce and service delivery.</p> <p>9c.3 When new technology is implemented, departments should be able to demonstrate tangible benefits to patients and should continually monitor newly-implemented technology.</p>

Improving Quality and Outcomes in Adult Audiology Rehabilitation Services through Critical Evaluation

A Quality Rating Tool for Audiology Services¹⁹

¹⁹ This quality rating tool has been developed for adult audiology service providers and other interested parties to highlight best practice in rehabilitation service provision in order to ensure local audiology services meet population requirements and address health inequalities.

Foreword

This quality rating tool has been developed to assist providers of adult rehabilitation services in assessing their ability to deliver adult audiology rehabilitation services to meet the needs of their local population against the Quality Standards for Adult Hearing Rehabilitation Services

It is envisaged that service providers will find the format of the tool helpful in measuring their progress towards meeting and indeed exceeding the quality standards for adult rehabilitation services. Beyond use by providers for self assessment, the tool could also be employed within an external (independent) assessment process. In this application, all interested parties could regard outcomes of service quality rating as a valid and reliable indicator of the performance of providers, within the context of wider frameworks for healthcare standards set out by the UK health departments.

The publication of externally verified service quality ratings could also help potential service users (and their advisers) make more informed decisions on the services that they choose to access.

The Quality Rating Tool can be implemented in different ways, depending on the medium used, but on-line self assessment can be readily achieved.

Using the quality rating tool

This quality rating tool covers the 9 Quality Standards for adult rehabilitation services in audiology.

Standards are only part of the cycle within which services are delivered and reviewed/monitored. Assessment against the standards will inform participating stakeholders of areas of good practice and areas in need of development, performance management and consolidation. Assessment should be an ongoing service management function. External quality assurance programmes will reinforce local ratings and contribute additional objectivity and transparency.

Each section contains several quality statements relating to different criteria within the quality standards. Providers can rate their current activity against the scale 1-5 where 1 means that no elements of the quality statement are met/implemented and 5 represents full compliance with good to best practice, with graduations in between. Examples of what a score of 1 and 5 might look like have been given so that users of the tool can make better judgements about where on the scale the service corresponds. The 5 positions are:

1. No elements of the quality statement are met (or not evident*)
2. Few elements of the quality statement are met
3. Meets around half of the elements of the quality statement
4. Almost fully meets the quality statement
5. Fully compliant with good to best practice as indicated by quality statement criteria

In judging evidence of performance (assigning an overall score for each standard) those completing assessment should consider the following **elements** of compliance:

- All examples of best practice (where there is more than one)
- The population served, (eg, all geographical areas, and all facilities)
- Reflecting practice over the preceding 12 week period as a minimum (prior to the date of the assessment)

* NB An inability to provide evidence of performance against a standard (sufficient for external scrutiny) cannot be regarded as compliant with good practice.

In addition, a separate field provides suggestions of evidence to assist users of the tool in their rating assessment and direct discussion for any external quality assurance visit. On completion of the quality rating tool, an overall position will indicate those areas that require further development and review.

Understanding the score

The underlying assumption used here is that, when scoring each standard, all quality statements (criteria) are equally important and therefore carry the same score weighting. Some criteria may have more aspects than others but each criteria should only be scored once. For instance when a criteria achieves 2 out of 4 different standards that the service should meet then appropriate approximate score would be 3 out of 5. A reminder of how to score the standards can be found in the rating scale at the top of each standard. For each standard, a percentage quality score can be calculated and an interpretation given of the meaning of these scores (eg needs urgent attention, needs attention, does not need attention). For instance; if a service scores a total of 32 out of 40 then the service is deemed to have 80% compliance with standard 1.

Standard 1 – Accessing the Service

1a . All patients with hearing problems and their significant other(s), who require referral (for first or subsequent appointments) to audiology services are able to:

- (i) access the correct audiology service to meet their needs,
- (ii) conveniently access the services they require,
- (iii) see Audiology or specialist medical professionals as first points of contact, as determined by agreed local clinical criteria,
- iv) gain access to audiology service as quick as any other specialist medical service.

1b Service demand and referral patterns are accurately monitored, reviewed, reported against available indicators and used to guide service planning.

1c There is effective ongoing life time maintenance of hearing aid use - including supportive care.

Rating Scale

	1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)		Few elements of the quality statement criteria are met	Meets around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria1a.1-a.3 - Direct referral pathways

Quality Statement rationale

Direct referral to audiology services is a more effective and efficient way of meeting patients' clinical needs where there is no robust evidence of otological pathology. Allocation to the wrong referral pathways (or absence of alternative pathways) means additional inconvenience to the patient and inefficient use of time and resources. Correct information to an Audiology service results in more effective use of available resources.

1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				

There is no process for patients to be referred to or access audiology directly.

All adult patients with hearing problems and their significant other(s) have access to Audiology via Direct Referral where this is clinically indicated

The information about referrals and the criteria which patients need to meet to be referred is clear so that they are fully understood by referrers.

Information about referral criteria and pathways, including any changes, is widely disseminated to all potential referrers on a regular basis.

Evidence sources relevant to criteria

- Written referral pathways,
- Written referral criteria,
- Written policy on communication with referrers,
- Copies of communications with referrers,
- Results and outcomes of audit.

Criteria 1a.4-a.5 - Ease of access

<p>Quality Statement rationale Public Health principles promote delivery of services close to patients for their ultimate healthcare benefit. To provide an equality-based service, audiology centres must allow for all different types of patients to gain physical access to the service.</p>					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>The proximity of patients to centres that deliver audiology services is far worse than for other adult services. The audiology centres are impossible to get into and/or impossible to navigate around once inside.</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>The proximity of patients to centres delivering audiology services is similar to other adult services in the Board/district. The audiology centres provide ease of physical access to all areas where audiology is delivered.</p>				
<p>Evidence sources relevant to criteria Maps of service locations against demographic information of patients relative to other adult services, Audit of services against Disability Discrimination Act, Patient satisfaction surveys.</p>					

Criteria 1a.6-a.7 - Waiting times

Quality Statement rationale Simple equity implies that no patient should be penalised by having to wait longer for a direct referral to Audiology that they would have experienced by referral to a specialist medical service. Simple equity implies that patients who have previously accessed an audiology service must be able to access it again, should the need arise, without prejudice.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Waiting times are not equal for direct/indirect referrals to Audiology The waiting time target is not known and waiting times are not monitored.	Waiting times for direct referrals to Audiology are the same as waiting times for patients who are referred to other specialist medical services, such as ENT or Audiovestibular Medicine. The maximum waiting time from referral to treatment ²⁰ of hearing should meet the national target regardless of the referral route and regardless of whether a patient is re-accessing the service or accessing it for the first time. ²¹				
Evidence Data to hand ideally over several time points to indicate trends against national targets					

²⁰ Treatment is defined as fitting of hearing aid. Fitting following re-assessment is assumed.

²¹ At time of writing, the national target in Scotland is 18 weeks from referral to treatment and work is ongoing on a document called principles and definitions for the 18 weeks referral target, which will help clarify how audiology services help to achieve the 18 week patient target when patients are referred on to other healthcare services.

Criteria 1b.1-b.2 - Monitoring and managing referral patterns

Quality Statement rationale The number of incorrect referrals to the specialist medical route informs the effectiveness/clarity of the criteria and compliance of referrers to those criteria. Improvements can then be made to ensure that patients are not incorrectly referred to certain services.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
There is no monitoring of compliance with referral criteria	The number of inappropriate direct referrals is monitored. The number of inappropriate referrals to specialist medical services is monitored. Action plans are implemented to address significant non-compliance with referral criteria.				
Evidence Audit, Data to hand (for direct referrals), ideally over several time points to indicate trends.					

Criteria 1b.3 - Monitoring and reviewing waiting times

<p>Quality Statement rationale Effective allocation of health resources is reliant upon accurate information on the balance between demand for services and available resources. It is important that waiting times for all stages of the patient pathway from referral through to treatment (eg hearing aid fitting) for new and existing patients are collected and monitored in an effective manner. The use of IT systems to compute information such as demographic data and waiting times will inform allocation of services and help prevent an overload of patients accessing the same service and resources being strained.</p>					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p>				
<p>Waiting times are not monitored.</p>	<p>Waiting times are monitored within the department. Monitoring of waiting times is based upon robust data collection.</p>				
<p>Evidence Monthly data to hand from a patient management system, Audit of robustness of data collection, Policies and protocols to support data collection A random sample of relevant patients to check data collection through to presentation in reported waiting times.</p>					

Criteria 1b.4 - Service Planning

Quality Statement rationale Effective allocation of resources relies upon information on actual demand and potential/projected demand for specific services.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No data is collected regarding uptake, referral and demographics of patients.	The following data are collected, reviewed and used in annual service review: <ul style="list-style-type: none"> the uptake of NHS hearing aids in the local population compared with the predictive need for services, the number and type of referrals to Audiology services, demographics of locally served populations, including factors such as ethnic diversity, social deprivation and age.²² 				
Evidence Data on hearing aid uptake, Data on referrals to audiology services, Data on patient demographic, Annual service review.					

²² This is to establish a benchmark and to gauge the service trends over time.

Criteria 1c.1 - Life long hearing aid use - ear care and wax management

Quality Statement rationale					
To ensure effective initial and ongoing care; agreed multidisciplinary local ear care / wax management procedures should be in place.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Advice about ear care and wax management is not systematically given to all patients There are limited ear care/wax management services There are no written agreed protocols for ear care/wax management	All patients are advised of and have access to ear care / wax management services There are protocols agreed between Primary Care, Audiology and ENT services and patients.				
Evidence Written information on ear care/wax management available to all patients, Ear care/wax management services available, Written and agreed protocols for ear care and wax management					

1c.2-1c.5 - Life long hearing aid use - access to hearing aid repairs and battery replacement

Quality Statement rationale Prompt access for existing hearing aid patients to a basic repair service and replacement batteries (and onward referral as necessary) is required to help maintain long term use and benefit from hearing aid use. Uptake of such services will benefit from promotion of the service to patients.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No hearing aid repairs are carried out within 2 days of the repair service receiving the hearing aid. There are no repair clinics where audiology services are delivered away from their main centre. Replacement battery requests are not fulfilled within 2 days of the request being received. No information is ever offered about repair/replacement battery services.	All hearing aid repairs are carried out within 2 days of the repair service receiving the hearing aid. Where Audiology services are delivered away from the main Audiology base; there is at least 1 clinic per month for repair services. Audiology departments will fulfill requests for replacement batteries within 2 days of the request being received. Patients are actively offered information about repair/replacement battery services at each appointment. This is provided in writing and verbally.				
Evidence Clinic lists, Written information for service users on how to access repair services and battery replacements service, Log of service receipts and issues by ATOs at each stage of the process, Monitoring of logs to ensure that repairs are carried out within 2 days of receipt.					

Standard 2 - Information Provision and Communication with Individual Patients

2a Timely and relevant information is provided to meet the needs of hearing impaired patients and their significant other(s), in formats that accommodate their communicative abilities.

Rating Scale

1	No elements of the quality statement criteria are met (or not evident)	2	Few elements of the quality statement criteria are met	3	Meet around half of the elements of the quality statement criteria	4	Almost fully meets the quality statement criteria	5	Fully compliant with good to best practice as indicated by quality statement criteria
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Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 2a.1 – Good information prior to assessment

Quality Statement rationale					
Good communication before during and after intervention benefits patients – through reduction in anxieties/concerns and encouraging appropriate uptake of further care.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No written information is provided to patients and their significant other(s) prior to appointment.	Written information is provided for all new and existing patients and their significant other(s) prior to appointment about :- <ul style="list-style-type: none"> • the service, • assessment procedures, • types of assessment, • possible interventions and • clinicians involved This will include a request to contact the department in advance of an appointment if an interpreter is required.				
No reference is made to patients and/or significant other(s) about the availability of interpreting services.					
Evidence Written information leaflets or letters, Auditing					

Criteria 2a.2 – Consent

Quality Statement rationale					
Good communication before during and after intervention benefits patients – through reduction in anxieties/concerns and encouraging appropriate uptake of further care.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Consent is not gained from the patient for assessment of their hearing.	Consent is gained from the patient for assessment of their hearing and their significant other(s) being present.				
Evidence					
Written information leaflets or letters, Auditing					

Criteria 2a.3-a.4 – Good information after assessment

Quality Statement rationale					
Good communication before during and after intervention benefits patients – through reduction in anxieties/concerns and encouraging appropriate uptake of further care.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Results are not recorded, explained or given to patients and their significant other(s) following assessment. Audiology does not provide any information regarding services offered by other agencies.	Straight after assessment, results are recorded, explained verbally and given to patients and/or their significant other(s). Information is provided, by audiology, regarding services offered by other agencies (including voluntary sector organisations).				
Evidence Written information leaflets or letters, Auditing					

Criteria 2a.5-a.6 - Accessible information

Written information that is clear, up to date and in a format that is accessible to the individual facilitates understanding of the service.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>The written information provided to patients has not been developed in conjunction with service user groups, does not have the crystal mark plain english approval and is not reviewed annually.</p> <p>No written individual management plan is provided.</p>	<p>5</p> <p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>All written information provided to patients: -</p> <ul style="list-style-type: none"> • is developed in conjunction with service user groups, • has the Crystal Mark plain English approval (or similar) and • is reviewed annually <p>A written individual management plan is provided and updated at subsequent visits.</p>				
<p>Evidence</p> <p>A random sample of patient records is checked to ascertain whether written IMPs are carried out and updated, Minutes of meetings to review information, Crystal mark or similar on information.</p>					

Criteria 2a.7 - Meeting specific communication/information needs

Quality Statement rationale					
To avoid discrimination, services should meet the specific communication and information needs of hearing impaired patients and their significant other(s) accessing the service.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Deaf awareness and communication training is not given to frontline staff as part of induction.	All frontline staff with direct patient contact ²³ receive deaf-awareness and communication training as part of their induction, This training is updated every 3 years. This training is approved by a relevant third party such as a voluntary sector organisation. The training will include deaf-blind awareness and also underline key areas of communication. ²⁴				
Evidence Staff training records, Written policies, Staff CPD accreditation certificates.					

²³ Including call centre staff if applicable

²⁴ For example, the importance of staff introducing themselves, greeting the patient and showing empathy towards the patient.

Criteria 2a.8-a.9 - Accessibility of information

Quality Statement rationale Technology should be used to enable audiology staff to communicate effectively with the patient group and to ensure that the information is given in a manner that the patient understands.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Up-to-date technology is not used to support communication between patients and the audiology services.	Prior to their appointment, up-to-date technology is used to support communication between patients and the Audiology service (e.g. email, text phones, sms messaging, department websites). At clinics, up-to-date technology is used to support communication with patients (e.g. message boards and loop systems in reception areas and waiting rooms). All staff responsible for the technologies used prior to appointment and at the clinic are trained on how to use it and carry out maintenance checks.				
Evidence Technology in place, Log of all staff who have received training on use of technology					

Criteria 2a.10 - Lighting

Quality Statement rationale					
Well lit rooms help aid the ability of hearing impaired patients to lip read and improve communication generally.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
All areas used for staff and patient communication are extremely dim.	All areas used for staff and patient communication are well lit.				
Evidence					

Criteria 2a.11 - Involving significant others

Quality Statement rationale The involvement of significant others (e.g. spouse) in the rehabilitative process can provide improved outcomes.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Significant others are not routinely encouraged to participate in clinical contacts. Significant others are not encouraged to engage with the service.	Significant others are routinely encouraged, through formal invitation, to participate in clinical contacts (where consent has been provided). They are also encouraged to engage with the service through patient forums to facilitate planning, satisfaction auditing and information development etc.				
Evidence Letters/written invitations to participate, Written policy on inclusion of significant others in clinical contacts, Consultation rooms large enough to comfortably accommodate additional people					

Standard 3 – Assessment

- 3a All patients receive an individually-tailored audiological assessment which is carried out to recognised national standards, where available, and includes:
- measurement of hearing impairment,
 - assessment of activity limitations related to hearing impairment,
 - evaluation of social and environmental communication and listening needs and an evaluation of attitudes, expectation and behaviours as a result of hearing impairment,
 - a relevant medical history

Rating Scale

1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)	Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 3a.1-a.2 - Acquiring information on hearing status

Quality Statement rationale The need for, and content of, any Individual Management Plan requires knowledge of a patient's hearing status. The quality of assessment is more likely to be assured if undertaken in accordance with nationally recommended procedures.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
There are no written standard procedures or protocols for assessment.	The following are established for every patient: <ul style="list-style-type: none"> • hearing thresholds by air and bone conduction, • thresholds of uncomfortable loudness levels²⁵, • additional/further diagnostic procedures as required. • a relevant medical history. There are written BAA/BSA recommended procedures or protocols available to all staff in the department and these include air and bone conduction testing, thresholds of uncomfortable loudness levels, and tympanometry.				
Written protocols and/or procedures are not available to all staff in the department					
Evidence Written protocols, Case audit					

²⁵ Unless clinically contraindicated

Criteria 3a.3-a.4 - Equipment calibration and test environment

Quality Statement rationale					
Measures are compromised if not gathered using equipment calibrated to national and international standards and if they are not used in a quiet test environment.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Equipment is not checked daily and calibrations are not always up to date	Equipment is calibrated annually, and daily checks are carried out and documented to international standards.				
Assessment is not always carried out in acoustical conditions conforming to national and international standards	Hearing tests, with the exception of domiciliary visits, are always carried out in acoustical conditions conforming to national and international standards ²⁶ - except when the service has to be taken to the patient for clinical reasons (e.g. household).				
Evidence					
Calibration and equipment check logs/certificates					

²⁶ To enable the accurate testing of normal air and bone conduction hearing threshold levels down to 0 dB HL, ambient sound pressure levels should not exceed any of the levels shown in Tables 2 and 4 respectively from BS EN ISO 8253-1. However, it is reasonable to relax this requirement for BC testing so as to provide for testing down to 10 dB HL by adding 10 dB to the figures in Table 4.

Criteria 3a.5-a.6 - Acquiring other information relevant to developing an Individual Management Plan (IMP)

Quality Statement rationale	1	Fully compliant with good to best practice as indicated by quality statement criteria	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>Hearing status is a necessary prerequisite, but is not sufficient information alone to configure an Individual Management Plan (IMP)</p> <ul style="list-style-type: none"> The goal of the service is to alleviate listeners' activity limitations rather than manage hearing losses. Services should select a validated self-report questionnaire to assess activity limitations related to hearing impairment. Situation-specific structured questionnaires have been shown to offer significant advantages in clinical settings over more general disability and handicap inventories (e.g. GHABP). <p>No elements of the quality statement criteria are met (or not evident)</p> <p>A validated self report questionnaire is not used as part of the assessment protocols and social and personal information relevant to patient management is not assessed.</p> <p>There is no standardised recording of information.</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>A self report questionnaire is a routine part of the assessment protocols²⁷ and is used in conjunction with all information gathered relating to social circumstances, psychological impacts, communication and listening needs and expectations.</p> <p>Information is recorded in a standardised way and is used to develop the content of the IMP. Included in this information should be details of why an assessment or intervention could not be carried out.</p>	<p>Self assessment score based on evidence sources</p>	<p>QA visitor score and comments</p>	<p>Actions / comments</p>	<p>Good practice example</p>	
<p>Evidence</p> <p>Completed questionnaires, Case audit showing use of information from the questionnaire to develop IMP, Clinical record review (random sample of cases), Service policies and procedures relating to standardised gathering of information Associated service educational/promotional activity.</p>						

²⁷ Questionnaires will always be used unless recorded as clinically contraindicated.

Standard 4 - Developing an Individual Management Plan

4a An Individual Management Plan (IMP)²⁸ is: -

- developed for each patient, initially based on information gathered at the assessment phase,
- determined in conjunction with the patient and/or their significant other(s),
- updated on an ongoing basis and
- accessible to the clinical team.

Rating Scale

1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)	Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

²⁸ Examples of an IMP can be found in appendix 5

Criteria 4a.1-a.2 - Factors for Consideration in Developing the IMP

Quality Statement rationale					
An IMP is most effective if it takes into account a range of factors in addition to the type and level of hearing loss. An effective IMP also relies on consultation between the Audiology professional, the hearing impaired person and his or her significant other(s). Only when all parties are committed to the joint goals is an optimal outcome received.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Intervention is based on information about the hearing level and unstructured one to one discussions with the patient only. It does not contain an IMP.	<p>The IMP is contained within the clinical record. It contains details of:</p> <ul style="list-style-type: none"> • hearing status, expectations, • social circumstance, options for rehabilitation (including hearing instrument management), • referral to other agencies and • specific goals associated with assessment information. <p>The IMP is agreed with the patient and significant other(s) at each appointment and a copy is made available for them.</p>				
Evidence					
Sample of clinical records, Service policies and procedures relating to the patient pathway and development of the IMP.					

Criteria 4a.3 - Further Development of the IMP

Quality Statement rationale To be successful, IMPs need to be flexible. Flexibility within the structure of the IMP is beneficial because the content and the goals of the IMP may change over time, reflecting the positive outcomes of interventions.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
The clinical record contains information about the hearing level and intervention agreed only.	The specific goals of the IMP are recorded in the clinical record. The plan includes details of: <ul style="list-style-type: none"> • the decision-making process, • the implementation plan and • proposed timescales. 				
Evidence Sample of clinical records, Service policies and procedures relating to the patient pathway and development of the IMP.					

Criteria 4a.4 - Updating the Individual Management Plan (IMP)

Quality Statement rationale

An effective IMP will detail specific actions associated with agreed goals that take into account a listener's social, communication and listening needs, in addition to their hearing impairment and related activity limitations, e.g. living alone vs family setting vs sheltered accommodation. The IMP is flexible so that different goals can be set if the patient's circumstances/environment changes.

1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p>				
<p>Information about expectations, social needs and or listening needs are not recorded over time.</p>	<p>Information is recorded in the patient's clinical record²⁹ which is updated over the period of the journey through the IMP. This consists of information about the individual's hearing impairments, expectations (goals), psychological impacts, social, communication and listening needs.</p>				
<p>Evidence Completed questionnaires, Case audit showing use of information from the questionnaire to develop IMP, Clinical record review (random sample of cases), Service policies and procedures relating to standardised gathering of information and Associated service educational/promotional activity.</p>					

²⁹ For the purposes of this tool, the clinical record is defined as including NOAH data and descriptive text.

Standard 5 - Implementing an Individual Management Plan

5a The Individual Management Plan (IMP) is implemented over a series of coordinated appointments with the opportunity for revision of outcome goals at each stage.

5b Where provision of hearing aid(s) is required the service ensures:

- hearing aids fitted are functioning correctly,
- nationally agreed procedures and protocols are followed at a local level,
- that patients are offered a hearing aid for each ear where clinically indicated,
- performance of hearing aid(s) is carefully matched to individual requirements and settings recorded.

5c Following implementation of the plan, a process of ongoing support and maintenance continues.

Rating Scale

1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)	Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 5a.1 - Referral to other agencies/services

Quality Statement rationale					
In order for agreed interventions to be effective, referral to another agency/service for interventions should be prompt so as to be based upon an up-to-date appraisal of need.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Where referral to an external agency/service is indicated, referral is never made within 7 days of appointment And/or Information about the length of referral is not available i.e. it is not recorded and/or monitored.	Where referral to an external agency/service is indicated, referral is made from Audiology within 7 days of appointment in at least 95% of cases.				
Evidence Written records, Electronic records, Audits					

Criteria 5a.2-a.3 - Recording interventions and their effectiveness

Quality Statement rationale Planned and coordinated intervention leads to better outcomes. Such an approach requires recording of interventions and their effectiveness to guide on-going development of the IMP.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
There is no standardised recording of information about non-instrumental interventions and/or their effectiveness and/or There is no standardised recording of information about instrumental interventions and/or their effectiveness	The clinical record and IMP includes the details, justifications and effectiveness of all non-instrumental interventions implemented. ³⁰ The clinical record and IMP includes the details, justifications and effectiveness of all instrumental (hearing aid) interventions implemented. ³¹				
Evidence Written records, Electronic records					

³⁰ This will include referrals to other agencies (e.g. to voluntary sector, social services, advanced rehabilitation; counseling, assertiveness, lip-reading, etc).

³¹ This will include earmoulds selected, basic settings/acoustical characteristics of the prescribed hearing aids/s and advanced features (such as directional microphones, noise reduction algorithms and multiple programmes).

Criteria 5b.1 - Ensuring hearing aids are working to specification

Quality Statement rationale Audiologists should be confident that the aid is working to specification before fitting it to a patient so that the aid does not cause harm.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Prior to use, hearing aids do not have their technical performance tested to specification.	Prior to issue; every hearing aid has its technical performance tested to specification. ³²				
Evidence Written records, Electronic records, Audits					

³² Electroacoustic performance will be tested directly on a test box or by using REM. The acoustical consequences of any activated feature of the hearing aid(s) (e.g. directional microphones) are also verified where standard procedures exist.

Criteria 5b.2 – Selection, fitting and verification of hearing aids

Quality Statement rationale					
Professional bodies and national guidelines should be followed to ensure provision meets the needs of the individual.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
There are no local protocols for: <ul style="list-style-type: none"> • Selection • fitting and • verification of hearing aids. 	Local protocols should be in operation concerning selection, fitting and verification of hearing aids. These should comply with the latest professional body and/or national guidance. ³³				
Evidence Written records, Electronic records, Audits					

³³ E.g. the BAA, BSA and Scottish national guidelines.

Criteria 5b.3 - Bilateral hearing aids

1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>Quality Statement rationale Laboratory based evidence suggests that many patients with bilateral hearing impairment gain more benefit from hearing aids fitted bilaterally rather than unilaterally. Emerging evidence, particularly from studies of open canal fittings indicates more real life self-reported benefit too.</p> <p>No elements of the quality statement criteria are met (or not evident)</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p>				
<p>No patients who are clinically suitable for bilateral hearing aids are offered 2 hearing aids.</p> <p>Evidence Written protocols, Electronic records, Audits</p>	<p>At least 95% of patients who need and are clinically suitable for bilateral hearing aid fitting should be offered 2 hearing aids.</p>				

Criteria 5b.4-b.7 - Hearing aids (Real Ear Measures)

Quality Statement rationale Evidence suggests that hearing aids are most effective when their performance is carefully matched to the requirements of the individual.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Real Ear Measurements are not used at all. Where REM is performed the acoustical target is never verified at these three different input levels (50, 65 and 80 dB). Where REM is performed measurements usually deviate from the recommended target at more than one frequency	Real Ear Measurements (REM) of hearing aid performance are to be used to verify at least 95% of hearing aid fittings ³⁴ , unless clinically contraindicated for individual patients. Where REM is performed: the acoustical target is verified at three different input levels (50, 65 and 80 dB) in more than 75% of cases. Where REM is performed: measurements do not deviate from the recommended target at more than one frequency (in 95% of cases) unless clinically indicated. The maximum power output of the hearing aid/s is checked (in 95% cases) by REM if performed, or by coupler measurement. Adjustments are				

³⁴ Explained whenever IMP's are completed and recorded in patient held records.

	made, if required, to ensure that the individual;s uncomfortable loudness level is not exceeded.				
Evidence Written protocols, Electronic records, Audits					

Criteria 5c.1-c.2 - Achieving ongoing use and benefit from hearing aids

Quality Statement rationale On-going use and benefit from hearing aid use is likely to be increased if the process of support and maintenance includes routine audiological reviews and potential for updating the IMP. Such provision is required to accommodate the changing rehabilitation needs of individuals.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No patients are given follow-up appointments. Review appointments are not actively offered to any patient and patients are never advised that they can self refer for reviews or repairs.	Each patient is given a follow-up appointment following hearing aid fitting within a maximum time of 12 weeks. A review appointment is offered to all hearing aid patients every 3 years (in at least 95% of cases). Patients are regularly advised that they can self refer for review or repairs at any time.				
Evidence Written protocols, electronic records, audits					

Standard 6 – Outcome

6a The outcome and effectiveness of the Individual Management Plan are evaluated and recorded following a post-management assessment of the impact of intervention.

Rating Scale	
1	5
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria
2	4
Few elements of the quality statement criteria are met	Almost fully meets the quality statement criteria
3	3
Meet around half of the elements of the quality statement criteria	
4	2
Many elements of the quality statement criteria are met	
5	1
Most elements of the quality statement criteria are met	

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 6a.1 - Measuring outcome

Quality Statement rationale

The management of hearing impairment, within a comprehensive management plan, involves more than a simple technical matter of hearing aid fitting. It involves the provision of a systematic approach, supported by evidence, which addresses not only the hearing impairment, but also other related activity limitations, participation restrictions, and consequent reductions in quality of life (QOL). Subjective outcome measures, in the form of disease-specific questionnaires, can assess the impact of a hearing impairment on the patient's communication functioning, activity limitation, and participation restrictions. This can then be used in the evaluation process to measure how effective the IMP has been. IMP's help to record multiple hearing aid outcomes; such as functional benefit, satisfaction and QOL within a single questionnaire. Measurement of outcome is required to shape further progression of IMP's.

1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>Validated outcome questionnaires are carried out for less than 10% of patients</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>Validated outcome measures e.g. the Glasgow Hearing Aid Benefit Profile (GHABP), IOI-HA and COSI are used to evaluate the outcome of intervention and further develop the IMP in at least 95% of cases (unless clinically contraindicated).</p>				
<p>Evidence</p> <p>Random sample of cases, Case audit, Service audits.</p>					

Criteria 6a.2 – The clinical record and intervention outcomes

Quality Statement rationale Measurement of outcome is required to: - <ul style="list-style-type: none"> • obtain feedback (including a progressive evidence base) on the effectiveness and benefit associated with the service delivered to the patient group. • facilitate further development of IMP, and judge progress on patient outcomes. 					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
The clinical record contains no information about goals and outcomes	Clinical records are used to facilitate further development and judge patient progress. The records contain information about the extent to which the interventions helped meet the specified goals (outcomes)				
Evidence The clinical record					

Standard 7 - Professional Competence

7a The Head of Service/Clinical Lead ensures that:

- Each service provides, within a governed team approach, the clinical competencies necessary to safely and effectively support the assessments and interventions undertaken,
- Where tasks are undertaken by non-registered persons (e.g. volunteers) this takes place within an established competency-based framework and
- Links with external agencies are in place to provide complementary service.

Rating Scale

1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)	Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 7a.1 - Training and education

Quality Statement rationale					
To help ensure a safe and effective service, clinical audiology staff should work within their agreed Scopes of Practice and have the skills required for their contribution towards the rehabilitation of hearing impaired patients.					
Health Professions Council 'Standards of Proficiency' for practitioners statement details requirements for registered practitioners to remain registered. These are produced for the safe and effective practice of the professions they regulate and are deemed to be the minimum standards which are necessary to protect members of the public.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Most of the audiologists and clinical scientists are not registered at least voluntarily with a registration council.	All audiologists and clinical scientists are registered at least voluntarily with a registration council.				
Evidence CPD records/portfolio, Registration status of clinical staff operating as independent practitioners					

Criteria 7a.2 - Access to CPD

Quality Statement rationale Registration bodies and some employers require demonstration of regular CPD activity. Facilities to access CPD close to the point of work and the CPD being received in association with colleagues is advantageous.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Staff do not have access to sufficient CPD.	All clinical staff have evidence of access to an appropriately maintained CPD programme that provides for active participation - normally run internal to the service (or in formal association with another organisation).				
Evidence CPD certificates, Training records					

Criteria 7a.3 - Competency peer review

Quality Statement rationale					
Peer review provides a useful approach to help ensure clinical competencies are maintained.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Competency of staff undertaking clinical procedures is not verified on an ongoing or systematic basis.	Competency for all clinical procedures is verified formally by peer review observation at least every 2 years for all clinical staff undertaking such procedures. Ongoing assessment of all clinical staff's competency should also be carried out, informally, by local audiology centres.				
Evidence					
Records of competency reviews					

Criteria 7a.4 - Volunteer staff

Quality Statement rationale To ensure safe and effective outcomes for patients it is important that there are safeguards in place governing the employment and deployment of volunteers.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
There are no defined quality standards for volunteer staff to work towards.	Volunteer staff supporting the audiology service should work to clearly defined quality standards ³⁵ , applicable to all such staff. These include:				
There are no locally agreed scopes of practice.	<ul style="list-style-type: none"> working to locally agreed scopes of practice, in-house training using competency-based frameworks, recruitment is compliant with national and local requirements. 				
There are no in-house training programmes.					
There are no formal recruitment policies					
Evidence Records of competency reviews, Volunteer standards and audit against them, Formalised in-house training programmes with associated records, Policies for recruitment of volunteers.					

³⁵ <http://www.vds.org.uk/tabid/232/Default.aspx>

Standard 8 – Multi-Agency Working

8a Each audiology service has in place processes and structures to ensure collaborative working with the appropriate agency to meet the needs of patients through the pathway. These include:

- social,
- specialist audiological and
- other health needs

Rating Scale

1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)	Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 8a.1- Co-coordinating multi-professional and multi-agency working

Quality Statement rationale					
Multi-agency collaborative working is more likely to result in services that address the needs of those hearing impaired patients who benefit from a more supportive, social environment.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>Audiology does not take a lead role in setting up meetings with any collective representatives from social work; voluntary sector organisations; local volunteer schemes and patients.</p> <p>Meeting are not formal, do not happen quarterly and areas of planning, development, delivery and audit of services are not discussed.</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>Audiology takes a lead role in setting up meetings with collective representatives from social work; voluntary sector organisations; local volunteer schemes and patients.</p> <p>Formal quarterly meetings take place and the planning, development, delivery and audit of services is discussed.</p>				
<p>Evidence Minutes of meetings</p>					

Criteria 8a.2 - Referral to other agencies

Quality Statement rationale					
Having awareness of and appropriate links to specialist audiological services is more likely to result in the hearing and communication needs of patients being met.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No written protocols or processes are in place to support referral to any other services/ agencies.	<p>Written protocols/processes are in place to support referral to the following services/agencies: -</p> <ul style="list-style-type: none"> • Social work, • Volunteer services, • Voluntary organisations, • Local NHS mental health services, • specialist audiological and other health needs, such as, speech and language therapy and falls prevention clinics. 				
Evidence					
Referral protocols					

Criteria 8a.3 – Audit of multi-professional and multi-agency working

Quality Statement rationale					
Awareness of and appropriate links to other health services is more likely to result in additional health needs of hearing impaired patients being met.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Audit of multi-professional and multi-agency working is not carried out.	<p>Audit of multi-professional and multi-agency working is carried out annually and includes the take up of referral to these agencies.</p> <p>The Audiology Lead is aware of concerns that arise from the audit and discusses these with agencies involved before developing plans to mitigate areas of concern.</p>				
Evidence					
Audit outcomes Plans					

Standard 9 – Service Effectiveness

- 9a Each service has processes in place to measure service quality
 9b Each service has processes in place to regularly consult with patients and stakeholders.
 9c Each service has processes in place to keep up to date with and employ key audiological innovations.

Rating Scale

	1	2	3	4	5
No elements of the quality statement criteria are met (or not evident)		Few elements of the quality statement criteria are met	Meet around half of the elements of the quality statement criteria	Almost fully meets the quality statement criteria	Fully compliant with good to best practice as indicated by quality statement criteria

Please use the rating scale and examples given in the 1 and 5 columns as an indicator to help you score the self-assessment table below. Each table should only ever have 1 self-assessment score. When you perceive there to be more than 1 aspect of the table that you could give a score for, please use an average of each of the aspects.

Criteria 9a1 – Patient Satisfaction Surveys

Quality Statement rationale Measurement of qualitative and quantitative data helps to inform ongoing service improvement.						
	1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)		Fully compliant with good to best practice as indicated by quality statement criteria				
Patients and significant others are not encouraged to complete surveys to determine satisfaction with the service.		Patients and significant others are encouraged to complete surveys on at least an annual basis to determine satisfaction with different elements of the service received. These include: <ul style="list-style-type: none"> • accessibility, • proximity, 				

³⁶ An example of a survey satisfaction questionnaire used by audiology services is listed in appendix 8.

	<ul style="list-style-type: none"> • information provision, • professionalism of staff, • care and treatment and • overall service received. <p>Participation rates in the survey are checked, on an annual basis, to ensure an acceptable proportion of patients have participated and a representative sample of the local population is covered (including gender and ethnicity).</p> <p>Sufficient analysis and interpretation of the findings from satisfaction surveys are carried out each year by audiology services.</p> <p>Action plans are implemented, when needed, to address areas of concern arising from surveys.³⁶</p>				
<p>Evidence Copies of surveys and responses Action plans</p>					

Criteria 9a.2 - Glasgow Hearing Aid Benefit Profile

Quality Statement rationale Measurement of qualitative and quantitative data helps to inform ongoing service improvement.						
	1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
	No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
	Annual quantitative analysis on the quality/effectiveness of the service is not undertaken.	Annual quantitative analysis on the quality/effectiveness of the service is undertaken using GHABP.				
Evidence GHABP reviews						

Criteria 9b.1-b.2 - Informing and consulting with patients

Quality Statement rationale					
Audiology services that seek, consider and respond to the views of users will be more likely to meet the needs of their patients.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>There is no consultation with patients and stakeholders.</p> <p>Results from satisfaction surveys and service QRT scores are never made available or discussed with the public.</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>The audiology service has a framework in place to ensure regular consultation with patients and stakeholders.</p> <p>Results of satisfaction surveys and service QRT scores are made available and discussed with patients on an annual basis.</p>				
<p>Evidence</p> <p>Calendar of planned consultation events</p> <p>Publication of results</p>					

Criteria 9c.1 – Responsibility for identifying new technologies

<p>Quality Statement rationale Use of up to date hearing instrument technology is integral to effective service delivery and ongoing improvement. New technologies make new models of service delivery possible.</p>					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
No one in the audiology service is responsible for identifying, appraising, local development or implementing new technologies.	There is a named lead in Audiology services with responsibility for coordinating the identification, appraisal of potential benefits, local development and implementation of new technologies.				
Evidence					

Criteria 9c.2 – Appraisal of new technologies

<p>Quality Statement rationale Use of up to date hearing instrument technology is integral to effective service delivery and ongoing improvement. New technologies make new models of service delivery possible.</p>					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
<p>No elements of the quality statement criteria are met (or not evident)</p> <p>National meetings are not held by audiology services to appraise new national/international technology developments.</p>	<p>Fully compliant with good to best practice as indicated by quality statement criteria</p> <p>Regular, national meetings are held by audiology services to appraise new national/international technology developments.</p> <p>Meetings include evidence from pilots/trials where the new technology has been tested.</p> <p>The analysis includes the potential patient benefit and the impact the technology could have on workforce and service delivery.</p>				
<p>Evidence</p>					

Criteria 9c.3 – Implementation of new technologies

Quality Statement rationale Use of up to date hearing instrument technology is integral to effective service delivery and ongoing improvement. New technologies make new models of service delivery possible.					
1	5	Self assessment score based on evidence sources	QA visitor score and comments	Actions / comments	Good practice example
No elements of the quality statement criteria are met (or not evident)	Fully compliant with good to best practice as indicated by quality statement criteria				
Departments cannot demonstrate any benefit to patients from using new technology and newly – implemented technology is never monitored.	When new technology is implemented, departments should be able to demonstrate tangible benefits to patients and should continually monitor newly- implemented technology.				
Evidence					

Appendices

Appendix 1

Group Membership

Name	Role	Representing
Adam Beckman	Head of Audiology Services	British Academy of Audiology Plymouth Hospitals NHS Trust
Angela Bonomy	National Audiology Manager	NHS Scotland
Katy Bullock	Public Partnership Officer	NHS Quality Improvement Scotland
Adrian Carragher	Head of Audiology	NHS Ayrshire & Arran
Adrian Davis	Director	MRC Hearing and Communication Group
Hugh Davis	Consultant	MRC Hearing and Communication Group
John Day	Audiologist	Welsh Assembly Government
Jo Edwards	Lecturer in Audiology	Queen Margaret University
Martin Evans	Consultant	MRC Hearing and Communication Group
Theresa Fail		Department of Health
Delia Henry	Director	RNID Scotland
Phil Holt	Senior Audiologist	MRC Hearing and Communication Group
Marian Hoyle	Senior Lecturer in Audiology	Bristol University
Bill McKerrow	ENT Consultant	NHS Highland
Karen Shepherd	Audiological Services Manager	Ormerods
Pauline Smith	Audiologist	British Academy of Audiology
Kevin Wyke	Assistant Director	NHS North West

Appendix 2: Evidence Base

Standard 1

Designed for Life: a new strategy for health and social care in Wales. In May 2005, the Welsh Assembly Government.

Standard 2

Benefits of Good Communication:

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Greenberg PB. Walker C. Buchbinder R. Optimising communication between consumers and clinicians. *Medical Journal of Australia*. Vol. 185(5)(pp 246-247), 2006.

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Harris M. Bayer A. Tadd W. Addressing the information needs of older patients. *Reviews in Clinical Gerontology*. 2002 Feb; 12(1): 5-11.

DiSarno NJ. Informing the older consumer -- a model. *Hearing Journal*. 1997 Oct; 50(10): 49, 52.

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Hines, J (2000) Communication problems of hearing-impaired patients. *Nurs Stand*. 14(19):33-7

Features of Effective Information:

Toolkit for producing patient information, Department of Health, 2003.
www.nhsidentity.nhs.uk/patientinformationtoolkit/patientinformationtoolkit.pdf
EXTRACT: "Patients with hearing difficulties: Use written information."

Measures to Avoid Discrimination:

Disability Discrimination Act, 1995.

'You Can Make a Difference' – Improving hospital and primary care services for disabled people. Guidance from the Disability Rights Commission & Department of Health, June 2004. www.dh.gov.uk/publications

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University of Louisville School of Medicine, Program in Audiology, Louisville, KY 40292, USA.

Standard 3

British Society of Audiology (BSA) Procedure: Pure tone air and bone conduction threshold audiometry with and without masking and determination of uncomfortable loudness levels (2004).

ISO 8253-1:1989 Acoustics. Audiometric test methods - Part 1: Basic pure tone air and bone conduction threshold audiometry.

Standard 4

Kochkin S. (1999) Reducing hearing instrument returns with consumer education. *Hear Rev*. 6(10):18-20.

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Wilson, C, Stevens, D (2003) Reasons for referral and attitudes toward hearing aids: do they affect outcome? *Clin Otolaryngol Allied Sci*, 21(2): 142-6

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Greene, MG, Adelman, RD, Friedmann, E, Charon, R (1994) Older patient satisfaction with communication during an initial medical encounter. *Soc Sci Med*. 38(9):1279-88

McCarthy, PA, Montgomery, AA, Mueller, HG (1990) Decision making in rehabilitative audiology. *J Am Acad Audiol*. 1(1):23-30

Standard 5

Souza, PE, Yueh, B, Sarubbi, M, Loovis, CF (2000) Fitting hearing aids with the Articulation Index: impact on hearing aid effectiveness. *J Rehabil Res Dev.* 37(4):473-81

Gatehouse, S, Stephens, SDG, Davis, AC, Bamford, J (2003) Good Practice Guidance for Adult Hearing Aid Fittings and Services. Needs Assessment Report on NHS Audiology Services in Scotland. Appendix 5

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Improving Access to Audiology Services in England (2007). Dept of Health

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Pilot Study: Efficacy of Recalling Adult Hearing Aid Users for Reassessment after 3 Years within a Publicly-Funded Audiology Service – accepted for publication by IJA, October 2008

Bilateral Amplification:

Noble, W. & Gatehouse, S. 2006. Effects of bilateral versus unilateral hearing aid fitting on abilities measured by the Speech, Spatial, and Qualities of Hearing Scale (SSQ). *International Journal of Audiology.* 45, 172-181.

Mencher, G.T. and Davis, A. 2006. Bilateral or unilateral amplification: Is there a difference? A brief tutorial. *International Journal of Audiology.* 45 (Supplement 1): S3-S11.

Dillon H, 2001. *Hearing Aids*. Boomerang Press: Turramurra, Australia p370-403

Standard 6

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Cox R, Alexander G. (1995) The Abbreviated Profile of Hearing Aid Benefit. *Ear Hear* 16:176-186.

Cox, R.M., and Alexander, G.C. "The International Outcome Inventory for Hearing Aids (IOI-HA): psychometric properties of the English version." *International Journal of Aud.* 41(1): 30-35 (2002).

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Ventry I, Weinstein B. (1982) The hearing handicap inventory for the elderly: a new tool. *Ear Hear* 3:128-134.

Standard 7

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Faulkner, Mark (1); Davies, Sue (2). Social support in the healthcare setting: the role of volunteers. *Health & Social Care in the Community*. 13(1):38-45, January 2005.
(1)Department of Community Ageing Rehabilitation, Education and Research, University of Sheffield, Rotherham, UK (2)Department of Community Ageing Rehabilitation, Education and Research, The University of Sheffield, Sheffield, UK.

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Seeking the Views of Service Users:

Welsh Assembly Government and OPM. 2003, *Signposts 2: Putting Public and Patient Involvement into Practice in Wales*. Cardiff. Welsh Assembly Government

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National Service Framework for Older People in Wales. March 2006. Welsh Assembly Government, Cardiff.

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Standard 9

Appendix 3: The Individual Management Plan (IMP)

A Usable Interpretation of Individual Management Plans within Adult Rehabilitation Questions and Answers

What is an Individual Management Plan?

Individual Management Plans are a set of **agreed needs** and **actions** that aim to improve a person's *participation* in life by reducing the disabling effects of a hearing impairment. When first developed it will be a list of the **needs** you and the patient have agreed need to be addressed and a list of the **actions** you are going to take in an attempt to address these needs.

Who has them?

They will probably be developed for all patients entering a new care pathway. These may be patients who have accessed audiology services before (audio reviews) or they may be new patients (Direct Referrals or ENT HA referrals).

Who develops them?

The Audiologist and patient will develop the Plan together using the information gathered during the assessment and following explanation and discussion about the care options. A list of **agreed needs** and **actions** will be recorded. A copy will be given to the patient as part of their information booklet.

What do they look like?

Initially you will develop and record the needs and actions

Management Plan

Agreed Needs: *a list of the issues that you and the patient have agreed need to be addressed/managed/rehabilitated*

Actions: *a list of the actions you going to do or what are you going to ask somebody else to do to actually attempt to meet these needs*

And then as you begin to deliver the Plan you will add:

Completed Actions: *a list of the actions you actually do at each stage*

Outcomes: *a summary of the effects of the actions – have they met needs*

What do you mean 'agreed needs'?

What is it that you and the patient have agreed that needs to be addressed or managed or rehabilitated. This will be based on in-depth history, discussion, hearing impairment, condition of ext/ME, expectations etc.

They will be broad statements of need but will be specific to an individual

Examples:

- Improve comfort of ear mould
- Better understand the effects and implications of sensorineural HL
- Investigate conductive hearing loss
- Improve hearing for speech in noisy environments
- Improve patients confidence in group social situations

What do you mean 'actions'?

What are you going to do or what are you going to ask somebody else to do to actually attempt to meet these needs. They will be specific and directive, probably written in the future tense and attached or relevant to one or more of the needs.

Examples:

Need: Improve comfort of ear mould

Possible actions you may decide upon:

- File and polish earmould to remove uncomfortable ridge
- Take new impression of right ear and order replacement ear mould
- Take new impression of right ear and order earmould made from softer material
- Guide patient on correct insertion of ear mould and provide written

What do you mean 'completed actions'?

These are the actions you (or other audiologists/agencies) actually do at each stage (as opposed to plan to do). They will be directly linked to actions (very similar) and probably written in past tense.

Action: Take new impression of right ear and order earmould made from softer material

Completed Action: Took new impression of RT ear (2108 microflex) and arranged for fitting appointment

What do you mean 'outcomes'?

These will be a summary of the effects of actions and will enable you to evaluate if the actions have met the needs? Ideally these will be supported by a more formal overall outcome measure.

They will be linked to needs and may often reference specific actions. They will probably be written in the present tense.

Need: Improve comfort of ear mould

Action: Take new impression of right ear and order earmould made from softer material

Completed Action: Took new impression of RT ear (2108 microflex) and arranged for fitting appointment

Outcome: New earmould good fit and patient reports softer material much more comfortable than previous earmoulds.

When is a management plan completed and how do we record this?

The management plan is complete when there are no outstanding actions and when outcomes indicate that needs have been met. 'Management plan complete' will be added as a final statement to the bottom of the management plan and the patient will be discharged to maintenance and support services.

You need to consider how you include outcomes or effects of referral to external agencies that may not have been delivered at final follow up appointments.

What happens then?

Some patients will then be discharged to the maintenance and support services where they are able to access audiology for repairs and maintenance and can self refer for reassessment (at this point they would re-enter a new care pathway and would have a new management plan developed).

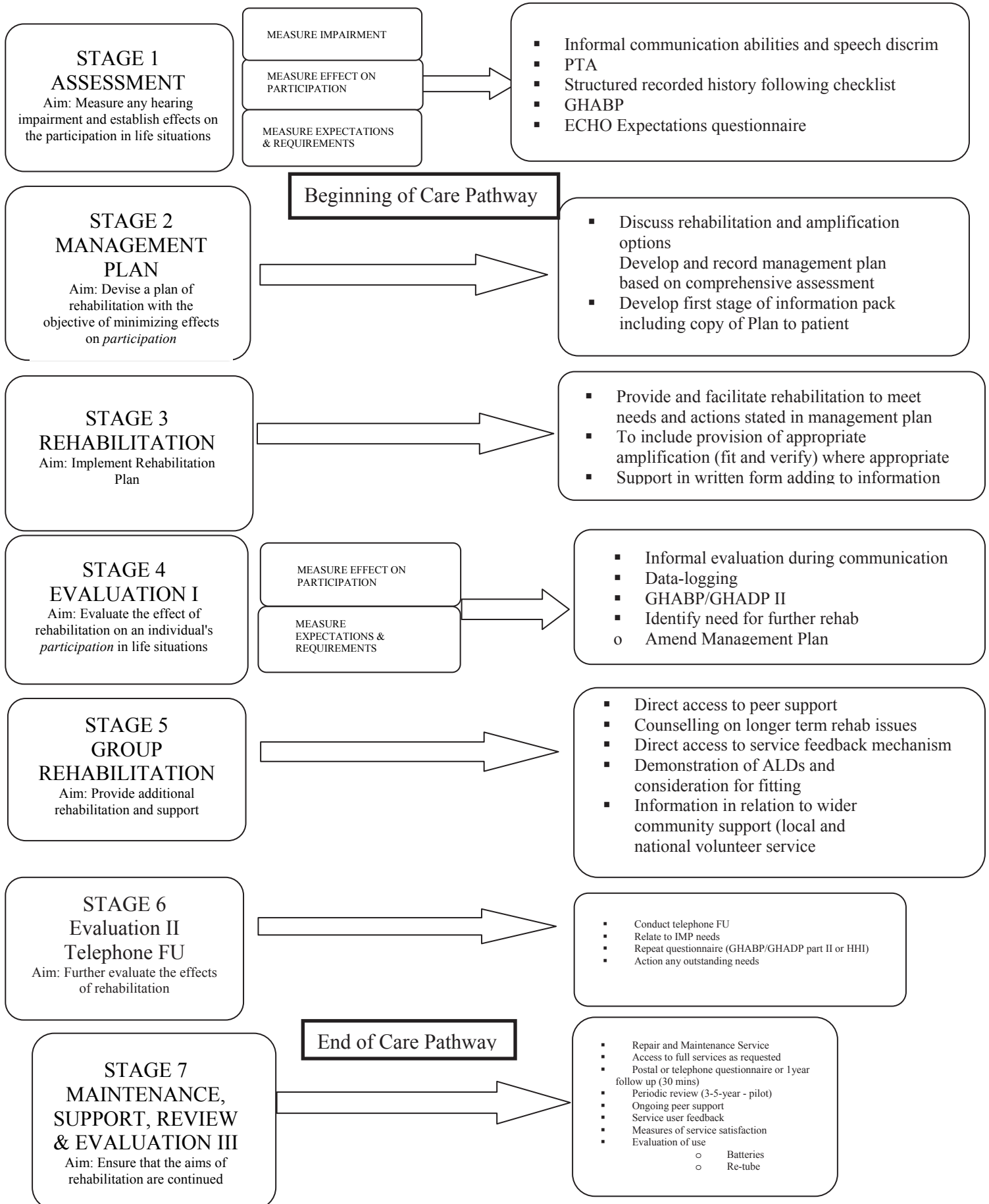
Appendix 4: Adult Rehabilitation Patient Pathway

An Example of How the Individual Management Plan Fits within an Audiology Adult Rehabilitation Patient Pathway

Audiology Adult Rehab Patient Pathway

Green - Currently within service

Red - Development of Service



Appendix 5: Example of an Individual Management Plan (IMP)

CASE 1 - Journal entry including Individual Management Plan

Direct Referral

History – Service User reported:

General

Service User attended alone. Self referred via GP. Main difficulties hearing at work over last 12 months.

Physical

Vision corrected with glasses

Mobility and dexterity good

Social

Lives with wife and two teenage sons. No problems with hearing telephone ring or callers at door. Tend to shop and bank on-line so no recent problems hearing for these scenarios. Alarm clock and smoke alarm OK

Employment

Fitter by trade - worked on shop floor for 15+ years - no problems. Recently promoted to supervisor - job now involves: training/presenting, management meetings, Q&A sessions with people he supervises/line manages. Hearing problems seem to be mainly at work and since change in role. Management meetings of about 12 people around table - people vary and sometimes struggles. Monday morning meetings with staff are difficult - poor env and lots of people talking/asking questions at once. Problematic as people used to be friends and concerned they think he's changed since promotion. Training sessions in lecture theatre difficult. Has to go back and pass on info and worried he's not understood properly

Lifestyle and associated hearing disabilities

Mainly socialises with family. No signif problem - family tend to understand and adapt.

Enjoys attending concerts about 6/year. Goes with same group of friends. Used to go to pub after but struggling more in this environment recently and tending to go straight home.

Medical

Sudden/progressive: had minor difficulties for a long time (?since childhood). Seems to have become worse since change in job but really only at work and with unfamiliar groups of people. No real change at home.

Asymmetric: no

Fluctuating: no

Otalgia/ME pathology/surgery: no

Ext ear pathology/irritation: no

Tinnitus: yes - bilaterally all the time but doesn't notice if busy or distracted.

Sometimes keeps awake at night or there if wakes up at night. Recognises it may be linked to 'worry/stress'.

Rotational vertigo: no

Family History: dad wore HA since middle age

Noise exposure: at work but wore hearing protection. At concerts (~6/year)

Head Injury: no

General Health: well

Expectations

Expects to be told he has a hearing loss but hopes hearing can be improved (surgery/medication). See ECHO for further details.

Otoscopy

NAD

Audiometry

Mild mid freq SN HL

Questionnaires

GHABP complete What are the scores?

ECHO scores What is the scale here? Is 6.0 high?

Scores	Average
Overall	5.3
Sub Scale	
Positive effect	6.0
Service and cost	5.5
Negative Features	5.0
Personal Image	4.7

Management Plan

Agreed needs: Improve ability to hear colleagues when at training sessions; management meetings and Monday morning meetings at work. Build confidence in hearing ability so that you can begin to go out socially with music friends again. Manage expectations about hearing aid use. Reduce the negative impact of tinnitus.

Planned Actions: Trial bilateral digital hearing aids with directional programme. Refer to voluntary sector employment advisor for support within workplace. Complete tinnitus handicap inventory and consider referral to hearing therapist following trial of hearing aid. Provide verbal and written information about the potential benefits and limitations of hearing aids

Completed Actions: Took bilateral impressions and arranged hearing aid fitting appointment. Completed tinnitus handicap inventory. Referred to RNID employment advisor. Discussed expectations, benefits and limitations of hearing aids. Supported by written info in blue book.

Information booklet

Given to patient.

Final Follow Up

Copy of Management Plan

Agreed needs: Improve ability to hear colleagues when at training sessions; management meetings and Monday morning meetings at work. Build confidence in hearing ability so that you can begin to go out socially with music friends again. Manage expectations about hearing aid use. Reduce the negative impact of tinnitus.

Planned Actions: Trial bilateral digital hearing aids with directional programme. Refer to RNID employment advisor for support within workplace. Complete tinnitus handicap inventory and consider referral to hearing therapist following trial of hearing aid. Provide verbal and written information about the potential benefits and limitations of hearing aids

Completed Actions: Took bilateral impressions and arranged hearing aid fitting appointment. Completed tinnitus handicap inventory. Referred to voluntary sector employment advisor. Discussed expectations, benefits and limitations of hearing aids. Supported by written info in blue book. Fitted bilateral hearing aids with dir prog; added further written info to booklet; discussed expectations further; hearing therapy appt arranged; voluntary sector employment advisor has made contact with pt. Tinnitus advice and information provided by hearing therapist. Activated telecoil prog bilaterally; voluntary sector employment advisor has visited work place and advised;

Outcomes: *Hearing in most situations has improved as has confidence in hearing ability. Location for Monday morning meetings changed and now managing well. Unable to evaluate full benefit in training centre at work yet - telecoils activated today - good benefit during training sessions at work using loop system; now meeting friends in local pub regularly; information about HL and tinnitus and increased confidence in hearing at work has reduced stress and negative impact of tinnitus. Pt has a positive and realistic approach to hearing aid use and benefit. Supported by GHABP*

Management plan complete

People present at appt

Pt attended alone

Service User reports

Continuing to use both hearing aids regularly. Slightly more use out of work than at previous FU. EM no longer causing discomfort

Data logging

Data logging supports patient reports

Hearing Aid Adjustments

1.1.1 R - none

1.1.2 L - none

Other rehabilitation comments

Discussed longer term management of hearing aids and access to services.

Gave further written info to support this for pt information booklet.

GHABP parts 1&2

	% raw score		% raw score
Initial disability	59	Residual Disability	6
Handicap	75	Benefit	72
Use	88	Satisfaction	84

Service satisfaction questionnaire completed and given to reception

Appendix 6: List of useful websites

www.baaudiology.org

www.dh.gov.uk

www.mrcheam.ac.uk

www.nhshealthquality.org

www.phis.org.uk

www.rnid.org.uk

www.scotland.gov.uk

www.thebsa.org.uk

[**www.18weeks.scot.nhs.uk**](http://www.18weeks.scot.nhs.uk)

<http://www.vds.org.uk/tabid/232/Default.aspx>

<http://iiv.investinginvolunteers.org.uk/>

Appendix 7 – Glossary

- **Higher Frequency sounds**-are high in pitch, like the right hand end of a piano, or a violin rather than the left hand end of a piano or a double bass.
- **Lower frequency sounds**- are low in pitch, like the left hand end of a piano, or a double bass rather than the right hand end of a piano or a violin.
- **Threshold of hearing**-the lowest intensity of sound that a person can detect, measured using a standard procedure and usually at a range of pure tones at various frequencies.
- **Thresholds of uncomfortable loudness**-the lowest intensity of sound that a person finds uncomfortably loud, measured using a standard procedure and usually at a range of pure tones at various frequencies.
- **Dynamic range**-the difference between threshold of hearing and uncomfortable loudness level.
- **Reduced dynamic range**- usually occurs when threshold of hearing is poor, but threshold of uncomfortable loudness is normal.
- **Air conduction testing**- threshold of hearing measured with earphones that sit over the ears. The sound therefore passes through the outer, middle and inner ear.
- **Bone conduction testing**- threshold of hearing measured with a bone vibrator sitting on the bone (mastoid process) behind the ear. The sound therefore bypasses the outer and middle parts of the ear, and goes directly to the inner ear.
- **Sensorineural**- a type of hearing loss caused by damage in the inner ear or auditory nerve, rather than in the middle ear.
- **Potentiometer**- A piece of electronic circuitry which can be physically altered to alter the characteristics of the circuit, e.g. the amount of amplification at high frequencies.
- **DSP Digital Signal Processing**. A means by which computer programming can alter the characteristics of the circuit, e.g. the amount of amplification at a particular frequency in a hearing aid.
- **Compression**. When the range of intensities of sound that are audible and comfortable to a normally hearing listener are “squashed” into a smaller range for a hearing impaired listener.
- **Compression characteristics**. Ways of defining how much, and how quickly a normal range of sounds are “squashed”
- **Acoustical characteristics**. Ways of defining a sound, or the way a sound is processed.
- **Tympanometry**. A test whereby a small tip sits in the outer part of the ear canal and measurements are made of the moving parts of the middle ear.
- **Real ear measurement**. When a thin tube, connected to a microphone, is inserted into the patient’s ear canal, enabling measurements of sound to be made from within the ear canal. These measurements are usually made both with, and without a hearing aid in place, in order to measure exactly what the hearing aid is doing.
- **Hearing Impairment**- When hearing is below that defined as normal. There are defined levels of severity of hearing impairment (mild, moderate, severe, profound) based on pure tone threshold measurement.

- **Deaf-** Usually profound hearing impairment, people who refer to themselves as Deaf (with a capital D) regard deafness as a way of life rather than a disability.
- **Deafblind-** a person has a combination of hearing and visual impairment, and is therefore unable to use one to compensate for the other.
- **Deafened -** a person who loses their hearing (or acquires a hearing impairment), as opposed to a person who is born with impaired hearing
- **CPD Continuing Professional Development.** Ongoing education and training for a registered professional, usually as part of a structured scheme, by which they maintain clinical competence.
- **Review** – an appointment at which the patient’s rehabilitative needs are reassessed and their IMP recommences. Basic hearing aid repairs (maintenance) or straightforward replacement of faulty hearing aids do not constitute a review although they may highlight the need for one to be arranged.
- **Audiovestibular medicine** - The medical specialty concerned with the investigation, diagnosis and management of adults and children with disorders of balance, hearing, tinnitus, and auditory communication - including speech and language disorders in children.
- **COSI Client Oriented Scale of Improvement.** A validated interview tool to measure listening needs at assessment and outcomes after intervention, see Dillon et al 1997.
- **GHABP Glasgow Hearing Aid Benefit profile.** A validated interview tool to measure initial disability and handicap at first assessment, followed by use of hearing aids, benefit and satisfaction with hearing aids and residual disability at follow up. See Gatehouse, 1999.
- **GHADP Glasgow Hearing Aid Difference profile.** A validated interview tool to measure use of existing hearing aids and disability at re-assessment, followed by use of hearing aids, and comparative disability, benefit and satisfaction with new hearing aids at follow up. See Gatehouse, 1999
- **IOI-HA International Outcome Inventory for Hearing aids.** A validated questionnaire, available in many different international languages, to measure outcomes after intervention with hearing aids. See Cox and Alexander, 2002.

Appendix 8 – AASSQ Adult Audiology Service Satisfaction Questionnaire

Please complete the questionnaire below to help us improve Audiology services. Indicate your level of satisfaction for each item with a tick. Please base your responses on all of the appointments you have received over the last few months.

Overall, how satisfied are you with:

	Very satisfied	Satisfied	Somewhat Dissatisfied	Very dissatisfied
Accessibility				
Your experience communicating with the Audiology Service?				
The time you waited <u>for</u> your appointments?				
The time you waited <u>at</u> your appointments?				
The location of your appointments? (How accessible from your home)				
The postal hearing aid repair and battery replacement service?				
Surroundings				
The signage directing you to the Audiology department?				
Your welcome at reception?				
The appearance of the waiting room?				
The appearance of the clinic rooms?				
The comfort of the clinic rooms?				
Information				
The information you received with the appointment letters?				
The written information you received at your appointments?				
The information in the waiting room?				
Staff				
The professionalism of the reception staff?				
The professionalism of the audiologist?				
Care & Treatment				
The opportunities to discuss any problems or difficulties?				
Any explanations you were given?				

The assessment and management of your hearing needs?				
The appropriate involvement of your significant other?				
Overall				
The audiology service you received?				
Please state below one improvement you would make to the Audiology Service or please add any comments?				

Section below for completion by Audiology staff:

Clinic _____

Date _____

Type of Appointment

Comments:



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RR Donnelley B60164 04/09

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ISBN 978-0-7559-7301-9



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