

Best Practice Statement ~ *November 2005*

Maximising Communication with Older People who have Hearing Disability



Queens Nursing
Institute Scotland

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Introduction

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. NHS QIS does this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

Background to Best Practice Statements

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing, midwifery and allied health professional practice.

The development of best practice statements reflects the current emphasis on delivering care that is patient-centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

A series of best practice statements has been produced, designed to offer guidance on best practice relating to specific areas of practice and to encourage a consistent and cohesive approach to care.



Key Principles of Best Practice Statements

A best practice statement describes best and achievable practice in a specific area of care. The term 'best practice' reflects the commitment of NHS QIS to sharing local excellence on a national level. Best practice statements are underpinned by a number of shared principles below:

- Best practice statements are intended to guide practice and promote a consistent and cohesive approach to care.
- Best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may also contribute to multidisciplinary working and be of guidance to other members of the healthcare team.
- Statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary.
- Information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus.
- Statements are targeted at practitioners, using language that is accessible and meaningful.
- Consultation with relevant organisations and individuals is undertaken.
- Statements will be nationally reviewed and updated every 3 years.
- Responsibility for implementation of statements will rest at local level.
- Key sources of evidence and available resources are provided.

Use of Evidence in Best Practice Statements

The need to embrace evidence in its broadest sense has been acknowledged by NHS QIS in the development of best practice statements. Best practice statements represent a unique synthesis of research evidence, evidence complemented by audit, patient surveys and evidence derived from expert opinion, professional consensus and patient/public experience.

The process for developing these statements adopts a rigorous, transparent and consistently inclusive approach to articulating best practice that involves professionals and patients, and is based on all types of available evidence.

Key Stages in the Development of Gerontological Nursing Best Practice Statements

A unique feature of the Gerontological Nursing Demonstration Project best practice statements is that they are refined through evaluative research to enhance practice.

Review Evidence

Research, major reports, national audits, existing care guidance, expert nursing opinion, evidence from older people.



Draft Best Practice Statement

Identify nursing contribution, apply gerontological nursing values, identify level and type of evidence.



Pilot within a Demonstration Site

Base-line audit, facilitate practice development and problem-solve, involve users, pool expertise of gerontological community of practice, refine statement, follow-up audit. External consultation on the revised draft.



Disseminate and Update 3-yearly

Paper copies, on-line in PDF format, face-to-face seminars, e-based practice facilitation with gerontological nursing community of practice.

Promote networking between community of practice nurses, demonstration site staff and practitioners involved in progressing implementation.

How Can the Statement be Used?

The best practice statement on maximising communication with older people who have hearing disability is intended to serve primarily as a guide to good practice and promote a consistent and cohesive approach to care. The statement is intended to be realistic but stretching, and can be used in a variety of ways, including:

- as a basis for developing and improving the care that nurses give to older people
- to stimulate learning among teams of nurses
- to promote effective interdisciplinary team working
- to determine whether a quality service is being provided
- to stimulate ideas and priorities for research.

Who was Involved in Developing the Statement?

Steering Group

Jo Booth	Senior Research Fellow in Gerontological Nursing, Glasgow Caledonian University
Tracy Day	Senior Audiologist/Hearing Therapist, NHS Grampian
Mary Dowds	Bettercare Lecturer in Gerontological Nursing, Glasgow Caledonian University
Morag Francis	Sister and Education Co-ordinator, Royal Blind, Braeside Care Home, Edinburgh
Debbie Tolson	Professor of Gerontological Nursing, Glasgow Caledonian University

Demonstration Site Staff

Sue Gardiner	Clinical Nurse Practitioner, Royal Victoria Hospital, Edinburgh
Carol Paterson	Charge Nurse Ward 7, Royal Victoria Hospital, Edinburgh
Christine Tonge	Team Leader, Health Visiting for Older People, Lerwick Health Centre, Shetland
Edna Williamson	Staff Nurse, Day Hospital, Montfield Hospital, Lerwick, Shetland
Hazel Wilson	Depute Ward Manager, Ward 7, Royal Victoria Hospital, Edinburgh

Nurse Reference Group

Maximising communication with older people with hearing disability
Community of Practice (see Appendix 6)

Best Practice Statement: Maximising communication with older people who have hearing disability

This best practice statement has been produced by NHS QIS from the collaborative development work of the Gerontological Nursing Demonstration Project research team (Glasgow Caledonian University), the Maximising communication with older people who have hearing disability Community of Practice (Appendix 6), the staff of Ward 7, Royal Victoria Hospital, Edinburgh and community staff in Lerwick, Shetland. It is the first of the best practice statements to be demonstrated in a community nurse's caseload in addition to an inpatient facility.

The underlying aim of this work is to offer evidence-based nursing guidance to maximise communication with older people with hearing disability. In particular, it is relevant to older people in hospital, attending a day hospital or living in their own homes.

The ability to communicate effectively is fundamental to quality of life and wellbeing in older people. However, there is evidence that older people with hearing disability are not well served by healthcare professionals, both in terms of recognising and detecting the nature of the difficulties, and managing them effectively^{3,14}. A general failure to recognise hearing impairment as problematic for older people has been found³³ despite the increasing prevalence with advancing years.¹ In addition, there is a tendency within the specialist literature to focus on the provision of personal hearing aids,³¹ consequently, relatively little attention has been given to other aspects of audiological rehabilitation, including management of the older person's listening environment.²⁶

Conservative nursing interventions have the potential to improve much of the distress associated with this common, but under-recognised condition, and significantly improve the older person's healthcare experience. In order to achieve this, a knowledgeable nursing staff is required. To date, however, there has been little in the way of specific care guidance, the implicit assumption within the literature being that nurses intuitively know how to recognise and manage hearing disability among older people.²⁶

This best practice statement provides the explicit detail necessary to guide the development of knowledge and skills among nursing staff, and enable a level and quality of practice to be achieved to minimise the impact of hearing disability on older people in their care.

The Gerontological Nursing Demonstration Project

This practice innovation research project involves the development of best practice statements, which are informed by a review of existing evidence and refined through testing and user involvement in a demonstration site. The presentation of the statement reflects the emerging definition of gerontological nursing, and an agreed set of values developed by the Scottish Gerontological Nursing Community of Practice. The statement reflects the beliefs of nurses and has been demonstrated to be achievable within practice areas similar to the demonstration site. To see the definition and list of values refer to Appendix 7; alternatively to find out more about the project, visit the website (www.geronurse.com).

Section 1: Promoting nurses' awareness of hearing disability in the older person

Key Points ~

- 1 60% of people over 70 have significant hearing disability¹ and in long-term care this figure rises to 90%²
- 2 Public and professional attitudes fail to recognise hearing disability as abnormal, requiring assessment and management.^{3,4}
- 3 Older people may not admit to difficulties with hearing^{4,5}
- 4 Nurses are ideally placed to identify the older person with age-related hearing disability.⁶

[The numbers above the text correspond with the sources of evidence in Appendix 1]

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nurses and care staff are knowledgeable about:</p> <ul style="list-style-type: none"> • age-related communication needs, and • the impact of hearing loss on older people's psychological and social wellbeing and overall quality of life. 	<p>Age-related hearing disability can have a negative influence on a person's quality of life. The person may avoid social situations and is at increased risk of isolation.^{8,9} Hearing loss may contribute to or exacerbate mental health problems such as depression or paranoid beliefs.¹⁰</p> <p>Family and other significant relationships may be affected by hearing loss.⁷</p> <p>There is evidence that age-related hearing loss is not recognised as a problem which is amenable to healthcare intervention.^{4,5}</p>	<p>There are local guidelines on deaf awareness and communicating with older people with hearing disability. Staff education and training programmes are in place. Staff training records provide evidence of education and training.^{3,4,28}</p> <p>Access to local guidelines is made known to nursing and care staff at induction training.²⁷</p>
<p>Nurses and care staff are aware of the range of interventions that minimise the effects of age-related hearing loss for the older person and their family.</p>	<p>Nurses and care staff are in an ideal position to identify older people with hearing difficulty and to act to minimise the effects.⁶</p> <p>Hearing loss in older people may be mistaken for cognitive impairment.^{4,5,7,14}</p>	<p>Documentation shows that the individual's hearing abilities and disabilities are an important component of the assessment and care process.¹²</p> <p>There is a range of legible and clear information, for staff, older people and carers on:</p> <ul style="list-style-type: none"> • deaf awareness • methods of communicating • access to advice and services, and • current therapeutic approaches.^{3,15}

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
		There is evidence to show that appropriate communication methods are used to help older people and their families to understand and interpret information about their care and treatment. ^{12,16,17}

Key Challenges ~

- 1 *Challenging the stigma associated with hearing disability that many older people feel.*^{5,16}
- 2 *Accurately distinguishing between hearing disability and cognitive impairment.*^{4,11}
- 3 *Challenging the perception that age-related hearing disability is a normal part of ageing.*¹⁸
- 4 *Ensuring that nurses and care staff view hearing disability as a priority area for intervention.*
- 5 *Providing information in a range of formats to meet the needs of older people with complex communication needs.*¹⁶

Section 2: Assessment and care planning

Key Points ~

- 1 *The provision of best practice is dependent upon early and accurate identification of individual needs, through systematic screening and comprehensive assessment.¹²*
- 2 *Relying on self-report of hearing difficulties tends to underestimate problems.^{11,12,22} Individual self-report, however, may be a reliable indicator of hearing disability.²⁰*
- 3 *Not all hearing disability in older people may be attributed to age-related presbycusis; the progressive sensorineural deafness that occurs with age.¹²*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The registered nurse undertakes screening for the presence of hearing disability on initial contact with the older person.</p> <p>A variety of screening approaches may be utilised according to the individual's presentation.^{4,13}</p>	<p>Early identification of potential hearing deficits facilitates effective communication and enhances the wellbeing of older people with hearing disability, their spouses and other supporters.^{12,25}</p> <p>Alternative means of screening, eg based on observation of body language, behaviour, voice and language use, are used to ensure all older people can be screened for age-related hearing disability.²²</p>	<p>Self-reported hearing problems are documented in nursing records and lead to screening and in-depth assessment.^{23,26}</p> <p>Screening is undertaken where a hearing disability is suspected, using an appropriate screening tool.²⁶</p> <p>Findings from the initial screening are documented and inform subsequent assessment and collaborative care-planning.²² Appendix 3 provides an example of a screening tool.</p>
<p>Where indicated by the findings from the initial screening, the registered nurse undertakes a comprehensive assessment with the older person and the person's family, to the extent the older person desires, of:</p> <ul style="list-style-type: none"> • individual communication needs, and • factors that may affect hearing, listening and communication abilities.⁴ 	<p>The ability to communicate effectively depends on a range of factors, internal and external, to the person.</p> <p>Effective rehabilitation is dependent upon accurate identification and evaluation of need.²⁶</p>	<p>Nursing documentation includes assessment by the registered nurse of:</p> <ul style="list-style-type: none"> • the older person's first language and preferred method of communicating • personal and health factors affecting communication • visual, cognitive, psychological and language impairments • other diagnosed conditions affecting hearing, eg tinnitus, Menieres disease • medication used, and over what time period • the person's listening environment, including preferences and causes of frustration¹⁸ • ear wax status

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The registered nurse involves the older person and the person's family, to the extent the older person desires, in devising and reviewing an individual plan of care.</p> <p>The plan of care identifies and records agreed actions to meet the person's communication needs.^{6,26}</p> <p>The registered nurse involves members of the multidisciplinary team with appropriate specialist knowledge or skills in devising, delivering and reviewing the care plan.^{2,6}</p>	<p>The potential for deterioration in physical and/or mental health is reduced when the person has control in their environment.¹⁸</p> <p>Care plans that are agreed and updated by the team members, including the older person and the person's family (where appropriate), enhance communication and overall quality of care.²⁶</p>	<ul style="list-style-type: none"> • the older person's desire for assistance with hearing disability • communication strategies used including use of aids and adaptations,²¹ and • factors influencing the use of hearing aids. <p>Local criteria for referral to audiology services are in place and accessible.²⁸</p>
<p>The registered nurse involves the older person and the person's family, to the extent the older person desires, in devising and reviewing an individual plan of care.</p> <p>The plan of care identifies and records agreed actions to meet the person's communication needs.^{6,26}</p> <p>The registered nurse involves members of the multidisciplinary team with appropriate specialist knowledge or skills in devising, delivering and reviewing the care plan.^{2,6}</p>	<p>The potential for deterioration in physical and/or mental health is reduced when the person has control in their environment.¹⁸</p> <p>Care plans that are agreed and updated by the team members, including the older person and the person's family (where appropriate), enhance communication and overall quality of care.²⁶</p>	<p>Ear cerumen (wax) status is assessed and recorded with evidence of management methods where appropriate. (See Appendix 5.)</p> <p>Type, condition and use of hearing aids and other assistive devices is recorded, including how often and by whom it is serviced.¹³</p> <p>Activities to manage the person's listening environment are documented.^{4,18}</p> <p>There is evidence of equity of access to team members and services.^{14,17}</p> <p>Care records indicate the effectiveness of hearing rehabilitation activities.²⁸</p>

Key Challenges ~

- 1 *Enabling older people to feel confident in reporting perceived hearing difficulties.*
- 2 *Identifying a suitable nurse-administered screening tool for hearing disability in older people.*
- 3 *Providing education to ensure registered nurses are competent to screen for age-related hearing disability.⁶*
- 4 *Instigating early rehabilitation and supportive actions following screening and assessment.¹²*

Section 3: Maximising interaction opportunities for older people with hearing disability

Key Points ~

- 1 *Older people's ability to maintain their quality of life depends on their capacity to communicate their needs and engage in social interaction.^{10,30}*
- 2 *Effective communication involves attention to the full range of auditory rehabilitation strategies including verbal and non-verbal techniques, environmental and supportive strategies in addition to the use of assistive devices. This includes the appropriate use of hearing aids and staff awareness of their advantages and limitations.^{6,13}*
- 3 *Older people demonstrate a positive attitude towards trials of hearing aids to reduce their disability.²⁸*
- 4 *Only a minority of older people who might benefit from hearing aids own them and even less use them.³⁰*
- 5 *The quality of the listening environment has a profound effect on the older person's opportunity for effective communication.¹⁸*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nurses and care staff ensure that older people with hearing disability have access to appropriate rehabilitation and supportive measures, including the use of hearing aids, to maximise interaction and communication.</p>	<p>If older people are to experience positive health, they must have opportunities to engage socially.^{10,29}</p>	<p>Local guidelines for communicating with older people are available. Appendix 4 is an example of a communication guideline.</p> <p>There is access to, and use of, approved interpreters, including British Sign Language (BSL), lip speakers and deaf blind communicators.³²</p> <p>There is evidence of knowledge and use of communication tactics including non-verbal communication, lip-reading and use of assistive devices such as communicators and loop induction systems.¹³</p> <p>Nurses and care staff provide more time to maximise interaction opportunities with older people with hearing disability.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nurses and care staff are aware that hearing aids do not restore full hearing ability and thus hearing disability may be reduced, but not eliminated.</p>	<p>Age-related hearing loss commonly occurs at higher sound frequencies, which makes speech particularly difficult to understand, especially when there is background noise.^{10,31}</p>	<p>Hearing devices other than hearing aids are used appropriately, eg visual alerting devices (including smoke detection), communicators, loop induction systems.</p>
<p>Where the older person has a hearing aid(s) nurses and care staff encourage them to wear it (them) and provide any support they require to insert, use and maintain it (them).</p>	<p>Devices to aid hearing only function correctly when properly used and maintained.^{1,13,21}</p>	<p>Nursing and care staff are knowledgeable about different types of hearing aids, their proper usage, care and maintenance.^{4,13}</p> <p>A range of equipment to maintain optimal hearing aid function is available to nursing and care staff, and hearing aid maintenance checks are routinely provided.^{2,4}</p>
<p>Nurses and care staff give consideration to factors that impact on the effectiveness of hearing aids in older people.</p>	<p>A range of personal and environmental factors may influence the use of hearing aids and benefits gained by older people.</p>	<p>The older person receives education to prevent further hearing disability and maximise hearing potential, eg individualised communication strategies, cerumen management techniques, noise control techniques, understanding and management of the listening environment.</p> <p>Proactive consideration and management of the listening environment is evident,¹⁸ including measures to reduce background noise.⁶</p> <p>Quiet areas for private and sensitive communication are available.¹³</p> <p>Ear function is maintained and control of ear wax is evident. (See Appendix 5.)</p>

Key Challenges ~

- 1 *Team development to enable proactive management of the listening environment.¹⁸*
- 2 *Background noise reduction in care environments, eg hospital wards.⁶*
- 3 *Accessing a full range of approved interpreters at appropriate times.¹⁷*
- 4 *Ensuring access to evidence-based, timely ear care to maintain ear function.*
- 5 *Nursing and care staff devoting time to the maintenance of hearing aids.*
- 6 *Developing clinical research evidence to support the practice base of ear care and control of ear wax.*

Section 4: Education and training

Key Points ~

- 1 *Education of nurses and care staff is essential to the provision of evidence-based quality care.^{2,4,6}*
- 2 *There is evidence to support the need for improved knowledge and skills among nursing and care staff in communicating with older people with hearing disability and in auditory rehabilitation.^{4,6,27}*
- 3 *Older people and their families benefit from the inclusion of family and other supporters in ongoing education and training programmes.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Training programmes for nursing and care staff include:</p> <ul style="list-style-type: none"> • deaf awareness^{14,27} • attitudinal awareness • understanding of the structure and function of the ear, and the nature and impact of age-related hearing loss,⁶ • screening and assessment of hearing ability according to local guidelines⁶ • communication skills for people with hearing disability and those who are deaf-blind • audiological rehabilitation techniques, including the creation of an ideal listening environment, the role of the communication partner and consideration of older people with additional needs, eg those with dementia,⁶ • the proper use, care and day-to-day maintenance of hearing aids (analogue and digital) and other assistive devices,⁶ and • ear care and maintenance of ear functions. 	<p>Older people with hearing disability experience a range of difficulties communicating with health service professionals.^{3,14}</p> <p>There is evidence of inadequate preparation of nurses and care staff to meet the communication needs of older people with hearing disability – these include attitude, knowledge and technical skills deficits.^{4,6}</p>	<p>All staff demonstrate deaf awareness and create opportunities to maximise communication for older people with hearing disability.^{3,14}</p> <p>There is evidence of ongoing training and development for all staff, and records of programme content.</p> <p>Staff are given time to attend education and training.</p> <p>Training and education programmes include opportunities for regular updates.</p> <p>Training is evaluated to ensure it meets learning requirements of staff in their practice areas.</p>

Key Challenges ~

- 1 *Acknowledging communication with hearing-disabled older people as an education and training priority.*
- 2 *Providing educational and training materials, and resources that appropriately reflect the needs of older people and principles of gerontological practice.*
- 3 *Challenging the perception in nurses and care staff that age-related hearing disability is a normal part of ageing*

Appendix 1

Sources of evidence

[The numbers in square brackets relate to the Scottish Intercollegiate Guidelines Network (SIGN) guideline levels of evidence contained in Appendix 2]

- 1 Davis A. (1995) *Hearing in Adults*. London: Whurr. [4]
- 2 Tolson D and McIntosh J. (1992) Hearing impairment in elderly hospital residents. *British Journal of Nursing* 1(14):705-710. [3]
- 3 Royal National Institute for the Deaf. (2004) A simple cure - a National report into deaf and hard of hearing peoples experience of the NHS. London: RNID. [4]
- 4 Heron R and Wharrad HJ. (2000) Prevalence and nursing staff awareness of hearing impairment in older hospital patients. *Journal of Clinical Nursing* 9(6):834-841. [3]
- 5 Herbst KG. (1986) Hearing. In: Redfern S. ed. *Nursing Elderly People*. Edinburgh: Churchill Livingstone. [4]
- 6 Tolson D. (1997) Age-related hearing loss: a case for nursing intervention. *Journal of Advanced Nursing* 26(6):1150-1157. [3]
- 7 Knussen C, Tolson D, Swan IRC, Stott DJ, Brogan CA and Sullivan F. (2004) The social and psychological impact of an older relative's hearing difficulties. *Psychology, Health and Medicine*, 9(1):3-15. [1+]
- 8 Brooks DN, Hallam RS and Mellor PA. (2001) The effects on significant others of providing a hearing aid to the hearing-impaired partner. *British Journal of Audiology*, 35(3):165-171.
- 9 Mulrow CD, Aguilar C, Endicott JE, Velez R, Tuley MR, Charlip WS and Hill JA. (1990) Association between hearing impairment and the quality of life of elderly individuals. *Journal of the American Geriatrics Society*, 38(1):45-50. [2++]
- 10 Strawbridge WJ, Wallhagen MI, Shema SJ and Kaplan GA. (2000) Negative consequences of hearing impairment in old age: a longitudinal analysis. *The Gerontologist*, 40(3):320-326. [2++]

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- 11 Corbin S, Reed M, Nobbs H, Eastwood K and Eastwood MR. (1984) Hearing assessment in homes for the aged: comparison of audiometric and self-report methods. *Journal of the American Geriatrics Society*, 32(5):396-400. [2+]
 - 12 Kiessling J, Pichora-Fuller MK, Gatehouse S, Stephens D, Arlinger S, Chisholm T, Davis AC, Erber NP, Hickson L, Holmes A, Rosenhall U and von Wedel H. (2003) Candidature for and delivery of audiological services: special needs of older people. *International Journal of Audiology*, 42:2S92-2S101. [4]
 - 13 Hearing Concern. (1997) *Communication with deaf and hard of hearing patients. A guide for healthcare professionals*. London: Hearing Concern. [4]
 - 14 Hines J. (2000) *Communication problems of hearing-impaired patients. Nursing Standard*, 14(19):33-37. [3]
 - 15 Public Health Institute of Scotland. (2003) *A report on the modernisation of audiological services in Scotland*. Glasgow: NHS Health Scotland. [4]
 - 16 Scottish Human Services Trust. (2003) How is it for you? *Conference proceedings*. March 2003. [4]
 - 17 Disability Discrimination Act. (1995) London: HMSO. ISBN 0 10 545095 2.
 - 18 Tolson D and McIntosh J. (1997) Listening in the care environment - chaos or clarity for the hearing impaired elderly person. *International Journal of Nursing Studies*, 34(3):173-182. [3]
 - 19 Tolson D, Swan I and Knussen C. (2002) Hearing disability: a source of distress for older people and carers. *British Journal of Nursing*, 11(15):1021-1025. [1+]
 - 20 Sindhusake D, Mitchell P, Smith W, Golding M, Newall P, Hartley D and Rubin G. (2001) Validation of self-reported hearing loss. The Blue Mountains Hearing Study. *International Journal of Epidemiology*, 30(6):1371-1378. [2++]
 - 21 Tomita M, Mann WC and Welch TR. (2001) Use of assistive devices to address hearing impairment by older persons with disabilities. *International Journal of Rehabilitation Research*, 24(4):279-290. [2+]

- 22 Tolson D and Nolan M. (2000) Gerontological nursing 4: age-related hearing explored. *British Journal of Nursing* 9(4):205-208. [4]
- 23 Clark K, Sowers MF, Wallace RB and Anderson C. (1991) The accuracy of self-reported hearing loss in women aged 60-85 years. *American Journal of Epidemiology*, 134(7):704-708.
- 24 Davis A, Stephens D, Rayment A and Thomas K. (1992) Hearing impairments in middle age: the acceptability, benefit and cost of detection (ABCD). *British Journal of Audiology*, 26(1):1-14.
- 25 Wallhagen MI, Strawbridge WJ, Shema SJ and Kaplan GA. (2004) Impact of self-assessed hearing loss on a spouse: a longitudinal analysis of couples. *The Journals of Gerontology*, 59B (3):S190-S196. [2++]
- 26 Tolson D and Stephens D. (1997) Age-related hearing loss in the dependent elderly population: A model for nursing care. *International Journal of Nursing Practice*, 3(4):224-230. [4]
- 27 NHS Management Executive Letter (1999) 67. The Disability Discrimination Act (1995) - Equality for disabled people in the NHS - good practice. Edinburgh: Scottish Executive Health Department.
- 28 Tolson D, Swan IR and McIntosh J. (1995) Auditory rehabilitation: needs and realities on long-stay wards for elderly people. *British Journal of Clinical Practice*, 49(5):243-245. [3]
- 29 Hickson L, Worrall L, Yiu E and Barnett H. (1996) Planning a communication education program for older people. *Educational Gerontology*, 22(3):257-269. [3]
- 30 Smeeth L, Fletcher AE, Ng ES, Stirling S, Nunes M, Breeze E, Bulpitt CJ, Jones D and Tulloch A. (2002) Reduced hearing, ownership and use of hearing aids in elderly people in the UK - the MRC trial of the assessment and management of older people in the community: a cross-sectional survey. *The Lancet*, 359(9316):1466-1470. [2++]
- 31 Brooks D. (1989) *Adult Aural Rehabilitation*. London: Chapman and Hall. [4]
- 32 Ebert DA and Heckerling PS. (1995) Communication with deaf patients: knowledge, beliefs, and practices of physicians. *Journal of the American Medical Association*, 273(3):227-229. [3]

33 Herbst KG and Humphrey C. (1981) Prevalence of hearing impairment in the elderly living at home. *Journal of the Royal College of General Practitioners* 31(224):155-160.

Appendix 2

Revised SIGN Grading System

Levels of evidence

- 1++ High quality meta analyses, systematic reviews of Randomised Controlled Trials (RCT)s, or RCTs with a very low risk of bias
 - 1+ Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
 - 1 - Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
-
- 2++ High quality systematic reviews of case-control or cohort or studies
High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal
 - 2+ Well conducted case control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
 - 2 - Case control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal
-
- 3 Non-analytic studies, e.g. case reports, case series
 - 4 Expert opinion

Grades of recommendation

- A At least one meta analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
- B A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 1++ or 1+
- C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 2++
- D Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+

On occasion, guideline development groups find that there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. These are marked in the guideline as Good Practice Points. It must be emphasised that these are not an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Appendix 3

Example of a screening tool

Screening of an older person for potential hearing disability	
SCREENING QUESTIONS	YES/NO
• Do you have to turn up the television or radio more than you used to?	
• Does your family complain the TV or radio is turned up too loudly?	
• Do you sometimes wish people would stop mumbling?	
• Do you ever miss your name being called, eg at the doctor's surgery?	
• Do you sometimes miss what people say to you?	
• Do you find yourself asking people to repeat things?	
• Do you have difficulty hearing when you are in a crowd of people?	
• Do you ever have difficulty hearing the telephone or doorbell?	
OBSERVATIONS	YES/NO
• On examination, do ears show signs of cerumen build-up, infection or inflammation?	
• Is the person inattentive to other people?	
• Does the person fail to respond to sounds in the environment?	
• Does the person ask for things to be repeated?	
• Does the person cup an ear towards the speaker?	
• Does the person have difficulty following clear directions?	

Adapted from: Schofield I. (2002) Caring for older people who have a hearing disability. *Nursing Older People* 13(10):20-25.

Appendix 4

Example of a communication guideline

Guidelines for effective communication with an older person who has hearing disability.

- Always be patient and friendly, and take time to communicate.
- Ensure that there is sufficient lighting so that your face can be seen clearly.
- Endeavour to minimise the level of background noise. (Carpeting and soft furnishings can help reduce this.)
- Make sure you have the person's attention and ensure that he or she is looking at you.
- Always introduce yourself and others to the person. Touch the person gently on the shoulder/hand to alert him or her to your presence.
- Look directly at the person and do not turn away while talking. Maintain a distance of between 1 and 2 metres.
- Make sure that your face or mouth is not hidden behind your hands, your hair or facial hair.
- Establish the person's communication preference. Note this and the degree of hearing impairment in the nursing notes and complete the hearing disability care plan.
- Ensure hearing aids, if worn, are functioning and properly fitted.
- Ensure that the person can see you properly, eg if the person wears glasses make sure that they are being worn.
- If a person uses sign language keep an A-Z finger spelling chart and/or pen and paper handy.
- Use personal communicators, if required, for one-to-one interactions or use a portable loop system.
- Always ensure confidentiality.
- All information should be provided in plain English. Do not be too technical. Be realistic.
- Wherever possible, supplement information by writing it down or provide leaflets or booklets so that the person can read the information at their own pace and ask questions later.

- Ensure all written information is in a large, clear, size 14 font, eg Arial or Helvetica.
- Provide a fax number so that the person does not have to rely on the telephone.
- Inform the person in advance of the subject of the conversation.
- Only one person should talk at a time.
- Keep the normal rhythm of speech, but slow down slightly.
- Do not shout.
- Use facial expression, body language and gestures where appropriate.
- If a sentence is not heard try to rephrase it, or as a last measure, write it down.
- Offer to summarise for the person. Alternatively, ask the person to summarise; this will allow you to know if the person has understood the conversation.
- If there is any doubt about a person's hearing ability and you need advice, contact the audiology department.

Adapted from: Waddell L (2003), Sensory Impairment Guidelines. Forth Valley NHS Primary Care Trust, Royal Scottish National Hospital, Larbert.

Appendix 5

Cerumen management

<p>Excessive or impacted wax should be removed to prevent/reduce hearing loss, tinnitus, vertigo or pain.</p>
<p>Ear drops are the first line treatment if the ear canal is occluded with wax. This may reduce the need for ear irrigation and its associated risks.</p> <p>Ear irrigation should not be considered as a first line treatment.</p>
<p>Drops have been shown to be effective in cerumen management.¹² There is insufficient research evidence to recommend one type of ear drop over another.</p> <p>Factors to consider are that some drops:</p> <ul style="list-style-type: none">• may cause irritation to some people, and• may contain nut oil so should be avoided by those with nut allergy.
<p>An eardrop regime should be tailored to individual needs, eg 2-5 drops of warmed, wax softening ear drops (olive oil, saline or older person's choice) twice a day for 3-5 days.</p>
<p>If the older person experiences any pain, the nurse should stop the drops and seek specialist advice. This will reduce the risk of increased ear damage.</p> <p>If the use of drops has not been effective, removal methods include irrigation, instrumentation or microsuction and specialist help will be required.¹</p>


¹ Keane E M Wilson H McGrane D Coakley Walsh J B (1995) Use of solvents to disperse ear wax. *British Journal of Clinical Practice* 49 7-12

² Burton MJ, Doree CJ (2005) - Ear drops for the removal of ear wax (Cochrane review). In The Cochrane Library, volume 3 Chichester UK. John Wiley and Sons Ltd

Appendix 6

Maximising communication with older people who have hearing disability Community of Practice

Christine Aitken	Ward Manager, Stracathro Hospital, NHS Tayside
Margaret Brown	Lecturer/Practitioner, Bell College, Hamilton
Brenda Caddis	Charge Nurse, Ayrshire Central Hospital, NHS Ayrshire & Arran
Allison Cavinue	Charge Nurse, Strathclyde Hospital, NHS Lanarkshire
Duncan Clarkson	Director of Nursing, Whim Hall Nursing Home, Peebleshire
Shona Cringeon	Staff Nurse, Stobhill Hospital, NHS Greater Glasgow
Ann Dean	Service Co-ordinator, Community Older Team, NHS Greater Glasgow
Morag Francis	Sister and Education Co-ordinator, Royal Blind Braeside House Care Home, Edinburgh
Sue Gardiner	Clinical Nurse Practitioner, Royal Victoria Hospital, NHS Lothian
Gillian Graham	Older People's Nurse Specialist, Motherwell, NHS Lanarkshire
Evelyn Hood	Charge Nurse, Whyteman's Brae Hospital, NHS Fife
Margaret Inglis	Staff Nurse, Wester Moffat Hospital, NHS Lanarkshire
Michael Labonte	Charge Nurse, Lynebank Hospital, NHS Fife
Dawn McDonald	Community rehabilitation nurse, IRIS Team, NHS Greater Glasgow
Patricia McDonald	Ward Manager, Mearnskirk House, NHS Greater Glasgow



Linda Merriman	Staff Nurse, Balfour Hospital, NHS Orkney
Lorna Milton	Practice development/clinical governance Link Nurse, Ashludie Hospital, NHS Tayside
Sharon Morrison	Charge Nurse, Wishaw General Hospital, NHS Lanarkshire
Patricia-Anne Murphy	Ward Manager, Udston Hospital, NHS Lanarkshire
Carol Paterson	Charge Nurse, Ward 7, Royal Victoria Hospital, NHS Lothian
Anne Stewart	Charge Nurse, Gartnavel Hospital, NHS Greater Glasgow
Debbie Sutherland	Senior Staff Nurse, Old Age Mental Health, Migdale Hospital, NHS Highland
Christine Tonge	Team Leader, Health Visiting for Older People, Lerwick Health Centre, NHS Shetland
Hazel Wilson	Depute Ward Manager, Ward 7, Royal Victoria Hospital, NHS Lothian
Isobel Wood	Lead Nurse, Cameron Hospital, NHS Fife

Appendix 7

Definitions and Principles of Gerontological Nursing

Gerontological nursing contributes to, and often leads, the interdisciplinary and multi-agency care of older people. It may be practiced in a variety of settings, although it is most likely to be developed within services dedicated to the care of older people. It is a person-centred approach to promoting healthy ageing and the achievement of wellbeing, enabling the person and their carers to adapt to health and life changes and to face ongoing health challenges.

These are the principles of gerontological practice agreed by the nurses in the community of practice which developed the best practice statement in 2004. They represent a revision of the original principles prepared by the inaugural community of practice in 2001. Further information on these can be obtained at www.geronurse.com

1 Commitment to relationship-centred care

Recognition that the older person is best understood in the context of his or her relationships with others and that, while the focus of care is the individual, they are part of a network of complex relationships that may impact on the person's care processes, which should be acknowledged for the most successful care to be achieved. Promoting continuity of care that values the older person's unique past, present and future individuality and respects the person's role and contribution to family and wider society.

2 Commitment to negotiating care decisions


Recognising that the older person has the right to make informed choices, with assistance from family members if they wish. The older person's choices and priorities are respected and may include an element of risk.

3 Promoting dignity and respect

Promoting dignity and respect for the older person in all aspects of care, regardless of setting, including consideration for the person's privacy and confidentiality.

4 Maximising potential

Recognising that caring events are also therapeutic opportunities and developing attitudes, knowledge and skills to empower the older person to live a life that reflects their individuality and enables them to achieve their potential.



5 Commitment to an enabling environment

Promoting a positive work culture together with a supportive physical and organisational environment in order to create an enabling living or care environment that conveys a sense of hope and achievement for the older person.

6 Establishing equity of access

Striving to secure, on behalf of all older people, the same access to services as other age groups and challenging age-discrimination where evidence of it exists.

7 Commitment to developing innovative practice

Adopting strategies to promote evidence based gerontological nursing, acknowledging the value of multiple forms of evidence including practice expertise. Recognising the importance of choosing to specialise in gerontological nursing as a prerequisite to successful advancements in practice.

8 Consistency of vision

Developing a shared care philosophy that clearly articulates the value base of gerontological nursing and the standards of care older people and their families can expect.

9 Commitment to teamworking

Working as part of a team who recognise, seek out and respect each other's contribution and commitment to the care of the older person. Directing the collective effort towards attaining goals negotiated with the older person and their family according to their needs and wishes.

10 The value of reciprocity

Recognising the value of mutual respect between all parties involved in the giving and receiving of care and the dynamic nature of the interactions in which benefits for all are appreciated.

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