| Paediatric Hearing Aid Assessment<br>Clinical guideline<br>Hearing Services Department<br>MSS Directorate | University Hospitals of Leicester NHS<br>NHS Trust<br>**Trust Ref: C69/2023** |
|---|---|

## 1. Introduction and who guideline applies to

The following are guidelines to be used by Paediatric Audiologists when assessing a child aged <16 years, for hearing aid/s provision. Young adults, age >= 16years, will be assessed by the Adult Hearing Services Audiologists. It is expected that the Audiologist will use this as a guide only and that further questioning/testing should be done; as required, to ensure an accurate picture of hearing, history and diagnosis are obtained. The aim of this assessment is to gain clarification of the above in order to give clear options to parents/child to enable them to make informed management decisions.

Children diagnosed with a PCHI at birth will be referred by EDS to the Hearing Support Education Service for hearing aid assessment. The Hearing Support Education Service will liaise with a senior member of the Paediatric Audiology team who; based on these guidelines, will advise regarding suitable options for hearing aid provision to be discussed by the Education team with the parents at home.

Children referred for a hearing aid/s via other routes e.g. ENT, Community Audiology, Hearing Services diagnostic service, will have these guidelines applied during a paediatric hearing aid assessment clinic appointment at the HSD or outreach clinic.

Behavioural diagnostic test guidelines should be used for the hearing testing part of the hearing aid assessment (1T & 2T Paediatric Diagnostic Guidelines, 2023 refer).

## 2. Guideline Standards and Procedures

### Babies referred from NHSP ABR diagnostic test.

See the following triage/admin guidelines for more detailed processes;

*Paediatric Protocol for triage of Paediatric Audiology referrals.C60/2023 & Paediatric hearing aid service admin guidelines. C59/2023 (2023 & 2023a)*

- EDS will email all clinical and demographic information for babies diagnosed with unilateral or bilateral PCHI, to the HSD Paediatric Service email address (paediatricHSD@uhl-tr.nhs.uk) and cc Head of Paediatric Audiology within 24 hours of informing the Education Service. This will be clearly labelled PCHI.

- The Paediatric Administrator will enter the child's demographic details on to PN and print the information for the Head of Paediatric Audiology

- An Audiologist competent in ABR analysis will derive an estimated threshold from the waveforms for programming purposes for each ear, at each frequency tested.

- If the Audiologist feels that additional ABR testing is required, this will be communicated to the EDS, as return email or face to face immediately once the need is identified to ensure that the baby is still young enough to sleep for testing.

- When ABR testing is completed or, if hearing aid/s are to be fitted before ABR testing is complete, the Audiologist will enter estimated threshold summary and other test results onto PN notes along with relevant history and management plan. The note will be clearly labelled as 'ABR waveform summary and management plan'

- The Audiologist will discuss the results with the relevant member of the Education Service to advise on aiding options. This should include type/side of mould, AC or BC aid/s, estimated hearing loss, any missing information or uncertainties and urgency of aiding e.g. for mild/unilateral losses parents may choose to aid early or wait until 8 month behavioural testing results (Guidelines for audiological assessment and management of babies from the NHSP v3.1 July 2013 NHSP clinical group).

- The audiologist should arrange a fitting date for 2 weeks from the date of the Education Service home visit when impressions for ear moulds are to be taken, ensuring that there is time for the moulds to be received. The ear moulds will be posted home to parents, directly from the manufacturer, and the professional taking the impressions will ensure that parents know to take the ear moulds to the fitting appointment, or inform the Paediatric Administrator at LRI if they haven't been received 48 hours prior to the fitting appointment.

- The date the aid/s were offered (Date of Education Service home visit) should be entered onto S4H by the Audiologist and the Paediatric Administrator informed to add to hearing aid spreadsheet new referrals tab if aiding is to proceed

- If parents decline hearing aids, the Education Service will inform and discuss with the Audiologist to decide on a suitable action plan e.g. 8 month behavioural test, 4 month clinic visit to discuss aiding or safeguarding issue if parents refusal to engage with the service, as it is likely to be immediately detrimental to the child's access to a formal language and mode of communication

## Hearing aid assessment clinic appointment (1T, 1.5T or 2T h-aid ax)

### Appointments

See the following triage/admin guidelines for more detailed processes;

- Paediatric triage guidelines (2023)
- Paediatric hearing aid admin guidelines (2023)

- Referrals will be coded weekly by an audiologist as 1T, 1.5T or 2T (T=testers) dependent on the behavioural age of the child

- If the referral or previous history suggests that a child may not want to consider, or may not be suitable for, hearing aid/s, the referral will be coded for a phone triage appointment instead of a face to face appointment

- The Audiologist will pass the coded referrals to the Paediatric Administrator who will;

    1. Enter the demographics onto PN and scan the referral onto the notes
    2. Obtain missing audiograms or clinic letters as requested by the Audiologist
    3. Enter the details onto the hearing aid spreadsheet new referrals tab
    4. Book an appointment within 6 weeks of the coded date (2 weeks if phone triage) at the clinic most convenient to the family or, if an appointment is not available within the 6 weeks, an alternative venue
    5. All appointments will be 1 hour (30 mins phone triage)

### Pre appointment checks

- Read patient notes and referral from PN

- Plan session
- Calibrate/check equipment as per departmental (BSA, 2018) stage A calibration guidelines and set up room appropriately
- Ensure all potential equipment is available e.g. impression equipment
- Check that hand gel and anti-bacterial wipes are available
- Check whether an interpreter is booked and has arrived (If applicable)

**Introduction**

- Invite all attending adults and children into the clinic room
- Introduce all persons in the room
- Check the relationship to the child of accompanying adults and, if not parents, has consent been obtained from the parent to bring the child to the appointment.
- Check patient address and GP are correct on PN and addresses for copies of reports, including school/nursery and other relevant professionals as requested by parents (This can be checked at the end of the appointment if more appropriate)
- Explain who referred the child, the purpose of the appointment and how it will proceed. Obtain verbal consent to proceed.

**History**

- The Audiologist should consider whether to take the history before or after testing dependent on the child's age and behaviours e.g. if very shy then a history first allows time for the child to feel comfortable but if a child is unlikely to sit still for long then testing first is advisable
- Depending on the age of the child, try to ask the child for their opinion prior to asking parents. This helps when determining child's motivation for hearing aids and prevents the child's answer being influenced by the parents
  Concerns re hearing at school, home and socially with examples, regularity and impact of problems
    - Have teachers commented on hearing, where does child sit in the classroom, academic progress
- History of ear infections, grommets or other ear surgery. Which ear, regularity of infections, dates of surgeries etc. It is important to build a picture of improvements over time or persistent problems
- Speech and language development/concerns
- General development and medical history
- Other medical, neurological, neurodevelopmental or behavioural problems
- NHSP result and family history of hearing problems
- If reason/diagnosis not clear then a more thorough history is required based on NHSP risk factors.

**Phone triage appointment**

- Aim of a telephone triage apt is to preliminarily assess whether the child/parent wants a hearing aid assessment, whether this is appropriate, the best appointment type for the child and to complete the history and demographic/report copies section of the report
- Complete all relevant steps as above (pre appointment check, introduction and history)
- Generate and complete phone triage part of hearing aid assessment/fitting report and save in 'partial complete' reports folder (for completion at face to face appointment)
- Discuss next steps/options as follows;

    - Diagnostic test apt to establish hearing thresholds before considering hearing aid/s
    - Hearing aid assessment apt to complete a hearing test and discuss aiding options
    - Apt for impression/s followed by separate hearing aid fitting apt (suitable if hearing thresholds already available & confirmed and suitable for aiding and child/parents want aiding)
- Children referred for hearing aid assessment should not be discharged without being seen for an apt i.e. should not be discharged from a phone triage apt, unless aiding is not wanted and the child has a known hearing loss (bank child) or risk factor requiring monitoring (Paediatric Audiological Surveillance Chart, 2023), in which case, re refer to HSD/Community Audiology as appropriate for ongoing monitoring and discharge from hearing aid service.
- Book follow up apts as appropriate or/and complete hearing aid outcome sheet. Complete PN notes. Attend appointment. Add medical consultation but don't close referral or stop clock (unless discharging) as this will be done following the arranged face to face appointment/s

**Diagnostic Tests**

- Prior to testing it may be necessary to ask additional family members to wait outside to minimise distractions for the child.
- Age appropriate behavioural hearing tests should be carried out to obtain ear and frequency specific thresholds for AC and BC (See Diagnostic Test Guidelines).
- Previous test results should be considered in order to prioritise which frequencies and transducers will give the most information and create as complete an audiological picture as possible.
- Testing must be performed using inserts (attached to foam tips or ear mould/s) to enable measured RECD
- Ensure ear specific AC and BC thresholds available for as many frequencies 0.25-8KHz as possible, in accordance with national guidelines (BAA, 2022)
- Accurate and masked thresholds at fewer frequencies are more important than obtaining all frequencies e.g. 0.5 + 2KHz, right + left, ac + bc
- Compare all available test results to check for consistency of diagnosis and note fluctuations due to middle ear effusion
- If no reliable behavioural test results are obtainable due to a child's development or other issues, An ABR under GA referral should be discussed with parents.
- Tympanometry to be completed at each apt to monitor middle ear function in order to confirm diagnosis and provide information for RECD/REM

**Other Tests**

- OAE if any sign of NOHL or variable responses. If there is doubt as to the validity of the hearing loss then further testing is required, probably at a separate appointment, before a decision regarding hearing aid fitting/s is made
- Age appropriate speech discrimination tests
    - If unclear whether a hearing aid would be beneficial e.g. If hearing loss very mild or at minimal frequencies
    - If a parent/child need additional information to demonstrate that a hearing aid/s is needed

## Explanation

- Based on diagnostic test results and history taken, explain hearing loss to parents and child. Try to relate the explanation to the reported concerns and child's 'real life' situations. Ensure that parents/child understand the diagnosis and implications before discussing management options so that they are able to be part of the management decision process
- If reason/cause of hearing loss is not clear and child not already under ENT, refer for further investigation, with parental consent
- Discuss all viable options, briefly explaining the pros and cons of each for the child. Pros and cons will include audiological, cosmetic and practical considerations.
- Consideration of a hearing aid/s is appropriate even if the hearing loss is unilateral or very mild (>= 2 frequencies at >=25dBHL) if potentially affecting the child. If the hearing loss is very mild, advise the child/parent that aiding would be a trial as it may/may not be beneficial and, in some instances, may be detrimental e.g. If only low frequencies amplification required, this may increase hearing of background noise but 'mask' speech
- AC aids should be prioritised above BC aids unless the following conditions are met;
    - Recurrent ear infections **or**
    - Unable to establish reliable hearing levels (doesn't matter whether this is ear specific or not) **or**
    - Significant fluctuation of hearing which can't be managed via a volume control and would cause regular over/under amplification or inconsistent aid use e.g. fluctuation between normal hearing and hearing loss, or of +/-20dBHL for younger child unable to manage volume control

    - Aiding options to be discussed are:
        i. Do nothing – no aid (with/without further monitoring)
        ii. AC aid/s
        iii. BC aid/s
        iv. CROS/BiCROS aid
        v. Grommets/other ENT procedure (if appropriate)
        vi. Cochlear Implant assessment referral (this should be encouraged if hearing thresholds are within CI criteria). Emphasize to parents/child that a referral for CI assessment doesn't mean that they have to have the surgery but they will learn a lot about what the child can and can't hear with current aids during the assessment process.

## Discussion

- What do parents/child think of each option, answer any questions that they may have
- Agree and document a plan of action
- If 'do nothing' option is chosen, consider the following:
    1. Discharge if hearing within normal limits or hearing aid not wanted and appropriate to discharge
    2. If child has Downs Syndrome, CLP or any other condition requiring ongoing monitoring (Paediatric Audiological Surveillance Chart, 2023), discharge back to Community Audiology or add to HSD pending list as appropriate for continued monitoring
    3. Monitor hearing if concern re fluctuation or temporary conductive loss whereby monitoring rather than hearing aid is appropriate. Monitoring should be for a specified period e.g. over winter, at HSD, add to appropriate diagnostic pending list and discharge from hearing aid service.

- If monitoring is being done via community audiology (bank child or risk factor as above) or ENT, discharge from the hearing aid service and ensure report is clear that these services are being asked to book for further appointments if not already scheduled i.e. re refer back to the monitoring department
- Repeat hearing aid assessment either immediately (If hearing thresholds not established so no decision can be made) or after agreed time period (3-6 months) if hearing aid not required but parent/child or Audiologist think that it may be in near future. Complete hearing aid outcome sheet with 'ax' as next appointment
- If permanent hearing loss, ask for parental consent to refer to TOD and Community Audiology for child to be monitored via the 'bank' (Minimum annual hearing test and advice to school as required till age 16yrs or referred back for further hearing aid assessment as necessary). If not already under ENT, refer for aetiological investigation. If new PCHI diagnosis, outside of NHSP referral, refer as per HSD late identified PCHI pathway
- If hearing aid required
    1. Consider audiological, practical and safety implications of earmoulds vs slim tubes/domes. This will depend on the age of the child and whether they are likely to be able to fully insert the slimtube/dome reliably. If in doubt, ear moulds should be tried first.
    2. Take impressions if ear moulds to be used. Ear moulds should be posted to the parents directly from the manufacturers and parents informed to bring the ear moulds to the hearing aid fitting appointment or inform the paediatric administrator if moulds haven't been received within 48 hours of the fitting appointment.
    3. Consider the acoustic properties of the mould style and the material used. Children under 5years should have soft moulds (silicone) for safety reasons. Babies and children likely to have retention issues e.g. shallow concha's of Downs Syndrome children, may benefit from carved microflex earmoulds due to its 'gripping' properties. Write 'glue tube' on the mould box rather than using digi tubing if required.
    4. Offer colour/logo for moulds, be aware that not all options are available for all mould types
    5. Offer, select and allocate colour and type of aid/s (From standard options). Discuss whether battery drawers need to be tamper proofed taking into consideration the child, family members, visitors and peers. All <=4yrs must be tamper proofed.
    6. Offer a referral to the TOD and complete the consent form (If child's school within Leicester/Leicestershire/Rutland), including parent/guardian signature. If child's school is outside LLR, obtain verbal consent for the referral and note this on PN and in the report. If parents do not consent to the referral, this should be noted on PN notes and in the report, with a reason if known. Do not discuss level of TOD involvement as this will be discussed with parents when contacted by the TOD
    7. All hearing aid fittings to be within 4 weeks of assessment unless delayed for management reasons or at the parent's request. If it is possible to offer and book the fitting apt at the time of the assessment then this is best practice. Ask parents which is their preferred clinic venue and, if a fitting apt cannot immediately be booked at that venue; and parents prefer to wait longer for the fitting, note this on the outcome form. If there are no apts within 4 weeks at any venue, note this on the outcome form.
    8. If arranging fitting apt directly, decide whether 1T, 1.5T or 2T clinic, consideration should be given as to whether further behavioural testing is required at the fitting apt, compliance of the child for REM and time required for apt

9. If not booking fitting apt directly, put 'next available' on outcome form and note any restrictions e.g. after xx/xx/xx to allow for ear mould to be received or any timing preferences for apts e.g. day/time of apt.

• If CI assessment referral is required

1. Proceed with conventional hearing aid fitting as child must be aided conventionally for CI assessment
2. Send report (as referral) with all relevant other information available, including NHSP ABR results and waveforms, ENT letters, aetiology results, previous HSD reports and history, to NAIP. This can be sent once hearing aid fitted

**Documentation**

- Refer as per late identified PCHI pathway if new PCHI diagnosis outside NHSP
- Ensure that all information, options discussed and management plan are clearly recorded on PN notes using PN notes hearing aid template
- Put child's name on allocated aid/s and put in allocated aids place in appropriate clinic for fitting appointment. Document if aid/s need to be tamper proofed and, if possible, change the battery door before allocating
- Using hearing aid assessment/fitting report template, complete assessment section with test results, summary of discussion and management plan. Complete addresses for copies to be sent i.e. parents, TOD (if referred), referrer school and GP if consented by parents. If hearing aid fitting appointment booked/to be booked, save report in 'partial complete' reports folder on H drive. If the report is complete (No hearing aid to be fitted or already fitted) save a copy of the report in main body of reports folder and print required number of copies (Including a copy for emailing to TOD).
- Send email copies of completed reports (Not TOD copy as this will be sent by Admin via the printed copy as above) as required
- TOD consent form to be attached to front of printed report
- Complete outcome sheet (note how many copies need printing if not already printed i.e. at outreach clinics). If a fitting apt has been booked, put the date on the outcome form. If the child is discharged from the hearing aid service but added to an HSD pending list, write 'discharged' on outcome sheet
- Place collated reports, outcome sheet and demographic sheets in the paediatric hearing aid admin 'reports in' tray in the Admin office (email to paediatricHSD@uhl-tr.nhs.uk if at outreach clinic)
- Complete medical referral and consultation on PN – do not close referral or stop clock unless discharging from hearing aid service or repeating h-aid assessment i.e. immediate hearing aid fitting appointment not arranged
- Ensure patient is attended on PN

## 3. Education and Training

No training is required for current staff.

New staff to the department or to the paediatric team will require a period of supervision dependent on their experience and skill level. The peer review process will be undertaken before they are able to work unsupervised.

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| Room prepared appropriately and plan for | Peer review process | Head of Paediatric | New starter after initial | Required actions to be given to |

| | | | | |
|---|---|---|---|---|
| appointment prepared | | Audiology | supervisory period.<br><br>All applicable paediatric staff every 2 years | audiologist by the peer reviewer and recorded on peer review documented |
| Introduction of adults present and demographic details checked as appropriate | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |
| Appropriate level of history taking | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |
| Appropriate diagnostic tests undertaken with appropriate interpretation of results | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |
| Appropriate explanation of results for the family/child and related to their concerns as identified in the history | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |
| Appropriate explanation of habilitation options in order to allow family/child to make an informed choice | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |
| Appropriate action plan agreed with family/child | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |

| | | | | |
|---|---|---|---|---|
| Documentation complete | Peer review process | Head of Paediatric Audiology | As above | Required actions to be given to audiologist by the peer reviewer and recorded on peer review documented |

## Supporting References


British Academy of Audiology (2022) Quality standards in Paediatric Audiology.

British Society of Audiology (2013) *British Society of Audiology recommended procedures* - Guidelines for the early audiological assessment and management of babies referred from the Newborn Hearing Screening Programme

British Society of Audiology (2018) *British Society of Audiology recommended procedures* – Pure tone and air conduction and bone conduction threshold audiometry with and without masking.

Hartland, S. (2023) Paediatric Audiological Surveillance Chart v1.3. Available via HSD shared drive:
H:\IQIPS Leicester LRI\Guidelines\Clinical Guidelines (Team Leads)\Paediatric Team\Pathways\ paediatric audiological surveillance chart version 1.3 June 2023

UHL Paediatric Service (2023) *Paediatric Protocol for triage of Paediatric Audiology referrals.C60/2023*

UHL Paediatric Service (2023a) *Paediatric hearing aid service admin guidelines. C59/2023*


## 6. Key Words

Hearing aid; Paediatric Audiology; Hearing Services; Hearing; Audiology

| CONTACT AND REVIEW DETAILS | |
|---|---|
| **Guideline Lead (Name and Title)**<br>**Sheena Hartland**<br>**Head of Paediatric Audiology** | **Executive Lead**<br>**Hazel Busby-Earle (Consultant)** |
| **Details of Changes made during review:**<br>**Appendix added regarding PVP shunt version 1.1**<br>**Addition of discussion regarding need for tamperproof battery drawer version 1.2**<br>**Reference to stage A check guidelines added to pre appointment check section, page 2 version 1.3**<br><br>**Version 2**<br>**Removal of PVP shunt information**<br>**Removal of TOD as guidelines to be used by**<br>**Addition of 1.5T clinic**<br>**Addition of phone triage guide**<br>**Minor changes/clarification of procedures in line with current practice** | |

| Title of P&G Document Being Reviewed: Insert Details Below: | | Yes / No / Unsure | Comments |
|---|---|---|---|
| **1.** | **Title and Format** | | |
| | Is the title clear and unambiguous? | | |
| | Does the document follow UHL template format? *If no document will be returned to author* | | |
| **2.** | **Consultation and Endorsement** | | |
| | Complete the consultation section below | | |
| **3.** | **Dissemination and Implementation** | | |
| | Complete the dissemination plan below | | |
| | Have all implementation issues been addressed? | | |
| **4.** | **Process to Monitor Compliance** | | |
| | Ensure that the Monitoring Table has been properly completed. | | |
| **5.** | **Document Control, Archiving and Review** | | |
| | Ensure that the review date and P/G Leadis identified. | | |
| **6.** | **Overall Responsibility for the Document** | | |
| | Ensure that the Board Director Lead is identified | | |

## 1. OVERVIEW

## 2. EQUALITY IMPACT ASSESSMENT

| | | Comments | |
|---|---|---|---|
| **1.** | **What is the purpose of the proposal/ Policy** | To standardise practice for hearing aid assessment | |
| **2.** | **Could the proposal be of public concern?** | No | |
| **3.** | **Who is intended to benefit from the proposal and in what way?** | Audiologists as it provides guidance for clinic planning and patients/family as it provides standardisation of practice | |
| **4.** | **What outcomes are wanted for the proposal?** | Standardised and thorough assessment for hearing aids with informed child/family choice being the focus of decision making | |
| | | **Yes/No** | **Comments** |
| **5.** | **Is there a possibility that the outcomes may affect one group less or more favourably than another on the basis of:** | | |
| | Race | No | |
| | Ethnic origins (including gypsies and travellers) | No | |

| | | Comments | |
|---|---|---|---|
| | Nationality | No | |
| | Gender | No | |
| | Culture | No | |
| | Religion or belief | No | |
| | Sexual orientation including lesbian, gay and transsexual people | No | |
| | Age | Yes | Guidelines are for children <16 years old |
| | Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| **6.** | Is there any evidence that some groups are affected differently? | No | |
| **7.** | If you have identified that some groups may be affected differently is the impact justified E.g. by Legislation: National guidelines that require the Trust to have a policy, or to change its practice. | n/a | |
| **8.** | Is the impact of the proposal / policy likely to be negative? | No | |
| **9.** | If so can the impact be avoided? | n/a | |
| **10.** | What alternatives are there to achieving the proposal/ policy without the impact? | n/a | |
| **11.** | Can we reduce the impact by taking different action? | n/a | |

If you have identified a potential discriminatory impact; please ensure that you do a Full Impact Assessment.

If you require further advice please contact Service Equality Manager on 0116 2584382.

## 3. CONSULTATION SECTION

(To be completed and attached to Policy and Guidance documents when submitted to the UHL Policy& Guidelines Committee)

| **Elements of the Policy or Guidance Document to be considered (this could be at either CMG/Directorate or corporate level or both)** | **Implica-tions** (Yes/ No) | **Local or Corpor-ate** | **Consul-ted** (Yes/ No) | **Agree with P/G content** (Yes/No) | **Any Issues** (Yes / No) | **Comments / Plans to Address** |
|---|---|---|---|---|---|---|
| Education (ie training implications) | No | | | | | |
| Corporate & Legal | No | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| IM&T (ie IT requirements) | No | | | | | |
| Clinical Effectiveness | No | | | | | |
| Patient Safety | No | | | | | |
| Human Resources | No | | | | | |
| Operations (ie operational implications) | No | | | | | |
| Facilities (ie environmental implications) | No | | | | | |
| Finance (ie cost implications) | No | | | | | |
| Staff Side/ (where applicable) | No | | | | | |
| Any others | No | | | | | |

| **Committee or Group (eg CMG/Directorate Board) that has formally reviewed the Policy or Guidance document** | **Date reviewed** | **Outcome / Decision** |
|---|---|---|
| MSS | 17/11/23 | Approved. |
| | | |

| **Lead Officer(s) (Name and Job Title)** | **Contact Details** |
|---|---|
| Hazel Busby-Earle (Consultant) | hazel.busby-earle@uhl-tr.nhs.uk |

**Please advise of other policies or guidelines that cover the same topic area:**

| **Title of Policy or Guideline:** |
|---|
| See References |
| |

## 4. IMPLEMENTATION AND REVIEW

| Please advise how any implications around implementation have been addressed: | |
|---|---|
| **Financial** | N/a |
| **Training** | N/a |
| **REVIEW OF PREVIOUS P&G DOCUMENT** | |
| **Previous P&G already being used?** Yes | **Trust Ref No:** |
| **If yes, Title: Paediatric Hearing Aid Assessment. Clinical guideline v2** | **N/a** |

| | |
|---|---|
| **Changes made to P&G?** Yes | **If yes, are these explicit** Yes<br>**If no, is P&G still 'fit for purpose?** Yes |
| **Supporting Evidence Reviewed?** Yes | **Supporting Evidence still current?** Yes |

## 5. DISSEMINATION PLAN

| **DISSEMINATION PLAN** | | | |
|---|---|---|---|
| **Date Finalised:** | **Dissemination Lead (Name and contact details)**<br>**Sheena Hartland, Head of Paediatric Audiology** | | |
| **To be disseminated to:** | **How will be disseminated, who will do and when?** | **Paper or Electronic?** | **Comments** |
| **HSD Paed Team** | **Via staff meeting – HSD shared drive** | **Electronic** | |

| **CATEGORY 'C' POLICIES OR GUIDELINES ONLY**<br>**CMG/Directorate Approval Process**: | |
|---|---|
| **CMG Approval Committee:** | MSS |
| **Date of Approval:** | 17/11/23 |
| **Copy of Approval Committee Minute to be submitted with request to upload into Policy and Guideline Library** | |

## Glossary of terms

| | | |
|---|---|---|
| 1T | - | One tester |
| 2T | - | Two tester |
| ABR | - | Auditory Brainstem Response |
| AC | - | Air conduction |
| Apt | - | Appointment |
| BC | - | Bone conduction |
| CI | - | Cochlear Implant |
| CLP | - | Cleft lip and palate |
| EDS | - | Electro diagnostics Service |
| ENT | - | Ear, Nose and Throat |
| GA | - | General Anaesthetic |
| GP | - | General Practitioner |
| HSD | - | Hearing Services Department |
| NAIP | - | Nottingham Auditory Implant Programme |
| NHSP | - | New born Hearing Screening Programme |
| NOHL | - | Non-organic Hearing Loss |
| PCHI | - | Permanent Childhood Hearing Impairment |
| PN | - | Practice Navigator |
| RECD | - | Real ear to coupler difference |
| REM | - | Real ear measurement |
| S4H | - | Smart4hearing |
| TOD | - | Teacher of the Deaf |
| TYMP | - | Tympanometry/Tympanometer |