Draft Guidelines for the Onward Referral of Adults with Hearing Loss Directly Referred to Audiology Services (2016)

Produced by: Service Quality Committee of the British Academy of Audiology

Key Authors:

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Introduction

This document is intended to guide Audiologists in service planning and in making referrals for a medical or other specialist opinion.

Along with "Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016)[1]", this document replaces the earlier guidelines (BAA 2009[2], TTSA 1989[3,4]) and has been approved by the Board of the British Academy of Audiology and its membership.

This document comprises a set of criteria which apply to adults with hearing difficulties who have been referred directly to Audiology services. If any of these are met, then the patient should be referred to an Ear, Nose and Throat (ENT) department, back to the referring GP or to other specialist services, including those within the Audiology service, depending on the local pathways. The criteria have been written for all adults (age 16+), but local specifications regarding age range for direct referral should be adhered to.

A simple checklist has been included as an appendix, to summarise the criteria detailed in this document.

This document is intended to be used in conjunction with "Guidelines for the Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016)1" and Audiology services are expected to make reasonable efforts to make local GPs aware of these guidelines.

Background

In the past, direct referral guidelines were written to provide a simple pathway to hearing aid provision for older adults (age 60+) with routine hearing loss. The age range for direct referrals now varies between services. Some Audiology services are taking direct referrals for all adults (age 16+)2.

There is a lack of research evidence to support some of the criteria, but they are well accepted both in the UK and internationally[5,6]. We recommend that these criteria are investigated further to provide an evidence base to support future guidance.

Scope of this Document

Local arrangements may be in place for the direct referral of other conditions to Audiology, such as tinnitus, balance problems and auditory processing difficulties. Local services vary and practitioners are encouraged to make use of specialist pathways which may be more appropriate, or can be used as an alternative to ENT referral[7]. These referral routes are outside the scope of this document, but referrers should ensure they follow the appropriate regional policies. Audiology services are encouraged to have additional protocols to allow for regional variability.

Please note that these guidelines relate to the direct referral of adults with hearing difficulties to Audiology services and may not be directly interchangeable with guidelines for other pathways, for example, Any Qualified Provider (AQP).

For service planning, this document may need to be considered alongside the BAA Guidance on Identifying Non-Routine Cases of Hearing Loss in Adults (2015)[8].

This document assumes that the adult referred does not already have an NHS hearing aid. Audiology services are encouraged to have regional policies in place regarding the referral of existing hearing aid users to Audiology services. This document is not intended to guide Audiologists in the reassessment of existing hearing aid users.

In some services, Audiologists may undertake extended roles and provide pathways which substitute for medical referral. They must always operate within their defined role, according to their regional and/or professional protocols. Examples include:

- Audiologists removing ear wax.
- Undertaking vestibular function and tinnitus assessments followed by delivery and review of appropriate rehabilitation programmes.
- Assessment and consideration of audiological suitability for implantable hearing devices.
- Requesting MRI scanning in the case of an asymmetrical sensorineural hearing loss.

Notes on the onward referral of adults by an Audiologist for medical opinion

Direct referral assessments must be conducted by a Healthcare Science Practitioner at a minimum of career level 5 (equivalent to NHS Band 5). For further definition, see the BAA Scope of Practice Document[7]. This will usually be a qualified Audiologist, registered with the RCCP, a Clinical Scientist (Audiology) or a Hearing Aid Dispenser, registered with the HCPC.

If any of the following criteria become evident on assessment in Audiology, a specialist opinion should be sought. Depending on local protocol, this referral will usually be to an Ear, Nose and Throat (ENT) department, Audiovestibular Medicine or back to the referring GP. In certain services, this may be to another specialist or private service. Pre-existing and investigated (medical) conditions should be taken into account, if relevant. Referral for a medical opinion should not normally delay impression taking or hearing aid provision. The Audiologist must make a professional decision, based on ear examination, whether it is safe to proceed with impression taking[9] and hearing aid fitting.

All findings and advice given must be recorded and the patient's GP informed of the outcome, including any onward referrals which have been made.

It is acknowledged that Audiologists with less experience in particular areas may need support from more experienced colleagues in identifying those adults who require onward referral.

Criteria for onward referral by the Audiologist

History

- Persistent pain affecting either ear (defined as pain in or around the ear lasting more than 7 days in the last 90 days and which has not resolved as a result of prescribed treatment).
- History of discharge (other than wax) from either ear within the last 90 days, which has not responded to prescribed treatment, or which is recurrent.
- Sudden loss or sudden deterioration of hearing (sudden=within 72 hours, in which case send to A&E or Urgent Care ENT clinic). Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery[10,11].
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less)[12].
- Fluctuating hearing loss, other than associated with colds.
- Unilateral or pulsatile tinnitus lasting more than 5 minutes at a time.
- Tinnitus which has significantly changed in nature.
- Troublesome tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression. (For further guidance on the referral of adults with tinnitus, please see related evidence[13,14,15]).
- Vertigo which has not fully resolved or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include spinning, swaying or floating sensations and veering to the side when walking. For further guidance on vertigo, see www.vestibular.org[16]).
- Normal peripheral hearing, but with altered auditory perceptions or abnormal difficulty hearing in noisy backgrounds. This may include having problems with sound localization, the perception of pitch and loudness or difficulty following complex auditory directions[17,18].
- Altered sensation or numbness in the face or observed facial droop[19].

Ear examination:

- Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression. If wax is obscuring the eardrum or there is a current infection, local wax care or treatment procedures should be followed.
- Abnormal appearance of the outer ear and/or the eardrum[20] (Examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, growths, swelling of the outer ear or blood in the ear canal).

Tympanometry (performed if there is any indication of middle ear effusion)

- Unilateral Type B flat tympanogram, regardless of the associated level of hearing loss[21,22,23].

Audiometry:

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz[24]. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist.
- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000 or 4000 Hz. (Other frequencies may be included at the discretion of the Audiologist)[25,26].
- Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz. In the absence of any recordable bone conduction thresholds, air conduction thresholds should be considered instead.

Other findings:

- Any other unusual presenting features at the discretion of the Audiologist.
- Any other “red flags” identified, as agreed locally.
- Further guidance on identifying non-routine cases of hearing loss can be found in the BAA guidance8.

Conclusion

This document has listed the criteria for Audiologists to assess when adults with hearing difficulties are referred directly to Audiology. This should ensure that adults receive further assessment and care with the correct professionals, when it is appropriate.

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Appendix – Onward referral of patient by an Audiologist (summary)

History	
Persistent pain affecting either ear (defined as pain in or around the ear lasting more than 7 days in the past 90 days)	Yes / No
History of discharge (other than wax) from either ear within the last 90 days	Yes / No
Sudden loss or sudden deterioration of hearing (sudden=within 72 hours, in which case send to A&E or Urgent Care ENT clinic)	Yes / No
Rapid loss or rapid deterioration of hearing (rapid=90 days or less)	Yes / No
Fluctuating hearing loss, other than associated with colds	Yes / No
Unilateral or pulsatile tinnitus lasting more than 5 minutes at a time	Yes / No
Tinnitus which has significantly changed in nature	Yes / No
Troublesome tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression	Yes / No
Vertigo (see detail in document)	Yes / No
Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.	Yes / No
Altered sensation or numbness in the face, or facial droop.	Yes / No
Ear Examination	
Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression.	Yes / No
Abnormal appearance of the outer ear and/or the eardrum (Examples include: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, growths, swelling of the outer ear or blood in the ear canal).	Yes / No
Tympanometry (if performed)	
Unilateral Type B flat tympanogram, regardless of the associated level of hearing loss.	Yes / No

Audiometry	
Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.	Yes / No
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000 or 4000 Hz.	Yes / No
Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz. In the absence of any recordable bone conduction thresholds, air conduction thresholds should be considered instead.	Yes / No
Other	
Any other unusual presenting features at the discretion of the Audiologist. Please give details below:	Yes / No