MANCHESTER 1824
The University of Manchester

BRITISH ACADEMY OF AUDIOLOGY

Remote working Webinar 22nd May 2020:

Questions and answers.

Questions and answers (grouped by topic):

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- Q. I would be interested in other departments' thoughts on keeping distancing between staff - do staff move between rooms or always in the same room/work from home/work alternative hours? 2
- Q. We have a staff member with a significant hearing loss and uses bilateral hearing aids. She struggles with people wearing masks because she can't lip read. As far as I'm aware she doesn't use BSL or other visual language. Do you have any tips to help her with this? 3

Admin: 4

- Q: Are you counting these tele consultations as sufficient to "stop the clock" when considering the waiting lists? 4
- Q: On Auditbase how you differentiate with codes or symbols those done by phone or video? 4

Technology: 4

- Q: Is there helpful guidance on system requirements for our nhs IT teams? We have always had issues with computers with poor specs and poor networks in place. I just hope this recommendations provide us with ammunition to appeal for funding for all these necessary upgrades. 4
- Q: Is there a correlation between PTA done in clinic and in situ PTA? 4
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- Q: Do you discharge a tinnitus patient without a PTA and if so how have you excluded a red flag related to hearing or a mild/moderate hearing loss which would benefit from hearing aids? Thanks 5

Vestibular 5

- Q. Have you tried app based VR like physio tools and what do you feel about it? Thanks 5

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Staff working/support:

Q. I would be interested in other departments' thoughts on keeping distancing between staff - do staff move between rooms or always in the same room/work from home/work alternative hours?

- We all have allocated rooms & try as much as possible to stay in those rooms whenever we see our patients! We do however all share one office \ stock room & try to ensure social distancing when going in & out of there...
- Plymouth have a variety – some working from home, but mainly focused on good hygiene of the clinic rooms between sessions. We have a reversible sign "Room clean and ready to use" (when finished with and left clean) or "Room in use".
- Dawn has shared her procedure:
  - Allow colleagues space when moving around the department – stop and wait for someone to pass etc.
  - Do not lean over to reach for an item. Be patient and ask permission beforehand so that your colleague can move
  - Please wipe down door handles, doors and surfaces daily.
  - Be mindful in the workshop area that we are closer to each other than is recommended: Offer to get something for a colleague rather than assume they are comfortable being too close, prepare your stock and consumables within a room for the day. Can you stock your workstation appropriately to minimise contact and moving around the department?
  - Restrict people entering the department: if they are not working in the area do they need to come in? Whenever possible do not admit people to the department. This is for the consideration and safety of colleagues as well as your own
  - If other staff need to enter the department, please remind them to use the sanitizer which is at the entrance EVERY TIME they enter.
  - The workshop area is not a kitchen. All food should remain in the fridge or your locker. The sink and drainer needs to remain free of cutlery and dirty cups/mugs and plates. We are undertaking hearing aid repairs in this area.
  - Lunch should be taken in staggered times to minimise staff contact. I appreciate this is at odds to trying to have a social break but we need to make sure we are not crowding areas.
  - Aim to stay within your workspace. Use starleaf and phone calls rather than face to face meetings whenever possible.
  - Clothes do not need to be changed if you are remaining in the department but the vestibular room is available for changing should staff wish to.
  - Consider printing in batches so that you are not moving to and from the printer repeatedly.

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Q. We have a staff member with a significant hearing loss and uses bilateral hearing aids. She struggles with people wearing masks because she can't lip read. As far as I'm aware she doesn't use BSL or other visual language. Do you have any tips to help her with this?

- Staff can ask for any adjustment which is 'reasonable', including not performing duties (e.g. phone calls) that they would really struggle with.
- For seeing patients in person, consideration should be given to e.g:
  Seeing patients with 2m+ distance and no mask while conversing. Putting on masks for close work only.
- Perspex screen - like supermarkets and reception areas are using.
- Hearing aid accessories which bring the patient's speech 'closer' (e.g. Roger pen/Multi mic/portable loop etc) - especially in conjunction with the above.
- Working as part of a pair - e.g. in paeds, where many services have adopted a 'one clean, one dirty' approach.
- Sending out questionnaires/discussion tools in advance, to bring along.
- Seeing patients who have had a history taken beforehand (by a colleague/over the phone etc).
  (See-through masks for vulnerable patients would be good if possible, but not widely available as yet)
- Captioning apps - I am sure lots of people are trying them - see online e.g:
  https://mynewimplant.wixsite.com/rachel/single-post/2020/05/13/No-masking-this-Hearing-loss-in-the-COVID-19-pandemic
  https://actiononhearingloss.org.uk/2019/05/what-app/
  https://www.android.com/accessibility/live-transcribe/ (Android only)
  https://texthear.com (free on Android, pay on iPhone)
  https://apps.apple.com/us/app/hearing-helper/id1391454121(iPhone only)
  https://www.ava.me (payment required for some uses)
  https://webcaptioner.com (website for using subtitles on a computer - not for mobile phone)

For online working:

- Automatic captioning/subtitles if possible - I notice more announcements of subtitles being available - hopefully on the increase. 'Chat' function to clarify if needs be.
- Advice to patients/colleagues regarding making themselves easy to understand - lighting, good distance from camera etc
- Agreed agenda/questions beforehand.
- See useful advice in this blog by an audiologist who uses a CI:
  https://mynewimplant.wixsite.com/rachel/blog
- Plymouth's local IPC does not require patients to wear masks, so there could be a reasonable adjustment here for a staff member, with an appropriate risk assessment (so we wear masks, but patients don't).

Video work is good here, as no masks or other PPE to get in the way, and you can use technology to ensure good SNR (depending on the degree of loss).

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- Facebook group for deaf audiologists is run/supported by Anne Davies, and I am sure it's filling up with ideas. She's on the BAA Facebook group so can be signposted to from there.

Admin:

Q: Are you counting these tele consultations as sufficient to "stop the clock" when considering the waiting lists?

- In theory, the clock shouldn't stop with the history/needs assessment – it should stop when the PTA is carried out. But it depends on how your IT system is set up at the moment (so Plymouth's stops at 1st apt, even though it shouldn't!).

Q: On Auditbase how you differentiate with codes or symbols those done by phone or video?

- Chester have created new Auditbase symbols for appointments completed remotely.
- Plymouth have new symbols for remote appts – we haven't differentiated between telephone/video on A/Base, but do in the journal so it's clear for future clinicians.

Technology:

Q: Is there helpful guidance on system requirements for our nhs IT teams? We have always had issues with computers with poor specs and poor networks in place. I just hope this recommendations provide us with ammunition to appeal for funding for all these necessary upgrades.

- We have included some details on technology requirements in the document titled 'practical consideration for remote working'. We can be more specific in the updated version e.g. Windows 10, Microsoft 365 etc.
- Adam Beckman: Now is the time (if not too late) to get ICT improvements. Just write "remote working for covid" over everything and the technology should follow.

Q: Is there a correlation between PTA done in clinic and in situ PTA?

- If by in-situ audiometry you mean the testing of pure tone thresholds using signals generated by a hearing instrument, there is a small amount bit of data out there. Convery et al (2015) said although reliability and validity were negatively affected when the patient conducted the procedure alone, the results were still clinically acceptable: test-retest correspondence was 10 dB or lower in 97% of cases, and 91% of automatic thresholds were within 10 dB of their manual counterparts. Boyman and Dreschler (2017) also reported that hearing thresholds obtained via in-situ audiometry and conventional audiometry with one particular hearing aid was comparable. On the other hand, Kiessling et al. (2015) showed more variation in findings when they looked at thresholds collected via hearing aids from four major manufactures (Resound, Phonak, Starkey, and Oticon) and compared them to conventional audiometry. They found that the in-situ thresholds overestimated severity of hearing loss at low frequencies and underestimated it at higher frequencies. There were also large variations across each manufacturer's hearing aid, and there was an interaction between the error and degree of hearing loss. The hearing aids evaluated in this study were manufactured over five years ago. It will be interesting to find out whether in-situ audiometry with newer models of hearing aid yields more comparable findings. Personally, I think it will..

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Boymans M, Dreschler WA. In situ Hearing Tests for the Purpose of a Self-Fit Hearing Aid. Audiol Neurootol. 2017;22(1):15-23

Convery E, Keidser G, Seeto M, Yeend I, Freeston K. Factors affecting reliability and validity of self-directed automatic in situ audiometry: implications for self-fitting hearing AIDS. J Am Acad Audiol. 2015 Jan;26(1):5-18.

Kiessling J, Leifholz M, Unkel S, Pons-Kühnemann J, Jespersen CT, Pedersen JN. A comparison of conventional and in-situ audiometry on participants with varying levels of sensorineural hearing loss. J Am Acad Audiol. 2015;26(1):68-79.

- Adam Beckman: In general, I think this would need to be redone for each manufacturer and each range of aids. Could be a recurring MSc project each year!?! In general, my (limited) understanding is low frequencies only work with a really occluding mould, so might be good to get the data to then give some guidance on the more reliable frequencies. In 2-3 years, patients now being fitted with aids that can be used remotely will be wanting retests, so would be good to have the data ready for that.
- Dawn Bramham: I'm thinking using it as a triage, perhaps as a first test when doing the phone assessment and then also as a troubleshooting tool? if hearing has changed from previous, or is low frequencies shift could that indicate that there is leakage/mould issues. To be discussed further at the next webinar.

Q: Which BC aids are you using please?

- Sheffield use https://my.supplychain.nhs.uk/Catalogue/product/ghb10830
- Chester have used to use Contact Mini BC aids which we liked but price became an issue. Before lockdown we had just started to try the Starkey APBCH aids - available on supply chain,

Tinnitus:

Q: Do you discharge a tinnitus patient without a PTA and if so how have you excluded a red flag related to hearing or a mild/moderate hearing loss which would benefit from hearing aids? Thanks

- All the patients we have seen at Chester for remote tinnitus assessment have already seen ENT and so have had a PTA and any appropriate investigations.

Vestibular

Q. Have you tried app based VR like physio tools and what do you feel about it? Thanks

- Answer to be added shortly……please check the document again in 1 week.

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