Referral Guidelines for HCPC registered Hearing Aid Dispensers (Updated September 2017)

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A. Scope

This document is for Hearing Aid Dispensers (HADs)¹ whose registration with the Health and Care Professions Council (HCPC) authorises them to practise autonomously. It provides guidance on when HADs should consider referring clients.

B. Clients accessing hearing services

Clients might consult HADs in multiple ways, including but not limited to

I. Directly without referral.
II. Referral from medically qualified colleagues specialising in a field related to hearing – e.g. ENT Surgeons, audio-vestibular physicians et al.
III. Referral from clinically qualified colleagues without relevant specialist expertise – e.g. General Practitioners, optometrists, other audiologists/HADs et al.
IV. Other reasons for example, for wax removal or advice on noise protection etc.

Regardless of how clients access hearing care, as an autonomous professional you should:

• work in the best interests of clients at all times²

¹ ‘Hearing Aid Dispenser’ is a protected title. It is a health profession regulated by Health and Care Professions Council (HCPC)
http://www.hcpc-uk.org
This section helps HCPC registrants meet these and other professional standards.

I. Clients accessing services directly without a referral

People have always been able to access private hearing care directly from HADs without the need for a referral letter and this is standard practice across the UK. The NHS still routinely requires people to see their GP to obtain a referral letter in order to access NHS hearing services.

Current UK norms, therefore, mean that clients can access hearing care directly from HADs if they fund their own care, but should see their GP if they want to see the same HAD on the NHS. NHS pathways remain subject to local commissioning decisions. Therefore, HADs should be mindful that a local NHS contract might require clients to have a GP referral even when the clients do not need a medical/clinical opinion from the GP.

II. Clients accessing services with a referral from clinically qualified colleagues without specialist knowledge of hearing care

HADs should accept referrals from colleagues that are within their scope of practice and where it is in the best interests of the client to do so. This is relatively straightforward when providing services in the private sector. For example, a colleague might refer certain tinnitus patients to you if they are within your scope of practice.

There are many other scenarios in which HADs may receive referrals from other clinically qualified colleagues. Often the case presentation will influence how clients access care. For example, clients are likely to see their GP or other medical colleagues (who may or may not have specialist knowledge of hearing care) before they see HAD for their hearing care, if their primary complaint includes any of the following:

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4 Throughout this section we use the HCPC definition of scope of practice, for more detail see page 4 of, HCPC, 2014, Standards of Proficiency – Hearing aid dispensers. Available at http://www.hpc-uk.org/assets/documents/10002CBCStandardsofProficiency-Hearingaiddispensers.pdf Accessed on 04 September 2017
- Vertigo/dizziness or balance and coordination issues
- Ear ache within the last week or active ear discharge
- Sudden hearing loss
- Unilateral, pulsatile or objective tinnitus

III. Clients accessing services with referral from a medically qualified colleague specialising in a field related to hearing

A client might be seen and treated by a doctor with a relevant hearing care specialty and then referred to you for ongoing management/support. It is appropriate for HADs to accept these referrals provided each HAD works within their own scope of practice. For example, an ENT specialist might diagnose noise-induced hearing loss and refer a client to you for hearing assessment and hearing aids. Another example is when you refer a client to ENT or a GP for a second opinion (e.g., for unilateral tinnitus, sudden hearing loss or dizziness etc.) and once treated/discharged they are referred back to you for ongoing support with hearing loss. In other cases, somebody born with hearing loss might decide as an adult to access private hearing care and therefore the NHS audiology service might refer these clients to you.

IV. Other reasons

Clients may access the hearing care service for a variety of reasons, which may or may not be directly related to their hearing ability. For example, they may want to get earwax removed from an appropriately qualified professional. Clients may also visit HADs for devices for music/noise protection or swim moulds etc.

C. Making referrals

As an autonomous professional, HADs need to work in the best interests of clients at all times and make appropriate referrals. Table 1 provides common signs/symptoms which might warrant referral. More detail can be found in Appendix 1 on page 6.

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<thead>
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<tbody>
<tr>
<td>1</td>
<td>Where management of an obstruction of the external auditory canal is out of your scope of practice and the obstruction prevents a full assessment.</td>
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<tr>
<td>2</td>
<td>Abnormal appearance of the eardrum and/or the outer ear</td>
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<td>3</td>
<td>Persistent pain affecting either ear</td>
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<td>4</td>
<td>Unexplained conductive hearing loss</td>
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<td>5</td>
<td>A unilateral or asymmetrical hearing loss (20dB HL drop at two consecutive frequencies)</td>
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<td>6</td>
<td>Sudden sensorineural hearing loss (within 72 hours)</td>
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Rapid onset of hearing loss or rapid deterioration in hearing (in 90 days or less)

Evidence of a clinically significant deterioration in hearing

Fluctuating hearing loss

Tinnitus that is unilateral, pulsatile or objective

Hyperacusis if it is outside of your scope of practice

Vertigo/dizziness or balance and coordination issues

Auditory processing issues (known as auditory processing disorder)

Table 1: Signs and symptoms that might require referral. Please see Appendix I for more detail.

HADs would be expected to refer the signs and symptoms in table 1 for a medical opinion, unless there is a clear reason not to do so. For example, if a medically qualified colleague has referred somebody with troublesome tinnitus to a HAD for support with an underlying hearing issue then the HAD would not have to automatically re-refer the client, although good communication between professionals and the client would remain a priority. However, where any of the signs or symptoms have not been recorded before and these are outside your scope of practice then you should refer for a medical opinion.

D. When a referral may not be required

HADs, in consultation with the client, might make a professional judgement that an onward referral is not the preferred course of action.

This may arise if:

- the condition has been fully investigated by an appropriate professional, any possible treatment has been provided and the condition remains unchanged
- the condition lies within the HAD’s scope of practice, because they have appropriate training and experience in dealing with the condition e.g. HAD qualified to remove ear wax or deal with bilateral tinnitus with symmetrical hearing loss
- the client has made an informed and competent decision and declined a referral. In this case, HAD must make appropriate records of the basis on which this decision has been reached. They must ensure that informed consent has been obtained from the client or their carer or

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5 For example, an increasing number of HADs have the requisite training and experience to manage some of the signs/symptoms listed in table 1, including removing obstructions from ear canal, tinnitus management etc. Therefore, clinicians are encouraged to make their own professional judgement whether a client’s condition is outside their scope of practice. Furthermore, pre-existing and managed/unchanged signs/symptoms/conditions that have already been investigated by an appropriately qualified professional need not be automatically re-referred. In all cases good record keeping, communication between professionals and consent from the client is important.

other competent advisor\(^7\) on the basis of sufficient information\(^8\), including associated risks, and the records\(^9\) confirm all the necessary considerations about client’s best interests. In all cases HADs should try and obtain consent to inform the client’s GP about their decision.

### E. Making an onward referral

When a referral is required the following actions should be taken:

- Obtain client’s or their carer’s informed consent before providing information to referrer
- Referrer should be informed, preferably, in writing and without undue delay. The reason for referral should be clear and should accompany all the relevant details e.g. audiograms etc.

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\(^7\) Clients known or suspected to be suffering from any condition affecting their ability to make informed decisions should be advised by a person who can and has the authority to act on your client’s behalf and in your client’s best interests

\(^8\) HAD must be able to answer any questions so that they can be confident that their decisions is “informed”

Appendix I

Signs and symptoms that might require referral

Throughout this appendix we use the HCPC definition of scope of practice for HADs, which is fully supported by BSHAA:

- “Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself.”\(^\text{10}\)

- “will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain area or with a particular client group, or a movement into roles in management, education or research.”\(^\text{11}\)

As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice, you should be certain that you can work lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training or gaining experience, before moving into a new area of practice.”

For more detail on the signs and symptoms that might require referral see below:

1. Refer an obstruction of the external auditory canal if
   - it prevents examination of the eardrum and/or the safe and accurate taking of an aural impression, \textbf{and}
   - it is outside of your SoP to manage the cause of the obstruction – e.g. if the cause of obstruction is impacted ear wax and it is within your SoP to manage this then this will \textbf{not} require a referral.

2. Refer clients for a medical opinion unless the client is already being managed or has been discharged/referred to you by a medically qualified colleague that has already documented any of the below:
   i. Inflammation of the external auditory canal
   ii. Active discharge
   iii. Abnormal findings in the ear canal (e.g. Cholesteotoma)
   iv. Perforated eardrum, which has not been investigated previously


v. Visible congenital or traumatic deformity of the ear that has not previously been investigated
vi. Any other suspect clinical signs of the eardrum and/or the outer ear

3. Refer persistent pain affecting either ear, where clinically indicated. For example, if the pain has completely subsided in the last week then a referral might not be required but if there is a recurring pattern the client might benefit from referral. You should work within your SoP at all times and refer if clinically necessary.

4. Refer unexplained conductive hearing loss where audiometry shows 20 dBHL or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 Hz or 4000 Hz. Clients with unexplained or previously undocumented conductive hearing loss might also benefit from a referral to exclude an underlying treatable condition.

Glue ear can cause hearing loss. Unilateral glue hear in adults should be referred as these clients might benefit from examination of post nasal space by an ENT Consultant (Leonetti, 2013). In certain syndromes, e.g. Large Vestibular Aqueduct (LVS), the air-bone gap can mimic middle ear disease (Merchant et al., 2007)

5. Refer a unilateral or asymmetrical hearing loss where there is

- 20 dBHL asymmetry between two contiguous frequencies if bilateral loss or 15 dBHL if normal hearing in one ear. (Obholzer, Rea, & Harcourt, 2004; Nash, Majithia, & Singh, 2016)

- 15 dBHL asymmetry at one frequency 500-4000 Hz with unilateral tinnitus (Welling, Glasscock, Woods, & Jackson, 1990)

It is important to note that the British National Study of Hearing (Davis, 1989) found up to 10 percent of general population may have 15 dBHL asymmetry. This significantly exceeds the prevalence of serious underlying medical conditions that are associated with asymmetric hearing loss. Therefore, referral on this basis might result in additional false positive referrals to ENT. You are therefore encouraged to work with local ENT departments and GPs to agree local protocols and training to improve referral pathways and reduce false positive referrals. Where this is not possible you should continue to refer based on the established national criteria noted above.

It is important to note that the diagnostic accuracy of non-imaging screening protocols for vestibular schwannoma in clients presenting only with asymmetrical hearing loss alone remains uncertain (Hentschel, Scholte, Steens, Kunst, & Rovers, 2017). In contrast, the presence of unilateral tinnitus and asymmetrical hearing loss is shown to have good diagnostic accuracy. For example, 15 dBHL asymmetry at one frequency 0.5–4 kHz with unilateral tinnitus is likely to result in a positive finding in 90% of MRI scans (Welling et al., 1990). Therefore, unmanaged/undocumented unilateral tinnitus and asymmetric hearing loss of 15 dB should always be referred.
6. Urgently refer sudden sensorineural hearing loss (SSHL) (Leung et al., 2016). SSHL is to be treated as an otologic emergency requiring immediate recognition and referral to A&E and/or Urgent Care ENT clinic. SSHL can develop rapidly with hearing loss progressing within 72 hours. Diagnose presumptive SSHL, if audiometry confirms a 30-dB hearing loss at 3 consecutive frequencies (Stachler et al., 2012).

7. Refer rapid onset of hearing loss or rapid deterioration in hearing. ‘Rapid’ is within 90 days or less. All clients with a rapid progression recorded on the audiogram, should be considered for onward referral.

8. Evidence of deterioration of hearing outside of expected normal limits. In the adult population hearing loss is typically gradual and slowly progressive. Epidemiological studies have shown for example that the average rate of change in PTA thresholds is between 0.5 to 8K Hz is about 2 dBHL or less per year (Wiley et al, 2008; Cruickshanks et al., 2003).

For example, a deterioration of 15 dBHL or more in air conduction threshold readings at two or more of the following frequencies 500, 1000, 2000, 4000 Hz over 24 months should be referred. Where there is a large time gap in two successive audiograms the decision to refer is best made on a case by case basis. You might for example compare the client’s history, age, and previous records to make a professional judgement on whether the client needs to be referred immediately or reviewed in few weeks or months to repeat tests and make a decision on whether to refer. It is important to keep good records and explain results and agree the plan of action with the client.

9. Refer fluctuating hearing loss that is not associated with head colds or respiratory tract infection. Test/retest reliability of the pure tone audiometry is within 5 dBHL and an average change of hearing thresholds for the general population is around 2 dBHL per year. Significant variation in hearing thresholds (e.g.10-15 dBHL) within a relatively short period of time might therefore be considered to be a fluctuating hearing loss.

10. Not all presentations of tinnitus are referable

- Always refer tinnitus which is objective (can be heard by both the client and examiner) unilateral or pulsatile.
- Subjective (only heard by client not examiner) bilateral tinnitus is most often associated with hearing loss and idiopathic. Clients with bilateral tinnitus and symmetrical hearing are not likely to show retro-cochlear pathology on MRI (Choi, Sajisevi, Kahmke, & Kaylie, 2015). Unless there are other reasons to do so, people with bilateral tinnitus and symmetrical hearing loss are less likely to require a referral. You may support these clients if it is within your SoP.
- In other, and rarer cases, bilateral subjective tinnitus might be associated with wax, otosclerosis, significant noise exposure, ototoxicity, otitis media, head or neck injury, multiple sclerosis, diabetes, metabolic disorder or thyroid disease (Tunkel et al., 2014). This
means you might also choose to refer to an ENT specialist for the diagnosis of underlying cause or confirmation that the tinnitus is idiopathic (NICE, 2010).

- In some cases, you might refer to a colleague (e.g. another HAD/audiologist, psychologist, psychiatrist, or other appropriately qualified person) where the tinnitus is intrusive and may lead to sleep disturbance or be associated with symptoms of anxiety or depression.

11. Hyperacusis, (the experience where every day sounds become intrusively loud, uncomfortable, and sometimes painful) can be a symptom of a migraine, dehiscence syndrome, post head injury syndrome, Lyme disease, William’s syndrome and Bell’s palsy etc. Therefore, it may be important to seek a medical opinion as part of treatment plan for the client. For further information on Hyperacusis, readers are directed to (Baguley, Andersson 2007).

12. Refer clients presenting with balance, coordination or dizziness issue, to their GP, ENT doctor or an Audio-vestibular physician as appropriate.

13. Auditory processing disorder (APD), where peripheral hearing is within normal limits, as assessed audiometrically, but client presents with abnormal listening ability in noisy backgrounds. Note that clients with sensorineural hearing loss will have auditory processing issues by definition because sensorineural hearing loss results in dysfunction of auditory cells along the auditory pathways, affecting the processing of sounds and speech.

References


