LINDLEY (4)

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Background

At present, the same model of service delivery is applied to adults living in ACFs and adults living independently in the community: individuals people eligible for hearing services are provided with a voucher which they can take to any hearing service provider It is argued that this is not appropriate for a number of reasons:

1. **The ACF client population has greater need**

Residents in ACFs have more complex health conditions than those living in the community and these health conditions have necessitated that they receive the levels of assistance provided in an ACF. There is a very high prevalence of communication impairments in older people living in ACFs, a significantly higher prevalence than is found in the wider elderly community. Research studies typically show that hearing loss occurs in 80 - 90% of ACF residents, compared to approximately 40 - 50% of older adults living in the community. In addition, those in ACFs are more complex in terms of management as they have other serious co-occurring health conditions that mean that rehabilitation for this population is more complex. The major relevant health conditions are dementia and vision impairment.

2. **Clients in ACFs require assistance from others in hearing health care**

Although older people living independently in the community require assistance from others at times, such assistance is essential for ACF residents and staff in the facilities will be the main providers of such assistance. Therefore, education of staff is essential for successful outcomes of any rehabilitation offered eg hearing aid fitting, assistive device fitting, communication strategy use. Education needs to be ongoing as there is a high rate of staff turn-over in ACFs. Current lack of staff knowledge about hearing and communication is well-documented.

3. **The ACF environment is different**

The nature of the physical and social environment in ACFs hinders effective and satisfying communication exchanges thus special care needs to be taken to provide hearing services that address these issues. It would be very beneficial if ACFs could be provided with information about the most appropriate physical and social environment to allow people with hearing impairment to have successful conversations with other residents, staff and family and friends.

What is the evidence about the efficacy of audiological interventions in ACFs?

Traditional audiological care for older people involves audiological assessment and the fitting of hearing aids. The take-up rates of this form of intervention by residents in ACFs are low and, if aids are fitted, particularly poor outcomes are reported. For example, Ferguson and Nerbonne (2003) found that 58% of hearing aids in an ACF were not working when tested. The most common reasons were because of dead batteries and wax occlusion. The American Speech Language Hearing Association

stated that only 5% to 10% of hearing aids are used in an ACF at any one time (ASHA, 1997) and our Australian experience is similar to this (Looi et al., 2004; Worrall, Hickson & Dodd, 1993).

For the reasons stated above, audiological intervention for residents in ACFs is complex. Different models of practice are required than with community based older people. Research evidence indicates that better outcomes are obtained if:

- Assistive Listening Devices, particularly personal amplification systems, are fitted rather than hearing aids (Pichora-Fuller, 1997; Rizzolo & Snow, 1989. Telephone and television listening systems are also beneficial (Pichora-Fuller & Robertson, 1994).
- Residents receive ongoing on-site support from an audiological service (Lewsen & Cashman, 1997; Looi, Hickson, et al., 2004). A problem with the current system is that residents in the same ACF are seen by many different service providers. This does not allow effective coordination of hearing care as staff and family are frequently unaware of who to contact when a particular resident requires assistance.
- Interventions that treated the whole ACF environment were included as part of the rehabilitation i.e., staff training, modifications to the physical and social environment, family education (Looi, Hickson et al., 2004; Worrall & Hickson, 2003).

How can the situation change?

It is proposed that the model of service delivery be changed so that coordinated services are provided for a facility or group of facilities. This allows the service provider to take a holistic approach to supporting residents and staff. Providers could be asked to tender for work in ACFs outlining the details of the service they would provide. It would be essential that such providers were cognisant of all of the issues described above. They would need to offer:

- **Amplification assistance – assistive devices being more likely to be appropriate and successful than hearing aid fitting, although the latter may be appropriate in some cases.**
- **Advice to the ACF re possible changes to enhance communication in the environment eg visual displays, captioned TV, acoustic shielding, changes to seating arrangements**
- **Education for staff and family and friends that meets the needs of the target audience.**
- **A means of evaluating outcomes eg qualitative reports from residents, staff, family, ACF management.**

Each ACF would therefore have a 'preferred provider' arrangement with a hearing service provider. This already occurs in ACFs in a number of other health areas such as pharmacy. Individual residents can still elect to see a particular hearing service provider if they wish. This is most likely to occur when they have been under the care of a particular provider before entering the ACF.

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