Practice Guidance

Guiding Principles of Person-Centred Care in Adult Hearing Rehabilitation

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General foreword

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This is a revised and updated version of BSA Practice guidance produced in 2016 that was titled Guiding Principles of Rehabilitation for Adults in Audiology Services.

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Shared Decision-Making

It is implied throughout this document that the patient should be involved in shared decision-making when undertaking audiological intervention, receiving subsequent information, and understanding how it will impact on the personalisation of care. Individual preferences should be considered and the role of the clinician is to enable a person to make a meaningful and informed choice. Audiological interventions bring a variety of information for both the clinician and the patient which can be used for counselling and decision-making regarding technology and anticipated outcomes.

Contents

1. Abbreviations

ARIG: Adult Rehabilitation Interest Group
HASK: Hearing Aid Skills and Knowledge
NICE: National Institute for Health and Care Excellence
PROTEA: Patient Reported OuTcomEs in Audiology
SDM: Shared decision-making

2. Introduction

Hearing issues are typically chronic, they can be managed but rarely cured. Effective auditory rehabilitation is best achieved through a holistic approach that supplements sensory intervention with support to the person (the 'patient') and to their significant other(s)/communication partner(s).

The purpose of this document is **to provide practical clinical recommendations to audiology and other healthcare professionals directly involved in the adult rehabilitation pathway** based on the guiding principles used in adult rehabilitation. We recommend using a reflective approach to rehabilitation where the audiology professional plays the role of the 'facilitator', not the 'fixer'. This document reflects best available evidence and is **intended to support audiology professionals in identifying patient preferences for their care**, especially for those who have long-term hearing conditions.

These guidelines outline current best practice in the audiological management of adults in hearing rehabilitation. Our approach has been to provide guidance regarding the way clinical interactions and processes are conducted rather than providing step by step guidance on specific practices because the evidence around these is evolving, while approaches to care are more established. We also acknowledge that due to time restrictions in some services, consultations may need to be prioritised to address the main needs of the individual and the guidelines should be considered with this in mind. Therefore, the recommendations should be interpreted as best practice and not mandatory.

Adaptations for special populations are important and necessary but are outside of the scope of these guidelines. For patients with intellectual disabilities, please refer to the BSA Intellectual Disabilities guideline. For Dementia Care adaptations, we recommend reading Hearing Assessment and Rehabilitation for People Living with Dementia (Dawes et al., 2021).

Following a short background in Section 2, we use Sections 3 and 4 to define the concepts used in our recommendations, and then in Section 5 provide specific recommendations for clinical practice. The ARIG PCC Toolkit (2024) provides information and links to useful support materials. A summary of our recommendations can be found in Appendix 1.

3. Background and Aims

Practical recommendations have been made around best clinical practice to support audiology professionals delivering adult rehabilitation. Each of these recommendations is linked to the tenets of person-centred care. In person-centred care: *'professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills, and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual and, crucially, it ensures that people are always treated with dignity, compassion, and respect'* (The Health Foundation, 2016, p3).

The principles of person-centred care were originally defined by Picker, an international charity that works across health and social care in the UK, Europe and the US to understand and further the link between patient experiences, person-centred care, and clinical excellence (Picker, 2024). The Picker principles were developed from interviews and focus groups with patients, their carers, and health professionals over a period of 20 years (Gerteis et al., 1993; Shaller, 2007), and the work continues today across Europe. The Picker charity and associated publications refers to 'patient-centred' care, which, throughout this document we refer to as 'person-centred' care.

In this document we take each Picker principle and use it to provide guidance across a typical audiological patient pathway.

To assist with understanding, we first provide a glossary of terms and concepts.

4. Concepts

4.1 Glossary

The following concepts used throughout this guidance:

Accessibility: Accessibility is about designing products, devices, services, environments etc., so that they are usable by people with disabilities. In 2017, the NHS released the Accessible Information Standard that specifies the approach that NHS care and/or publicly funded adult social care organisations are legally required to follow regarding identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Continuity of care: The extent to which a person experiences an ongoing relationship with a clinician or clinical team to ensure co-ordinated clinical care that progresses smoothly as they move through their healthcare pathway.

Deaf awareness: Deaf awareness refers to being sensitive to the experiences, communication needs, and cultural identity of deaf and hard of hearing people.

Family-centred care: An approach to healthcare that recognises the vital role that families play in audiological treatment and rehabilitation. The engagement of family members (or communication partners) in the hearing consultation enables them to become valuable allies in the rehabilitation process. It accepts and considers the family to be the client, rather than just the person with the health condition (Epley et al., 2010; The Ida Institute).

Joint goal setting: Joint goal setting is the process by which individuals, significant others and relevant clinical professionals work together to discuss what they hope auditory rehabilitation will achieve in terms of hearing-related outcomes (McKenna, 1987; Hickson et al., 2016)

Joined-up working: Working collaboratively with other professionals and multidisciplinary teams and services.

Person-centred or patient-centred care: A person- or patient-centred approach means working collaboratively with the individual and their significant other(s) focusing on the elements of care, support and treatment that matter most to them, recognising they are an expert in their own hearing and treating them with dignity, compassion, and respect (The Health Foundation, 2016; The Ida Institute, 2023).

Rapport building: Rapport is defined as the ability to establish and sustain a working partnership and is considered critical to developing trust (Godsell et al., 2013; Workman et al., 2013). Relationships characterised by trust contribute to better care experiences, alleviate anxiety, and distress, and enhance patients' involvement in decisions about their care.

Shared decision-making: Shared decision-making (SDM) is an approach where clinicians and individuals share the best available evidence when faced with the task of making decisions, and where individuals are supported to consider options, to achieve informed preferences. This has become an important feature of contemporary healthcare and offers an intermediate alternative between the individual having full decision-making control and having no say at all.

Self-efficacy: Self-efficacy is an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1997). It reflects confidence in the ability to exert control over one's own motivation, behaviour, and social environment. It can underpin the ability to self-

manage hearing loss, where the audiology professional builds the individual's confidence in their ability to achieve their goal(s). The audiology professional has a role to play in providing knowledge and support so that individuals can eventually live well with their hearing loss.

Self-management: There are many definitions of self-management but generally they encompass the concept that it involves the individual taking responsibility for their own behaviour and well-being. For long-term conditions, this refers to management of symptoms, interventions or treatment, and physical and psychosocial consequences alongside life-style changes (Barlow et al,. 2002).

Teach-back technique: The teach-back technique is a simple way to check your individual's understanding by asking them to 'teach back' in their own words, the information and instructions you provided. You can expand it to have individuals 'show you' what you taught them about handling hearing aids (https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html). Teach-back has been shown to increase self-efficacy, self-management, and knowledge recall (Ha Dinh et al., 2016).

4.2 Picker principles of person-centred care

Picker principles of person-centred care (Shaller, 2007):

A. Access to care and reliable advice
B. Effective treatment by trusted professionals
C. Continuity of care and smooth transitions
D. Involvement and support for family and carers
E. Involvement in decisions and respect for preferences
F. Clear information communication and support for self-care
G. Emotional support, empathy, and respect
H. Attention to physical and environmental needs.

5. Recommendations for Practice

Below we provide recommendations for clinical practice based on the Picker principles of person-centred care. We provide recommendations as they apply to each of the Picker principles (A to H).

A. Access to care and reliable advice

Accessibility is fundamental to care provision. For care to be successful it is essential that the individual can communicate with and understand the audiology professional and the information they provide (ARIG PCC Toolkit, 2024). To achieve accessibility all staff should undergo deaf awareness training (Parmar et al., 2022; Morisod et al., 2022; Ubido et al., 2002;ARIG PCC Toolkit, 2024).

As per the Accessible Information Standard (2017) the overarching guidelines to enhance accessibility should include the following:

A1. Identify individual access needs (e.g., British Sign Language interpreter, a language translator, or use of live speech to text applications) and preferences (e.g., remote vs in-person) prior to the initial appointment and schedule accordingly for all future appointments and see (ARIG PCC Toolkit, 2024)

A2. Record the identified needs by documenting them in the individual record, and ensure they are used at every contact.

A3. Flag the identified needs by adding an alert in the individual database describing access needs to ensure there is continuity of use.

A4. Use visual or tactile communication tools in the waiting room (e.g., visual alerting system, white board, vibrating pager) to alert the person when calling them to their appointment .

A5. Make sure to use the information about access needs at all appointments.

Note: Although not directly associated with auditory rehabilitation, if the individual gives consent, share the individual's access needs with their other providers so the correct support is received throughout their care.

B. Effective treatment by trusted professionals

Trust between individuals and their care providers leads to better health outcomes, greater satisfaction with care (Birkhäuer et al., 2017), greater adherence to the treatment and self-efficacy to adhere to the treatment, and higher expectations about outcomes (Fuertes et al., 2017; Olaisen et al., 2020). This is why

it is critical to find ways to build trust with individuals. Some overarching approaches to building trust include:

B1. Be upfront in your communication and do not palliate messages to generate trust between you and your individuals.

B2. Be empathetic and show respect through active listening. Active listening entails l**istening attentively to what a individual is saying to understand the real meaning of what is being said, responding to the feelings shared, and noting non-verbal cues as well as verbal content (Rogers & Farson, 1987). Active listening requires empathy and openness to discussing emotional issues around hearing loss and providing** emotional support when it is needed (ARIG PCC Toolkit, 2024).

B3. Use valid standardised tools to collect both self-report and behavioural (e.g. speech in noise performance) outcomes data to assess the effectiveness of the care you have provided (ARIG PCC Toolkit, 2024).

B4. Discuss outcomes and how they relate to meeting the individual / communication partner goals.

C. Continuity of care and smooth transitions

Joined-up working across health and social care is important for the individual (DHSS, 2022; Jeffers & Baker, 2016) therefore provide continuity of care. To facilitate this:

C1. Make detailed notes about the individual's needs and preferences for the next audiologist to use, this might include noting the individual's feelings, worries, concerns, beliefs, wishes and consent for treatment options.

C2. Read the individual's notes from prior visit and check-in with the individual at the start of the appointment on any outstanding issues identified at the previous appointment so the individual has confidence that their needs have been heard and understood.

C3. Good record keeping is essential to keep other audiology colleagues informed of progress, and ensure the individual feels understood by the Audiologist and the wider service (Health and Care Professions Council, 2024).

C4. Ensure there is effective communication between any multi-disciplinary services, external agencies, and the referrer, and ensure the individual is kept informed throughout, this may involve email updates, phone calls or letters (Accessible Information Standard, 2017).

D. Involvement and support for family and carers

Where individuals' consent, the involvement and engagement of family, carers and other communication partners in the rehabilitation process should be supported to ensure good adherence to clinical recommendations and improved outcomes (Kokorelias et al., 2019; Clay and Parish 2016; Ekberg et al., 2022) (ARIG PCC Toolkit, 2024). To achieve this:

D1. Encourage the individual to bring a communication partner to all appointments. Explain why this is recommended and take time to discuss which family member/friend might provide the best support. If the individual is resistant to this then let the matter lie.

D2. When present, actively involve the communication partner throughout all appointments - they are there to participate and share their views and experiences (ARIG PCC Toolkit, 2024). Engagement during needs assessment and goal setting is critical because these might differ between the partners (Manchaiah et al., 2012; Barker et al., 2017). If so, encourage discussion in the safe environment of the clinic so joint goals can be agreed.

D3. Observe the interactions between the individual and the communication partner with a view to providing supportive advice. Saunders et al. (2017) provide suggestions such as using individual and communication partner scores on companion questionnaires like the International Outcome Inventory for hearing aids (IOI-HA; Cox and Alexander, 2002) and the significant other companion version (IOI-HA SO; Noble, 2002) as the basis for a discussion of where opinions diverge and converge.

D4. Explain to the communication partner that they too have a role in the rehabilitation process that entails their use of effective communication strategies.

D5. Check that the management pathway and outcomes are meeting the needs of the communication partner as well as the individual.

Note: For adults with specialist communication needs (e.g., learning disabilities, Dementia, Autism), involve a multidisciplinary team to devise a communication plan, this may involve specialist Speech and language therapists (total communication) or third sector organizations (Empowered Conversations, 2024)

E. Involvement in decisions and respect for preferences

While the individual is not an expert in audiology, they know their own goals and preferences, even if it takes time and conversation to find out what these are. Individuals should thus be involved in decisions about management and intervention selection.

Note: Some individuals will vocalise that you, not they, should be guiding the decision-making process. This is a choice they have the right to make and one that should be respected.

Joint goal setting and shared decision-making entails working with the individual to involve them in decisions. This shows respect for individual preferences. NICE guideline 197 section 1.2 (2021) provides details for putting shared decision-making into clinical practice. Joint goal setting requires a thorough understanding of the individual's needs and goals which can be obtained through a needs/goals assessment (see below), while shared decision-making requires that the audiologist and individual work together to come to a joint decision regarding management options. To these ends, the following is recommended:

E1. Use either the recommendations in NICE Guideline 197 section 1.2 or the SHARE approach to conversation (Agency for Healthcare Research and Quality, 2014) throughout the individual's care (NICE guideline 197, 2021; ARIG PCC Toolkit, 2024) This approach will help to facilitate conversation and provide advice whilst also considering the individual's perspective. An understanding of the individual's needs and expectations will allow you to tailor your care accordingly, e.g., if the individual is concerned about the cause of their hearing loss then spend time discussing this, if they have concerns about the loss progressing, then focus on that, and if they struggle at work then spend time focusing the rehabilitation on this.

E2. Consider using a decision aid to engage the individual in the decision-making process. Decision aids should provide information about all suitable and available treatment options (including the option to do nothing), list the pros and cons of each, the potential outcomes with each, and whether each has the potential to allow the patient to meet their goals. When using a decision aid, it is important to give the patient time to read and consider its contents at home with a partner, and then to discuss it with you at an appointment (NICE guideline 197, 2021; ARIG PCC Toolkit, 2024).

E3. Ensure the individual knows that (a) they can and should be an active participant in decisions about their care, (b) the management pathway is flexible and can be changed in the future and (c) that their communication partner should participate in decision making (ARIG PCC Toolkit, 2024).

E4. At each appointment ask the individual how the hearing technology is and is not meeting their needs/goals and whether they want to consider new goals and/or try alternative treatments. Celebrate positive outcomes, offer specific advice on how to deal with what is not working well.

E5. During assessment use audiometric test measures and explain the findings within the context of the individual's needs/goals and their social and medical histories. i.e., make things relevant to the individual's life (ARIG PCC Toolkit, 2024).

E6. Once hearing aid output has been verified using real ear measurements, be willing to adjust the output based on the individual's sound preferences. However, be aware that self-report of hearing-aid sound quality is imprecise and can be inconsistent (Caswell-Midwinter and Wittmer, 2019). Consider features such as a volume control, additional programmes, mobile apps and / or hearing aid streaming to empower self-management in different listening situations.

E7. Document all decisions and actions in an Individual Management Plan that you complete in collaboration with the individual. Update the management plan with the above information and offer the individual/communication partner a copy in an accessible format.

Use management approaches and interventions that meet the individual's needs (ARIG PCC Toolkit, 2024).

Ensure you know the local set up for accessing assistive technology so it can be provided if this is the individual's preferred management approach.

See Table 1 for content to consider during goal setting.

Category of needs	Considerations
Occupational	The individual's working arrangements The acoustics of the individual's workplace e.g., open plan situation, outside, classroom
Phone use	Frequency of use Difficulties encountered Video versus audio only
Social	Regular communication partners Difficulties encountered Activities (e.g., clubs, group meetings, large or small groups, other) Hobbies Role of listening Acoustic environments encountered Availability of assistive technology
General	Frequency of communication with unfamiliar talkers Impact of accents

Table 1. Content to consider when goal setting.

F. Clear information communication and support for self-care

F1. Provide information in manageable chunks and check for understanding using teach-back. This process is sometimes referred to as 'Chunk and Check' (ARIG PCC Toolkit, 2024). Teach-back allows you to check individual understanding of information provided. Re-teach and

retest if problems are encountered. This process will increase the individual's self-efficacy for hearing aid use and management.

F2. All printed materials should be co-developed with the end-user (e.g., individual, communication partner). All materials must be easy to see, read and understand (ARIG PCC Toolkit, 2024).

F3. Many individuals struggle to understand graphs so rather than using the standard audiogram to explain the results of the hearing test, consider alternative approaches that are more focused on conversation. One such example is the Ida My Hearing Explained Tool (The Ida Institute, 2024). Another suggestion is to use online videos such as the C2Hear interactive multimedia videos (C2Hear, 2015) to help with hearing aid management.

F4. Use a structured assessment tool such as the Hearing Aid Skills and Knowledge (HASK, Saunders et al., 2018) or the Hearing Aid Skills and Knowledge Inventory (Bennett et al., 2018) to assess where the individual requires additional instruction and support with hearing device management.

F5. Signpost individuals to sources of extra help and information regarding, for example, lip-reading classes, hearing accessories, charities, and government support schemes, volunteer clinics, peer support, hearing aid repair appointments, written materials etc.

F6. Encourage independence, self-management and ownership of the Individual Management Plan but provide support as needed.

F7. Provide advice on communication tactics, how to deal with specific situations where hearing is challenging, how to access support at work (e.g., Access to Work, Deaf Awareness training for colleagues), and disclosing their hearing loss to others.

G. Emotional support, empathy, and respect

Systematic reviews show hearing loss is associated with increased odds of depression (Lawrence et al., 2020), loneliness (Shukla et al., 2020) and anxiety (Shoham et al., 2019) which may or may not require intervention from a mental health specialist. With this in mind:

If you think the individual needs help beyond that of an audiologist's scope of practice, then refer them to the appropriate service and/or their GP. As noted by Greer-Clark et al. (2021) it is important for all providers, including audiologists to *'watch attentively for concerns and situations, both stated and unstated, that may necessitate further activity for mental health exploration and the need for professional outside referral. When these are recognised, we must be comfortable addressing them directly and confidently to ensure that appropriate assistance is forthcoming.'*

Under all other circumstances and if the individual is willing to do so:

G1. Ask the individual about their motivation(s) for coming to the appointment and what they want to achieve from their hearing care. If their motivation seems unclear, consider using tools such as the Ida motivation tools to further explore the matter (ARIG PCC Toolkit, 2024).

G2. Ask about other conditions that could affect intervention outcome, such as vision, memory, and manual dexterity. Being aware of the individual's holistic needs will give a better understanding of their lifestyle and priorities. Individuals with multiple chronic medical conditions often place their hearing care at a low priority. Help the individual navigate this.

G4. Discuss how hearing loss is impacting the individual's life in terms of mental health (do they feel lonely, socially isolated, vulnerable, or depressed?), and cognition (is listening fatiguing and/or effortful?) and the impact of these (do they lack confidence? how do they cope? do they need additional support?)

G5. Get to know your individuals by exploring what they enjoy doing, ask about their hobbies, who they regularly visit.

G6. Check in at follow-up visits to see whether any or all the above have changed following intervention.

H. Attention to physical and environmental needs

Physical needs should not take a backseat in audiology. Check in regularly whether:

H1. The individual is comfortable with the door of the soundproof booth closed.

H2. The transducers are comfortable.

H3. The individual needs a break at any time.

H4. The hearing aids are comfortable. Point out that the dome can be changed, or the ear mould remade.

If your individual is unable to self-report, point out to care staff and family the signs to look for that indicate the hearing aids may not be comfortable (e.g. redness at the opening to the ear canal, flinching when the hearing aid is inserted, pushing or pulling on the hearing aids).

6. Summary

Effective auditory rehabilitation is best achieved through a holistic approach that supplements sensory intervention with support to the person (the 'individual') and to their significant other(s). In this document we have provided **recommendations that can enhance the success of auditory rehabilitation through application of the principles of person- and family-centred care.** We emphasise the need for the audiologist to not only provide care in a compassionate and respectful manner, but also to work collaboratively with the individual and their family to help them develop the knowledge, skills, and confidence to manage and make informed decisions about their own health and health care more effectively. The eight Picker principles of person-centred care are used to structure our guidance for clinical care across a typical audiological individual pathway. Our approach has been to provide guidance regarding the way clinical interactions and processes are conducted rather than providing step by step guidance on specific audiological practices because these are changing constantly, while approaches to care do not.

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Appendix 1. Summary Table

Appendix 1 - Summary Table for printing

PICKER PRINCIPLES OF PERSON-CENTERED CARE	Pre-Assessment / Assessment	Treatment	Follow Up	Ongoing Care
Access to care and reliable advice	• Address accessibility needs • Put support in place	• Address accessibility needs • Put support in place	• Address accessibility needs • Put support in place	• Address accessibility needs • Put support in place
Effective treatment by trusted professionals	• Active listening • Empathy • Communication	• Active listening • Empathy • Communication	• Active listening • Empathy • Communication	• Active listening • Empathy • Communication
Continuity of care and smooth transitions	• Note needs and preferences for other audiologists to use • Good communication between MDT services • Good record-keeping	• Note needs and preferences for other audiologists to use • Good communication between MDT services • Good record-keeping	• Note needs and preferences for other audiologists to use • Good communication between MDT services • Good record-keeping	
Involvement and support for family and family-centred care	• Involve communication partner in needs assessment and goal-setting • Reiterate importance of involving communication partner in appointments	• Involve communication partner in discussion of expectations, the rehabilitation process, and support services	• Involve communication partner in outcome review • Ask about the impact of management on the communication partnership	• Encourage communication partner to remain engaged with management

Clear information communication and support for self-care	• Consider tools to help understanding of assessment and test results • Signpost for extra help and information	• Check patient can use technology – re-teach if necessary • Signpost for extra help and information	• Consider tools to assess where patient requires additional support with device management • Use questionnaires or speech testing to counsel on outcomes • Signpost for extra help and information	• Encourage continued self-management and provide support as needed • Encourage patient and communication partner to take ownership of IMP
Involvement in decisions and respect for preferences	• Discuss ALL needs • Individualise testing • Discuss ALL treatment options • Debrief with relevance • Individualise management plan • Keep plan flexible • Provide copy of IMP	• Check for changes in needs or goals and adjust management accordingly • For hearing device fitting - use verification methods as starting point but make adjustments based on feedback • Consider additional features as appropriate	• Check for changes in needs or goals and adjust management accordingly • Jointly review IMP	
Emotional support, empathy and respect	• Ask about motivations • Ask about non-auditory issues • Discuss psychosocial impacts of hearing loss		• Discuss any changes to psychosocial impacts of hearing loss • Consider whether care from other provider is needed. If so,	

	• Consider effect of multiple chronic conditions		refer patient to GP.	
Attention to physical and environmental needs	• Assess access needs prior to initial appointment, document them in the patient record, and ensure they are used at every contact	• Check and apply individual access needs	• Check and apply individual access needs	