

A World of Silence

The case for tackling
hearing loss in care homes

By Melissa Echaliér

ACTION ON HEARING LOSS



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Contents

Foreword	4
Executive summary	5
Introduction	12
1. Context	16
2. Hearing check	17
3. Reactions to the hearing check	19
4. Diagnosis of hearing loss	25
5. Comparisons – diagnosed and undiagnosed hearing loss	26
6. Management of hearing loss	28
7. Hearing aid use	35
8. Training needs	42
9. Conclusion and recommendations	44
10. Appendix A. Research methods and interviews	48

Foreword

This report comes at a time when the care and support of older people is under increasing scrutiny. And rightly so. Residential care homes deserve special attention, and the people living there deserve the care that's right for them as individuals.

Managing hearing loss effectively is an important, but often ignored, part of this picture. A large proportion of care home residents have a hearing loss and, as their numbers rise, the scale of the problem grows. It's estimated that, by 2032, there will be 620,000 people living in England's care homes. We estimate that almost half a million of them will have a hearing loss.

Unless this hidden crisis is tackled, these people face a future with a vastly diminished quality of life.

It doesn't matter how well a care home is run if a resident is locked in a world where they can't hear. Missing out on all the words and sounds that make up everyday communication leaves older people feeling isolated. We would be shocked if we found care home staff ignoring a resident who was staring at a TV with broken spectacles; why should it be any different for people with hearing loss?

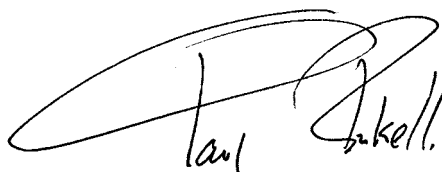
We want to stop that happening. That's why we commissioned the research leading to *A World of Silence*. Its findings, sometimes alarming, often worrying, add to the evidence that diagnosing hearing loss earlier must be a priority. Once someone moves into a home, it becomes

much harder to diagnose and manage, especially if there are other health problems, such as dementia, to factor in.

We are calling for a public health programme that encourages older people to take earlier action on their hearing loss. We also want to make sure that everyone who is directly involved in the care of older people, from GPs to care workers, recognises just how important early intervention is.

We've come up with specific recommendations for social care regulators. We're calling on them to raise awareness of the needs of people with hearing loss in residential care; and to include a special communication standard in their standards of quality.

The government has recently published its white paper on reforming social care. The Secretary of State for Health underlined the government's commitment to a modern system of care and support designed around the needs of individual people, and with dignity and respect at its heart. We trust that the government will make sure that people with hearing loss will benefit fully from this essential overhaul.



Paul Breckell, Chief Executive,
Action on Hearing Loss, October 2012

Executive summary

Four hundred thousand older people live in the UK's care homes, and that number is set to grow year on year. Making sure that these people receive the best care we can give them is an urgent priority, and will lay the foundations for services that can fully meet older people's needs in the future.

Care home residents are disproportionately affected by hearing loss. We estimate that around three-quarters of older people who live in these settings have a hearing loss and, as the number of people in care homes increases, more and more residents will be affected by hearing loss.



Hearing loss in care homes – 2012

A significant number of people live in the UK's care homes, and this is set to increase. A recent report shows that there are at least 330,000 older people living in care homes in England¹. Of these, around 250,000 have a hearing loss.

By 2032, there will be around 620,000 older people living in care homes. We can reasonably assume that, of these, almost half a million will have hearing loss.

In Spring 2011 we visited three care homes in England to explore carers' and residents' attitudes to hearing loss; and to find out how they were managing it. We carried out interviews and held focus groups, and also screened residents' hearing so we could gauge how many people had hearing loss but had never been properly diagnosed. The research took place in 'mainstream' care homes – those care homes that typically cater to the needs of older people.

What we found

Our research confirmed what we already knew: if care home residents' hearing loss is managed effectively, there is a real chance of improving their quality of life. But, on the flip side, we also identified a worrying trend – hearing loss not being diagnosed and managed properly, flagging up an urgent need for substantial improvements to be made. Managers and staff in care homes must make the effective management of hearing loss a major priority.

Jack, care home resident,
on his hearing aids

“They’re a wonderful help to me.”

Florence, care home resident, on life
without her hearing aids (one lost,
one sent off for repair)

“I mean, now I am hopeless and I can’t help it.”

Undiagnosed hearing loss

When we checked residents' hearing, the results suggested high levels of hearing loss. When we discussed their results with them, however, the overwhelming majority of people were unwilling to take any further action. One reason for this is many residents' acceptance that hearing loss is just something that comes with old age.

Margaret, care home resident

“I don’t think my hearing is too bad for my age. You go by the age, don’t you.”

Barbara, care home resident

“I am so old, I am 91... I feel ‘leave well enough alone.’”

¹King D, Malley J, Wittenberg R, Darton R, Comas-Herrera A, *Projections of demand for residential care for older people in England*, PSSRU, 2010.





Communication

Although there were many cases of undiagnosed hearing loss, on the whole, staff had a good understanding of how to communicate effectively with residents with hearing loss. For example, we witnessed care home staff making sure that they looked directly at residents when they were speaking to them.

High levels of background noise, such as the TV or radio being on constantly, can make things more difficult for people with hearing loss. Many staff did demonstrate an awareness of how this affected residents and, in some cases, took steps to minimise this. It's very important, however, that this happens routinely and consistently.

Hearing aids and equipment

We found mixed levels of hearing aid use. Some residents relied on them, while others felt they didn't make much difference or had trouble using them.

We saw for ourselves, and were told about, a range of problems experienced by residents who wore hearing aids, and care home staff, including flat batteries and whistling. A clear picture emerged of residents simply not getting the most from their hearing aids. We also observed or were told about people's hearing aids falling out, aids getting lost, and residents waiting a long time to get them repaired.

Both residents and staff said they had trouble adjusting hearing aids:

“Well, it’s not the getting it in, it’s whether you know it’s switched on. Like you press the button so many times or something, don’t you? And hear different pips and things.”

(Staff member)

And even the staff who provided care on a daily basis for residents with hearing loss had only a very limited understanding of the special products available, such as amplified or hearing aid compatible telephones.



Some care home residents rely on their hearing aids but far too many aren’t getting the most from them.

How we can change this

As a result of this research, we've come up with three major recommendations that will underpin all our work with care homes. But we can't do all of it on our own. That's why we're calling on everyone involved, directly or indirectly, in providing care and support, to join us in taking action in the following areas:

1. Intervene earlier in hearing loss

As soon as someone moves into a care home, it becomes more difficult to diagnose and manage this hearing loss, as they may have another long-term condition such as dementia. Ideally, an individual's hearing loss will have been diagnosed much earlier, and they will already be used to wearing, adjusting and looking after their hearing aids. This early intervention would go a long way in reducing the destructive impact of hearing loss on people in care homes, enabling them to manage their hearing loss as effectively as possible.

Right now, however, diagnosis is opportunistic and ad hoc – on average, there is a 10-year delay between people identifying they might have a problem and seeking help. This delay has significant and sad consequences: many people living in care homes miss out completely on getting the hearing aids that could benefit them hugely.

We're determined to change this, so we're asking the government to introduce an adult hearing-screening programme for everyone over the age of 65.

We're calling GPs and community nurses to commit to early intervention, and integrate hearing checks into routine health assessments, particularly those targeting older people.

We're also calling on care homes to assess residents' hearing when they enter their care home. Care home staff should also know how to recognise hearing loss – and what they should do if they think that a resident has undiagnosed hearing loss.

2. Meet communication needs in care homes

We're calling on the regulators, the Care Quality Commission (England) and the Regulation and Quality Improvement Authority (Northern Ireland), which set standards for care homes, to recognise the importance of communication. Specifically, we want them to introduce a 'communication' standard, which all adult care services will have to meet.

This isn't a radical request: work is already being done on this in Wales, while Scotland's National Care Standards include a standard focusing on communication needs. We're simply calling on the regulators in England and Northern Ireland to build on this approach.

We're also calling on care homes to ensure that their staff receive training so that they understand and meet residents' communication needs.

3. Improve hearing aid use and management in care homes

Care home residents' hearing aids must be looked after and made more use of, if people are to benefit fully from them. Later this year we'll be publishing detailed information for care homes on how to use and get the most from hearing aids. We're also calling on care homes to take steps to make sure that their staff have the necessary training in:

- adjusting hearing aids
- maintaining hearing aids, including replacing batteries
- making sure fewer residents lose their hearing aids

- managing environmental factors, such as background noise
- using induction loops and assistive technology.

Finally, we're calling for GPs, and audiology and ENT departments, to get systems in place so that they can visit care homes to carry out hearing aid maintenance and meet residents' needs related to hearing loss.

To read our full report detailing our research findings and incorporating residents' experiences, go to www.actiononhearingloss.org.uk/worldofsilence



Everyone wins if care home staff are trained in using and maintaining hearing aids.

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Introduction

The experience of people in care homes is important. There is a significant number of people living in the UK's care homes – for example, a recent report shows that at least 330,000 older people live in this type of setting in England². This group is particularly important in terms of Action on Hearing Loss's work, as the majority of people in care homes are older, meaning that they are more likely than other groups to have hearing loss.

We estimate that, in England, there are about 250,000 older people in care homes who have, or would benefit from, hearing aids³. By 2032, there will be around 620,000 older people living in care homes⁴. We can reasonably assume that, of these, almost a million will have a hearing loss.

In the past, anecdotal evidence provided by our staff suggested that hearing loss often remains undiagnosed in these types of settings and staff may not know how to use hearing aids effectively. This, in turn, may have implications for the quality of care that residents receive in such settings.

Background

There are around 21,000 care, nursing and residential homes in the UK. This group encompasses a wide range of homes that meet variable needs. However, what we do

know is that a high proportion of people in many care homes will have some degree of hearing loss.

Similarly, many care homes share specific characteristics that mean that it is necessary to take particular approaches to the management of hearing loss. For example, most care homes have communal areas where residents watch television, so staff adjust the television volume to try and meet the needs of all residents. Moreover, typically residents themselves don't have control over the management of their environment, so it's essential that care home managers and staff work with residents to understand the impact of their hearing loss and the ways in which this can be managed.

Both policy and practice around social care has focused on areas such as choice and control in care homes. Organisations such as the Joseph Rowntree Foundation and Age UK have worked with people in care homes to capture a vision of what constitutes a good life in this type of setting. For example, the My Home Life programme identified areas such as relationships and communication as being essential to a positive experience in care homes⁵.

Hearing loss makes it more difficult to achieve both of these. Similarly, it is

² King D, Malley J, Wittenberg R, Darton R, Comas-Herrera A, *Projections of demand for residential care for older people in England*, PSSRU, 2010.

³ Figures based on the application of prevalence figures for people with a hearing loss of ≥ 35 dB in the better ear derived from Davis, A. (1995), *Hearing in Adults*, Medical Research Council, London and applied to population figures, Office for National Statistics, 2009.

⁴ King D, Malley J, Wittenberg R, Darton R, Comas-Herrera A, *Projections of demand for residential care for older people in England*, PSSRU, 2010.

⁵ <http://myhomelifemovement.org/>

more difficult for residents to exercise choice in these types of setting if they have a sensory impairment that makes it very difficult to communicate.

Previous research has evaluated ways (including improved use of hearing aids) in which depression can be addressed in care homes⁶. However, while there has been recognition of the importance of communication and the impact of sensory loss, our research goes further in that it investigates to what extent hearing is undiagnosed in care home settings, the management of hearing loss in this setting, and then goes on to explore the impact.

Research aims

The overall aim of the research was to establish how we could facilitate the effective management of hearing loss in care home settings. More specifically, the research objectives were:

- to investigate the extent to which residents in some care homes have undiagnosed hearing loss
- to explore the ways in which diagnosis of hearing loss and use of hearing aids and effective communication can make a difference to people in care homes
- to investigate the extent to which hearing aids are being used effectively in some care homes

- to explore care home staff's training requirements in terms of diagnosis of hearing loss, use of hearing aids, effective communication and how to minimise the effects of hearing loss for care home residents.

Scope of the research

We conducted the research in three care homes in England. These were mainstream care homes – those that typically cater to the needs of older people. Under the previous Care Quality Commission (CQC) system (homes are no longer rated in this way) all of the care homes were rated as good. Our research proceeded, therefore, on the basis that the care homes were offering a good service to their clients and were consequently well placed to act on any of our recommendations. Two of the homes offer residential care while the third home offers residential and nursing care.

The three care homes were selected on the basis that they cater for residents with different combinations of needs and, as a result, interviews with residents enabled us to explore a range of different experiences of hearing loss.

⁶ Lyne K, Moxon S, Sinclair I, Young P, Kirk C & Ellison S 'Analysis of a care planning intervention for reducing depression in older people in residential care', *Aging & Mental Health*, 10, (4), 394-403, 2006.

Research stages

The three stages of the research were as follows (a detailed methodology is included at the end of the report):

1. Screening

We offered a hearing check, using a handheld screener, to all people in the care homes who did not wear hearing aids in order to capture the number of people with undiagnosed hearing loss.

We conducted the hearing check with 20 residents (this represented around a fifth of residents).

2. Interviews

We conducted interviews with those residents in the care homes who had volunteered to take part in the research. This stage of the research explored the following different issues, depending on whether residents had a previously diagnosed hearing loss.

Thirty-eight residents volunteered to take part in this piece of research. However, over the course of the research, 13 residents either dropped out or were no longer eligible to take part in the research (for example, if they had left the care home).

Two groups of residents took part in the research:

1. Residents who had a previously diagnosed hearing loss (13 residents)
We explored their experiences related to hearing loss, including the use and management of their hearing aids.

2. Residents who had not previously been diagnosed with a hearing loss. These residents had taken the hearing check at the first stage of the research (12 residents – the hearing check suggested that 11 of these residents had a hearing loss, while the result was borderline for the remaining one resident).
We explored this group's perceptions around their own hearing. Where the hearing check suggested that this group had an undiagnosed hearing loss or their result was borderline, we explored their reactions to the result.

We also explored areas such as general attitudes to hearing loss, quality of life and communication with all of the research participants in order to draw out any comparisons and differences of experience between those people with diagnosed and undiagnosed hearing loss.

3. Focus groups

We conducted a focus group in each of the three care homes with 15 members of staff in total. These explored staff knowledge and practice around the management of hearing loss and, in particular, hearing aids. We also explored challenges to the effective management of hearing loss in care homes as well as staff preferences around the format and delivery of training.

We have included quotes from participants in the report to illustrate the themes that emerge from the research. However, in order to maintain participants' anonymity, we have included fictional names and indicated whether they had been previously diagnosed with a hearing loss. None of the photographs in the report are of participants. Where we have included a quotation from a member of staff we have also indicated that this is the case. However, we have not specified the care home for either residents or staff.

The report is structured into the following sections:

1. Context
2. Hearing check
3. Reactions to hearing check
4. Diagnosis of hearing loss
5. Comparisons – diagnosed and undiagnosed hearing loss
6. Management of hearing loss
7. Hearing aids
8. Training needs
9. Conclusion.

General policy and practice recommendations are at the end of the report.

1. Context

It is important to understand both people's experiences around hearing loss and this piece of research in the context of their lives. This enables us to see how the lives of people in care homes follow certain patterns that are not typical of other groups.

In many cases, people had come to live in the care homes as a result of illness and some upheaval has been involved. Therefore, many had had turbulent experiences in the recent past. Similarly, some residents felt that they had given up their home to move to the care home:

"I had to go into hospital... a heart bypass... and when I was ready to come out they wouldn't let me live on my own."

(Brian, hearing aid wearer)

As the quotation above demonstrates, residents frequently had other conditions that had an impact on their day-to-day lives. For example, some had heart or respiratory conditions while others had experienced a stroke. Similarly, mobility and sight problems were common.

In addition, residents occasionally had some difficulty with memory. For example, it was not unusual for them to be unable to recall for exactly how long they had lived in the care home. However, they were typically able to recall details of their day-to-day experiences.

Later in this report, the research demonstrates how some of the above had some bearing on people's reactions to their hearing loss. It is worth bearing this context in mind when considering both the research findings and the recommendations.

2. Hearing check

We would expect a high proportion of care home residents to have hearing loss because of their age. Also, UK figures for people living in residential care and those related to levels of hearing loss suggest high levels of undiagnosed hearing loss in care homes. Our experiences over the course of this research supported this.

We offered the check to residents who didn't wear hearing aids.

We conducted the hearing check with 20 residents in total. The results were as follows:

Indication from hearing screener	Number of residents
Suggested hearing loss	13
Borderline	4
No hearing loss suggested	3

A more detailed overview of the hearing screener is included in Appendix A.

These findings suggest relatively high levels of undiagnosed hearing loss, which isn't surprising given the age profile of most care home residents. But they don't tell us the degree of hearing loss that each resident has.

Our experiences during the interviews also supported this finding. The interviews were conducted one-to-one in a relatively quiet location. Even so, some of the residents had extreme difficulty in hearing

the interviewer. This stage of the research also identified that it was not unusual to find a significant amount of wax in residents' ears that occasionally prevented us from conducting the hearing check.

These findings should be treated as indicative (in terms of generalisation) of all care homes for two reasons: The Siemens screener is not a diagnostic test. However, it has a proven capacity to predict the need and benefit of hearing aids. Similarly, use of the screener relies on the person understanding the test instructions. While residents appeared to understand our instructions, we cannot be absolutely certain that this was the case for all residents.

We cannot guarantee that the people who took the hearing check were representative of all care home residents in the UK (who don't wear hearing aids). So, we cannot extrapolate from the specific results to say that there is a particular level of undiagnosed hearing loss in care homes.

Where the hearing check suggested a hearing loss we discussed the result with the resident and gave some advice about possible courses of action. But residents were typically very unwilling to take steps to address their hearing loss. This was a finding supported by staff who pointed out that, when they noticed that residents showed signs of hearing loss, they experienced difficulty in encouraging them to take action.

“It can be frustrating on both sides, because you want to help but you don’t want to push it too far. All you can do is observe and report back and take it from there really.”

(Staff comment)

“You’ve got to give them that choice, you can’t make the choice for them, and if it’s no, it’s no, you have to leave it.”

(Staff comment)

Staff comments on this issue also showed how a balance needs to be struck between a duty of care and giving the residents the space to make a choice regarding management of their hearing loss.

Overall, the high number of people with suggested hearing loss provided us with an unusual opportunity to speak to people who are unwilling to address their hearing loss and to explore some of the reasons for this.

3. Reaction to the hearing check

The following areas of discussion provide us with some insight as to why residents are unwilling to act upon their hearing loss.

Overall, different factors had led residents to underestimate the level of their hearing loss and/or to lower their expectations around their hearing. Experienced either separately or together, these factors led residents to conclude that they did not wish to take action about their hearing. We can speculate that this means that the gap between expectations and experiences around hearing narrows, removing the motivation for people to act. A lower expectation as to what you should be able to hear leads to a favourable assessment of your own hearing, something that could potentially lead two people with the same level of hearing to reach different conclusions as to whether they have a hearing loss.

3.1 Specific factors

Specific factors that deterred people from acting on their hearing loss were:

- normalisation
- age
- resignation/release
- impact of other conditions
- practical issues
- motivation to hear.

- **Normalisation**

Some residents' reactions suggested that they had altered their expectations as to what they should be able to hear. When asked whether he could hear in different situations, a resident responded:

“Well, in normal situations ... OK ... I can’t hear what they’re talking about on the other side of the room but normal, yes, normal hearing.”

(Leonard, check suggested undiagnosed hearing loss)

While it is difficult to judge what someone with ‘normal’ hearing can hear, the room that the resident was referring to was small and the interviewer judged that someone without a hearing impairment would be able to hear a conversation on the other side of the room. Therefore, this suggests that the resident’s expectations as to what is ‘normal’ hearing and what he would expect to hear had altered. This, in turn, had an impact on his assessment of his own hearing, leading him to conclude that he did not have a hearing impairment.

- **Age**

Another type of normalisation of hearing loss was assessment by reference to age.

“I don’t think my hearing is too bad for my age, you go by the age don’t you?”

(Margaret, check suggested undiagnosed hearing loss)

In this case, the resident’s reaction to the hearing check results is tempered by her expectation that, at her age, she might expect to have some degree of hearing loss.

“I am so old, I am 91... I feel ‘leave well enough alone.’”

(Barbara, check suggested undiagnosed hearing loss)

As we know, this has some basis in physical reality – our hearing deteriorates as we get older. However, at the same time, this reaction doesn’t take account of steps that can be taken to manage hearing loss and bears witness to a belief that old age brings with it a degree of impairment that is to be accepted without question.

Similarly, this resident related her unwillingness to do anything to her age – which indicates both resignation and an acceptance that things are as they are.

- **Resignation/release**

“I like it here now and do what they say... don’t bother about anything very much.”

(Anne, check suggested undiagnosed hearing loss)

“I just get on... I don’t bother about anything... I’ve got past all that now... worrying.”

(Brian, hearing aid wearer)

These residents suggested an acceptance around different issues, including any hearing loss. This type of resignation can extend to issues around health, including

sensory loss, deterring residents from acting on their hearing loss. The residents themselves presented this as either neutral or positive, a reflection of where they saw themselves in their lives.

Resignation frequently brings with it a sense of release. This type of attitude, therefore, can contribute to someone’s quality of life in one sense while detracting from it in another (in this type of case, preventing someone from taking the steps to manage their hearing loss that could improve communication and their quality of life).

- **Impact of other conditions**

Participants drew comparisons between their hearing and their eyesight and, less frequently, other faculties.

“It’s been mostly my eyes hasn’t it?”

(Gwyneth, check suggested undiagnosed hearing loss)

“Yes, most things are wearing out, but I don’t think my hearing is too bad.”

(Catherine, check suggested undiagnosed hearing loss)

“I can hear but I can’t see and I can’t walk.”

(Mollie, check suggested undiagnosed hearing loss)



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Where someone has sight impairment, it makes it more important that their hearing loss is managed effectively. Their sight impairment may prevent them from lipreading and, on a more general level, they need to rely to a greater extent on their hearing to know what is happening around them. However, the reverse appears to be the case – where someone has other impairments, they may compare their

hearing favourably with these, something that leads them to underestimate the level of their hearing loss. This will vary according to the degree of hearing loss that someone has. However, it appears to narrow the gap between someone's expectations and their experiences around their hearing.

It may be that people find it difficult to accept that they have multiple impairments, seeing this as a sign of deterioration in their physical health or a further challenge to their independence. This highlights the fact that it is essential to be sensitive to these types of issue, something that care home staff also emphasised during the focus groups.

• Practical issues

Staff gave specific reasons for residents' unwillingness to address their hearing loss – for example, one resident indicated that she didn't want to make a trip to the hospital, as this would be exhausting.

Staff also gave insights into why some residents may be unwilling to attend a hearing test:

“She has quite severe dementia, doesn't she, and doesn't like anybody touching her really, does she?”

(Staff comment)

This also highlights the potential impact of dementia on the diagnosis and management of hearing loss.

- **Motivation to hear**

The research at the core of *A World of Silence* aimed to understand attitudes towards hearing loss in the context of people's lives – in part, due to the recognition that people in care homes live in a particular setting that has an impact on their reaction to hearing loss.

In this particular setting we found that we cannot always assume that people want to hear. Moreover, people's reactions demonstrated that it is impossible to separate the acts of hearing, understanding and the willingness to hear/understand from the subject matter. For example, residents described how they hear what they want to hear and staff also reported hearing residents say this. In some cases, this was given as a reason why the resident did not want to get hearing aids:

“I can hear all I want to hear.”

(Mollie, check suggested undiagnosed hearing loss)

“A lot of it I don't want to hear. No, I mean I can hear the television and I don't find that I'm limited by hearing.”

(Catherine, check suggested undiagnosed hearing loss)

Another resident described how he could hear his visitors because they talk about a subject that he has an interest in:

“I can hear well with visitors yes... 'cause my visitors who come usually are country people quite often... and we talk the same subject.”

(Jack, hearing aid wearer)

It is difficult to say how this process works. It may be that, in this case, the resident knows what he is expecting to hear and, consequently, finds it easier to hear. However, these experiences also demonstrate how subject matter can motivate a person either to get hearing aids or to wear their hearing aids. Conversely, the lack of motivating factors or facts that deter people from getting or wearing their hearing aids (for example, extraneous noise, which is covered later in this report) may mean that people are not moved to try hearing aids or to wear their hearing aids.

3.2 Additional context

Low levels of conversation

Similarly, the fact that many residents reported low levels of conversation in their care homes suggests that those factors that typically motivate us to hear better may not be so compelling in this setting.

“None of us is that talkative.”

(Iris, hearing aid wearer)

“When they’re having their meal they don’t talk an awful lot... in the sitting room they sometimes do... watching television they don’t talk a lot.”

(Teresa, check suggested undiagnosed hearing loss)

“We haven’t got much to talk about I suppose, really... some of them don’t do anything.”

(Lily, hearing aid wearer)

Where there’s a low degree of conversation in the care homes, this may remove one source of motivation for the diagnosis and effective management of hearing loss. Different circular processes may also be in operation here. For example, hearing loss may make conversation more difficult and mean that people don’t converse.

Ultimately, this lack of conversation may lead to lowering people’s motivation to hear well. Staff also suggested that this may be complicated by other factors, for example, the television is turned up very loud, making it difficult to hold a conversation.

It may also be that other factors, such as being in pain or having difficulty with speech, also deter residents from conversation, something that may have the same impact on their motivation to hear better.

“I don’t say a lot now because I can’t, you know, and they can’t hear what I’m saying.”

(Anne, hearing aid wearer)

When we discussed this finding with the care homes, it became clear that they’d already recognised it as an issue and had initiated, with some success, projects to stimulate conversation among residents.

For example, they had partnered residents, who are not usually talkative or in contact with each other, who have a similar history. They found that the residents talked to each other for around two hours. At the same time, we discussed the impact of the physical environment. For example, in some rooms, seats are arranged side by side in rows, something that may discourage conversation.

3.3 Other residents’ hearing loss

Some residents observed that other residents demonstrated some degree of hearing loss:

“They don’t hear me I don’t think, some of them seem to be very deaf.”

(Catherine, whose check suggested undiagnosed hearing loss)

“[Name] can’t hear me, [name] has a terrible job.”

(Lily, hearing aid wearer)

“They have got hearing aids but they don’t wear them.”

(Florence, hearing aid wearer)

“Sometimes [name] has a bit of difficulty.”

(Teresa, whose check suggested undiagnosed hearing loss)

Hearing loss has a real impact on partners and families. For the most part, the situation is different in care homes as the people residents live with are not usually partners or family, though they may consider them to be friends. This doesn’t necessarily mean, however, that one person’s hearing loss doesn’t have an impact on others in the care home.

It may be that hearing loss contributes to a low degree of conversation in care homes by, for example, making it difficult for residents to build a rapport with other residents. Observation – such as looking at seating arrangements and interactions – in this type of setting would enable us to find out more about how this process works.

3.4 Staff views

Staff views around the diagnosis of hearing loss provide us with some additional insights:

“You have to be quite delicate with things like that because it’s part of people’s independence isn’t it, and they don’t like to admit that there’s something that isn’t going to make them independent.”

(Staff comment)

Moreover, some members of staff felt that their role was to encourage residents to retain their independence, and that advising someone that they have a hearing loss could sometimes be ‘tricky’ in this context. Their response was that they would slowly build up a relationship with the resident and gradually introduce the idea of hearing aids.

For us, at Action on Hearing Loss, this represents an area that is both essential but also difficult to address as it is rooted in people’s attitudes. In fact, hearing aids can actually act as a powerful aid to independence and, as such, much of this problem lies around perceptions. This connects to issues around acceptance of hearing loss and hearing aids that we have already identified in both this and other research.

4. Diagnosis of hearing loss

Where residents had been diagnosed with a hearing loss this had usually happened before they came to the care home. This, along with residents' unwillingness to wear hearing aids – and staff comments – suggests that diagnosis can be difficult in care home settings.

“I think the majority of them have it diagnosed before and they’ve got their hearing aids and things with them when they come.”

(Staff comment)

It is essential to recognise the importance of the diagnosis of hearing loss but also the challenges around this in such settings. Other research and policy work has already recognised this. For example, Alzheimer Scotland points out that the difficulties caused by dementia are made much worse when someone cannot hear properly and, when we consider some of the symptoms of dementia, it is easy to see why this is the case. For example, dementia itself can cause communication problems where people have difficulties finding the right words. Where someone cannot hear properly this can compound the problem⁷.

At the same time, the symptoms of dementia can make both diagnosis and management of hearing loss more difficult. For example, memory problems are a core

symptom of dementia, so it will be hard for someone to remember how long they’ve experienced hearing difficulties. Similarly, they may forget to wear their hearing aids.

This suggests that the greater the delay in diagnosing hearing loss, the more difficult it becomes to manage hearing loss effectively – some people who will miss out on hearing aids completely could have benefited greatly if their hearing loss had been diagnosed earlier. This is supported by other research that finds that, as people grow older, they find it more difficult to adapt to their hearing aids⁸. It makes sense, therefore, for someone’s hearing loss to be diagnosed before they move into a care home setting.

These findings support our calls for early intervention, for example, the introduction of a hearing-screening programme for over 65s. This will mean that people have the opportunity to assess their hearing loss and get used to their hearing aids before they go to live in a care home.

At the same time, it is important that, where somebody is already in a care home, their hearing loss is diagnosed and effectively managed. It is important that care home staff continue to have conversations about hearing loss with residents, enabling them to benefit from assessment and hearing aids where this is something that they would be happy to pursue.

⁷ <http://www.alzscot.org/pages/info/deafness.htm>

⁸ Davis, A et al. ‘Acceptability, benefit and costs of early screening for hearing disability: a study of potential tests and models’, *Health Technology Assessment*, Vol II: 42, 2007.

5. Comparisons – diagnosed and undiagnosed hearing loss

When we started out, we intended to compare three groups of residents to explore any differences in quality of life: people with diagnosed hearing loss, people with undiagnosed hearing loss and people with no hearing loss. This comparison proved to be impossible for a number of reasons. Primarily, the group of people with no hearing loss was not big enough to enable any comparisons. While we did not screen sufficient numbers to generate statistically significant findings, this in itself bears witness to the scale of undiagnosed hearing loss in care homes.

In addition, everyone we interviewed had other conditions, ranging from sight loss to recent stroke to mobility problems. It was difficult, therefore, to isolate the impact of hearing loss on quality of life. Finally, as we outline above, in communal settings one person's hearing loss can have an impact on other people. All of the above might distort any findings around quality of life.

Despite this, it was possible to make some limited observations in this respect. Some people with hearing aids expressed very high levels of appreciation of these, suggesting that, in their cases, the hearing aids have made a real difference to their quality of life. The other observation was that, when residents were very engaged with other people and life in the care home, they were more likely to be hearing aid wearers.

Both of these findings suggest that if their hearing loss is managed effectively, people's quality of life can be improved significantly. The high levels of hearing loss

that the hearing screen identified suggest that we have a real opportunity to change things for the better.

5.1 Hearing aids – people appreciate them

Some, although not all, residents with hearing aids expressed their appreciation of their hearing aids and that they'd made a real difference.

“They’re a wonderful help to me.”

(Jack, hearing aid wearer)

This was particularly highlighted by the experiences of another resident, who did not have her hearing aids when she was being interviewed, because one had been sent off for repair and the other had “disappeared”. She described how difficult life was without them:

“They said I must have hearing aids, which I did, and I found them very useful. I mean, now I am hopeless and I can’t help it and one of the things I really think about having hearing aids, I don’t want to be asking people, ‘yes, no, thank you, no’ and all this because I can’t hear.”

(Florence, hearing aid wearer)

‘Florence’ obviously values the role hearing aids have played in giving her a sense of independence. This contrasts with the

view that the initial diagnosis represents a challenge to independence and shows just how important it is to recognise the real benefits hearing aids can bring.

5.2 Greater engagement

The residents we met who were very engaged – making a real effort to converse and socialise with other residents – tended to be hearing aid wearers.

For example, staff asked one resident with hearing aids to visit another resident who couldn't leave her bed, because they knew she liked talking to people. Similarly, she played the organ and was happy to entertain everyone at the care home's cocktail party.

Another resident with hearing aids described how she helps and welcomes other residents:

“There's one... I'm friendly with her... when I go shopping I do a bit of shopping with her... I help her with whatever she wants, fetch her walker and all that... the other woman at the table, she's the same, I do the same for her... and, as I say, if a new resident comes in I go and see them and make them welcome.”

(Caroline, hearing aid wearer)

We observed this in a small number of cases and we'd like to explore further whether this is the case more widely. We'd also like to explore what lies behind this. Do hearing aid wearers feel more able to engage more fully with other people? Or is it that communication is more important to these people; something that motivates them to get hearing aids in the first place?

5.3 Staff views

Staff also tended to consider hearing loss from the resident's point of view. Less frequently, they recognised how managing residents' hearing loss effectively had a good impact on the running of the care home:

“I think she has serious hearing problems and, if you ask her a question and she mishears, she can become verbally aggressive. For instance, the other day, I said to her, ‘Would you like me to assist you to the toilet?’ and she thought I said, ‘I'm going to go and use your toilet’ and she was not a happy woman. Therefore, if you sort out hearing problems, it can make a wealth of difference in the running of the home.”

(Staff comment)

6. Management of hearing loss

6.1 Recording hearing loss

The management of hearing loss requires either the resident or staff to take action at particular points – for example, noticing that someone has a hearing loss so that testing and diagnosis can take place, and putting people’s hearing aids in. All of this requires robust processes for recording information, and for people to act on this information. We found that processes were in place for recording and communicating hearing loss at different stages and that staff described following these. For example, one member of staff described the assessment that takes place before someone comes to the care home:

“Say for instance we go and see somebody in hospital or in their own home, there is a section for hearing loss so you can write down what the problem is... before they come in, you take that from the assessment and put it into the care plan.”

(Staff comment)

Another member of staff noted how, if they noticed that someone’s behaviour suggested a hearing loss, they would document it.

Similarly, staff knew that hearing loss is documented in each resident’s care plan and some staff said they looked at this regularly to understand residents’ needs. But staff did not always follow these processes. For example, some members

of staff described relying on memory or residents informing them to know who wears hearing aids.

“We get to know who wears them and who doesn’t.”

(Staff comment)

“They’ll tell you because [name], a gentleman here who wears hearing aids, and he will talk to you, but when you talk back to him, he’ll say ‘I haven’t got my hearing aids in.’”

(Staff comment)

In many situations, where residents are aware of their hearing loss and their hearing aids, this approach is successful some of the time. But problems arise where someone wears their hearing aids intermittently – something that is common where residents have dementia and they only wear their hearing aids if they feel like it that day.

This was supported by the focus groups – for example, at one home staff were surprised to find out from colleagues that a particular resident had hearing aids. In this type of situation, residents may need prompting, so it’s vital that the fact that they wear hearing aids is documented very clearly – and that this information is read regularly.

Staff also reported that, occasionally, hearing loss might be de-prioritised compared with other issues such as

sight loss, pain or safeguarding. For example, they described that, where it is documented, it may not be followed up to the same degree.

“Yes, I think it would take more of a back seat. Where it would be documented and be put in, it probably wouldn’t be chased up as much as something say like safeguarding or best interest.”

(Staff comment)

“I come in of a morning and if I see somebody at the breakfast table without their glasses on... I immediately go and get their glasses because they can’t even see their breakfast. But having said that, I probably wouldn’t even notice if they were wearing their hearing aids until later in the day.”

(Staff comment)

This may well be because glasses are much more visible than hearing aids. However, staff also referred to specific training around vision; this suggested that this training has been effective in raising awareness among staff, something that could be duplicated around hearing loss.

6.2 Steps to enable hearing

Staff had a good understanding of communication ‘tactics’. They also recognised the impact of background noise on hearing and why it’s important to try and minimise this, although it’s not always possible.

“I do try to get down on to their level to talk to them, try to be face to face, and I do try not to shout.”

(Staff comment)

“You get to their level, and you’re one to one, you’re not talking and looking the other way, you’re eye-to-eye level.”

(Staff comment)

Staff demonstrated an awareness of the high levels of background noise (described in more detail in the next section). For example, a member of staff described how, when a resident presses the ‘call button’, this can be heard in all the residents’ rooms:

“That beep goes in every room you know; not just the room where it is used.”

(Staff comment)

Less frequently, staff described some of the approaches they took to minimise the amount of background noise. It was difficult to gauge whether this happened across the board, so staff may well benefit from regular reminders:

“If the TV is on in the lounge and it is going against the radio we’ll turn the radio off.”

(Staff comment)

A positive aspect of the built environment in care homes was that all of them had quiet, communal rooms for residents to use.

6.3 Induction loops

An induction loop converts sound (speech or music picked up by a microphone or direct connection) into a magnetic field, which is then picked up by hearing aids that have a T (telecoil) programme, or a hearing loop setting. The hearing aid converts the magnetic field back to the original sound and amplifies it (makes it louder). If you don’t use a hearing aid, you can still listen to a loop system by using a loop listener, a portable listening device that has earphones or headphones.

These loops work best where people are listening to one source of sound, for example, if someone comes into the care home to give a talk to residents.

People’s understanding of induction loops varied a lot. In one care home, a new building had been designed with an induction loop in the reception and all

the communal rooms. But, in another care home, staff weren’t aware of induction loops and didn’t know how they worked.

In the third care home, staff were aware of induction loops and had an appreciation of how they worked ... but there were no induction loops:

Staff member 1

“We haven’t got them here.”

Staff member 2

“It would be a good idea.”

Interviewer

“Why do you say it would be a good idea?”

Staff member 1

“It might help, it would just be ...”

Staff member 2

“And there are things that you can use for television aren’t there? Like earphones and we haven’t got anything like that here.”

For induction loops to be effective, people’s hearing aids must be switched to ‘T’. This needs to be taken into account when considering how induction loops might be used in a particular setting. They can,

however, make a big difference to people's ability to hear in some circumstances, such as when someone comes in to give a talk.

6.4 Role of families

Staff drew our attention to the need to provide information to residents' families and, in some cases, we found that families were instrumental in the management or the diagnosis of hearing loss. For example, one resident described how her daughter's intervention led to her getting hearing aids:

"I didn't think I needed hearing aids but my daughter did"

(Alice, hearing aid wearer)

This confirms findings in other research⁹.

Another resident described how her daughter-in-law arranged appointments with audiology on her behalf, whereas other family members collected batteries for residents. This emphasises the fact that any information should be designed so that families can also access it.

6.5 Specific challenges around hearing loss diagnosis and management

Extraneous noise

Both residents and staff pointed out issues around hearing loss management that were specific to care homes. Staff felt that the level of extraneous noise, such as television and the noise created during meal

preparation, deterred residents from using their hearing aids. This wasn't something that the residents identified that much.

"... doesn't like wearing his and I think that's because, several people have said this to me, that it's too loud, and particularly when they're in, you know the lounge or the dining room, the little noises like the cutlery chinking and all that, you know it's extremely loud and it's almost sort of painful."

(Staff comment)

"I think it's because it's this environment: there's a lot going on, people around. If they were at home watching television it would probably be fine."

(Staff comment)

Digital hearing aids do have features that are able to identify speech and suppress noise, but they are not perfect and cannot discriminate between and filter out background sound to the same extent that the ear can.

Hearing aids with directional microphones are now available from the NHS, but not everyone has this type of hearing aid. As mentioned earlier, some members of staff make efforts to minimise the

⁹ Matthews, L (2011) *Seen but not heard*, RNID

impact of hearing loss, but it may be useful to manage this in a more systematic way so that reducing background noise is something that's done as a matter of course.

The acoustics of a room can have an impact on residents' ability to hear – for example, the use of tablecloths can improve the acoustics, making it easier for residents to hear.

Television was a particularly problematic area, reflecting what we've found in previous research about trying to find a volume level that meets everybody's needs. This challenge is magnified in a care home setting where several people are watching the same television set and some of them have either a diagnosed or undiagnosed hearing loss.

Staff member 1

"I mean [name]... she's one of the ladies who said, 'I don't want a hearing aid'. She's right next to it but it just makes it very difficult doesn't it to have a conversation with any of these folk when the television is up so loud. You sort of have to try and shout over it."

Staff member 2

"... and that irritates [resident's name], he's really deaf, isn't he, and that irritates him."

Staff member 3

"Because he does turn his hearing aid on."

In this type of situation, a resident with undiagnosed hearing loss wants the television to be turned up loud, while this is unpleasant for a hearing aid wearer. It also makes conversation very difficult. In some cases, residents had used subtitles, but with mixed success.

This type of situation is difficult to manage even with specialist equipment, particularly where some people are trying to watch the television while others are trying to hold a conversation. Some types of equipment can help, for example, wireless TV listeners and headphones.

Similarly, an induction loop can help, provided people's hearing aids are switched to the 'T' setting. But if someone is wearing headphones, they cannot hold a conversation at the same time as watching TV. Some newer hearing aids can be used with a TV listener, enabling someone to hear the television better and also to hear conversation around them.

Simply put, there is no perfect solution. In practice, a combination of approaches should help, for example, some people using subtitles while others would benefit from a listener. Other people would be better off going to a quiet room to have a chat.

Overall, we found that care home staff knew very little about equipment, such as TV listeners or amplified telephones, that can minimise the impact of hearing loss and/or make sure that people really benefit from their hearing aids.

“And there are things that you can use for television, aren’t there, like earphones and we haven’t got anything like that here.”

(Staff comment)

This was echoed in our discussions about telephones, where a mixed picture emerged. Some of the residents have their own telephones, and staff pointed out that, in many cases, their families dealt with these; the implication being that it was the family who was responsible for making sure that their relative had a phone that was appropriate for someone with a hearing loss.

In another of the care homes, staff pointed out that most residents don’t have telephones in their rooms. Where residents tend to use a central telephone, the picture is, again, mixed. In one care home, staff pointed out that the volume on the office telephone could be increased:

“Our cordless, you can push the button, and it’s quite loud.”

(Staff comment)

This may be adequate for some residents, while others may require further amplification.

Some staff and residents suggested that, in some cases, telephone conversations could be difficult, particularly when there’s a lot of background noise.

“[Name of resident]’s got one. I don’t know how he manages but I’ve heard him on the phone and he does lots of shouting.”

(Staff comment)

“Because I can’t hear very well when it’s noisy... they’ve got the television on and the talking and I still can’t hear very well so I don’t phone very often and they don’t phone me very much.”

(Teresa, whose check suggested undiagnosed hearing loss)

Someone with a hearing loss needs to use the telephone in a quiet place. Similarly, telephones should have a loop and a sign indicating the need to switch hearing aids to the ‘T’ setting.

Staff time

Some members of staff also faced time pressures, meaning they have to prioritise different activities so find it hard to take time to manage hearing loss:

“You’ve got so much to do and to get done.”

(Staff comment)

“Yes, I think, first of all the residents come first and then everything after, but still in the back of your mind you know you’ve got x amounts of beds to make, x amounts of commodes to empty, clean...”

(Staff comment)

Role of memory and understanding instructions

As we mentioned earlier, it was not uncommon for residents to have problems with their memory. For example, some residents couldn’t remember exactly how long they’d lived in the care home. Similarly, because of the symptoms associated with dementia, some care home residents will have trouble understanding instructions.

This makes diagnosing hearing loss problematic in two ways. First, when people recognise their own hearing loss, they rely on memory to tell them how their hearing compares with their hearing in the past (that is, whether it has got worse). They also rely on their memory to tell them how long they have been experiencing a hearing loss. Any loss of memory will make this process more difficult and, ultimately, means that people may be less likely to recognise their own hearing loss.

Secondly, diagnosing hearing loss relies on the person understanding what the audiologist is asking them to do – difficult where someone has dementia and, as a result, is confused.



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7. Hearing aid use

We found that some residents really relied on their hearing aids, whereas others felt that they didn't make enough difference to their hearing, or they simply couldn't manage the controls. In many cases, this had led to them using them only intermittently – or not at all.

“And then the batteries go... and one goes and the other doesn't... and then you have to change them... and it's just being fussy I suppose... and getting used to how loud you get them... until you get used to turning the mic down.”

(Philip, hearing aid wearer)

Similarly, another resident reported that earwax made her hearing aids less effective and, as a consequence, she doesn't wear them all the time:

“I haven't put them in all the time because one of them doesn't work very well with the wax and that, so they are a help for some things, but not an awful lot, not as much as I thought they would be.”

(Alice, hearing aid wearer)

Similarly, even where they registered high levels of appreciation of their hearing aids, some residents reported that they still

experienced difficulty hearing when wearing their hearing aids. For example, one resident reported difficulty hearing in a crowd and hearing family members if they're not talking to her directly:

“If I'm in a crowd, you know... or when I used to sit at the table with my son and daughter-in-law when they were talking between themselves, I'd no idea what they were saying.”

(Caroline, hearing aid wearer)

7.1 Difficulties around memory loss or confusion

We also observed or were told about the specific difficulties residents had, linked to memory loss or confusion.

For example, staff reported that one resident forgot that she had been diagnosed with a hearing loss; while another resident was fixated on wearing his hearing aid in the wrong ear. The risk here is that staff eventually forget that the resident wears hearing aids and don't find out from them whether they'd like to wear them that day.

In terms of the hearing aids themselves, staff felt that people with dementia would find it hard to understand the controls. They also pointed out that these residents are likely to fiddle with their hearing aids, leading to the setting or the hearing aids themselves getting lost.

“With dementia as well they would probably sit and play, they would probably change settings.”

(Staff comment)

“We have a couple who continually fiddle, you never know where it is, you can just spend all day trying to get it right.”

(Staff comment)

7.2 Hearing aid management

Hearing aids worked effectively for many residents and staff reported that they had no trouble in particular areas, such as putting hearing aids in. Similarly, members of staff not responsible for residents' personal care said that they would help when necessary, for example, if someone needed their hearing aid to be put back in when they were in the dining room.

But we also observed or were told about particular issues. While there can be problems with hearing aids – and they can appear complex – with the correct training and instructions, they should be easy to manage. The specific problems mentioned included:

Discomfort

While most residents reported that their hearing aids were comfortable, people occasionally experienced some discomfort:

“I find this one now... the earpiece... is making my ear sore.”

(Caroline, hearing aid wearer)

Whistling

During the interviews, we witnessed hearing aids that whistled. Both residents and staff also recognised that this happened. Whistling occurs where the hearing aid mould is not placed correctly in the ear or if someone's ear canal is blocked with wax.

“That one... it does whistle in the night.”

(Mary, hearing aid wearer)

“I was on duty a couple of weeks ago and I couldn’t pinpoint it at first and it was horrific, horrible, I thought where’s it coming from? You check everything; is it the microwave, something is on and I can’t find it?”

“I happened to go past a particular client, there it is, that’s what it is and it wasn’t quite fitting in properly so I put it back in, made sure it’s all right and turned it down a little bit and, I have to say, she was just having a fiddle around with it and I kept saying, ‘Can you hear that noise?’ It was just one of those days, she was just having a ‘whistley’ day!”

(Staff comment)

Being able to adjust their hearing aids

While staff put the hearing aids in for many residents, some residents do put theirs in. Both staff and residents highlighted their difficulty in knowing how to adjust them.

One resident said she’s unable to adjust the volume on hers:

“I mean, there is the button on the top but I’m afraid to push it because when I came in here my daughter-in-law didn’t give me the book that came with them which explained what to do, so I’m afraid to touch it.”

(Caroline, hearing aid wearer)

While staff found it easy to put hearing aids in, several said they were sometimes confused about the controls.

Staff member 1

“Well, it’s not the getting it in, it’s whether you know it’s switched on. Like you press the button so many times or something, don’t you, and hear different pips and things. The old sort of what I call the old-fashioned type, you know, where it’s sort of on/off or telly.”

Staff member 2

“The numbers.”

Staff member 1

“It’s easier and the numbers, yes, to turn it up or down. The digital one I would struggle with.”

Most members of staff learned about hearing aids on the job. They were also unaware of where the instructions leaflet would be kept.

“It’s not in the Standex because there’s two – there’s the Standex care plan for the Care Assistants and then, in the office, is a file which you keep for their prescriptions. I’d like to think it was in there.”

(Staff comment)

This suggests that staff could well benefit from having accessible information about hearing aids and more structured training around how they work. As we outlined earlier, staff also highlighted the need for information to be in a format that can be shared with families.

“I think any information would benefit us and we can get it to the clients’ families. It’s good because we’re then sharing the information, we’re showing it not just to the clients, but to their families as well and to the rest of the team.”

(Staff comment)

Similarly, a member of staff made the point that any leaflets about hearing aids should be somewhere the resident and their family can access them.

Replacing tubes and batteries

Residents occasionally reported (or we observed) that some hearing aid tubing or batteries needed to be replaced. The tubing had become stiff, which makes the hearing aid work less effectively because sound does not transmit down the tubes well.

“I used to go to [name] and they would replace the tubes but I haven’t had them done lately... I don’t know the last time they were done but they do feel a bit stiff”

(Brian, hearing aid wearer)

This is of concern because many residents may not be aware that the tubing or the batteries need replacing.

In some cases, care homes reported a routine for replacing batteries regularly, to ensure that this doesn’t happen.

“If you’re talking to a client and it’s obvious they haven’t heard a word you’ve said, we’ll check that it’s turned on for a start, then we’ll change the batteries; anyway, we usually do them every couple of weeks now.”

(Staff comment)

However, in other cases, staff reported relying on residents to tell them when the batteries needed changing. For example, when asked how they knew that people needed their batteries changing, staff replied:

“Sometimes they say they can’t hear you.”

(Staff comment)

It may be that batteries are routinely checked and, at the same time, that staff react if a resident indicates that their batteries are not working. It’s important that both of the above are happening in all care homes. It is particularly important to ensure that this is still happening for residents who only wear their hearing aids intermittently.

While many staff had experience of replacing hearing aid tubing, one of the care homes was also dependent on ad hoc arrangements:

“We have got a client with us here now whose daughter can do that, she’s volunteered her services so I think anybody that knows [name] now will be asking [name] to do that for them – so yeah, we’ll probably be asking her and I’m sure she’ll be more than happy to show us how or to do it for us.”

(Staff member)

However, we recommend that several members of staff in each care home be trained to replace hearing aid tubing so that there’s always someone on hand to do it.

Our Hear to Help services support people to carry out basic hearing aid maintenance, such as replacing tubes and batteries. In some areas we provide this service to care homes.

Relying on staff to put hearing aids in
As already pointed out, while some residents put in their own hearing aids, others rely on staff or family members to do this. Some residents do not ask for the help that they need in this respect.

One resident explained that he did not wear his hearing aids every day. When asked when he does wear them, he responded:

“When somebody asks me... helps to put them in... and get me all right... my eldest son, he understands it a bit more.”

(Jack, hearing aid wearer)

Another resident reported that her hearing aids fell out repeatedly and then she had to find a member of staff to put them back in for her.

“Because when I turn out those things then I’ve got to get somebody to put them back in.”

(Eva, hearing aid wearer)

Lost hearing aids

Occasionally, residents or staff reported that hearing aids were lost.

“Well, as far as I know, I can’t remember but I had one and they took it to have something done to it, my other one was here in the box and it disappeared. They searched high and low but can’t find it and, of course, the other one is with somebody being looked at. Who they are, I don’t know.”

(Florence, hearing aid wearer)

Of course, this issue is complicated by the fact that residents themselves may lose their hearing aids. But it’s important that care homes keep track of hearing aids and that they obtain replacements when necessary.

Hearing aids being sent for repairs for long periods of time

Both residents and members of staff had had experiences where hearing aids had been sent off for repairs for an unreasonable length of time. This is a real problem if a resident depends on their hearing aids, particularly if no one tells them when they can expect to have them back.

“We would send it off and it normally comes back in three to four weeks. It could be better.”

(Staff comment)

“Hers were broken so we rang audiology for an appointment to go and have them fixed and that took a few weeks. Then they were private ones so he said I can’t do anything with these, you’ll have to be referred for a full hearing check and we can give you some new ones.”

(Staff comment)

7.3 Additional difficulties reported by staff

Cleaning

While some members of staff found cleaning the hearing aids straightforward, others had trouble cleaning the tubes.

“It’s the tube that I find frustrating because we haven’t got anything small enough to go up the tube, but the actual hearing piece itself we can wipe over with a damp cloth, that’s easy to clear.”

(Staff comment)

While you can use soap and water to clean the tubes, there are special kits that make it easier.

Wax

Staff reported – and we observed – high levels of wax that partially or completely blocked residents’ ears. While this is not

uncommon for older people, it can make it more difficult to hear and can also mean that hearing aids do not work effectively. It also makes it more difficult for an audiologist to take a new mould for hearing aids.

Some care home staff reported that checks for wax are not done on a regular basis:

“People with hearing aids – surely they need to be having their ears checked for wax regularly, because their hearing aids won’t work if they’ve got wax, will they? But I don’t really feel that that is done on a regular basis; it’s not until a problem is highlighted.”

(Staff comment)

There were also reports of confusion as to whether the district nurse would syringe people’s ears to get rid of wax build-up.

Staff member 1

“Well, I mean now they’ve stopped syringing haven’t they? Syringing the ears?”

Staff member 2

“We’ve got one who, it was on the ... but now she’s on something different for a month and then she shouldn’t go back into hospital because she has got a blockage.”

Staff member 3

“Now they’ve put her on, is it bicarbonate of soda? And she’s got an appointment that’s come through for her to have microsuction, because we went to the nurse again after goodness knows how many weeks of olive oil. She tried with one ear because there was wax in it, but because she could partially see her eardrum she wouldn’t syringe it.”

Interviewer

“Why didn’t she want to syringe it?”

Staff member 3

“Because that’s dangerous, she said.”

Again, this is a tricky area. In some cases, medical staff will decide that syringing is not the best approach to wax management. Without knowing the details of specific cases, we cannot make any judgement, but staff would benefit from some clarity regarding local protocols around wax management, both at their local GP surgery and within the care home.

8. Training needs

Members of staff had had relevant training. For example, many had studied for an NVQ that had a strong emphasis on communication and covered several areas of care, such as sight and incontinence.

Members of staff highlighted as particularly successful some dementia training, which made them consider particular day-to-day activities from the resident's point of view. For example, how might someone with dementia feel if someone comes into their room?

“It opened your eyes as to how people were feeling. They were talking about going into somebody’s bedroom and, probably with dementia, that’s their home, and they’ve just got strange people walking in. How they must feel, things like that.”

(Staff comment)

Similarly, a member of staff talked about some training that made her consider the importance of personal space and how this might play out in different situations – for example, when someone is in a wheelchair or in bed.

“About personal space, that was really interesting, because you don’t realise, when you’re stood up there, chatting away, that’s fine, personal space, everyone knows that, but if you’re sat there in a wheelchair or on a bed, there’s nothing more frightening than someone looming over you, so you need to bring yourself down to that level, but you don’t always think about that.”

(Staff comment)

What both of these training courses have in common is that they encourage staff to put themselves in the resident's shoes and then apply this knowledge to situations as they arise in the care home.

Another member of staff highlighted how this should be replicated in terms of hearing loss.

“You need to get over how important it is really, hearing, and what it must be like to lose that sense.”

(Staff comment)

There was also support for a practical aspect to the training, with staff being able to put skills into practice during the training or shortly after the training.

There was no real consensus about particular aspects of training such as the format (for example, online or a DVD), whether there should be a test and certificate, or whether staff wanted role-play included. It is likely, however,

that training around these issues will be most effective if it is integrated, as far as possible, with other training.

Similarly, any training should highlight the importance of communication as a precursor to effective care. If hearing loss is managed effectively, other issues, such as safeguarding and pain can be managed more effectively.



Andy Gallagher

Conclusion and recommendations

Our research shows that diagnosing and managing hearing loss in care homes is challenging, but crucial. Attributes particular to this setting, such as high levels of dementia and low levels of conversation, can work against residents recognising and taking action on their hearing loss. At the same time, the high incidence of other conditions, such as sight loss and dementia, mean that it's extremely important that hearing loss is managed in these settings, as unmanaged hearing loss can make difficulties caused by such conditions much worse.

Where residents had been diagnosed with hearing loss, usually this had happened before they came to the care home. This, along with residents' unwillingness to take action on their hearing loss, suggests that, in practice, it is more difficult to diagnose hearing loss once someone is in a care home where other complicating factors such as dementia may be present. In turn, it may be more effective to diagnose hearing loss before someone enters a care home setting.

These findings support our calls for early intervention – for example, the introduction of a hearing-screening programme for over 65s, so that hearing loss is diagnosed earlier. This will mean that people have the opportunity to assess their hearing loss and get used to their hearing aids before they go to live in a care home.

We recently commissioned a cost-benefit analysis of just such a hearing-screening

programme, which showed that the benefits of hearing screening for older people clearly outweigh the costs. At a cost of £255m over 10 years, a hearing-screening programme for over 65s could save £2bn, representing a benefit cost-ratio of more than eight to one¹⁰.

However, it is essential that, as an organisation, Action on Hearing Loss continues to push for the diagnosis and management of hearing loss in care homes, recognising and meeting the challenges in such settings.

Key themes to emerge from this piece of research were relatively high levels of undiagnosed hearing loss and residents' unwillingness to take action on their hearing loss. Specific factors that deterred residents from action included the normalisation of hearing loss, particularly in terms of age. These also included the comparison of their hearing loss with other conditions, something that appears to lead residents to underestimate the level of hearing loss, and practical issues.

The research also noted additional context, such as very low levels of conversation in care homes, something that suggests that those factors that typically motivate us to hear better may not be so compelling in these settings.

We were able to make some limited observations about the impact of hearing aids on quality of life. However, the fact that some residents with hearing loss

¹⁰ RNID and London Economics, *Cost Benefit Analysis of Hearing Screening for Older People*, RNID, London, 2010

registered very high levels of appreciation with their hearing aids suggests that these have made a difference to their quality of life. Similarly, although we only observed a small number of people, it was clear that the people who were very engaged in the social life of the care home tended to be hearing aid wearers.

The research found that care home staff manage some aspects of hearing loss very effectively. There were robust processes in place for the recording of hearing loss, although, in some cases, staff relied on memory or a resident informing them to know who wears hearing aids.

Similarly, staff have good knowledge around communication tactics for people with hearing loss and use these effectively. They also demonstrated an awareness of the impact of background noise and, in some cases, take approaches to minimise this. However, it is important to ensure that certain processes, such as recording and reading notes around hearing aids and the minimising of background noise, happen routinely.

There were mixed levels of hearing aid use, with some residents relying on them while others felt that they did not make enough difference to their hearing or they simply could not manage the controls.

While staff found particular aspects of hearing aid management straightforward, both residents and staff noted issues such as whistling, difficulty using the hearing aid

controls and lost hearing aids. Similarly, the fact that, in some cases, hearing aids were sent away for repairs for a period of weeks caused frustration among both residents and staff.

While there is scope for some aspects of hearing aids to go wrong and they can seem complex, the correct training and instructions can make them easier to manage. Similarly, it is relatively straightforward to train staff to replace the tubing on hearing aids and undertake simple repairs.

While one of the care homes had induction loops in the reception area and the communal areas, staff in other care homes reported that these homes did not have loops. Similarly, knowledge and use of equipment that can benefit people with hearing loss was low.

Both of the above are relatively straightforward to address compared with much more complex issues such as low levels of conversation and a lack of motivation to address hearing loss. It is important that, in the first instance, the more straightforward areas, such as hearing aid maintenance, are addressed to enable those people who do want to manage their hearing loss to obtain the full benefit from their hearing aids. Similarly, it is essential that the risk of losing hearing aids is minimised and there are clear processes for obtaining replacements for lost hearing aids.

We are producing a briefing and written information for care homes, which will cover the following:

- Recognition, diagnosis and documentation of hearing loss
- Communication tactics and management of background noise
- Induction loops and assistive technology
- The operation and maintenance of hearing aids.

We will produce guidance for doctors, audiologists and community nurses around the effective management of hearing loss, and wax management, in care homes.

We're asking for:

The government and public health bodies:

- to introduce an adult hearing screening programme for over 65s
- to recognise hearing loss as a major public health issue, embedding strategies to prevent and reduce its impact in national and local public health plans.

GPs and community nurses:

- to recognise the importance of early diagnosis, and provide timely referral to audiology and hearing services
- to integrate hearing checks and effective management of hearing loss into the health services provided to care home residents, including routine health assessments.

GPs, audiology and ENT departments:

- to make sure systems are in place to conduct hearing checks and hearing aid maintenance in care homes
- to establish local systems around wax management so that harder-to-reach groups, such as care home residents, are able to access services such as syringing.

The Social Care regulators (the Care Quality Commission [England], and the Regulation and Quality Improvement Authority [Northern Ireland]):

- to raise awareness of people with hearing loss in residential care
- to include communication in their standards – these are the standards that individuals can expect from all adult care services. They currently include areas such as safety and dignity.

This work has already started in Wales while the National Care Standard in Scotland includes a standard around communication needs. We are calling for the regulators in England and Northern Ireland to build on this approach.

Care homes:

- To make sure that their staff receive training so that they understand and meet residents' communication needs.
- To have clear procedures around assessment and recording of hearing loss and to ensure that staff follow these.
- To ensure that staff know how to recognise hearing loss and what they can do if they think that a resident has an undiagnosed hearing loss.
- To consider and manage environmental factors, such as seating arrangements and background noise, that affect residents' ability to hear.
- To ensure that staff are aware of communication tactics for people with hearing loss, and that they use these.
- To use induction loops and assistive technology to support residents where this will enable them to hear better.
- To ensure that staff understand how to use hearing aid controls, such as the volume control and the 'T' switch.
- To ensure that hearing aids are effectively maintained and batteries are replaced as appropriate.
- To minimise the number of lost hearing aids, and to ensure that lost hearing aids are replaced as quickly as possible.
- To consider how training can deliver an appreciation of what hearing loss feels like.
- To assess residents' hearing when they enter their care home.

Appendix A

Methodology

This research had three stages:

- hearing screening with those residents who had not been previously diagnosed with a hearing loss
- qualitative interviews with residents
- focus groups with staff.

Recruitment of participants

Screeners and qualitative interviews with residents

Staff in the three care homes were asked to 'recruit' residents who were interested in taking part in the research. Residents were provided with an information sheet that summarised the purpose of the research, and explained what participants could expect and how we would use any findings. This also covered areas such as confidentiality. A consent form was also given to residents for their signature.

Staff focus groups

Similarly, staff were given detailed information and asked to sign a consent form.

Research methodology

Hearing screening

We offered a hearing check, using a handheld screener, to all people in the care homes who did not wear hearing aids in order to capture the number of people with undiagnosed hearing loss.

We conducted the hearing check with 20 residents.

The screening instrument we used was the Siemens HearCheck screener. This is a handheld plastic instrument that is held against each ear for each participant. Six tones are sounded and the participant indicates with their hand when they hear each tone. This screener was used at a frequency of 1kHz and 3kHz to test the ability to hear at 75dB, 55dB and 35dB. Research has shown that the threshold of 3kHz and the ability to hear at 35dB were the best predictors of benefit from hearing aids¹¹.

The HearCheck screener is not a diagnostic test, as someone with a hearing loss would subsequently need to undergo pure tone audiometry. However, it has a proven capacity to predict the need and benefit of hearing aids. An evaluation of this instrument against pure tone audiometry demonstrated that it has a positive predictive value of 87%.

Therefore, the screener was sufficiently accurate to enable the capture of levels of undiagnosed hearing loss.

Where the screener suggested that a resident had some hearing loss, we suggested that they request a referral by their GP to audiology.

¹¹ Davis, A et al. 'Acceptability, benefit and costs of early screening for hearing disability: a study of potential tests and models'. *Health Technology Assessment*, vol II: 42, 2007.

¹² Parving et al. 'Evaluation of a Hearing Screener', *Audiological Medicine*. 2008; 6: 115_119.

Interviews with residents

This research adopted a qualitative methodology of face-to-face interviews with residents. Qualitative methods are ideal for exploring people's experiences and the meanings that these experiences hold for them.

Social research is either quantitative or qualitative. Quantitative research typically takes the form of a survey and is used to measure experiences and beliefs, producing numerical data. Qualitative research typically takes the form of in-depth interviews or focus groups and is used to gain an insight into people's lives and the processes that inform their behaviour and experiences. We selected a qualitative methodology for this research in order to explore residents' attitudes to hearing loss and their experiences of hearing loss in the context of their daily activities and experiences. These findings would not have been so accessible using a quantitative methodology. However, while this type of qualitative research enables us to identify the range of people's experiences, it does not look to produce statistics.

Twenty-five interviews took place between March and April 2011. The breakdown of participants was as follows:

- 13 hearing aid wearers, of whom nine were female and four were male.
- One person for whom the hearing check's result was borderline, who was male.
- 11 people for whom the hearing check suggested they had a hearing loss.

The interviews took place in the care homes. We recorded the interviews, as agreed by the participants.

Focus groups

We conducted focus groups with 15 members of care home staff. These also took place in the care homes and were recorded, as agreed with the staff.

Analysing and interpreting the findings

Written transcriptions of the data from the interviews were undertaken to provide a full, anonymised record of each interview, and a summary of the remaining interview. Each of these transcripts was then coded in terms of emerging themes. This report outlines findings from the information provided by the people who chose to take part in this study. We have drawn out themes on the basis of what the participants said and remembered during the interviews.

We have included quotations in the report in order to illustrate some of the themes that emerged. These quotations are taken directly from the verbatim transcripts of the research. All the quotations are anonymous.

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