Inter-professional teamwork and hearing care for older adults with cognitive loss

BY KATE DUPUIS, MARILYN REED AND KATHLEEN PICHORA-FULLER

There is growing awareness that hearing loss is linked to dementia [1]. The average first-time hearing aid user is about 70 years old. By this age, approximately 1 in 2 people have hearing loss and 1 in 7 have cognitive loss. There are pressing needs for hearing healthcare professionals (HHCP) to a) increase their own understanding of how these losses combine to affect the lives of older people and b) work with other clinicians so that appropriate care is provided to older adults who have comorbid impairments. HHCP can strengthen inter-professional teamwork by working with other healthcare professionals to achieve the following:

Factor hearing loss into cognitive assessments

Primary care professionals are often the first to be consulted regarding concerns about cognition and / or hearing. All too often, the importance of hearing loss may be discounted because hearing problems are considered to be simply ear problems. Sometimes complaints about hearing difficulties receive little attention because hearing loss is considered to be 'normal' for older people. HHCP need to deliver the message to other clinicians that hearing loss can influence many aspects of health because it hampers communication and social interaction, which are key ingredients of an active and healthy lifestyle [2]. Indeed, hearing loss can increase the risk and exacerbate the functional consequences of other age-related health conditions, in particular dementia.

It may be difficult for clients, family members, primary care providers, or even geriatricians to disentangle the effects of hearing loss from the effects of cognitive loss because both can affect how well individuals function in everyday life and also how well they perform on cognitive screening tests [3]. HHCP are uniquely positioned to raise awareness that accurate cognitive assessment must factor in sensory loss. Clinicians who are not experts on hearing should be encouraged to screen for hearing loss using methods appropriate to their situation. Screening may begin by asking, "Do you have difficulty conversing in a group or when it is noisy? Do people seem to mumble? Do others complain about your hearing or say you turn the television up too loud?" Because cerumen build-up can reduce hearing and the effective use of hearing aids, with consequences to communication and cognitive functioning [4], HHCP should advise other clinicians on how to check for cerumen and develop protocols for referral. HHCP can also encourage other clinicians to be more alert to hearing loss and its consequences when recommendations and decisions about care are being made. It should not be assumed that if a client does not own hearing aid(s) then he / she does not have trouble hearing, or that owning a hearing aid has solved all hearing problems, or that there are no other options available if a person does not want, or is not a good candidate for, a hearing aid. Inadequate knowledge about hearing loss and options for its treatment may prolong delays in help-seeking which can be a decade or more [5].

Delaying intervention for hearing loss may, in turn, have negative effects on cognitive health by exacerbating the symptoms of dementia or possibly even accelerating the rate of cognitive decline. HHCP can encourage other clinicians to make referrals based on current knowledge of treatment options so that the hearing problems of older individuals are addressed promptly and appropriately.

Increase knowledge of treatment options to guide referral

Clients who report hearing problems or who have suspected hearing loss should be referred to an appropriate HHCP, especially since hearing loss is potentially a modifiable risk factor in the progression of cognitive decline. Referral for a hearing aid evaluation may be an obvious option, but it should not be the only option that is considered [6]. Provision of a hearing aid may not be a sufficient or even the most appropriate option for all individuals. Clients may be better served by an audiologist who isn't 'just focused on fitting a hearing aid, but also on ensuring that the patient can communicate effectively in all settings' [7]. Some older adults may not want hearing aids, perhaps due to cost, self-stigma, fear of stigmatisation by others, or other reasons [8, 9]. Many may be open to additional rehabilitation options, such as learning strategies to improve communication. They may benefit from using assistive listening devices to amplify specific sound sources (e.g. television), to improve home safety (e.g. visual alerting devices to signal sounds such as the doorbell, phone ring, fire alarm), or to enable participation in group activities (e.g. FM system). For those who already have a diagnosis of mild cognitive impairment or dementia,

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family members / caregivers may also benefit from knowing about options that could be helpful for maintaining communication, which in turn could reduce problem behaviours [10] and alleviate caregiver burden [3].

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Complex decision-making about when to offer which treatments to a person who has both hearing loss and cognitive loss will depend on the individual's abilities and comorbid health issues (e.g. vision, mobility, etc.), as well as the support available from family and others. Of utmost importance are the person's communication needs, the needs of family members / caregivers, and their readiness for various rehabilitative options. HHCPs should actively share knowledge about a full range of technological, behavioural and environmental hearing care options with other clinicians working with older adults. More effective solutions and improved quality of life for these older adults may be achieved by strengthening inter-professional collaborations and teamwork.

Make healthcare hearing accessible

Hearing accessibility is important in almost all healthcare contexts so that clients who are hard of hearing benefit as fully as possible from information that is given by clinicians. Hearing accessibility is also important to ensure that test results are not compromised by difficulty hearing instructions or test items (e.g. repeating words in a memory test). HHCPs should encourage other clinicians to increase hearing accessibility by adopting strategies to optimise communication when services are delivered to individuals with suspected and / or identified hearing loss. Strategies to accommodate hearing loss include optimising the environment, using appropriate technology, and / or adopting communication behaviours to facilitate speech understanding.

A quiet environment will make listening easier by minimising masking and distraction by competing sounds. A well-lit environment will make speech-reading easier and improve attention. Clinicians can actively promote good communication by encouraging the client to use their sensory aids (hearing aids, glasses). Basic hearing aid trouble-shooting skills and a supply of spare batteries may be helpful if a client has a hearing aid that does not seem to be working. If the client has hearing problems and does not have an amplification device, the clinician can offer to use an assistive listening device (e.g. Pockettalker, Williams Sound). Perhaps most importantly, clinicians can learn to improve communication by altering their own communication behaviours, including speaking slowly and clearly, keeping sentences short and simple, using plain language, providing supplemental visual materials, and verifying that information was correctly understood by asking for it to be repeated. Clinicians should face the client, speak at their physical level (i.e. don't talk 'down' to individuals in a wheelchair), maintain eye contact, and use appropriate body language.

Staying on topic and providing clear transition statements between topics (e.g. "Now I am going to test your eyesight") will boost comprehension by helping the listener to use prior knowledge and expectations. Scheduling more frequent but shorter appointments and involving a family member / caregiver may also ease communication by reducing stress and information overload. In general, these tips for enhancing communication could be used with any older client, and they are particularly useful for those who are hard of hearing, especially if they may also have cognitive loss. However, accommodation must be individualised rather than simply applying ageist stereotypes ('elderspeak') during communication [11]. HHCPs can play an important role in coaching other clinicians to use appropriate communication techniques for specific individuals by including relevant information about his / her auditory abilities and communication needs in referrals, reports, and when sharing information verbally or in written entries in medical charts.

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